Fall 2018
Facility Workshops

Louisiana

Our Mission

To improve the health and lives of Louisianians

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

To serve Louisianians as the statewide leader in offering access to affordable healthcare by improving quality, value and customer experience

Welcome

Your Provider Relations Team at Blue Cross and Blue Shield of Louisiana

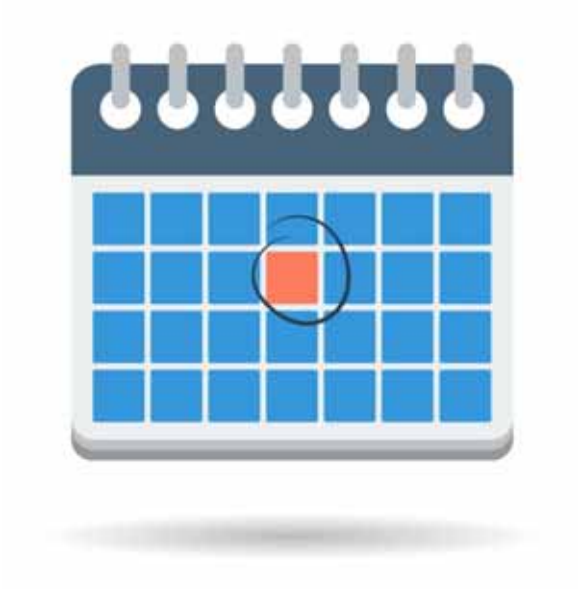
Left to right: Marie Davis, Melonie Martin, Anna Granen, Patricia O'Gwynn, Jami Zachary, Mary Guy, Kelly Smith, Lisa Roth

Agenda

Credentialing
&
Provider Data

Credentialing Process

- Blue Cross credentials both professional and facility providers
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross and Blue Shield Association
- The credentialing process can take up to 90 days once Blue Cross receives all required information
- Providers will remain non-participating in our networks until their application has been approved by the credentialing subcommittee
- Network providers are recredentialed every three years from their last credentialing acceptance date
- Required credentialing and recredentialing packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks



After 90 days, you may inquire about your credentialing status by contacting our Credentialing unit at 1-800-716-2299, option 2

New Credentialing & Provider Data Policy

Effective April 9, 2018, Blue Cross implemented a new policy for credentialing and provider data maintenance requests to help ensure completed requests are processed timely

- Requests to join our networks or maintain network participation, including the credentialing and recredentialing processes, must be submitted on appropriate applications
- Requests for provider data maintenance must be submitted on the appropriate Blue Cross form

Requests that are incomplete, missing information or submitted on the incorrect form will be returned. The processing time will start over once all required information is received.

All forms and credentialing packets are available online at
www.BCBSLA.com/providers >Provider Networks >Join Our Networks

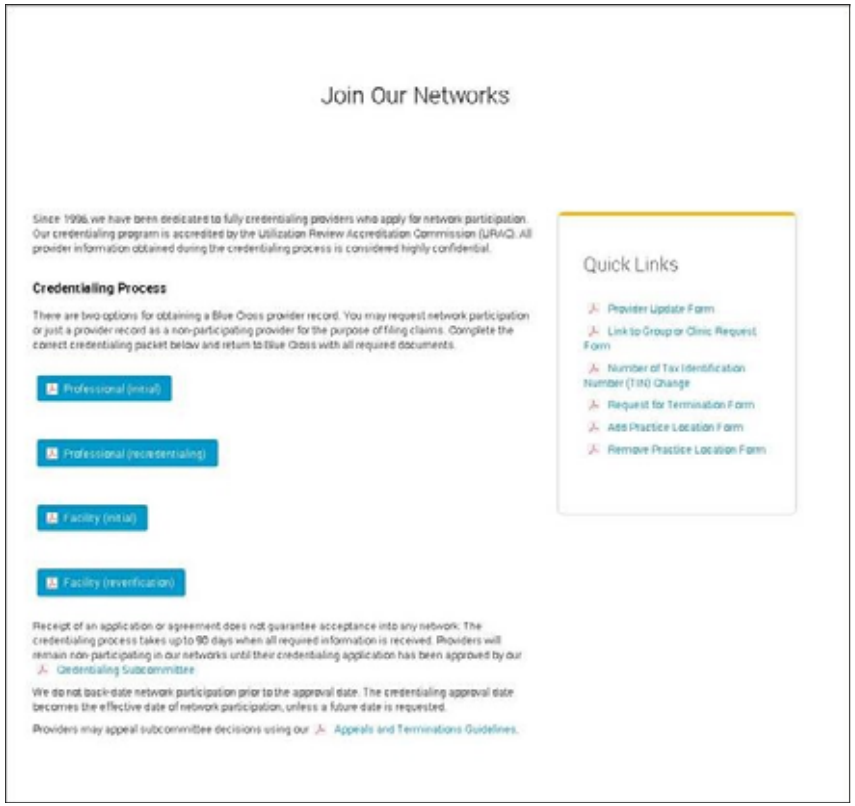
Incomplete Applications

Below are the most common reasons applications are returned upon receipt:

- No original signature on application *(stamped or typed signatures are not accepted)*
- No application signature date *(stamped or typed signature dates are not accepted)*
- Application signature is 180 days old or greater
- No effective date listed
- Professional provider does not submit the current version of the Louisiana Standardized Credentialing Application
- Facility does not submit the Health Delivery Organization (HDO) Information Form
- An alternative application is submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*

NEW

New Credentialing Webpage



Visit our "Join Our Networks" page to find:

- Credentialing packets for professional and facility providers
- Recredentialing packets for professional and facility providers
- Checklists with all required documents for participating or non-participating providers *(submit the applicable completed checklist with all indicated documents)*
- Quick Links to provider update forms
- Credentialing Criteria for professional, facility and hospital-based providers

www.BCBSLA.com/providers >Provider Networks >Join Our Networks

Credentialing Criteria

The following facility provider types must meet certain criteria requirements to participate in our networks:

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services
- Dialysis Facility
- DME Supplier
- Home Health Agency
- Home Infusion
- Hospice
- Hospitals
- IOP/PHP Psych/CDU
- Laboratory
- Lithotripsy/Orthotripsy
- Nursing Home
- Radiation Center
- Residential Treatment
- Retail Health Clinic
- Skilled Nursing Facility
- Sleep Lab/Center
- Specialty Pharmacy
- Urgent Care Clinic

View the *Credentialing Criteria* online at
www.BCBSLA.com/providers >Provider Networks >Join Our Networks

Required Recredentialing Documents

Network facility providers should use our **Health Delivery Organization (HDO) Reverification Form**

This application is part of the **Facility (Reverification)** packet

The **Facility (Reverification)** packet includes a checklist of all required documents

Packets with incomplete, missing information or submitted on the incorrect forms will be returned

Find our credentialing packets online at
www.BCBSLA.com/providers >Provider Networks >Join Our Networks

Required Recredentialing Documents

The **HDO Reverification Form** may also require an HDO attachment as indicated below by facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital or Ambulatory Surgical Center
- HDO Attachment D: Urgent Care Clinic/Walk-In Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health Clinics
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

HDO Attachment applications are available online at
www.BCBSLA.com/providers >Resources >Forms

Hospital-based Providers

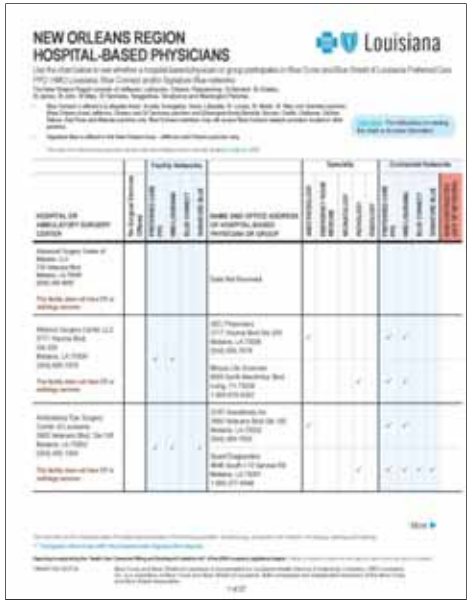
- A hospital-based provider is defined as a provider who **only** sees patients as a result of their being admitted or directed to the hospital
- A provider IS NOT considered hospital-based if you have patients referred directly to you from another physician or organization
- The classification as a hospital-based provider applies for the hospital location only, and NOT for any other practice locations outside the hospital
- Hospital-based providers can be allowed to participate in our networks without credentialing requirements. We do not list such providers in the directory and allow the hospital's credentialing to stand.
- Hospital-based providers who wish to be listed in our provider directories must adhere to the credentialing criteria for **professional providers**

We have a guide to help understand *Credentialing for Hospital-based Providers*. The guide is available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

Hospital-based Providers

The Health Care Consumer Billing & Disclosure Act (or Consumer's Right to Know Act) requires that facilities (acute and ambulatory surgery centers) inform health plans of its hospital-based physicians in the specialties of:

- Anesthesia
- Emergency Medicine
- Neonatology
- Pathology
- Radiology



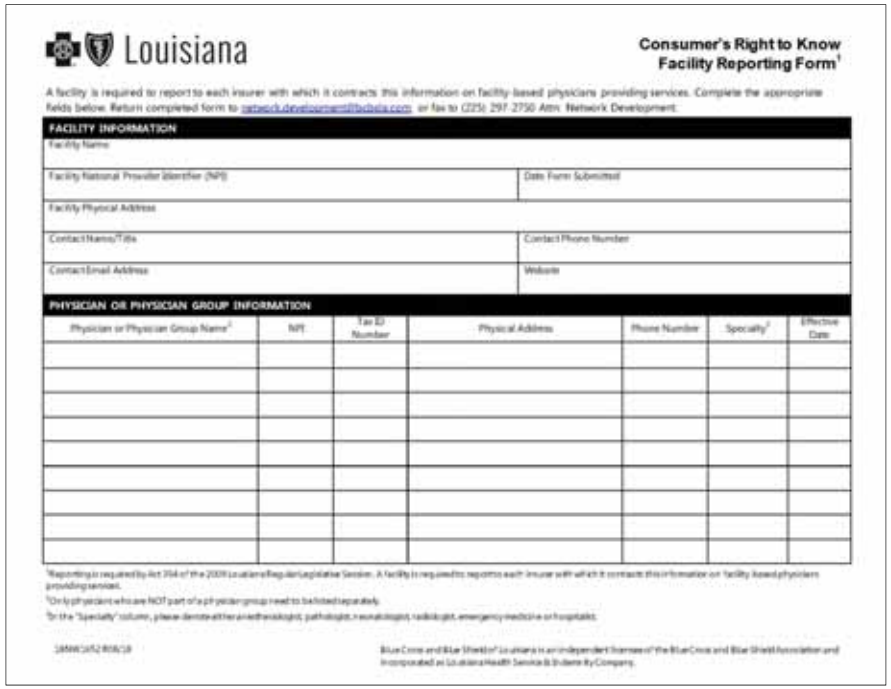
According to the legislation, health insurers must be notified of any changes made to this information within 30 days of the change

This information is presented to our members on our Hospital-based Physician Provider Lists, available online at **www.BCBSLA.com/find-a-doctor** >ER/OR Information >Hospital-based Physician Providers

Submitting Changes for Hospital-based Providers

- Blue Cross asks that network facilities submit changes on the Consumer's **Right to Know Facility Reporting Form** every time there is a change in hospital-based physician for any specialties listed on the previous slide
- Email completed forms to **network.development@bcbsla.com**
- Forms may also be faxed to (225) 298-7698, Attn: Network Development

Updated Interactive Form



Louisiana

Consumer's Right to Know Facility Reporting Form[1]

A facility is required to report to each insurer with which it contracts this information on facility-based physicians providing services. Complete the appropriate fields below. Return completed form to network.development@bcbsla.com or fax to (225) 297-2750 Attn: Network Development.

FACILITY INFORMATION

Facility Name	
Facility National Provider Identifier (NPI)	Date Form Submitted
Facility Physical Address	
Contact Name/Title	Contact Phone Number
Contact Email Address	Website

PHYSICIAN OR PHYSICIAN GROUP INFORMATION

Physician or Physician Group Name[2]	NPI	Tax ID Number	Physical Address	Phone Number	Specialty[3]	Effective Date

[1] Reporting is required by Act 354 of the 2009 Louisiana Regular Legislative Session. A facility is required to report to each insurer with which it contracts this information on facility-based physicians providing services.

[2] Only physicians who are NOT part of a physician group need to be listed separately.

[3] In the "Specialty" column, please denote either anesthesiologist, pathologist, neurologist, radiologist, emergency medicine or hospitalist.

The form is located online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

It is important that we always have your most current information in our files. Our Provider Data unit manages demographic changes to your provider record.

Below are the required forms for making the indicated changes to your record:

Use our **Provider Update Form** if you have an address, phone, fax, email address or hours of operation change

Use our **Link to Group or Clinic Request Form** when an individual provider is linking to a provider group or clinic

Use our **Notice of Tax Identification Number (TIN) Change Form** to report a change in your tax ID number

These forms are located online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

Below are the required forms for making the indicated changes to your record:

Use our **Request for Termination** to request termination from one or more of our networks

Use our **Add Practice Location Form** when an individual provider is adding a practice location(s)

Use our **Remove Practice Location Form** when an individual provider is removing a practice location(s)

After 90 days, you may inquire about your demographic change by contacting our Provider Data Management unit at 1-800-716-2299, option 3

These forms are located online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

Complete the checklist:

- Our provider update forms include a checklist of **required** supporting documentation needed for us to complete your request
- Please ensure **all** requested items on the checklist are included or completed before submitting
- Submissions that are missing checklist items will be returned

PHYSICAL ADDRESS

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

Accepting New Patients: ☐ New ☐ Existing Only ☐ Other: _____

Age Range of Patients (check all that apply): ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

PHYSICAL ADDRESS

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

Accepting New Patients: ☐ New ☐ Existing Only ☐ Other: _____

Age Range of Patients (check all that apply): ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ This form is fully completed, including the effective date of link
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ This form is signed and dated
- ☐ Only if a new group or clinic not already on file with Blue Cross, a completed LinkBlue agreement packet is included (available online at www.BCBSLA.com/providers >Electronic Services >LinkBlue)

Signature of Authorized Representative | Date

Contact Email Address | Contact Phone Number

Return Form To:

Email: network.administration@bcbsla.com
Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: (225) 297-2750
Phone: 1-800-716-2299, option 1

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How to Submit Your Information

Submit completed applications and forms by:

Email: network.administration@bcbsla.com

recredentialingapplication@bcbsla.com
(recredentialing applications only)

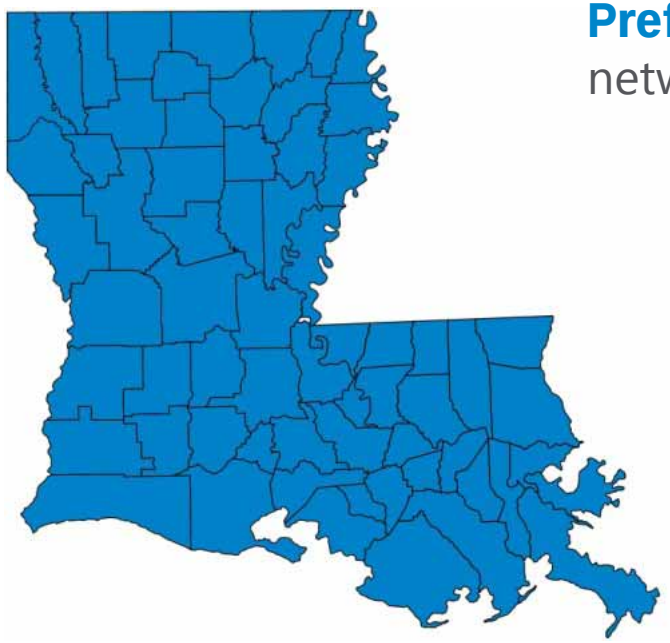
Fax: (225) 297-2750

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

We prefer applications and provider update forms be submitted via email. This allows us to begin working on your requests faster than if it were faxed or mailed.

Our Networks

Our Provider Networks



Preferred Care PPO and **HMO Louisiana, Inc.** networks are available statewide to members

Louisiana

HMO Louisiana

We have a Provider Tidbit to help identify a member's applicable network when looking at the ID card. The *Identification Card Guide* is available online at **www.BCBSLA.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Select Provider Networks

These networks are available to members in select parishes

Blue Connect

New Orleans area

Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany

Lafayette area

Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion

Shreveport area

Bossier and Caddo

Community Blue

Baton Rouge area

Ascension, East Baton Rouge, Livingston and West Baton Rouge

Signature Blue

New Orleans area

Jefferson and Orleans

Blue Connect, Community Blue and Signature Blue members are identifiable by their member ID card, which includes the HMO Louisiana, Inc. logo in the top left corner and the network name in the top right corner

Blue Advantage (HMO) Network

Blue Advantage (HMO) is our Medicare Advantage product currently available to seniors in 30 parishes. In 2019, we intend to expand.

Blue Advantage Parishes

- Acadia
- Ascension
- Assumption
- East Baton Rouge
- East Feliciana
- Evangeline
- Iberia
- Iberville
- Jefferson
- Lafayette
- Lafourche
- Livingston
- Orleans
- Plaquemines
- Pointe Coupee
- St. Bernard
- St. Charles
- St. Helena
- St. James
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Tangipahoa
- Terrebonne
- Vermilion
- Washington
- West Baton Rouge
- West Feliciana

BlueCard® Program

BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area.

The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic

The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product

The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product

National Alliance

(South Carolina Partnership)

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC)
- BCBSLA taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC
- Claims are processed through the BlueCard® program

Our *Identification Card Guide* provider tidbit can help you identify and better understand our policies that are handled directly through the National Alliance program. The guide is available online at **www.BCBSLA.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Member ID Prefixes

- As of April 15, 2018, providers may see prefixes on member ID cards that contain numeric characters
- Due to growth in the number of products being sold by Blue Cross companies nationwide, the Blue Cross Blue Shield Association has determined the need to expand the prefixes to be alpha-numeric
- Prefixes can be alpha only or a combination of alpha and numeric characters in one of the following combinations
- The prefix is the first three characters of the member number that appears on the member ID card. It is required for claims processing and is critical for member eligibility and benefit inquiries. The prefix identifies which Blue Plan and product the member has.

Example:

A2A	2AA	22A
AA2	2A2	A22

Free-standing Skilled Nursing Facilities Can Now Join Our Provider Networks

Effective January 1, 2019, free-standing skilled nursing facilities have the option to participate in the following networks:

- Preferred Care PPO
- HMO Louisiana, Inc.

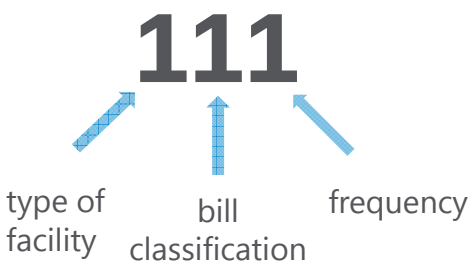
For questions regarding network participation, please contact Network Development at **network.development@bcbsla.com** or 1-800-716-2299, option 1

Billing & Claims

Bill Types

- Facility claims must be submitted with a bill type (a three-digit code that represents specific information about the claim being filed)
- The first digit is the type of facility – no exclusions
- The second digit indicates the bill classification – no exclusions
- The third digit indicates frequency. There ARE exclusions related to the frequency digit:
  - **Blue Cross will not accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. We do not accept interim billings for inpatient services.**

    ***Exception:** An interim bill will be accepted only if the total charge is $800,000 or greater and at least 60 days of service
  - **Any interim bills or late charge claims should be aggregated into one final claim and submitted using a frequency code of 1**
  - **For submission of adjustments or replacement claims the frequency code 7 is acceptable**
  - **Use frequency code of 8 for void claims**



*If you meet the criteria to file an interim bill, please call Brian West at (225) 297-2654 to discuss how to submit your claim

These guidelines are outlined in the *Member Provider Policy & Procedure Manual*, available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section

Bill Type Examples

Acceptable Bill Types:

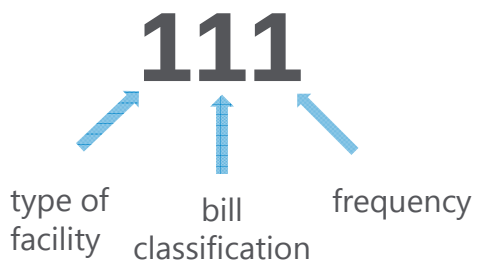
- Bill Type 11**1** (hospital, inpatient, admit through discharge)
- Bill Type 21**1** (skilled nursing, inpatient, admit through discharge)
- Bill Type 18**7** (hospital, swing bed, replacement/adjustment claim)

Unacceptable Bill Types:

- Bill Type 11**2** (hospital, inpatient, interim-first claim)
- Bill Type 11**3** (hospital, inpatient, interim-continuing claim)
- Bill Type 11**4** (hospital, inpatient interim-final)
- Bill Type 21**5** (skilled nursing, inpatient, late charge)

The only acceptable bill types are xx1 and xx7

Bill type xx8 is for void claims

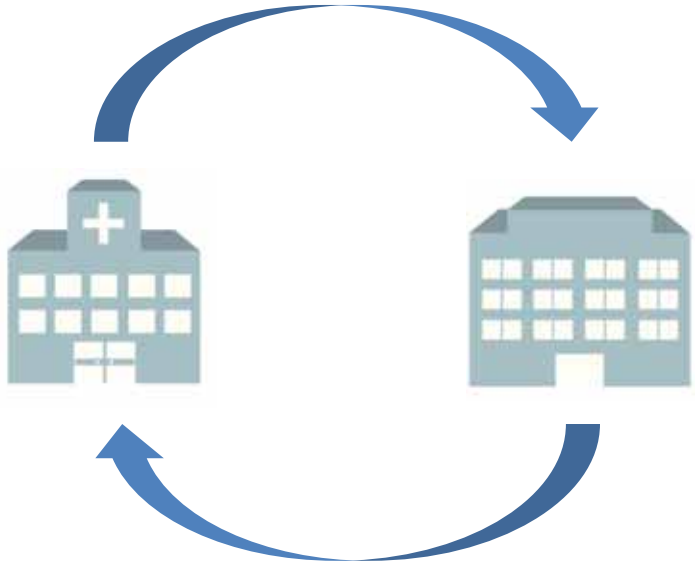


Affiliated

Two companies are affiliated when one company owns less than a majority of the voting stock or interest of the other, when one company owns a portion of the voting stock or interest of the other, or when both are subsidiaries of a third corporation.

A subsidiary is a company where more than 50 percent of the voting shares are owned by another corporation, called the parent company.

A subsidiary is also an affiliate company. Two subsidiaries of the same parent company are affiliates of each other.



Admissions Through the Emergency Room/Observations

- When a patient is in observation status or in the emergency room affiliated with the acute care facility and is subsequently admitted to the affiliated acute facility, the observation and/or emergency room record should become part of the affiliated acute facility admission record, and the associated charges should be included when billing the inpatient claim
- This is the case for one or multiple emergency room visits in the same day or across two days
- If there is a subsequent inpatient admission, the emergency room visit(s) and/or observation should be filed with the inpatient hospital claim, and will be included in the inpatient stay
- The admission date indicated on the UB-04 claim form should reflect the date when services were first provided in the emergency room, rather than the date when the patient was admitted in the acute facility
- These rules apply regardless of whether the emergency room is physically located on the same campus as the affiliated acute facility or off campus
- If an ambulance is used to transport the patient from an emergency room (whether free standing or located within an acute hospital) to an affiliated acute facility, the ambulance service furnished by the hospital, or by others, under arrangements with the hospital, are not separately reimbursed

Observation

- Charges for outpatient procedure services (as defined by the CPT/HCPCS procedure code range available in this manual) rendered to a member classified by the member provider as observation status will be reimbursed according to the Member Provider Agreement Reimbursement Appendix
- Charges for outpatient services in which an outpatient procedure was NOT performed and is classified by the member provider as observation status will be reimbursed according to the lesser of:
    1. The Member Provider Agreement Reimbursement Appendix for Outpatient Services limiting the payment for observation to a maximum of 30 hours of observation (claim will require review and adjustment) or;
    2. The contracted inpatient reimbursement (the Member Provider must follow inpatient billing guidelines)
- The 30-hour count commences when outpatient services begin (when the member arrives at the hospital for treatment), not when the stay in observation begins
- The place of service is based on the status of the patient is the time of the physician visit

Ground Ambulance Transportation

A member may be transported on land for a reasonable and medically necessary ground ambulance transport

The following coverage requirements apply to ground transports:

- A Blue Cross member is transported
- The destination is local
- The facility is appropriate
- Due to the member's condition, the use of any other method of transportation is inadvisable
- The purpose of the transport is to obtain a Blue Cross-covered service or to return from obtaining such service

Please refer to the "Resources" section of iLinkBlue (**www.BCBSLA.com/ilinkblue**) for ambulance authorization guidelines in the *Member Provider Policy & Procedure Manual*

Air Ambulance Transportation

A member may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport. The following coverage requirements apply to air transports:

- The member's medical condition requires immediate and rapid ambulance transport
- It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the member's survival or seriously endangers his or her health
- The point-of-pickup (POP) is not accessible by ground vehicle. POP is the location of the member at the time he or she is placed on board the ambulance.
- The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30-60 minutes)
- The instability of ground transportation

Air Ambulance Claims

Ambulance providers **must** include the 5-digit ZIP code of the point-of-pickup

This applies for:

- Emergent and non-emergent air ambulance services
- Medicare crossover claims when Medicare benefits do not cover the service

Where to file air ambulance claims:

- If the pickup location ZIP code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana
- If the pickup location ZIP code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pickup
- If the pickup location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the Blue Cross Blue Shield Global Core Program

Claims that do not include the point-of-pickup ZIP code will be denied for insufficient information

Mother and Newborn Claims

- The hospital must submit combined billings for mothers and newborns who are discharged on the same date or newborns discharged before mothers
- Maternity per diem and DRG case rates have been developed with this consideration
- Maternity per diems are inclusive of singleton and/or multiple deliveries
- For Federal Employee Program (FEP) members, when billing the newborn's claim with a NICU revenue code, it must be filed separately from the mother's claim

Sick (Boarder) Baby Billing

- Upon delivery of a newborn, if the baby's discharge date is prior to or equal to the mother's discharge date, the newborn's charges are generally combined with the mother's inpatient hospital claim
- If the baby is sick and the discharge date is after mother's discharge date, the sick (boarder) baby charges should be filed as a separate claim
- These charges should not be combined with the mother's claim. The admit date of the baby's claim should be the baby's date of birth, not the mother's discharge date.
- The facility should request a "temporary" authorization for the baby's stay under "baby girl" or "baby boy" (a temporary authorization can be requested within 48 hours of admission or when mom is discharged)

Provider-based Billing

Blue Cross **does not** recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals.

What it is

Under provider-based billing, the office/clinic visit is split into two bills:

1. UB-04 claim bills a clinic charge for any facility or technical component
2. CMS-1500 claim bills for professional services separately

- Blue Cross **does not** recognize provider-based billing of office services even if the office is located on the hospital campus or uses the hospital tax identification number
- All professional services in an office or clinic setting should be billed on a CMS-1500 claim form with an "office" place of service code 11
- A separate facility claim on a UB-04 **should not** be submitted for a facility/treatment room or technical fee associated with the office/clinic visit

Facilities operating provider-based clinics **should submit** a global bill for all services rendered in the clinic on a CMS-1500 claim form. Payment for the professional provider's services includes any technical or facility fees.

Multiple Service Reduction for Diagnostic Imaging Services

Blue Cross added multiple service reduction logic to diagnostic imaging radiology services performed for the same patient encounter

For facility providers, the multiple service reduction applies to outpatient diagnostic imaging radiology services

When more than one radiology service from Medicare's diagnostic imaging family grouping is performed for the same patient encounter:

- The allowable charge for the primary radiology service will be paid at 100 percent of the allowable charge
- Second and subsequent services will be reduced by 50 percent
- The primary service will be identified as the code with the highest allowable charge

Applicable radiology services are identified by Medicare's diagnostic imaging family groupings as published in the *CMS National Physician Fee Schedule Relative Value File*

Not Separately Reimbursable Codes

- Blue Cross does not reimburse separately for certain codes such as, CPT Category II codes and most HCPCS Documentation, Measurement and Demonstration codes

- These codes should not be used as a substitute for any services, unless otherwise instructed by Blue Cross

NEW

InterQual Criteria for Sleep Studies

On and after September 1, 2018, Blue Cross will use InterQual (IQ) criteria for facility-based sleep studies for non-respiratory sleep disorders

Suspected Parasomnia
Sleep disruptive to other household members or potentially violent or injurious to self or others during sleep

Suspected Narcolepsy

- Excessive daytime sleepiness >8 weeks or sleep attacks AND
- Cataplexy or Sleep paralysis or hypnagogic hallucinations AND
- Medical conditions considered and treated if indicated AND
- No psychiatric disorder by history or psychiatric disorder managed AND
- Medications deemed noncontributory AND
- Drug or Alcohol misuse excluded

Suspected Idiopathic Hypersomnia

- Excessive daytime sleepiness >8 weeks AND
- No observed apneas or snoring during sleep AND
- Difficulty morning awakening or prolonged night sleep or sleep drunkeness AND
- Unrefreshing or unintended daily naps AND
- Medical conditions considered and treated if indicated AND
- No psychiatric disorder by history or psychiatric disorder managed AND
- Medications deemed noncontributory AND
- Drug or alcohol misuse excluded

Suspected Periodic Limb Movement Disorder

- Witnessed periodic limb movements during sleep AND
- No observed apnea or snoring during sleep AND
- Excessive daytime sleepiness >8 weeks. Insomnia, fragmented sleep >8 weeks,
- frequent awakenings or difficulty maintaining sleep AND
- Medical conditions considered and treated if indicated AND
- No psychiatric disorder by history or psychiatric disorder managed AND
- Medications deemed noncontributory AND
- Drug or alcohol misuse excluded

For more information about Sleep Study billing guidelines, see our *Member Provider Policy & Procedure Manual* available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) >Resources >Manuals

Subrogation

Subrogation is a contract provision that allows healthcare insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. All claims submitted to Blue Cross must indicate if injuries or illnesses are the result of an accident.

Providers should:

- Not require the Blue Cross member or the member's lawyer to guarantee payment of the entire billed charge
- Not require the Blue Cross member to pay the entire billed charge up front
- Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge
- Charge the member no more than is ordinarily charged other patients for the same or similar service
- Bill the member only for any applicable deductible, coinsurance, copayment and/or non-covered service

If amounts in excess of the allowable charge are collected, once identified you have 30 days to refund that amount to the member

Workers' Compensation

In most circumstances, services and treatment rendered as a result of any occupational or work-related disease or injury compensable under any federal or state workers' compensation law is a contract exclusion under the terms of a member contract and Blue Cross is not responsible for the claim

Providers should:

- Submit claims to Blue Cross indicating if illnesses or injuries are the result of an work-related disease or injury

- If its determined the service is not covered by workers' compensation or the member's contract does not exclude these services and the claim is not filed to Blue Cross, the provider is at risk of future consideration by failing to meet administrative filing requirements outlined in the member's contract

Timely Filing

Blue Cross, HMO Louisiana, Blue Connect, Community Blue & Signature Blue:

- Claims must be filed within 15 months of the date of service

FEP:

- Claims must be filed by December 31 of the following year after the service was rendered

Blue Advantage:

- 12 months from the date of service to file an initial claim
- 12 months from the date the claim was processed (remit date) to resubmit or correct the claim

OGB:

- Claim must be filed within 12 months of the date of service

Self-insured & BlueCard®:

- Timely filing standards may vary so always verify the member's benefits, including timely filing standards, through iLinkBlue

Claims received after the timely filing deadline will be denied and the member and Blue Cross are held harmless

Payment Integrity Program

Claims Auditing

- We routinely audit claims to validate the accuracy of our payments, including the verification of the diagnosis and procedure codes submitted on each claim form
- To perform these reviews, we have authorized various vendors to request and receive supporting medical or billing documentation on behalf of Blue Cross
- Failure to comply with requests for medical records or billing documentation within 30 days may result in denial of any previous claim payment made for the requested case. Previous payments will be recovered through offsets to future payments.

You are required to provide us with medical records at no charge as outlined in your Blue Cross network agreement

Blue Cross has partnered with VARIS to request medical records for this program

NEW

Pre-pay Itemized Bill Review

Effective November 15, 2018, Blue Cross will begin reviewing high-dollar, acute care claims

- When filing an inpatient acute claim that has a billed charge of greater than $250,000, please submit an itemized bill by fax, email or mail and include the **Itemized Bill Cover Sheet**
- It is highly recommended that itemized bills are faxed or emailed at the same time claims are filed. Claims received with a billed amount of greater than $250,000 without itemized bill information may be denied or result in delayed reimbursement.
- The itemized bill must list each service and item supplied to the member and match the dollar amount and dates of service
- If you have questions about this claim review process, please email the Payment Integrity department at **PIIHBillReview@bcbsla.com**

Louisiana

Please include this cover sheet when submitting itemized bills with charges greater than $250,000 to the Payment Integrity department.

Itemized Bill Cover Sheet

Providers may submit itemized bills required by the Payment Integrity department to Blue Cross in the following ways:

Fax: (225) 298-7675

Email PIIHBillReview@bcbsla.com

Mail: Payment Integrity – BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

For Internal Use:
Please deliver the enclosed documents with this cover sheet directly to Blue Cross' Payment Integrity department, Network Administration Division.

CONFIDENTIALITY NOTICE

The documents accompanying this cover sheet contain confidential health information that is legally privileged. This information is intended only for use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return of these documents.

Blue Cross and Blue Shield of Louisiana is a registered [illegible] Company. HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

The **Itemized Bill Cover Sheet** is located online at **www.BCBSLA.com/providers** >Resources >Forms

Subcontracted Services

Services furnished to patients by providers other than the facility while the patient is inpatient or outpatient

- The reimbursement outlined in the Member Provider Agreement is intended to cover all hospital services rendered to a patient, including those services performed by subcontracted providers
- Subcontracted providers should seek payment solely from the facility
- Subcontracted providers should not bill Blue Cross or the member for such services
- At least annually, facilities should furnish Blue Cross with a listing of any subcontracted providers to your Network Development Representative. To find the representative for your area, visit **www.BCBSLA.com/providers** >Provider Networks >Provider Support.
- Full information is included in our *Member Provider Policy & Procedure Manual* available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) >Resources >Manuals.

These services include, but are not limited to EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, etc.

Preadmission Testing Billing

- According to National Uniform Billing Committee (NUBC) guidelines, all outpatient services provided within 72 hours prior to an inpatient admission are included in the reimbursement amount for the inpatient stay
- These services must be billed to Blue Cross as part of the inpatient claim
- This provision applies only to outpatient services performed at the same (or affiliated) facility where the patient is subsequently admitted
- The “Statement From” date reference on the UB-04 should represent the beginning date associated with the services as indicated on this bill
- The “Statement From” date is not necessarily the same as the “Admission Date,” nor should it be compromised in its meaning
- The “Admission Date” is another field on the UB-04; it is specifically designed to capture the admit date

Member Benefit Terms

- Fully insured group – Group pays a fixed premium cost per class coverage each month. The funds for claims reimbursement come from Blue Cross.
- Self-funded group – Group pays a fixed cost each month, but they fund monthly claims payments along with funds for unexpected claims fluctuations. These groups use Blue Cross only to process claims.
- Grandfathered – A benefit plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by the Patient Protection and Affordable Care Act (PPACA). New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Nondiscrimination (Section 1557)

- Blue Cross does not discriminate on the basis of race, color, national origin, sex, age or disability
- Policies affected: All fully insured policies
- Your Blue Cross patients may contact the Section 1557 Coordinator to file discrimination complaints:
  - Email: **section1557coordinator@bcbsla.com**
  - Phone: 1-800-711-5519 (TTY 711)
  - Fax: (225) 298-7240

Resolving Claims Issues

Submit an Action Request through iLinkBlue or contact Customer Care at 1-800-922-8866

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 working days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 working days for second request

When to Contact Provider Relations for Claims Help

You may email an overview of the issue along with your two reference numbers to **provider.relations@bcbsla.com** after the allotted timeframes if one of the following applies:

- You have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers/action request dates, or
- It is a system issue affecting multiple claims

Pharmacy

NDC Billing Guidelines on Claims

Use the following billing guidelines to report required NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

- NDC code editing will apply to any clinician-administered drugs billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician-administered drug must be billed on a separate line item
- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs
- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

Failure to report NDCs on claims will result in automatic denials

Reporting NDC on Facility Claims

For Hardcopy Claims

On the UB-04 claim form, report the NDC and the quantity in Box 43 (description field). The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g. N49999999999. The drug quantity and measurement/qualifier should be included.

For Electronic Claims 837i

Report the NDC in loop 2410, Segment LIN03 of the 837. The code should consist of a CMS 11-digit NDC in a fixed length 5-4-2 (no hyphens) configuration. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBlue Claims

NDC codes cannot be filed on facility outpatient claims via iLinkBlue. Any iLinkBlue facility outpatient claim that requires an NDC code should be filed via hardcopy claim.

NDC Reporting Clarification

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format.

How should the NDC be entered on the claim? See the examples below:

10-Digit Format on Package	10-Digit label format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

If the NDC is not submitted in the correct format, the claim will be denied

Revenue Code 250

- For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) **that line will not be reimbursed**
- Providers should always use the published HCPCS/CPT code associated with the NDC being billed. If there is not a published code that accurately identifies the NDC being billed, providers should use the appropriate unlisted HCPCS/CPT code for the NDC.
- **Exception:** We will not be looking for NDC/HCPCS/CPT for rev code 250 for Medicare crossovers or any secondary claims

CII and CIII Opioid Coverage Policy

#6	Louisiana has the sixth highest opioid prescription per capita rate, making the state 1 of only 8 that have more opioid prescriptions dispensed in a year than they have residents
861	More than 800 Louisiana residents died from opioid overdoses, both prescription and illicit, in 2015. From 2014 to 2015, opioid overdoses increased by 12% in the state, according to the Louisiana Department of Health.
2M	In 2015, 20.5 million Americans 12 or older had a substance use disorder. Two million of them had a substance use disorder involving prescription pain relievers.

Opioid Louisiana Laws in Effect

Among the bills that the Louisiana legislature passed during the 2017 Regular Session that addressed the opioid epidemic in Louisiana were 2 that affect prescribing:

Act 82 (House Bill 192)

- Effective August 1, 2017, implements a 7-day prescription limit for first-time fills on opioid drugs to treat pain. The bill exempts the limit for people with certain conditions like cancer or chronic pain, and allows doctors to override the limit in certain cases, such as for medical necessity.

Act 76 (Senate Bill 55)

- Provisions effective beginning January 1, 2018, tightens Louisiana's Prescription Monitoring Program, which is a database doctors and pharmacists can check to make sure patients do not have dispensing records that indicate potential abuse. The law requires healthcare providers to check the database before prescribing opioids to a patient and recheck it every 90 days, if the prescription continues beyond that period.

References: The Associated Press | The Center for Public Integrity | American Society of Addictions Medicine | National Safety Council

Prescribing Opioids

3.7%	Opioids account for 3.7% of prescription claims
21%	21% of members with our pharmacy benefits had at least one claim for an opioid prescription in 2016
94%	94% of opioid prescriptions are for short-acting opioids
	Top prescribing specialties include (in no particular order): primary care specialties, pain management, orthopedists, dentists/oral surgeons and others

Based on Blue Cross 2016 Claims Data. Excludes opioids prescribed by oncologists.

2018 Opioid Policy

In order to set appropriate coverage guidelines, Blue Cross developed this policy after considering a breadth of:

- clinical guidelines
- industry best practices
- state regulatory requirements
- our own member population

The policy:

- places safety edits for acetaminophen, ibuprofen and aspirin on all short-acting opioid prescriptions
- requires prior authorization for short-acting opioids more than a certain days' supply, within a set period of time
- requires prior authorization for new users of long-acting opioids
- provides certain exceptions or adjusted limitations for existing users within a set time and members with cancer or receiving end-of-life care based on claims history and/or provider information

2018 Opioid Policy Goals

Our Goals

- Decrease the amount of opioids in the community

- Minimize the number of patients becoming chronic opioid users

2018 Opioid Policy

DRUG CLASS	POLICY
ACETAMINOPHEN (TYLENOL) SAFETY EDIT	▪ Limits all Tylenol® containing medications to 3 grams or less of Tylenol per day ▪ No exceptions ▪ Applies to opioid and non-opioid drugs
IBUPROFEN SAFETY EDIT	▪ Limits all ibuprofen/short-acting opioid combination medications to 5 tabs or less per day ▪ No exceptions
ASPIRIN SAFETY EDIT	▪ Limits all aspirin/short-acting opioid combination medications to 4 grams or less of aspirin per day ▪ No exceptions
SHORT-ACTING OPIOIDS (examples: Percocet® and generics, Lortab® and generics, codeine, oxycodone)	▪ Prior authorization required for fills longer than 7-day supply ▪ Prior authorization required for fills longer than 21-day supply within 60 days' time ▪ Existing users who filled short-acting opioid prescriptions in the previous 130 days will be grandfathered ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information
LONG-ACTING OPIOIDS (examples: Butrans®, fentanyl patch, OxyContin®, MS Contin®, morphine ER, oxycodone ER)	▪ Prior authorization required for new users ▪ Existing users who filled long-acting opioid prescriptions in the previous 130 days will be grandfathered ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information

Opioid Prescribing Toolkit

- The toolkit and coverage policy were developed by Blue Cross clinical pharmacists and physicians and approved by its Pharmacy and Therapeutics Committee, a group of Louisiana doctors and pharmacists who guide coverage decisions
- The resources were compiled from a number of sources including the Louisiana Department of Health, Centers for Disease Control and Prevention (CDC) and others

The toolkit can be found online at **www.BCBSLA.com/providers** >Pharmacy

Opioid Prescribing Toolkit

The toolkit includes a compilation of best practices to plan and execute various tactics to help you and your patients manage pain safely and reduce risk. The toolkit includes:

- Drug Alert: Blue Cross Opioid Coverage Policy
- CDC Guidelines for Prescribing Opioids for Chronic Pain
- CDC Assessing Benefits and Harms of Opioid Therapy
- Opioid Screening Risk Assessment Tool and Opioid Safety Survey
- Sample Treatment Plan Outline, Definitions and Agreement
- Sample Pain Treatment with Opioid Medications Patient Agreement
- Louisiana Prescription Monitoring Program (PMP) Overview
- Behavioral Health Services Information from New Directions
- Prescription Drug Safety Saves Lives Patient Information

The toolkit can be found online at **www.BCBSLA.com/providers** >Pharmacy

Medical Documentation

Benefits of Proper Documentation

- Allows identification of high-risk patients
- Allows opportunities to engage patients in care management programs and care prevention initiatives
- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross
- Reduces costs associated with submitting corrected claims

Provider Role in Documenting

Accuracy and specificity in medical record documentation and coding is critical in creating a complete clinical profile of each individual patient

- Each page of the patient's medical records should include the following for a face-to-face visit:
  - Patient's name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials)
- Report ALL applicable diagnoses on claims and report at the highest level of specificity
- Include all related diagnoses, including chronic conditions you are treating the member for
- Medical records **must support ALL** diagnosis codes on claims

Common Errors

Common errors found in medical chart audits include:

- Illegible handwriting on paper charts
- Lack of chronic conditions included in documentation
- Lack of coding to the highest specificity
- Coding errors
- Lack of evidence of action taken for condition:
  - Condition noted in the problem list not supported in the exam
  - Monitored, Evaluated, Assessed or Treated should be noted
- Lack of clarification of whether a condition is chronic or acute
- No reference to a condition as controlled or uncontrolled
- Lack of identification for the type of diabetes
- Not documenting cause and effect relationships:
  - Notes will say Diabetes Type II and CKD Stage III; but if stated "CKD III Due to Diabetes" results in a different ICD-10 Code

Medical Record Requests

From time to time, you may receive a medical record request from us or one of our vendors to perform medical record chart audits on our behalf

- Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee

Blue Cross is currently partnered with these vendors to assist us in conducting medical record reviews

- Centauri
- Health Data Vision, Inc. (HDVI)
- Inovalon
- Varis

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS

HEDIS is a set of healthcare performance measures developed by the National Committee for Quality Assurance (NCQA) and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring managed care organizations

- A subset of HEDIS measures will be collected and reported for the Marketplace (healthcare exchanges) product lines
- HEDIS results measure performance, help us to identify quality initiatives and lead us in the development of educational programs for providers and members
- HEDIS data is collected through:
  - Administrative data (claims only)
  - Hybrid data (claims data and medical record review)
  - Survey data (member and provider surveys)

Blue Cross has partnered with Health Data Vision, Inc. (HDVI) and Inovalon to conduct medical record reviews in 2019

HEDIS

- Provide appropriate care to meet the criteria and timeframes of each measure
- Document care provided in the patent's medical record
- Submit accurate coding for claims. Remember, claim/encounter data is the most clean and efficient way to report HEDIS.
- Provide medical records upon request during the HEDIS process to help us validate the quality of care provided to our members
  - HEDIS data not captured by coding will be obtained via EMR access or medical record request to your facility
  - The medical record request will include a member list that indicates the assigned measures and the minimum necessary information needed
  - Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization
  - We appreciate your cooperation in sending the requested medical record information ASAP (ideally in 5 to 7 business days)

Improving Quality of Care (HEDIS)

Please share this information with your quality, case and disease management departments

You can help improve quality of care by:

- Encouraging patients to schedule preventive exams
- Reminding patients to follow up with ordered tests and procedures
- Making sure necessary services are being performed in a timely manner
- Submitting claims with proper codes
- Accurately documenting all services and results (if appropriate) in the patient's medical chart

We need to work together to improve and maintain higher quality of care. When our members are healthy, everyone benefits.

Questions related to HEDIS?

Please contact the Health and Quality Department: **QualityBlue@bcbsla.com**

2019 HEDIS Measurements

Emergency Department Utilization (EDU)
For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year

Inpatient Hospitalization Utilization (IHU)
For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery Medicine and Total

Plan All-cause Readmission (PCR)
For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by unplanned acute readmission for any diagnosis within days and the predicted probability of an acute readmission

2019 HEDIS Measurements

Use of Imaging Studies for Low Back Pain (LBP)
The percentage of members ages 18-50 with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Follow-up After Hospitalization for Mental Illness (FUH)
The percentage of discharges for member 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner. Two rates are reported: follow-up within 7 days of discharge and 30 days of discharge.

2019 HEDIS Measurements

Follow-up After Emergency Department Visit for Mental Illness (FUM)
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: follow-up within 7 days of the ED visit (8 total days) and within 30 days of the ED visit (31 total days).

Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: follow-up within 7 days of the ED visit (8 total days) and follow-up within 30 days of the ED visit (31 total days).

Emergency Department Utilization (EDU)

Implement ED Care Plan

Primary Users: ED Clinicians
Includes summary of prior visits, social and behavioral factors, care to minimize repeated tests, imaging or alternatives to avoid inpatient readmission

Enhanced Discharge Process

1. Discharge instructions/education—diagnosis, prognosis, treatment plan and expected course of illness
2. Telephone follow-ups
3. ED made appointments

Evaluate ICD-10 Coding Accuracy

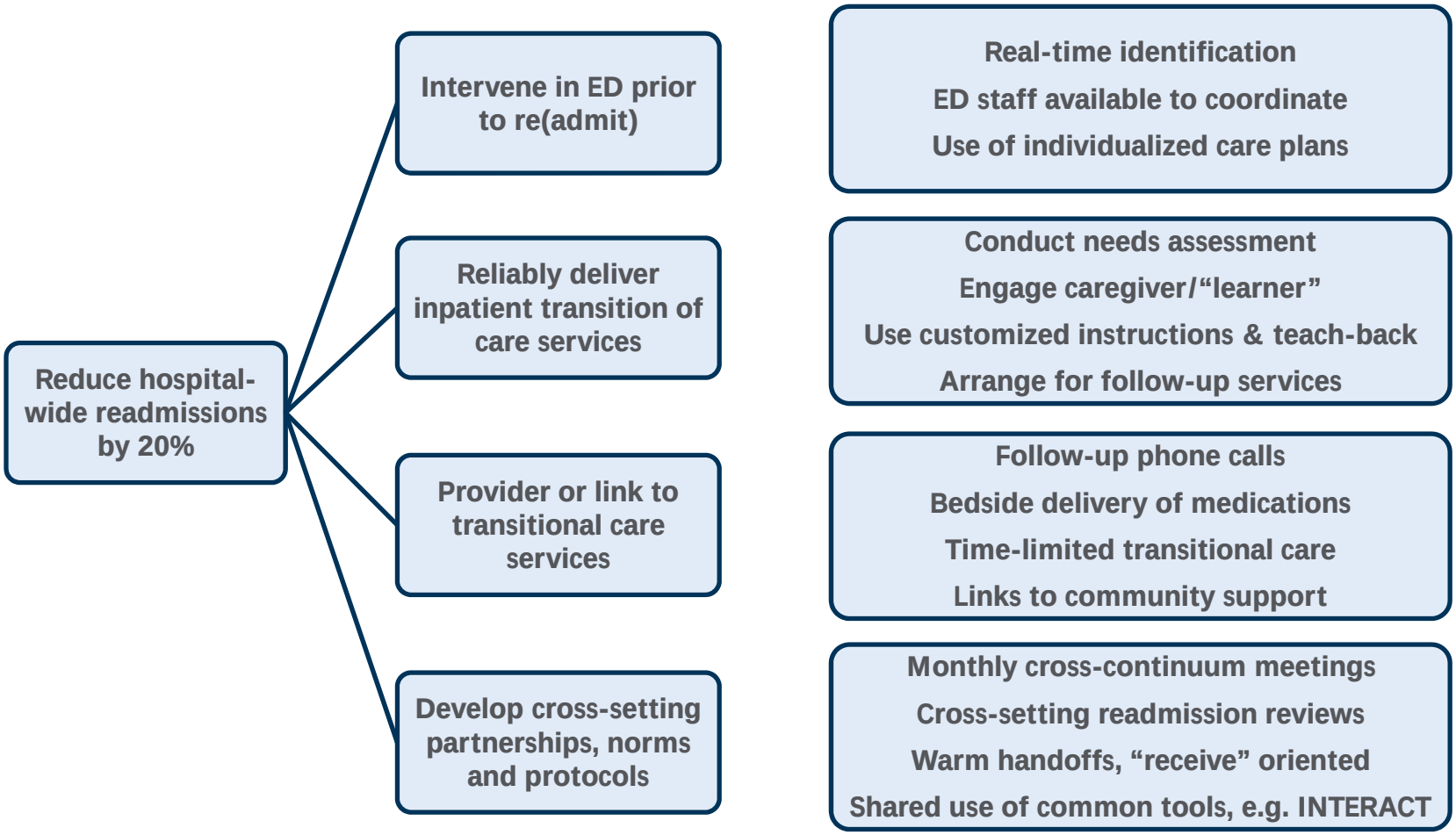
Common Coding Errors:
1. Using outdated codes
2. Coding the diagnosis code, but forgetting the procedure code
3. Confusing similar numbers and letters
4. Coders leave out laterality and specificity

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/medicaidreadmissions.pdf

Inpatient Hospital Utilization (IHU)

- Diagnostic accuracy is the key
- Be specific with coding—code out to the highest specificity possible and ensure the final number/letter reflects proper location and acuity

Plan All-cause Readmission (PCR)



Follow-up After Hospitalization for Mental Illness (FUH)

Helpful Actions to Improve Patient Outcome:

- Ensure that mental health follow-up appointments are with a behavioral health practitioner in person or telehealth
- A follow up with a PCP does NOT meet criteria for this HEDIS measure
- A follow-up visit **within seven days** of discharge (not same day of discharge) with a behavioral health provider; not to exceed 30 days from discharge. Ideally the visit takes place within seven days of the discharge.
- Care Transitions Tips
  - Begin discharge planning on the day of admission. Include utilization review, discharge planner, New Directions care transitions team, PCP, the patient and his/her family, significant others, guardian or others desired by the patient.
  - Encourage medication adherence and to report side effects

Call 1-877-300-5909 to use the Rainmaker list from New Directions, our behavioral health manager, to locate a provider for the member's follow-up visit

Follow-up After Emergency Department Visit for Mental Illness (FUM)

Helpful Actions to Improve Patient Outcome:

- Ensure that mental health follow-up appointments are with a behavioral health practitioner in person or telehealth
- A follow up with a PCP does NOT meet criteria for this HEDIS measure
- An appointment should be scheduled **within eight days** of discharge with a behavioral health provider; not to exceed 31 days from discharge
- It can include visits that occur on the date of the emergency department visit

Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Helpful Actions to Improve Patient Outcome:

- A follow-up visit with any practitioner, with a principal diagnosis of Alcohol and Other Drug Abuse or Dependence **within 30 days** after the emergency department visit (31 total days)
- A follow up with a PCP does meet criteria for this HEDIS measure
- It can include visits that occur on the date of the emergency department visit

Referrals

Member Referrals

Network providers should always refer members to contracted providers

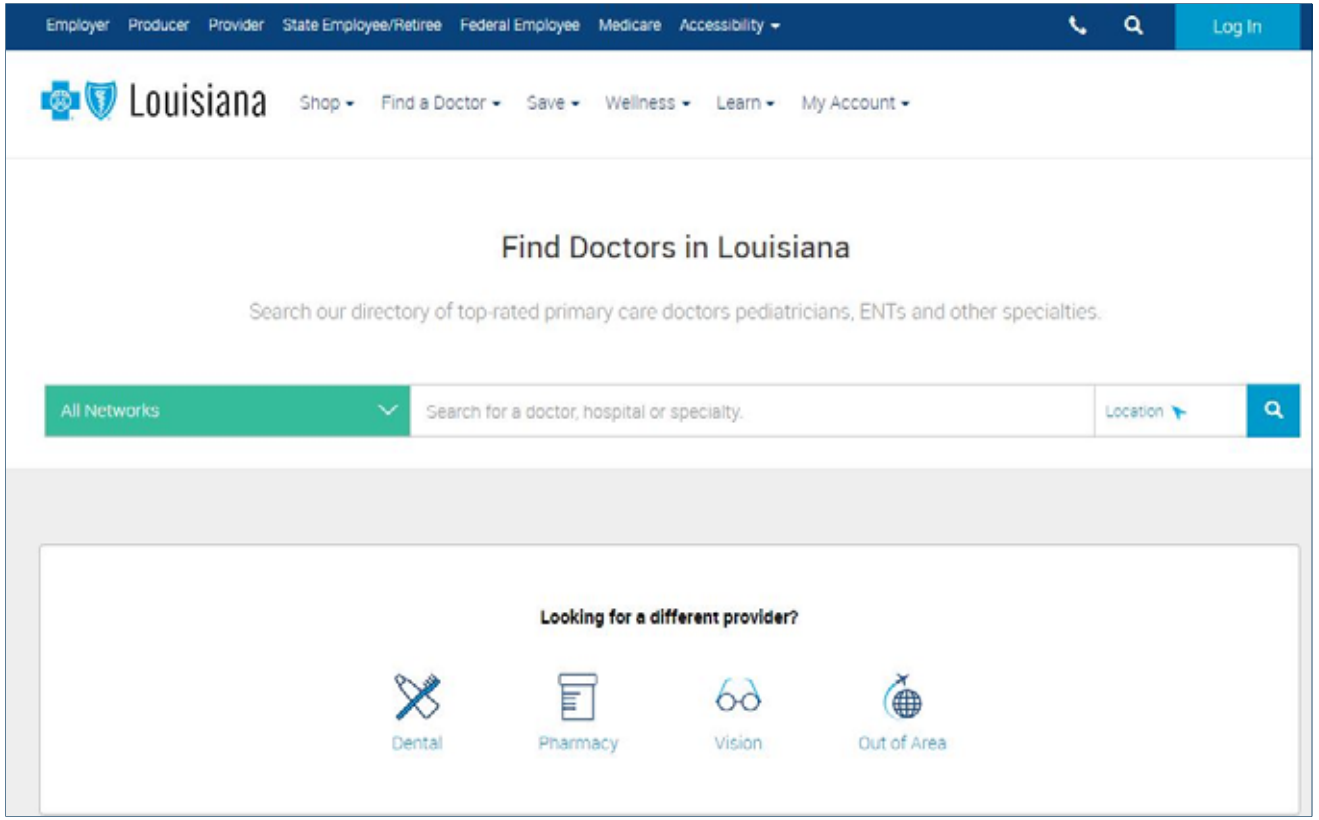
- Referrals to non-network providers result in significantly higher cost shares to our members and it is a breach of your Blue Cross provider contract
- The ordering/referring provider NPI is required on all laboratory claims. Place the NPI in the indicated blocks:
  - UB-04: Block 78
  - 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

Examples:

- Outpatient Facilities
  - LTAC, SNF, Behavioral Health, Home Health
- Therapists
- Hospitals
- DME
- Laboratories

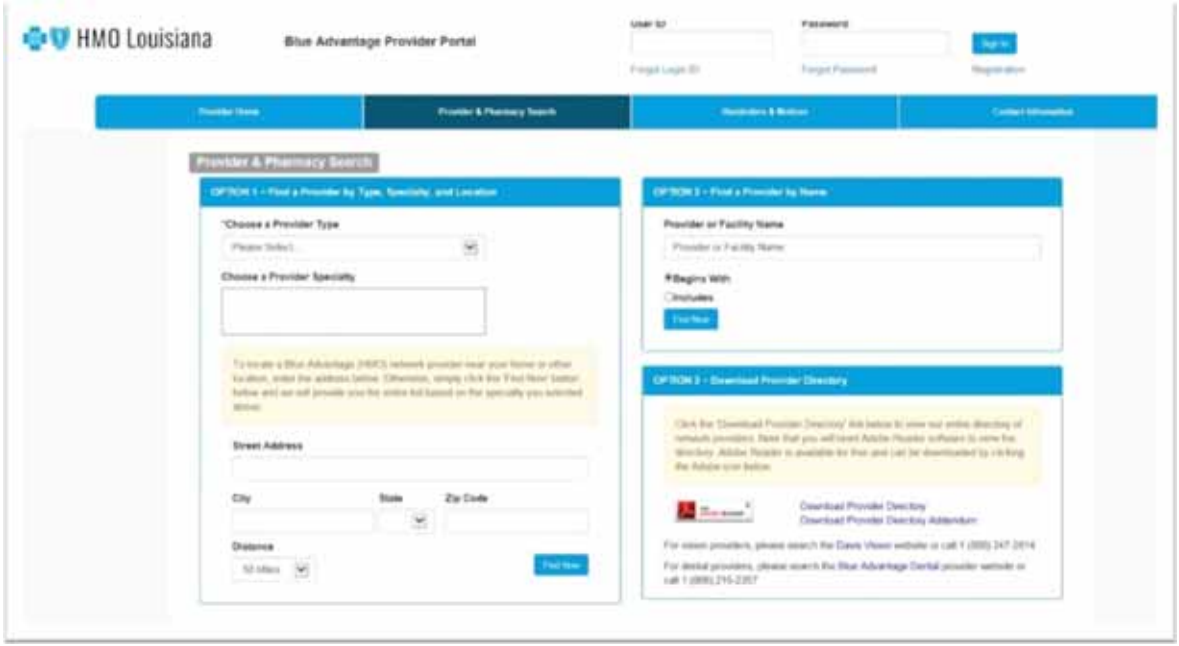
Finding Participating Providers

You can find network providers to refer members to in our online provider directories at **www.BCBSLA.com** >Find a Doctor



Finding Participating Providers for Blue Advantage (HMO)

To refer Blue Advantage (HMO) members to other providers, use the "Provider & Pharmacy Search" feature of the Blue Advantage Provider Portal (accessed through iLinkBlue)



Preferred laboratories for all specimens for the Blue Advantage network

- Clinical Pathology Labs (CPL)
- Quest Diagnostics
- Lab Corp

Out-of-network Referrals

The impact on your patients when you refer Blue Cross members to out-of-network providers:

- Out-of-network member benefits often include higher copayments, coinsurances and deductibles
- Some members may have no benefits for services provided by non-participating providers
- Non-participating providers can balance bill the member for all amounts not paid by Blue Cross

NEW

FEP Skilled Nursing Facility (SNF) Benefit Changes

- Effective January 1, 2018, Federal Employee Program (FEP) member benefits at skilled nursing facilities (SNF) changed
- FEP now has specific, restrictive criteria for FEP members to receive coverage for SNF services
- Always verify member benefits prior to rendering services

NEW

Criteria for FEP members to receive coverage for SNF services

- Must be Medicare Certified as a SNF
- Licensed in accordance with state or local law, or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such agencies or organizations)
- Admitting SNF has a transfer agreement in effect with one or more in-network hospitals
- Is primarily engaged in providing skilled nursing care and related services for individuals who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons
- Facility is physically separate from the rest of the institution
- Must provide skilled services seven days a week or therapy five days (minimum of two hours daily) a week with skilled nursing service for admissions solely for physical rehabilitation
- The facility must be able to provide nursing rehabilitative, respiratory, nutritional, educational, pharmacological and behavioral health services
- The member must have returned a signed consent agreeing to FEP case management prior to admission or transfer to SNF

Quality Blue Programs

Quality Blue Programs

Quality Blue programs recognize providers who are working in partnership with Blue Cross to transform healthcare systems and improve the way care is delivered to Blue Cross patients to help them achieve better health outcomes

Blue Cross offers its network providers opportunities through Quality Blue:

- To Earn Recognition
- Additional Payments
- Other Incentives

Quality Blue Programs currently offered:

- Blue Distinction®
- Quality Blue Primary Care (QBPC)
- Quality Blue PT/OT Program
- Specialty Care Insight Program

Blue Distinction Specialty Care

Blue Distinction Specialty Care Centers are part of a national designation program that recognizes facilities demonstrating expertise in delivering quality specialty care, safely and effectively. These designations are only awarded to the specific facility and specific location.

Two designation levels:

Blue Distinction® Center

Blue Distinction® Center+

The current programs are:

- Bariatric Surgery
- Cardiac Care
- Knee and Hip Replacement
- Maternity
- Spine Surgery
- Transplants

Specialty Program selection criteria can be found at **www.bcbs.com** >About Us >Capabilities & Initiatives >Blue Distinction >Blue Distinction Specialty Care

Questions related to Blue Distinction?

Contact Jode Burkett at **Jode.Burkett@bcbsla.com**

Blue Distinction Level Comparison

Evaluation Criteria for Participation Focused on:	Blue Distinction® Center Healthcare facilities recognized for their **expertise** in delivering specialty care	Blue Distinction® Center+ Healthcare facilities recognized for their **expertise** and **efficiency** in delivering specialty care
Identifying those facilities that demonstrate **expertise in delivering quality specialty care** – safely and effectively	✓	✓
Nationally **established quality measures** with emphasis on **proven outcomes**	✓	✓
Cost of care calculated on procedures, using episode-based allowable amounts		✓

Included in your folder is a listing of the Louisiana hospitals that are currently recognized for these distinctions for 2018

Care Management

Care Management Team

Blue Cross has a clinical care team of more than 200 doctors, nurses, dietitians, pharmacists and social workers to help our members achieve their health and wellness goals

Our care team supports your relationship with your patients (our members) and helps them stick to the treatment plans you recommend

In our Case and Disease Management programs:

- Patients get health coaching to help them stay on top of their health conditions, work toward wellness goals and practice good self-care between appointments
- Care is better coordinated between Blue Cross and your office, which helps improve quality and boost the patients' health outcomes
- The focus is on the whole person, using a proactive, patient-centered, population health improvement model that looks at each patient's individual needs, including health status and social determinants

Case Management Programs

Our case management programs work with your Blue Cross patients to develop and implement care plans to overcome or reduce barriers to getting needed care, focusing on boosting health outcomes and choosing cost-effective care

Case managers look for and work with customers to address gaps in care, wellness opportunities or transitions

Current Case Management Programs Offered:

- Transplant Care Management
- Healthy Blue Beginnings (high-risk pregnancy)
- Oncology Management
- Complex Case Management
- High Utilizers/High Cost (ER use, hospital discharge)
- Care Coordination

Disease Management Programs

Our Disease Management programs help improve the self-care and health of your Blue Cross patients with chronic health conditions

Our aim is to improve the physical and psycho-social well-being of Blue Cross members through cost-effective, personalized solutions that enable them to stick to the care plans recommended by their physicians

Current Disease Management Programs Offered:

- End Stage Renal Disease
- Chronic Kidney Disease
- Congestive Heart Failure
- Diabetes
- Pre-diabetes/metabolic syndrome
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease/Hypertension
- Asthma

Some of these conditions are also targeted in our Quality Blue programs

If a member is eligible for more than one program, he or she gets assigned according to a hierarchy process to address the most urgent need first

How to Refer Blue Cross Patients

Contact the Blue Cross Clinical Staff

Phone: 1-800-317-2299

M-F, 8 a.m. – 5 p.m.

(except office holidays)

- Providers can call on behalf of a Blue Cross patient or use the Referral Form located online at **www.BCBSLA.com/providers** >Programs >Care Management
- Blue Cross patients can self-refer
- Blue Cross members can refer an immediate family member

There is no added cost for Blue Cross members to participate in our Case and Disease Management programs. Our Case Management programs are offered as a member benefit on most of our individual and group plans (this benefit varies for some ASO groups).

Patients can call Blue Cross at the customer service number on the back of their member ID card to find out if this program is covered

Stronger Than Campaign

STRONGER THAN is a mindset, a way of engaging members and providers in their journey to better health. This platform will allow us to tell our care management services story from a cohesive, user-centered experience that brings our services to their life in a meaningful way to drive positive behaviors and build powerful relationships.

More information is available online at **www.BCBSLA.com/stronger**

Our Secure Online Services

Accessing Our Secure Online Services

We offer many online services that require secure access. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (BlueCard® members)
- and more (as we develop new services)

We require that each provider organization designate at least one administrative representative to self-manage user access to our secure online services

Administrative Representative

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online tools
- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- If you do not have an administrative representative registered with Blue Cross, please fill out and submit the Administrative Representative Registration Packet, which can be found on our Provider page (**www.BCBSLA.com/providers**)

Inactivity Policy

Beginning August 1, 2018, iLinkBlue and Sigma Security Setup Tool accounts that have not been accessed for a period of time will be suspended as follows:

- iLinkBlue user account suspends upon 90 days of inactivity
- iLinkBlue user account that remains inactive for 120 days will be terminated
- Sigma account suspends upon 90 days of inactivity
- Sigma account that remains inactive for one year will be terminated

When an account has been inactive for 60 days, the user will receive an email alert of the inactivity. Once suspended, to reactivate an account, iLinkBlue users must contact their administrative representative. Administrative representatives with suspended accounts must contact our PIM Team at **PIMTeam@bcbsla.com**.

Provider Identity Management Team

Need help?

Provider Identity Management (PIM) is a dedicated team to help you establish and manage system access to our secure electronic services

If you have questions regarding the administrative representative setup process, please contact our PIM Team

Email: **PIMTeam@bcbsla.com**

Phone: 1-800-716-2299, option 5

What they will do for you:

- Set up administrative representatives
- Educate and assist administrative representatives
- Outreach to providers without administrative representatives to begin the setup process

Common issues the PIM Team is asked to help with:

How do I change my administrative representative phone number?

This can be done with a phone call to the PIM team

How do I change my administrative representative email address?

Because your email address is your username, you must submit a new Administrative Representative Registration Packet

How do I terminate my administrative representative?

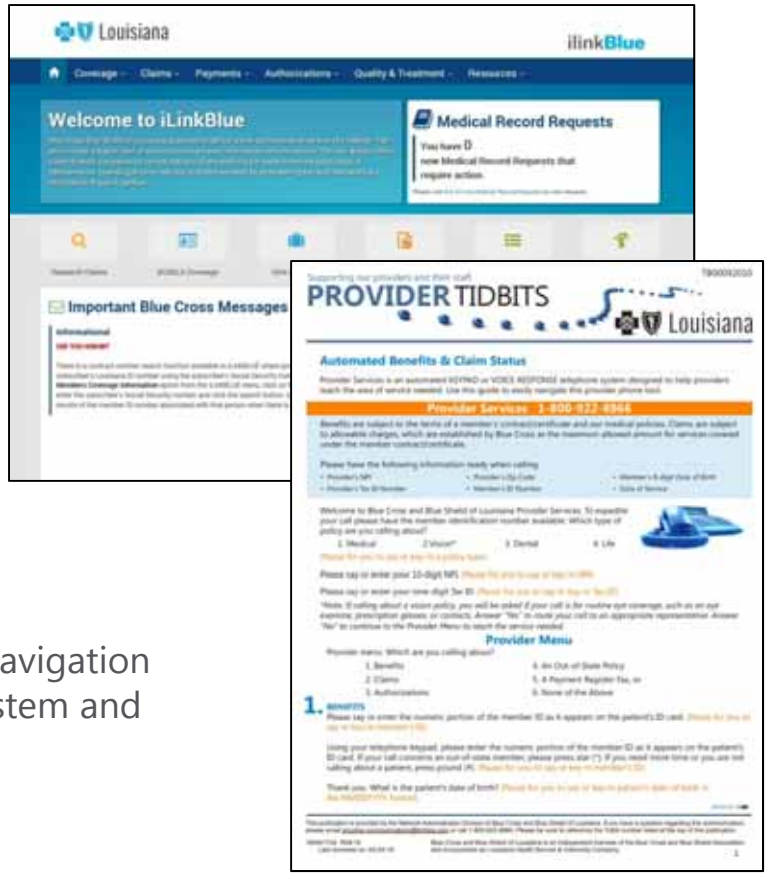
This requires a written notification be sent to the PIM team

Provider Self-service Initiative

Providers are now required to use our self-service tools for:

- member eligibility
- claim status inquiries
- professional allowable searches
- medical policy searches

These services will no longer be handled directly by our Customer Care Center



Self-service tools available to providers:

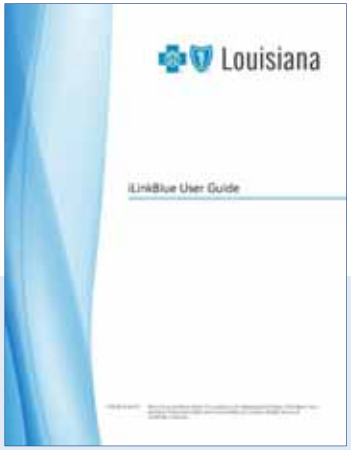
- iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- Interactive Voice Recognition (IVR) (1-800-922-8866)
  - The Automated Benefits & Claim Status (IVR Navigation Guide) Tidbit will help you navigate the IVR system and is available at **www.BCBSLA.com/providers** >Resources >Tidbits
- HIPAA 27x transactions

Included in your folder is a **Provider Self-service Quick Reference Guide** that provides more information about using these provider tools

iLinkBlue

- iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:
  - Coverage & Eligibility
  - Benefits
  - Coordination of Benefits (COB)
  - Claims Status (BCBSLA, FEP and Out of Area)
  - Medical Code Editing
  - Payment Registers/EFT Notifications
  - Allowables Search
  - Authorizations
  - Medical Policy
  - 1500 Claims Entry
- UB-04 Claims Entry is no longer available
- For iLinkBlue training and education, contact **provider.relations@bcbsla.com**

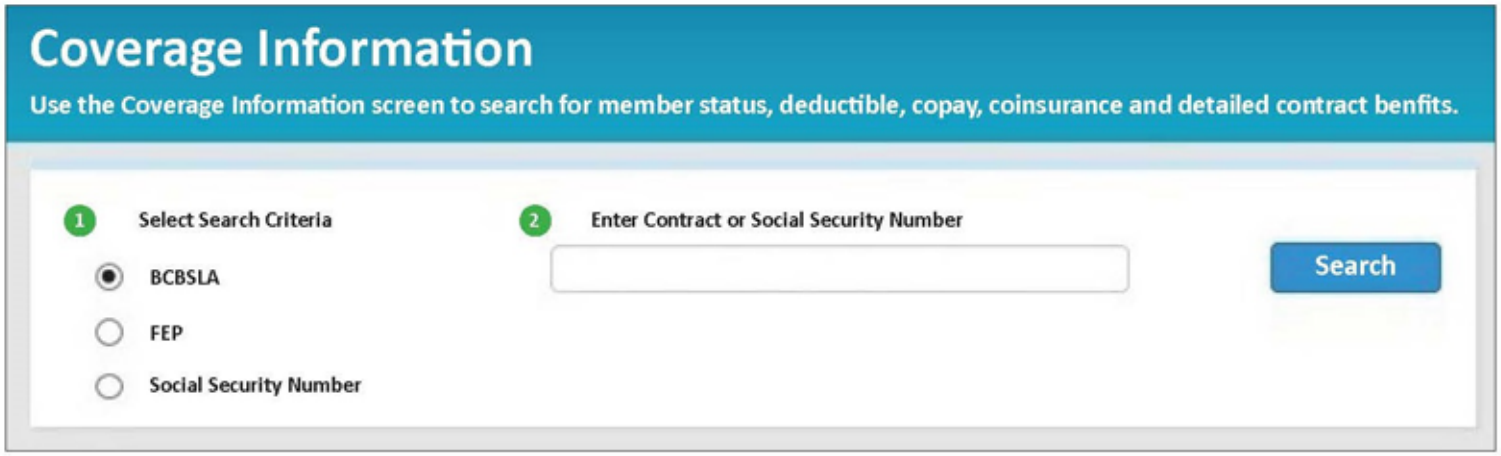
www.BCBSLA.com/ilinkblue



We have an *iLinkBlue User Guide* available online at **www.BCBSLA.com/providers**, then click on "Resources"

iLinkBlue - Coverage & Eligibility

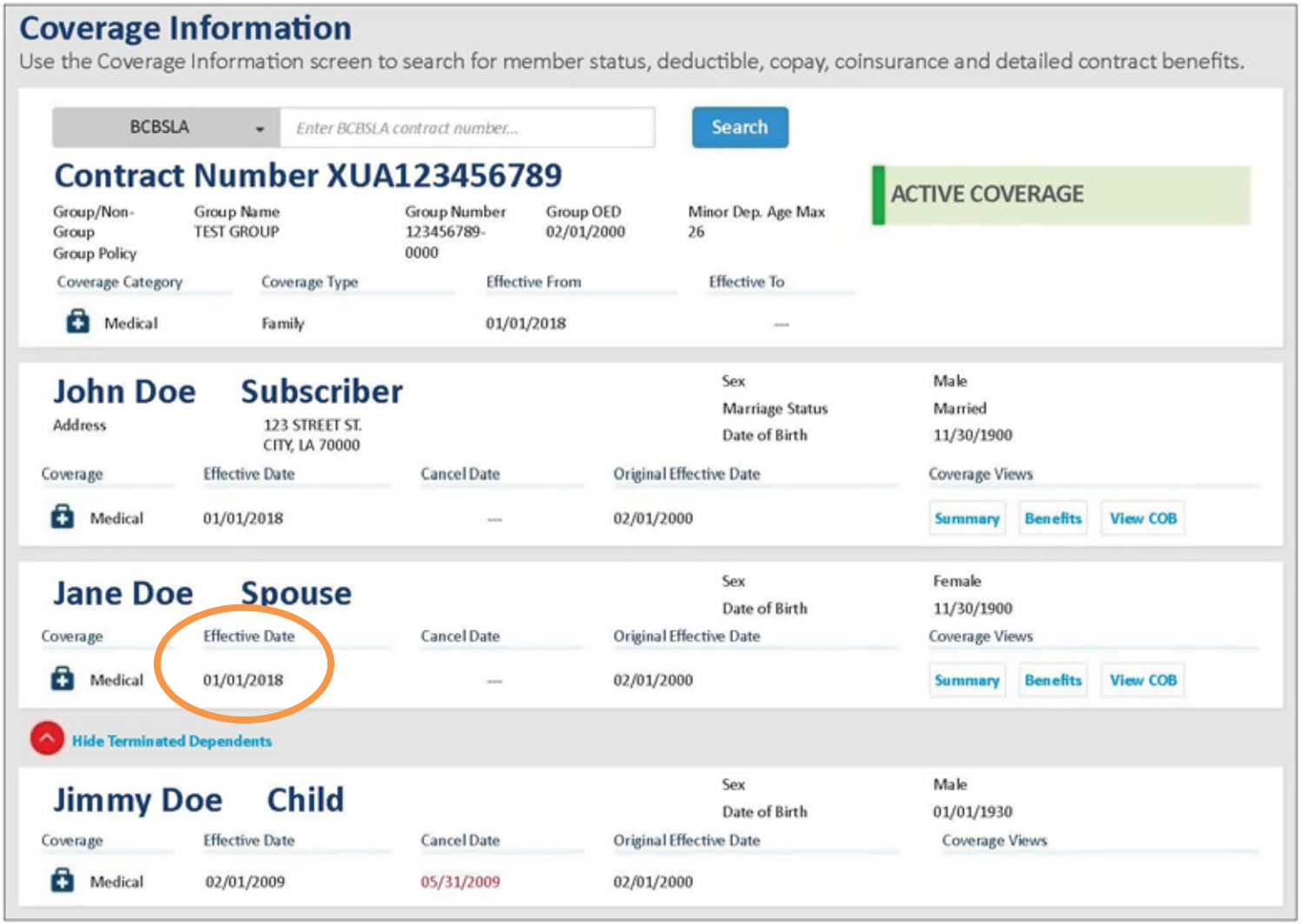
1.



Use the “Coverage” menu option to research Blue Cross and Federal Employee Program (FEP) member eligibility, copays, deductibles, coinsurance and detailed contract information

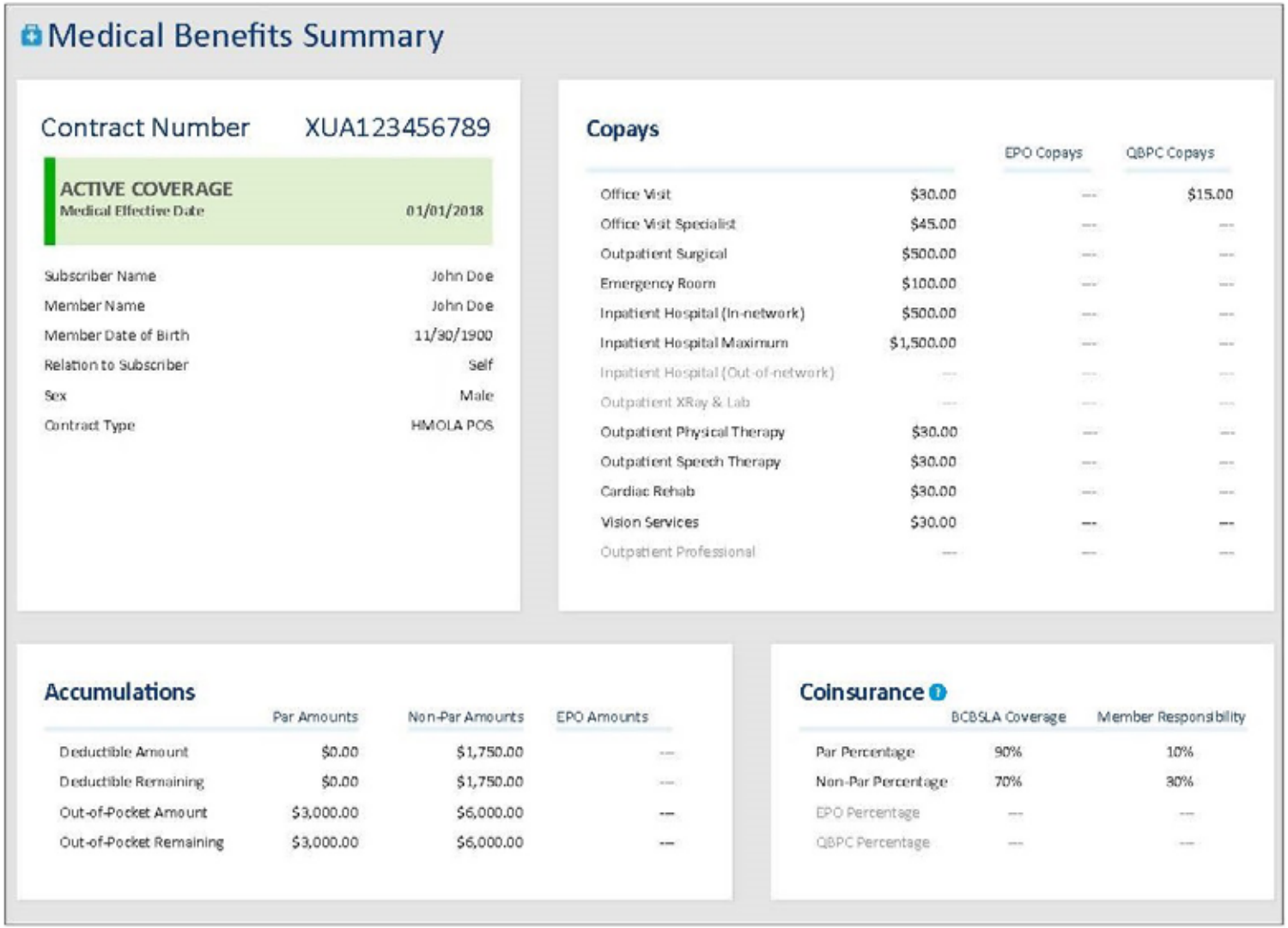
iLinkBlue - Coverage & Eligibility

2.



iLinkBlue - Coverage & Eligibility

3.



Medical Benefits Summary

Contract Number XUA123456789

ACTIVE COVERAGE
Medical Effective Date 01/01/2018

Subscriber Name	John Doe
Member Name	John Doe
Member Date of Birth	11/30/1900
Relation to Subscriber	Self
Sex	Male
Contract Type	HMOLA POS

Copays

		EPO Copays	QBPC Copays
Office Visit	$30.00	---	$15.00
Office Visit Specialist	$45.00	---	---
Outpatient Surgical	$500.00	---	---
Emergency Room	$100.00	---	---
Inpatient Hospital (In-network)	$500.00	---	---
Inpatient Hospital Maximum	$1,500.00	---	---
Inpatient Hospital (Out-of-network)	---	---	---
Outpatient XRay & Lab	---	---	---
Outpatient Physical Therapy	$30.00	---	---
Outpatient Speech Therapy	$30.00	---	---
Cardiac Rehab	$30.00	---	---
Vision Services	$30.00	---	---
Outpatient Professional	---	---	---

Accumulations

	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	---
Deductible Remaining	$0.00	$1,750.00	---
Out-of-Pocket Amount	$3,000.00	$6,000.00	---
Out-of-Pocket Remaining	$3,000.00	$6,000.00	---

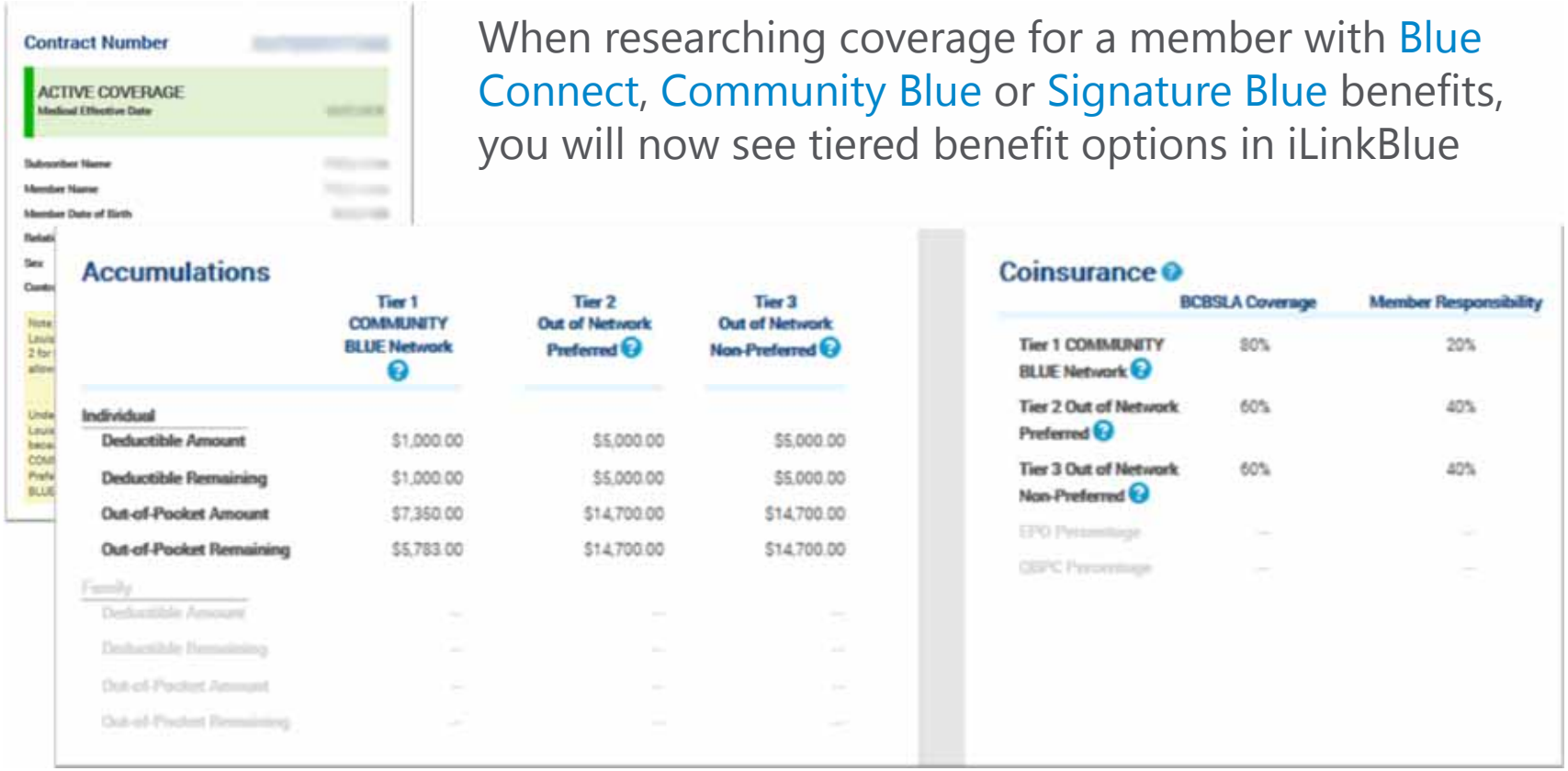
Coinsurance

	BCBSLA Coverage	Member Responsibility
Par Percentage	90%	10%
Non-Par Percentage	70%	30%
EPO Percentage	---	---
QBPC Percentage	---	---

iLinkBlue - Coverage & Eligibility

Tiered Benefits for Select Networks

When researching coverage for a member with Blue Connect, Community Blue or Signature Blue benefits, you will now see tiered benefit options in iLinkBlue



Tiered benefits do not display for members with Preferred Care PPO or HMO benefits

iLinkBlue - Coverage & Eligibility

Tiered Benefits for Select Networks

Tier 1
In Network
Preferred

Applies to providers participating in the member's select network

Example Scenario:

- A Community Blue member sees a Community Blue provider
- The member copay and accumulators identified under Tier 1 should be applied
- Provider may not bill the member for any amount over the allowed amount

Tier 2
Out of Network
Preferred

Applies to providers participating in-network with Blue Cross but NOT in the member's specific network

Example Scenario:

- A Community Blue member sees a Preferred Care PPO provider
- The member copay and accumulators identified under Tier 2 should be applied
- Provider may not bill the member for any amount over the allowed amount

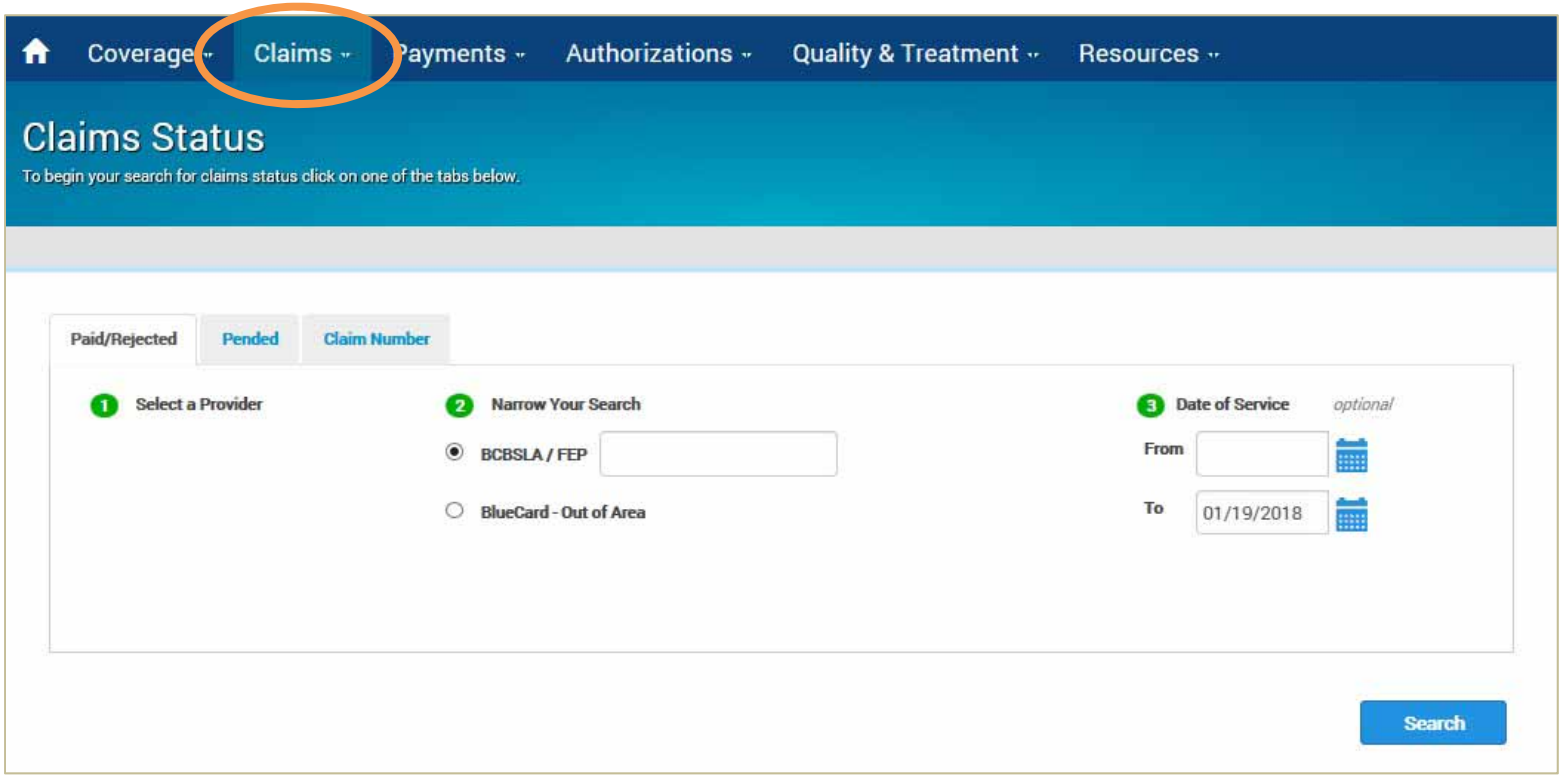
Tier 3
Out of Network
Non Preferred

Applies to providers who do not participate in any Blue Cross network

Example Scenario:

- A Community Blue member sees a non-participating provider
- The member copay and accumulators identified under Tier 3 should be applied
- Provider can bill the member for all amounts over the allowed amount

iLinkBlue – Claims Research



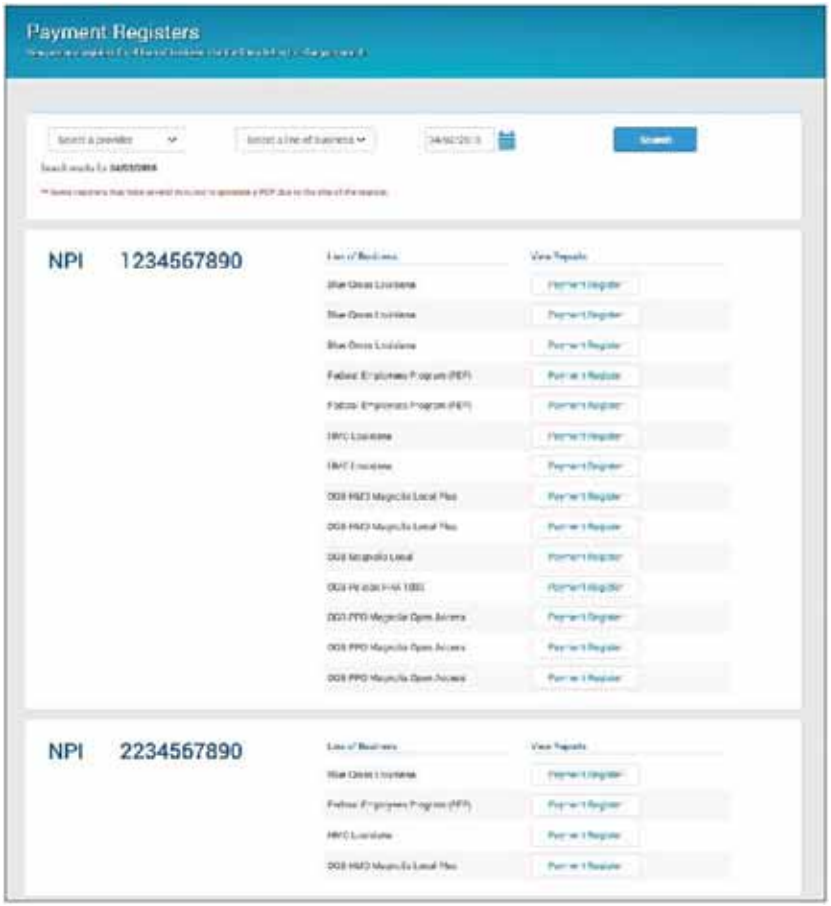
- Use the "Claims" menu option to research paid, rejected and pended claims
- You can research BCBSLA, FEP and Out-of-area claims submitted to Blue Cross for processing

iLinkBlue – Claims Research

Submitting Action Requests

- Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim
- On each claim, providers have the option to submit an Action Request to request a review for correct processing
- You may click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim
- Please include your contact information

iLinkBlue – Payment Registers



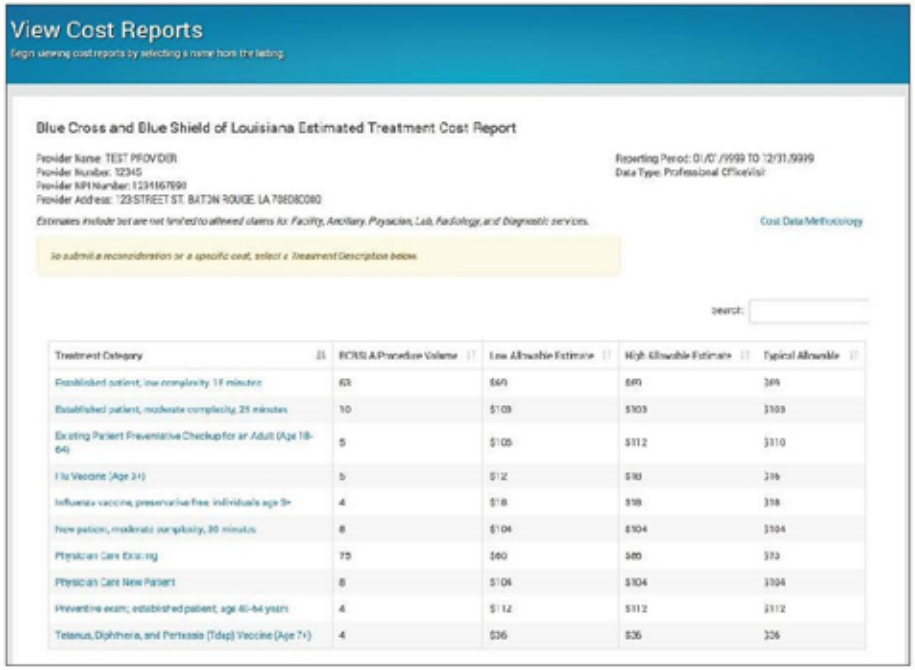
- Use the “Payments” menu option to find your Blue Cross payment registers
- Payment registers are released weekly on Mondays
- Notifications for the current week will automatically appear on the screen
- You have access to a maximum of two years of Payment Registers in iLinkBlue
- If you have access to multiple NPIs, you will see registers for each

iLinkBlue – Authorizations

- Use the "Authorizations" menu option to access our authorization tools
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Pre-Service Review

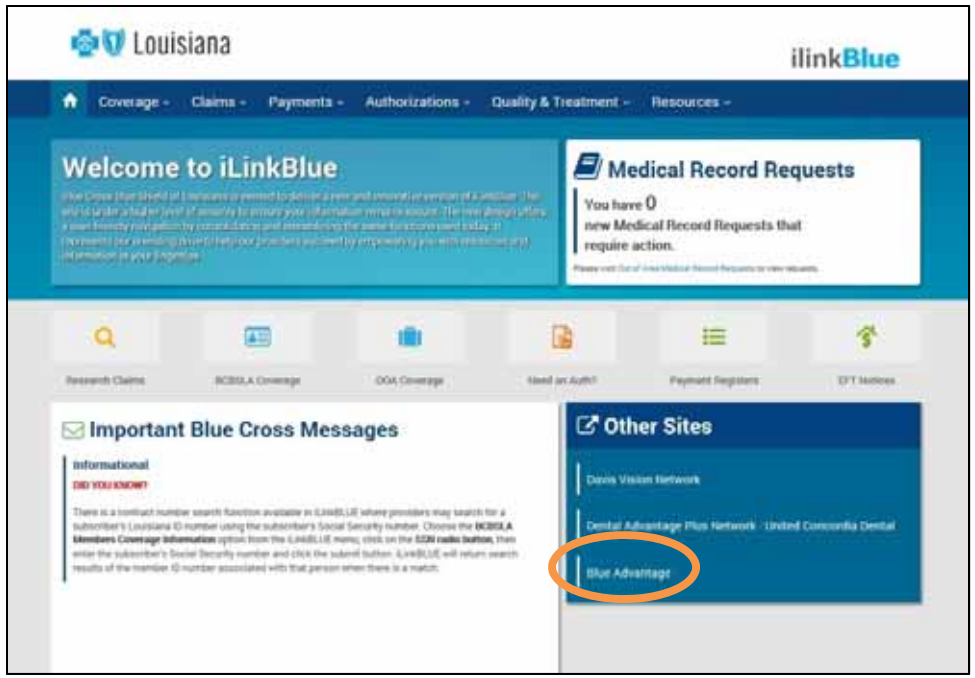
Invitations to register for our upcoming behavioral health workshops have been sent via email to our network behavioral health providers

iLinkBlue – Cost Reports



- Twice a year (spring and fall), Blue Cross refreshes the Estimated Treatment Cost Tool with updated provider costs to enable our members to be more active in managing their own healthcare choices
- When this occurs, providers are sent a letter advising them they have 30 days from the date of notice to review their cost reports and request a reconsideration, if needed
- Use the "Quality & Treatment" menu option to find your **Estimated Treatment Cost Reports**
- The **View Reports** option allows you to view the most recent reports calculated for your facility or professional provider
- The **Electronic Reconsideration Form** for a treatment will be available to providers only during the reconsideration period

Accessing the Blue Advantage Provider Portal



- The processes for Blue Advantage (HMO) differ from our other provider network processes
- We have created a separate portal for these contracted providers to access those processes
- You must access the Blue Advantage Provider Portal through iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- The Blue Advantage Provider Portal also requires a higher level of security access that must be assigned to users by your organization's security administrative representative

Future Enhancements

New facility provider tools coming in 2019

- Facility outpatient providers will soon have an **Allowable Charges Search** tool to research their allowables

- We are in the process of implementing a new **Claims Editing System (CES)** for both facility outpatient and professional providers
  - CES is an auditing system used to manage reimbursement, medical policy, benefit rules and industry standard coding
  - CES will help ensure accurate and consistent payments
  - Many existing edits will remain the same, however there will be some differences to conform to changes in coding standards, updated reviews of existing code editing logic and enhanced functionality of the new system. As a result, you may see changes in your payment once CES is implemented .

We will communicate additional information about these enhancements through future mailings and our provider newsletter

Authorizations

Prior Authorizations

- Services that require prior authorization can be found in our provider manuals and network speed guides. These are available in iLinkBlue (**www.BCBSLA.com/ilinkblue**) under "Resources."
- Authorization requirements may vary by product
- The ordering/rendering provider must initiate the authorization process at least 48 hours prior to the service by:
  - Using iLinkBlue to access our online authorization portal, or
  - Calling the authorization number on the member ID card

Top reasons for claim denials related to authorizations:

- Place of treatment and/or date of service does not match authorization
- Diagnosis and/or procedure code does not match authorization
- Servicing provider does not match authorization

Urgent Authorizations

The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received

The authorization process is designed only to evaluate the medical necessity of the service and is not a guarantee of payment or a confirmation of coverage for benefits

Approved Requests

- The contact person/practitioner is notified by telephone
- A confirmation letter is sent to the member, physician and hospital, as applicable

Denied Requests

- The contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the expedited appeal process
- A letter listing appeal rights is sent to the member, physician and hospital, if applicable, within one business day of the determination

Process for Changing an Authorization

You can ask our authorization department to change or add a code to an already approved authorization when all of the following conditions are met:

- There is an approved authorization on file
- Provider states a claim has not been filed
- The requested code is surgical or diagnostic
- The requested code is not on a Blue Cross medical policy or a non-covered benefit
- If the above criteria is met, an authorization can be changed within seven calendar days of the services being rendered

If the procedure being added or changed is on a Blue Cross medical policy or is a non-covered benefit, it cannot be updated on the authorization

Once the claim is filed, fax medical records to (225) 298-2906 or 1-800-515-1150

Failure to Obtain an Authorization

Failure to obtain a prior authorization can result in:

- A 30 percent penalty imposed on Preferred Care PPO and HMO Louisiana, Inc. network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization
- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized *(Note: some policies contain a different inpatient penalty provision)*
- The denial of payment for services for our Office of Group Benefits (OGB) members

Authorization penalty amounts or services that are denied for no authorization are not billable to the member

Faxed Approval Letters

- Our Care Management team sends all approval of service notification letters via fax
- Approval letters are no longer mailed
- Professional providers and facilities may receive up to three separate batches of faxes: inpatient, outpatient and recertification.
- Batches are sent Monday-Saturday beginning at 4 a.m.
- Each batch will include all of the members who were approved for services from the previous business day
  - e.g. if there were 15 outpatient services authorized for your facility, the outpatient batch fax will include all 15 approval letters

Update or change your fax number for approval and denial letters through our **Utilization Management Approval and Denial Fax Form**, available online at **www.BCBSLA.com/providers** >Resources >Forms

OGB Authorizations

OGB authorization requirements are different and the member has NO benefits if an authorization is not obtained

Section 4: Medical Management

OGB PLAN SERVICES REQUIRING AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required once the combined benefit limit of 50 visits of PT/OT have been achieved. Providers may request authorization by calling our Authorization line. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans effective January 1, 2018.

INPATIENT
- Inpatient Hospital Admissions (except routine maternity stays*)
- Mental Health/Substance Use Disorder Admissions
- Skilled Nursing Facility
- Transplant Services (organ, tissue, bone marrow)

OUTPATIENT
- Air Ambulance (non-emergency)
- Applied Behavioral Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- CT Scans**
- Day Rehabilitation Programs
- DME greater than $300
- Electric Al Custom Wheelchairs
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over $2000 (including but not limited to defibrillators and insulin pumps)
- Infusion Therapy (includes home and facility administration) Exceptions: Infusion therapy performed in a physician's office (the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery
- Organ Transplant Evaluation
- Orthotic Devices greater than $300
- Outpatient Pain Rehabilitation/Pain Control Programs
- Partial Hospitalization Programs
- PET Scans**
- Physical/Occupational Therapy (greater than 50 visits)
- Certain Prescription Drugs - The complete list of drugs requiring an authorization is available online on our Provider Page
- Prosthetic Appliances greater than $300
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery (including but not limited to gamma knife & cyberknife)
- Vacuum Assisted Wound Care Therapy

* Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery.

** Request for prior authorization for these services may be completed online through LinkBlue using AIM's Provider Portal.

Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

4-9
December 2017

Blue Cross and Blue Shield of Louisiana
Member Provider Policy & Procedure Manual

Louisiana

- The list of OGB authorization requirements can be found in our *Member Provider Policy and Procedure Office Manual* located on iLinkBlue
- The list also appears on the OGB Speed Guide located on **www.BCBSLA.com/providers** >Resources

Included in your folder is a copy of the *OGB Speed Guide*

Blue Advantage (HMO) Inpatient Admissions & Discharges

Blue Advantage network providers are required to provide notification of Blue Advantage members' inpatient admissions within 24 hours of inpatient admission and for observation cases longer than 48 hours

Blue Advantage providers must submit clinical documentation supporting the requested level of care to Blue Advantage within 24 hours of notification

Blue Advantage providers may call or fax admission and/or discharge information (date & disposition) to the Blue Advantage Medical Management team:

Phone: 1-866-508-7145

Fax: 1-877-528-5818

The phones are forwarded to a secure voice mail system during non-business hours and the fax is available 24 hours a day, 7 days a week

Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment.

Providers who are denied payment because notification was not received may not bill the member

InterQual Criteria Update

- Recently, the 2018 version of the Change Health InterQual (IQ) Criteria was released
- We use IQ criteria for utilization management, medical necessity, level of care and appropriateness decision making and care coordination
- **Effective October 1, 2018**, we will switch from the 2017 version to IQ's 2018 version
- The updated criteria will be integrated into the Blue Cross Authorization Tool that is available through iLinkBlue (**www.BCBSLA.com/ilinkblue** >Authorizations >BCBSLA Authorizations). Within this tool, providers can access the 2018 criteria for authorization requests.

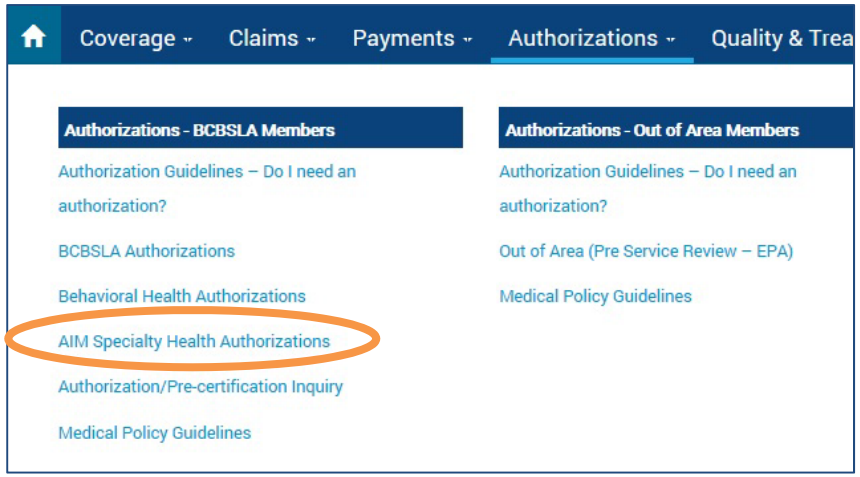
Blue Cross Authorization Portal

Advantages of our Blue Cross Authorization Application:

- Accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue** >Authorizations >BCBSLA Authorizations)
- Submit authorizations and upload clinical documents 24 hours a day, seven days a week
- Likely to get an automatic approval for your authorization request
- Immediate ability to view request decision, length of stay assigned and reason for pending decision
- Eliminates time on the phone for notifications
- Discharges can be entered without faxing
- Ability to view and print denial letters

AIM Authorizations & Reviews

AIM Specialty Health® (AIM) is an independent company that administers services for Blue Cross:



Use the AIM ***Provider****Portal*$_{SM}$ in iLinkBlue to set up an authorization or request a medical necessity review

- AIM has a shopper program that allows members to choose, based on quality and cost, the diagnostic imaging facility where their services are rendered
- AIM manages select elective outpatient hightech imaging service authorizations
- AIM also administers medical necessity reviews for select utilization management (UM) programs

AIM Specialty Care Shopper Program

- AIM has a shopper program that allows members to choose, based on quality and cost, the diagnostic imaging facility where their MR and CT services are rendered
- This program includes both Preferred Care PPO and HMO Louisiana, Inc. members covered under individual policies and covered under fully-insured employer groups. The program is also available to self-funded employer groups upon request.
- Your Blue patients may be contacted directly by AIM for the purpose of informing them of a high-quality, lower-cost diagnostic imaging center

How the AIM Specialty Care Shopper Program Works:

- The ordering provider enters an authorization in the AIM ***Provider****Portal*$_{SM}$ and selects a rendering provider
- Once the authorization is complete, AIM determines if there are any alternative diagnostic imaging providers of high-quality and lower-cost
- AIM then notifies the member of the alternatives with the offer to switch the member to a high-quality, lower-cost facility. If the member chooses to switch, AIM schedules a new appointment at the alternate facility, updates the member authorization and reminds the member to cancel the original appointment.
- AIM notifies the ordering physician and the member of the new authorization information

Imaging Authorizations

The ordering physician should always use the AIM ***Provider****Portal*$_{SM}$ in iLinkBlue to set up an authorization

AIM Specialty Health$_{®}$ allows you to submit and receive pre-authorizations over the Web on a real-time basis eliminating the need to call AIM for the following outpatient high-tech diagnostic services:

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

Blue Advantage (HMO) providers currently only use AIM for their Blue Advantage members' authorizations for advanced radiological imaging or radiation therapy services

Top reasons for claim denials related to outpatient imaging authorizations:

- No authorization on file
- Facility location (place of treatment) does not match authorization
- Servicing provider does not match authorization

UM Program: MSK – Spine Surgery and Spine Pain Management

- We have a UM musculoskeletal (MSK) program that now requires an authorization for spine surgery and spine pain management services through the AIM ***Provider****Portal*$_{SM}$ in iLinkBlue
- AIM Specialty Health$_{®}$ administers, for Blue Cross, medical necessity reviews
- Services that do not meet criteria will be denied and are not billable to the member
- Criteria are available online at **www.aimspecialtyhealth.com**. For the Clinical Guidelines, click on "Download Now," and then on "Musculoskeletal."

For a listing of codes, contact **provider.relations@bcbsla.com**

NEW

UM Program: MSK – Joint Surgery

- We are expanding our UM MSK program to include joint surgery for large joint replacement and arthroscopy of the hip, knee and shoulder
- Blue Cross will require a prior authorization for these services for dates of service on and after **September 1, 2018**
- AIM began accepting pre-service authorization reviews for MSK joint surgery services on August 27
- Between August 27 and October 26, 2018, authorization requests will be approved even when medical necessity is not met. Peer-to-peer discussions will be offered on cases that do not meet medical necessity criteria to educate providers.
- Beginning October 27, 2018, MSK joint surgery services that do not meet criteria will be denied as not medically necessary and are not billable to the member.
- Criteria are available online at **www.aimspecialtyhealth.com**. For the Clinical Guidelines, click on "Download Now," and then on "Musculoskeletal."

For a listing of codes, contact **provider.relations@bcbsla.com**

UM Program: Radiation Oncology

- We now require an authorization for radiation therapy for oncology through through AIM's ***Provider****Portal*$_{SM}$ in iLinkBlue
- AIM administers, for Blue Cross, medical necessity reviews
- Services that do not clearly meet criteria will be reviewed by board-certified-like specialists. These reviews will be based on AIM appropriate-use criteria.
- Services that do not meet criteria will be denied and are not billable to the member
- Criteria are available online at **www.aimspecialtyhealth.com**. For the Clinical Guidelines, click on "Download Now," and then on "Radiation Oncology."

For a listing of codes, contact **provider.relations@bcbsla.com**

NEW

UM Program: Cardiology

In November, we will host webinars to help you better understand this new UM Program:

- Tuesday November 27: 2 – 3 p.m.
- Wednesday, November 28: 9 – 10 a.m.
- Thursday, November 29: 3 – 4 p.m.

- Certain cardiology services will be reviewed for medical necessity beginning January 1, 2019
- This will apply for non-emergent cardiology services performed in an office or outpatient setting
- AIM will begin accepting pre-service authorization reviews for cardiac services on December 17, 2018
- We strongly recommend physicians obtain a pre-service authorization for these services
- Claims received without a pre-service review will be denied by Blue Cross until a post-claim review is completed by AIM

More information about this new utilization management program, including a listing of codes, will soon be sent to providers

Medical Appeals

Medical Necessity Appeals

Blue Cross receives large volumes of medical necessity appeals

- We require network providers to disclose ineligible services to members prior to performing or ordering services
- Investigational or experimental procedures are not considered medically necessary according to our policy

Please remember to check the medical policies section on iLinkBlue to view the most current medical policies. Benefit determinations are made based on the medical policy in effect at the time of the provision of services.

- You can easily search for medical policies using the index within iLinkBlue

- Our medical policies include:
  - coverage eligibility
  - background information related to technology
  - devices and treatments
  - technology assessments
  - literature sources
  - the rationale for coverage determinations

For medical necessity appeals, providers must send a written request to:

Blue Cross Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837

Accessing our Medical Policies

1.

2.

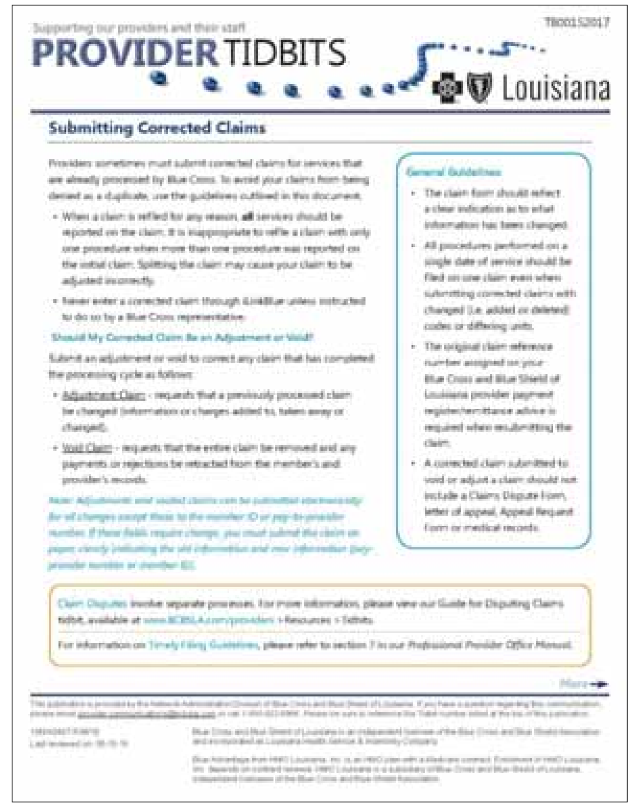
- From the iLinkBlue menu, select "Authorizations" then "Medical Policy Guidelines" to open the **Medical Policy Index**
- Our medical policy index offers the following search features:
  - On the "**Keyword**" tab, you can enter a policy number or title in the search tool to research current BCBSLA medical policies. You can also enter a procedure code to find policies that include that code.
  - Use the "**Letter**" tab to open an alpha-index list of all policies that allows you to alphabetically search for a BCBSLA medical policy
  - The "**View All**" tab opens a complete list of all current BCBSLA medical policies

Medical policies are reviewed, updated and developed every month. We publish these updates in our quarterly *Provider Network News* newsletters, available online at **www.BCBSLA.com/providers** >Newsletters.

Correcting or Disputing Claims

Correcting Claims Tidbit

- Submitting corrected claims can be easy when the appropriate steps are followed
- Use the “Submitting Corrected Claims” tidbit as a guide to properly adjust or void a claim so it does not deny as duplicate or process incorrectly
- The tidbit outlines the steps for submitting a corrected claim by paper or electronically (via clearinghouse or iLinkBlue)
- Available online at **www.BCBSLA.com/providers** >Resources


Supporting our providers and their staff
PROVIDER TIDBITS
Louisiana
Submitting Corrected Claims

Available online at **www.BCBSLA.com/providers** >Resources >Tidbits

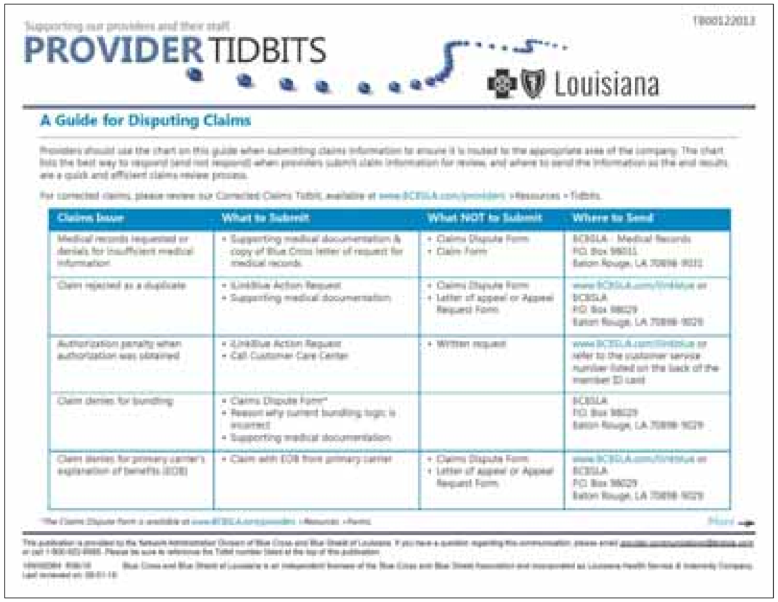
Electronic Corrected Claims

Submitting corrected claims electronically can be easy when the appropriate steps are followed

Please follow the steps below so your claims will not deny as duplicates or process incorrectly

- In Loop 2300 ~ CLM05-03 must contain a “7” or “8” REF01 must contain an “F8” and REF02 must contain the Original Reference Claim Number

Disputing Claims Tidbit



PROVIDER TIDBITS

Louisiana

A Guide for Disputing Claims

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denials for insufficient medical information	• Supporting medical documentation & copy of Blue Cross letter of request for medical records	• Claims Dispute Form • Claim Form	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	• iLinkBlue Action Request • Supporting medical documentation	• Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	• iLinkBlue Action Request • Call Customer Care Center	• Written request	www.BCBSLA.com/ilinkblue or refer to the customer service number listed on the back of the member ID card
Claim denies for bundling	• Claims Dispute Form* • Reason why current bundling logic is incorrect • Supporting medical documentation		BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029

- We recognize that disputes may arise between providers and Blue Cross regarding covered services
- Use the "Disputing Claims" tidbit as a guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross
- Examples of issues that qualify as disputes:
  - Claims issues related to authorizations
  - Claims based on adverse determinations of medical necessity or benefit determinations
  - Reimbursement reviews

Available online at **www.BCBSLA.com/providers** >Resources >Tidbits

Claims Dispute Form

- Use the Claims Dispute Form to properly request a review of your claim
- Be sure to place the form on top of your claim when submitting for review to ensure it is routed to the appropriate area of the company
- Use the Claims Dispute Form when:
  - Claim rejected as duplicate
  - Claim denied for bundling
  - Claim denied for medical records
  - Claim denied as investigational or not medically necessary
  - Claim payment/denial affects the provider's reimbursement
  - Claim payment affects the member's cost share
  - Claim denied for a BlueCard® member

Louisiana

Claims Dispute Form

Complete this form to dispute a claim. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to return the proper information based on your reason for review and that it is sent to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER

☐ Professional ☐ Facility ☐ Other

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form

Contact Email Address | Contact Phone Number

PATIENT INFORMATION

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

Claim Number | Date(s) of Service | Amount Charged

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-Op History and Physical 4. Asst. Surgeon Credential (If not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your claims dispute. Please check only one reason per form. In order for us to review your claim dispute, we must receive the entire form.

A printable PDF of this form is available online at www.BCBSLA.com/providers, then click on Resources > Forms

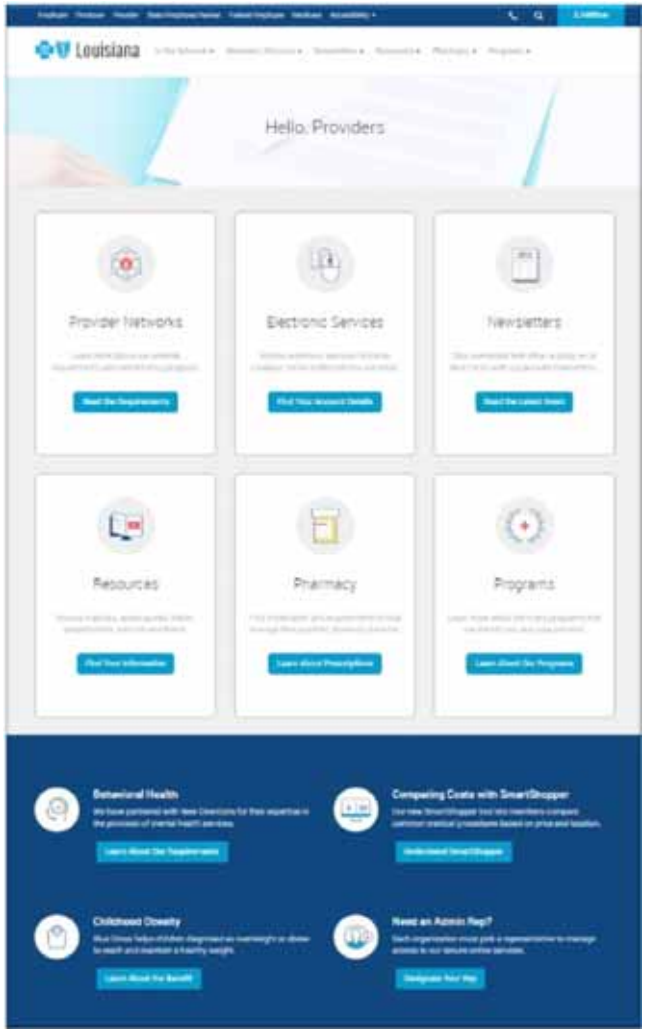
Page 1 of 2

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Available online at **www.BCBSLA.com/providers** >Resources >Forms

Support & Resources

Provider Page



www.BCBSLA.com/providers

The Provider Page is home to such online resources as

- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

The *Member Provider Policy & Procedure Manual* (our facility manual) is located only in iLinkBlue (**www.BCBSLA.com/ilinkblue**)

Manuals & Newsletters

Our provider **Manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our networks.

www.BCBSLA.com/ilinkblue >Resources

Our provider **Newsletters**, contain information and tips on changes to processes, such as claims filing procedures or reimbursement changes, along with a number of featured articles

www.BCBSLA.com/providers >Newsletters

Speed Guides & Tidbits

Our **Speed Guides** offer quick reference to network authorization requirements, policies and billing guidelines

Provider Tidbits are quick guides designed to help you stay informed of our current business processes

www.BCBSLA.com/providers >Resources

Call Centers

Customer Care	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-877-250-9167**

For information NOT available on iLinkBlue

Other Provider Phone Lines

BlueCard Eligibility Line® – 1-800-676-BLUE (1-800-676-2583)
for out-of-state member eligibility and benefits information

Fraud & Abuse Hotline – 1-800-392-9249
Call 24/7 and you can remain anonymous as all reports are confidential

Network Administration – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing/recredentialing
- **option 3** – for questions regarding your provider data management
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding administrative representative setup

Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary supervisor

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard

Kelly Smith
Acadia, Ascension, Calcasieu, Cameron, Iberville, Jefferson Davis, Livingston, Pointe Coupee, St. Landry, St. Martin, Vermilion, West Baton Rouge

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn

Marie Davis
Assumption, Iberia, Lafayette, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana

Melonie Martin
East Baton Rouge

Patricia O'Gwynn
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll

provider.relations@bcbsla.com | 1-800-716-2299, option 4

Jennifer Aucoin **Darnell Kling** **Angela Jackson**

Network Development

Provider Contracting

Jennifer Caveny — **jennifer.caveny@bcbsla.com**
director

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manager

Cora LeBlanc – **cora.leblanc@bcbsla.com**
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St. Tammany, Tangipahoa, Washington

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Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge, West Feliciana

Shannon Taylor – **shannon.taylor@bcbsla.com**
Blue Advantage, Special Projects

network.development@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean **Mary Landry** **Karen Armstrong**

Network Operations

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Wendy Barber provider data manager

Gloria Burns credentialing manager

The **network.administration@bcbsla.com** email address should be used by providers as an electronic option for submitting contracts, applications and forms

Recredentialing applications can be emailed to **recredentialingapplication@bcbsla.com**

These email addresses should not be used to submit general inquiries

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Network Operations Department by calling 1-800-716-2299

To create more efficiency and reduction in processing time, information emailed and faxed to Network Operations should be sent as separate documents

Example:

1. Contract
2. Application and supporting documentation (licenses, education, etc.)
3. EFT & iLinkBlue agreements

1-800-716-2299 • option 2 – credentialing • option 3 – provider data management
Fax: 225-297-2750 • **network.administration@bcbsla.com**

Thank you