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Information

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What is the iLinkBLUE Provider Suite?

Blue Cross and Blue Shield of Louisiana's iLinkBLUE *Provider Suite* is our secure online tool for facility and professional healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, and payment queries and transactions. With iLinkBLUE, providers have access to features such as:

- coverage information
- claims entry
- claims research
- allowable charges
- authorizations
- remittance advice/electronic funds transfer (EFT)
- BlueCard® (out-of-area network)
- manuals
- medical policies
- medical code editing
- estimated treatment costs
- and MORE!

iLinkBLUE is FREE of charge for ALL providers. To gain access to iLinkBLUE, you must complete the appropriate iLinkBLUE agreement packet. The iLinkBLUE provider agreement packets are available online at www.bcbsla.com/providers >Electronic Services >iLinkBLUE:

- Professional Provider Agreement Packet
- Institutional Provider Agreement Packet
- Billing/Collection Agency Agreement Packet

Each packet includes a Business Associate Agreement that allows Blue Cross to receive and disclose protected health information electronically via iLinkBLUE. Each packet also includes an Electronic Funds Transfer (EFT) Form. EFT is required as a part of iLinkBLUE, and allows us to have your payments directly deposited into your financial account.

In this newsletter, we explore the many functions of iLinkBLUE, so please share this newsletter with your billing staff and those in your office who use iLinkBLUE.

The MESSAGE BOARD

iLinkBLUE contains a bulletin board feature that appears after you first log in. This area contains up-to-the-minute posts for upcoming events, new features, system outages, holiday notices and other important bulletins.

In 2013, we added a new feature to the message board that gives you an alert message when there are open BlueCard® (out-of-area) medical record requests for your patients. You can access current and worked requests by clicking on the link in the alert message or from the [Medical Record Requests](#) option on the iLinkBLUE menu.



You have **15 New Medical Record Requests**. Please visit [Medical Record Requests - Out Of Area](#) menu to view the requests.

CONTRACT # SEARCH

Blue Cross uses unique identifiers called member identification (ID) numbers in place of using members' Social Security numbers. This is to prevent identity theft and protect member privacy. While Blue Cross requires the member ID number for eligibility and benefits verification and claims processing, we also understand that, at times, members may not have their ID card available. For this reason, there is a contract number search function available in iLinkBLUE where providers may search for a member's ID number using the Social Security number.

Choose the [Contract # Search](#) option from the iLinkBLUE menu, click on the SSN radio button, then enter the member's Social Security number and click the submit button. iLinkBLUE will return search results of the member ID number associated with that person when there is a match.

COVERAGE INFORMATION

When you click on the [Coverage Information](#) option on the iLinkBLUE menu, a sub-menu with four links is revealed.

These options are for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members only. Information is not available under these options for BlueCard® members.

- The [Coverage Summary](#) screen lists members on the contract, active and terminated, and allows you to view the member's Coverage Report (a detailed health benefit coverage summary that includes deductible and out-of-pocket amounts that have been met) and COB (coordination of benefits) information when the member also has coverage with another carrier.
- The [Eligibility](#) screen provides information on who is covered on the Blue Cross policy number entered, including the effective date and the status of the contract (active, pending, cancelled).
- The [Contract Benefits](#) screen includes a search function to research and view specific member benefits information based on key words such as wellness, diagnostic, etc.

This option is for Federal Employee Program (FEP) members only.

- The [FEP Benefits and Eligibility](#) screen shows copay, coinsurance, deductible, out-of-pocket, accumulation, contract status, effective/termination dates and other contract related information for FEP members only.



The CLAIMS ENTRY Option

Claims Entry

- UB04
- 1500
- Contract Prefix Validation
- Place of Service File

When you click on the **Claims Entry** option on the iLinkBLUE menu, a sub-menu with four links is revealed.

- The **UB04** and **1500** screens require a separate security access. Applicable providers may use these screens to directly file claims to Blue Cross. Please contact Blue Cross' EDI department at ilinkblue.provider.info@bcbsla.com or 225.293.5465 for

more information on filing claims directly through the iLinkBLUE *Provider Suite*.

- The **Contract Prefix Validation** screen verifies where you should directly file a member's claims based on the member ID alpha prefix. You must enter the member's alpha prefix, claim type (inpatient, outpatient or professional) and beginning date of service.
- The **Place of Service File** feature allows you to enter the place of service(s) once prior to filing claims in iLinkBLUE. Then, while filing claims in iLinkBLUE, your pre-entered place of service information can be auto-inserted on each claim using a drop down box in the place of service file. This saves you from having to re-enter the full place of service information on every claim.

CLAIMS RESEARCH

Claims Research

- Claims Status
- ITS Out of Area Claims
- Action Request Inquiry
- Check Information
- Claims Tracking

When you click on the **Claims Research** option on the iLinkBLUE menu, a sub-menu with five links is revealed.

- The **Claims Status** page provides information on Blue Cross and HMOLA paid, rejected and pended claims. Providers can view claims detail pages that display the amounts applied toward the deductible, ineligible amounts or coinsurance amount

for a specific claim. When you choose to view pended claims, an additional menu will prompt you to select a line of business (All, Federal, ITS BlueCard®, Reg BC, Supplemental) category. When 'All' is selected, you will be able to view all pended claims on file. On each claim, providers have the option to submit an Action Request when they have questions or concerns about the claim.

- The **ITS Out of Area Claims** screen provides the same claims information as the Claims Status page, but for BlueCard® (out-of-area) members only.
- The **Action Request Inquiry** screen allows you to view Action Requests submitted on any pended, processed or rejected claims. You may only view Action Requests submitted for your provider.
- After a claim is processed, a "check" (usually an electronic payment) is issued when a payment is due. Once the payment is issued, the specifics of the payment information are displayed on the **Check Information** screen.
- The **Claims Tracking** area displays claims that cannot be located in pended or processed claims and/or any applicable pre-admission certification information.



Blue Cross does not want our providers taking risks when it comes to advanced premium tax credit (APTC) members. For this reason, we are enhancing the iLinkBLUE *Provider Suite* to include Premium Grace Period notifications. These premium status notifications for BCBSLA's APTC members will be available in multiple places within iLinkBLUE so you can stay abreast of your Blue patients who are in the grace period and the possibility of denied claims for the second and third months.

For more information on this enhancement, view the October issue of HCRNews; available online at www.bcbsla.com/providers >News.

MEDICAL RECORD REQUESTS (Out-of-Area)

We've added a new BlueCard® feature to iLinkBLUE where you may now view BlueCard® medical records requests for your BlueCard® patients in iLinkBLUE by clicking the link on the message board (like the one at right) or directly from the iLinkBLUE menu under [Medical Record Requests](#).

You have **15** New Medical Record Requests.
Please visit [Medical Record Requests - Out Of Area](#) menu to view the requests.

Once on the [Outstanding Requests](#) page, second requests and reopened requests will be highlighted in red and will appear at the top of your outstanding request list. A second request is displayed when we have requested records more than one time and have not yet received records from the provider. A reopened request is used when we have received medical records from the provider but the records were either incomplete or had incorrect information.

You may also research the status of your medical records on the [Requests Completed By Provider](#) and [Requests Received by BCBSLA](#) screens. When sending medical records to Blue Cross, please be sure to print and include the Outstanding Requests detail page specific to the patient for whom you are sending us records. The Outstanding Requests detail page includes information such as your provider number and name, patient name and date of birth, date of service, claim number and an address for where to send the medical records.

ALLOWABLE CHARGES for Professional and Dental Services

With iLinkBLUE, you can look up your professional allowable charges by network, date of service and individual or multiple codes. Click on the [Allowable Charges](#) option on the iLinkBLUE menu. You will be prompted to enter a date of service. This is important because providers can search current, past or future (when available) allowables. Once you've entered a date of service, click the Continue button. You must then enter the appropriate network and code. Modifiers and site of service codes are optional. Once you've entered your information, press submit to obtain the allowable charge for the desired date of service and code. Please note that if you have a pop-up blocker, you will need to turn it off for this function. If you would prefer to research multiple allowables, enter only the first few numbers followed by an asterisk. [See chart at right.](#)

DID YOU KNOW? Dentists' allowable charges are shown on iLinkBLUE for dental codes when the Key Dental Network is selected in the network drop down box.

Professional Provider Allowable Charges

Please Select a Date: (YYYY-MM-DD)

Network:

CPT Code: An asterisk (*) can be used as a wildcard.

Modifier (Optional):

Site of Service (Optional):

(* Click on reset to change the date selected.)

Allowable Research Examples:

- 99214 - only shows the allowable for 99214
- 992* - generates a list of all codes starting with 992
- 99* - generates a list of all codes starting with 99
- 9* - generates a list of all codes starting with 9

Complete listing(s) of services that require authorization are available in the following manuals and speed guides:

- Professional Provider Office Manual
- Member Provider Policy & Procedure Manual*
- BlueConnect Speed Guide
- Community Blue Speed Guide
- HMOLA Provider Speed Guide
- Office of Group Benefits (OGB) Speed Guide
- Preferred Care PPO Speed Guide
- Premier Blue Speed Guide



Available online at
www.bcbsla.com/providers
>Education on Demand.

*Member Provider Policy & Procedure Manual is available only under the Manuals link on iLinkBLUE.

AUTHORIZATIONS

▶ Authorizations

Inpatient Authorizations
 Outpatient Authorizations
 American Specialty Health (AIM)
 — AIM Training Tutorial

The authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided. Authorization requirements may vary slightly by product. Providers should initiate the authorization process at least 48 hours prior to the service being rendered. You can research and view and even submit some authorization requests from iLinkBLUE using the **Authorizations** menu option.

- With the **Inpatient Authorizations** screen, providers may research the status of an inpatient authorization by entering the member's contract number. Information on your patient is then shown, including the status of the authorization. This option can also be used to view the status of recertification or requests for extended inpatient days. The initial inpatient authorization and the extended authorization will share the same authorization number and be listed on the same report for your patient.

Inpatient authorization is not a guarantee that benefits will be provided. It only certifies that the inpatient hospital setting is or is not medically necessary according to the information presented at the time of preadmission certification. Benefits will be determined upon receipt of claims in accordance with conditions and provisions of the subscriber's contract/certificate.

- The **Outpatient Authorizations** screen enables users to view the status of specific outpatient authorizations by entering the member's contract number or a referral reference number (assigned by Blue Cross' authorization department when the authorization process is initiated).

Authorizations for surgical procedures and/or diagnostic procedures include services for both the specialist (MD) and the facility provider. The two authorizations are combined into a single transaction. E.g. An authorization for a colonoscopy procedure will display two approved days. This means that there is one approval for the specialist performing the procedure and one approval for the facility where services will be performed. The authorization does not indicate two colonoscopy procedures have been approved.

- With the **American Specialty Health (AIM)** option (or "high-tech imaging" authorizations option), providers are redirected to an external site called the **ProviderPortal_{SM}** administered for Blue Cross by AIM. **Ordering physicians** must contact AIM for the authorization of the services for Blue Cross, HMOLA and Federal Employee Program (FEP) members. AIM conducts authorization services for the following outpatient, non-emergent imaging services:

- ✦ Computerized Tomography (CT) Scans
- ✦ Computerized Tomography Angiography (CTA)
- ✦ Magnetic Resonance Imaging (MRI)
- ✦ Magnetic Resonance Angiography (MRA)
- ✦ Nuclear Cardiology Procedures
- ✦ Positron-Emission Tomography (PET) Scans

The ordering physician (whether a primary care physician or a specialist) is required to provide AIM with basic clinical information and patient demographics and obtain a notification number. The PCP is not expected to obtain the notification number when the specialist orders the test. The facility that performs service(s) cannot obtain a notification number, but they can check the status of the notification request in AIM's **ProviderPortal_{SM}**. In addition to using AIM's **ProviderPortal_{SM}**, ordering physicians may also contact AIM directly at 1.866.455.8416. For more information on imaging authorizations, visit www.bcbsla.com/providers >Imaging Authorizations.

WHAT is the STATUS of your OPTINET® ASSESSMENT?

All network providers who provide imaging services are required to complete an assessment through OptiNet® and are required to maintain an 80 percent performance score on each modality performed. This includes hospitals, freestanding diagnostic centers and physician clinics. The information we gather is used to understand the quality of radiology services and/or future network programs. Once in iLinkBLUE, click on the **American Specialty Health (AIM)** link under **Authorizations**. Once in AIM's **ProviderPortal_{SM}**, click on "Access Your Optinet® Registration" on AIM's left menu, then click the green "Access Your Optinet® Registration" button. OptiNet® allows you to complete the assessment online. Remember to keep your information updated before it expires as this affects your score.

CONFIRMATION REPORTS

Under the [Confirmation Reports](#) menu option on iLinkBLUE, you can access daily reports that we generate to confirm claims that were accepted or not accepted by the Blue Cross editing system. Reports are available for up to 120 days.

Accepted Claims Reports

The next workday following the submission of your Blue Cross claims, you will receive an ACCEPTED CLAIMS report. This report confirms claims that were accepted and processed by the Blue Cross system. Claims (whether filed directly through iLinkBLUE or Blue Cross' provider download feature) accepted by the Blue Cross front-end editing system will be listed on your ACCEPTED CLAIMS report. It is very important that you check your NOT ACCEPTED claims report when a submitted claim DOES NOT appear on this report.

Not Accepted Claims Reports

Claims entered directly into iLinkBLUE will not be on the NOT ACCEPTED report as they must pass all edits to be accepted into our claims processing system at the point of entry. Claims entered through Blue Cross' provider download feature that are not accepted by the Blue Cross front-end editing system are listed on your NOT ACCEPTED claims report. These claims must be corrected and rebilled. A NOT ACCEPTED claim will NOT be found on the Blue Cross pending or processed screens found under the [Claims Research](#) menu option of iLinkBLUE as they've never been accepted into our claims processing system.

EFT NOTIFICATIONS

Electronic Funds Transfer (EFT) is a free service where Blue Cross deposits your payment directly into your checking account. By clicking on [EFT Notifications](#), you can access your latest EFT statements showing your most recent as well as past weekly payment transactions. A maximum of two (2) years of EFT notifications is available in iLinkBLUE. EFT notifications for the current week will automatically appear at the bottom of the screen. All lines of business (Blue Cross, HMO, OGB and FEP) will display and you may see EFT notifications for more than one NPI, depending on how many NPIs you have access to. Click the 'EFT Payment Message' link to preview an EFT notification or 'Print & Download' to create a printable PDF.

Please note that providers not enrolled in iLinkBLUE and EFT do not receive hardcopy payment registers as they are only available through iLinkBLUE.

REMITTANCE ADVICE

The [Remittance Advice](#) option allows providers to view remittance advices (commonly called payment registers). Reports for the current week will appear at the bottom of your remittance listing (separate reports for each applicable line of business; Blue Cross, HMO, OGB and FEP). Providers may view remittances for more than one NPI, depending on how many NPIs you have access to. Much the same as the EFT notifications, you may view or print remittances.



The [Remittance Advice Total](#) function is a tool that allows you to query and view the total payment from all of your remittances (Blue Cross, HMOLA, OGB and/or FEP, as applicable) for a given week.

Like the EFT notifications, remittances for a maximum of two years are available in iLinkBLUE. Remittance advices may also be saved as electronic copies directly from iLinkBLUE to your computer.

BLUECARD® - OUT OF AREA

- ▶ BlueCard - Out of Area
 - Coverage Information Request
 - Coverage Information Response
 - Claims Research Request
 - Claims Research Response

iLinkBLUE includes the option to request eligibility and benefit inquiries for both out-of-area Blue Plan and National members. It is located in the iLinkBLUE menu under [BlueCard® - Out of Area](#).

- The **Coverage Information Request** and **Response** options are used to submit an electronic request to the member’s Blue plan then wait for an electronic response to be delivered. Though not immediate, out-of-area results are transmitted usually within less than a minute. Click on Coverage Information Request, then enter the member’s three letter alpha prefix, contract number and required patient information fields then press submit. You will receive a message stating “transmission submitted successfully.” To view response, click on Coverage Information Response, then choose the “Review New” button to view new responses. Locate the member’s contract number to view and print requested information.
- The **Claims Research Request** and **Response** options allow you to request out-of-area claims information in the same manner as when requesting coverage information. You will need the member’s alpha prefix and the contract number. Please note that more information (such as remittance advices, check information and claim numbers) on BlueCard® claims processed by Blue Cross and Blue Shield of Louisiana is available through iLinkBLUE’s [Claims Research](#) option.

MANUALS

- ▶ Manuals
 - Claims Inquiry
 - BlueCard
 - Clear Claims Connection
 - Dental
 - Hospital
 - Professional
 - Allowable Charges

When you click on the [Manuals](#) option on the iLinkBLUE menu, you will find much more than manuals.

The **Claims Inquiry Manual** provides step-by-step details on the many functions of iLinkBLUE outlined in this newsletter.

The **BlueCard®** link gives you access to *The BlueCard® Program Office Manual*, which is designed to provide information to aid you in servicing members of a Blue Plan other than

Blue Cross and Blue Shield of Louisiana. The *BlueCard® (Out-of-Area) Tool User Manual* provides step-by-step instructions on using the **BlueCard® - Out of Area** function highlighted at the top of this page. The ITS Overpayments Notification form is a printable PDF form that providers should complete when they feel an overpayment has been made to a BlueCard® member’s claim.

The **Clear Claims Connection Manual** provides step-by-step details on the many functions of the Clear Claims Connection tool that is outlined on Page 9 of this newsletter.

The **Dental** link gives you access to *The Dental Network Office Manual* and *Dental Network Speed Guide*, as well as printable PDFs of the FEP Standard Option Dental Allowables Listing and FEP Basic Option Dental Allowable Listing.

The **Hospital** link is accessible by facility providers only. This is the only location that Blue Cross houses the *Member Provider Policies & Procedures Manual*.

The **Professional** link gives you access to the *HMOLA Provider Manual* and *Professional Provider Office Manual*. These manuals are extensions of your Blue Cross and HMOLA network agreements. Also available is the *1500 Claims Entry Manual* which can be used in conjunction with filing claims in iLinkBLUE as outlined on Page 3 of this newsletter.

The **Allowable Charges** link houses printable PDF listings for the two most recent Drug Allowable Charge updates, including pricing for standard, durable medical equipment (DME), home infusion, Oncology Management Program and administration drug codes. Also available on this page are the HCPCS allowable charge listings for DME.

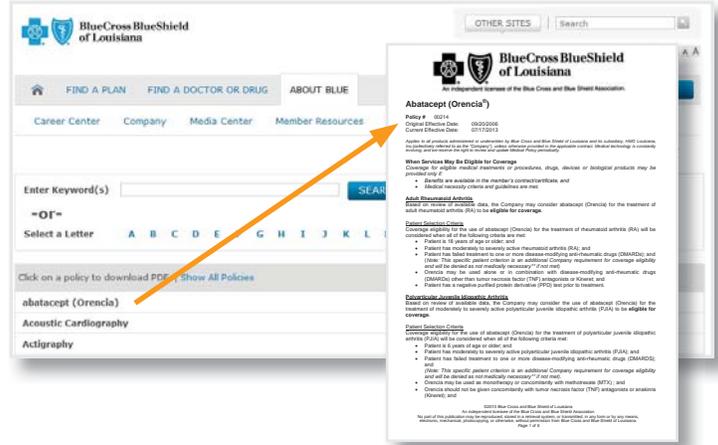
MEDICAL POLICY COVERAGE GUIDELINES

Researching medical policies online is easy with iLinkBLUE. Providers can search for approved and current medical policies. Using the [Medical Policy Coverage Guidelines](#) menu option, providers may view medical policies for our (BCBSLA) members as wells as BlueCard® ([Out-of-Area](#)) members.

▶ Medical Policy Coverage Guidelines

BCBSLA Out-of-Area

- Providers can easily research medical policies for BCBSLA members using an index that lists policies in alphabetical order. Each month, we add newly approved and/or revised medical policies to iLinkBLUE. Because medical technology is constantly evolving, our medical policies are regularly reviewed, often resulting in updates or revisions, so check iLinkBLUE frequently for the latest and most current policies.
- To view medical policies for BlueCard® (out-of-area) members, you must know the member's alpha prefix. After entering the member's alpha prefix, you will be routed to the member's Blue Plan to access their medical policy information. The format for researching medical policies varies from Blue Plan to Blue Plan.



Out-of-Area Medical Policy Coverage Guidelines

To view the out-of-area Blue Plan's medical policy information, please enter the first three letters of the member's identification number on the Blue Cross Blue Shield ID card, and click "Submit".

Alpha Prefix

Overview Coverage Guidelines UM Guidelines Search

By Category

Coverage Guidelines

Sample of one Blue Plan's Medical Policy format.

PRE-AUTHORIZATION/PRE-CERTIFICATION INFORMATION

The [Pre-Authorization/Pre-Certification Information](#) function on iLinkBLUE allows providers to research and view authorizations for BlueCard (out-of-area) members. Like researching medical policies for BlueCard members, you must enter the member's alpha prefix to be routed to the member's Blue Plan.

Pre-Authorization/Pre-Certification Information

To view Blue Plan's general pre-authorization/pre-certification information, please enter the first three letters of the member's identification number on the Blue Cross Blue Shield ID card, and click "Submit".

Alpha Prefix

MEDICAL CODE EDITING (CLEAR CLAIM CONNECTION)

Medical Code Editing

Clear Claim Connection

The **Medical Code Editing** menu option is home to the **Clear Claim Connection (C3)** tool. C3 is an easy-to-use Web-based code-auditing reference tool designed to audit and evaluate code combinations. C3 is a self-service inquiry tool to help reduce manual inquiries and time-consuming appeals. C3 also indicates whether or not a CPT®, Modifier and/or CPT/Modifier combination is valid for the date of service entered on the inquiry.

After clicking on Clear Claim Connection, you must accept the terms and conditions.

Note: Be sure to disable your pop-up blocker when using this tool. You are then routed to a web-based tool administered by McKesson Corporation. The first screen you encounter is the 'Claim Entry' screen. You will need to enter the patient's gender and date of birth, procedure codes, date of service and any applicable modifiers. You may enter up to 10 procedure codes per query.

Example 1

The patient is a male, born January 1, 2000, and the provider performed two procedure codes (99203 and 30200) on December 15, 2013.

Claim Entry

Gender: Male Female
 Date of Birth: 01/01/2000 (mm/dd/yyyy)

Procedure	Date of Service	Mod 1	Mod 2	Mod 3	Mod 4
99203	12/15/2013				
30200	12/15/2013				
	__/__/__				
	__/__/__				
	__/__/__				

[Add More Procedures>>](#)

After entering the patient's information and codes, click the 'Review Claim Audit Results' button. When the codes are compatible, no edit results are generated.

Claim Audit Results

Gender: Male Date of Birth: 1/1/2000

Recommend	Procedure	Date of Service	Description	Modifiers
Allow	30200	12/15/2013	INJECTION TREATMENT OF NOSE	
Allow	99203	12/15/2013	OFFICE/OUTPATIENT VISIT NEW	

C3 includes the following edits or overrides as they apply to a single code or code pairs:

- Modifier 25, 59 and 57 Edit Overrides
- Age Edits
- Gender Edits
- Duplicate Edits
- Mutually Exclusive Edits
- Incidental Edits
- Visit Processing Edits
- Assistant Surgeon Edits
- Pre/Post Op Processing Edits

Example 2

The patient is a male, born January 1, 2000, and the provider performed three procedure codes (99203, 30200 and 99001) on December 15, 2013.

Claim Entry

Gender: Male Female
 Date of Birth: 01/01/2000 (mm/dd/yyyy)

Procedure	Date of Service	Mod 1	Mod 2	Mod 3	Mod 4
99213	12/15/2013	25			
30200	12/15/2013				
99001	12/15/2013				
	__/__/__				
	__/__/__				

[Add More Procedures>>](#)

After entering the patient's information and codes, click the 'Review Claim Audit Results' button. When the codes are not compatible, you will receive an edit. Click on the "Disallow" link to see a full description of the claim edit.

Claim Audit Results

Gender: Male Date of Birth: 1/1/2000

Recommend	Procedure	Date of Service	Description	Modifiers
Allow	30200	12/15/2013	INJECTION TREATMENT OF NOSE	
Allow	99213	12/15/2013	OFFICE/OUTPATIENT VISIT EST	25
Disallow	99001	12/15/2013	SPECIMEN HANDLING PT-LAB	

ESTIMATED TREATMENT COST

One of the tools available to our Preferred Care PPO members is the Estimated Treatment Cost Tool. With this tool, members can view information about the value you bring to the healthcare community and are enabled to be more active in managing their own healthcare choices. The tool features the costs and volumes associated with 402 elective/planned procedures, which include 45 new treatment categories as of Fall 2013. These new treatment categories include 35 new inpatient, outpatient and diagnostic treatment categories and 10 new office visit treatment categories. *This service will expand to include our HMO Louisiana, Inc. (HMO) members in the future.*

Estimated Treatment Cost

- [View Reports](#)
- [Reconsideration Form](#)
- [Cost Data Methodology](#)
- [FAQs](#)
- [Treatment Codes Listing](#)

Where does the cost data come from?

It is a provider-specific estimate of cost ranges for an episode of care. Cost estimates are developed using 12 months of claims data for inpatient, outpatient and diagnostic and six months of claims data for office visits. The facility data is modeled (re-priced) to represent the most current contract as of the time of processing.

For **INPATIENT** treatment categories, inpatient facility claims for specific DRG code(s) are combined with professional, diagnostic and other claims for services the patient incurs from the admission through the discharge date to arrive at total estimates for display.

For **OUTPATIENT** procedure categories, CPT® codes identify each treatment category and all costs that members receive on the day of the procedure are summed up to create aggregates and estimates for both the facility and professional provider of the procedure.

For **DIAGNOSTIC** service treatment categories, the technical and professional components are combined. Costs are aggregated and estimates are created for both the facility and professional provider of the procedure.

For **Professional Office Visits**, primary CPT® codes identify each treatment category. For chiropractic and physical therapy, all costs for the visit are summed to create the estimate.

For **Other** categories, weighted average costs per CPT codes create the estimate.

Twice a year (spring and fall), Blue Cross refreshes the tool with updated provider cost data. When this occurs, we send a letter to our providers advising them that they have 30 days from the date of notice to review the cost data and request a reconsideration if needed. This process is completed through the iLinkBLUE **Estimated Treatment Cost** menu option.

- The **View Reports** option allows you to view the most recent report that contains the cost ranges calculated for your facility or practicing location, as well as an overview of the methodology used to develop these cost ranges.
- The **Reconsideration Form** is only available to providers during the reconsideration period prior to each cost data submission. During times outside this window, the link to the form will be inactive. Prior to submitting the interactive electronic form, you will have the option to print a copy for your records. All required fields must be completed in order to submit the form electronically. Faxed or mailed forms will not be accepted.
- The **FAQs** option is a printable PDF listing of frequently asked questions about the Estimated Treatment Cost tool and data to help our providers better understand the cost data process and the member tool.
- The **Treatment Codes Listing** is a printable PDF listing of all the procedures included in the Estimated Treatment Cost tool. This listing is updated as we add new procedures and is available to view and print at any time.

National Consumer Cost Tool - MANDATED				Version 1.4		Total (ALL): 402	
Treatment Categories for Fall Refresh 2013							
Methodology Logic	TC Code	TC Type Code	Inpatient Treatment Categories	Code Type	Code(s)	ICD9	Submission Format
Inpatient Facility	00101	2	Bariatric Surgery - Laparoscopic Gastric Bypass	MS-DRG	621		Facility
Inpatient Facility	00201	2	Cardiac Aortic/Dissect - w/ Dual Bypass Stent	MS-DRG	247		Facility
Inpatient Facility	00301	2	Cardiac Defibrillator Implant w/o Cardiac Catheterization	MS-DRG	227		Facility
Inpatient Facility	00401	2	Coronary Bypass (CABG) w/o Cardiac Catheterization	MS-DRG	236		Facility
Inpatient Facility	00501	2	C-Section Delivery	MS-DRG	765 + 795		Facility
Inpatient Facility	00502	2	Vaginal Delivery	MS-DRG	775 + 795		Facility
Inpatient Facility	00601	2	Hip Replacement	MS-DRG	470	81.51, 81.52	Facility

BLUE HEALTH RECORDS

A **Blue Health Record** is a patient's complete claims health record (CHR) history of current and past prescriptions filled, illnesses and associated treatments, surgeries performed, immunizations and preventive healthcare received within the last two years. These records are useful for treating new patients, as well as patients with complex health issues and chronic diseases. Facilities can also benefit from the use of Blue Health Records when treating emergency room patients. We do require that providers limit access to this sensitive information and recommend that only physicians and designees of physicians responsible for patient care request access to the Blue Health Record. iLinkBLUE users must complete our iLinkBLUE System CHR Access Security Form. For more information, email ilinkblue.providerinfo@bcbsla.com.

Coverage Information

- Coverage Summary
- Eligibility
- Contract Benefits
- FEP Benefits and Eligibility

To access a patient's Blue Health Record, click on the **Eligibility** screen under the **Coverage Information** menu option. Enter the member's contract number then click the submit button. The screen will expand to show the member and dependent eligibility information. Under the "Member Health Information" is where the Blue Health Record link is found for each member on the policy.

Eligibility Information

Contract #

Member Health Information (Click here to see details)

Name	DOB	Sex	Relationship	Health OED	Health Portability	Waiting Period	Blue Health
John Q Subscriber	01/01/2000	M	Subscriber	01/01/2010	01/01/2000	View	View Report

Still not an iLinkBLUE user?

It's never too late to join iLinkBLUE and take advantage of its many perks. Use these easy instructions to gain access to iLinkBLUE:

1. Complete and return the appropriate iLinkBLUE agreement packet ([includes the Business Associate Addendum and the Electronic Funds Transfer Application](#)) for your provider location ([this only needs to be done once per location](#)). They are available online at www.bcbsla.com/providers >Electronic Services >iLinkBLUE.
2. After we process your agreement packet, you will be notified of your iLinkBLUE Identifier Number.
3. Each user for your office should go to www.bcbsla.com/ilinkblue/ and select "New User? Click here." Enter all appropriate information to create a user name ([each user must complete this process separately](#)). Make a note of your user name.
4. Each person that registers will receive a temporary password in the mail via PIN mailer. This will be sent to the correspondence address we have on your provider record.
5. After you have received your temporary password, go to www.bcbsla.com/ilinkblue/ and click "Enter iLB" and log on. You will then be asked to create a new password.

If you have questions regarding iLinkBLUE or EFT, please email ilinkblue.providerinfo@bcbsla.com or contact the LINKLine at 1.800.216.BLUE (2583).



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Healthcare Reform: *New Rules, New Challenges, New Opportunities*

Find more online about healthcare reform at:

www.BCBSLA.com/reform



HCR News

HCR News is a newsletter on Healthcare Reform changes for Blue Cross and Blue Shield of Louisiana network providers. We encourage you to share this newsletter with your staff.

The content in this newsletter is for informational purposes only. Diagnosis, treatment recommendations and the provision of medical care services for Blue Cross members are the responsibilities of healthcare professionals and facility providers.

If you would like to receive this newsletter by email, please contact us at provider.communications@bcbsla.com.

PROVIDER RESOURCES

Reform Web	www.BCBSLA.com/reform www.LHEC.net
Provider Web	www.BCBSLA.com >I'm a Provider
iLinkBLUE & EFT	iLinkBLUE.ProviderInfo@bcbsla.com 1.800.216.BLUE (2583)
Provider Relations	Provider.Relations@bcbsla.com 1.800.716.2299, option 4
Network Development	Network.Administration@bcbsla.com 1.800.716.2299, option 1
Provider Services	1.800.922.8866