Professional Workshop

Spring 2020

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

Thank You!

THANK YOU for all that you are doing during this novel coronavirus (COVID-19) crisis. We are grateful and appreciative for the healthcare providers who are on the front lines fighting for all of us.

Please know that you can count on us to serve and support you throughout this crisis as it affects our members, providers, employees and the communities we serve. One way we are doing that is to help ease your administrative burdens when working with Blue Cross.

Thank you to the many Louisiana providers and hospitals on the front lines fighting for us thought this COVID-19 crisis!

For policy and billing updates related to COVID-19, please visit our COVID-19 Provider Resources page by clicking the link at the top of the provider page at www.BCBSLA.com/providers.

Agenda

Provider Credentialing & Data Management

Join Our Networks Webpage

- 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 **PCDMstatus@bcbsla.com** or 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 management 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 forms

- Requests for provider data management must be submitted on the appropriate Blue Cross form
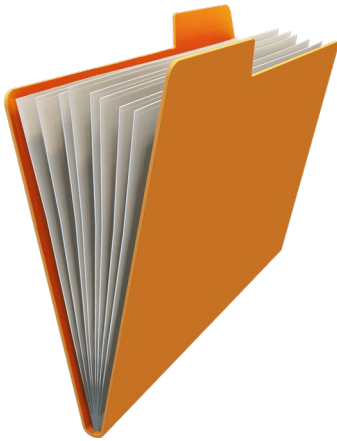
Requests that are incomplete, missing information or submitted on the incorrect form will be returned. The processing time will start over once all required information is received.

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

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Incomplete Credentialing Applications

Below are the most common reasons credentialing applications are returned:

- Professional provider did not submit the current version of the **Louisiana Standardized Credentialing Application**

- Facility did not submit the **Health Delivery Organization Information Form**

- Not submitting the proper attachments and/or forms

- 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 - Professional

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

- Acupuncturist
- 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

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Reimbursement During Credentialing

Louisiana has expanded their 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.

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.

- 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

- 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 the Louisiana Standardized Credentialing Application

- This application is part of the Professional Recredentialing Packet

- Submit your recredentialing packets (and find a checklist of all required documents) online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

LSCA Attachment A – Location Hours

- This new form is required as an attachment to the LSCA

- Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location

- Location information reported on this form must correlate to the locations reported on the LSCA, as applicable

- We use the information from this form to determine if the provider meets the qualifications to be listed in our provider directory

In order to be listed in the directory professional providers must be available to schedule patients appointments a minimum of 16 hours per week at the location listed

How to Update Your Information

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

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

Use our **Provider Update Request Form** if you have an address, phone, fax, email address or hours of operation change
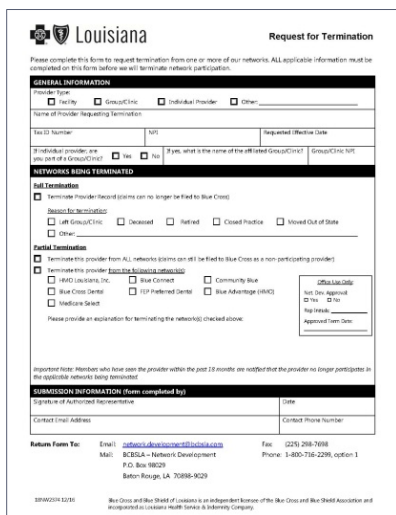
Use our **Link to Group or Clinic Request Form** when a credentialed provider is linking to a provider group or clinic

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

Submit these forms online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

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

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

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

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

Submit these forms online at **www.BCBSLA.com/providers** >Resources >Forms

Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

Blue Cross is excited to announce that we are enhancing your provider experience by streamlining how you can submit applications and forms to the Provider Credentialing & Data Management (PCDM) Department. You can now complete, sign and submit many of our applications and forms digitally with **DocuSign**.

This enhancement will help streamline your submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross. Through this enhancement, you will be able to electronically upload support documentation and even receive alerts reminding you to complete your application and confirm receipt.

What is DocuSign?
As an innovator in e-signature technology, that helps organizations connect and automate how various documents are prepared, signed and managed

To help with this transition, we created a DocuSign guide that is available online at **www.BCBSLA.com/providers >Join Our Networks**

Easily complete packets & forms with DocuSign

The following applications and forms have been enhanced with DocuSign capabilities:

Credentialing packets
- Professional (initial)
- Professional (recredentialing)
- Facility (initial)
- Facility (reverification)

Provider Forms
- Provider Update Request Form
- Link to Group or Clinic Request Form
- Notice of Tax Identification Number (TIN) Change Form
- Request for Termination Form
- Add Practice Location Form
- Remove Practice Location Form
- iLinkBlue Application Packet
- EFT Termination or Change Form

After submitting your documents through DocuSign, please do not send via email

Easily complete forms with DocuSign

Find our *DocuSign® Guide* at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

Our Networks

Our Provider Networks

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

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.
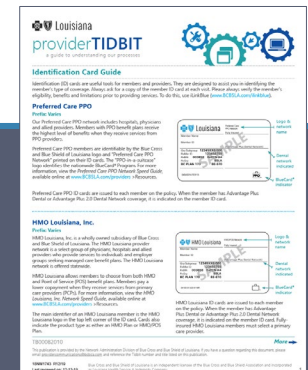
Our Provider Networks
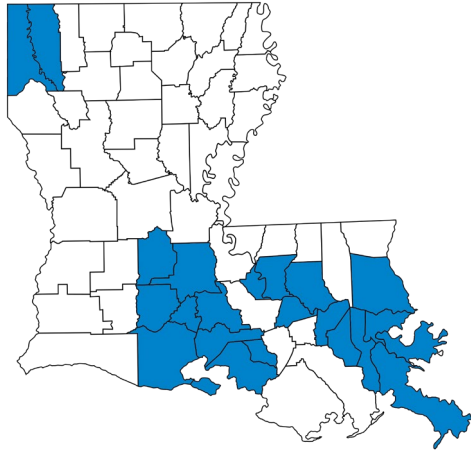
BLUE CONNECT

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

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

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

Shreveport area
Bossier and Caddo parishes

COMMUNITY BLUE

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

Our Provider Networks

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans parishes
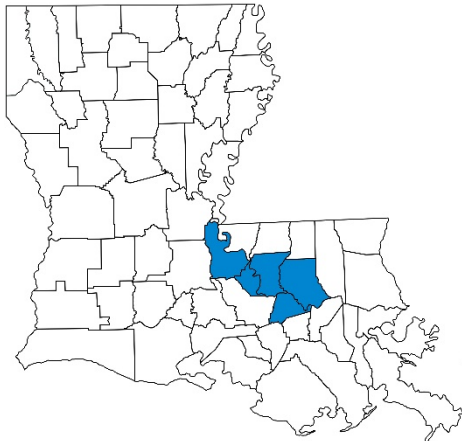
PRECISION BLUE

Baton Rouge area

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

Federal Employee Program

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

STANDARD OPTION
✓ In-network
✓ Out-of-network

BASIC OPTION
✓ In-network
✗ Out-of-network

FEP BLUE FOCUS
✓ **LIMITED** in-network
✗ Out-of-network

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

Our Blue Advantage Networks

Blue Cross Blue Shield of Louisiana — Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Advantage (HMO) and **Blue Advantage (PPO)** networks are available statewide to Medicare eligible members

Healthy Blue Dual Advantage (HMO D-SNP) Network

Healthy Blue Dual Advantage (HMO D-SNP) is our Medicare/Medicaid Dual Advantage special needs product currently available to Medicare/Medicaid-eligible members
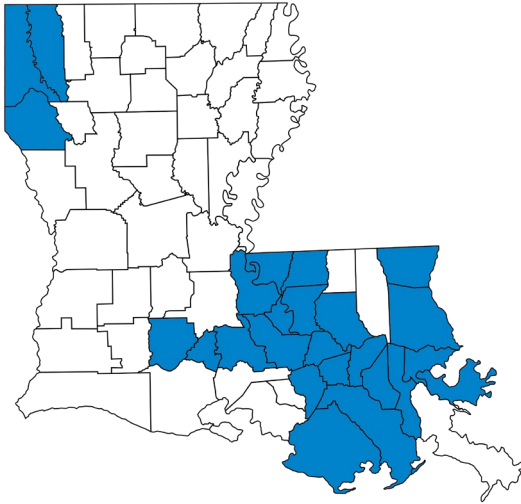
HEALTHY BLUE DUAL ADVANTAGE (HMO D-SNP)

New Orleans area

Jefferson, Lafourche, Orleans, St. Bernard, St. Charles, St. Helena, St. John the Baptist, St. Tammany, Terrebonne and Washington parishes

Lafayette area

Acadia, Lafayette, St. Martin and St. Mary parishes

Baton Rouge area

Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, Livingston, St. James, West Baton Rouge and West Feliciana parishes

Shreveport area

Bossier, Caddo and De Soto parishes

Healthy Blue

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

This list of prefixes is available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section

Fully Insured vs. Self-insured

Member ID Card Differences

FULLY INSURED

Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA
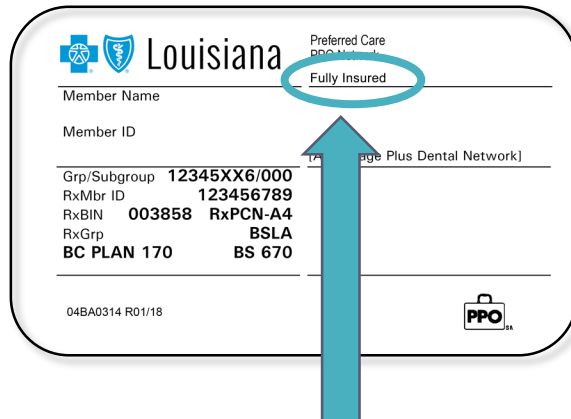
"Fully Insured" notation

SELF FUNDED

Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA
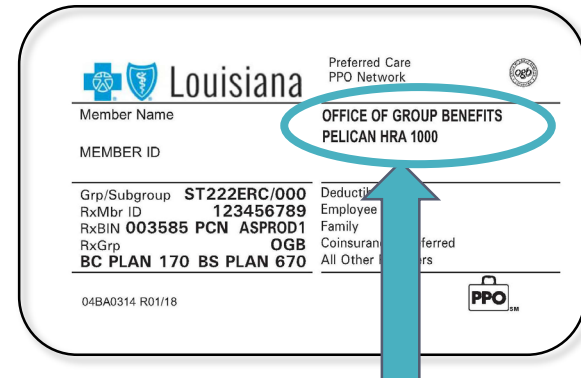
- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

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**).

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New Billing Requirements

Ordering/Referring Policy

The ordering/referring providers first name, last name and NPI are **required** on all claims for the following provider types:

- Diagnostic Radiology Center
- Durable Medical Equipment Supplier
- Infusion Therapy

- Laboratory
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy

Effective **March 1, 2020**, claims received without the ordering/referring provider's first name, last name and NPI will be returned and the claim must be refiled with the requested information. The ordering/referring provider should not be the same as the rendering provider.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below:

Paper Claims	• CMS-1500 Health Insurance Claim Form: Block 17B
Electronic 837P, Professional Claims	• Referring Provider - Claim Level: 2310A loop, NM1 Segment • Referring Provider - Line Level: 2420F loop, NM1 Segment • Ordering Provider - Line Level: 2420E loop, NM1 Segment

Consultations for Patients in Isolation

As more people are diagnosed with COVID-19, some may require isolated inpatient hospitalization

Please follow these guidelines for billing inpatient consultations when the provider is not able to physically enter the room of a patient in isolation:

- Continue using the standard hospital-based codes (CPT® codes 99251-99255) for new and established patients
- Report Modifier CR for these services

For these patients, Blue Cross is waiving the requirement for a physical exam and the provider should fully document the scope of their services—including why a physical exam could not be performed—in the patient's medical record. Claims will be processed the same as consultations where the patient is able to be physically examined.

Coverage of Antibody Testing for COVID-19

- Effective for dates of service April 10 through May 31, 2020, Blue Cross is waiving the deductible, coinsurance and copayment amount for medically appropriate antibody tests for SARS CoV-2 when ordered by a licensed provider practicing within the scope of their license

- During this timeframe, providers should not collect any cost share from members for this testing as Blue Cross will pay 100% of the allowable so there is no member cost share

- At this time, we are not covering testing that is done solely for employment status determinations for fully insured members

- Blue Cross has established interim fees for antibody testing through May 31, 2020. When billing for the Antibody Testing for SARS CoV-2 the following CPT® codes should be used:

- 86328 for an interim fee of $20 per test

- 86769 for an interim fee of $25 per test

Blue Advantage Changes

BA Transition to Vantage Health Plan

- Effective **January 1, 2021**, we will be transitioning this business from Lumeris Healthcare Outcomes to **Vantage Health Plan**, a Louisiana-based company

- This new partnership will allow us to further innovate and impact cost and quality of care, continue to deliver exceptional customer services and improve the health and lives of Louisianians

- Vantage has extensive Medicare Advantage experience, including operational resources, that aligns with our long-term strategy for the Blue Advantage networks. We are currently working with Lumeris to ensure this transition is seamless for both our members and providers.

Temporary Telehealth Expansion

Temporary Telehealth Policy Expansion

- BCBSLA has continued to monitor the spread of COVID 19, as to the emergency, we have **temporarily** expanded our telehealth policy

- This expansion of our policy allows any credentialed, network physician, nurse practitioner, physician assistant, behavioral health specialist, chiropractic, registered dietitian or physical, occupational or speech therapist to provide telehealth services to replace office visits

- Providers must follow the telehealth billing guidelines in the provider manual and agree to Blue Cross' allowable charges

- The expanded telehealth policies are effective for dates of service on and after March 16, 2020 and will continue to be in effect until we are past the national emergency. Blue Cross will notify providers when the expanded telehealth policies are no longer effective.

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

Additional Temporary Telehealth Changes

- Members in our HMO select networks (Blue Connect, Community Blue, Precision Blue and Signature Blue) may obtain telehealth and telephone-only services from any participating credentialed provider in any of our Blue Cross networks and the member's in-network level of benefits will be applied

For more information about our temporary telehealth changes visit our COVID-19 Provider Resources Page at **www.BCBSLA.com/providers**

Telehealth Temporary Member Cost Share Waiver

- Effective April 15, 2020, individual members who buy their own healthcare coverage and those who are covered through fully insured groups have $0 telehealth audio/video or phone-only visits. Self-insured employer groups have the option to waive the out-of-pocket costs for their employees if they desire. Visit the iLinkBlue (**www.BCBSLA.com/ilinkblue**) message board for the list of self-insured employer **groups that are not waiving the member cost share**.

- **Ends May 31, 2020**. The member's contractual cost share for telehealth services will apply on claims for dates of service on and after June 1, 2020. This includes telehealth visits with in-network providers who offer these services and visits through BlueCare.

- **During this timeframe providers should not collect any money from the member for these services. Blue Cross will pay our members' cost share on telehealth claim payments with the exception of the self-insured employer groups that are not waiving the member cost share.**

Visit iLinkBlue (**www.BCBSLA.com/ilinkblue**) message board for the list of self-insured employer groups that are **NOT** waiving the member cost share

Chiropractic Telehealth Temporary Expansion

The **temporary** expansion of telehealth policies includes Chiropractic services, effective for dates of service on and after March 16, 2020 and will continue to be in effect until we are past the national emergency. Blue Cross will notify providers when the expanded telehealth policies are no longer effective.

The following criteria also apply:

- In-network providers can deliver telehealth services through audio/video visits or by phone. As a reminder, chiropractors delivering telehealth services must continue to follow the billing and coding guidelines in Section 5.8 Chiropractic and Physical Medicine Services from our provider manual.

- Chiropractors may provide telehealth services to replace office visits, but the CPT® code billed should match the documentation of services provided in the medical record

- Services that require physical contact, manipulation, mechanical traction or massage therapy are not eligible for telehealth

- Provider must agree to Blue Cross' allowable charges

- Provider must fully document the encounter in the patient's medical record

- Provider must use either HIPAA-compliant or Health and Human Services Office of Civil Rights approved non-public facing platforms for telehealth services

The guidelines are outlined in our *Professional Provider Office Manual*, available online at **www.BCBSLA.com/providers** >Resources

Chiropractic Telehealth Guidelines

Billing Guidelines for Chiropractors:

- Telehealth claims should include the place of service code typically used by the chiropractor (e.g.,11) along with Modifier GT or 95

- Therapeutic procedures 97110, 97112, 97116, 97530 and 97535 are acceptable for telehealth services; however, they are excluded for telephone-only as it would be necessary to visually observe the patient

- For established patient office visits, the following CPT® codes are acceptable: 99211, 99212, 99213, 99214 and 99215

- For new patient office visits, the following CPT codes are acceptable: 99201, 99202, 99203, 99204 and 99205

Please refer to the evaluation and management (E&M) visit guidelines on p. 5.8-7 as well as p. 5.37-5 and p. 5.37-6 of our *Professional Provider Office Manual*

Telehealth Temporary Therapy Services

Until we are past the COVID-19 national emergency, any credentialed network physical, occupational or speech therapist can provide limited telehealth encounters to replace office visits. Blue Cross will notify providers when the expanded telehealth policies are no longer effective.

- Therapy providers filing claims for telehealth should use standard office billing practices and CPT codes along with a place of service code 11 and Modifier GT or 95 and must continue to adhere to the billing and coding outlined in Section 5.8 Chiropractic and Physical Medicine Services guidelines of our *Professional Provider Office Manual*

- Telehealth therapy services are limited to the following CPT® codes: 97161, 97162, 97164, 97110, 97112, 97116, 97530, 97535, 97165, 97166, 97168, 92507, 92521, 92523, 92524, 92610, 96105, 92522, 92526

- Blue Cross will not reimburse telehealth services for CPT codes 97163 and 97167 due to their complexity requiring a face-to-face encounter and examination

Facility Outpatient Therapy Telehealth Services

- The **temporary** expansion to our telehealth services also includes outpatient physical, occupational or speech therapy services delivered within credentialed network facilities as telehealth visits. This is effective for dates of service on and after March 16, 2020 and will remain in effect until we are past the novel coronavirus (COVID-19) national emergency. Blue Cross will notify providers when the expanded policies are no longer effective.

- The following criteria apply for outpatient therapy telehealth services:

  - Providers must operate within the scope of their license to deliver therapy services through telehealth encounters and must accept Blue Cross' allowable charges

  - The telehealth visit must be fully documented in the patient's medical record

  - Services must be provided using a non-public-facing platform for telehealth services that is either HIPAA-compliant or approved by the Health and Human Services Office of Civil Rights

  - Outpatient hospital claims for therapy telehealth services should indicate the appropriate CPT®/HCPCS code, along with Modifier GT or 95

  - Please refer to the previous slide on Telehealth Temporary Member Cost Share Waiver information related to this policy

Temporary Telephone-only Telehealth Services

Our telehealth policies were also expanded for telephone (audio-only) encounters as a replacement for office visits effective for dates of service on and after March 16, 2020. These policies will remain in effect until we are past this crisis. Blue Cross will notify providers when the expanded policies are no longer effective.

Credentialed network providers are allowed to bill office visit telephone encounters as follows:

- Claims for telehealth services delivered by telephone should include the place of service code typically used by the provider (e.g., 11), along with Modifier GT or 95

- Doctors, nurse practitioners, physician assistants and chiropractors can bill office visits for new patients using CPT codes 99201-99205. They can bill office visits for established patients using 99211-99215.

- Behavioral health specialists (psychiatrists, psychologists, licensed professional counselors and social workers) and registered dietitians can bill using their normal service codes for office visits

- Encounters must be fully documented in the patient's medical record

- Text messages and emails do not meet the complexity of services required for reimbursement

- Blue Cross will not reimburse calls for the sole purpose of one or two of the following: triaging patients, following up on test results, obtaining referrals to specialists, ordering tests, medication refills or other minimal services typically handled by physician offices through a routine telephone call

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

Telehealth Temporary Expansion - Preventative Medicine

Blue Cross Preventive Medicine Temporary Telehealth Policies

During the COVID-19 crisis, credentialed network providers can deliver telehealth services through audio/video visits or by phone-only as a replacement for office visits. **Telehealth encounters for preventive medicine services are encouraged to be delivered as audio/video visits**.

- This is effective for dates of service on and after March 16, 2020 and will remain in effect until we are past the novel coronavirus (COVID-19) national emergency. Blue Cross will notify providers when the expanded policies are no longer effective.

- Please refer to the previous slide on Telehealth Temporary Member Cost Share Waiver information related to this policy

- Provider must adhere to the telehealth guidelines in the provider manual and agree to Blue Cross' allowable charges

- Services must be provided using a non-public-facing platform for telehealth services that is either HIPAA-compliant or approved by the Health and Human Services Office of Civil Rights

- Telehealth encounters must be fully documented in the patient's medical record

Telehealth Preventative Medicine services

- There are many components to the preventive medicine exam that are not possible through a telehealth encounter. Providers are asked to close all care gaps when the patient can be seen through a face-to-face encounter later in the year. Examples include:

  - Blood pressure measurement

  - Retinal exam in a diabetic patient

  - Providing immunizations

  - Critical exam components for children under two years and mapping growth chart progress

  - Labs and other tests typically done during a preventive health exam

- Telehealth claims for preventive medicine visits should include the place of service code typically used by the provider (e.g., 11), along with Modifier GT or 95

- Providers operating within the scope of their license to deliver preventive medicine E&M services are allowed to bill these services as telehealth visits

- For new patient visits, CPT® codes 99381-99387 are allowed for telehealth. For established patient visits, CPT codes 99391-99397 are allowed for telehealth.

iLinkBlue Enhancements

Digital ID Cards in iLinkBlue

Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Coverage Information" menu option, then click "ID Card"

Members Can Access Their Digital ID Cards

Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal:

- To access through the Blue Cross mobile app, log on and choose the "My ID Card" option on the front page and use the dropdown menu to choose from the ID cards available

- To access through the Blue Cross member portal, log into the online member account at **www.BCBSLA.com**. There, click on "My ID Card" and use the dropdown menu to choose from ID cards available. These cards can be downloaded as PDFs and saved.
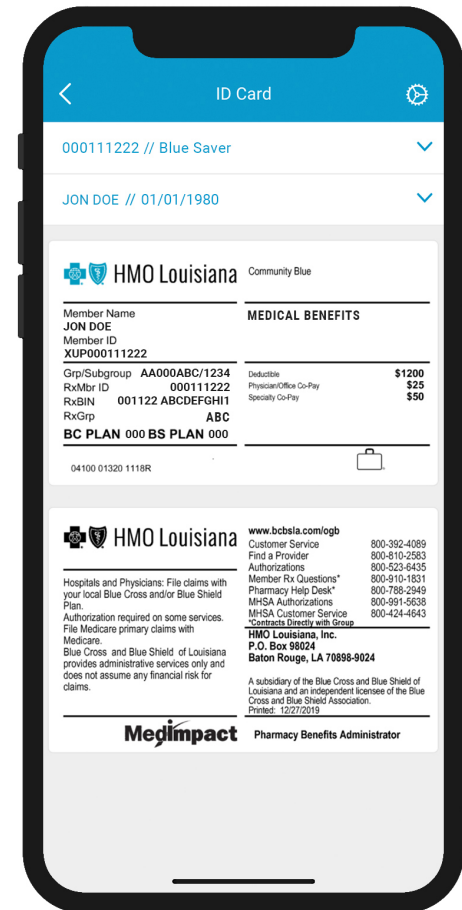
Document Upload Feature

We now offer a feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments

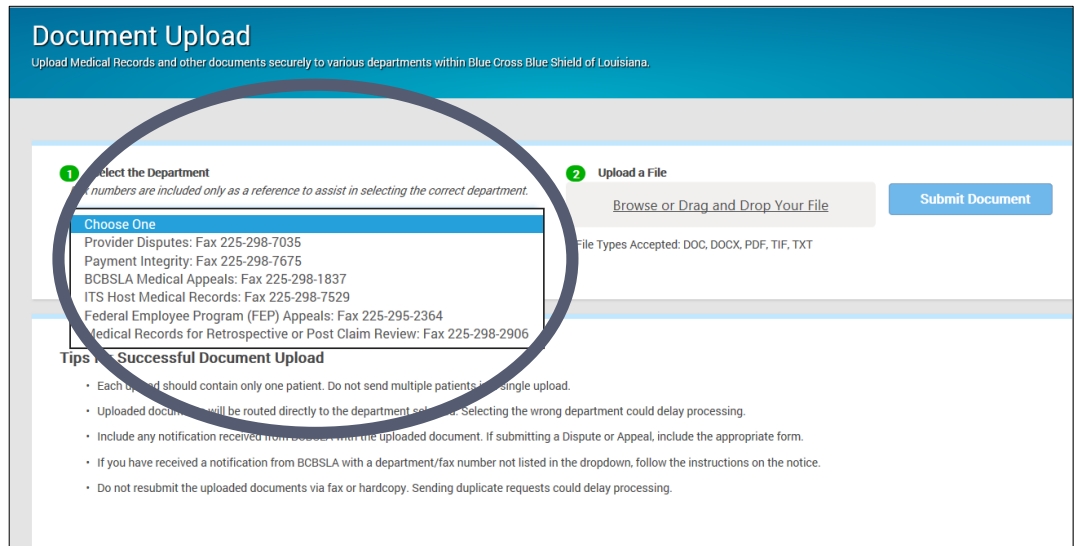The new feature is quick, secure and available at any time through the iLinkBlue provider portal
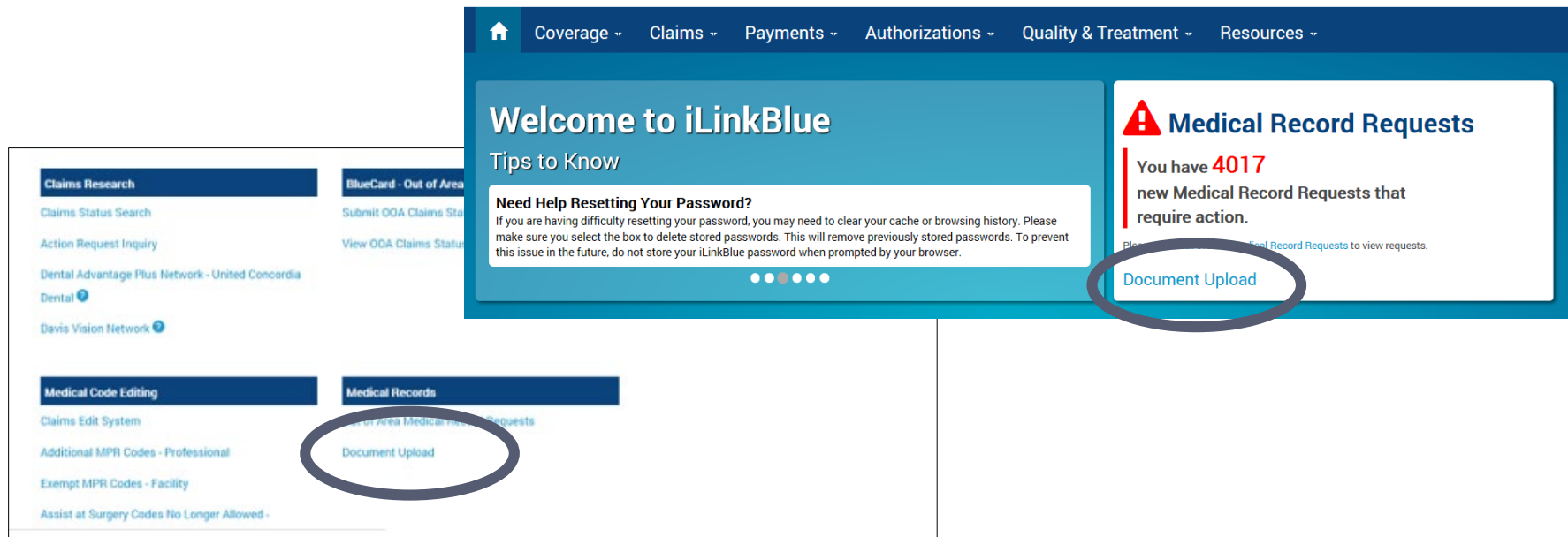
The Document Upload feature can be accessed on iLinkBlue (**www.BCBSLA.com/ilinkblue**) or under Claims >Medical Records >Document Upload

Document Upload Feature

Select the department from the drop down list you wish to send your document. The fax numbers are included only as a reference to assist in selecting the correct department.

- Provider Disputes
- Payment Integrity
- BCBSLA Medical Appeals
- ITS Host Medical Records
- Federal Employee Program (FEP) Appeals
- Medical Records for Retrospective or Post Claim Review

Document Upload
Upload Medical Records and other documents securely to various departments within Blue Cross Blue Shield of Louisiana.

1 Select the Department
Fax numbers are included only as a reference to assist in selecting the correct department.

Choose One
Provider Disputes: Fax 225-298-7035
Payment Integrity: Fax 225-298-7675
BCBSLA Medical Appeals: Fax 225-298-1837
ITS Host Medical Records: Fax 225-298-7529
Federal Employee Program (FEP) Appeals: Fax 225-295-2364
Medical Records for Retrospective or Post Claim Review: Fax 225-298-2906

2 Upload a File

Browse or Drag and Drop Your File

Submit Document

File Types Accepted: DOC, DOCX, PDF, TIF, TXT

Tips for Successful Document Upload

- Each upload should contain only one patient. Do not send multiple patients in a single upload.
- Uploaded documents will be routed directly to the department selected. Selecting the wrong department could delay processing.
- Include any notification received from BCBSLA with the uploaded document. If submitting a Dispute or Appeal, include the appropriate form.
- If you have received a notification from BCBSLA with a department/fax number not listed in the dropdown, follow the instructions on the notice.
- Do not resubmit the uploaded documents via fax or hardcopy. Sending duplicate requests could delay processing.

Document Upload Feature FAQs

What should be included in the uploaded document?

Include any notification, letter or form that is required with the request along with the medical records or other documentation requested. If submitting a Dispute or Appeal, include the appropriate form.

What file types are allowed in the upload process?

DOC, DOCX, PDF, TIF, TXT

Do I need to send a fax or hard copy request in addition to upload?

No. Sending the uploaded document thru fax, email or hardcopy mail **in addition** to uploading, will result in duplicate requests being received at Blue Cross. This will delay the processing of the request.

> More details will be emailed to our providers soon with a complete list of information and FAQs

Authorizations

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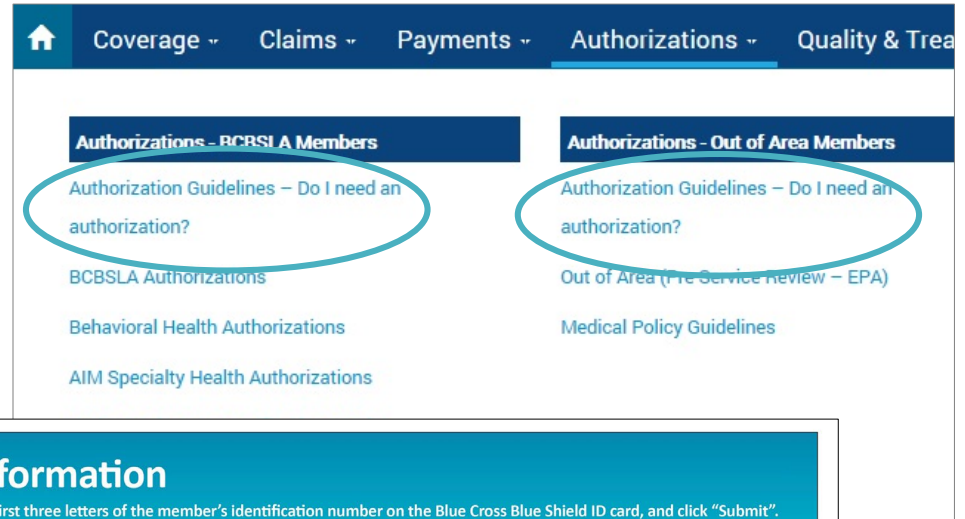
- Use the "Authorizations" menu option to access our authorization tools
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - o BCBSLA Authorizations
  - o Behavioral Health Authorizations
  - o Out of Area (Pre Service Review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

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

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)
  - o Interventional Pain Management
  - o Joint Surgery
  - o 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**.

AIM extensions - COVID Exceptions – For new authorizations requested from March 30 to June 30
- All new approved AIM authorizations are given a 90 day time span. Implemented March 30, 2020. This applies to all programs except Radiation therapy.

  - If the authorization was approved prior to March 30 and the time span has ran out, they must call and get a new authorization

- All CT's of the chest requested for known or suspected diagnosis of COVID-19 will get an auto approval by AIM. Implemented March 30, 2020. They still must request, but it will auto approve.

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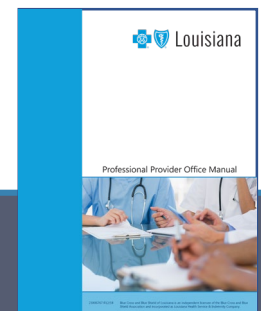
Imaging Authorizations

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

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

AIM Clinical Update

Effective **May 17, 2020**, AIM Specialty Health® (AIM) updated clinical appropriateness guidelines in the following areas:

- Vascular imaging
- Musculoskeletal (MSK) joint surgery

The full details for these new guidelines and all AIM appropriate-use criteria are available online at **www.aimspecialtyhealth.com**. Click "Download now" then choose the appropriate guidelines section

OptiNet Registration Tool in iLinkBlue

- AIM Specialty Health® offers **OptiNet**® an online registration tool that gathers information about the technical component capabilities of diagnostic imaging services and calculates provider scores based on self reported information

- Through this tool, we can offer members and their ordering providers the option to "shop" for quality, lower-cost diagnostic imaging services

- Without an OptiNet score, you miss out on this opportunity for exposure to Blue members

Why Is Your Score So Important?

- For any provider who performs imaging services and does not complete an assessment, a score will not be part of our benchmarking, meaning the provider will not be included in transparency programs such as our shopper program or future reimbursement incentives

OptiNet Registration Tool in iLinkBlue

How Is Your Score Calculated?

- The site score measures basic performance indicators that are applicable for the facility, such as general site access, quality assurance and staffing

- The modality specific scoring is based on indicators such as MD certification, technologist certification, modality accreditation and equipment quality

How to Access OptiNet?

- Log into iLinkBlue (**www.BCBSLA.com/ilinkblue**)

- Click on the "Authorizations" menu option Click on the "AIM Specialty Health Authorizations" link; this link takes you to the AIM ***Provider****Portal*$_{SM}$

- Click on "Access Your OptiNet Registration" on the left menu bar

- Click the green "Access Your OptiNet Registration" button

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:

  o Using iLinkBlue to access our online authorization portal, or

  o 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 Authorizations

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 Authorizations

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 Authorizations

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

- 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

Find a copy of the OGB Speed Guide at
www.BCBSLA.com/providers >Resources >Speed Guides

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

Temporary Authorizations

An authorization is required for many services. While authorizations are still required for those services, we are automatically approving all services related to the diagnosis or treatment of COVID-19 without medical review.

- This change applies to inpatient and outpatient services

- This automatic approval will be triggered by including the appropriate ICD-10 code for COVID-19:
    - B97.29 for dates of service prior to April 1, 2020
    - U07.1 for dates of service on and after April 1, 2020

Providers can electronically submit authorization requests for BCBSLA members through iLinkBlue (**www.BCBSLA.com/ilinkblue**) using our BCBSLA Authorizations tool under the "Authorizations" menu option, or you can call the number on the member ID card

Temporary Authorization Requirements for hospitals

We have implemented temporary changes to our authorization requirements for our credentialed Louisiana, participating facilities for emergent care. These updated provisions do not apply for non-participating and/or out of state facilities. They are effective for dates of service **March 16 to May 31, 2020**.

For initial inpatient admissions and acute hospital to acute hospital transfers:

- Continue to notify Blue Cross—upon admission—of basic patient information using the normal process you use today (BCBSLA Authorizations tool, authorizations number on the Member ID card or via fax)

- Blue Cross' Utilization Management staff will enter information into the system and authorize all admissions for seven days without a medical review

- At the end of seven days we will verify continued hospital stay and authorize additional days through discharge date without a medical review

- We are suspending concurrent record review, including for patients admitted prior to March 16, 2020

Temporary Authorization Requirements for hospitals

Non –Emergent Hospitalizations:

- Authorizations for non-emergent hospitalization (scheduled admissions for elective procedures) must be prior authorized if benefits require authorizations

Behavioral Health authorizations:

- Authorization for behavioral health services (inpatient admissions, IOP, PHP, RTC and ABA services) must be prior authorized

Transplant services:

- Transplant services must be prior authorized

Temporary Change for Transfer Authorizations

Transfers from an Acute Care Hospital to an LTACH, SNF or Inpatient Rehabilitation Facility (effective for dates of service March 16 to May 31, 2020)

- Blue Cross is **temporarily** suspending the requirement to obtain authorization to move patients from an acute care inpatient setting to a credentialed Louisiana participating LTACH, SNF or inpatient rehabilitation facility setting. The following applies:

    o The receiving facility should notify Blue Cross of the admission within 24 hours. We will automatically approve a three-day stay for the receiving facility.

    o Blue Cross will work with the receiving facility to perform a concurrent review by day four and authorize appropriate continued stay based on medical necessity

COVID-19 Provider Resources Page

Since March 2020, we have been making provisions to help our providers as they work tirelessly to treat patients

Visit **www.BCBSLA.com/providers**, then click on the link at the top of the page to get more information on the provisions we have put in place for:

- Authorizations

- Telehealth

- Billing & Coding Guidelines

- Credentialing & Provider Data Management

- Quality Blue

Check this page often, as we are constantly updating it with new information

Claims Editing System

Claims Editing Software

- We updated to a new claims editing software (CES) system that launched on July 27, 2019

- It applies edits to incoming claims to ensure proper coding and billing based on:
  - Reimbursement
  - Medical policy
  - Benefit rules
  - Industry standard and coding guidelines

- It promotes accurate and consistent payments

- It manages compliance with standard coding and billing practice between various types of services, such as:
  - Medical
  - Surgical
  - Lab and radiology

Claims Editing Software

Not Separately Reimbursable

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

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

New Patient Visit

- New visit codes, (e.g., 99201-99205), will deny if the patient has been seen by the same provider within three years from the date of the previous services

Multiple Procedure Reduction

- Additional multiple procedure reduction codes have been updated

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

A listing of the additional Multiple Procedure Reduction codes can be found on iLinkBlue **www.BCBSLA.com/ilinkblue** >Claims >Additional MPR Codes – Professional

Rebundles

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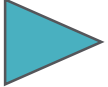
Examples:

80053 84443 85025	▶ 80050		
73560 73562	▶ 73564		

85025
86592
86762
86850
86900
86901
87340 ▶ 80055

85025
86592
86762
86850
86900
86901
87340
89389 ▶ 80081

Claims Editing System Tool

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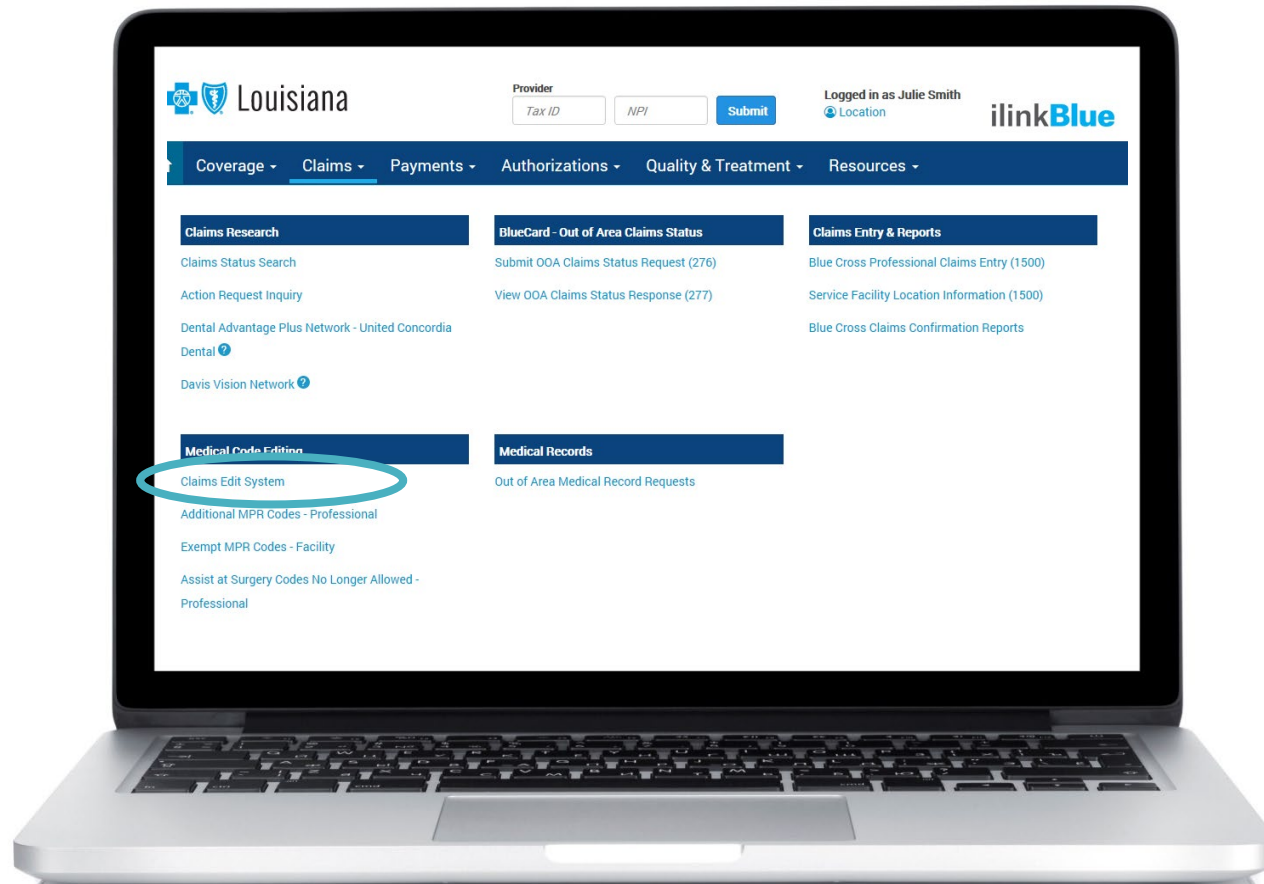
Claims Editing System Tool

This tool does not guarantee claims payment

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

- Historical claims previously billed

- Units billed

- Global day edits for procedures

- Multiple procedure reduction

- Member benefits and eligibility

- Provider contracts

- Modifiers that override edits

Claims Editing System Tool

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

CES Tool Mandatory Fields

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

CES Inquiry

- Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code. (CES edits will appear in lower case.)

- Submit an action request

- In order to properly route your inquiry please choose "**Code Editing Inquiry**" from the action drop down box when submitting your action request

- Please include your contact information

- Be specific and detailed

- Allow up to 15 working days for a response to each request

- Check in "Action Request Inquiry" for a response

- A second request may be submitted if there was no resolution

Questions?

Appendix

Future Webinars

- BlueCard
  - October 21, 2020

- New to Blue Cross (Facility & Professional)
  - November 18, 2020

- Provider Credentialing & Data Management
  - August 5, 2020
  - November 4, 2020

**Invitations for these webinars will be sent closer
to the webinar dates**

Provider Page
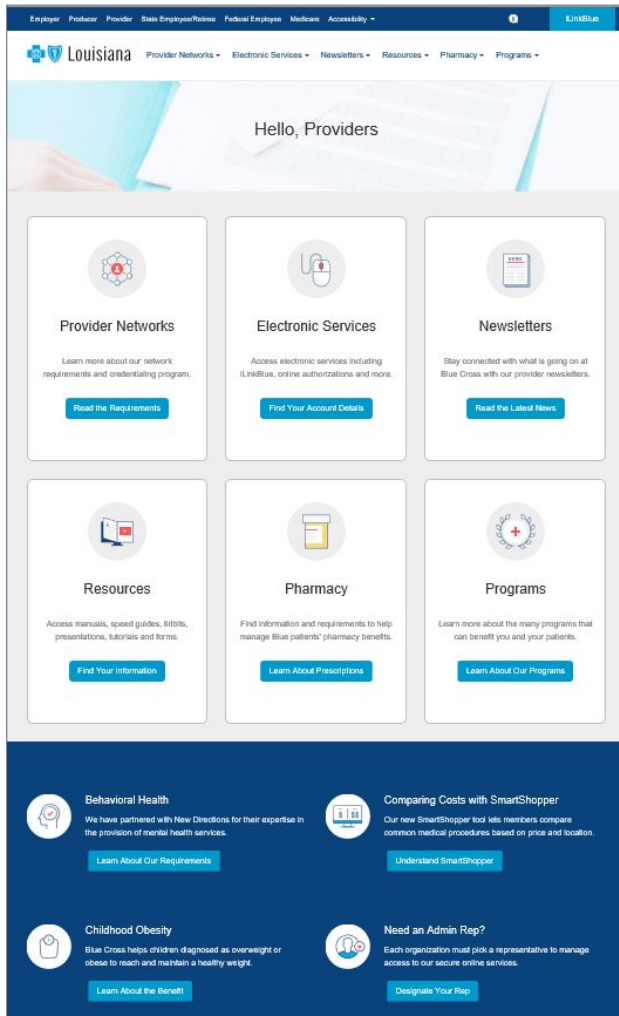
www.BCBSLA.com/providers

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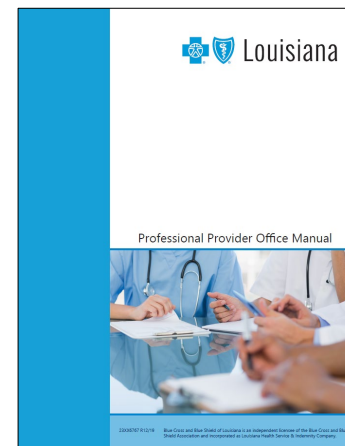
Our provider **newsletters**, contain information and tips on changes to processes, such as claims filing procedures or reimbursement changes, along with a number of featured articles

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

Speed guides offer quick reference to network authorization requirements, policies and billing guidelines

www.BCBSLA.com/providers
>Resources >Speed Guides

Provider tidbits are quick guides designed to help you with our current business processes

www.BCBSLA.com/providers
>Resources >Tidbits

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, 2020**

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 manager

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

Shelton Evans director **– shelton.evans@bcbsla.com**

Jode Burkett manager **– jode.burkett@bcbsla.com**

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

Ashley Wilson – **ashley.wilson@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

Shannon Taylor – **shannon.taylor@bcbsla.com**
Special Network Development Projects

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

Doreen Prejean   Mary Landry   Karen Armstrong

Provider Credentialing & Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Mary Reising Manager – **mary.reising@bcbsla.com**

Anne Monroe Provider Information Supervisor - **anne.monroe@bcbsla.com**

Rhonda Dyer Provider Information Supervisor - **rhonda.dyer@bcbsla.com**

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Provider Credentialing & Data Management Department by emailing **PCDMstatus@bcbsla.com** or by calling 1-800-716-2299

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

Annual Provider Survey

We value your input!

- As a result of the 2019 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.
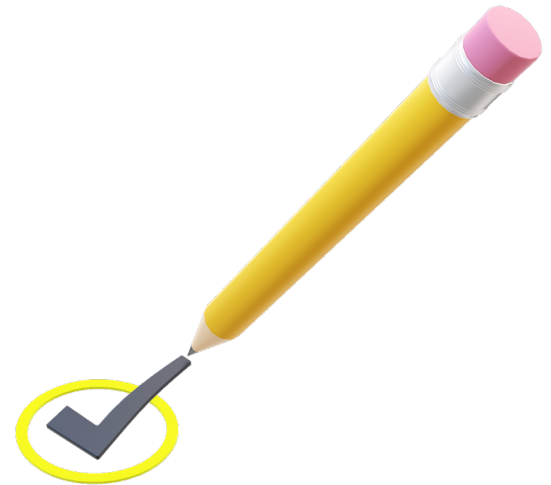
Remember to take our Provider Survey later this year!