Spring 2019 Professional 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

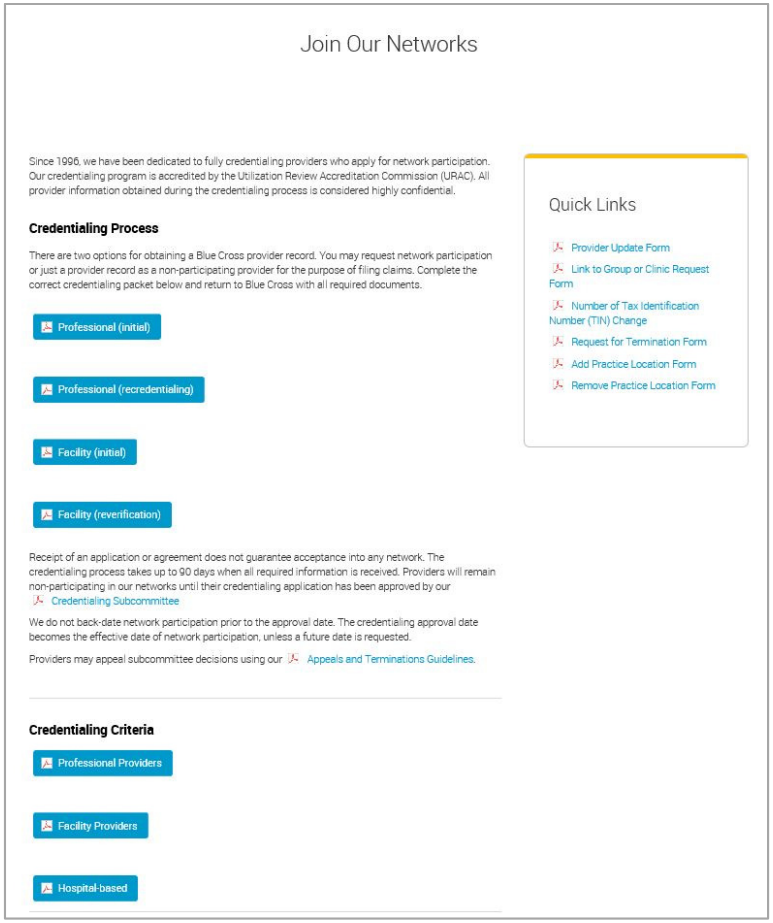
Your Blue Cross and Blue Shield of Louisiana Provider Relations Team

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 once Blue Cross receives all required information
- After 90 days you may inquire about your credentialing status by contacting our Provider Credentialing & Data Management department at 1-800-716-2299, option 2
- Required credentialing application packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks
- Blue Cross credentials professional, facility and ancillary providers
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross and Blue Shield Association
- Providers will remain non-participating in our networks until their application has been approved by the credentialing subcommittee. The credentialing subcommittee approves credentialing monthly.
- Network providers are recredentialed every three years from their last credentialing acceptance date

Provider Credentialing & Data Management Policy

Below is Blue Cross' policy for credentialing and provider data maintenance requests, which helps ensure requests are processed timely:

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

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

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

Incomplete 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 Criteria for Professional Providers

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

- Applied Behavioral Analyst (ABA)
- Audiologist
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Doctor of Chiropractic (DC)
- Doctor of Osteopathic (DO)
- Doctor of Medicine (MD)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Dental Surgery (DDS)
- Doctor of Medicine in Dentistry (DMD)
- Hearing Aid Dealer
- Louisiana Addictive Counselor (LAC)
- Licensed Clinical Social Worker (LCSW)
- Nurse Practitioner (NP)
- Occupational Therapist (OT)
- Optometrist (OD)
- Physician Assistant (PA)
- Psychologist (Ph.D.)
- Physical Therapist (PT)
- Registered Dietician & Nutritionist (RD)
- Speech-Language Pathologist & Audiologist (SLP)

View the *Credentialing Criteria* for these professional provider types at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

NEW

Reimbursement During Credentialing

Louisiana has amended its law allowing additional healthcare provider types to request that Blue Cross reimburse their claims as if they are a network provider during the credentialing process. Claims for network providers are paid directly to the provider.

To be eligible, the following criteria must be met:

- You must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Cross. This provision does not apply for solo practitioners;

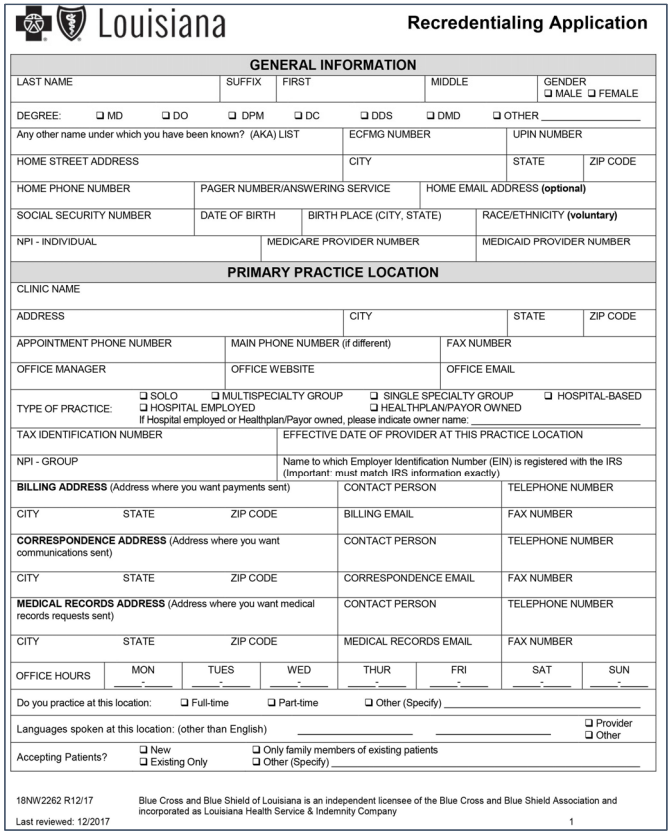
AND

- You must have admitting privileges to a network hospital. PCPs can have an arrangement with a hospitalist group to admit their patients.

- Your initial credentialing application for network participation must include a written letter of request asking Blue Cross to reimburse you at the group contract rate and an agreement to hold our members harmless for payments above the allowable amount

The Reimbursement During Credentialing Instruction Sheet is available online at **www.BCBSLA.com/providers** >Resources >Forms

Required Recredentialing Documents



Louisiana

Recredentialing Application

GENERAL INFORMATION

LAST NAME	SUFFIX	FIRST	MIDDLE	GENDER ❑ MALE ❑ FEMALE
DEGREE: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ OTHER _____				
Any other name under which you have been known? (AKA) LIST		ECFMG NUMBER		UPIN NUMBER
HOME STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE NUMBER	PAGER NUMBER/ANSWERING SERVICE		HOME EMAIL ADDRESS **(optional)**	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH PLACE (CITY, STATE)	RACE/ETHNICITY **(voluntary)**	
NPI - INDIVIDUAL	MEDICARE PROVIDER NUMBER		MEDICAID PROVIDER NUMBER	

PRIMARY PRACTICE LOCATION

CLINIC NAME			
ADDRESS	CITY	STATE	ZIP CODE
APPOINTMENT PHONE NUMBER	MAIN PHONE NUMBER (if different)	FAX NUMBER	
OFFICE MANAGER	OFFICE WEBSITE	OFFICE EMAIL	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED ❑ HOSPITAL EMPLOYED ❑ HEALTHPLAN/PAYOR OWNED
If Hospital employed or Healthplan/Payor owned, please indicate owner name: _____

TAX IDENTIFICATION NUMBER	EFFECTIVE DATE OF PROVIDER AT THIS PRACTICE LOCATION
NPI - GROUP	Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address where you want payments sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE ZIP CODE	BILLING EMAIL	FAX NUMBER
CORRESPONDENCE ADDRESS (Address where you want communications sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE ZIP CODE	CORRESPONDENCE EMAIL	FAX NUMBER
MEDICAL RECORDS ADDRESS (Address where you want medical records requests sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE ZIP CODE	MEDICAL RECORDS EMAIL	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	___-___	___-___	___-___	___-___	___-___	___-___	___-___

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

18NW2262 R12/17
Last reviewed: 12/2017

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

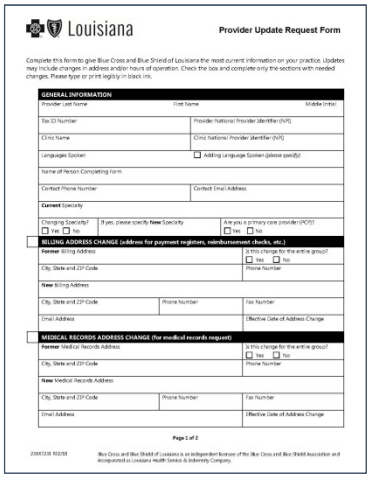
- Network providers who are due for recredentialing will receive a notification letter eight months in advance of their due date
- Current providers seeking recredentialing should use our **Recredentialing Application Form**
- This application is part of the **Professional (Recredentialing)** packet
- Find our recredentialing packets *(including a checklist of all required documents)* online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks
- Submit completed recredentialing packet to **recredentialing.application@bcbsla.com**

Please ensure you complete all forms in the packet

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

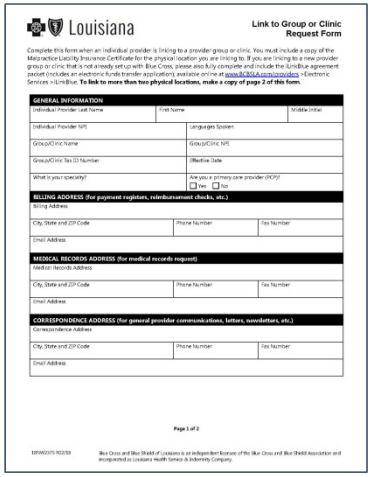
City, State and ZIP Code | Phone Number | Fax Number

Email Address | Effective Date of Address Change

Page 1 of 2

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.

Use our **Provider Update 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 ILink®Blue agreement packet (includes an electronic funds transfer application), available online at www.BCBSLA.com/providers >Electronic Services >ILink®Blue. **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

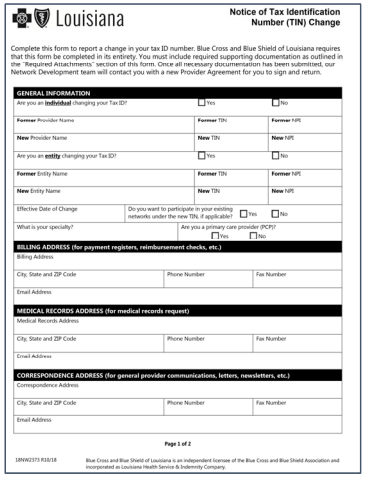
City, State and ZIP Code | Phone Number | Fax Number

Email Address

Page 1 of 2

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.

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

18NW2373 R10/18

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.

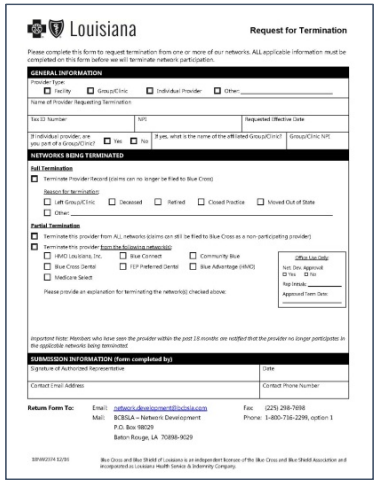
Use our **Notice of Tax Identification Number (TIN) Change Form** to report a change in your tax ID number

www.BCBSLA.com/providers >Resources >Forms

How to Update Your Information

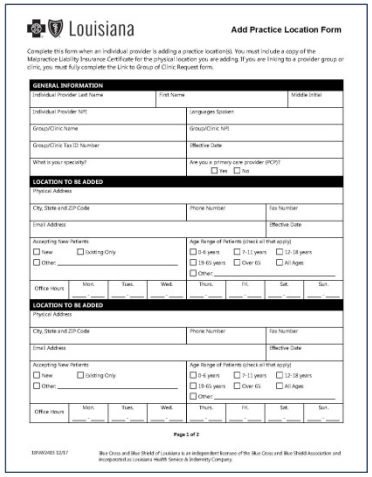
It is important we always have your most current information in our files. The Provider Credentialing & Data Management team manages demographic changes to your provider record.

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


Louisiana

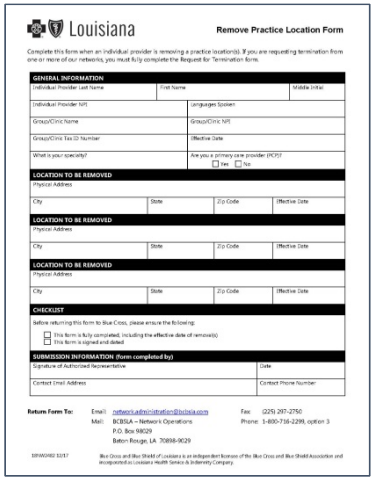
Request for Termination

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


Louisiana

Add Practice Location Form

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


Louisiana

Remove Practice Location Form

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

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 if they were mailed.

OUR NETWORKS

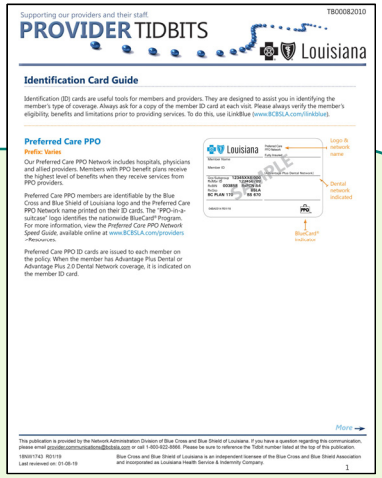
Our Provider Networks

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/ilinkblue).

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

SAMPLE

Logo & network name

Dental network indicated

PPOL

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 1-800-822-8660. Please be sure to reference the TIDbit number listed at the top of this publication.

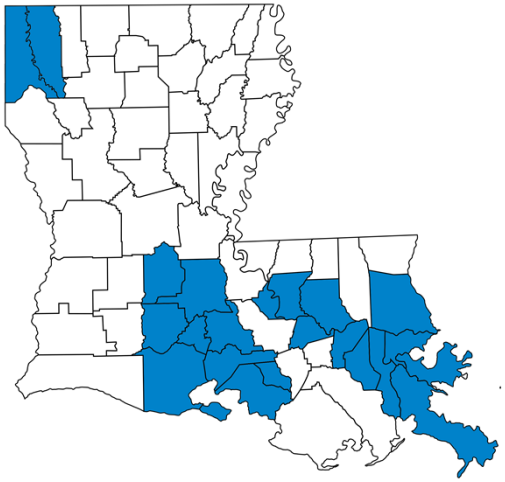
18NW1743 R01/19

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

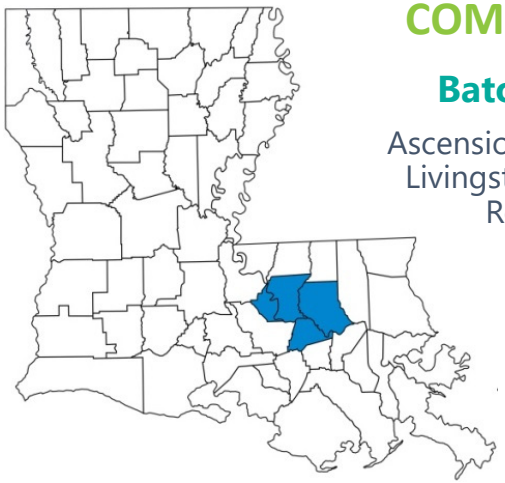
Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

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

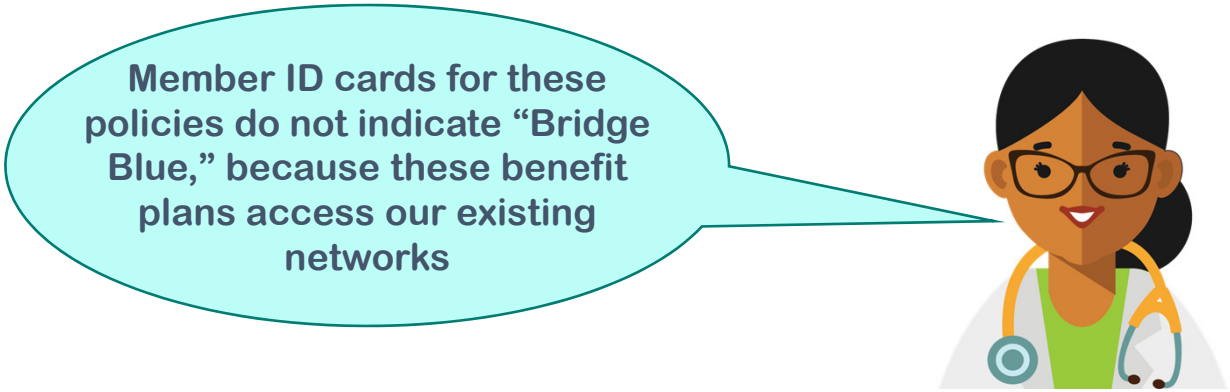
NEW

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

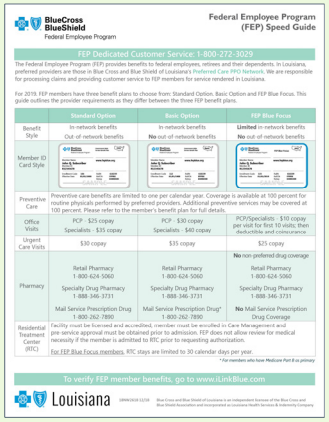
- ✓ In-network
- ✓ Out-of-network

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.iLinkBlue.com

Louisiana

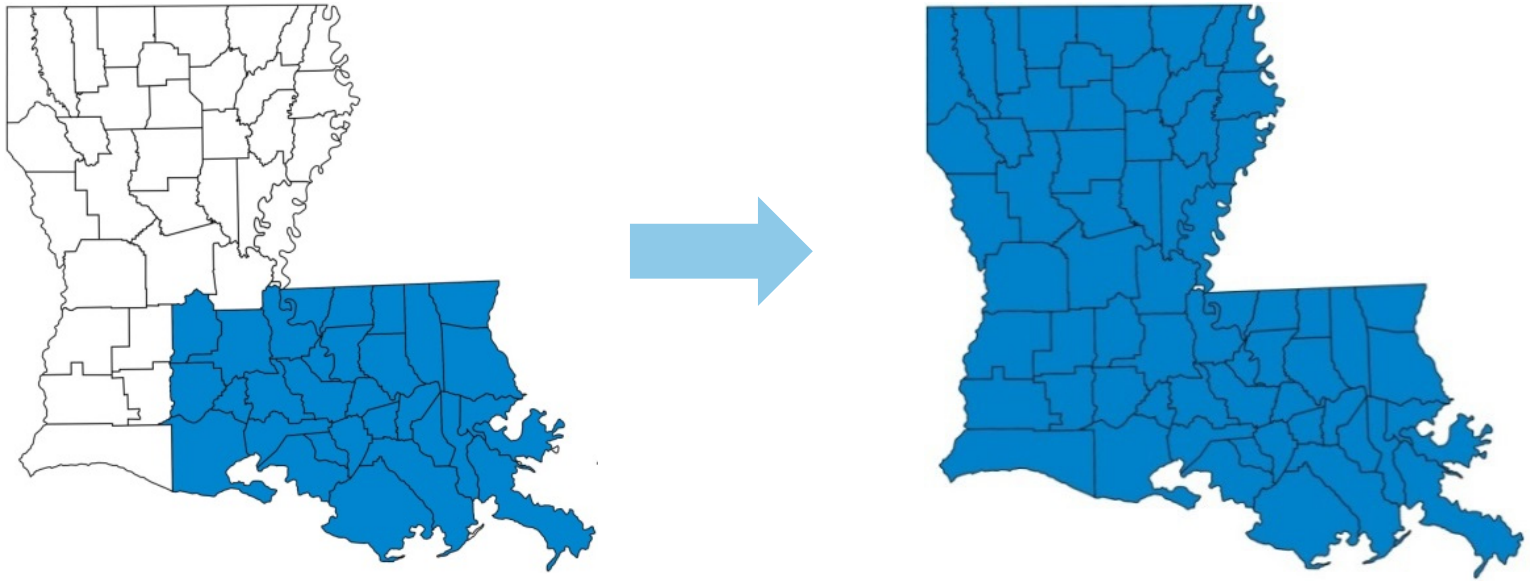
New FEP Speed Guide available! Visit **www.BCBSLA.com/providers** >Resources >Speed Guides

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 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

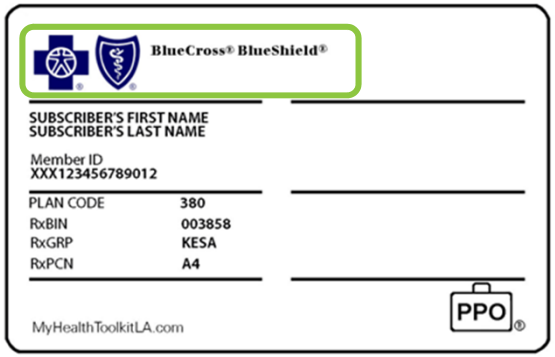
- The main identifiers for BlueCard members are the prefix and the “suitcase” logo on the member ID card. The suitcase logo provides the following information about the member:

  - 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



Included in your folder is a list of member prefixes for our policies that are handled directly through the National Alliance program. This list of prefixes is also available on iLinkBlue under the "Resources" section.

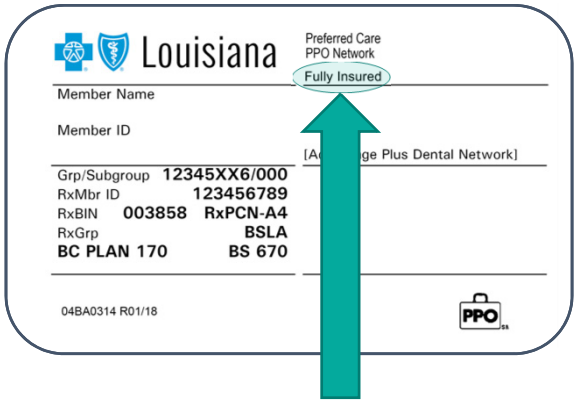
NEW

Fully Insured vs. Self-funded

Member ID Card Differences

FULLY INSURED

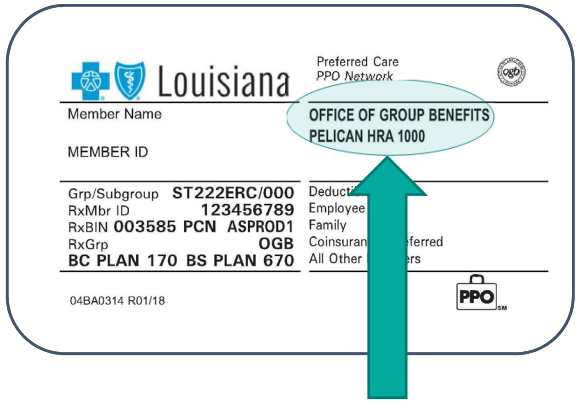
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA



"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**).

BILLING & CLAIMS

Member Benefit Terms

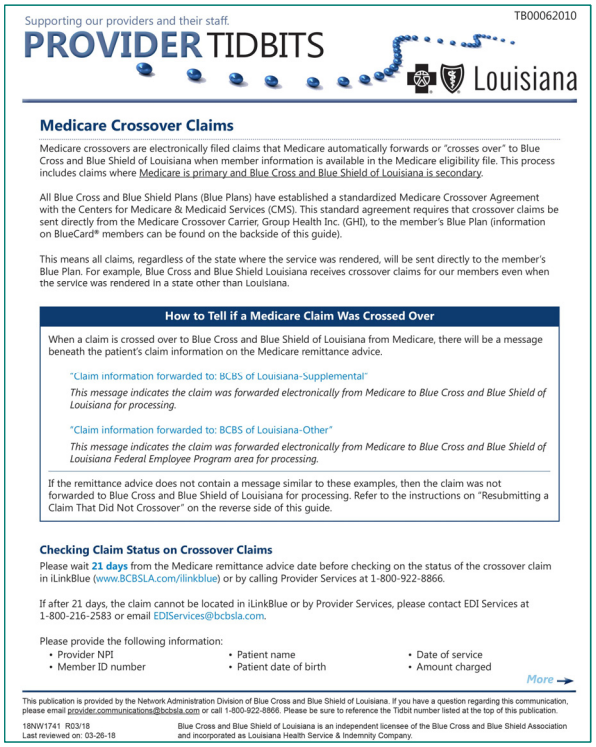
Term	Definition
Grandfathered	Grandfathered policies were in place before March 23, 2010, when the Affordable Care Act was signed into law. A grandfathered status policy might not include certain benefits or consumer protections that non-grandfathered plans are required to include.
Non-grandfathered	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

Medicare Crossover Claims

Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crossover" to us when member information is available in the Medicare eligibility file. This process includes claims where **Medicare is primary and Blue Cross and Blue Shield of Louisiana is secondary**

Reasons a Medicare Claim May Not Cross Over

- The Blue Plan does not have the patient's Medicare Health Insurance Claim (HIC) number or Medicare Beneficiary Identifier (MBI) in its files
- The HIC number or MBI on file with the Blue Plan is incorrect



Supporting our providers and their staff. TB00062010

PROVIDER TIDBITS Louisiana

Medicare Crossover Claims

Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crosses over" to Blue Cross and Blue Shield of Louisiana when member information is available in the Medicare eligibility file. This process includes claims where Medicare is primary and Blue Cross and Blue Shield of Louisiana is secondary.

All Blue Cross and Blue Shield Plans (Blue Plans) have established a standardized Medicare Crossover Agreement with the Centers for Medicare & Medicaid Services (CMS). This standard agreement requires that crossover claims be sent directly from the Medicare Crossover Carrier, Group Health Inc. (GHI), to the member's Blue Plan (information on BlueCard® members can be found on the backside of this guide).

This means all claims, regardless of the state where the service was rendered, will be sent directly to the member's Blue Plan. For example, Blue Cross and Blue Shield Louisiana receives crossover claims for our members even when the service was rendered in a state other than Louisiana.

How to Tell if a Medicare Claim Was Crossed Over

When a claim is crossed over to Blue Cross and Blue Shield of Louisiana from Medicare, there will be a message beneath the patient's claim information on the Medicare remittance advice.

"Claim information forwarded to: BCBS of Louisiana-Supplemental"

This message indicates the claim was forwarded electronically from Medicare to Blue Cross and Blue Shield of Louisiana for processing.

"Claim information forwarded to: BCBS of Louisiana-Other"

This message indicates the claim was forwarded electronically from Medicare to Blue Cross and Blue Shield of Louisiana Federal Employee Program area for processing.

If the remittance advice does not contain a message similar to these examples, then the claim was not forwarded to Blue Cross and Blue Shield of Louisiana for processing. Refer to the instructions on "Resubmitting a Claim That Did Not Crossover" on the reverse side of this guide.

Checking Claim Status on Crossover Claims

Please wait **21 days** from the Medicare remittance advice date before checking on the status of the crossover claim in iLinkBlue (www.BCBSLA.com/ilinkblue) or by calling Provider Services at 1-800-922-8866.

If after 21 days, the claim cannot be located in iLinkBlue or by Provider Services, please contact EDI Services at 1-800-216-2583 or email EDIServices@bcbsla.com.

Please provide the following information:

- Provider NPI
- Member ID number
- Patient name
- Patient date of birth
- Date of service
- Amount charged

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.

18NW1741 R03/18
Last reviewed on: 03-26-18

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.

For more information, refer to the Medicare Crossover Claims Tidbit (**www.BCBSLA.com/providers** >Resources >Tidbits)

NEW

2019 Enhancements

The following product enhancements were effective as of January 1, 2019 (and as policies renew):

- Diabetes Prevention Program (expanded to include fully-insured groups)
- Screening for Cervical Cancer (age limit changed)
- Screening for Osteoporosis (wellness benefit expanded)
- Screening for Diabetes Mellitus after Pregnancy (added to current wellness benefits for diabetes testing)
- Screening for Urinary Incontinence in Women (added to current wellness benefits for women)
- Flat Foot Surgery (select surgeries will be covered)
- Individual Short-term Medical Policies (covered on Bridge Blue slide)

Included in your folder is our ***2019 Product Enhancements Guide*** that outlines these and other enhancements for 2019

NEW

Incident-to Billing Policy Change

Blue Cross is updating our "Incident-to" reimbursement rules for provider types that are offered network participation

Effective June 1, 2019, if Blue Cross offers network participation for a provider type, then that provider is required to file claims under their own provider number for services rendered

Such provider types include:

- Nurse Practitioner
- Physician Assistant
- Dietitian
- Audiologist
- Certified Nurse Anesthetist
- Behavior Analyst

Please Note: If you are one of these providers who currently participate in our networks, there are no additional credentialing or provider data requirements. You should bill your services directly to Blue Cross.

Only provider types that are not offered network participation will be allowed to bill and be reimbursed under the supervising provider's Blue Cross contract number

CPT Category II

- Blue Cross encourages the use of CPT Category II codes; we do not reimburse separately for these codes or most HCPCS Documentation, Measurement and Demonstration codes
- These codes should not be used as a substitute for any services, unless otherwise instructed by Blue Cross
- Use of these codes may reduce the need for medical record requests

Subrogation

Subrogation is a contract provision that allows health insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. As a participating provider, you agree to submit claims for all covered services received by Blue members.

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

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

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 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 your provider manual

For more information about our telemedicine requirements, billing and coding guidelines, see our *Professional Provider Office Manual* at **www.BCBSLA.com/providers** >Resources >Manuals

NEW

New Telemedicine Codes

Effective January 1, 2019, Blue Cross has added the following CPT® codes to the billing guidelines for telemedicine found in the Professional Provider Office Manual:

Evaluation & Management Codes:

New:	99203	99204	99205
Established:	99213	99214	99215

Behavioral Health

90785	90791	90792	90836
90837	90838	90839	90840
90845	90846	90847	96150
96151	96152	96153	96154
96160	96161		

Modifier 95 has also been added to indicate telemedicine delivered in real time. Modifier **GT or 95, whichever is appropriate,** must be used to indicate delivery of telemedicine services in real time.

BlueCare Telehealth Services

- BlueCare is our first direct-to-consumer telemedicine platform designed to let members have online doctor visits using a computer, laptop, tablet, smartphone or other internet-accessible device

- Telehealth services through BlueCare or BCBSLA network providers are a benefit for all fully-insured group and individual members. Self-funded plans can choose to offer telehealth benefits to their covered members.

- BlueCare offers patients and providers a wraparound service to supplement the care delivered in your office. Our common goal is to avoid unnecessary after-hours care in an emergency room or urgent care.

- To ensure better care continuity, encounters on BlueCare can be shared with the provider via secure messaging through the patient's BlueCare account and/or app at any time

BlueCare Telehealth Services

How do my patients use BlueCare?

- BlueCare is available through the computer online at **www.BlueCareLA.com**. Patients will need a computer with audiovisual capability (mic and cam)
- The BlueCare app is available for mobile devices (smartphone, tablet, etc.) by searching "BlueCare" (one word) in the Apple App Store or on Google Play
- >60% of users access via the app and mobile device

What kind of visits will my patients have with doctors on BlueCare?

- For minor illnesses: URI, allergies, rash, conjunctivitis, UTI, etc. to avoid after hours Emergency Department use
- The patient and doctor will have an audiovisual "virtual" office visit
- Treatment and/or medicine may be prescribed if appropriate
- The BlueCare doctor may recommend follow-up care with the PCP
- The patient can access and share records of each encounter with the patient's primary care provider

BlueCare App Icon

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

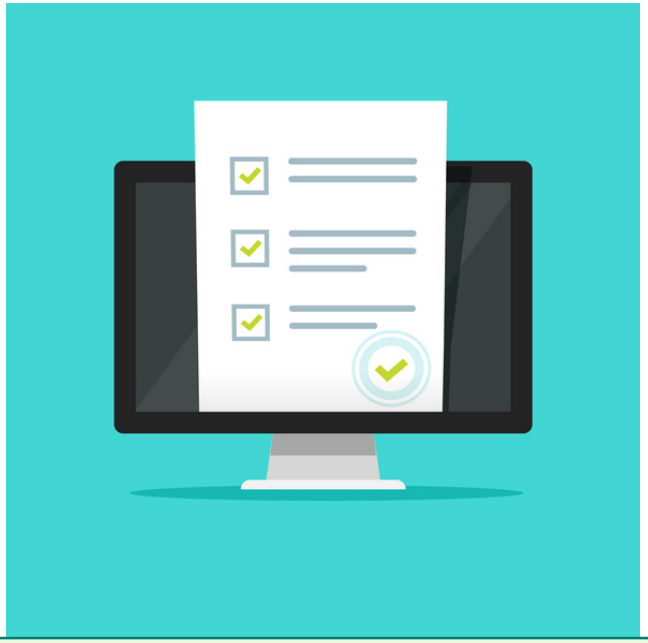
Self-funded & BlueCard®:

- 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

Evaluation & Management (E&M) Coding

- When billing E&M CPT® codes 99201-99215, your medical record documentation must support medical necessity of a service in addition to meeting the required components of the code
- It is not appropriate to bill a higher level E&M service when a lower level is warranted
- The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the number of problems and the extent that the problems are addressed and documented in the record.
- The amount of documentation should not be the primary factor for what level of service is billed. Medical decision-making should be the key component used to select the level of E&M code.
- Proper coding prevents inappropriate payments that eventually result in recoupment



These guidelines are available online at **www.cms.gov**

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 is it?

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 ID 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.

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

Of all the Action Requests received in 2018, more than 85% were successfully resolved without need for further disputes or appeals. All Action Requests are answered within specific Service Level Agreement timeframes.

Submitting Action Requests

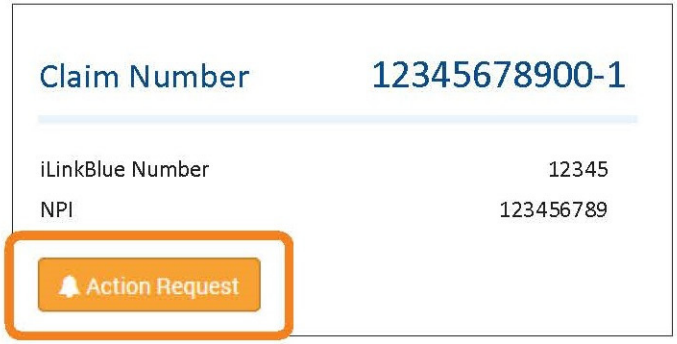
Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim

Common reasons to submit an Action Request

- 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

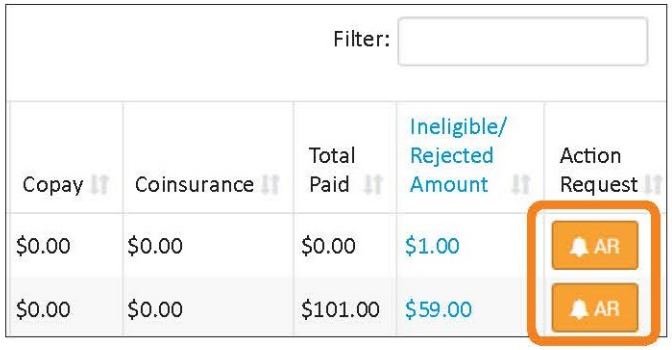


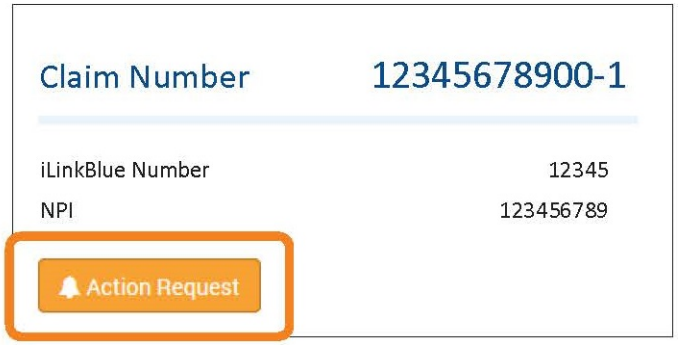
Submit an Action Request through iLinkBlue (**www.BCBSLA.com/ilinkblue**)

- On each claim, providers have the option to submit an Action Request review for correct processing
- Click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim
- Please include your contact information
- NOTE: You only have to do one AR per claim; not one AR per line item of the claim

As an alternative to filing an Action Request, you may also contact the **Customer Care Center at 1-800-922-8866**

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) 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

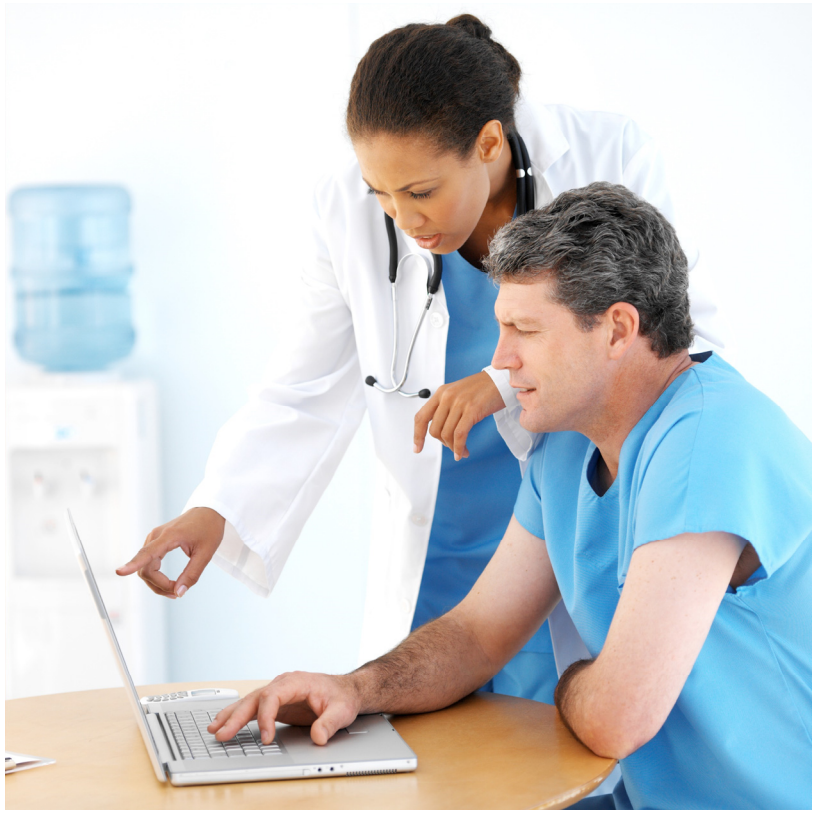
ADMINISTRATIVE APPEALS & GRIEVANCES

- 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. 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

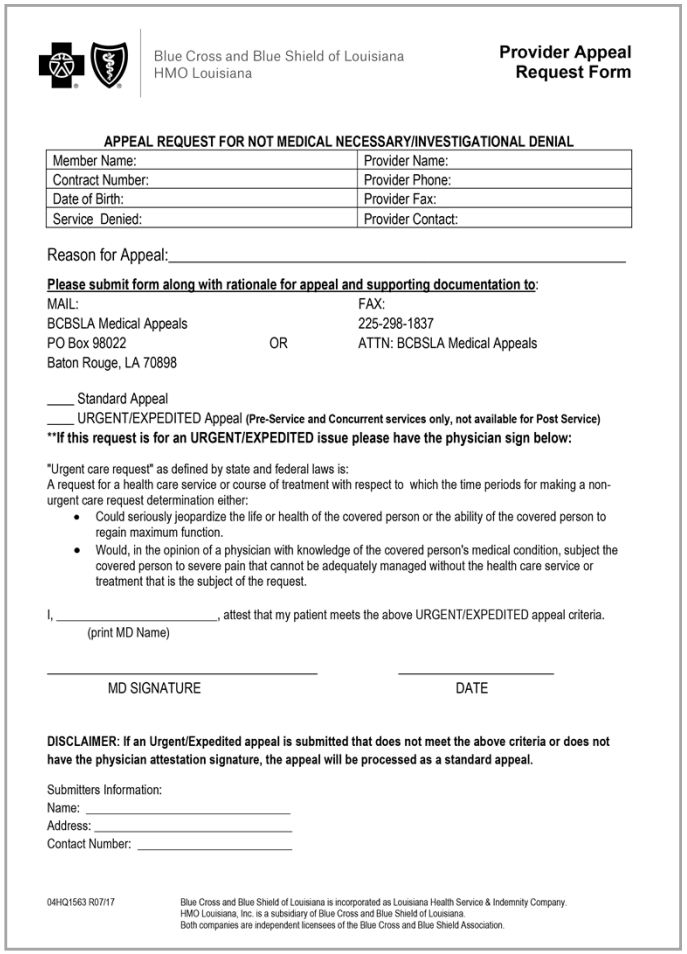
- Could seriously jeopardize the life or health of your patient or their ability to regain maximum function, **OR**
- Would, in the opinion of the treating physician with the knowledge of the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the 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.

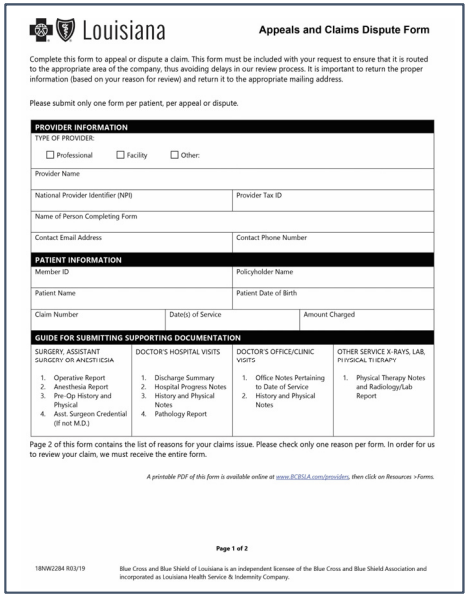
Administrative Appeals & Grievances

- 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
   - Co-insurance
   - 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

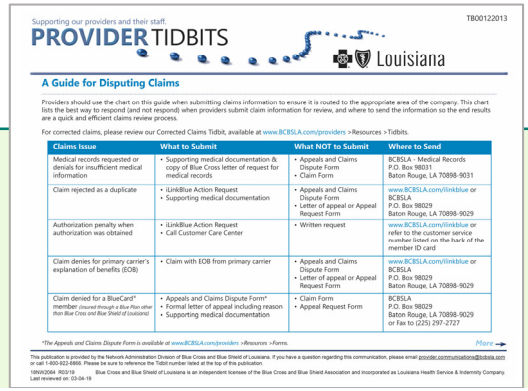
18NW2284 R03/19

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
  - Claim denied for bundling
  - Claim denied for medical records
  - Claim denied as investigational or not medically necessary
  - Claim payment/denial affects the provider's reimbursement
  - Claim payment affects the member's cost share
  - Claim denied for a BlueCard® member

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.

PROVIDER TIDBITS

Louisiana

TB00122013

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 provider.communications@bcbsla.com or call 1-800-922-8886. Please be sure to reference the Tidbit number listed at the top of this publication.

18NW6284 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.

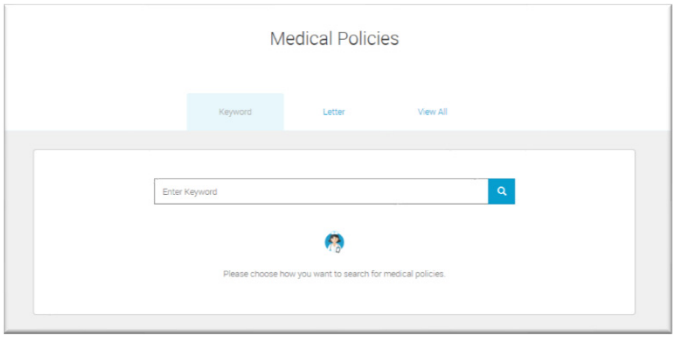
Last reviewed on: 03-04-19

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 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.

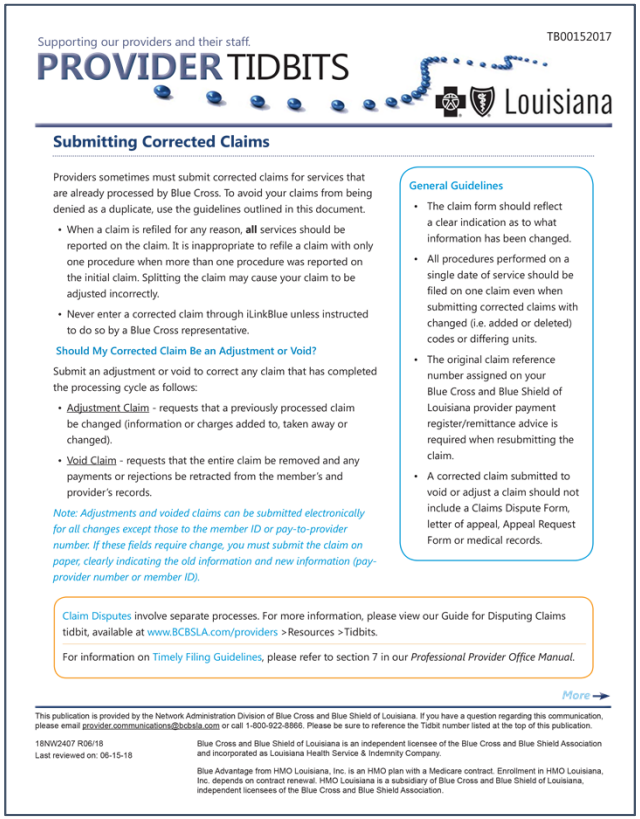
Our medical policies include: coverage eligibility, background information related to technology, devices and treatments, technology assessments, literature sources and the rationale for coverage determinations

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)



Supporting our providers and their staff.

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

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.

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

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

Refund Checks

- When sending claim refund checks for Louisiana policies, there should be no more than 100 claims per check. Limiting the volume will allow our system to manage the checks.

- Include Blue Cross member IDs on all correspondence and spreadsheets, as it is our identifier to process the claim refund

- All checks with correspondence should be mailed to:

  Blue Cross Blue Shield of Louisiana

  Attn: Accounts Receivable

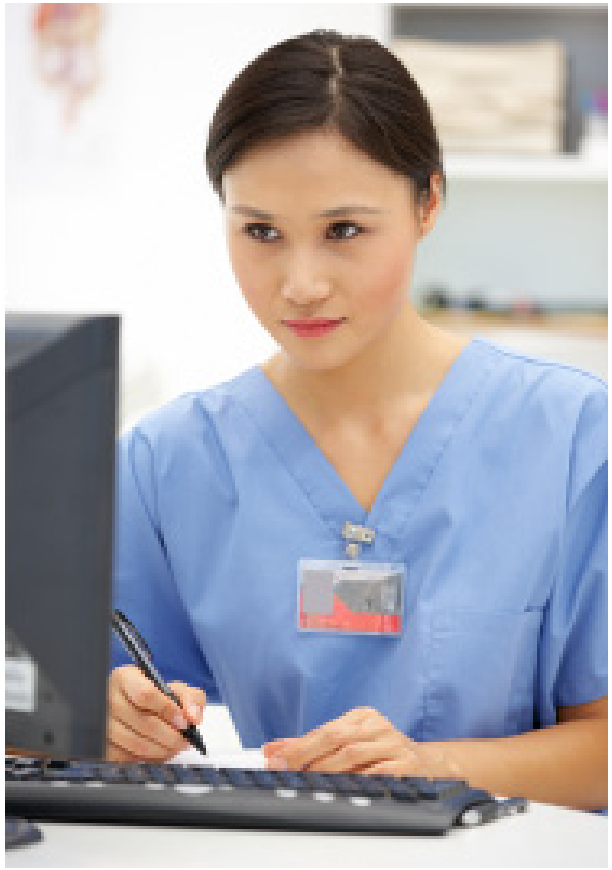
  P.O. Box 98029

  Baton Rouge, LA 70898-9029

PROPER CLINICAL DOCUMENTATION

Benefits of Proper Clinical 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 name
  - ✓ Date of birth or other unique identifier
  - ✓ Date of service including the year
- Provider signature (must be legible and include credentials)
- Report ALL applicable diagnoses on claims and report at the highest level of specificity (CMS-1500 claim forms can accommodate up to 12 diagnosis codes)
- Include all related diagnoses, including chronic conditions you are treating
- Medical records **must support ALL** diagnosis codes on claims
- Blue Cross offers free continued medical education courses for our primary care providers

Coding to the Highest Level of Specificity

- Include chronic conditions in documentation
- Code to the highest specificity
- Monitored, Evaluated, Assessed or Treated should be noted
- Clarify whether a condition is chronic or acute
- Clarify whether a condition as controlled or uncontrolled
- Clarify the type of diabetes

Example: Notes may say "Diabetes Type II and CKD Stage III," but if stated as "CKD III Due to Diabetes," it would result in a different ICD-10 Code

NOTE: Improper documentation could result in audits and/or the request of medical records

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

Some of the vendors Blue Cross is currently partnered with to assist us in conducting medical record reviews

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

Commercial Diagnostic Accuracy and Completion (DAC)

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 Health Data Vision, Inc. (HDVI) for in-state and Inovalon for out-of-state to conduct 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 60 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 Dx
  - –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 will begin in June

HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

Blue Cross has partnered with Health Data Vision, Inc. (HDVI) and Inovalon to conduct medical record reviews in 2019-2020

Healthcare Effectiveness Data and Information Set (HEDIS®)

- Adhere to the proper documentation practices outlined on slide 60 of this presentation
- Provide medical records upon request during the HEDIS process to help us validate the quality of care provided to our members
- 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

- Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed
- HEDIS data is generally collected and reviewed from January to May (excluding off season reviews)
- 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 promptly (ideally in 5 to 7 business days) from request

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.

For questions related to HEDIS, please contact the Health and Quality Department:
QualityBlue@bcbsla.com

2019 HEDIS® Measurements

Controlling High Blood Pressure (CBP)

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the measurement year based on the following criteria:

Members 18–85 years of age whose blood pressure was <140/90 mm Hg

Plan All-cause Readmission (PCR)

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

2019 HEDIS® Measurements

Use of Imaging Studies for Low Back Pain (LBP)

The percentage of members ages 18-50 with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Adult Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit:

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year

Controlling High Blood Pressure (CBP)

Challenge/Risk:

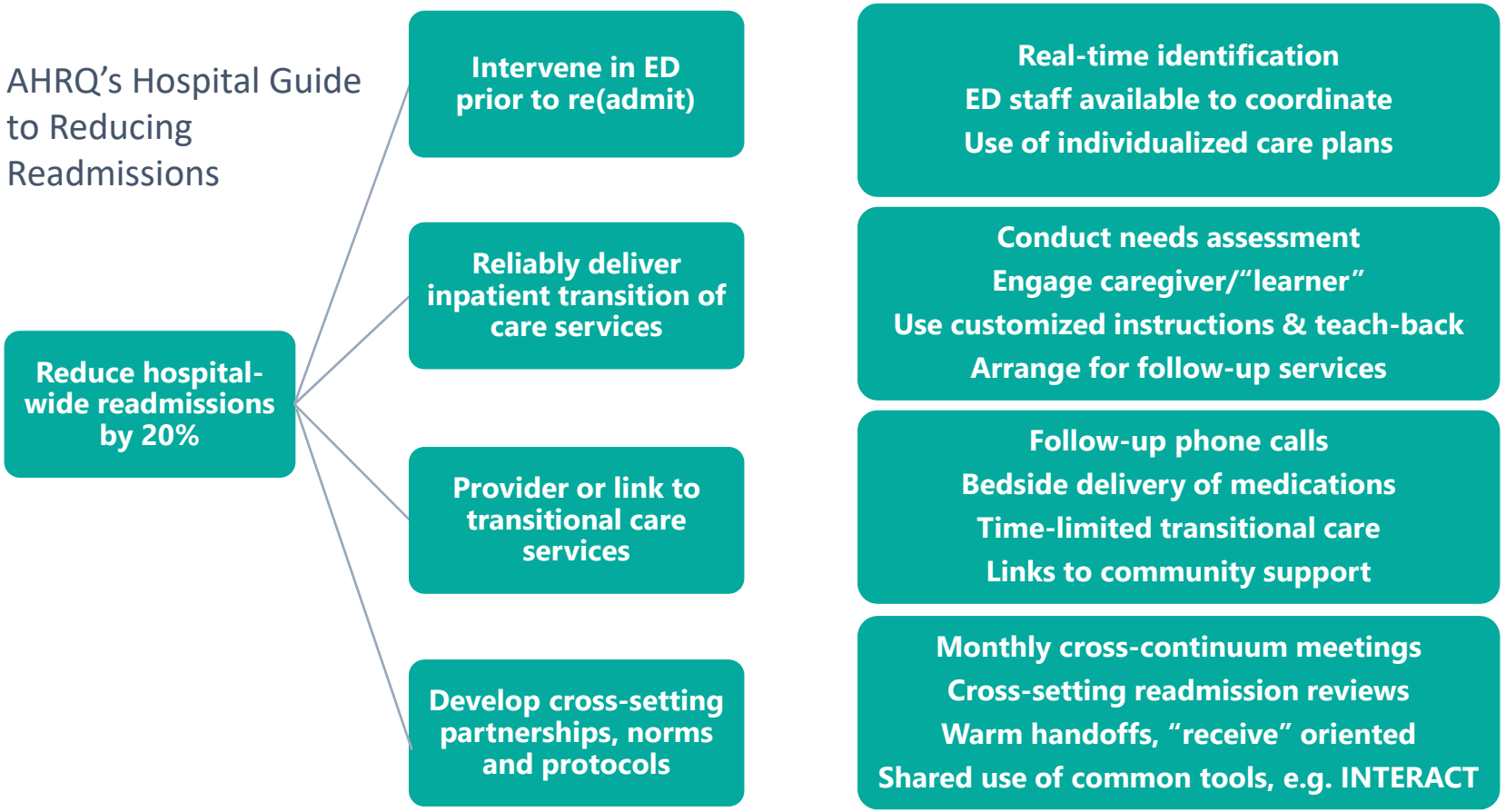
Uncontrolled blood pressure increases the risk of heart attacks, heart failure, stroke and kidney disease. The Centers for Disease Control and Prevention (CDC) reports heart disease as the leading cause of death in the United States.

Tips/Best Practices for Providers:

- Positioning: have the patient sit quietly with feet on the floor, back supported and arm at heart level. Utilize the most appropriate cuff size.
- Take two BP readings during the visit, one at the start of the visit and one at the end of the visit when systolic BP is greater than 140 and when diastolic BP is greater than 90 (HEDIS® allows use of the lowest systolic and lowest diastolic reading taken on the same day as a representative BP)
- Remind patients with hypertension about the importance of taking prescribed medication
- Encourage and educate patients with hypertension on low-sodium diets
- Encourage increased physical activity
- Send reminders by text, email, postcard or calls to contact members who need a follow-up/annual exam prior to the end of the year (for HEDIS, the last BP reading of the measurement year is what is utilized to determine blood pressure control)
- Ensure calibration of office BP cuffs and assist patients with calibration of home cuffs to ensure accuracy of home monitoring

Plan All-cause Readmission (PCR)

AHRQ's Hospital Guide to Reducing Readmissions



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

Low Back Pain

Conservative Treatment First 28 Days*

- Stay active
- Use heat
- Take over the counter medications
- Sleep on side or back
- Talk to a doctor for short-term pain medication and follow-up again if pain is not relieved
- Other treatments such as physical therapy, chiropractic care, acupuncture, yoga, massage, cognitive-behavioral therapy, progressive muscle relaxation (plans vary with coverage of these benefits)

In cases where red flags are identified—such as weight loss that cannot be explained, fever over 102° F, loss of control of bowel or bladder, loss of feeling or strength in legs, problems with reflexes, and a history of cancer are present—imaging may be warranted within the first 28 days of diagnosis.* **Consider coding the red flag diagnosis as primary rather than low back pain when they are present.**

*Choose Wisely Initiative

Avoidance of Antibiotics in Adults with Acute Bronchitis (AAB)

Challenge: Managing the patient's expectation of receiving a prescription for an antibiotic

Goal: Avoid prescribing antibiotics for patients with a diagnosis of acute bronchitis without a competing diagnosis or comorbidity. Code comorbid condition or bacterial condition when present.

Risk: Inappropriate use of antibiotics is the single most important factor in antibiotic resistance, C-Difficile and yeast infections

Interventions:

- Education and communication are important in managing patient expectations for medications to treat acute bronchitis symptoms
- Careful word selection such as defining the diagnosis as a chest cold or "viral upper respiratory infection" along with offering at home treatments can also be helpful
- Setting realistic expectations for symptom duration (cough may last about 3 weeks) gives the patient a better understanding of the disease process

Adult Access to Preventive Ambulatory Health Services (AAP)

Complete physical exam, including but not limited to: height, weight, BMI, vital signs, history & physical, review of systems, age appropriate screening tests, immunizations administered, all anticipatory guidance given, including but not limited to the following topics:

- Smoking cessation
- Avoiding alcohol and/or drugs
- Diet and nutrition
- The importance of safety belts
- Smoke detectors
- Fall prevention
- Regular dental visits/dental care
- Physical activity/fitness

Possible Interventions to Help Your Practice:

- Send reminders by text, email, postcard or calls to contact members who need an annual exam soon or new to your practice
- If you use an electronic medical record (EMR), create a flag to track members due for an upcoming preventive screening and contact them
- If you do not use an EMR, create a manual tracking method
- Complete annual health checks during sick visits; these may be missed opportunities for screenings
- Consider offering office hours into the evening, early morning or weekends to accommodate working adults

Effective primary care will provide the foundation to improve patient satisfaction and healthcare quality while reducing healthcare costs. At Blue Cross, we encourage our members to establish and maintain a relationship with a primary care provider to promote consistent and coordinated healthcare.

PHARMACY

NEW

2019 Annual Formulary Updates

Annual formulary updates were made January 1, 2019, or upon 2019 renewal depending on members' plans:

- Drugs removed from formulary and tier changes. Some drugs will no longer be covered on the closed formulary, and some drugs may move to a different cost-share tier on both closed and open formularies.
- Prior authorization additions and updates to some existing requirements
- New quantity-per-dispensing limits for select drugs
- More drugs that have over-the-counter options will be excluded

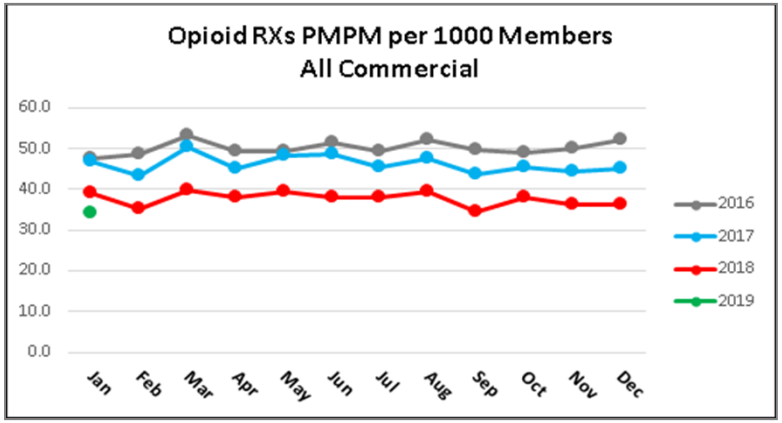
Full lists of drugs with **Specific Drug Coverage Requirements** are available at **www.BCBSLA.com/CoveredDrugs**

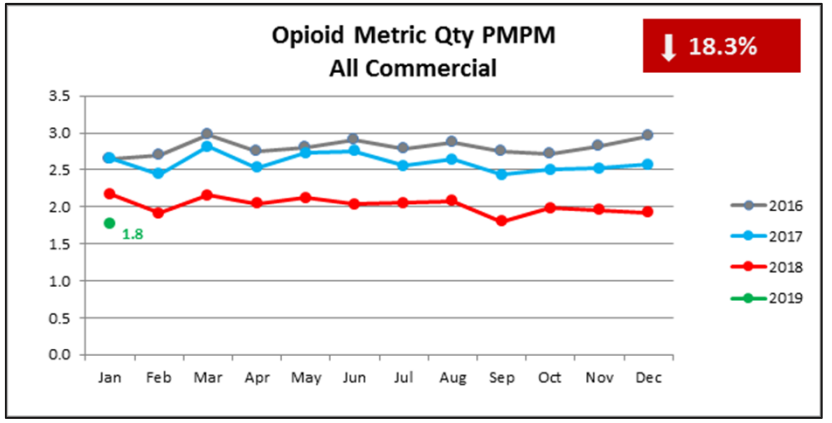
General Coverage Notes

- Full lists of drugs with **Specific Drug Coverage Requirements** are available at **www.BCBSLA.com/CoveredDrugs**
- **Please consider prescribing drugs that are covered** or have lower out-of-pocket costs when you believe it is appropriate. If members fill a prescription drug that is not on the covered drug list, they could have to pay the full cost of the drug out of pocket.
- **You may ask for a clinical review** (similar to prior authorization) if your patient has a medically necessary need for a *non-formulary* drug. Find information about submitting a prior authorization at **www.BCBSLA.com/providers** >Pharmacy. This is not available for drugs excluded from coverage.

Opioid Policy, Year One

From January 1, 2018 to January 1, 2019 — Blue Cross' Opioid Overutilization program's first full year — we show **13% fewer opioid prescriptions** per 1,000 members and **18.3% fewer opioid quantities** dispensed per member per month





- **Providers** are encouraged to use the **Opioid Prescribing Tool Kit** at **www.BCBSLA.com/providers** >Pharmacy
- **Members** can learn about **Safer Pain Care** at **www.BCBSLA.com/pharmacy**

REFERRALS

Member Referrals

Network providers should **always** refer members to **contracted** providers

- Referrals to out-of-network providers result in significantly higher cost-shares to our members and it is a breach of your Blue Cross provider contract
- Providers who consistently refer to out-of-network providers will be audited and may be subject to a **reduction** in their network reimbursement

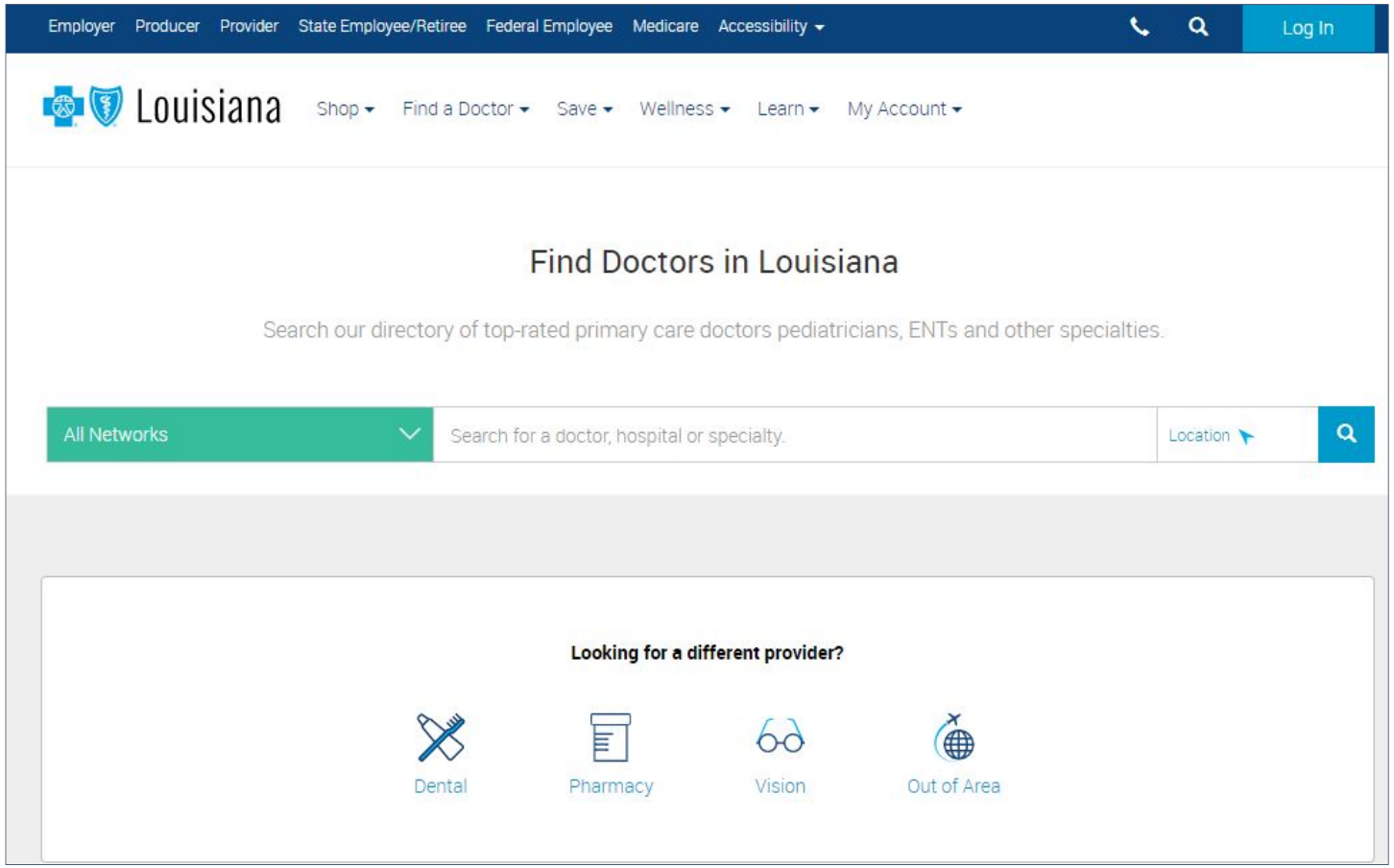
Out-of-network Referrals

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 of our network providers should refer members to preferred reference lab vendors when lab services are needed and are not performed in your office
- If you perform laboratory testing procedures in your office, we require a copy of your Clinical Laboratory Improvement Act (CLIA) certification
- HMO Louisiana, Blue Connect, Community Blue and Signature Blue physicians may perform a selection of lab tests from our In-office Lab List

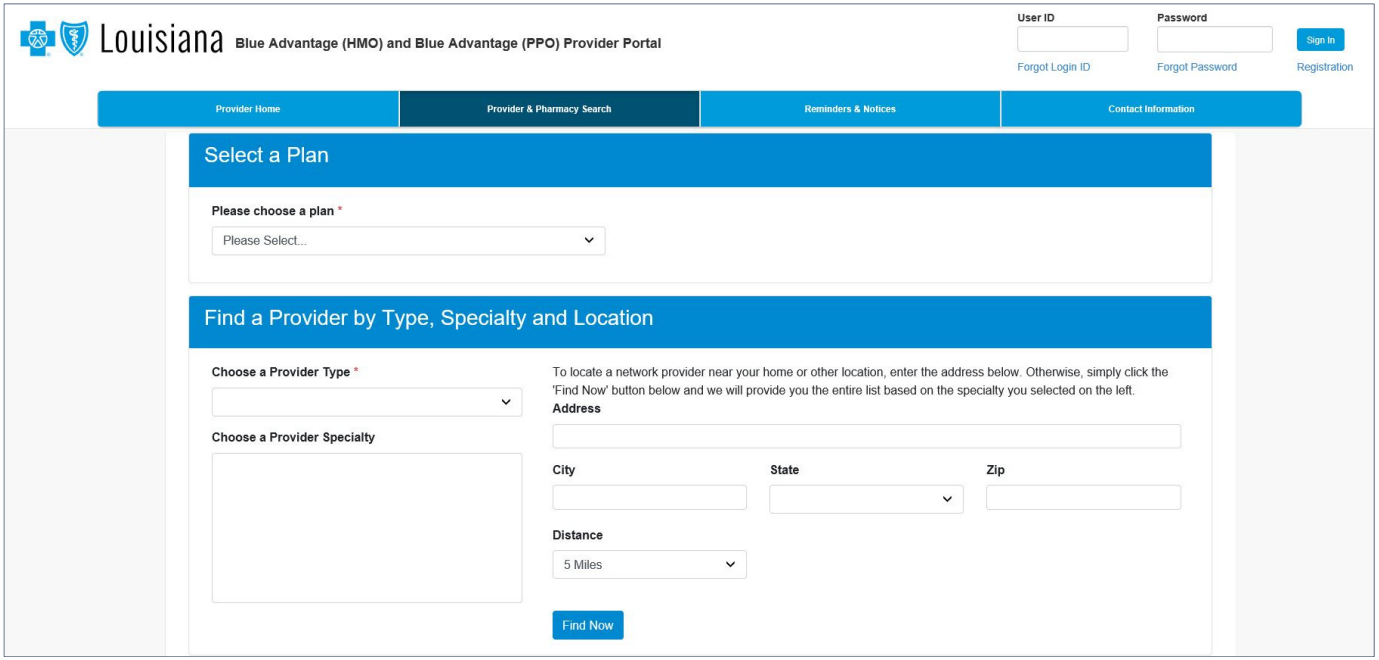
The ordering/referring provider NPI is required on all laboratory claims. Place the NPI in the indicated blocks:

- CMS-1500: Block 17B
- 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element

The In-office Lab List is in our network speed guides, available online at www.BCBSLA.com/providers >Resources

Finding Blue Advantage (HMO)/Blue Advantage (PPO) Providers & Lab Services

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



Preferred laboratories for all specimens for the Blue Advantage network

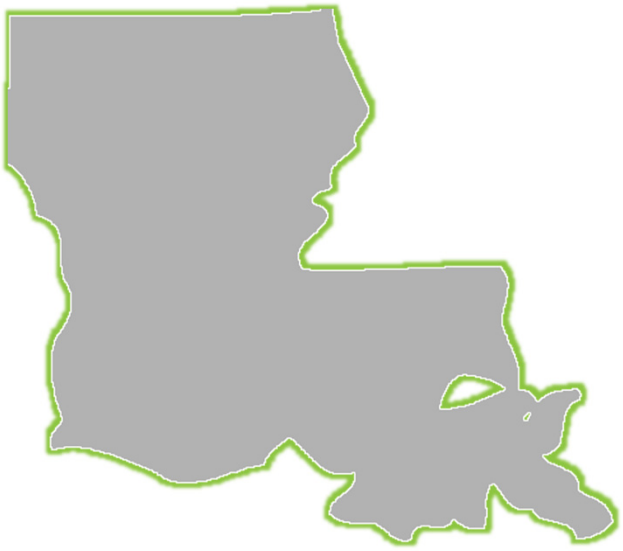
- Clinical Pathology Labs (CPL)
- Quest Diagnostics
- Lab Corp

NEW

2018 Performance – State of Louisiana

- Recently, two independent organizations published information ranking Louisiana as 49th or 50th out of the 50 states in terms of health status and health outcomes

- BCBSLA HEDIS measures (evidence-based care for a variety of conditions)
  - Approximately one third are in the bottom 25% compared to health plans across the country
  - Approximately 80% are below the national median



- Using Medicare data, Louisiana is ranked as the most expensive state in the country regarding the cost of health care
  - Compared to other developed countries, the United States spends up to 50% more for its healthcare, yet measures of quality and outcomes are no better than other countries.

- Louisiana is doing poorly from a value perspective (value=quality/cost)
  - Drives up the cost of insurance premiums to the point of unaffordability

NEW

2018 Louisiana Health Status

Measure	Description	U.S. Rank
Behaviors	Graduation Rates, Drug/Alcohol Abuse, Obesity, Smoking	50/50
Community and Environment	Children in Poverty, Air Pollution, Infectious Diseases, Violent Crime	50/50
Policy	Public Health Funding, Uninsured Rates, Immunization Rates	33/50
Clinical Care	Number of Providers, Preventable Hospitalizations, Low Birthweights	47/50
Determinants of Health	**(Summary of the Above 4 Categories)**	**50/50**
Clinical Outcomes	Death Rates, Diabetes Rates, Mental Health, Infant Mortality, Premature Death Rates	48/50
Overall		**50/50**

AMERICA'S HEALTH RANKINGS
UNITED HEALTH FOUNDATION

NEW

2018 Louisiana Health Status

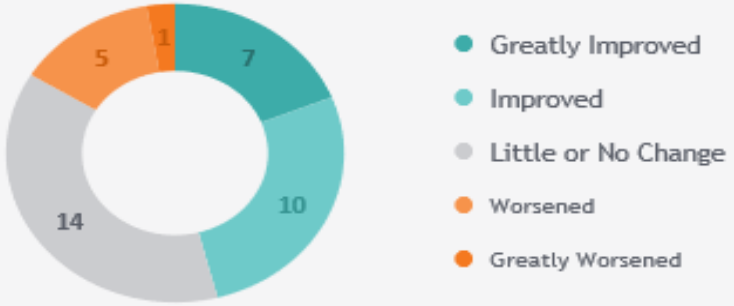
Louisiana

The Commonwealth Fund

Ranking Highlights

	2018 Rank[a]	Change[b]
Overall	49	+1
Access & Affordability	47	-3
Prevention & Treatment	47	0
Avoidable Use & Cost	50	+1
Healthy Lives	47	+2
Disparity	19	+17

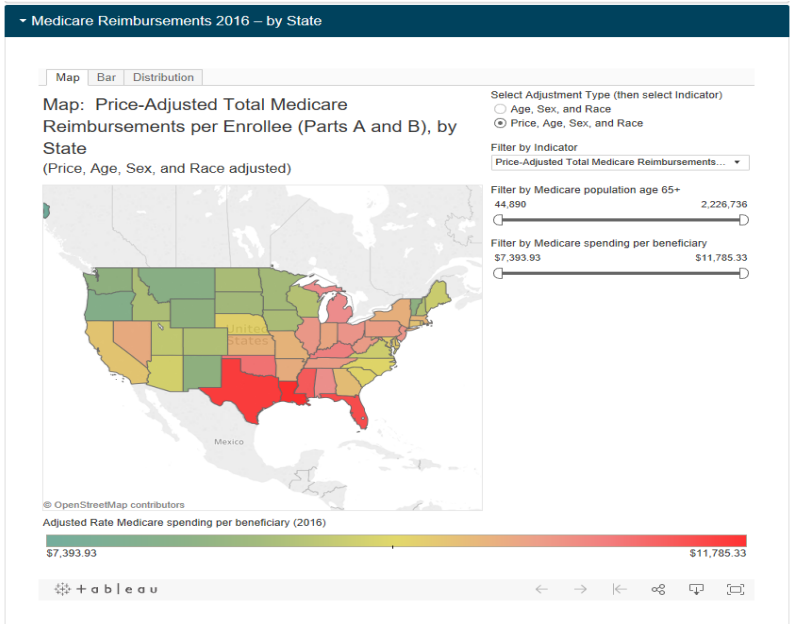
How Health Care in Louisiana Has Changed[c]

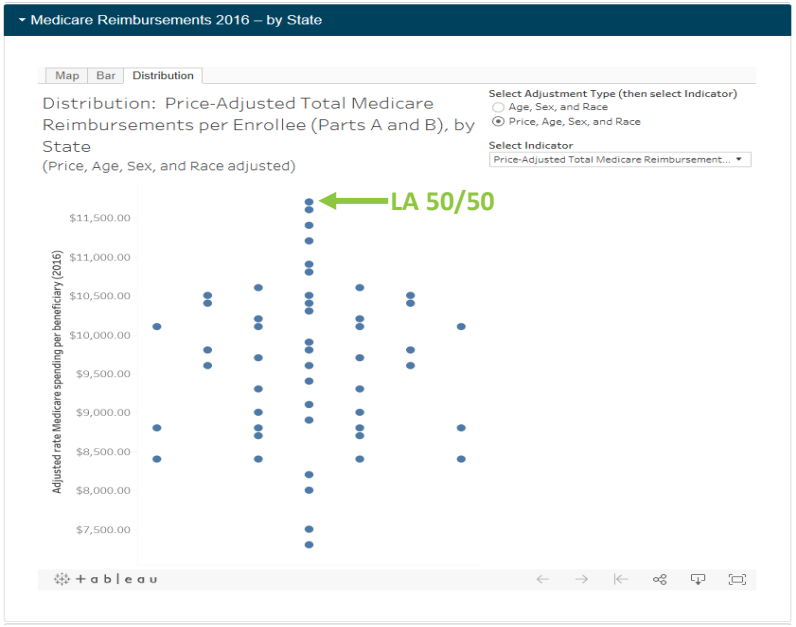


NEW

Dartmouth Atlas: Unwarranted Variation

Differences in healthcare service delivery that cannot be explained by illness, medical need, or dictates of evidence-based medicine. **Quality of care, access to care and patient satisfaction all are no better in higher spending regions.**





QUALITY BLUE PROGRAMS

Quality Blue Programs

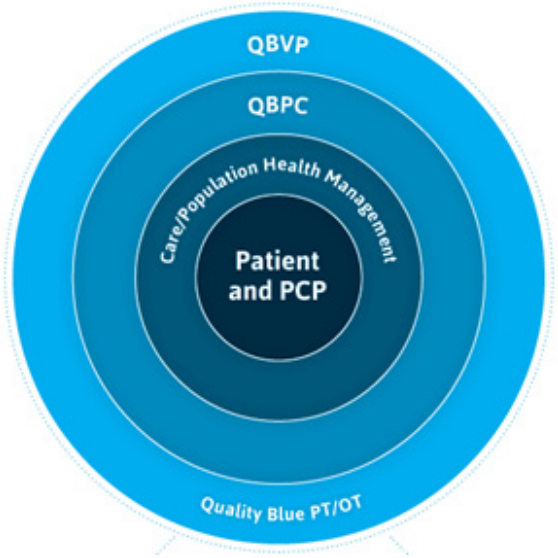
- Blue Cross and Blue Shield of Louisiana implemented a cost-saving program for members when services are performed by a Quality Blue provider
- Blue Cross reduces members' (depending on their plan) office copayment with visits to a Quality Blue enrolled primary care doctor
- The Quality Blue Primary Care Claims-Based (QBPC-CB) program is a bridge program for Blue Cross providers that do not have a EMR; the goal of the QBPC-CB program is for the provider to move into the Quality Blue Primary Care (QBPC) 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 and Nurse Practitioner
- 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

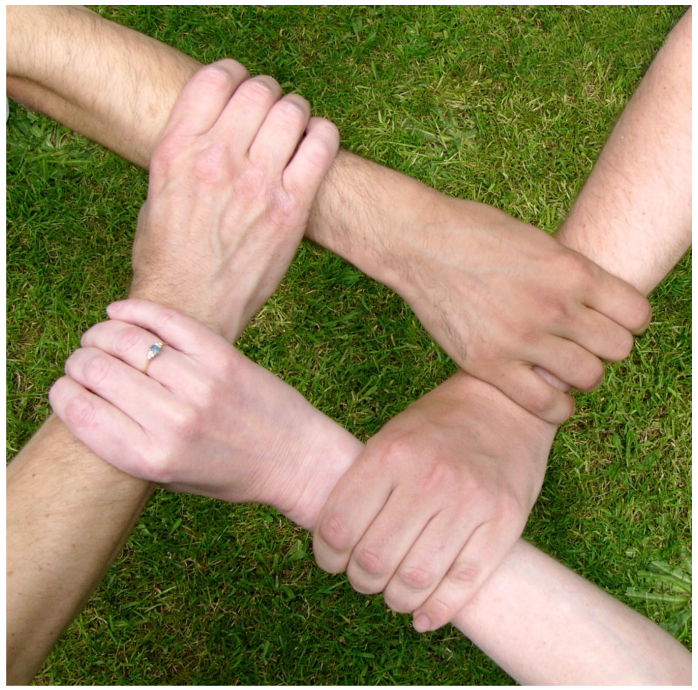
- Enables large physician groups, or Accountable Care Organizations (ACOs), to be **responsible for improving health quality & saving costs of care** across the system – primary care and specialty care, hospitalizations, labs, etc.
- ACOs that improve quality and keep costs down get a percentage of savings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

Partnership Successes

- Quality Blue Primary Care (QBPC) Program
  - Focused work with more than half of the Primary Care Physicians in Louisiana to improve care for hypertension, diabetes, chronic kidney disease and vascular disease
  - 26% improvement in hypertension control
  - 130% improvement in diabetes control

- Quality Blue Hospital Care (QBHC) Program
  - 39% reduction in central line infections
  - 20% improvement in sepsis management

- Quality Blue Value (QBVP) Program
  - Shared savings program for Accountable Care Organizations that requires meeting specific quality targets
  - 2017 results demonstrated a 4.26% reduction in total costs of healthcare



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 list of Blue Distinction Centers is available online at
www.bcbs.com/blue-distinction-center/facility

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		✓

Specialty Care Insight Program

- Our Specialty Care Insight Program makes information about efficiency and effectiveness more transparent to specialty providers in our network
- Blue Cross provides reports to network physicians in the following specialties:
  - Cardiology
  - Gastroenterology
  - General Surgery
  - Obstetrics and Gynecology
  - Orthopedics
  - Otolaryngology (ENT)
  - Urology
- The Specialty Care Insight Report provides analytical data that allows practices to see how they compare to peers on cost of care

Specialty Care Insight Program

- Blue Cross may share data from these reports with network primary care physicians (PCPs) enrolled in our Quality Blue Value Partnerships
- The overall effectiveness and efficiency data or med-markers for the seven specialties to which that PCP practice most often refers patients may be shared
- If you have questions about the Specialty Care Insight Reports, contact Provider Relations at **provider.relations@bcbsla.com** or 1-800-716-2299, option 4

More information on the Specialty Care Insight initiative is available online at **www.BCBSLA.com/providers** >Programs >Specialty Care Insight

CARE MANAGEMENT

Care Management & Clinical Expertise

Our Care Management Services:

Improving the Health and Lives of Louisianians

CARE MANAGEMENT

Member-focused programs that improve employees' health and hold down member costs

NEW

Stronger Than Campaign

101

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

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

Care Management Clinical Team

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

Doctors
Nurses
Pharmacists
Social Workers

Dietitians
Clinical Analysts
Data Engineers
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.

How to Refer Blue Cross Patients

Contact the Blue Cross Clinical Staff

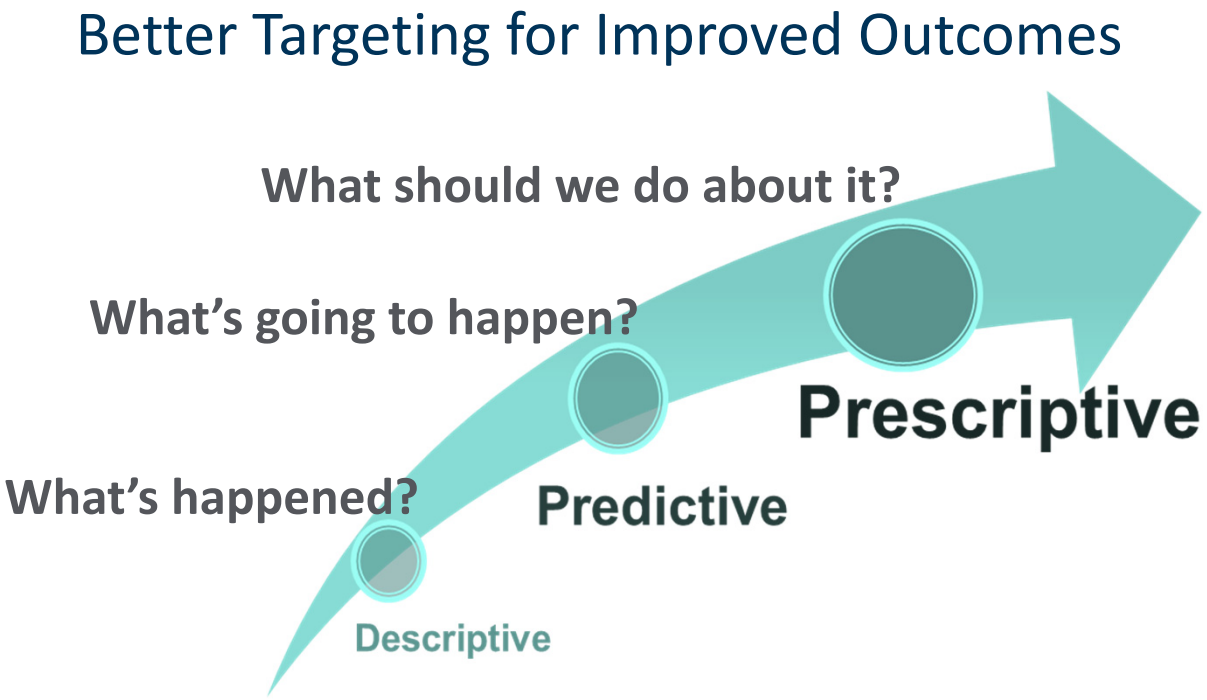
- Phone: 1-800-317-2299
- M-F, 8 a.m. – 5 p.m. (except office holidays)
- Providers can call on behalf of a Blue Cross patient
- Blue Cross patients can self-refer
- Blue Cross members can refer an immediate family member

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

Care Management Advanced Analytics

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

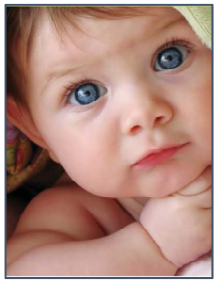


- Artificial intelligence is empowering our care teams
- Models focus resource intensity on members with whom we can make the most difference
- Prescriptive models, in particular, are delivering actionable solutions with more meaningful ROI

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

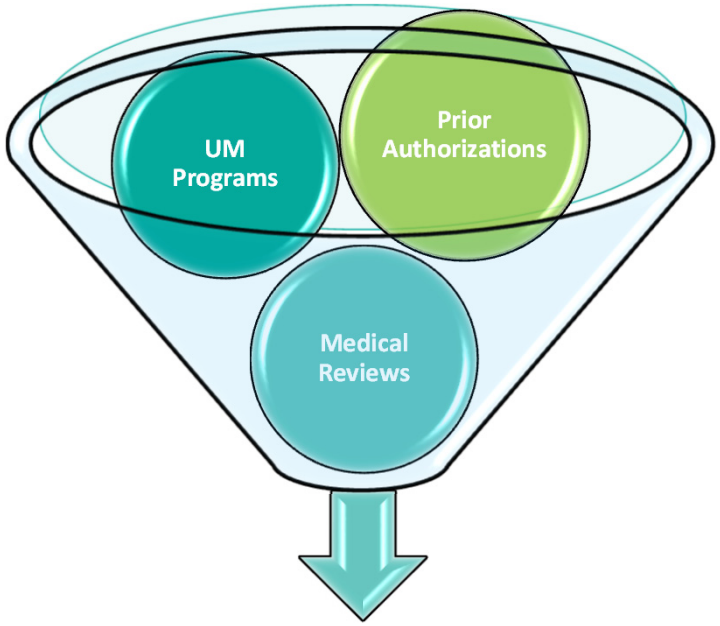
Continuous Care Management to Improve Health & Reduce Costs

- 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 x 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

Care Management Behavioral Health

Full range of behavioral health services to support our members

We've partnered with New Directions to provide our members with a full range of services for all their behavioral health needs.

Our full range of behavioral health services include:

- Inpatient and outpatient behavioral health services*
- 24/7 professional availability
- Health coaching
- Substance use disorder treatment
- Autism management

**Authorizations are required for all inpatient behavioral health services and may be required for some outpatient behavioral health services.*

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

NEW

Obesity Benefit Updates

- Starting January 1, 2019, or upon 2019 renewal, obesity treatment will be expanded for eligible population and ages
- Benefits will include 52 visits of intensive comprehensive treatment in a lifetime

ALLIANCE FOR A HEALTHIER GENERATION

For more information, visit **www.BCBSLA.com/providers** >Childhood Obesity

Obesity Provider/Member Engagement

Place an order for obesity treatment journals for your practice. Journals include:

- Goal guidance
- Nutrition resources
- Physical activity resources
- Tracking sheets

For questions, email **wellnessinfo@bcbsla.com**

Care Management Summary

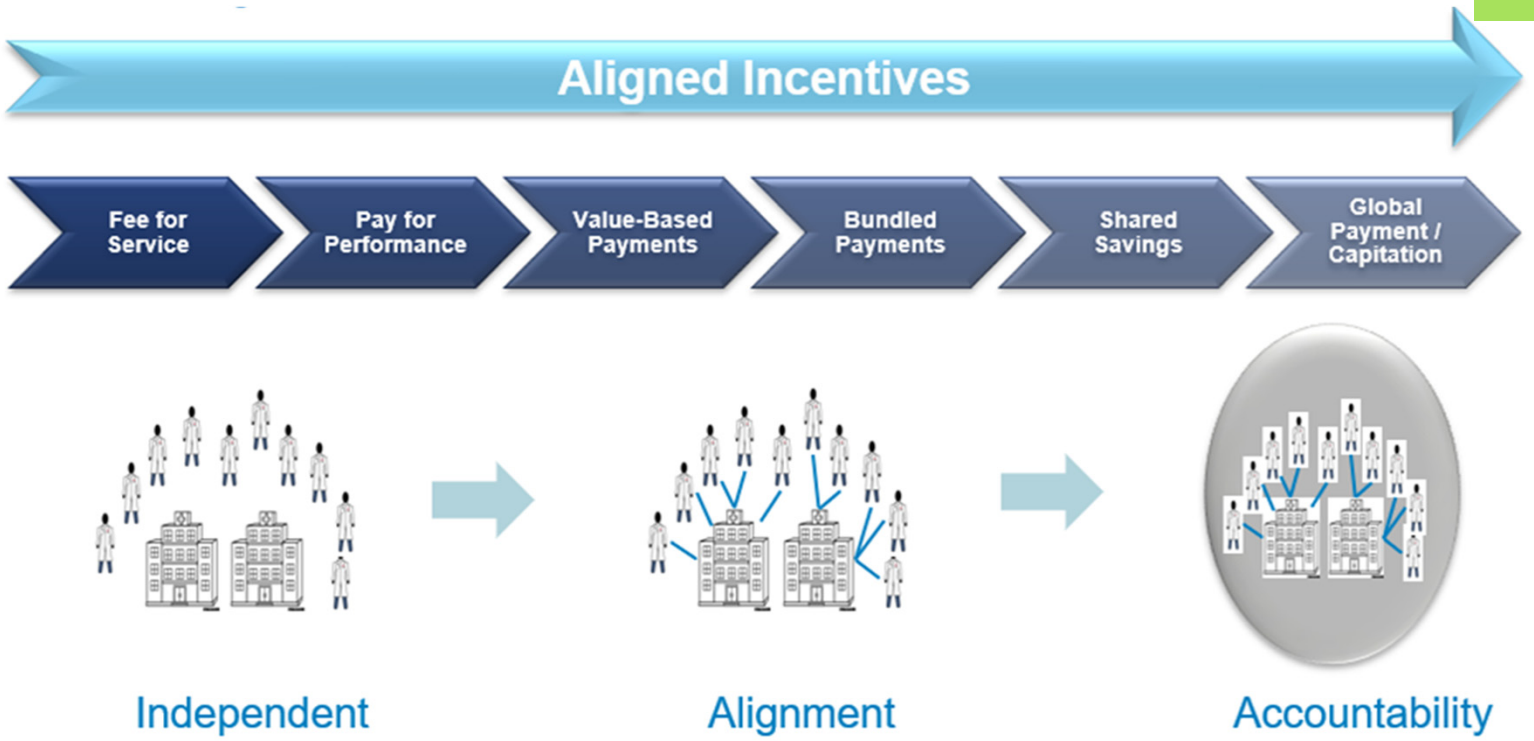
Piecing it all together

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 3 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

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 must designate at least one administrative representative to self-manage user access to our secure online services

Administrative Representative

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

Inactivity Policy

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 Team

Need help?

- Provider Identity Management (PIM) is a dedicated team to help you establish and manage system access to our secure electronic services
- If you have questions regarding the administrative representative setup process, please contact our PIM Team
  - Email: **PIMTeam@bcbsla.com**
  - Phone: 1-800-716-2299, option 5

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

NEW

New Email Security Technology

- We updated our email encryption technology and how you receive our secure emails. We transitioned from **Zix** to a new product called **Proofpoint**.
- By June 2019, you will no longer be able to access emails sent from the Zix system

What to expect with this change…

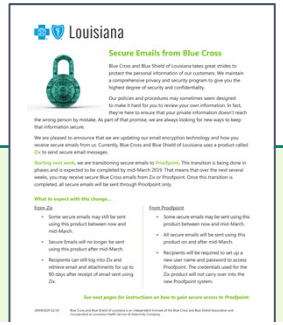
From Zix

- Some secure emails may still be sent using this product between now and mid-March
- Secure Emails will no longer be sent using this product after mid-March
- Recipients can still log into Zix and retrieve email and attachments for up to 90-days after receipt of email sent using Zix

From Proofpoint

- Some secure emails may be sent using this product between now and mid-March
- All secure emails will be sent using this product on and after mid-March
- Recipients will be required to set up a new user name and password to access Proofpoint. The credentials used for the Zix product will not carry over into the new Proofpoint system.

Refer to the ***Secure Emails From Blue Cross*** handout in your folder for more details

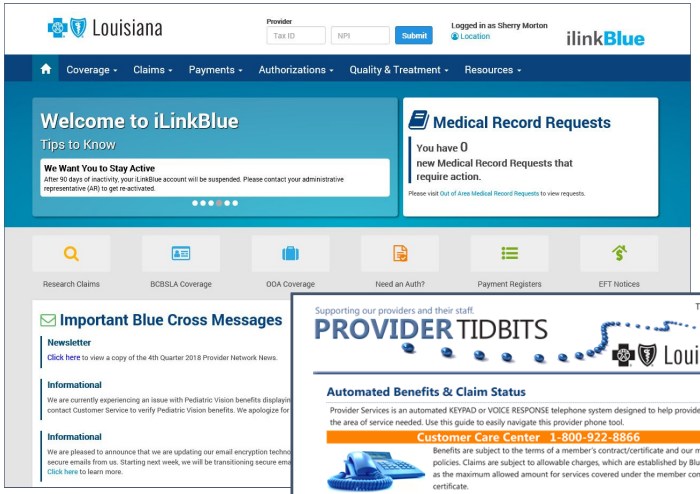


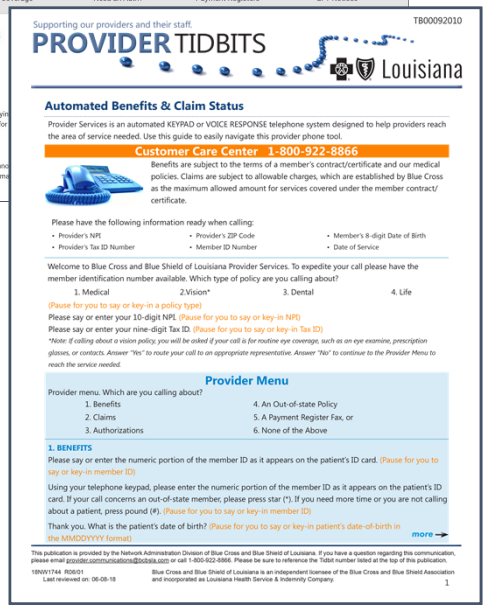
Provider Self-service Initiative

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

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

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





Self-service tools available to providers:

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

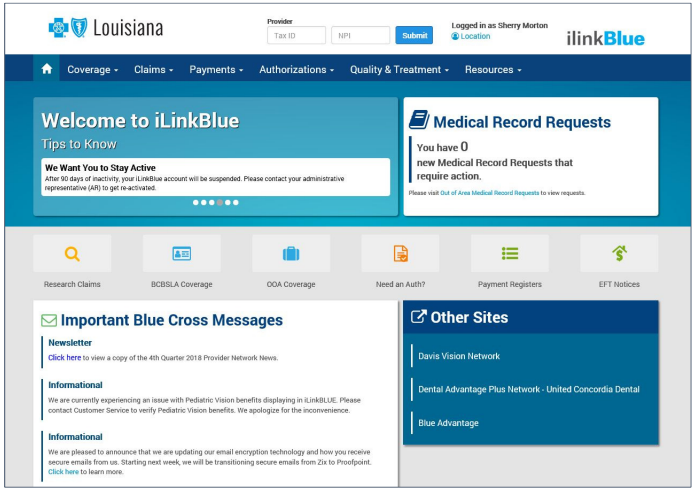
Included in your folder is a **Provider Self-service Quick Reference Guide** that has more information about using these provider tools

iLinkBlue

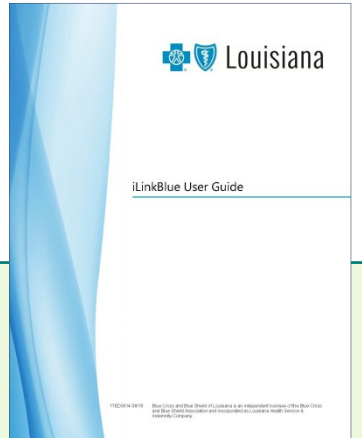
- iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:
  - Coverage & Eligibility
  - Benefits
  - Coordination of Benefits (COB)
  - Claims Status (BCBSLA, FEP and Out of Area)
  - Medical Code Editing
  - Payment Registers/EFT Notifications
  - Allowables Search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

ilinkBlue

www.BCBSLA.com/ilinkblue



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



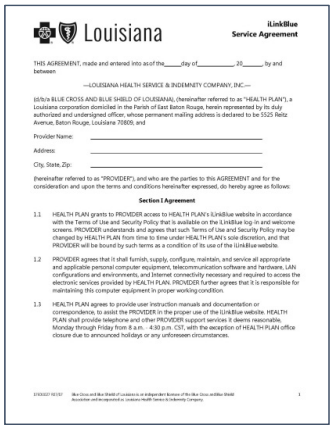
iLinkBlue Application Packet

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The **iLinkBlue Application Packet** is available at **www.BCBSLA.com/providers** >Forms

ALWAYS include NPI/tax ID on:

- ✓ iLinkBlue Service Agreement
- ✓ Business Associate Addendum to the iLinkBlue Service Agreement
- ✓ Administrative Representative Registration Form
- ✓ Electronic Funds Transfer (EFT) Enrollment Form

These four documents are required to access iLinkBlue:


Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the _____day of_____, 20_____, by and between:

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809; and

Provider Name: _____

Address: _____

City, State, Zip: _____

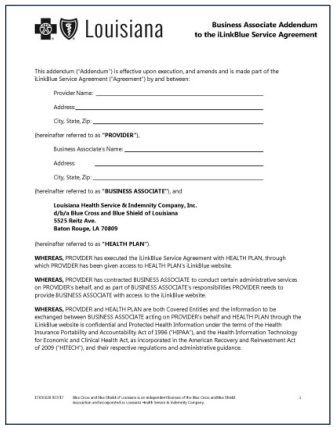
(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.


Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

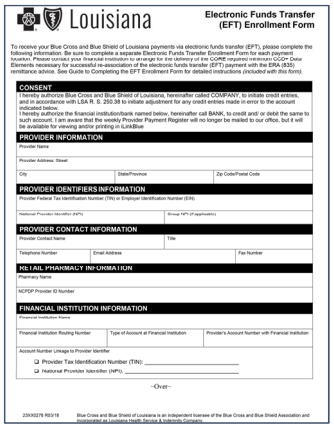
(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

Business Associate Addendum


Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions *(included with this form)*.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.
I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City | State/Province | Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) | Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name | Title

Telephone Number | Email Address | Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

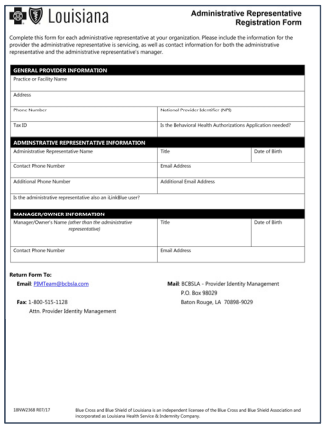
❑ Provider Tax Identification Number (TIN): _____

❑ National Provider Identifier (NPI): _____

--Over--

23KX0278 R03/18 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.

Electronic Funds Transfer Enrollment Form


Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION

Practice or Facility Name

Address

Phone Number | National Provider Identifier (NPI)

Tax ID | Is the Behavioral Health Authorizations Application needed?

ADMINISTRATIVE REPRESENTATIVE INFORMATION

Administrative Representative Name | Title | Date of Birth

Contact Phone Number | Email Address

Additional Phone Number | Additional Email Address

Is the administrative representative also an iLinkBlue user?

MANAGER/OWNER INFORMATION

Manager/Owner's Name (other than the administrative representative) | Title | Date of Birth

Contact Phone Number | Email Address

Return Form To:

Email: PAYTeam@bcbsla.com

Fax: 1-800-515-1128
Attn. Provider Identity Management

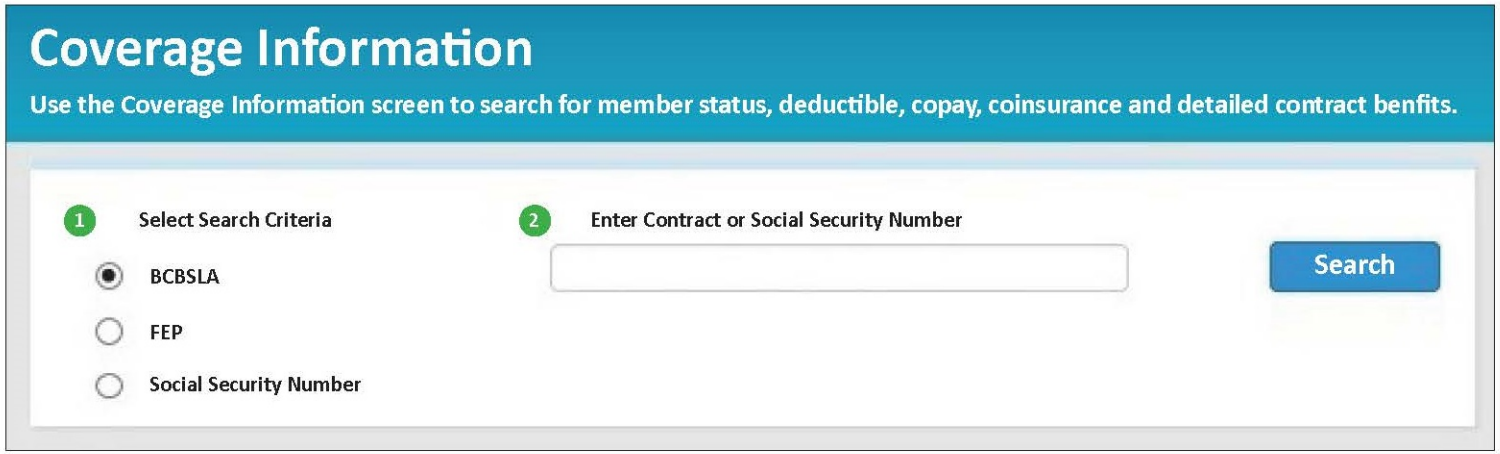
Mail: BCBSLA - Provider Identity Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

18NWA368 R07/17 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.

Administrative Representative Registration Form

iLinkBlue – Coverage & Eligibility

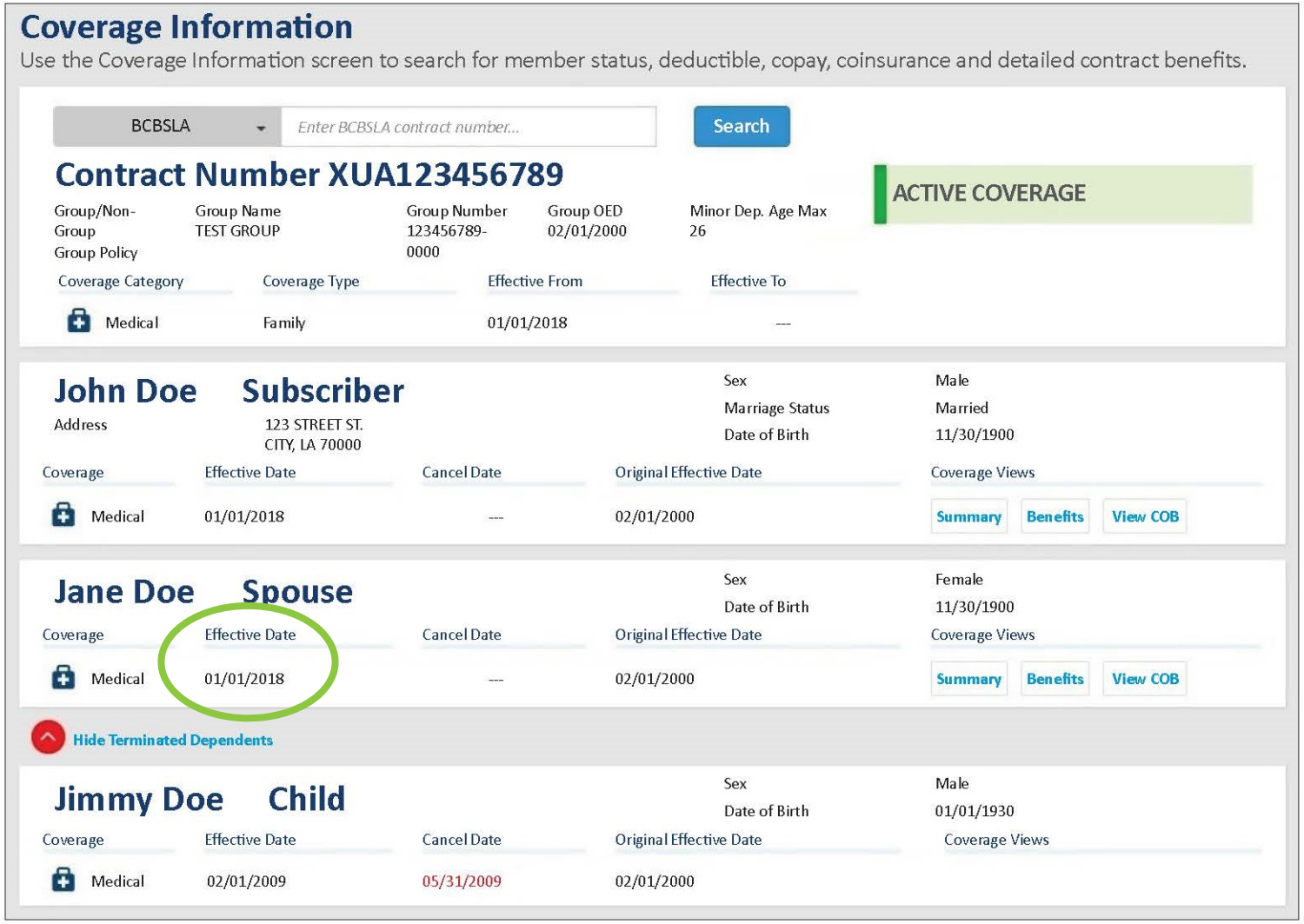
1.



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

iLinkBlue – Coverage & Eligibility

2.



iLinkBlue – Coverage & Eligibility

3.

Medical Benefits Summary

Contract Number XUA123456789

ACTIVE COVERAGE
Medical Effective Date 01/01/2018

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

Copays

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

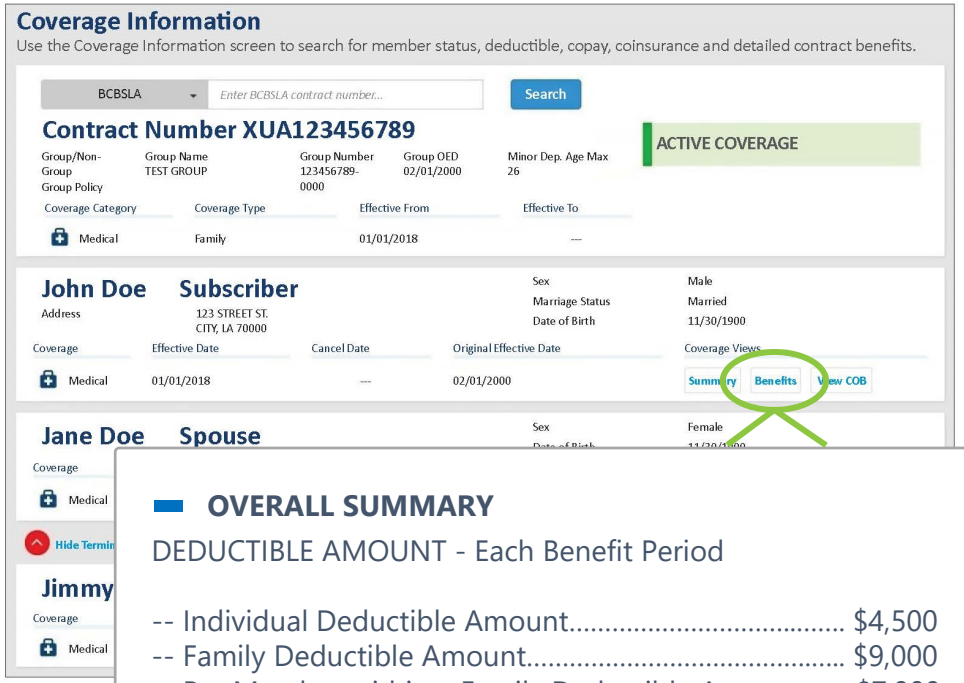
Accumulations

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

Coinsurance

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

iLinkBlue – Sample of Deductible Language



When viewing benefits, not all details are shown on the summary screen. Click the "Benefits" button to ensure you are viewing all of the member's benefits

OVERALL SUMMARY

DEDUCTIBLE AMOUNT - Each Benefit Period

SAMPLE

-- Individual Deductible Amount..... $4,500
-- Family Deductible Amount..... $9,000
-- Per Member within a Family Deductible Amount..... $7,900

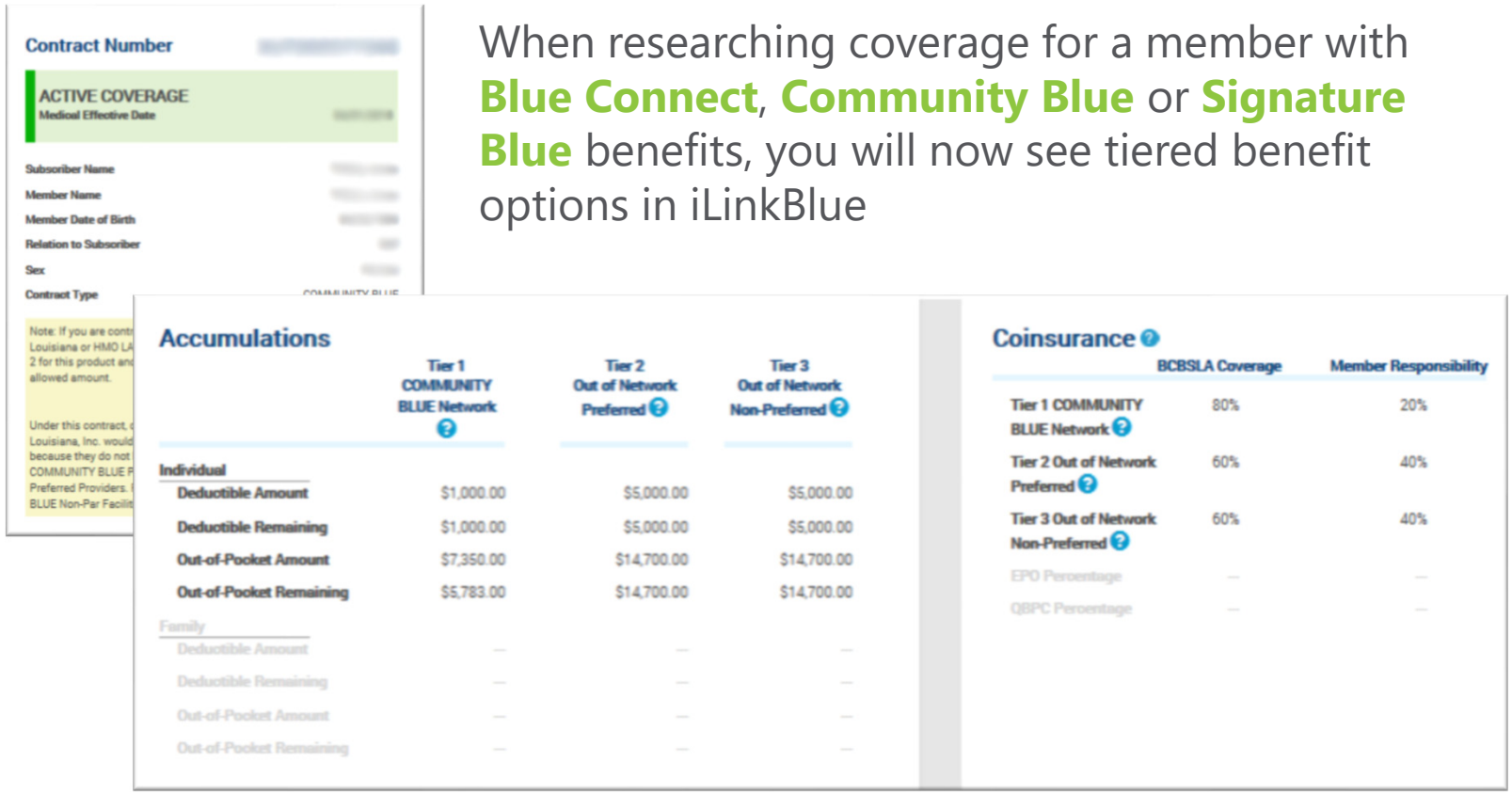
If the benefit plan includes more than one member:

- The individual benefit period deductible amount is not applicable and only the family benefit period deductible amount applies.
- No benefits are eligible for payment on any member of the family until the total family benefit period deductible amount has been satisfied.
- No family member may contribute more than the per member within a family deductible amount, as shown on the schedule of benefits, for covered services received in-network. Once a member has met the per member amount, benefits are eligible for payment.

NEW

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

NEW

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 • The member copay and accumulators identified under Tier 1 should be applied • Provider may not bill the member for any amount over the allowed amount	**Example Scenario**: • A Community Blue member sees a Preferred Care PPO provider • The member copay and accumulators identified under Tier 2 should be applied • Provider may not bill the member for any amount over the allowed amount	**Example Scenario**: • A Community Blue member sees a non-participating provider • The member copay and accumulators identified under Tier 3 should be applied • Provider can bill the member for all amounts over the allowed amount

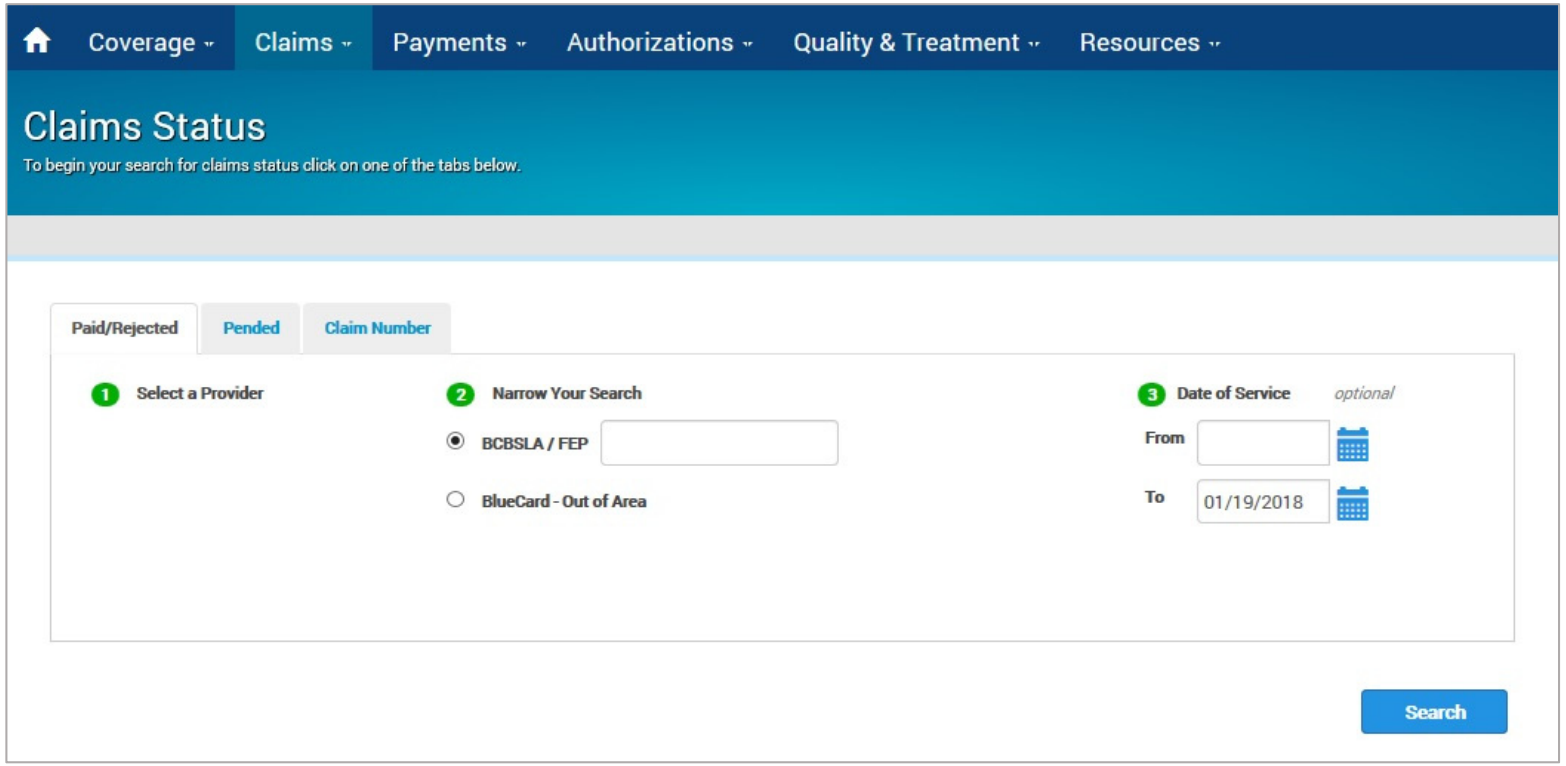
iLinkBlue –BlueCard Eligibility

Information on out-of-area eligibility/benefits can be found under "Coverage" as noted below. Use this section to research coverage information for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana).

Submit Eligibility Request (270) – Click on this link to submit an electronic eligibility inquiry to the out-of-area member's Blue Plan. Enter the member's prefix (the first three characters of the member ID number), the contract number and then click "Submit" to open the Eligibility Request (270) form (shown below). The red ***** indicates required fields.

View Eligibility Response (271) – Click on this link to access the electronic response from the member's Blue Plan (shown below). Though not immediate, out-of-area responses are transmitted back usually within less than a minute. Eligibility responses are retained for 21 days.

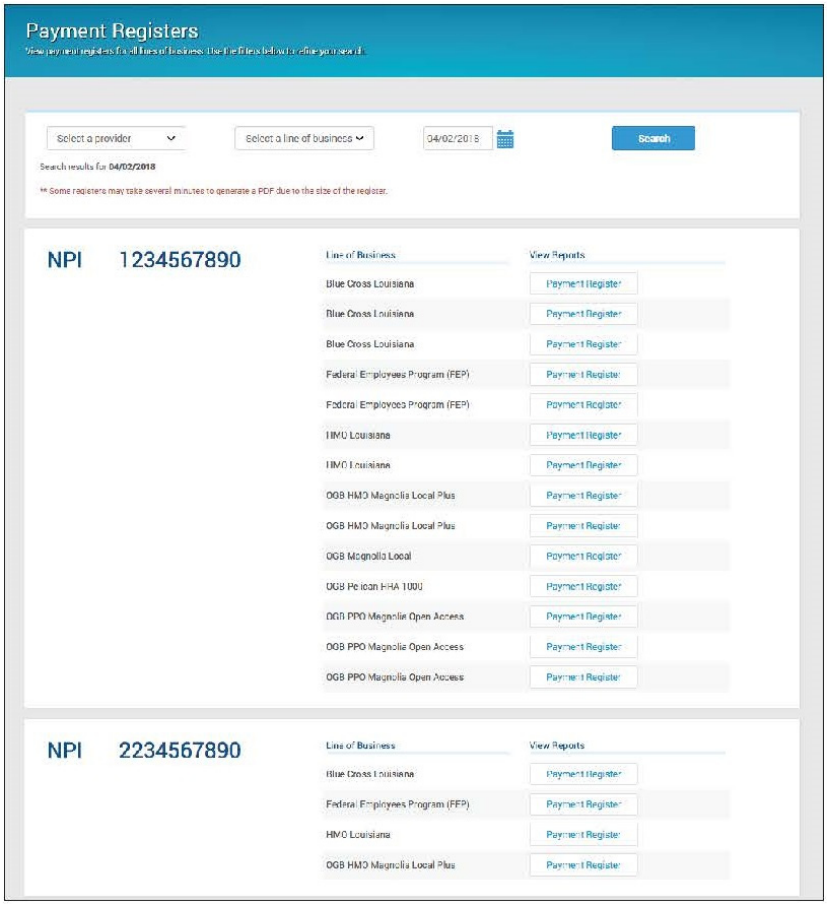
iLinkBlue – Claims Research



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

iLinkBlue – Payment Registers

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

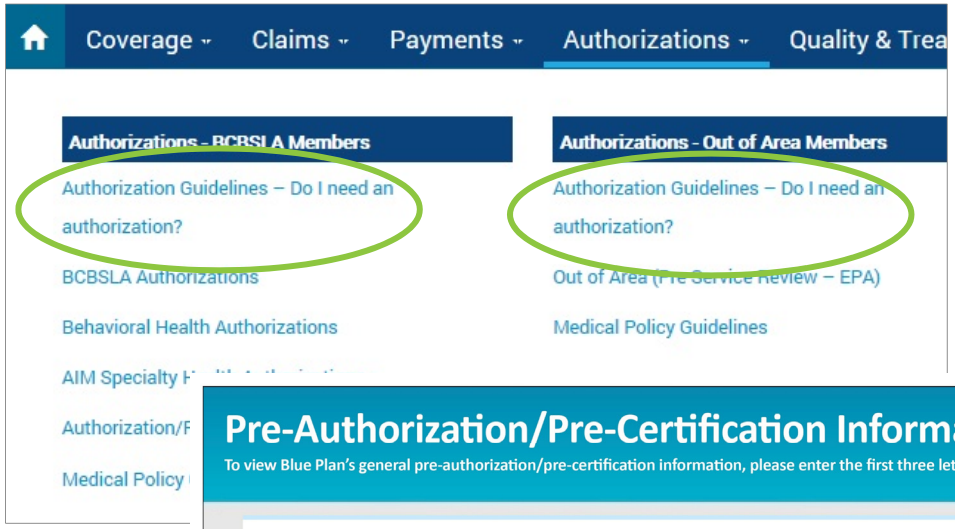


iLinkBlue – Authorizations

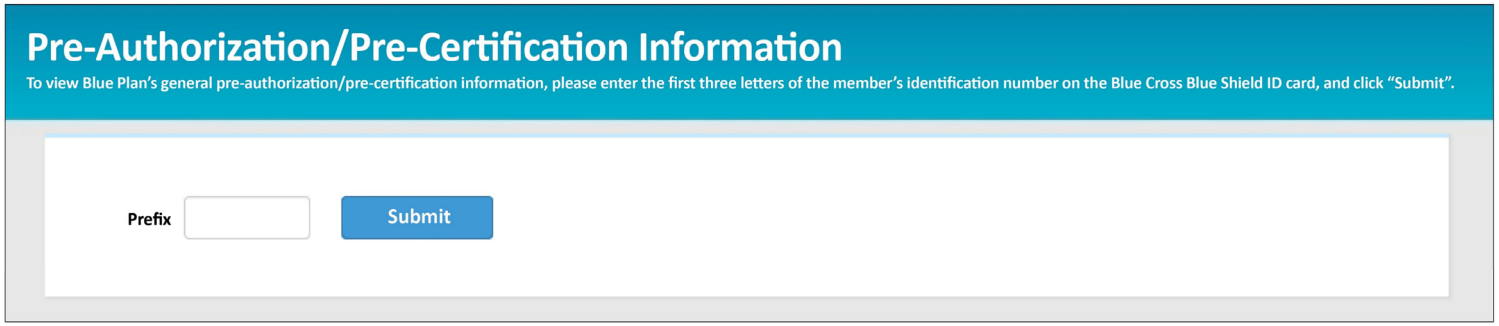
- Use the "Authorizations" menu option to access our authorization tools
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Out of Area (Pre Service Review – EPA)

Be on the lookout for invitations to register for our upcoming behavioral health webinars, which will be held in the fall

Where to Find Authorization Requirements

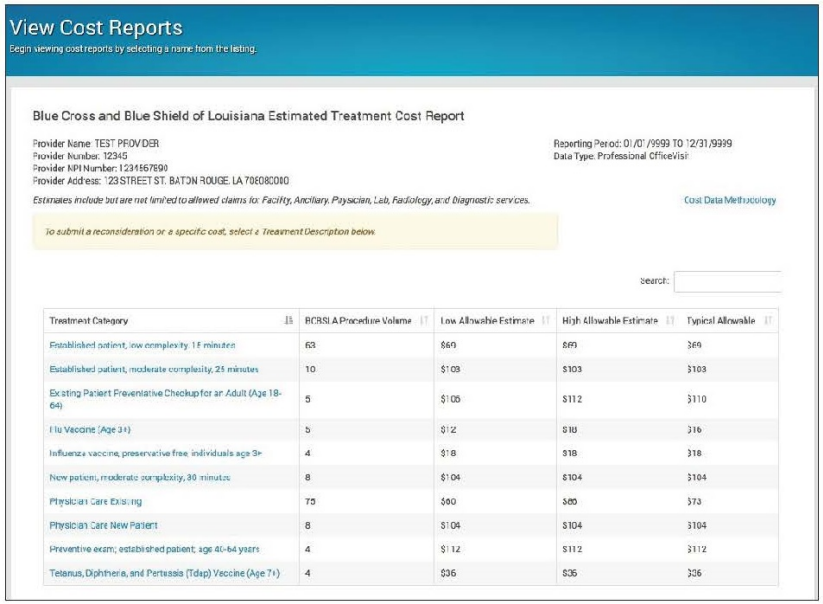


Do I need an authorization?
The Authorizations Guidelines tool allows providers to research and view authorization requirements for BCBSLA and BlueCard (out-of-area) members



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 Spring 2019. The data will only be available to review until **May 8, 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

NEW

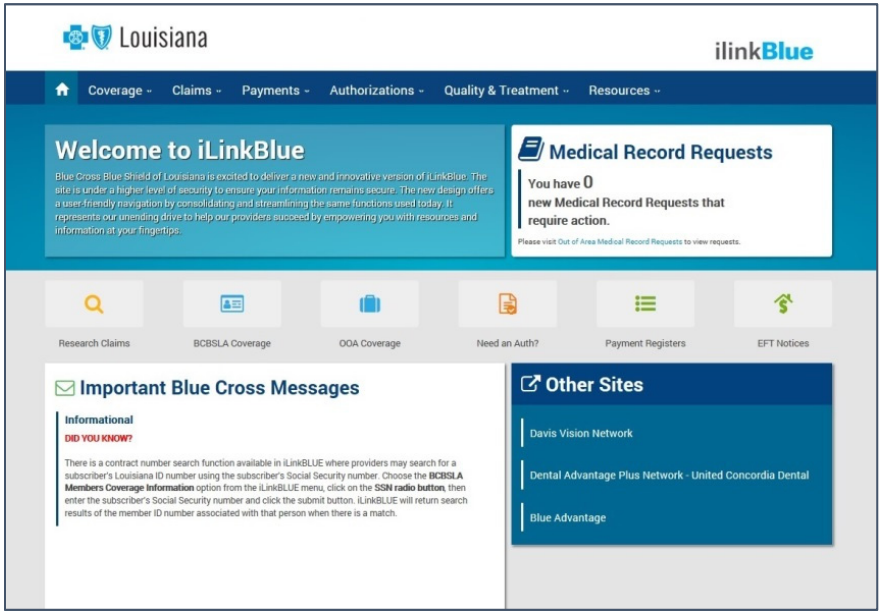
Claims Editing System

We are in the process of implementing a new Claims Editing System (CES) for both facility outpatient and professional providers

- Target date for the system to go live is summer 2019. We will continue to send updates on this as the go-live date approaches
- This tool will enable us to effectively manage healthcare delivery and reimbursement by identifying potentially incorrect coding relationships on submitted claims

- Many existing edits will remain the same
- However, there will be some differences to conform to changes in coding standards, updated reviews of existing code editing logic and enhanced functionality of the new system
- As a result, you may see changes in your payment once CES is implemented

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**)
- The Blue Advantage Provider Portal also requires a higher level of security access that must be assigned to users by your organization's security administrative representative

VARIOUS AUTHORIZATIONS

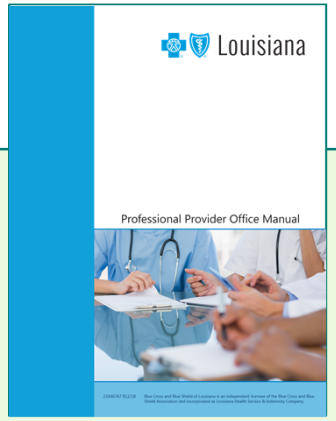
Utilization Management Programs

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
- 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**.

Additional information can be found in the ***Professional Provider Office Manual.*** Find it online at **www.BCBSLA.com/providers** >Resources >Manuals



Imaging Authorizations

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

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

- Computerized Tomography (CT) Scans
- Computerized Tomographic Angiography (CTA)
- NEW Fractional Flow Reserve using CT (FFR-CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron Emission Tomography (PET) Scans

The following FFR-CT services are being added to the High-Tech Imaging program **effective June 15, 2019**:

- 0501T
- 0502T
- 0503T
- 0504T

Blue Advantage (HMO)/Blue Advantage (PPO) providers currently use AIM for their Blue Advantage members' authorizations for radiation oncology, high-tech radiology, musculoskeletal (outpatient only) and cardiology (office and outpatient)

Top reasons for claim denials related to outpatient imaging authorizations:

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

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

Process for Changing an Authorization

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

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

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

Failure to Obtain an Authorization

Failure to obtain a prior authorization can result in:

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

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

OGB Authorization

OGB authorization requirements are different. **Failure to obtain an authorization will result in denial of payment for services.**

OGB PLAN SERVICES REQUIRING AUTHORIZATION

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

Authorization requirements for the following services apply for all OGB benefit plans.

INPATIENT

- Hospital Admissions (except routine maternity stays*)
- Mental Health/Substance Use Disorder Admissions
- Organ, Tissue and Bone Marrow Transplant Services
- Skilled Nursing Facility

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

**Request for prior authorization for these services are handled directly by AIM Specialty Health (AIM).

STOP

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

OUTPATIENT

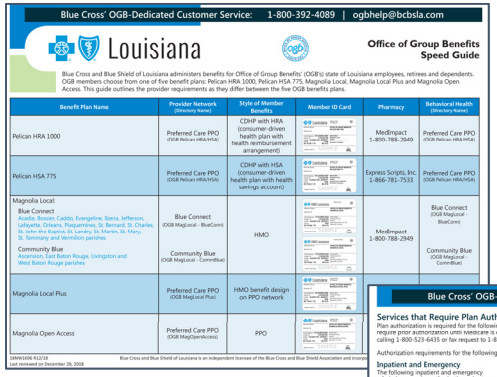
- Air Ambulance – Non-Emergency (no benefit without prior authorization)
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- CT Scans**
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000, including but not limited to defibrillators and insulin pumps
- Infusion Therapy – includes home and facility administration (exception: Physician's office, unless the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery (not required when performed in a Physician's office)
- Organ Transplant Evaluation
- Orthotic Devices (greater than $300)
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans**
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Residential Treatment Centers
- Sleep Studies (except those performed as a home sleep study)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknifeprocedures
- Vacuum Assisted Wound Closure Therapy

Louisiana

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

4-10
December 2018

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



Blue Cross' OGB-Dedicated Customer Service: 1-800-392-4089 | ogbhelp@bcbsla.com

Louisiana

Office of Group Benefits Speed Guide

Blue Cross and Blue Shield of Louisiana administers benefits for Office of Group Benefits' (OGB's) state of Louisiana employees, retirees and dependents. OGB members choose from one of five benefit plans: Pelican HRA 1000, Pelican HSA 775, Magnolia Local, Magnolia Local Plus and Magnolia Open Access. This guide outlines the provider requirements as they differ between the five OGB benefits plans.

Benefit Plan Name	Provider Network (Directory Name)	Style of Member Benefits	Member ID Card	Pharmacy	Behavioral Health (Directory Name)
Pelican HRA 1000	Preferred Care PPO (OGB Pelican HRA/HSA)	CDHP with HRA (consumer-driven health plan with health reimbursement arrangement)		MedImpact 1-800-788-2949	Preferred Care PPO (OGB Pelican HRA/HSA)
Pelican HSA 775	Preferred Care PPO (OGB Pelican HRA/HSA)	CDHP with HSA (consumer-driven health plan with health savings account)		Express Scripts, Inc. 1-866-781-7533	Preferred Care PPO (OGB Pelican HRA/HSA)
Magnolia Local: Blue Connect Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany and Vermilion parishes Community Blue Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes	Blue Connect (OGB MagLocal - BlueCare) Community Blue (OGB MagLocal - CommBlue)	HMO		MedImpact 1-800-788-2949	Blue Connect (OGB MagLocal - BlueCare) Community Blue (OGB MagLocal - CommBlue)
Magnolia Local Plus	Preferred Care PPO (OGB MagLocal Plus)	HMO benefit design on PPO network			
Magnolia Open Access	Preferred Care PPO (OGB MagOpenAccess)	PPO			

Blue Cross' OGB-Dedicated Customer Service: 1-800-392-4089 | ogbhelp@bcbsla.com

Services that Require Plan Authorization

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, plan does not require prior authorization until Medicare is exhausted or once the combined benefit limit of 50 visits of PT/OT has been achieved. Providers may request authorization by calling 1-800-523-6435 or fax request to 1-800-586-2299. Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans effective January 1, 2019:

Inpatient and Emergency

The following inpatient and emergency admissions require authorization prior to the services being rendered:

- Inpatient Hospital Admissions (except routine maternity stays*)
- Inpatient Mental Health and Substance Use Disorder Admissions
- Inpatient Organ, Tissue and Bone Marrow Transplant Services
- Inpatient Skilled Nursing Facility Services

* Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery. Hospital services for newborns and baby visits are included in the mother's stay. However, authorization is required for inpatient sick-baby services.

** Requests for prior authorization for these services may be completed online through iLinkBlue (www.BCBSLA.com/iLinkBlue) using AIM's *Provider*Portal℠. For more information on Imaging Authorizations, visit www.BCBSLA.com/providers >Electronic Services >Authorizations.

Failure to obtain prior authorization will result in the denial of payments for services.

Authorization of Outpatient Services and Supplies

- Air Ambulance – Non-Emergency (no benefit without prior authorization)
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- CT Scans**
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000, including but not limited to defibrillators and insulin pumps
- Infusion Therapy – includes home and facility administration (exception: Physician's office, unless the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery (not required when performed in a Physician's office)
- Organ Transplant Evaluation
- Orthotic Devices (greater than $300)
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans**
- Physical/Occupational Therapy (greater than 50 visits)
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.BCBSLA.com/providers >Pharmacy
- Prosthetic Appliances (greater than $300)
- Residential Treatment Centers
- Sleep Studies (except those performed as a home sleep study)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy

Go online for more on OGB www.BCBSLA.com/OGB

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

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

Blue Advantage Inpatient Admissions & Discharges

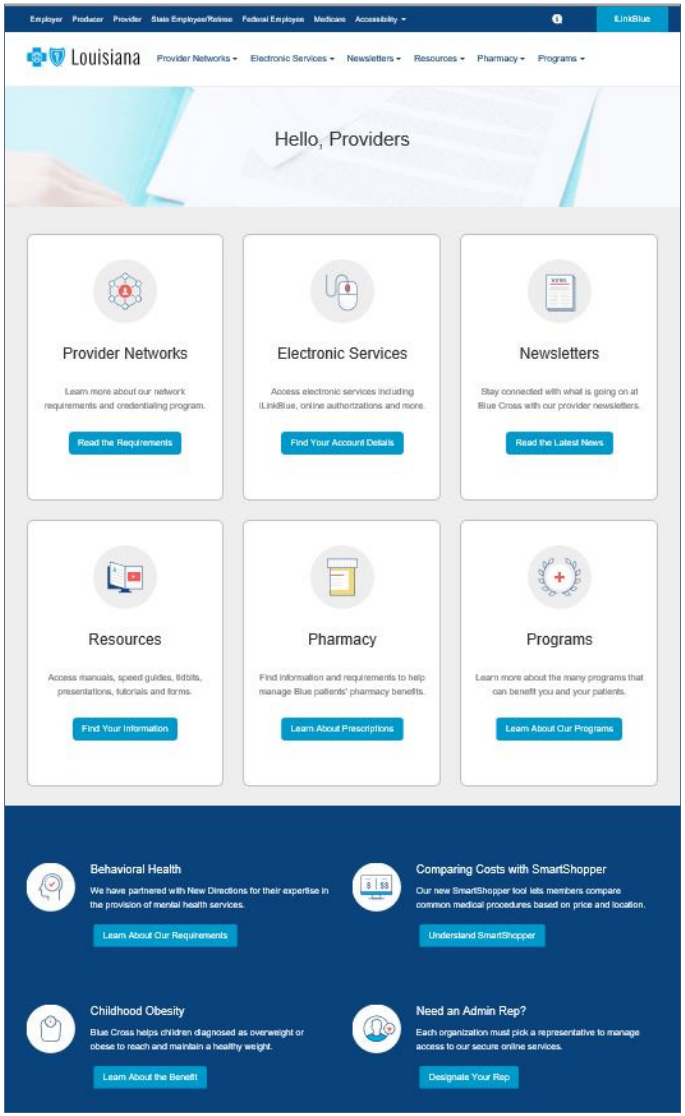
- Blue Advantage (HMO) and Blue Advantage (PPO) network providers are required to give notification within one business day of Blue Advantage members' inpatient admissions and fax discharge summary once the member is discharged
- Blue Advantage providers must submit clinical documentation supporting 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, 7 days a week

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

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

SUPPORT & RESOURCES

Provider Page



www.BCBSLA.com/providers

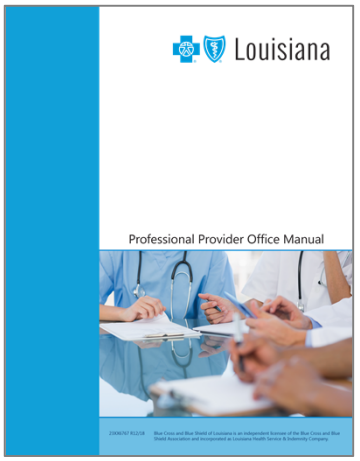
The Provider Page is home to online resources such as:

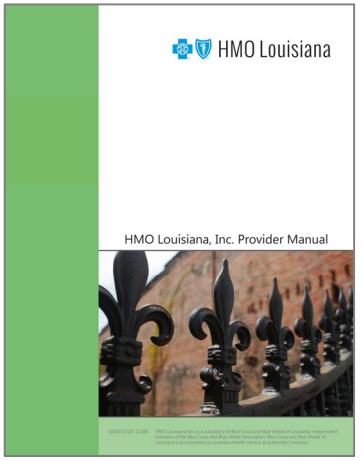
- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

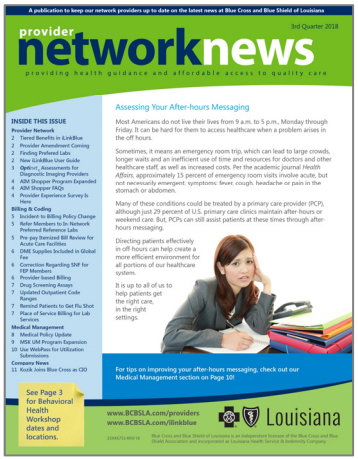
Manuals & Newsletters

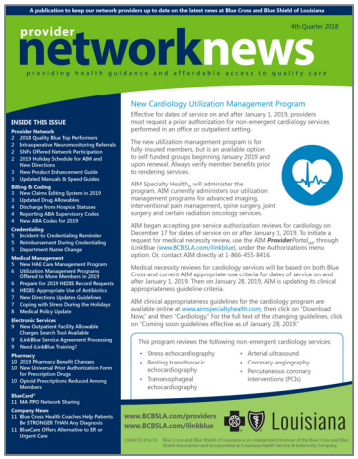
Our provider **Manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our networks.

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

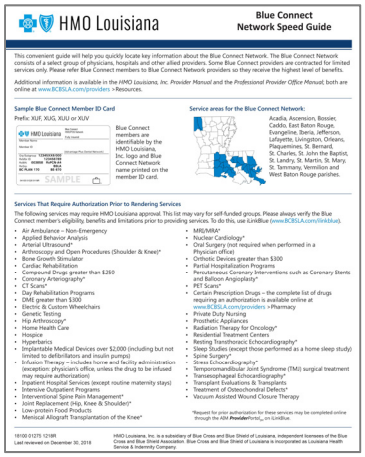
www.BCBSLA.com/providers >Newsletters

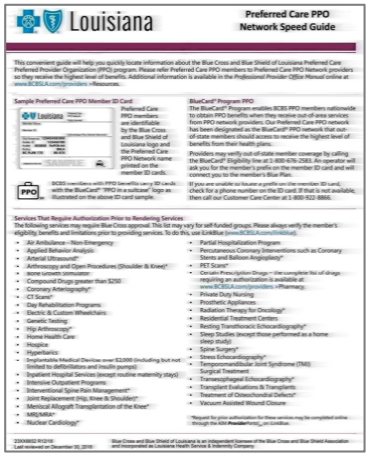
Not Getting Our Newsletters Electronically?

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





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

www.BCBSLA.com/providers >Resources

Continuing Medical Education

- We are offering free continuing medical education (CME) credits for our primary care providers directly through the Washington University CME portal
- More than 30 courses are available on a variety of topics
- Please be sure to take advantage of these free CME credits before this opportunity ends on **December 31, 2019**

Accessing the Washington University CME Portal:

1. Go to **https://cmeonline.wustl.edu/bcbsl/**
2. Click "New Account"
3. Enter registration information (* indicates required information)
4. Click "Sign Up"

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

Mary Reising – **mary.reising@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 **Mary Landry** **Karen Armstrong**

Provider Credentialing and Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Wendy Barber Provider Data Manager - **Wendy.Barber@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, applications and 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 and Data Management Department by calling 1-800-716-2299

To create more efficiency and reduction in processing time, information emailed and faxed to Provider Credentialing and Data Management should be sent as separate documents

Example:

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

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

NEW

Annual Provider Survey

We value your input!

- As a result of the 2018 survey, we implemented a new Provider Outreach initiative. We provide training and assistance for newly credentialed providers.
- We have received positive feedback regarding this initiative and look forward to hearing your additional ideas.

Remember to take our Provider Survey later this year!

Thank you!