Fall 2019
Facility Workshops

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

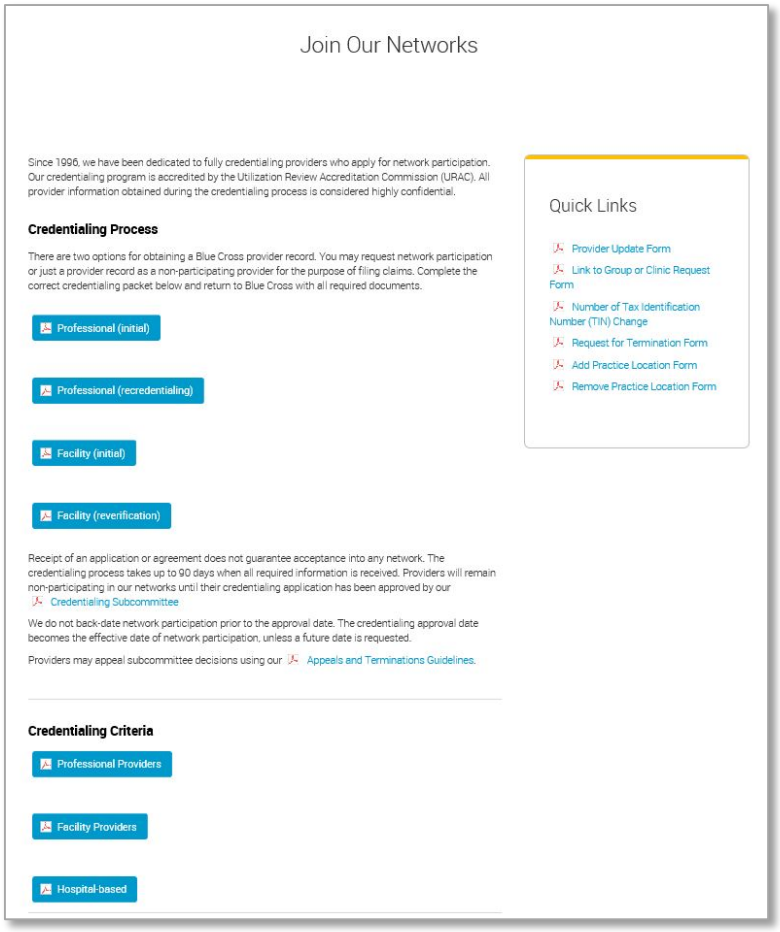
Your Blue Cross and Blue Shield of Louisiana Provider Relations Team

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

Agenda

CREDENTIALING & PROVIDER DATA

Join Our Networks Webpage



Join Our Networks

Since 1996, we have been dedicated to fully credentialing providers who apply for network participation. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC). All provider information obtained during the credentialing process is considered highly confidential.

Credentialing Process

There are two options for obtaining a Blue Cross provider record. You may request network participation or just a provider record as a non-participating provider for the purpose of filing claims. Complete the correct credentialing packet below and return to Blue Cross with all required documents.

Professional (initial)

Professional (recredentialing)

Facility (initial)

Facility (reverification)

Receipt of an application or agreement does not guarantee acceptance into any network. The credentialing process takes up to 90 days when all required information is received. Providers will remain non-participating in our networks until their credentialing application has been approved by our Credentialing Subcommittee

We do not back-date network participation prior to the approval date. The credentialing approval date becomes the effective date of network participation, unless a future date is requested.

Providers may appeal subcommittee decisions using our Appeals and Terminations Guidelines.

Credentialing Criteria

Professional Providers

Facility Providers

Hospital-based

Quick Links

Provider Update Form

Link to Group or Clinic Request Form

Number of Tax Identification Number (TIN) Change

Request for Termination Form

Add Practice Location Form

Remove Practice Location Form

- ✓ Credentialing and Recredentialing Packets *(including a checklist of all required documents)*
- ✓ Quick Links to provider update forms
- ✓ Credentialing Criteria

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

Credentialing Process

- The credentialing process can take up to 90 days after all required information is received
- Providers will remain non-participating in our networks until their application has been approved by the credentialing committee
- The committee approves credentialing twice per month
- Network providers are recredentialed every three years from their last credentialing acceptance date

After 90 days, you may inquire about your credentialing status by contacting our Provider Credentialing and Data Management department at pcdmstatus@bcbsla.com

Incomplete Credentialing Applications

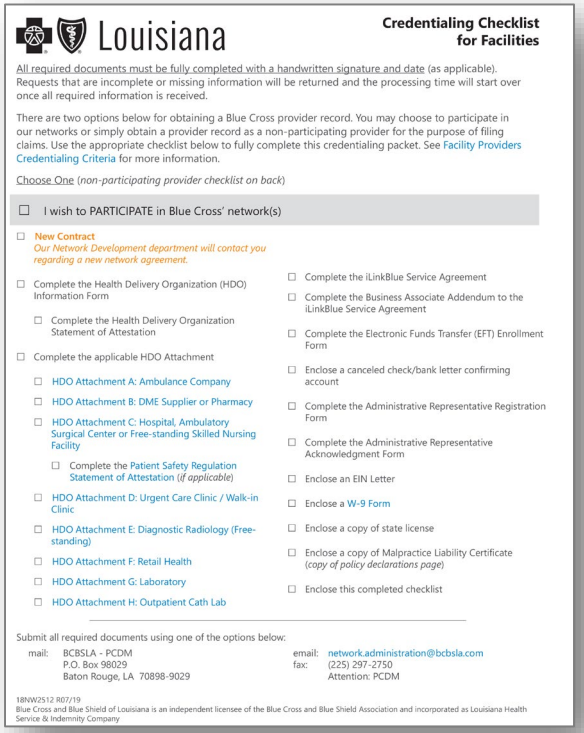
Below are the most common reasons credentialing applications are returned:

- 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 did not submit the current version of the **Louisiana Standardized Credentialing Application**
- Facility did not submit the **Health Delivery Organization Information Form**
- An alternative application was submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*

The 90-day processing time begins when we receive all required information. The application processing time starts over once a completed application is returned to Blue Cross. Submitting a completed form is key to timely processing.

Credentialing Checklist

- To ensure your application is not returned, **always** use the provided checklist
- The 90-day processing time begins when we receive **all** required information. The application processing time starts over once a complete application is returned to Blue Cross. Submitting a completed form is key to timely processing.



Louisiana

Credentialing Checklist for Facilities

All required documents must be fully completed with a handwritten signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

There are two options below for obtaining a Blue Cross provider record. You may choose to participate in our networks or simply obtain a provider record as a non-participating provider for the purpose of filing claims. Use the appropriate checklist below to fully complete this credentialing packet. See Facility Providers Credentialing Criteria for more information.

Choose One (*non-participating provider checklist on back*)

☐ I wish to PARTICIPATE in Blue Cross' network(s)

☐ **New Contract**
Our Network Development department will contact you regarding a new network agreement.

☐ Complete the Health Delivery Organization (HDO) Information Form

☐ Complete the Health Delivery Organization Statement of Attestation

☐ Complete the applicable HDO Attachment

☐ HDO Attachment A: Ambulance Company

☐ HDO Attachment B: DME Supplier or Pharmacy

☐ HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility

☐ Complete the Patient Safety Regulation Statement of Attestation (*if applicable*)

☐ HDO Attachment D: Urgent Care Clinic / Walk-in Clinic

☐ HDO Attachment E: Diagnostic Radiology (Free-standing)

☐ HDO Attachment F: Retail Health

☐ HDO Attachment G: Laboratory

☐ HDO Attachment H: Outpatient Cath Lab

☐ Complete the iLinkBlue Service Agreement

☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement

☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form

☐ Enclose a canceled check/bank letter confirming account

☐ Complete the Administrative Representative Registration Form

☐ Complete the Administrative Representative Acknowledgment Form

☐ Enclose an EIN Letter

☐ Enclose a W-9 Form

☐ Enclose a copy of state license

☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)

☐ Enclose this completed checklist

Submit all required documents using one of the options below:

mail: BCBSLA - PCDM
P.O. Box 98029
Baton Rouge, LA 70898-9029

email: network.administration@bcbsla.com
fax: (225) 297-2750
Attention: PCDM

18NW2512 R07/19

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

Find our credentialing checklist at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

Credentialing Criteria

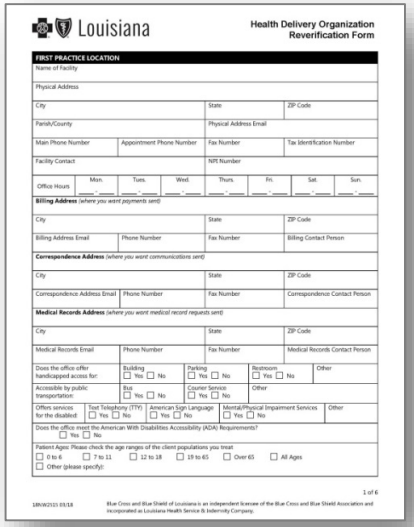
The following facility provider types must meet certain criteria to participate in our networks:

- 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 providers who are due for recredentialing will receive a notification letter eight months in advance of their due date


Louisiana

Health Delivery Organization Reverification Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat

☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages

☐ Other (please specify):

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18NW2121 03/18

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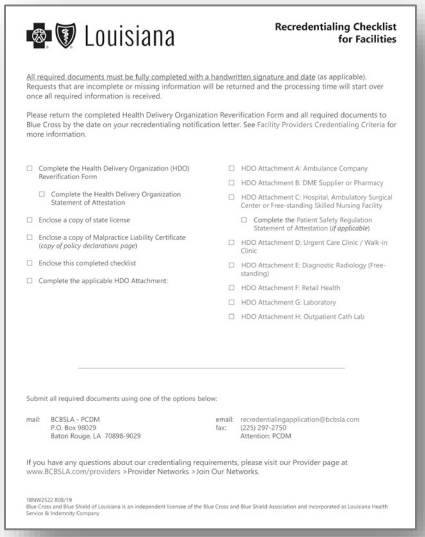
Network facility providers should use our **Health Delivery Organization Reverification Form**. This application is part of the **Facility (Reverification)** packet.


Louisiana

Recredentialing Checklist for Facilities

All required documents must be fully completed with a handwritten signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

Please return the completed Health Delivery Organization Reverification Form and all required documents to Blue Cross by the date on your recredentialing notification letter. See Facility Providers Credentialing Criteria for more information.

☐ Complete the Health Delivery Organization (HDO) Reverification Form

☐ Complete the Health Delivery Organization Statement of Attestation

☐ Enclose a copy of state license

☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*

☐ Enclose this completed checklist

☐ Complete the applicable HDO Attachment:

☐ HDO Attachment A: Ambulance Company

☐ HDO Attachment B: DME Supplier or Pharmacy

☐ HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility

☐ Complete the Patient Safety Regulation Statement of Attestation *(if applicable)*

☐ HDO Attachment D: Urgent Care Clinic / Walk-in Clinic

☐ HDO Attachment E: Diagnostic Radiology (Free-standing)

☐ HDO Attachment F: Retail Health

☐ HDO Attachment G: Laboratory

☐ HDO Attachment H: Outpatient Cath Lab

Submit all required documents using one of the options below:

mail: BCBSLA - PCDM
P.O. Box 98029
Baton Rouge, LA 70898-9029

email: recredentialingapplication@bcbsla.com
fax: (225) 297-2750
Attention: PCDM

If you have any questions about our credentialing requirements, please visit our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks.

18NW2522 R08/19

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The **Facility (Reverification)** packet includes a checklist of all required documents. Please ensure that you complete **all forms** in the packet. Packets with incomplete, missing information or submitted on the incorrect forms will be returned.

Submit completed recredentialing packet to **recredentialing.application@bcbsla.com**

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

Required Recredentialing Documents

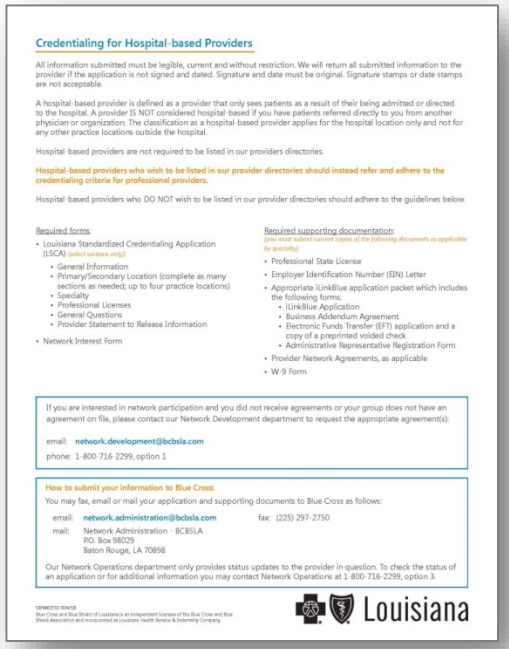
The **HDO Reverification Form** may also require an HDO attachment as indicated below by facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital or Ambulatory Surgical Center
  - Complete the Patient Safety Regulation Statement of Attestation (*if applicable*)
- 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 do not have to be individually credentialed for network participation. 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**



Credentialing for Hospital-based Providers

All information submitted must be legible, current and without restriction. We will return all submitted information to the provider if the application is not signed and dated. Signature and date must be original. Signature stamps or date stamps are not acceptable.

A hospital-based provider is defined as a provider that 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 are not required to be listed in our providers directories.

Hospital-based providers who wish to be listed in our provider directories should instead refer and adhere to the credentialing criteria for professional providers.

Hospital-based providers who DO NOT wish to be listed in our provider directories should adhere to the guidelines below.

Required forms:

- Louisiana Standardized Credentialing Application (LSCA) *(select sections only)*:
  - General Information
  - Primary/Secondary Location (complete as many sections as needed; up to four practice locations)
  - Specialty
  - Professional Licenses
  - General Questions
  - Provider Statement to Release Information
- Network Interest Form

Required supporting documentation:

(you must submit current copies of the following documents as applicable by specialty)

- Professional State License
- Employer Identification Number (EIN) Letter
- Appropriate iLinkBlue application packet which includes the following forms:
  - iLinkBlue Application
  - Business Addendum Agreement
  - Electronic Funds Transfer (EFT) application and a copy of a preprinted voided check
  - Administrative Representative Registration Form
- Provider Network Agreements, as applicable
- W-9 Form

If you are interested in network participation and you did not receive agreements or your group does not have an agreement on file, please contact our Network Development department to request the appropriate agreement(s):

email: network.development@bcbsla.com

phone: 1-800-716-2299, option 1

How to submit your information to Blue Cross:

You may fax, email or mail your application and supporting documents to Blue Cross as follows:

email: network.administration@bcbsla.com fax: (225) 297-2750

mail: Network Administration - BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898

Our Network Operations department only provides status updates to the provider in question. To check the status of an application or for additional information you may contact Network Operations at 1-800-716-2299, option 3.

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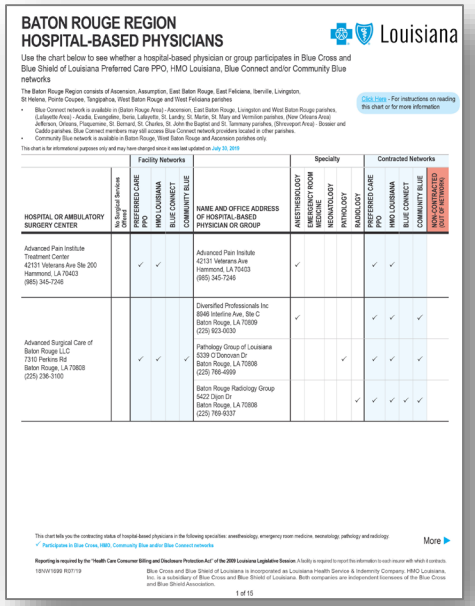
Louisiana

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



BATON ROUGE REGION
HOSPITAL-BASED PHYSICIANS

Louisiana

Use the chart below to see whether a hospital-based physician or group participates in Blue Cross and Blue Shield of Louisiana Preferred Care PPO, HMO Louisiana, Blue Connect and/or Community Blue networks

The Baton Rouge Region consists of Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Livingston, St Helena, Pointe Coupee, Tangipahoa, West Baton Rouge and West Feliciana parishes

- Blue Connect network is available in (Baton Rouge Area) - Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes. (Lafayette Area) - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes, (New Orleans Area) Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes, (Shreveport Area) - Bossier and Caddo parishes. Blue Connect members may still access Blue Connect network providers located in other parishes.
- Community Blue network is available in Baton Rouge, West Baton Rouge and Ascension parishes only.

Click Here - For instructions on reading this chart or for more information

This chart is for informational purposes only and may have changed since it was last updated on July 30, 2019

HOSPITAL OR AMBULATORY SURGERY CENTER	No Surgical Services Offered	Facility Networks: PREFERRED CARE PPO	Facility Networks: HMO LOUISIANA	Facility Networks: BLUE CONNECT	Facility Networks: COMMUNITY BLUE	NAME AND OFFICE ADDRESS OF HOSPITAL-BASED PHYSICIAN OR GROUP	Specialty: ANESTHESIOLOGY	Specialty: EMERGENCY ROOM MEDICINE	Specialty: NEONATOLOGY	Specialty: PATHOLOGY	Specialty: RADIOLOGY	Contracted Networks: PREFERRED CARE PPO	Contracted Networks: HMO LOUISIANA	Contracted Networks: BLUE CONNECT	Contracted Networks: COMMUNITY BLUE	Contracted Networks: NON-CONTRACTED (OUT OF NETWORK)
Advanced Pain Institute Treatment Center 42131 Veterans Ave Ste 200 Hammond, LA 70403 (985) 345-7246		✓	✓			Advanced Pain Institute 42131 Veterans Ave Hammond, LA 70403 (985) 345-7246	✓					✓	✓			
Advanced Surgical Care of Baton Rouge LLC 7310 Perkins Rd Baton Rouge, LA 70808 (225) 236-3100		✓	✓		✓	Diversified Professionals Inc 8946 Interline Ave, Ste C Baton Rouge, LA 70809 (225) 923-0030	✓					✓	✓		✓	
						Pathology Group of Louisiana 5339 O Donovan Dr Baton Rouge, LA 70808 (225) 766-4999				✓		✓	✓		✓	
						Baton Rouge Radiology Group 5422 Dijon Dr Baton Rouge, LA 70808 (225) 769-9337					✓	✓	✓	✓	✓	

This chart tells you the contracting status of hospital-based physicians in the following specialties: anesthesiology, emergency room medicine, neonatology, pathology and radiology.
✓ Participates in Blue Cross, HMO, Community Blue and/or Blue Connect networks

More ▶

Reporting is required by the "Health Care Consumer Billing and Disclosure Protection Act" of the 2009 Louisiana Legislative Session. A facility is required to report this information to each insurer with which it contracts.

18WW1939 R07119

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity 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.

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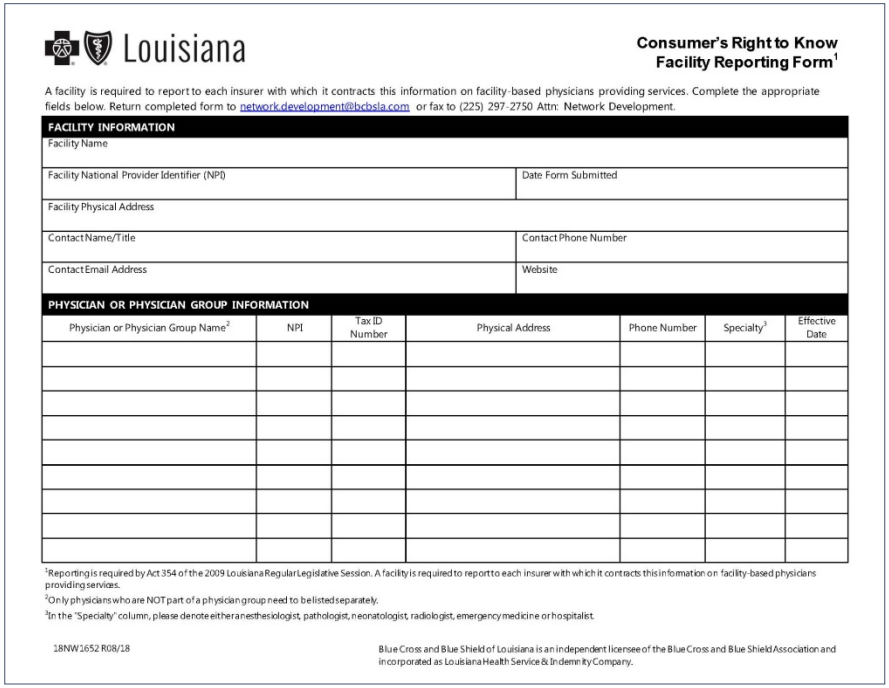
According to the legislation, health insurers must be notified of any changes made to this information within 30 days of the change

This information is presented to our members on our Hospital-based Physician Reports, 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

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, neonatologist, radiologist, emergency medicine or hospitalist.

18NW1652 R08/18

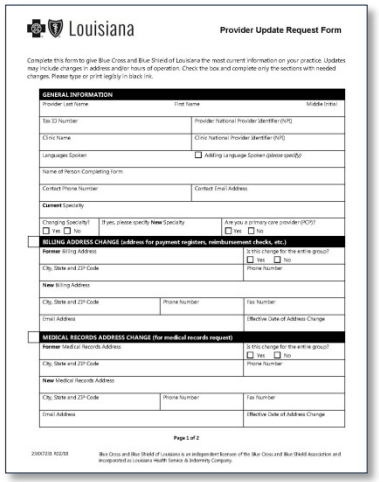
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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

How to Update Your Information

It is important we always have your most current information in our files. The Provider Credentialing & Data Management team manages demographic changes to your provider record.

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


Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Languages Spoken | ☐ Adding Language Spoken (please specify)

Name of Person Completing Form

Contact Phone Number | Contact Email Address

Current Specialty

Changing Specialty? ☐ Yes ☐ No | If yes, please specify New Specialty | Are you a primary care provider (PCP)? ☐ Yes ☐ No

☐ BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)

Former Billing Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Billing Address

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

Email Address | Effective Date of Address Change

☐ MEDICAL RECORDS ADDRESS CHANGE (for medical records request)

Former Medical Records Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

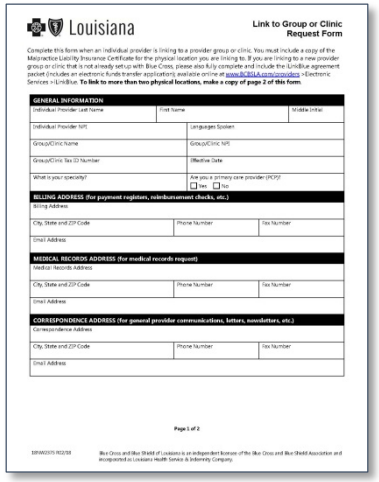
New Medical Records Address

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

Email Address | Effective Date of Address Change

Page 1 of 2

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


Louisiana

Link to Group or Clinic Request Form

Complete this form when an individual provider is linking to a provider group or clinic. You must include a copy of the Malpractice Liability Insurance Certificate for the physical location you are linking to. If you are linking to a new provider group or clinic that is not already set-up with Blue Cross, please also fully complete and include the LinkBlue agreement packet (includes an electronic funds transfer application) available online at www.BCBSLA.com/providers > Electronic Services > LinkBlue. **To link to more than two physical locations, make a copy of page 2 of this form.**

GENERAL INFORMATION

Individual Provider Last Name | First Name | Middle Initial

Individual Provider NPI | Languages Spoken

Group/Clinic Name | Group/Clinic NPI

Group/Clinic Tax ID Number | Effective Date

What is your specialty? | Are you a primary care provider (PCP)? ☐ Yes ☐ No

BILLING ADDRESS (for payment registers, reimbursement checks, etc.)

Billing Address

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

Email Address

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address

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

Email Address

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

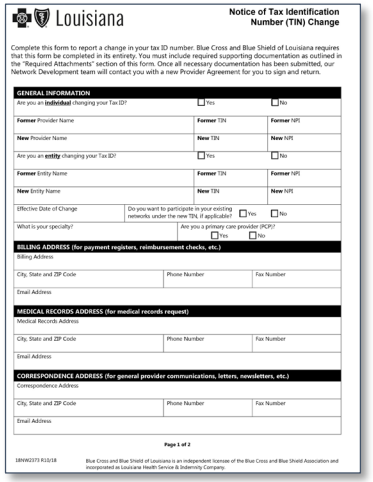
Correspondence Address

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

Email Address

Page 1 of 2

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


Louisiana

Notice of Tax Identification Number (TIN) Change

Complete this form to report a change in your tax ID number. Blue Cross and Blue Shield of Louisiana requires that this form be completed in its entirety. You must include required supporting documentation as outlined in the "Required Attachments" section of this form. Once all necessary documentation has been submitted, our Network Development team will contact you with a new Provider Agreement for you to sign and return.

GENERAL INFORMATION

Are you an **individual** changing your Tax ID? ☐ Yes ☐ No

Former Provider Name | **Former** TIN | **Former** NPI

New Provider Name | **New** TIN | **New** NPI

Are you an **entity** changing your Tax ID? ☐ Yes ☐ No

Former Entity Name | **Former** TIN | **Former** NPI

New Entity Name | **New** TIN | **New** NPI

Effective Date of Change | Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No

What is your specialty? | Are you a primary care provider (PCP)? ☐ Yes ☐ No

BILLING ADDRESS (for payment registers, reimbursement checks, etc.)

Billing Address

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

Email Address

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address

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

Email Address

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address

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

Email Address

Page 1 of 2

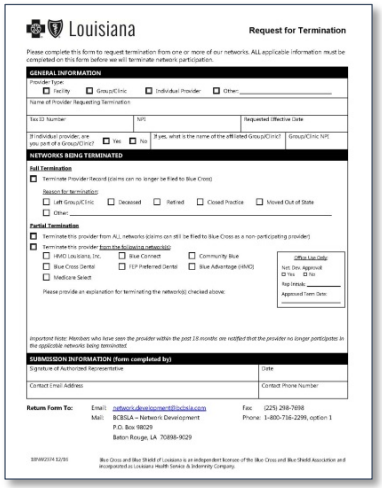
Use our **Notice of Tax Identification Number (TIN) Change** form to report a change in your tax ID number

www.BCBSLA.com/providers >Resources >Forms

How to Update Your Information

It is important we always have your most current information in our files. The Provider Credentialing & Data Management team manages demographic changes to your provider record.

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


Louisiana

Request for Termination

Please complete this form to request termination from one or more of our networks. ALL applicable information must be completed on this form before we will terminate network participation.

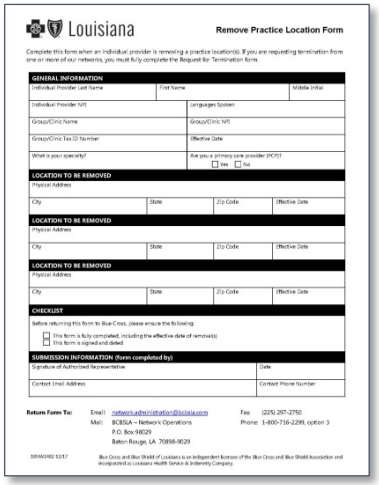
GENERAL INFORMATION

NETWORKS BEING TERMINATED

SUBMISSION INFORMATION (form completed by)

Return Form To:

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


Louisiana

Remove Practice Location Form

Complete this form when an individual provider is removing a practice location(s). If you are requesting termination from one or more of our networks, you must fully complete the Request for Termination form.

GENERAL INFORMATION

LOCATION TO BE REMOVED

LOCATION TO BE REMOVED

LOCATION TO BE REMOVED

CHECKLIST

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

SUBMISSION INFORMATION (form completed by)

Return Form To:

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

www.BCBSLA.com/providers >Resources >Forms

How to Submit Your Information

Submit completed applications and forms by:

Email: **network.administration@bcbsla.com**

recredentialing.application@bcbsla.com
(recredentialing applications only)

Fax: (225) 297-2750

Mail: BCBSLA – Provider Credentialing & Data Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

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

OUR NETWORKS

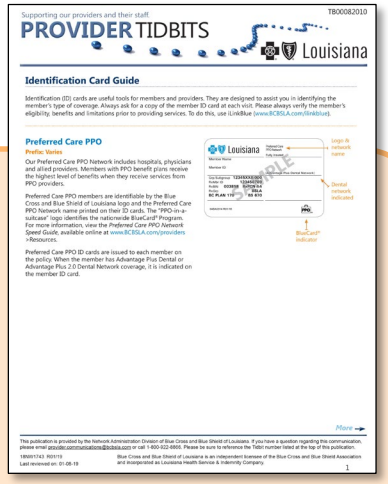
Our Provider Networks

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.



Supporting our providers and their staff

PROVIDER TIDBITS Louisiana

TB0008201O

Identification Card Guide

Identification (ID) cards are useful tools for members and providers. They are designed to assist you in identifying the member's type of coverage. Always ask for a copy of the member ID card at each visit. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (www.BCBSLA.com/linkblue).

Preferred Care PPO

Prefix: Varies

Our Preferred Care PPO Network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.

Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on their ID cards. The "PPO-in-a-suitcase" logo identifies the nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

Preferred Care PPO ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card.

Louisiana

Logo & network name

Dental network indicated

BlueCard® Indicator

More →

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this communication, please email provider.communications@bcbsla.com or call 1-800-922-6865. Please be sure to reference the TB0# number listed at the top of this publication.

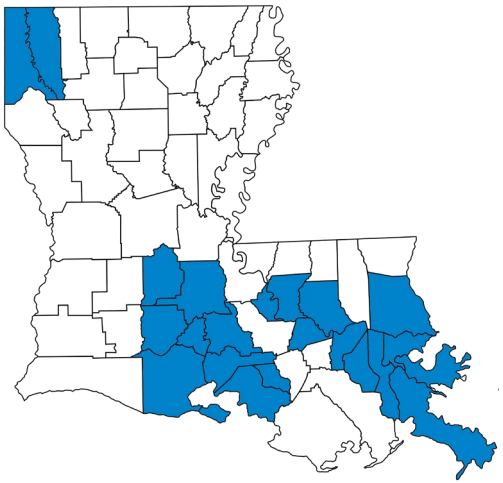
18N01743 R01/19

Last reviewed on: 01-08-19

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.

1

Select Provider Networks



BLUE CONNECT

New Orleans area

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

Baton Rouge area

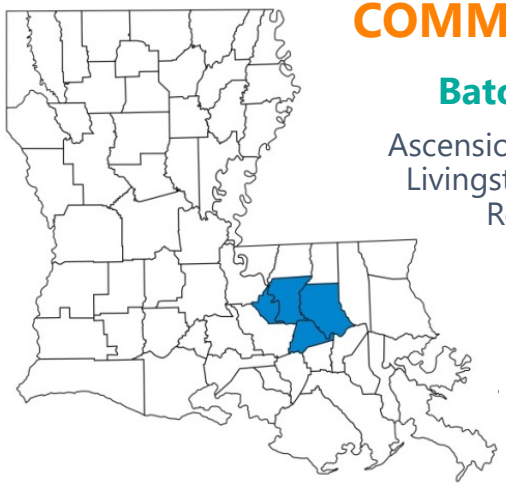
Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Lafayette area

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

Shreveport area

Bossier and Caddo parishes



COMMUNITY BLUE

Baton Rouge area

Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans parishes

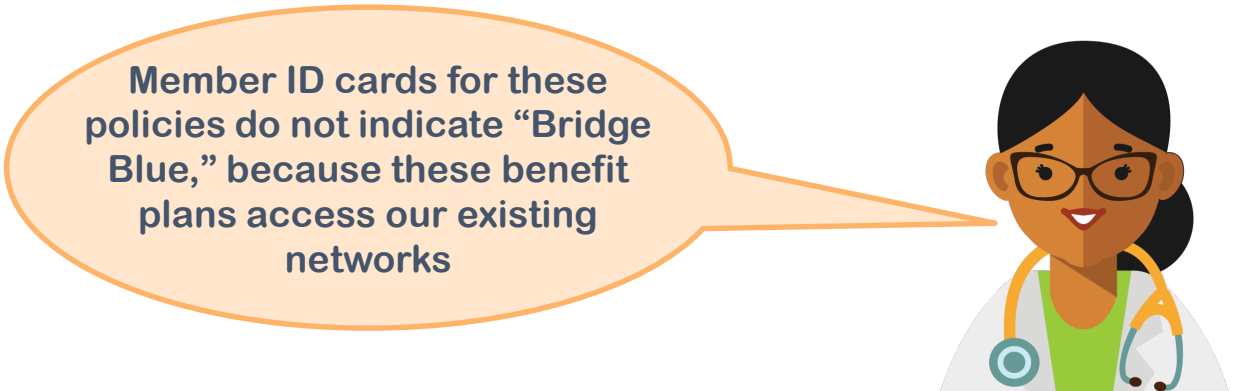
NEW

Bridge Blue

- Once open enrollment ends, customers are unable to purchase individual policies until the next open enrollment period
- As of January 1, 2019, HMO Louisiana, Inc. is offering individual **short-term medical (STM) policies** to qualifying customers
- Applications are accepted anytime throughout the year. Members may carry up to 11 months of coverage so they can maintain healthcare coverage until the next open enrollment in the marketplace.

We offer three Bridge Blue products that access the following networks:

- Bridge Blue POS accesses the **HMO Louisiana, Inc. Network**
- Bridge Community Blue POS accesses the **Community Blue Network**
- Bridge Blue Connect POS accesses the **Blue Connect Network**



Federal Employee Program

The Federal Employee Program (FEP) provides benefits to federal employees, retirees and their dependents. For 2019, FEP members may have one of three benefit plans: Standard Option, Basic Option or FEP Blue Focus (a new, limited plan).

NEW

STANDARD OPTION

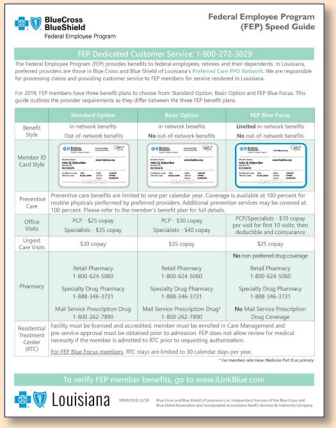
- ✓ In-network
- ✓ Out-of-network

BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

- ✓ **LIMITED** in-network
- X Out-of-network



BlueCross BlueShield Federal Employee Program

Federal Employee Program (FEP) Speed Guide

FEP Dedicated Customer Service: 1-800-272-3029

The Federal Employee Program (FEP) provides benefits to federal employees, retirees and their dependents. In Louisiana, preferred providers are those in Blue Cross and Blue Shield of Louisiana's Preferred Care PPO Network. We are responsible for processing claims and providing customer service to FEP members for service rendered in Louisiana.

For 2019, FEP members have three benefit plans to choose from: Standard Option, Basic Option and FEP Blue Focus. This guide outlines the provider requirements as they differ between the three FEP benefit plans.

	Standard Option	Basic Option	FEP Blue Focus
Benefit Style	In-network benefits Out-of-network benefits	In-network benefits **No** out-of-network benefits	**Limited** in-network benefits **No** out-of-network benefits
Member ID Card Style			
Preventive Care	Preventive care benefits are limited to one per calendar year. Coverage is available at 100 percent for routine physicals performed by preferred providers. Additional preventive services may be covered at 100 percent. Please refer to the member's benefit plan for full details.		
Office Visits	PCP - $25 copay Specialists - $35 copay	PCP - $30 copay Specialists - $40 copay	PCP/Specialists - $10 copay per visit for first 10 visits; then deductible and coinsurance
Urgent Care Visits	$30 copay	$35 copay	$25 copay
Pharmacy	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug 1-800-262-7890	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug* 1-800-262-7890	**No** non-preferred drug coverage Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 **No** Mail Service Prescription Drug Coverage
Residential Treatment Center (RTC)	Facility must be licensed and accredited, member must be enrolled in Care Management and pre-service approval must be obtained prior to admission.FEP does not allow review for medical necessity if the member is admitted to RTC prior to requesting authorization. For FEP Blue Focus members, RTC stays are limited to 30 calendar days per year.		

* For members who have Medicare Part B as primary

To verify FEP member benefits, go to www.myLinkBlue.com

Louisiana

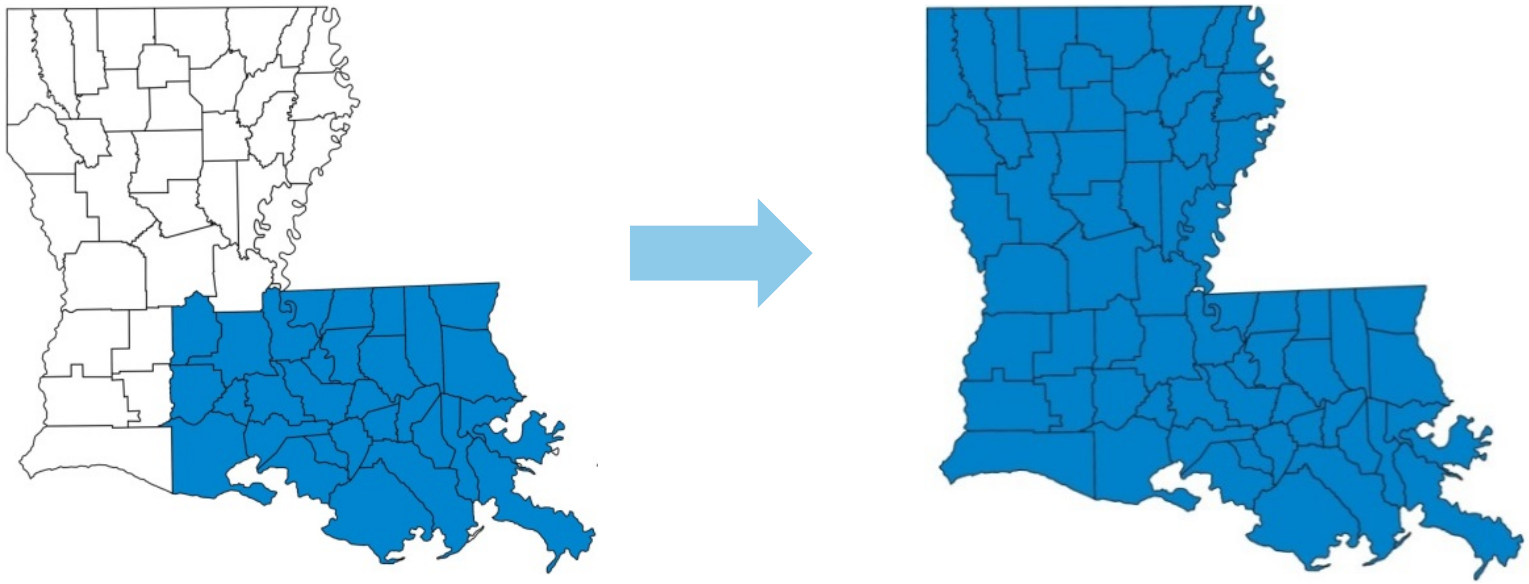
A new FEP Speed Guide is available! Visit **www.BCBSLA.com/providers** >Resources >Speed Guides

NEW

Our Blue Advantage Networks

Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)



Effective January 1, 2019, we expanded our **Blue Advantage (HMO)** network statewide and added a statewide **Blue Advantage (PPO)** network

NEW

Medicare Advantage (MA) PPO Network Sharing

All Blue Plans that offer a MA PPO Plan participate in reciprocal network sharing. This allows Blue MA PPO members to obtain in-network benefits in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

If you are a participating provider in our MA PPO network…	If you are NOT a participating provider in our MA PPO network…	If your practice is closed to new members…
you should provide the same access to care for Blue MA PPO members as you do for our members. Services will be reimbursed in accordance with your BCBSLA MA PPO allowable charges. The Blue MA PPO member's in-network benefits will apply.	but do accept Medicare and you see Blue MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergent care, you will be reimbursed at the member's in-network benefit level.	you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members.

MA | PPO
MEDICARE ADVANTAGE

Blue MA PPO members are recognizable by the "MA" suitcase on the member ID card

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

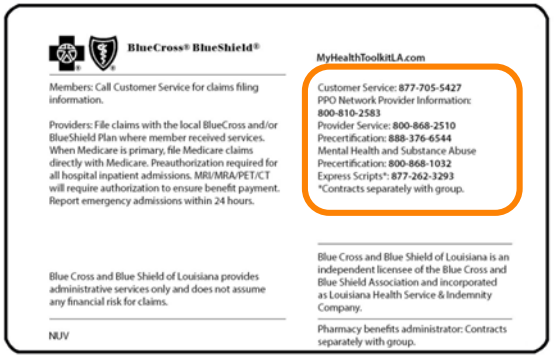
- The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product

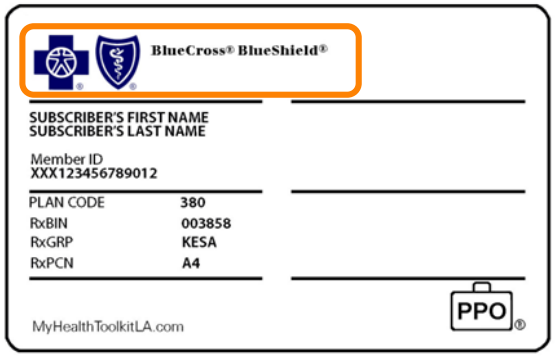
- The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product

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.

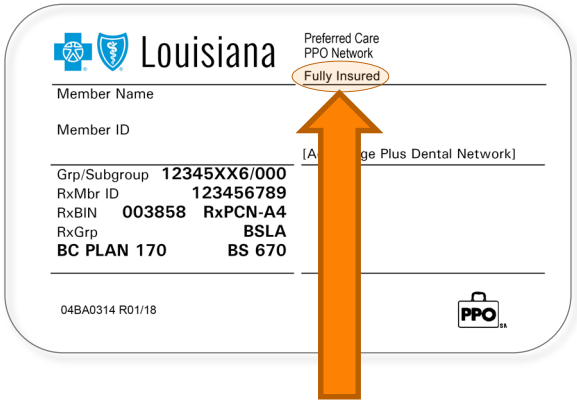
NEW

Fully Insured vs. Self-funded

Member ID Card Differences

FULLY INSURED

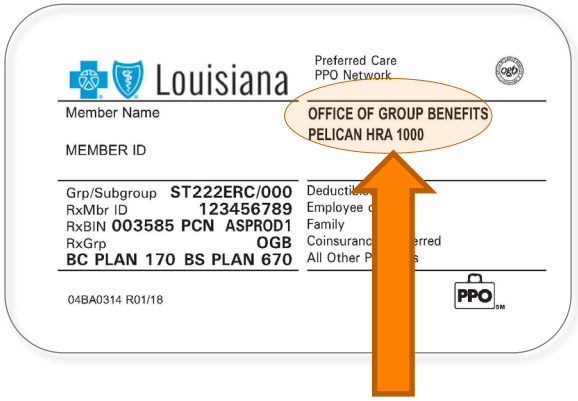
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA



"Fully Insured" notation

SELF FUNDED

Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA



- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

The benefit, limitation, exclusion and authorization **requirements often vary for self-funded groups**. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.BCBSLA.com/ilinkblue**).

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

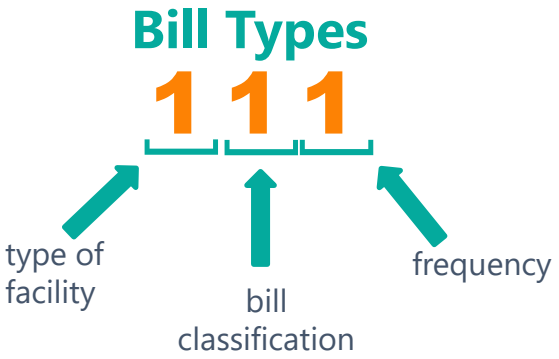
Member Benefit Terms

Term	Definition
Grandfathered	Grandfathered policies were in place before March 23, 2010, when the Affordable Care Act was signed into law. A grandfathered status policy might not include certain benefits or consumer protections that non-grandfathered plans are required to include.
Non-grandfathered	Non-grandfathered policies are issued after March 23, 2010, and include required benefits and consumer protections
Small Group	Employer groups with 50 or fewer members
Large Group	Employer groups with 51 or more members
Individual	A privately purchased policy for an individual and/or individual's family (not issued through an employer)
Fully-insured	This refers to group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA
Self-funded	This refers to group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA

Facility Billing Guidelines

Facility claims must be submitted on a UB-04 form. Bill types are three digits, and each position represents specific information about the claim being filed.

Blue Cross does **not** exclude first or second digits of a bill type. However, there **are** limitations and/or exclusions for the third digit (frequency code).



Frequency Code	Description	Blue Cross Acceptance Rule
Non-interim Claims		
1	Admit Through Discharge Claim	Accepted
Interim Claims		
2	Interim (First Claim)	We accept interim claims only when the total charge is $800,000 or greater **and** the length of stay is at least 60 days of service
3	Interim (Continuing Claims)	
Not Accepted		
4	Interim (Last Claim)*	Not Accepted
5	Late Charge Only	Not Accepted
6		Not Accepted
9	Final Claim for a Home Health PPS Episode	Not Accepted
Prior Claims		
7	Replacement of Prior Claim or Corrected Claim	Accepted
8	Void or Cancel of a Prior Claim	Accepted

**The final interim bill should aggregate all interim bills and late charge claims. (if applicable). The final interim bill should be submitted using a frequency code of 1 or 7.*

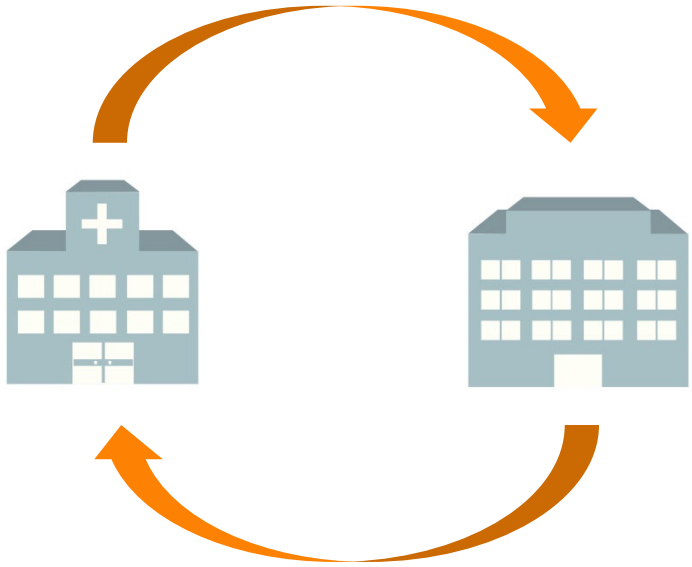
These guidelines are outlined in the *Member Provider Policy & Procedure Manual,* available on iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Resources" section

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% 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 ER/Observations

- When a patient is in observation status or in the emergency room (ER) 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 statement-covered period indicated on the UB-04 claim form should reflect the "from" date when the services were first provided, 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

Admissions Through the ER/Observations

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 the 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

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 single 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

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 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.

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:

- Indicate if the services are related to an accident or a work-related injury or illness when submitting claim
- Not require the Blue member or the member's attorney to guarantee payment of the entire billed charge
- Not require the Blue member to pay the entire billed charge up front
- Not bill the Blue 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 cost share (deductible, coinsurance, copayment) and/or non-covered service

If amounts in excess of the reimbursement amount/allowable charge were collected, you should refund that amount to the member

Subrogation guidelines vary by state. Providers should check with each home plan to determine their guidelines.

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
- Indicate if the services are the result of a work-related injury or illness

If it's 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 *(or length of time stated in the member's contract)* of date of service

FEP:

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

Blue Advantage:

- Providers have 12 months from the date of service to file an initial claim
- Providers have 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
- Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim

Self-funded & BlueCard:

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

The member and Blue Cross are held harmless when claims are denied or received after the timely filing deadline

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.

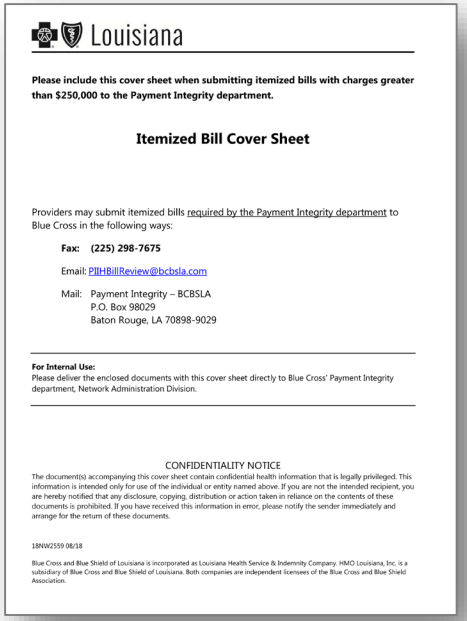
You are required to provide us with medical records at no charge as outlined in your Blue Cross network agreement

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

Pre-pay Itemized Bill Review

When filing an inpatient acute care claim that has a billed charge of greater than $250,000*, please follow these guidelines:

- File the claim using your usual process for filing claims; **in addition,** please submit an itemized bill and include the **Itemized Bill Cover Sheet**
- If the itemized bill is sent via fax or email, you will receive an acknowledgement of receipt
- We highly recommended that you send itemized bills **immediately after filing the claim or before filing the claim**. 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 document(s) 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.

18NW2559 08/18

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity 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

Submit your Itemized Bill Cover Sheet by:
Fax: (225) 298-7675
Email: **PIIHBillReview@bcbsla.com**
Mail: Payment Integrity – BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

***Effective January 1, 2020, the threshold will change to "greater than $200,000"**

NEW

Readmissions Policy

Reimbursement rates are set at the average cost to treat the condition and fully reimburse a facility for treatment of the condition. If the patient returns within the timeframes listed below with the same condition, a similar condition or a complication of the original condition, then the condition was likely not appropriately or fully treated, and the original payment is full reimbursement for treatment of the original condition and any complications.

In order to allow providers to take the necessary steps to reduce readmissions, we are pursuing implementation of this policy as follows:

- **Effective September 1, 2019**, readmissions to the same or affiliated facility for the same condition, similar condition or a complication of the original condition within **15 days** of discharge will not be reimbursed, as the original payment is full reimbursement for treatment of the original condition and any complications

- **Effective September 1, 2020**, the period from discharge will be extended to **30 days**

Providers cannot bill members for services recouped as a result of this policy

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.

Telemedicine

Reimbursement for **Direct-to-consumer (DTC)** telemedicine services is available when provided within the scope of your license and utilizing your own telemedicine platform

- The appropriate **place of service** for when performing **DTC telemedicine** this way is typically **POS 11** (office)
- The reimbursable **CPT® codes/services for DTC telemedicine** can be found in the *Professional Provider Office Manual* (section 5-2)
- Encounters must be performed in real time using audio **and** video technology

The following are examples of services that are not eligible for reimbursement as telemedicine services:

- Non-direct patient services (e.g. coordination of care before/after patient interaction)
- Services rendered by audio-only telephone communication, facsimile, email, text or any other non-secure electronic communication
- Services not eligible for separate reimbursement when rendered to patient in person
- Presentation/origination site facility fee
- Services/codes that are not specifically listed in the provider manual

Claims for services provided via telemedicine are paid the same as claims for in-office visits

Telemedicine Use for Facilities

In some circumstances, telemedicine can be billed when it takes place in a hospital. Below are some guidelines on how billing differs depending on where the patient is located at the time of service.

Patient at Home

- CPT codes: Direct-to-consumer codes (see next slide)
- POS: 11
- Modifier: GT or 95
- Example: A doctor consults with a patient about her cold symptoms through BlueCare

Patient at Hospital

- CPT codes: Same as if physician was physically present
- POS: Same as if physician was physically present
- Modifier: GT or 95
- Example: A cardiologist consults with an ICU patient through telemedicine

Telemedicine Codes

The following codes can be used for "Direct-to-consumer" telemedicine—when the telemedicine encounter occurs directly between provider and patient. These telemedicine billing and reimbursement guidelines **do not** apply to physician telemedicine or telehealth consultation/services rendered in an inpatient hospital, outpatient hospital or emergency room setting.

Direct-to-consumer Codes (bolded codes were added as of January 1, 2019)

EVALUATION AND MANAGEMENT					
99201	99202	**99203**	**99204**	**99205**	99211
99212	**99213**	**99214**	**99215**	99495	99496
DIETARY					
97802	97803				
BEHAVIORAL HEALTH					
90785	**90791**	**90792**	90832	90833	90834
90836	**90837**	**90838**	**90839**	**90840**	**90845**
90846	**90847**	**96150**	**96151**	**96152**	**96153**
96154	**96160**	**96161**	G0446		
SMOKING CESSATION					
99406	99407	G0436	G0437		
OBESITY					
G0447					

Use Modifier **GT or 95, whichever is appropriate**, to indicate delivery of telemedicine services in real time. Use **POS 11** to indicate place of service was in an office.

NEW CLAIMS
EDITING SOFTWARE

NEW

Claims Editing Software

- We have updated to a new claims editing software (CES) system that launched on July 27, 2019
- It applies edits to incoming claims to ensure proper coding and billing based on:
  - Reimbursement
  - Medical policy
  - Benefit rules
  - Industry standard and coding guidelines
- It promotes accurate and consistent payments
- Manages compliance with standard coding and billing practice between various types of services, such as:
  - Medical
  - Surgical
  - Lab and radiology

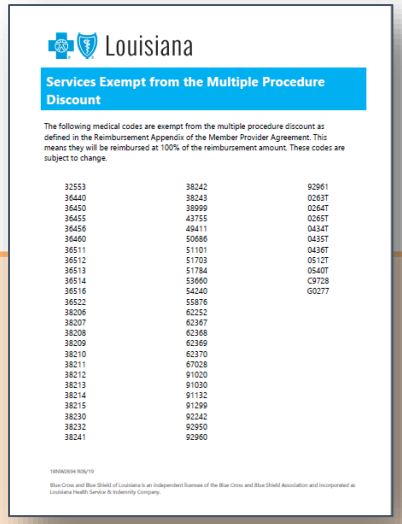
NEW

Multiple Procedure Reduction

Codes exempt from multiple procedure reduction have been updated

Note: The new CES edits applies for dates of service on and after August 1, 2019

A listing of the codes exempt from Multiple Procedure Reduction can be found on iLinkBlue (**www.BCBSLA.com/ilinkblue** >Claims >Exempt MPR Codes - Facility)



Louisiana

Services Exempt from the Multiple Procedure Discount

The following medical codes are exempt from the multiple procedure discount as defined in the Reimbursement Appendix of the Member Provider Agreement. This means they will be reimbursed at 100% of the reimbursement amount. These codes are subject to change.

32553	38242	92961
36440	38243	0263T
36450	38999	0264T
36455	43755	0265T
36456	49411	0434T
36460	50686	0435T
36511	51101	0436T
36512	51703	0512T
36513	51784	0540T
36514	53660	C9728
36516	54240	G0277
36522	55876	
38206	62252	
38207	62367	
38208	62368	
38209	62369	
38210	62370	
38211	67028	
38212	91020	
38213	91030	
38214	91132	
38215	91299	
38230	92242	
38232	92950	
38241	92960	

18NM2694 R06/19

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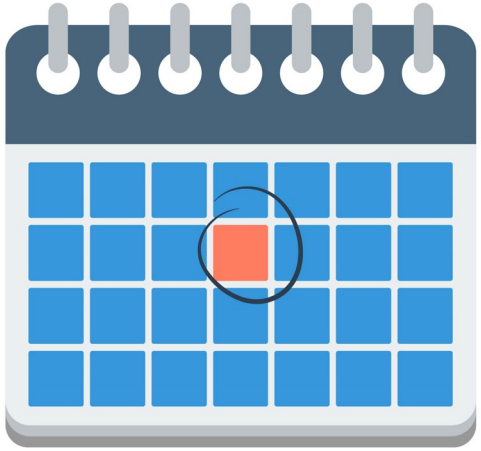
NEW

Not Separately Reimbursable



Certain codes will be denied because the services should be included with other services billed on the same day

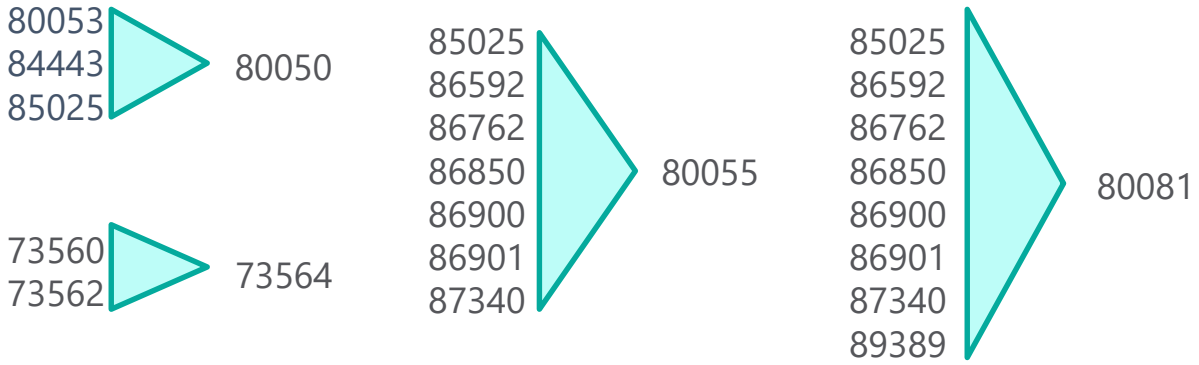
Examples: Codes billed for general surgical supplies, quality measure codes (e.g., 0001F-9000F)

NEW

Rebundles

Individual lines will be denied when two or more component codes are billed instead of a more appropriate, comprehensive code. The provider will need to refile the correct, comprehensive code.

Examples:



NEW

Important Things to Remember

- Most edits are based on date processed, **not** date of service*
- Any claim adjustments processed **after the implementation date** of the new CES system are subject to edits in the new system
- **Explanation codes and descriptions** on payment register may be different in the new system
- CARC codes on the 835 may be different. Example: Where you previously saw **CARC 97** for both mutually exclusive and incidental edits, you will now see CARC 97 for Incidental, 231 for Mutually Exclusive and 236 for Unbundle.

*With the exception of **multiple procedure reductions** and **max frequency**

NEW

Troubleshooting

If you do not understand the way your claim was processed, follow these steps to troubleshoot

Step 1

Check that you are following the proper billing guidelines. Refer to resources in your:

- Provider Manual
- Code Book
- Lists provided on iLinkBlue (You can locate these lists at **www.BCBSLA.com/ilinkblue** >Claims then look under the "Medical Code Editing" section)

Step 2

- Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code
- This tool is located at **www.BCBSLA.com/ilinkblue** >Claims >Claims Edit System
- CES edits will appear in lower case

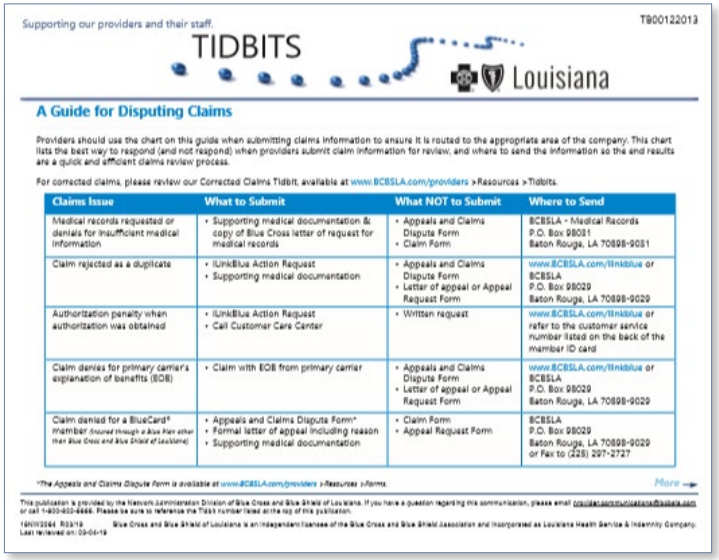
Step 3

- Submit an Action Request
- We will go into more details later in this presentation about how to submit an Action Request (refer to the "Resolving Claims Issues" section)
- In order to properly route your inquiry please choose "**Code Editing Inquiry**" from the action drop down box when submitting your action request

NEW

How to Inquire

If after completing steps 1-3, you still believe your claim did not process appropriately, please refer to the "**A Guide for Disputing Claims**" tidbit



Supporting our providers and their staff.

TB00122013

TIDBITS

Louisiana

A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

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	• Appeals and 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	• Appeals and 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 primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Appeals and 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
Claim denied for a BlueCard® member (Insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Appeals and Claims Dispute Form* • Formal letter of appeal including reason • Supporting medical documentation	• Claim Form • Appeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

*The Appeals and Claims Dispute Form is available at www.BCBSLA.com/providers >Resources >Forms.

More

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this communication, please email providercommunications@bcbsla.com or call 1-800-922-6666. Please be sure to reference the TIBS number listed at the top of this publication.

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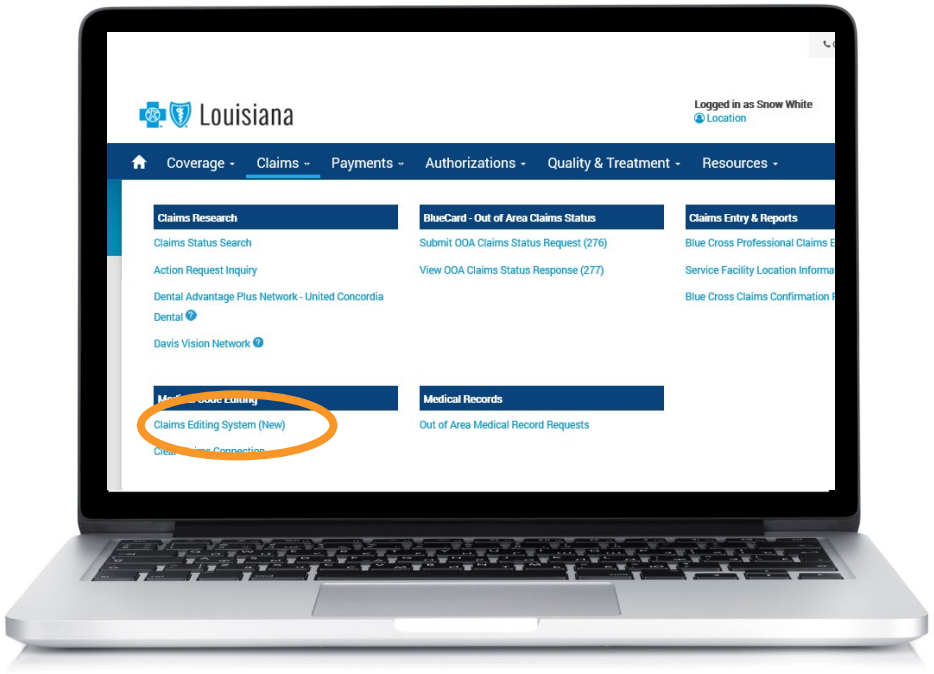
Last reviewed on: 03-04-19

www.BCBSLA.com/providers >Resources >Tidbits

NEW Claims Editing System Tool

With the implementation of the new CES system, we have a new tool in iLinkBlue for providers to calculate claim-edit outcomes



NEW

Claims Editing System Tool

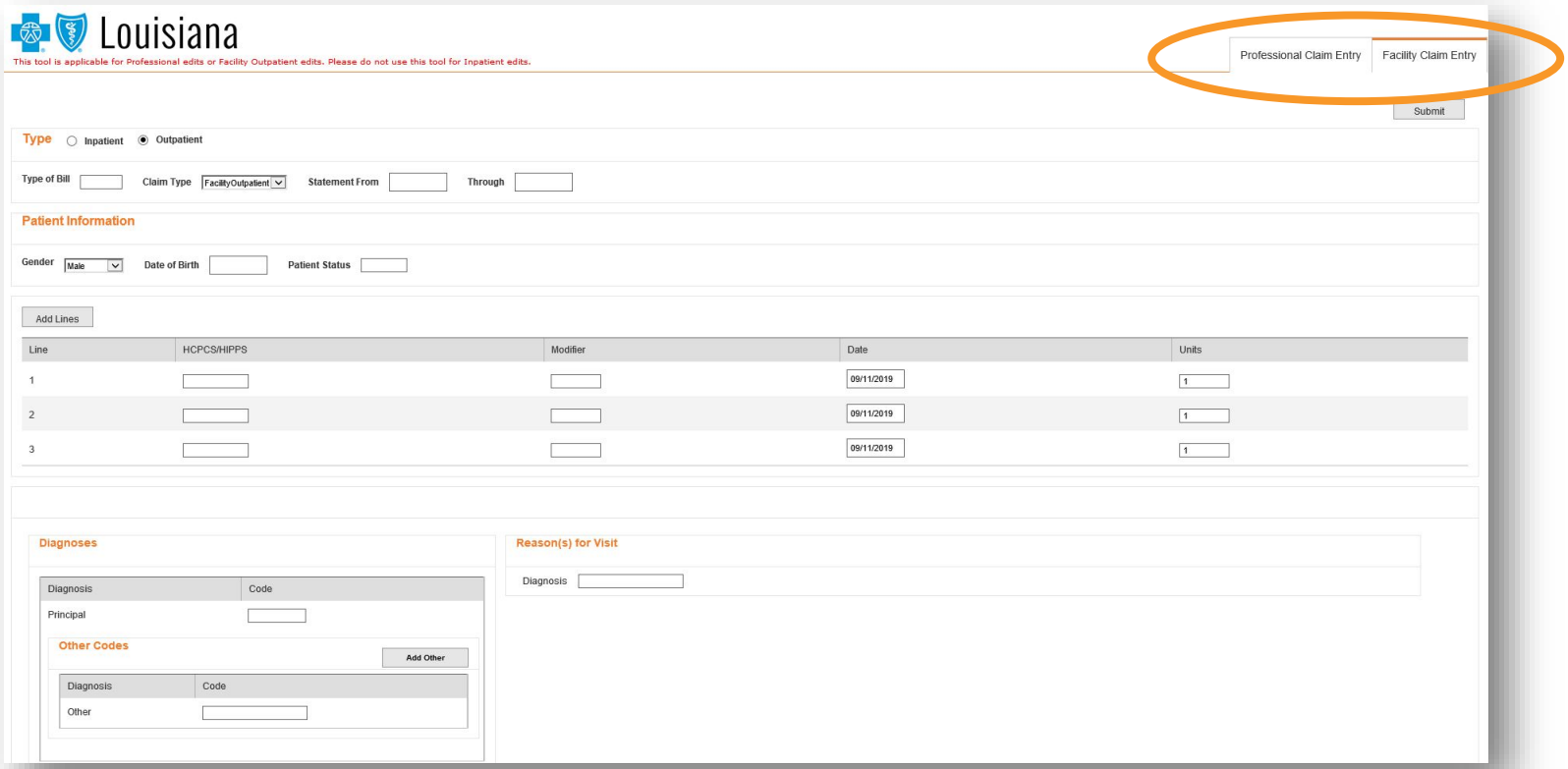
This tool applies to **hospital outpatient & ambulatory surgery center claims only** and does not guarantee claims payment

The results of the software do not consider all circumstances and factors that may affect payment including:

- Historical claims previously billed
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits
- Max frequency edits

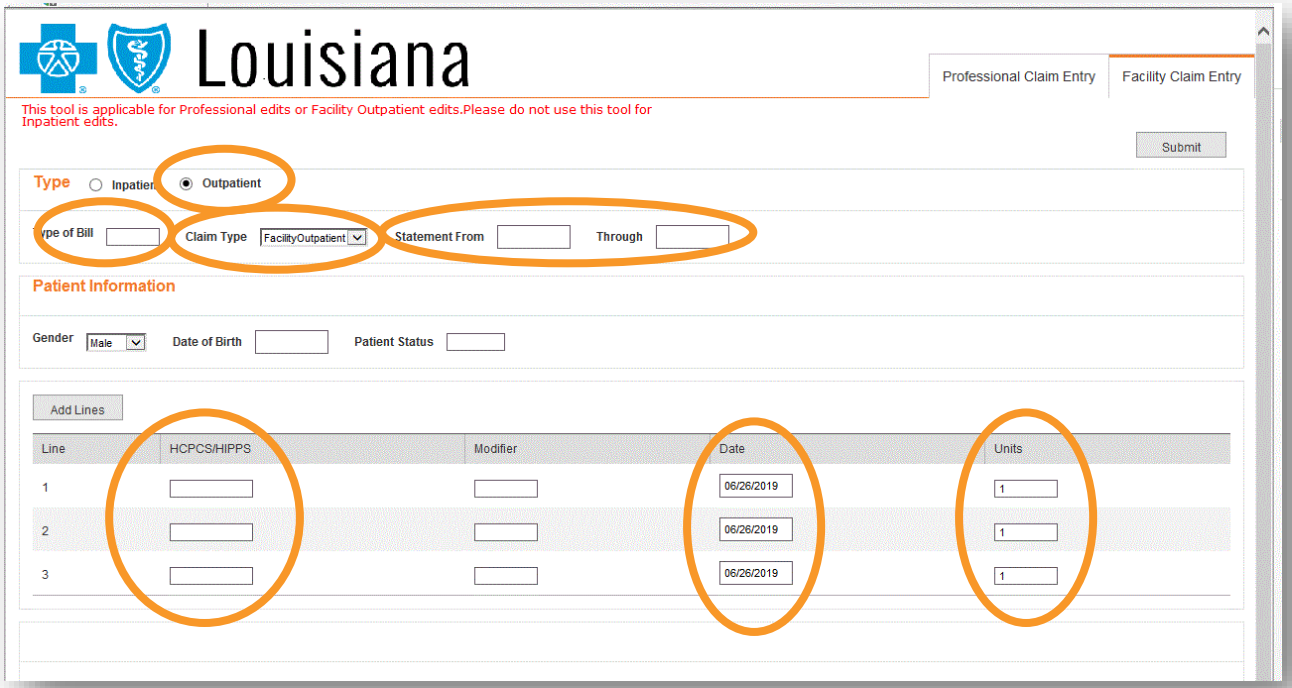
NEW Claims Editing System Tool

The new CES tool is available for both **outpatient facility** and **professional** claims. Please make sure you select the correct tab as the edits and modifiers will not be the same.



NEW

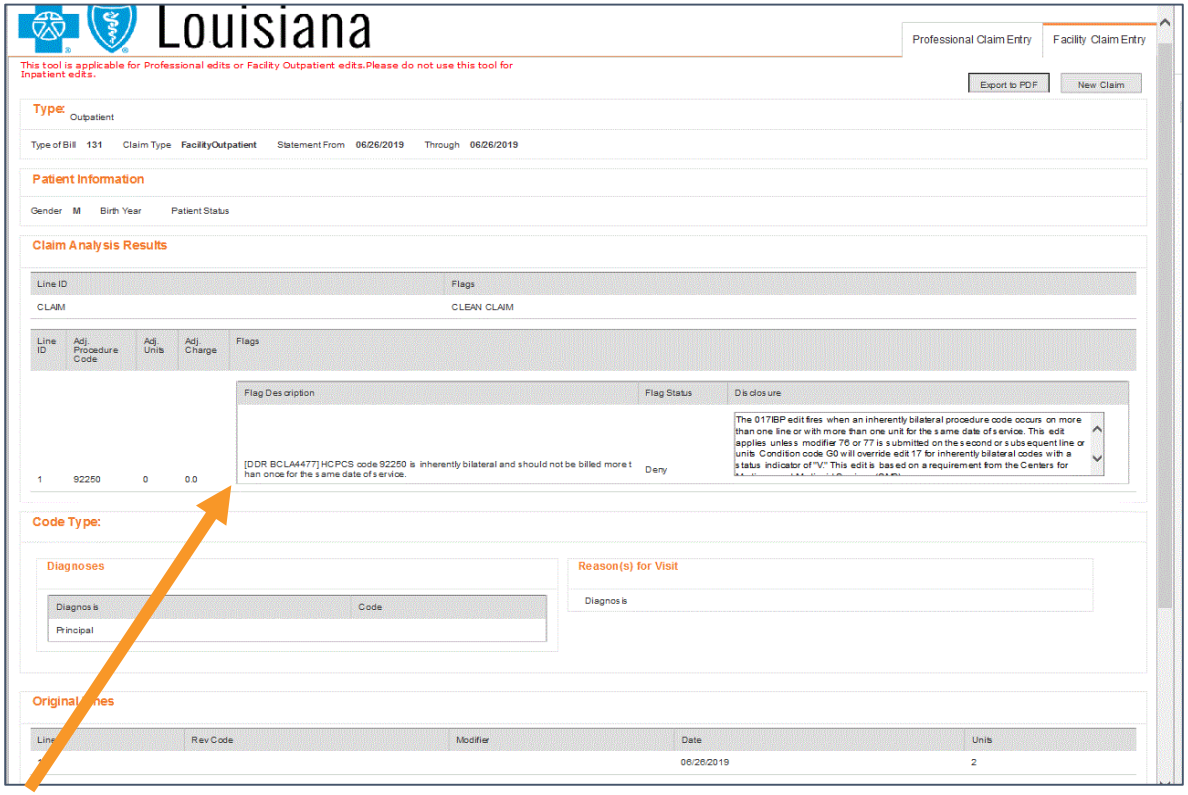
CES Tool Mandatory Fields



NOTE: If you do not enter the Statement From or Through dates, no edits will be returned, so the dates are necessary

NEW

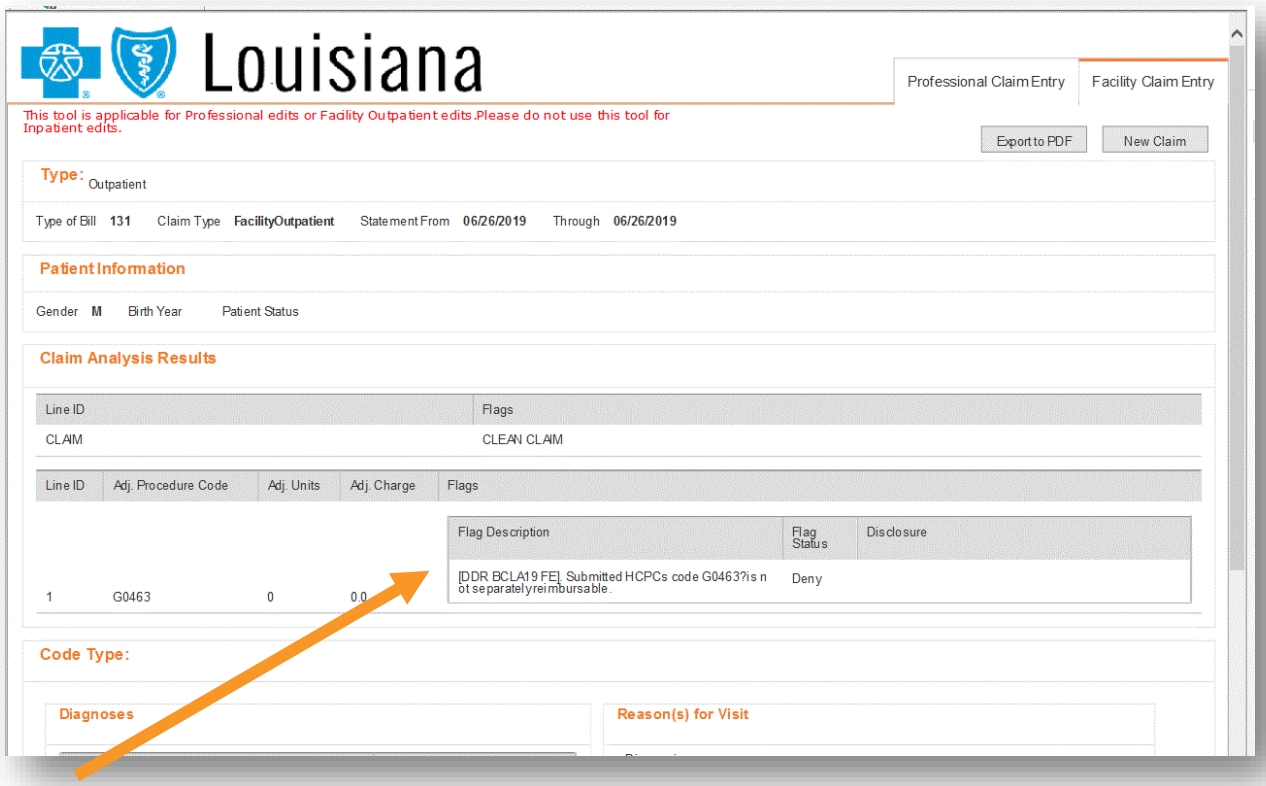
CES Tool Outputs



Bilateral procedure (92250) billed with 2 units

NEW

CES Tool Outputs



G0463 not separately reimbursable

PROPER CLINICAL 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's 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)
  - **Acceptable**: John Doe, MD
  - **Not Acceptable**: Dr. John Doe
- 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
  - Ex: chronic or acute, controlled or uncontrolled
- Medical records **must support ALL** diagnosis codes on claims
  - Monitored, evaluated, assessed or treated (MEAT)

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
- Inovalon
- Varis

Commercial Diagnostic Accuracy and Completion

Commercial Diagnostic Accuracy and Completion (DAC) is a component of the Affordable Care Act (ACA)

- Encourages health plans to focus on quality improvements, efficiency and stabilization of premiums
- DAC uses diagnosis codes reported on claims to determine the disease state or illness burden (overall health) of a patient, which allows CMS to assign a risk score to each patient
- DAC medical record requests typically begin in January

Blue Cross is currently partnered with Inovalon to conduct out-of-state DAC medical record requests

Commercial Risk Scores

Since risk scores are recalculated every year, diagnosis codes for all conditions must be documented by a provider every year:

- Adhere to the proper documentation practices outlined on slide 66 of this presentation
- Blue Cross identifies those members with potential diagnostic gaps by review of claims data
- Diagnostic gaps are identified through:
  - History: prior year diagnosis
  - Pharmacy: prescribed medication
  - Diagnostic: lab or diagnostic test
  - Other: diagnosis with potential co-existing condition

What can providers do?

1. Close gaps in care
2. Ensure all documentation reflects what is being billed
3. Ensure chart reflects complete clinical profile for the patient

Risk Adjustment Data Validation Audits

Required through the ACA, the framework for the risk adjustment data validation (RADV) audit process for the risk adjustment program was established

Components of the RADV Audits:

- Annual CMS mandate
- Required audit for every insurer who sells a policy on the ACA marketplace
  - Will be used to confirm risk reported
  - To confirm providers' medical records substantiate the reported data and accurately reflect the care rendered and billed
- The Accountable Care Law mandates medical records be provided
- RADV audit requests for medical records typically begin in June

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 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)

BCBSLA staff will perform the medical record retrieval for 2019-2020. We have reached out to many of you to obtain your preference of chart retrievals to include: EMR, access, on-site, fax or mail. At times, you may receive retrieval requests from vendors that we partner with. Currently, we use Centauri, Inovalon and Varis.

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 within 5 to 7 business days)

REMINDER: 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

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:

HEDISTeam@bcbsla.com

2020 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

Plan All-cause Readmission (PCR)
For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

2020 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/Bronchiolitis (AAB)
The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that were not dispensed an antibiotic prescription

2020 HEDIS Measurements

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 or intentional self-harm 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.

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

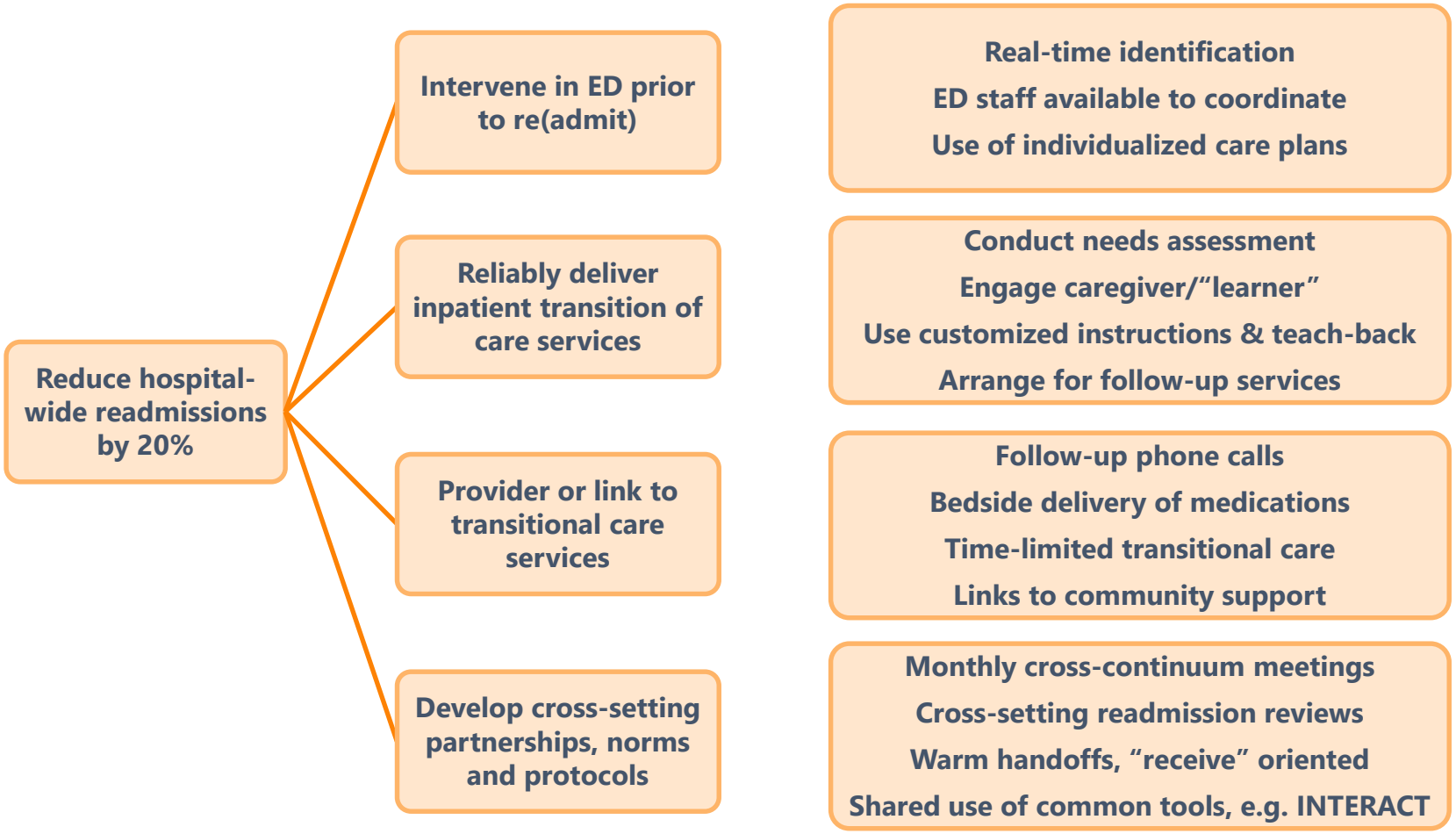
1. Discharge instructions/education—diagnosis, prognosis, treatment plan and expected course of illness
2. Telephone follow-ups
3. ED made appointments

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

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

Plan All-cause Readmission (PCR)



FUH

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

To locate a provider for the member's FUH visit, you can use the Rainmaker list provided by our behavioral health manager, New Directions. Email **LouisianaPR@ndbh.com** to get a copy of this list. If you are unable to schedule an appointment using the Rainmaker list, you may call **1-877-300-5909** for assistance in scheduling.

FUM

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

FUA

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 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

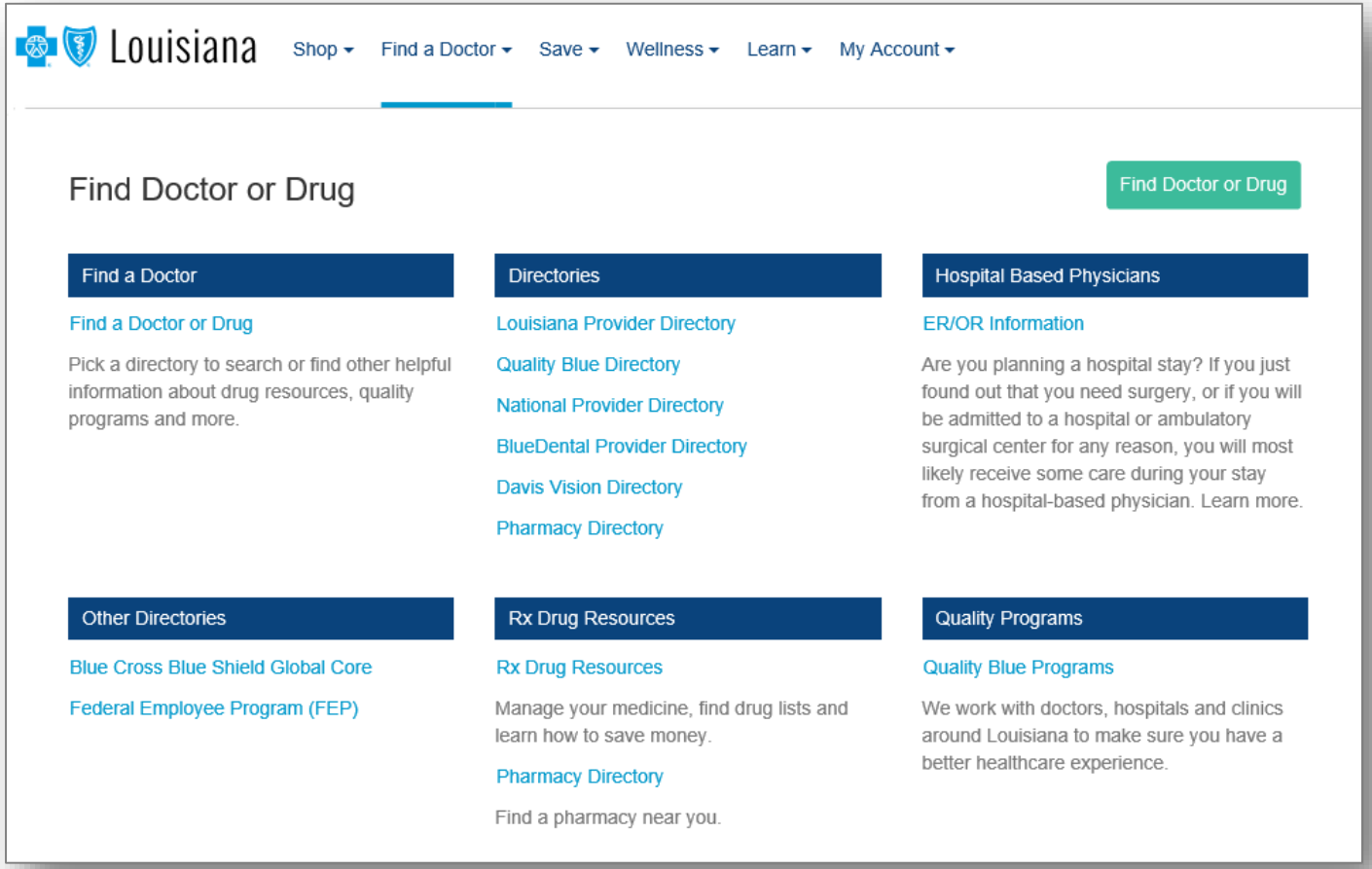
Out-of-network Referrals

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

Finding Participating Providers

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



Laboratory Referrals

- All network providers **must** refer members to preferred reference lab vendors when lab services are needed and not performed in the provider's office
- Please refer to the preferred lab requirements listed in the *Member Provider Policy & Procedure Manual* to ensure your patients receive the maximum benefits to which they are entitled
- We use a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Blue Cross and Blue Shield of Louisiana members **must** be submitted to a preferred reference laboratory in the member-patient's network.
  - For the most current list of statewide reference labs and full details on laboratory requirements for our Preferred Care PPO products, please refer to the Preferred Care PPO Preferred Reference Lab Guide
  - For HMO Louisiana products, please refer to the HMO Louisiana, Inc. Preferred Reference Lab Guide
  - For Blue Connect, Community Blue and Signature Blue products, please refer to the corresponding network speed guide

All of these guides are available online at **www.BCBSLA.com/providers**, >Resources >Speed Guides

QUALITY BLUE PROGRAMS

Quality Blue

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
- Quality Blue Value Partnerships (QBVP)

Quality Blue Programs

- Blue Cross and Blue Shield of Louisiana implemented a cost-saving program for members when services are performed by a Quality Blue provider
- Blue Cross reduces members' (depending on their plan) office copayment with visits to a Quality Blue enrolled primary care doctor
- The Quality Blue Primary Care Claims-Based (QBPC-CB) program is a bridge program for practices who currently meet, or will soon meet, the requirements for QBPC. The goal of this program is to move the provider to the QBPC Outcomes program.
- To determine a member's QBPC cost share, visit iLinkBlue (**www.BCBSLA.com/ilinkblue**)

- The Quality Blue program includes primary care physicians—family medicine, internal medicine or general practice, geriatrics and nurse practitioner
- QBVP also includes pediatricians
- Providers enrolled in QBPC have their performance measured against established program clinical quality and efficiency measures
- To learn more about the QBPC Program, visit **www.BCBSLA.com/QBPC**

Quality Blue Programs

Quality Blue
PRIMARY CARE

- Patient-focused care for **better health and lower costs**
- **Value-based care approach**: Doctors paid based on how well they coordinate care, get better health results and meet benchmarks

Quality Blue
VALUE PARTNERSHIPS

- Enables large physician groups, or Accountable Care Organizations (ACOs), to be **responsible for improving health quality & saving costs of care** across the system – primary care and specialty care, hospitalizations, labs, etc.
- ACOs that improve quality and keep costs down get a percentage of savings reimbursement from Blue Cross

Hospital Quality Program

- Our Hospital Quality Program is a pay-for-performance program that includes a range of nationally accepted measures such as healthcare associated infections, HCAHPS, perinatal core measures and sepsis

- The program is designed for acute care facilities with 50 beds or more
- The program guide can be found at **www.BCBSLA.com/providers** >Programs >Quality Blue >Hospital Quality and Value Improvement Program (HQVIP)
- For more information, contact your facility network representative or email **QualityBlue@bcbsla.com**

Hospital Bed Count Quality Notice

Standards under the ACA require Qualified Health Plan Issuers that contract with a hospital with greater than 50 beds to verify that the hospital:

- Utilizes a patient safety evaluation system and implements a mechanism for comprehensive person centered hospital discharge to improve care coordination and healthcare quality for each patient

OR

- Implements an evidence-based initiative to improve healthcare quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission or improves care coordination, via at least one of the following—Patient Safety Organization, Hospital Improvement Innovation Network, Quality Improvement Organization or an evidence-based strategy, such as The Joint Commission accreditation

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		✓

CARE MANAGEMENT

Care Management Team

Blue Cross has a clinical care team of 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

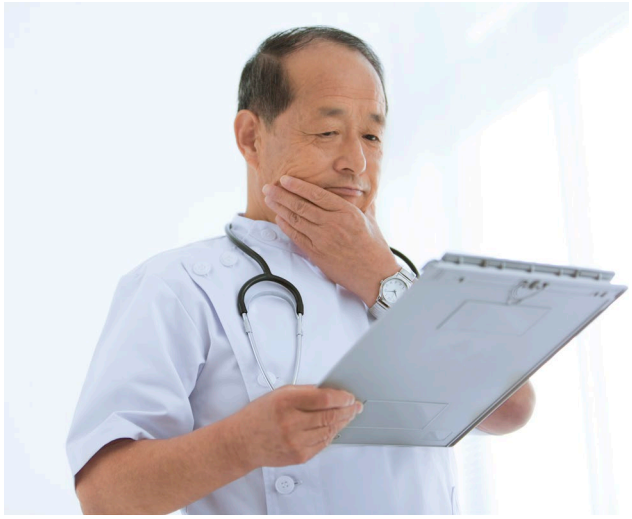
In our Case and Disease Management programs:

- 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
- Members with high service utilization or cost
- Care Coordination

Community Care Manager Nurse Model

The goal of a Community Care Manager is to provide case management presence that targets high risk members and supports primary care physician offices and facilities in achieving better healthcare outcomes and lower costs

The targeted population will be high risk members with admissions or complex needs and may include those with uncontrolled chronic conditions such as coronary artery disease (CAD), congestive heart failure (CHF), respiratory conditions and diabetes, that are:

- Newly diagnosed with potential for complications
- Have complex comorbid, behavioral health issues
- High risk, high cost utilizers
- Newly discharged requiring complex discharge 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 member or use the referral form located online at **www.BCBSLA.com/providers** >Programs >Care Management
- Blue Cross members 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

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, available online at **www.BCBSLA.com/providers** >Electronic Services >Admin Reps

Inactivity Policy

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 Provider Identity Management Team at **PIMTeam@bcbsla.com**

Provider Identity Management (PIM) Team

Need help?

- Provider Identity Management 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

The PIM Team Can Assist With:

- Setting up administrative representatives
- Educating and assisting 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?

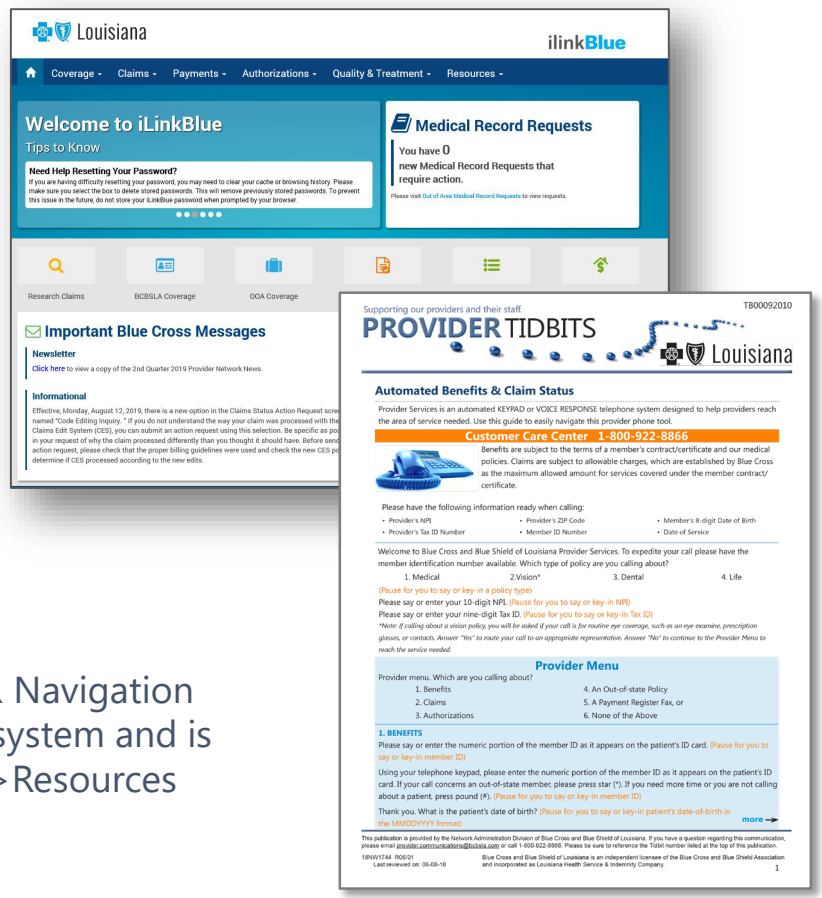
This requires a written notification be sent to the PIM team

Provider Self-service Initiative

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

- Member eligibility
- Claim status inquiries
- Professional allowable searches
- Medical policy searches

These services are no longer handled directly by our Customer Care Center



Self-service tools available to providers:

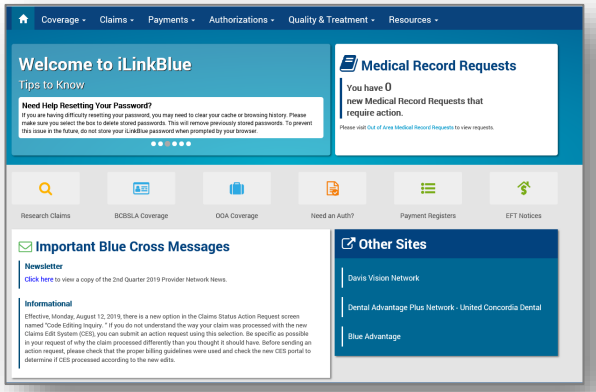
- iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- Interactive Voice Recognition (IVR) (1-800-922-8866)
  - The Automated Benefits & Claim Status (IVR Navigation Guide) tidbit will help you navigate the IVR system and is available at **www.BCBSLA.com/providers** >Resources >Tidbits
- HIPAA 27x transactions

iLinkBlue

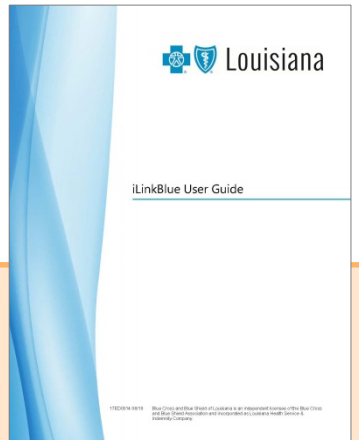
www.BCBSLA.com/ilinkblue

- 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**

ilinkBlue

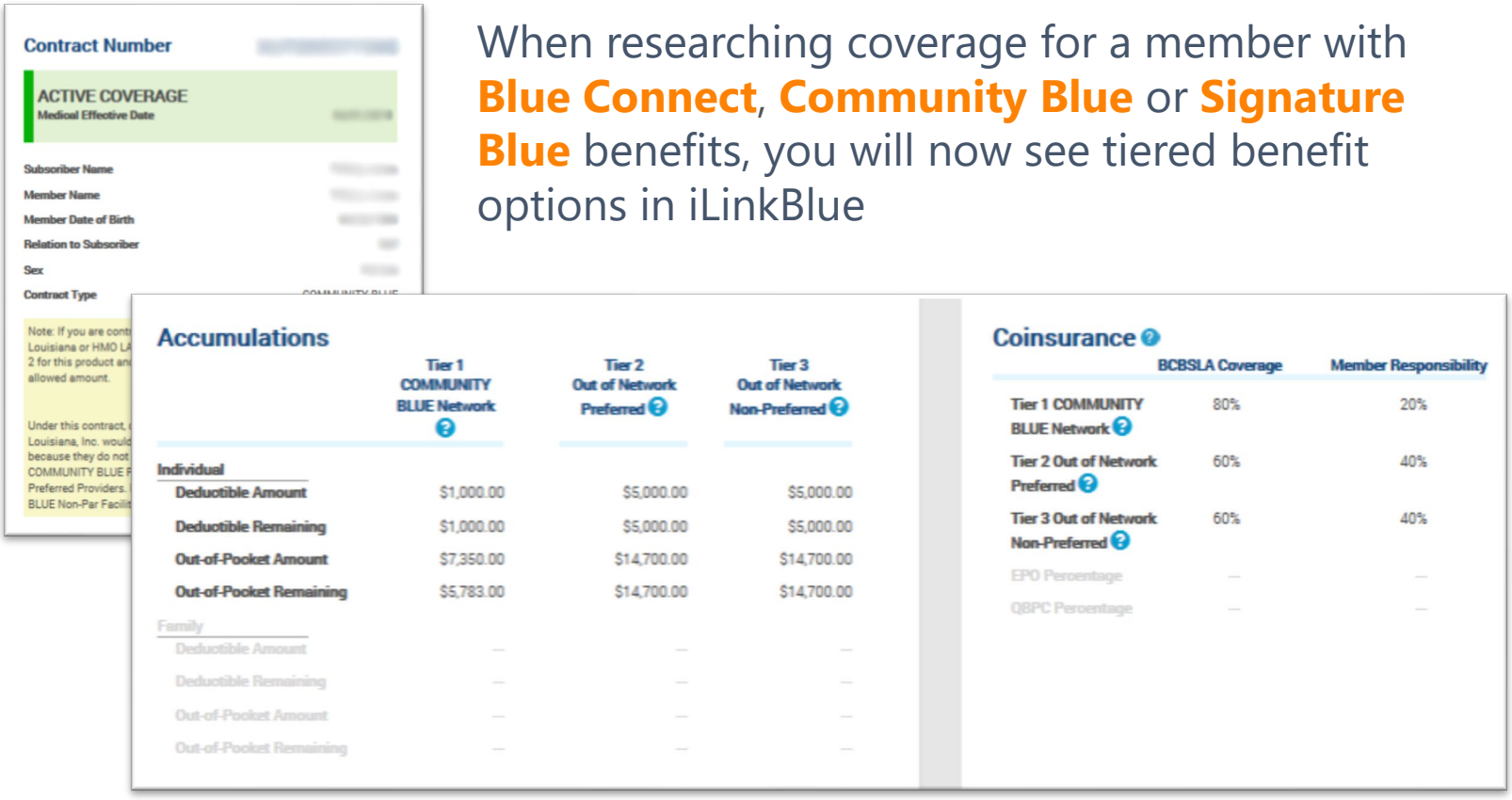


We have an *iLinkBlue User Guide* available online at **www.BCBSLA.com/providers**, then click on "Resources"



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

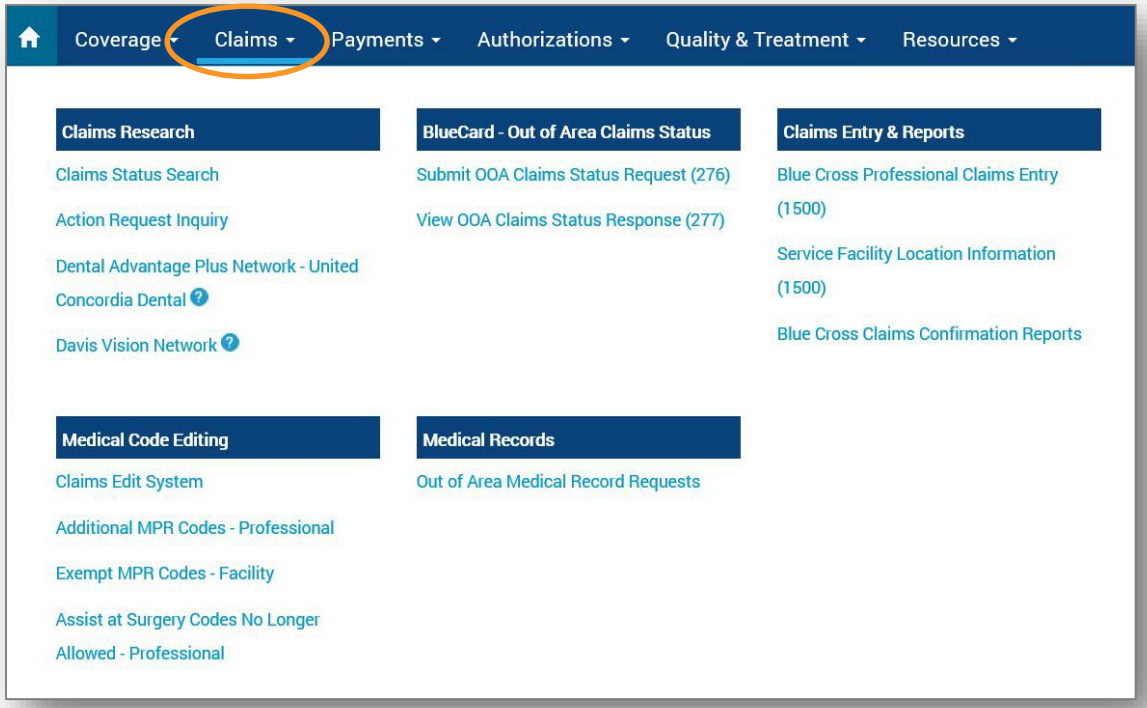
Tiered Benefits for Select Networks

Tier 1 In Network Preferred	Tier 2 Out of Network Preferred	Tier 3 Out of Network Non Preferred
Applies to providers participating in the member's select network	Applies to providers participating in-network with Blue Cross but NOT in the member's specific network	Applies to providers who do not participate in any Blue Cross network
Example Scenario: • A Community Blue member sees a Community Blue provider	**Example Scenario**: • A Community Blue member sees a Preferred Care PPO provider	**Example Scenario**: • A Community Blue member sees a non-participating provider
• The member copay and accumulators identified under Tier 1 should be applied	• The member copay and accumulators identified under Tier 2 should be applied	• The member copay and accumulators identified under Tier 3 should be applied
• Provider may not bill the member for any amount over the allowed amount	• Provider may not bill the member for any amount over the allowed amount	• Provider can bill the member for all amounts over the allowed amount

Claims Information in iLinkBlue

Use the "Claims" menu option to find online tools to:

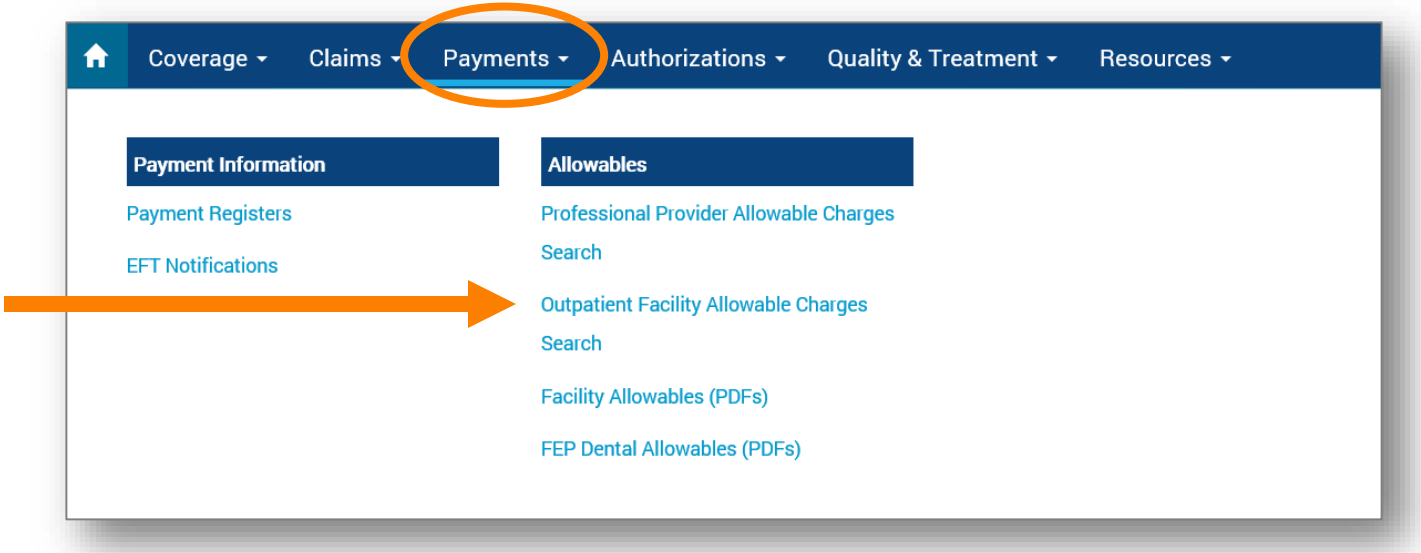
- Perform **Claims Research** on claims that were submitted for processing
- Submit **BlueCard - Out of Area Claims Status** inquiries for BlueCard (out-of-area) members
- Check status of claims that were filed electronically (even if they were filed through a clearinghouse) using the **Blue Cross Claims Confirmation Reports** tool
- View medical record requests for your BlueCard (out-of-area) patients in our **Medical Records** section



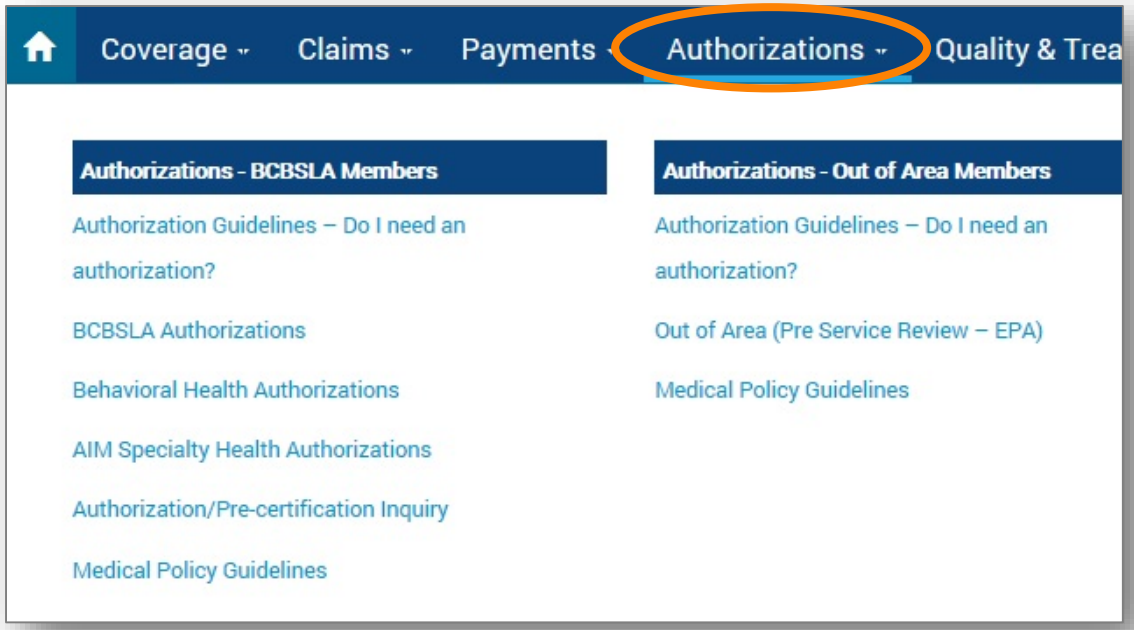
iLinkBlue – Allowable Charges Research

Facilities can now research outpatient allowable charges on iLinkBlue

- This tool is intended for acute-care hospitals and ambulatory surgical centers on a contracted fee schedule only
- From the iLinkBlue menu, select the "Payments" menu option, then "Outpatient Facility Allowable Charges Search" to open the tool
- To search for an allowable charge, first enter the date and select the facility provider by name and NPI. Then click on the "Continue" button to activate the remaining fields.
- Select the appropriate Blue Cross network and enter the CPT/HCPC code. The click on the "View Allowables" button

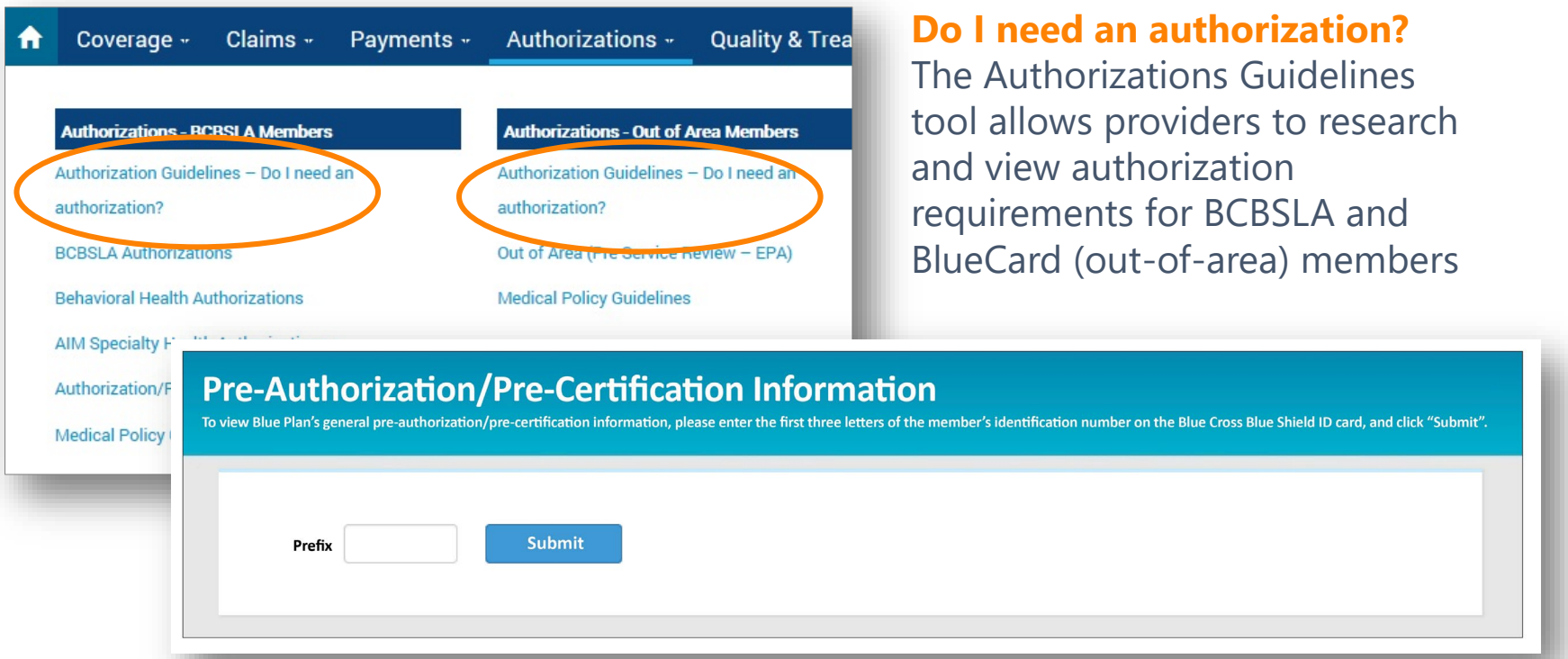


iLinkBlue – Authorizations



- 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

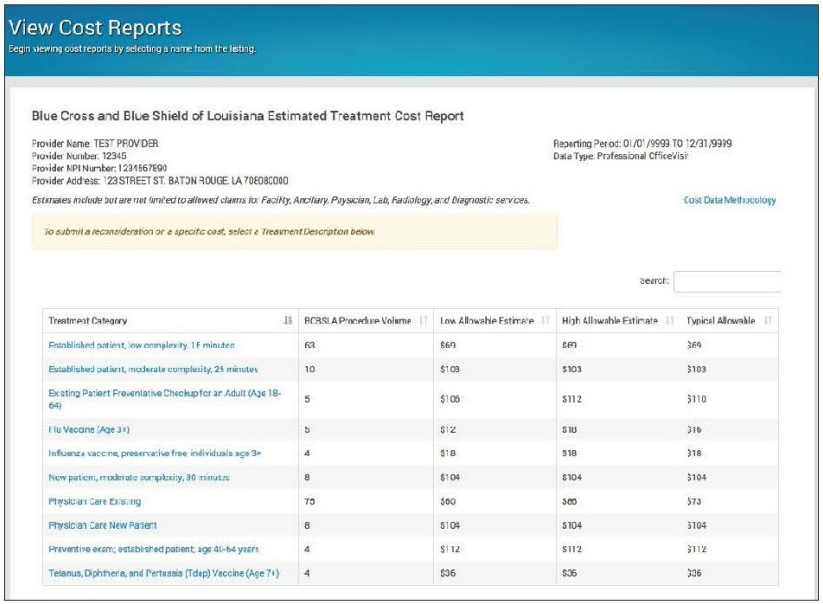
Where to Find Authorization Requirements



Do I need an authorization?
The Authorizations Guidelines tool allows providers to research and view authorization requirements for BCBSLA and BlueCard (out-of-area) members

Simply enter the member's prefix (the first three characters of the member ID number) to access general pre-authorization/pre-certification information

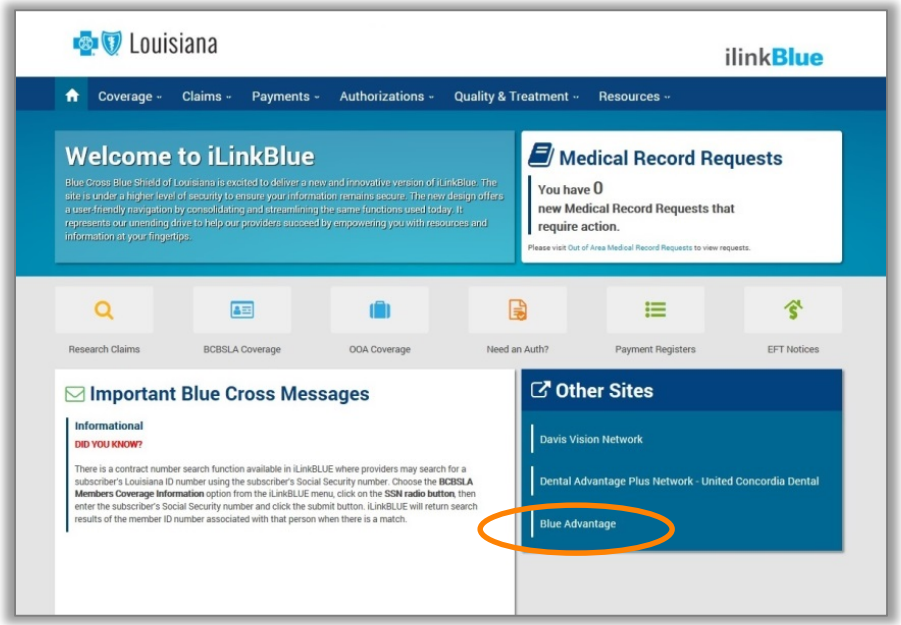
iLinkBlue – Estimated Treatment Cost Reports



We have recently made updates to the tool. It now features the costs and volumes associated with elective and planned procedures for Fall 2019. The data will only be available to review until **November 5, 2019**.

- 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)/Blue Advantage (PPO) 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**)
- To gain security access to the Blue Advantage Provider Portal, users must first self-register within the portal; this will start the process of getting the user access to the feature

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

AIM Authorizations & Reviews

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

Facilities may check the status of an authorization request through the AIM ***Provider****Portal*$_{SM}$ on iLinkBlue; however, they cannot and should not obtain authorizations for ordering physicians

- 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 high-tech 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 the 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

Utilization Management Programs

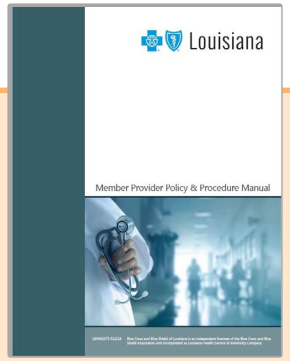
Blue Cross has several utilization management programs that require prior authorization for select elective services. AIM Specialty Health® (AIM), an independent specialty benefits management company, serves as our authorization manager for these services:

- Cardiology
- High-tech Imaging (CT, MRI/MRA, PET, Nuclear Cardiology)
- Radiation Oncology
- Musculoskeletal (MSK)
  - Interventional Pain Management
  - Joint Surgery
  - Spine Surgery

Authorization requests may be completed online using the AIM ***Provider****Portal*$_{SM}$ accessed through iLinkBlue. AIM clinical appropriateness guidelines are available at **www.aimspecialtyhealth.com**.

Ordering physicians are required to obtain the authorization. Hospitals and freestanding facilities that perform the technical component of the service(s) cannot and should not obtain authorizations for ordering physicians; however, they may check the status of an authorization request through the AIM ***Provider****Portal*$_{SM}$ on iLinkBlue.

Additional information can be found in the ***Member Provider Policy & Procedure Manual,*** available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section



Failure to Obtain an Authorization

Failure to obtain a prior authorization can result in:

- A 30% 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)*
- Denial of payment for straight HMO
- The denial of payment for services for our Office of Group Benefits (OGB) members

Authorization penalties or services that deny for no authorization are not billable to the member

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

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

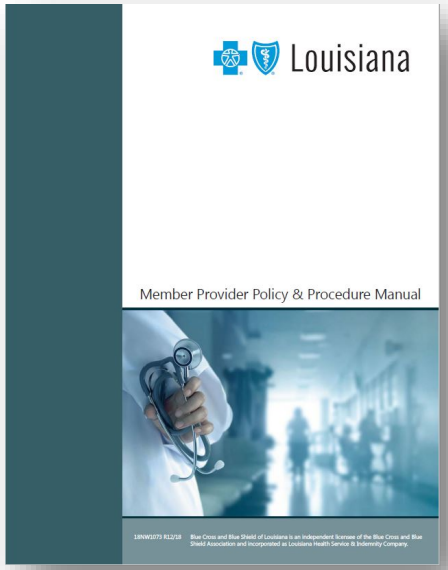
Process for Changing an Authorization

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 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

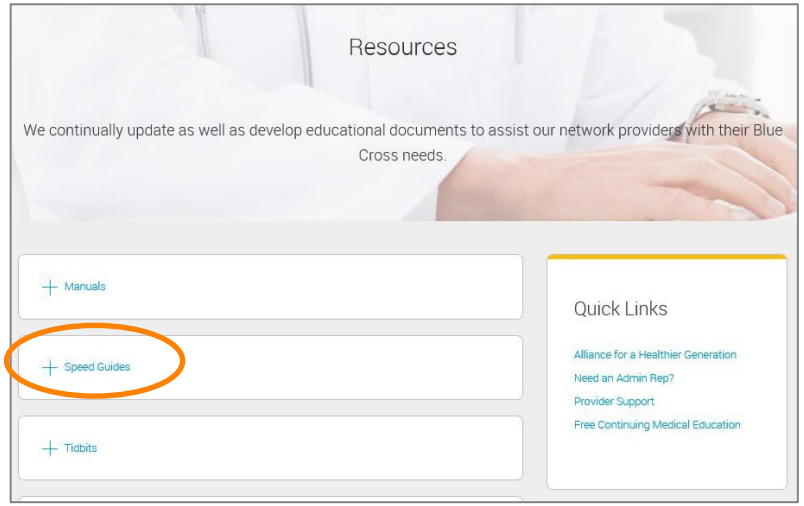
If the procedure being added or changed is on a Blue Cross medical policy or is a non-covered benefit, it cannot be updated on the authorization. Once the claim is filed, fax medical records to **(225) 298-2906** or **1-800-515-1150**.

Finding Authorization Requirements



The list of authorization requirements can be found in our *Member Provider Policy & Procedure Office Manual* located on iLinkBlue (**www.BCBSLA.com/ilinkblue**)

The authorization lists also appear on our network Speed Guides, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides



NOTE: For OGB authorization requirements, failure to obtain an authorization will result in denial of payment for services

Blue Advantage Inpatient Admissions & Discharges

- Blue Advantage (HMO) and Blue Advantage (PPO) network providers are required to give notification within one business day of Blue Advantage members' inpatient admissions and fax discharge summary once the member is discharged
- 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, seven 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.

Payments denied because notification was not received from the provider are not billable to the member

RESOLVING CLAIMS ISSUES

Resolving Claims Issues

Have an issue with a claim? We are here to help!

Depending on the type of claim issue, there are multiple ways to submit claims reviews that we will outline in this section:

- Action Requests
- Claims Disputes
- Medical Appeals
- Administrative Appeals & Grievances

Submitting an Action Request is a great option for getting a quick and accurate resolution for your claims issues. Action Requests:

- Reduce the time it takes for providers to receive a response from Blue Cross
- Allow providers to see responses directly from the adjustments team after review
- Allow providers to submit additional questions once they have reviewed the AR response

Submitting Action Requests

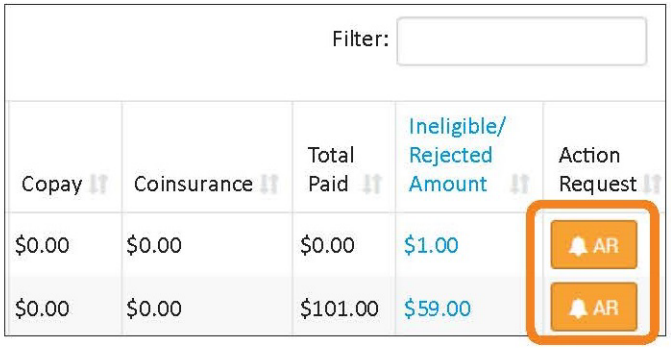
Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim (**www.BCBSLA.com/ilinkblue**)

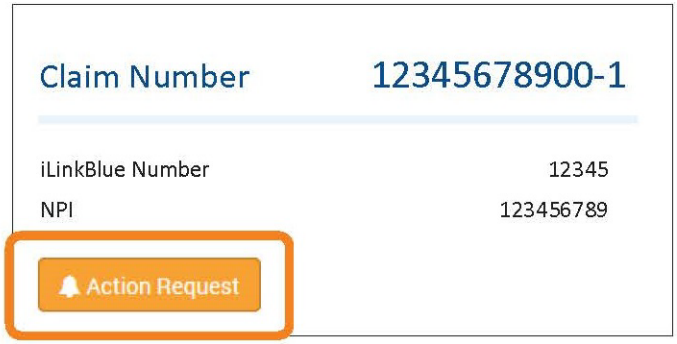
Common reasons to submit an Action Request

- Code editing inquiries
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No record of membership (effective and term date)
- Medical records receipt
- Recoupment request
- Status of an appeal
- Status of a grievance

NOTE: Action Requests do not allow you to submit documentation regarding your claims review

Submitting Action Requests





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

If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at **provider.relations@bcbsla.com**

Email an overview of the issue along with two action request dates OR two customer service reference numbers if one of the following applies:

- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center at **1-800-922-8866**) and have allowed 10-15 business days after second request, or
- It is a system issue affecting multiple claims

Claims Disputes & Appeals

Sometimes it may be necessary for a provider to dispute or appeal a claim

CLAIMS DISPUTES

Involves a denial that affects the provider's reimbursement

MEDICAL APPEALS

Involves a denial or partial denial based on:

- Medical necessity, appropriateness, healthcare setting, level of care or effectiveness
- Determined to be experimental or investigational

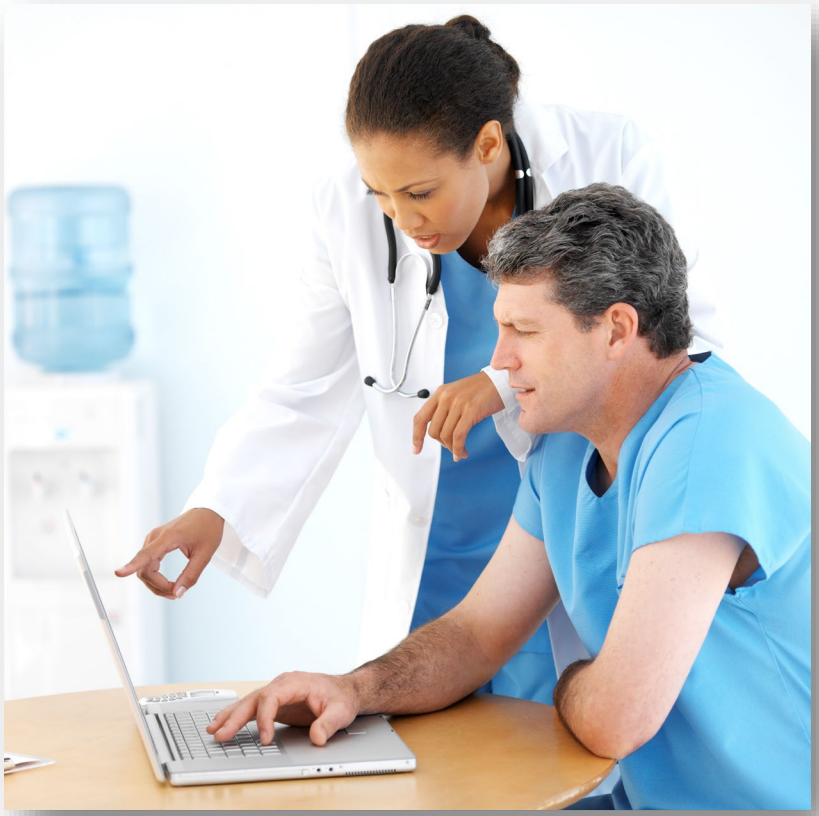
ADMINISTRATIVE APPEALS & GRIEVANCES

- Claim issue due to the member's contract benefits, limitations, exclusions or cost share
- When there is a grievance

On the next slides, we will detail each of these claims inquiries

Claims Disputes

- Reimbursement reviews:
  - Allowable disputes
  - Bundling issues
- Timely filing
- Authorization penalties
- Failed to obtain an authorization denials
- Refund disputes



Decisions upheld by the Claims Disputes department are not billable to the member

Medical Appeals

Claim denied as investigational or not medically necessary

STANDARD
APPEAL

COMPLETED WTIHIN 30 DAYS OF RECEIPT

- Complete ALL information on the appeals form (including contact information in case additional records are needed). Incomplete information may delay the review.
- Clearly identify service being appealed (ex: drug name, specific procedure, DME item, etc.)
- Include supporting rationale AND supporting clinical records
- Please read the "What can you do if you still disagree with our decision?" section of the initial denial letter and appeal denial letter for the appropriate appeal timeframes and instructions for the member's policy
- We require network providers to disclose ineligible services to members prior to performing or ordering services. Our medical policies are available on iLinkBlue (**www.BCBSLA.com/ilinkblue**).
- Benefit determinations are made based on the medical policy in effect at the time of service

Medical Appeals

Claim denied as investigational or not medically necessary

EXPEDITED
APPEAL

COMPLETED WITHIN 72 HOURS OF RECEIPT

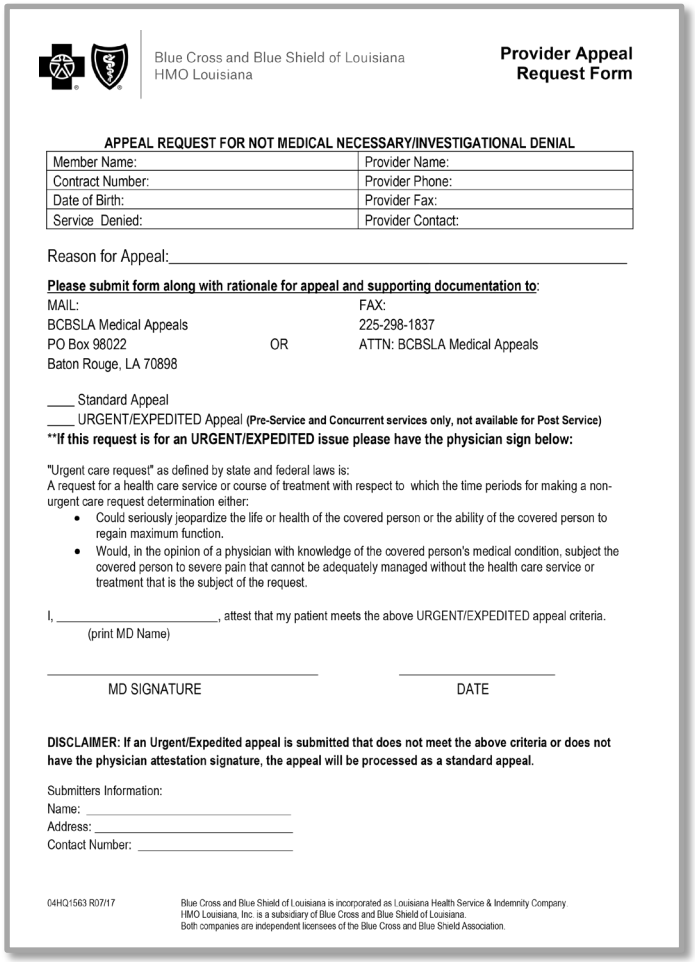
- Could seriously jeopardize the life or health of your patient or their ability to regain maximum function, **OR**
- Would, in the opinion of the treating physician with the knowledge of the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request
- If submitting with the appeal form included in the initial denial letter, the physician must clearly mark the form as **"Expedited"** (urgent) and sign the attestation that requested service meets the above expedited criteria
- Fax the appeal request along with supporting documentation to the number listed on the "A Guide For Disputing Claims" tidbit, available at **www.BCBSLA.com/providers** >Resources >Tidbits
- Expedited appeals are **not** available if services have been rendered

Medical Appeals

Claim denied as investigational or not medically necessary

Provider Appeal Request Form for Medical Appeals

- Use the Provider Appeal Request Form that was included in the initial denial notice to properly request a review of a medical necessity or investigational denial
- Be sure to complete all fields in the form and attach to the top of your appeal information
- Physician signature is ONLY required if the request to appeal is expedited



Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Provider Appeal Request Form

APPEAL REQUEST FOR NOT MEDICAL NECESSARY/INVESTIGATIONAL DENIAL

Member Name:	Provider Name:
Contract Number:	Provider Phone:
Date of Birth:	Provider Fax:
Service Denied:	Provider Contact:

Reason for Appeal:_____

Please submit form along with rationale for appeal and supporting documentation to:

MAIL:
BCBSLA Medical Appeals
PO Box 98022
Baton Rouge, LA 70898

OR

FAX:
225-298-1837
ATTN: BCBSLA Medical Appeals

____ Standard Appeal
____ URGENT/EXPEDITED Appeal **(Pre-Service and Concurrent services only, not available for Post Service)**
****If this request is for an URGENT/EXPEDITED issue please have the physician sign below:**

"Urgent care request" as defined by state and federal laws is:
A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination either:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.
- Would, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

I, _____, attest that my patient meets the above URGENT/EXPEDITED appeal criteria.
(print MD Name)

_____ _____
MD SIGNATURE DATE

DISCLAIMER: If an Urgent/Expedited appeal is submitted that does not meet the above criteria or does not have the physician attestation signature, the appeal will be processed as a standard appeal.

Submitters Information:
Name: _____
Address: _____
Contact Number: _____

04HQ1563 R07/17

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity 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.

Administrative Appeals & Grievances

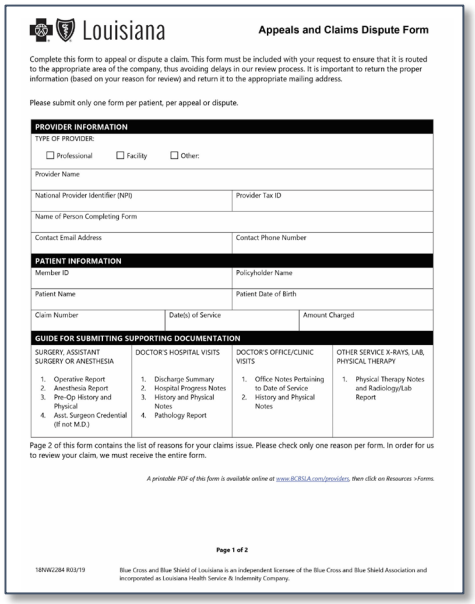
- Administrative appeals involve contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), with the member's authorization

- A grievance is a written expression of dissatisfaction with BCBSLA or a provider's services. Typically, grievances do not involve denied claims.

The top reasons for administrative appeals are:

1. Out-of-network (OON) providers
2. Contract limitations or exclusions
3. Claims processing (how cost sharing was applied)
   - Deductible
   - Coinsurance
   - Copayment

Appeals and Claims Dispute Form



Louisiana

Appeals and Claims Dispute Form

Complete this form to appeal or 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 return it to the appropriate mailing address.

Please submit only one form per patient, per appeal or 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 issue. Please check only one reason per form. In order for us to review your claim, 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

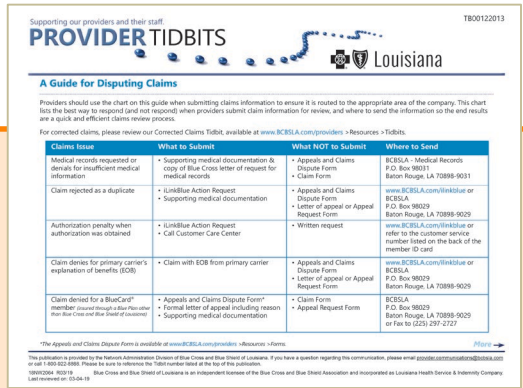
18NW2284 R03/19

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.

Form is available online at
www.BCBSLA.com/providers
>Resources >Forms

- Use the Appeals and 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 Appeals and Claims Dispute Form when claim:
  - Rejected as duplicate
  - Denied for bundling
  - Denied for medical records
  - Denied as investigational or not medically necessary
  - Payment/denial affects the provider's reimbursement
  - Payment affects the member's cost share
  - Denied for a BlueCard member

For details on where to submit claims issues, refer to the "A Guide For Disputing Claims" Tidbit (**www.BCBSLA.com/providers** >Resources >Tidbits)



Supporting our providers and their staff.

TB00122013

PROVIDER TIDBITS

Louisiana

A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

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	• Appeals and 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	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/linkblue 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/linkblue or refer to the customer service number listed on the back of the member ID card
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/linkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denied for a BlueCard® member (Insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Appeals and Claims Dispute Form* • Formal letter of appeal including reason • Supporting medical documentation	• Claim Form • Appeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

*The Appeals and Claims Dispute Form is available at www.BCBSLA.com/providers >Resources >Forms.

More →

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this communication, please email provider.communications@bcbsla.com or call 1-800-922-6988. Please be sure to reference the Tidbit number listed at the top of this publication.

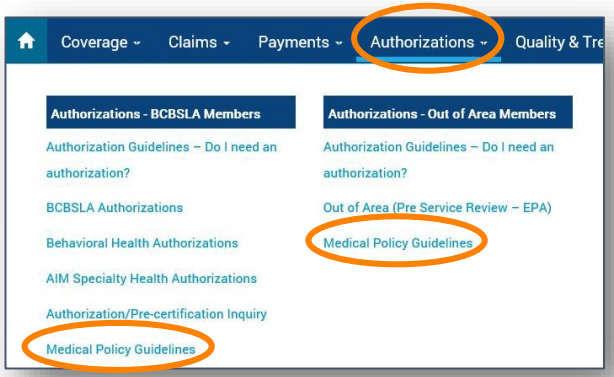
18NW2304 R03/19 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Last reviewed on: 03-04-19

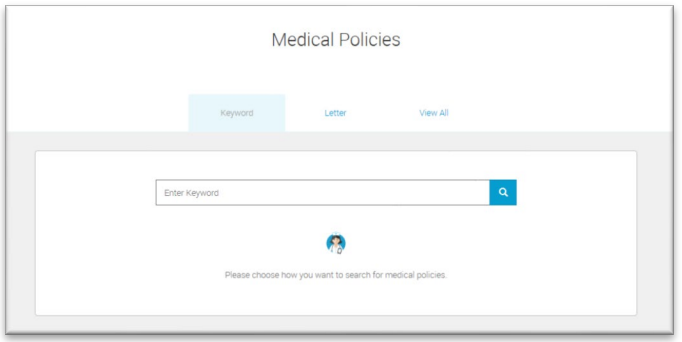
Accessing Our Medical Policies

- From the iLinkBlue menu, select “Authorizations” then “Medical Policy Guidelines” to open the **Medical Policy Index**
- Policies are listed in alpha order via the letter tab or you may search by keyword, procedure code, policy name or policy number

1.



2.



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.

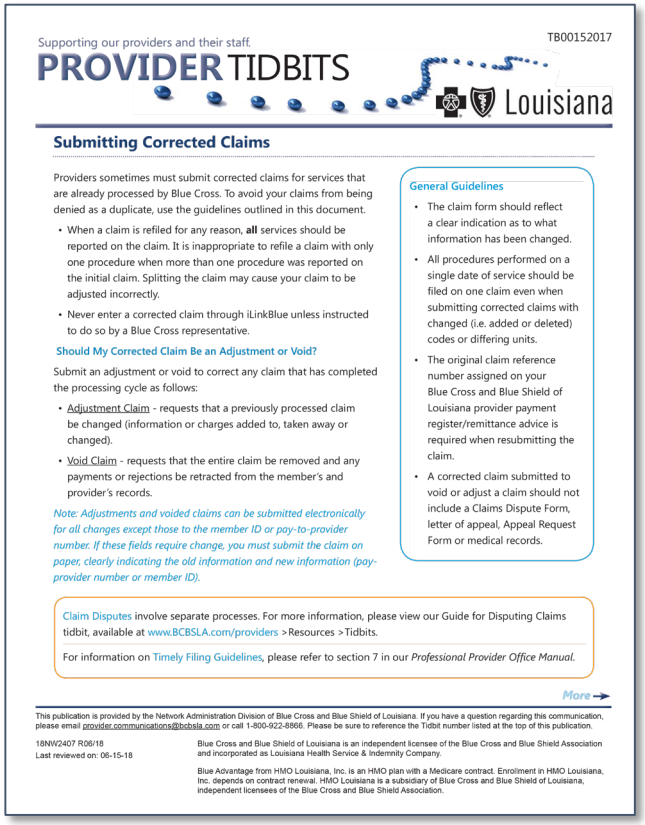
Our medical policies include: coverage eligibility, background information related to technology, devices and treatments, technology assessments, literature sources, applicable coding and the rationale for coverage determinations

Submitting Research to Evidence Street®

- Healthcare product manufacturers with new procedures or devices that may influence medical policy should consider submitting their research to the Blue Cross Blue Shield Association Evidence Street®
- Visit the Evidence Street® website at **https://app.evidencestreet.com** to monitor when BCBSA is reviewing particular medical categories and learn when to submit peer-reviewed evidence for consideration during scheduled submission periods
- Research should be submitted to **evidencestreet@bcbsa.com**
- If outside of a submission period, it is collected for review during the next submission period for that medical category

Submitting Corrected Claims

- 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)



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TB00152017

PROVIDER TIDBITS

Louisiana

Submitting Corrected Claims

Providers sometimes must submit corrected claims for services that are already processed by Blue Cross. To avoid your claims from being denied as a duplicate, use the guidelines outlined in this document.

- When a claim is refiled for any reason, **all** services should be reported on the claim. It is inappropriate to refile a claim with only one procedure when more than one procedure was reported on the initial claim. Splitting the claim may cause your claim to be adjusted incorrectly.
- Never enter a corrected claim through iLinkBlue unless instructed to do so by a Blue Cross representative.

Should My Corrected Claim Be an Adjustment or Void?

Submit an adjustment or void to correct any claim that has completed the processing cycle as follows:

- Adjustment Claim - requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim - requests that the entire claim be removed and any payments or rejections be retracted from the member's and provider's records.

Note: Adjustments and voided claims can be submitted electronically for all changes except those to the member ID or pay-to-provider number. If these fields require change, you must submit the claim on paper, clearly indicating the old information and new information (pay-provider number or member ID).

General Guidelines

- The claim form should reflect a clear indication as to what information has been changed.
- All procedures performed on a single date of service should be filed on one claim even when submitting corrected claims with changed (i.e. added or deleted) codes or differing units.
- The original claim reference number assigned on your Blue Cross and Blue Shield of Louisiana provider payment register/remittance advice is required when resubmitting the claim.
- A corrected claim submitted to void or adjust a claim should not include a Claims Dispute Form, letter of appeal, Appeal Request Form or medical records.

Claim Disputes involve separate processes. For more information, please view our Guide for Disputing Claims tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

For information on Timely Filing Guidelines, please refer to section 7 in our *Professional Provider Office Manual.*

More →

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this communication, please email provider.communications@bcbsla.com or call 1-800-922-8866. Please be sure to reference the Tidbit number listed at the top of this publication.

18NW2407 R06/18
Last reviewed on: 06-15-18

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Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana, Inc. depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

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

Electronic Corrected Claims

Please follow the steps below to ensure your claims will not deny as duplicates or process incorrectly. You can ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim

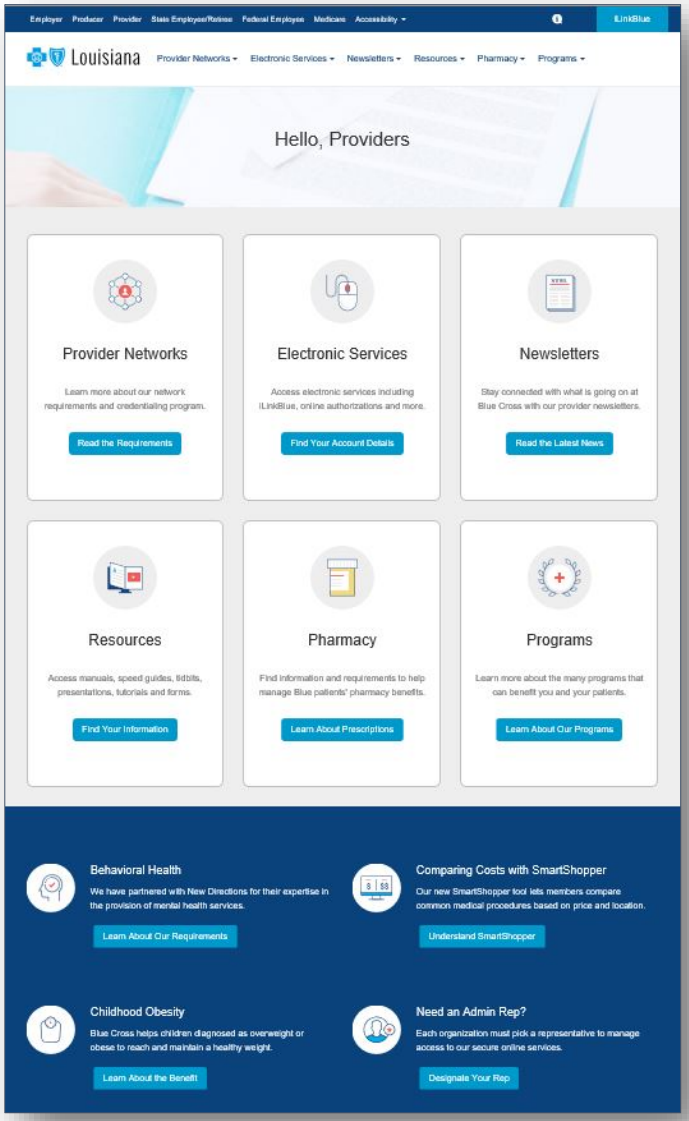
- Enter the frequency code "7" in Loop 2300 Segment CLM05-03
- Enter the 10-character ICN of the original claim (assigned on the processed claim) in Loop 2300 in an REF segment and use F8 as the qualifier
- Note: The Adjusted claim should include all charges (not just the difference between the original claim and the adjustment)

Void the Claim

- Use frequency code "8" in Loop 2300 Segment CLM05-03
- Use the 10-character ICN of the original claim (assigned on the processed claim) in Loop 2300 in an REF segment and use F8 as the qualifier

SUPPORT & RESOURCES

Provider Page



www.BCBSLA.com/providers

The Provider Page is home to online resources such as:

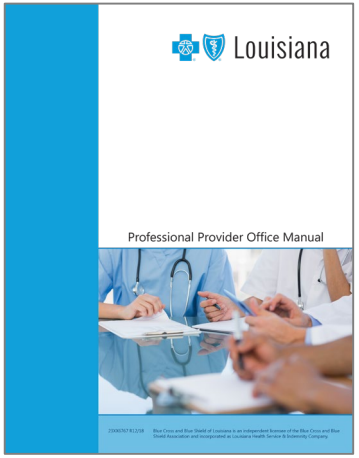
- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

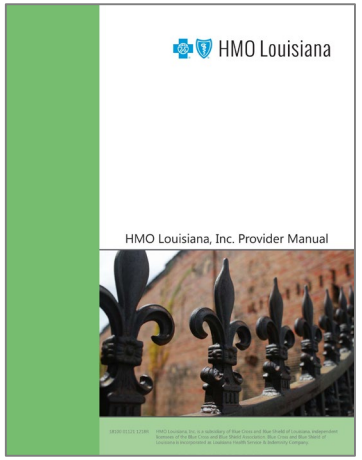
The *Member Provider Policy & Procedure Manual* (our facility manual) is located only in iLinkBlue (**www.BCBSLA.com/ilinkblue**)

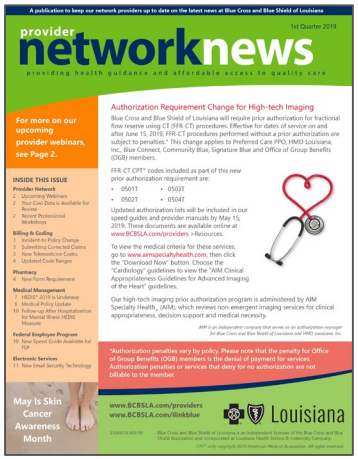
Manuals & Newsletters

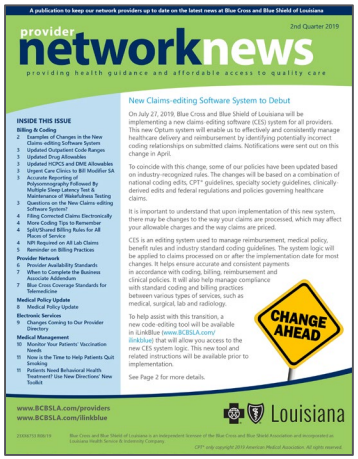
Our provider **Manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our networks.

www.BCBSLA.com/providers >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

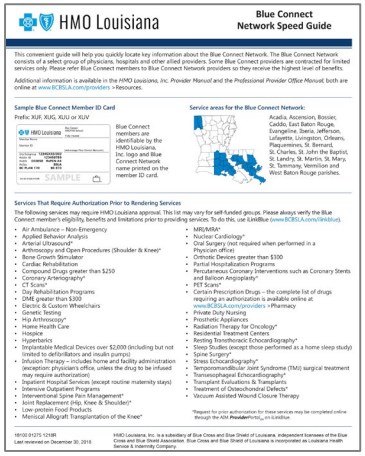
www.BCBSLA.com/providers >Newsletters

Not Getting Our Newsletters Electronically?

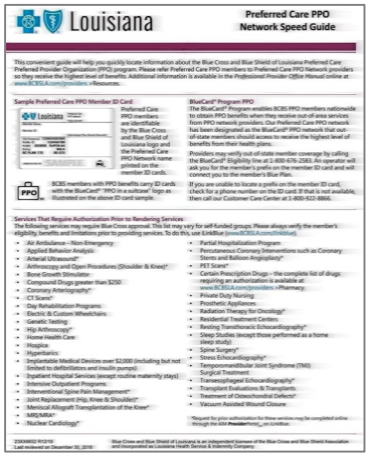
Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

Speed Guides & Tidbits

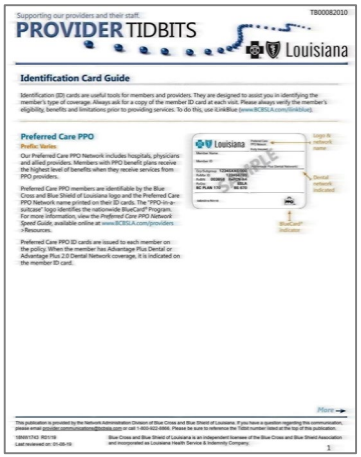
Our **Speed Guides** offer quick reference to network authorization requirements, policies and billing guidelines


HMO Louisiana

Blue Connect Network Speed Guide

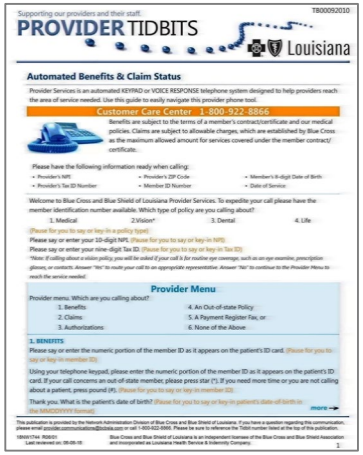

Louisiana

Preferred Care PPO Network Speed Guide


PROVIDER TIDBITS

Louisiana

Identification Card Guide


PROVIDER TIDBITS

Louisiana

Automated Benefits & Claim Status

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 Center	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

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

Network Development

Provider Contracting

Shannon Taylor – shannon.taylor@bcbsla.com
Interim Director

Jode Burkett – jode.burkett@bcbsla.com
Manager

Cora LeBlanc – **cora.leblanc@bcbsla.com**
Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne

Dayna Roy – **dayna.roy@bcbsla.com**
Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Grant, Jefferson Davis, LaSalle, Natchitoches, Rapides, Sabine, Vernon, Winn

Jason Heck – **jason.heck@bcbsla.com**
Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Red River, Richland, Tensas, Union, Webster, West Carroll

Jill Taylor – **jill.taylor@bcbsla.com**
Jefferson, Orleans, Plaquemines, St. Bernard

Vacant – **network.development@bcbsla.com**
St. Tammany, Tangipahoa, Washington

Mica Toups – **mica.toups@bcbsla.com**
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion

Sue Condon – **sue.condon@bcbsla.com**
Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge, West Feliciana

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

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

Provider Credentialing & Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright Director - justin.bright@bcbsla.com

Anne Monroe Provider Data Supervisor - anne.monroe@bcbsla.com

Rhonda Dyer Credentialing Supervisor - rhonda.dyer@bcbsla.com

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

Recredentialing applications can be emailed to **recredentialing.application@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 Provider Credentialing & Data Management Department by calling 1-800-716-229

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 • **pcdmstatus@bcbsla.com**

Thank you!

If you have additional questions after this workshop, please email **provider.relations@bcbsla.com**

APPENDIX A:
BILLING AND DOCUMENTATION

NDC Billing Guidelines on Claims

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

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). We follow the CMS guidelines when reporting the NDC. 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.

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.

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

APPENDIX B:
CARE MANAGEMENT

Stronger Than Campaign

STRONGER THAN is a mindset, a way of engaging members—and their providers—on the journey to optimal health. This platform will allow us to tell our Care Management story from a cohesive, user-centered experience that brings our services to their lives in a meaningful way to drive positive behaviors and build powerful relationships.

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

Care Management Clinical Team

Our in-house team of clinicians and professionals bring expertise to provide comprehensive, proven care management

Doctors
Pharmacists
Nurses
Social Workers

Dietitians
Data Engineers
Clinical Analysts
Data Scientists

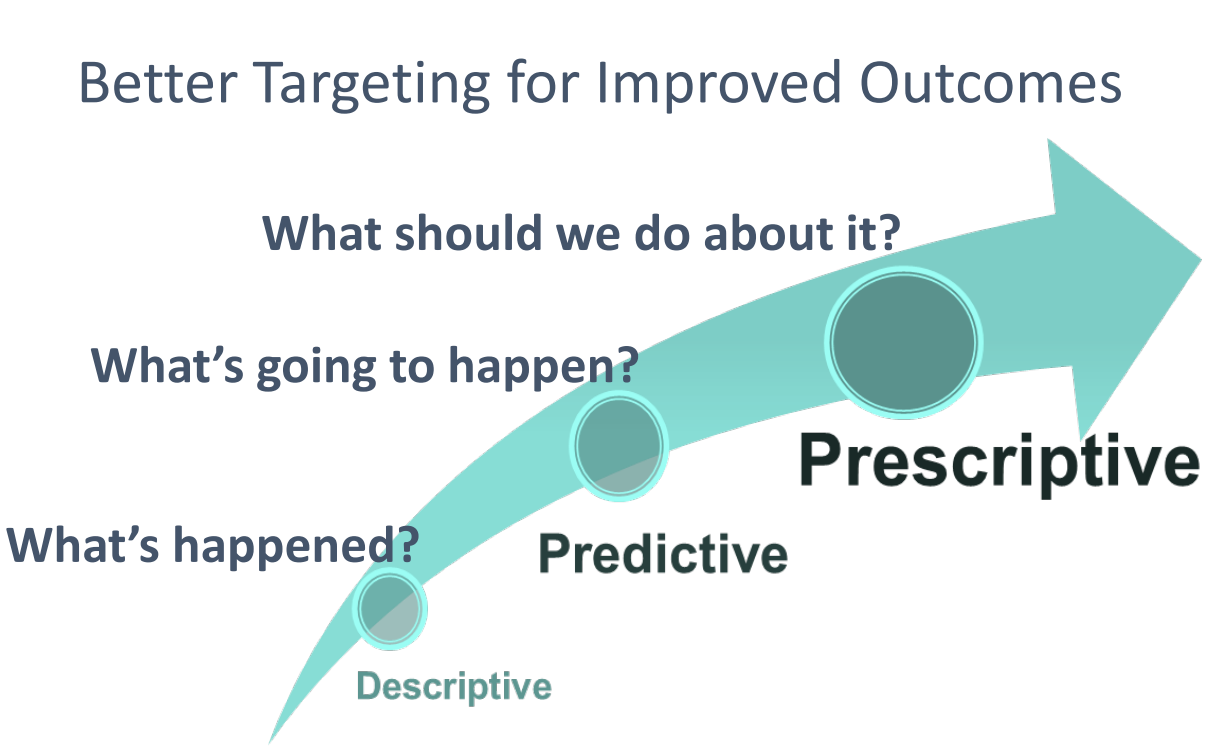
- HEALTH COACHING
- CASE & DISEASE MANAGEMENT
- CARE COORDINATION
- ADVANCED ANALYTICS

How do members enroll in Care Management?

Healthcare providers can call on behalf of a patient, patients can self-refer or they can refer an immediate family member. Our advanced analytics modeling also identifies likely candidates for efficient, proactive outreach.

Care Management Advanced Analytics

In-house advanced analytics allow for smarter, more proactive approach

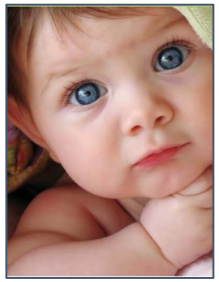


- Artificial intelligence is empowering our care teams
- Models focus resource intensity on members with whom we can make the most difference
- Prescriptive models, in particular, are delivering actionable solutions with more meaningful ROI

Goal of Advanced Analytics Models:
Predict who will potentially become high-cost members. Take appropriate action, at the right time, with personal intervention to improve their health outcomes.

About Case Management

- Support management for episodic care like major surgeries, transplants and maternity



Healthy Blue BEGINNINGS

text4baby℠
A free service of the National Healthy Mothers, Healthy Babies Coalition

- Work with members 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**
- Highly-skilled case managers look for and work with members to address gaps in care, wellness opportunities or transitions
- Strengthens the doctor-patient relationship

Disease Management Program Options

Chronic Conditions

Members are guided by our team of health coaches to improve self-management skills

For members with any of the following health conditions*:

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

Rare Conditions

Members are engaged in partnership with Accordant, an independent health management company, with health coaching, follow-up and education

For members with rare, chronic health conditions, including:

- ALS
- Crohn's Disease
- Hemophilia
- Multiple Sclerosis
- Parkinson's Disease
- Epilepsy
- And more…

Accordant®
My Health, My Way

**Blue Cross is constantly assessing the market and may add Disease Management programs for other conditions as appropriate.*

Care Management Member Experience

Member Outreach & Experience

Our members are **STRONGER THAN** any diagnosis or health condition, and our clinical team works to guide them to optimal health using proactive outreach

Care Management Outreach Goals

- Encourage Enrollment in Program
  - In-house Advanced Analytics models identify those who could benefit
  - Targeted Calls, Emails & Mailings
  - Website & Social Media
- Encourage Ongoing Participation

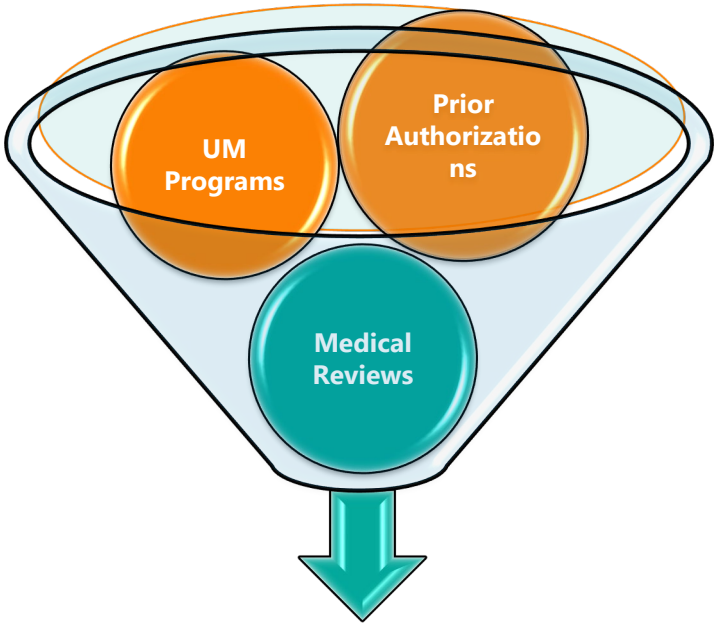
Continuous Care Management to Improve Health & Reduce Costs

- Ongoing patient engagement to manage members' illness or disease
- Education about Care Management resources and programs
- Health coaching to practice better self-care
- Encourage use of 24/7 BlueCare telehealth online doctor visits (more affordable than ER and ideal for follow-up doctor visits)

Utilization Management

Why is Utilization Management important?

Our set of effective Utilization Management (UM) techniques **manage healthcare costs and ensure the safety of members** based on medical necessity, evidence-based standards and clinical appropriateness of care



Utilization Management assists members in getting

the **right care**,

at the **right cost**,

with the **right provider**

UM is Guided by Medical Policy:

- Powered by national databases
- Uses nationally regarded experts to support our fine Louisiana providers
- Ensures provider activity fully complies with appropriate standards

Utilization Management Best Practices

Prior Authorizations

- Help control costs, as prior authorizations are typically required for services that are overused or have clinically appropriate, less-expensive alternatives

- Examples include MRI, certain spine and joint procedures and some specialty drugs

REDUCING COSTS

Retrospective Medical Reviews

- Post-service review protects our members' health and lowers costs by ensuring providers:
  - are not performing services that can be potentially harmful
  - are not performing services that are not medically necessary
  - are billing accurately and appropriately
- Helps determine new prior authorization policies to cut down on unnecessary overuse

Wellness & Health Promotion

Member-focused approach manages costs by keeping employees' well-being in check

Worksite Biometric Screenings
administered by approved participating worksite wellness providers with data integration and referrals to Blue Cross Population Health

Diabetes Prevention Program

Blue365 Wellness Discounts

Onsite Flu Clinic

Text4Baby
free prenatal and maternity management text program

Smoking Cessation Resources
QuitWithUsLA.org & SmokeFreeLA.org
(Smoking Cessation Trust)

Integrated Population Health Management
creates an environment for healthy behavior change and improved outcomes
*Non-chronic, chronic & rare diseases

Quality Blue

Exclusive Web Tools
Customized Wellness Portal with Personal Health Assessment

Care Management Summary

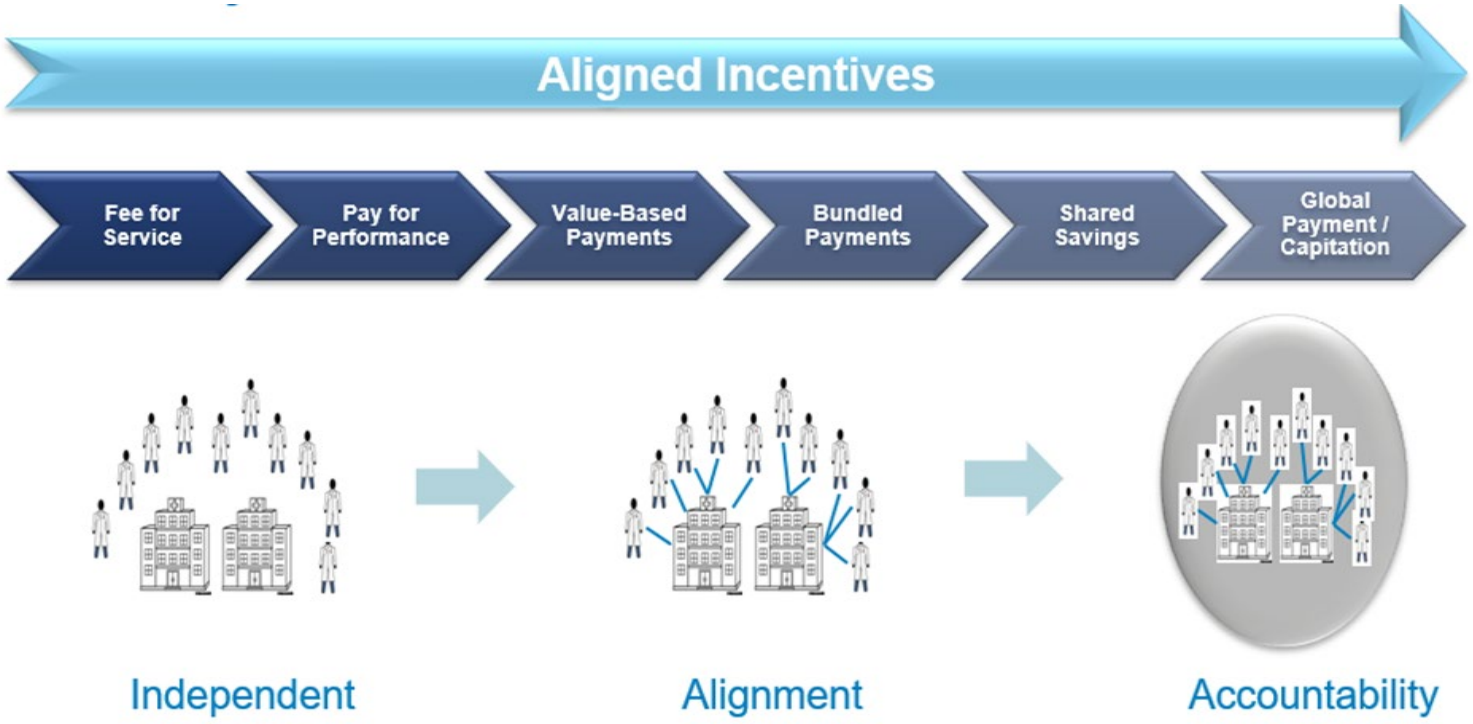
Piecing it all together

Our full suite of Care Management programs work together to improve health outcomes and reduce total cost of care (medical & pharmacy)

BCBSLA Improves Health and Lives

- Louisiana Obesity Prevention and Management Commission
  - Public effort to reduce the percent of the population with obesity
- Louisiana Perinatal Quality Coalition
  - Aim is to reduce the high rate of maternal mortality and infant complications across Louisiana
- Taking AIM at Cancer in Louisiana (TACL)
  - Statewide effort to improve cancer outcomes in Louisiana
- BCBSLA Opioid Reduction Program (2016 to 2018)
  - Reduction in the number of opioid prescriptions and the number of pills per prescription
  - Drug take back programs to reduce excess opioid pills in the public
- BCBSLA Colorectal Cancer Screening
  - Increase the percentage of our members with appropriate colorectal cancer screening
- BCBSLA Mental Health Initiative
  - Improve the rate of ambulatory follow up after hospital discharge for a mental health issue

BCBSLA – The Future



- Align incentives to promote evidence based medicine and provide resources and tools to improve quality and value
  - Expansion and integration of our three Quality Blue Programs
  - Increase our focus on quality, safety and cost measurement
  - Provide enhanced reports and feedback to our provider network
  - Optimize the use of telehealth and telemedicine interventions and tools
- Engage members as partners in their health

APPENDIX C:
QUALITY BLUE

Quality Blue

PRIMARY CARE

A **patient-focused**, population health and quality improvement program designed to transform our primary care provider network from an episode-driven, physician care delivery model to a **team-based care** delivery model

The Value of Quality Blue

Practice

- Support, tools and resources to do what you do best—treat your patients
- MDinsight 7.0 software to manage/coordinate care for **all** of your patients
- Care Management Fee – additional monthly payments for managing Blue Cross members with hypertension, diabetes, ischemic vascular disease or chronic kidney disease

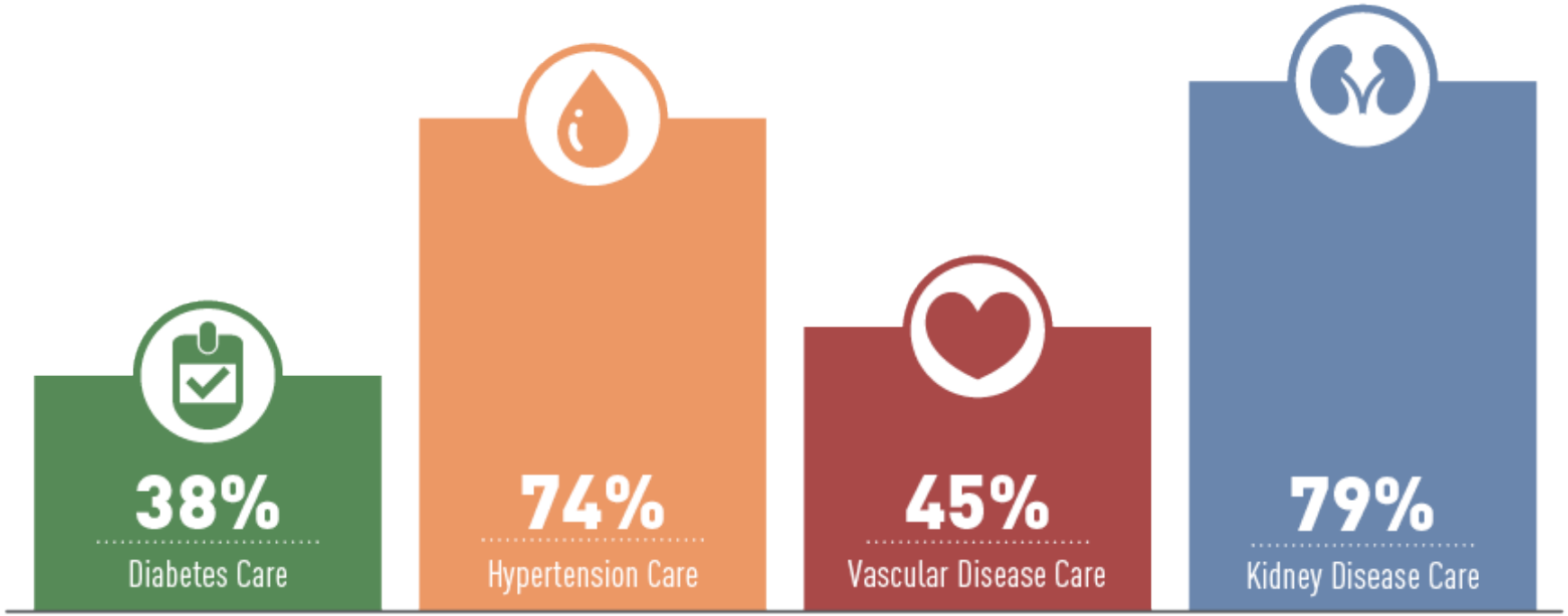
Patient

- Engages and empowers the patient; deepens patient/provider relationship
- Gets support and guidance from Blue Cross health coaches
- May have lower copayments for office visits (varies by plan type and benefits)

Healthcare

- Improved communication and quality of care delivered
- Improved patient experience
- Long-term cost of care lowered

QBPC Is Getting Better Health Results



SOURCE: QBPC Quality Measures data through September 2018.

Key Components

Population Management

- Providers given web-based tool that combines Blue Cross claims data with clinical data from practice's Electronic Medical Record (EMR)
- Care opportunities identified by chronic disease state

Team-based Care Supported by Blue Cross

- Care Management team provides care coordination for practice

Patient Engagement

- Coordinated, standardized care optimizes patient experience
- Integrates tools for health literacy, patient self-management and education

Continuous Quality Improvement and Provider Education

- Learning management system
- Test/learn/expand pilots
- Learning collaboratives
- Clinical initiatives based on industry best practices

Care Management Fee

- A Care Management Fee (CMF) is a performance-based payment paid to a contracted entity on top of existing fee-for-service payments for treating patients who have one of the four targeted chronic conditions and who have also had a face-to-face visit with the attributed PCP. The targeted conditions are: diabetes, hypertension, ischemic vascular disease and chronic kidney disease.

- The first year of the program, the CMF is a flat fee ($100 per member per year) for patients with at least one chronic condition
- Starting in year 2 of the program, CMF payments are adjusted according to the number of chronic conditions
- Also starting in year 2, performance thresholds are used to determine your tier (every 6 months), and your tier level determines the payment amount

Criteria for Participation – Provider

- Credentialed as PCP*
  - Family medicine, internal medicine, geriatrics and/or general medicine physician
  - Includes nurse practitioners credentialed as a PCP

- Minimum of 100 Blue Cross eligible patients

**Concierge providers excluded*

Criteria for Participation – Technology

- Have at least 6 months' experience actively using a currently installed Electronic Medical Record (EMR) system
- Install MDinsight at the practice site(s) in coordination with practice IT staff, including extraction of clinical data from practice EMR, lab, registry or other systems for submission to SPH Analytics
- EMR systems must have current Health IT certification from the Office of the National Coordinator for Health Information Technology to qualify for the program. A list of certified systems is available at **https://chpl.healthit.gov/#/search**.

Complete a Practice Readiness Assessment (PRA) – **www.BCBSLA.com/QBPC**

Criteria for Participation – Operations

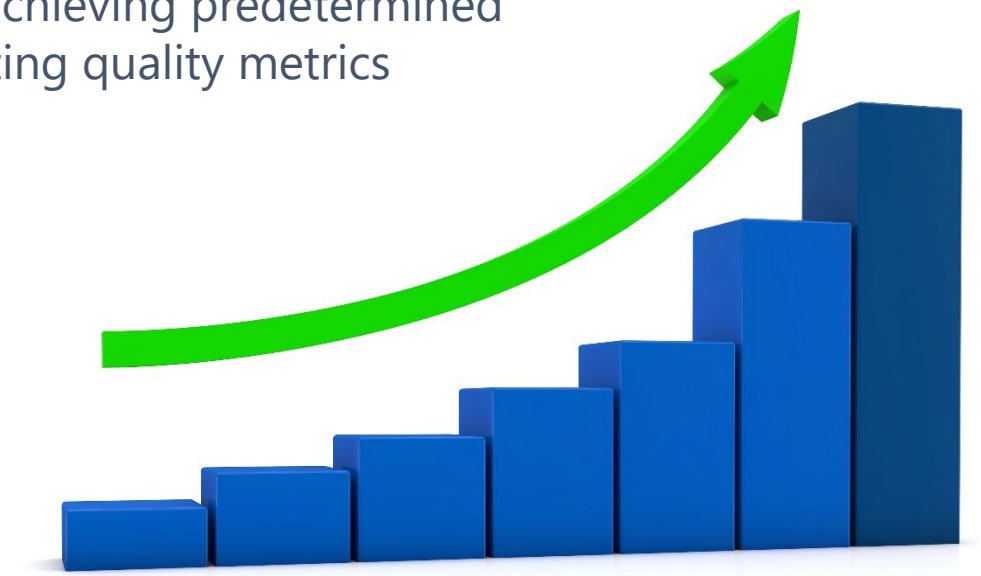
- Designation, onboarding and training of a practice coordinator (someone employed by the practice—likely an NP, RN, LPN or MA)
- Onboarding and training of practice physicians and key clinic staff
- Active engagement in the population management process, including patient attribution (the identification and assignment of a patient to a physician practice panel)

Criteria for Participation – Patients

- Patient has primary healthcare coverage through a Blue Cross plan that is not excluded from QBPC
- Patient is attributed to a primary care physician at the enrolled practice
- Patient is diagnosed with at least one targeted chronic condition and participating in a clinical suite via MDinsight:
  - Hypertension
  - Diabetes
  - Ischemic Vascular Disease
  - Chronic Kidney Disease
- Physician has billed an evaluation & management (E&M)code for a face-to-face visit with the patient for a service related to the targeted chronic condition or a preventive service within the required 12-month period

Quality Blue Value Partnerships Program Overview

- Value-based provider reimbursement program that encourages and supports engaged Quality Blue Primary Care (QBPC) providers with technology and analytics to improve quality and reduce the total cost of healthcare
- Driven by primary care population management
  - Eligible providers include family practitioners, general practitioners, internal medicine physicians, pediatricians, geriatricians, nurse practitioners* and physician assistants*
- Success measured by achieving predetermined trend targets and meeting quality metrics



**Operating in a primary care setting*

Quality Blue Value Partnerships (QBVP) Participation Guidelines

- Provider Participation Requirements
  - Meet the Blue Cross specifications of a Clinically Integrated Network (CIN)
  - PCPs contracted in the Quality Blue Primary Care Program
  - Total attribution greater than 3,000 members

- Performance evaluation
  - Assessment of actual performance on persistent attributed members in comparison to a budget target
  - If actual performance beats the budget target, the provider is eligible for a specified percentage of achieved savings
  - The provider's specified percentage is dependent upon the final quality score in QBPC and risk adjusted total cost of care