Facility Workshop

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform.

How to submit questions:

- Open the chat feature at the bottom of your screen to type your question related to today's training webinar.
- In the "Send to" field, select "All Hosts and Panelists."
- Once your question is typed in, hit the "Send" button to send it to the presenter.
- We will address submitted questions at the end of the webinar.

Blue Cross and Blue Shield of Louisiana

FACILITY WEBINAR

FALL 2021

Louisiana

Draft 9/23/2021

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

Jami Zachary

Anna Granen

Patricia O' Gwynn

Mary Guy

Lisa Roth

Marie Davis

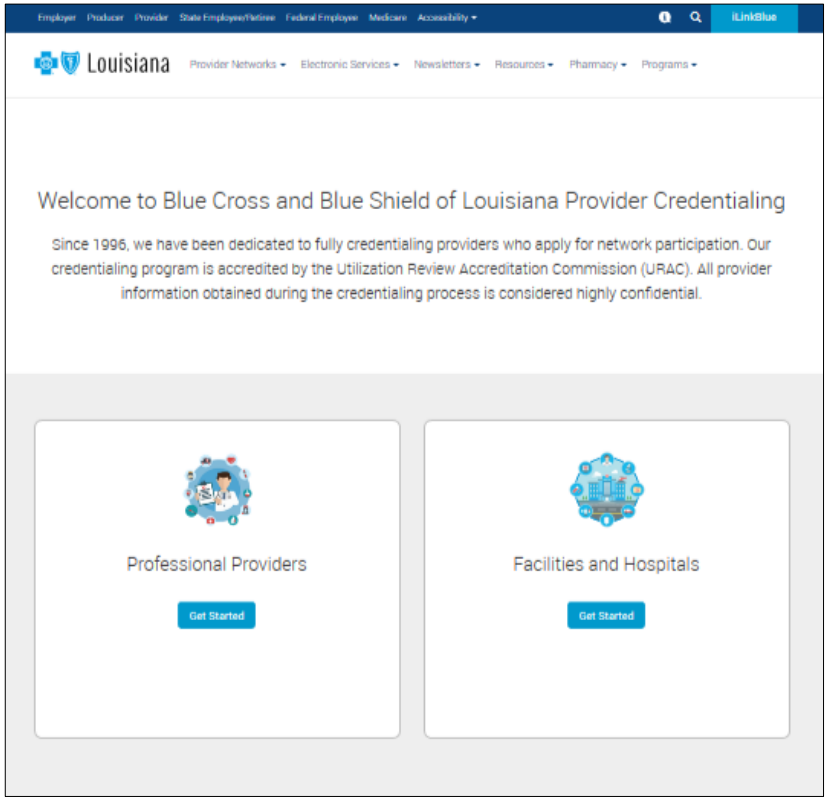
Melonie Martin

Agenda

Provider Credentialing & Data Management

Join Our Networks

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.



Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:

- Credentialing packets
- Quick links to the Provider Update Request Form
- Credentialing criteria for professional, facility and hospital-based providers
- Frequently asked questions

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

Credentialing Process

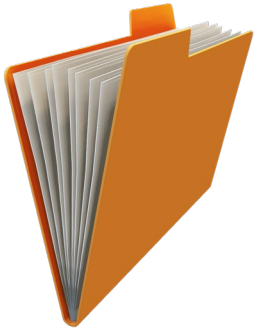
- The credentialing process can take up to 90 days after all required information is received.
- **Providers will remain non-participating in our networks until a signed and executed agreement is received by our contracting department.**
- The committee approves credentialing twice per month.
- Network providers are recredentialed every three years from their last credentialing acceptance date.

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

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.

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 - Facility

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

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

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

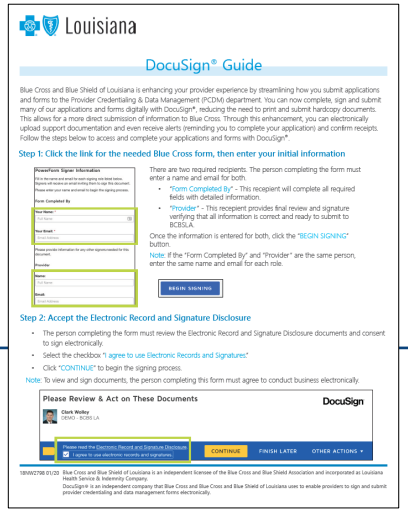
Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

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.


Louisiana

DocuSign® Guide

Blue Cross and Blue Shield of Louisiana is enhancing your provider experience by streamlining how you 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®, reducing the need to print and submit hardcopy documents. This allows for a more direct submission of information to Blue Cross. Through this enhancement, you can electronically upload support documentation and even receive alerts (reminding you to complete your application) and confirm receipts. Follow the steps below to access and complete your applications and forms with DocuSign®.

Step 1: Click the link for the needed Blue Cross form, then enter your initial information

There are two required recipients. The person completing the form must enter a name and email for both.

- "Form Completed By" - This recipient will complete all required fields with detailed information.
- "Provider" - This recipient provides final review and signature verifying that all information is correct and ready to submit to BCBSLA.

Once the information is entered for both, click the "BEGIN SIGNING" button.

Note: If the "Form Completed By" and "Provider" are the same person, enter the same name and email for each role.

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

- The person completing the form must review the Electronic Record and Signature Disclosure documents and consent to sign electronically.
- Select the checkbox "I agree to use Electronic Records and Signatures."
- Click "CONTINUE" to begin the signing process.

Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

Please Review & Act on These Documents

DocuSign

Clark Wolley

DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure

I agree to use electronic records and signatures.

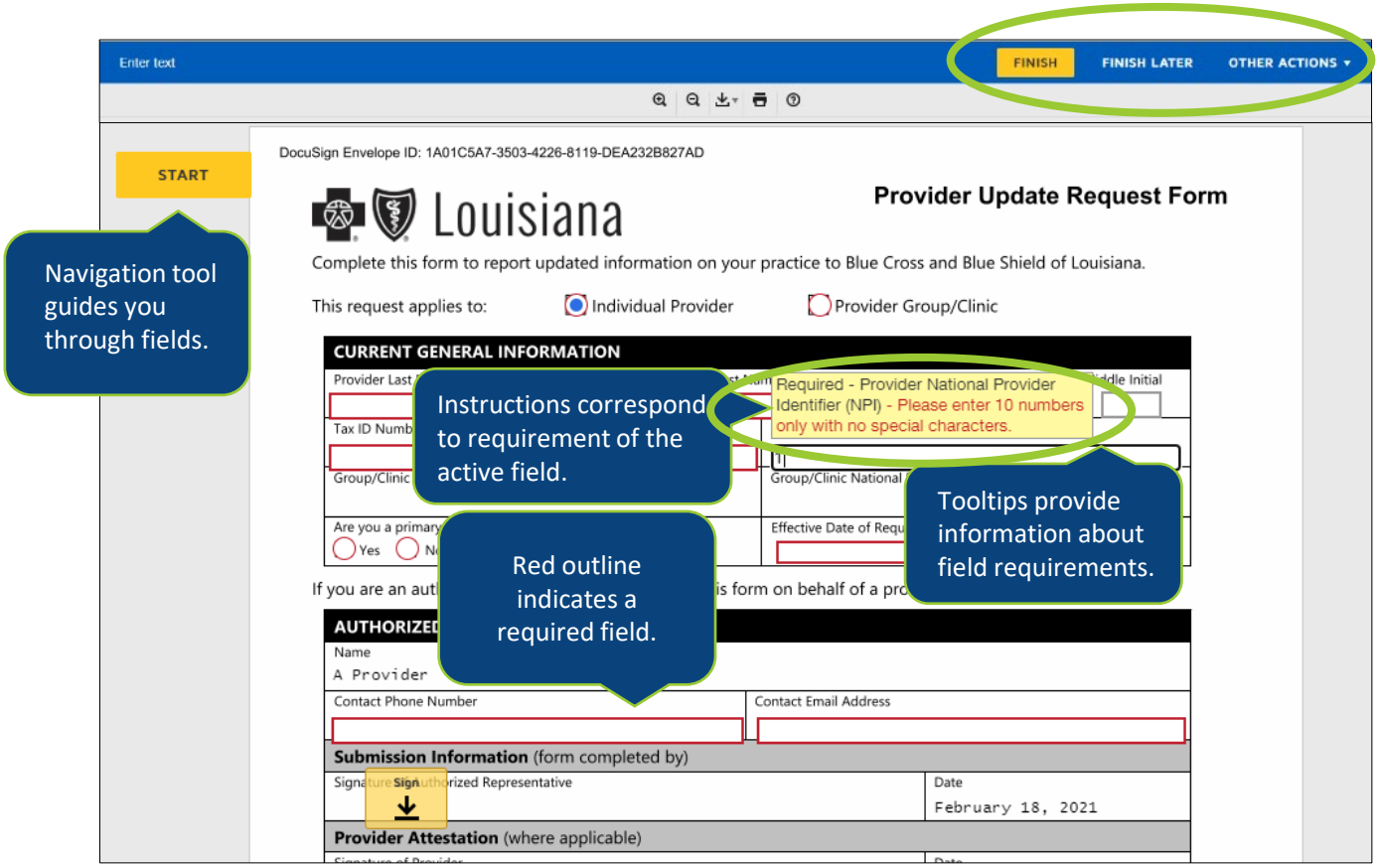
CONTINUE FINISH LATER OTHER ACTIONS

18WZ2708 01/23 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.

DocuSign® is an independent company that Blue Cross and Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

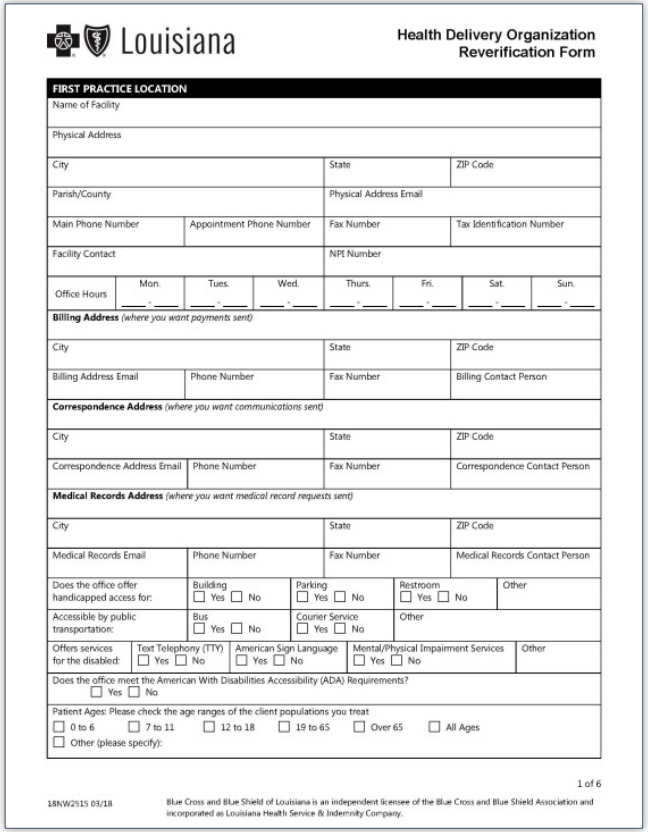
To help with this transition, we created a DocuSign guide that is available online at **www.BCBSLA.com/providers** >Provider Networks >Facilities and Hospitals >Join Our Networks.

Easily Complete Forms with DocuSign



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

Required Recredentialing Documents



Louisiana

Health Delivery Organization
Reverification Form

FIRST PRACTICE LOCATION

Name of Facility							
Physical Address							
City			State		ZIP Code		
Parish/County			Physical Address Email				
Main Phone Number	Appointment Phone Number		Fax Number		Tax Identification Number		
Facility Contact			NPI Number				
Office Hours	Mon. ___ - ___	Tues. ___ - ___	Wed. ___ - ___	Thurs. ___ - ___	Fri. ___ - ___	Sat. ___ - ___	Sun. ___ - ___
Billing Address *(where you want payments sent)*							
City			State		ZIP Code		
Billing Address Email	Phone Number		Fax Number		Billing Contact Person		
Correspondence Address *(where you want communications sent)*							
City			State		ZIP Code		
Correspondence Address Email	Phone Number		Fax Number		Correspondence Contact Person		
Medical Records Address *(where you want medical record requests sent)*							
City			State		ZIP Code		
Medical Records Email	Phone Number		Fax Number		Medical Records Contact Person		
Does the office offer handicapped access for:	Building ☐ Yes ☐ No		Parking ☐ Yes ☐ No		Restroom ☐ Yes ☐ No	Other	
Accessible by public transportation:	Bus ☐ Yes ☐ No		Courier Service ☐ Yes ☐ No		Other		
Offers services for the disabled:	Text Telephony (TTY) ☐ Yes ☐ No		American Sign Language ☐ Yes ☐ No		Mental/Physical Impairment Services ☐ Yes ☐ No	Other	
Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No							
Patient Ages: Please check the age ranges of the client populations you treat ☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages ☐ Other (please specify):							

1 of 6

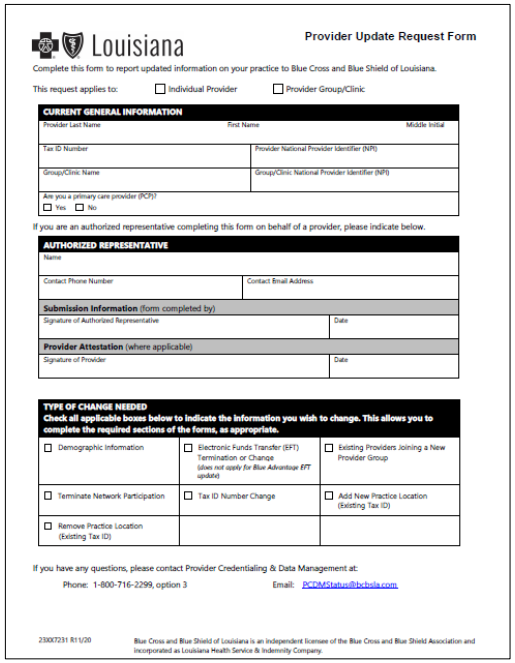
18NW2515 03/18

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.

- Current network providers are required to be recredentialed every 36 months and should use our **Health Delivery Organization Reverification Form**.
- This application is part of the facility (reverification) packet.
- Our Reverification application is now emailed to the correspondence email on file. Included in the email is a link to begin completing your reverification form. Once completed and signed, it will be submitted to Blue Cross via DocuSign.

How to Update Your Information

Maintaining information within your provider record is a key piece to participating in Blue Cross and Blue Shield of Louisiana provider networks or obtaining a provider record. It is important that you keep us abreast of any changes to the information in your record. This allows us to keep our directories current, contact you when needed as well as disperse payments. These forms are in DocuSign format, allowing you to easily submit them to Blue Cross electronically.



Louisiana

Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana.

This request applies to: ☐ Individual Provider ☐ Provider Group/Clinic

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Group/Clinic Name | Group/Clinic National Provider Identifier (NPI)

Are you a primary care provider (PCP)? ☐ Yes ☐ No

If you are an authorized representative completing this form on behalf of a provider, please indicate below.

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

Submission Information (form completed by)

Signature of Authorized Representative | Date

Provider Attestation (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change (does not apply for Blue Advantage EFT update)	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

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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.

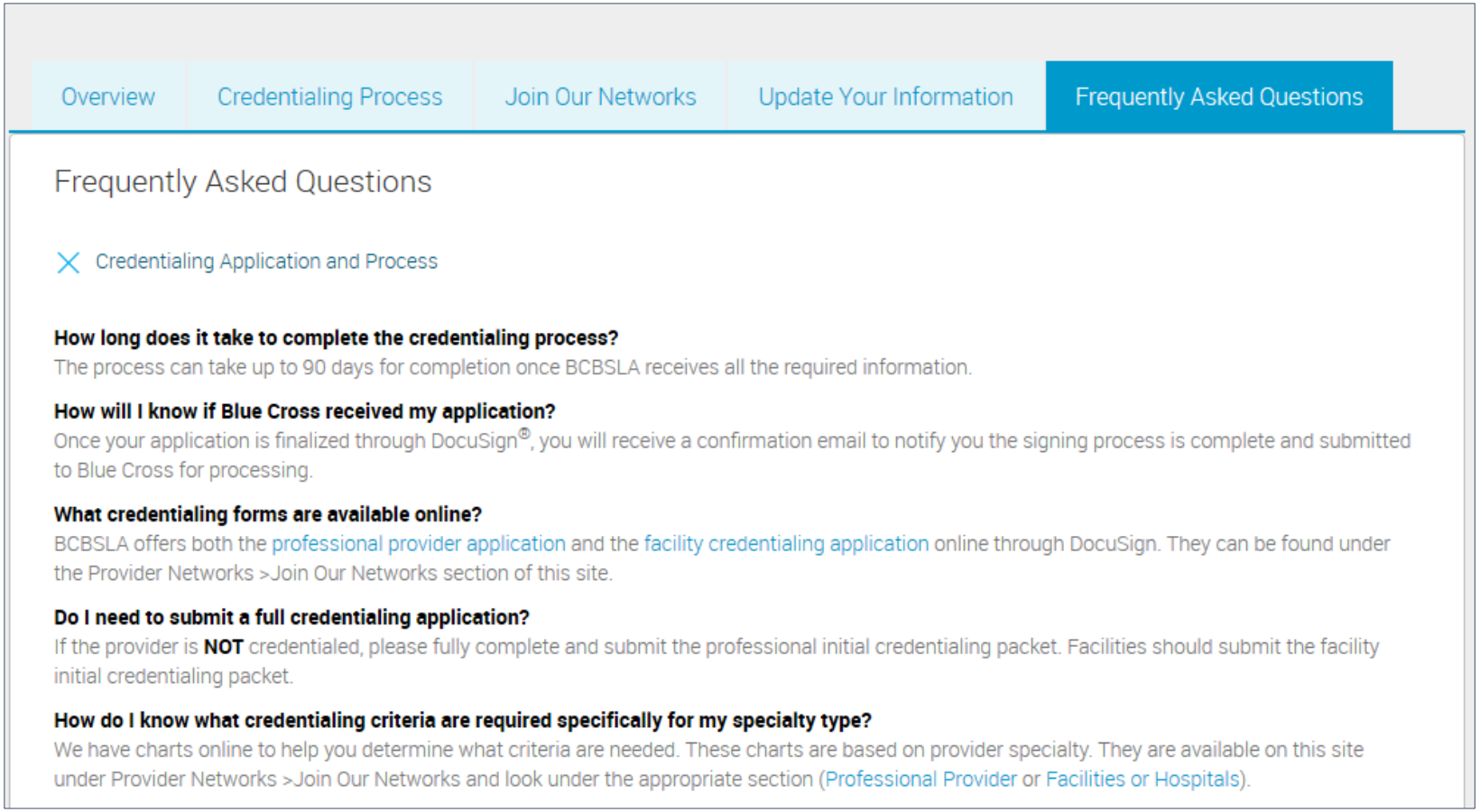
What changes do you need to make?

Provider Update Request Form – to update information such as:

- Demographic Information – for updating contact information.
- Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group.
- Add Practice Location – to add a practice location(s).
- Remove Practice Location – to remove a practice location(s).
- Tax Identification Number (TIN) Change – to change your Tax ID number.
- Terminate Network Participation – to terminate existing network participation or an entire provider record.
- EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method.

Submit these forms online at **www.BCBSLA.com/providers** >Provider Networks >Facility and Hospitals >Update Your Information.

Frequently Asked Questions



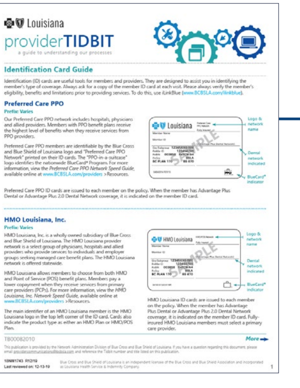
A list of FAQs are available at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks >Facilities and Hospitals >Frequently Asked Questions.

Our Networks

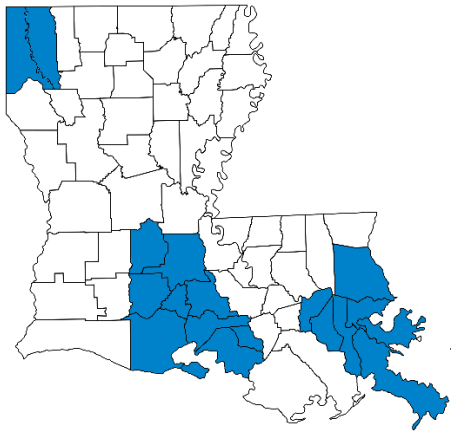
Our Provider Networks

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

Shreveport area

Bossier and Caddo parishes

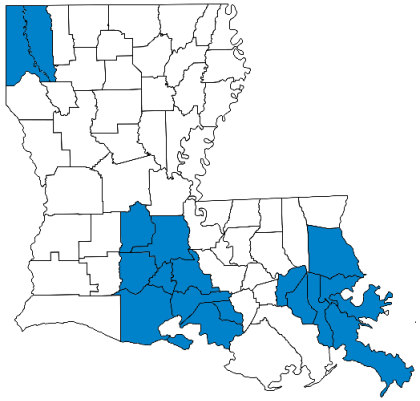
COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks

NEW NETWORK 2021



BLUEHPN

Lafayette area

Acadia, Evangeline, Iberia, Jefferson, Lafayette parishes

Shreveport area

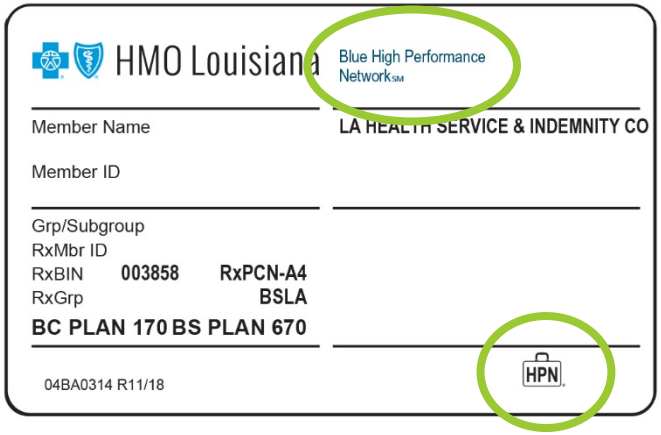
Bossier and Caddo parishes

New Orleans area

Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany and Vermilion parishes

BlueHPN members are identifiable by the HPN in a **suitcase logo** in the bottom right-hand corner of the card.

HPN®



Our Provider Networks

PRECISION BLUE

Baton Rouge area

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

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans 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

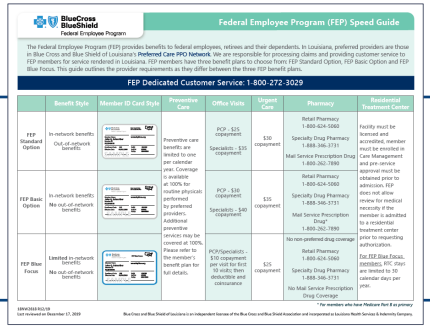
- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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

New Timely Filing guidelines:
In Network PPO providers must file claims within 15 months of the Date of Service.

An FEP Speed Guide is available at
www.BCBSLA.com/providers >Resources >Speed Guides.


BlueCross BlueShield
Federal Employee Program

Federal Employee Program (FEP) Speed Guide

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

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

	Benefit Style	Member ID Card Style	Preventive Care	Office Visits	Urgent Care	Pharmacy	Residential Treatment Center
FEP Standard Option	In-network benefits Out-of-network benefits		Preventive care benefits are limited to one per calendar year. Coverage is available at 100% for routine physicals performed by preferred providers. Additional preventive services may be covered at 100%. Please refer to the member's benefit plan for full details.	PCP - $25 copayment Specialists - $35 copayment	$50 copayment	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug 1-800-262-7890	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 a residential treatment center prior to requesting authorization.
FEP Basic Option	In-network benefits No out-of-network benefits			PCP - $30 copayment Specialists - $40 copayment	$35 copayment		
FEP Blue Focus	Limited in-network benefits No out-of-network benefits			PCP/Specialists - $30 copayment per visit for first 10 visits; then deductible and coinsurance	$35 copayment	No non-preferred drug coverage Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 No Mail Service Prescription Drug Coverage	For FEP Blue Focus members, PPC stays are limited to 30 calendar days per year.

* For members who have Medicare Part B as primary

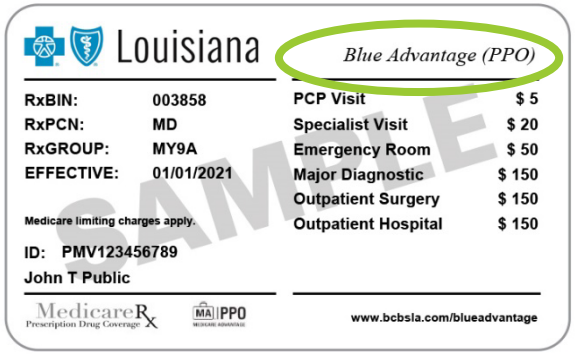
Last reviewed on December 17, 2019

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

Our Blue Advantage Networks

NEW PREFIXES FOR 2021

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



Prefix: PMV

Prefix: MDV

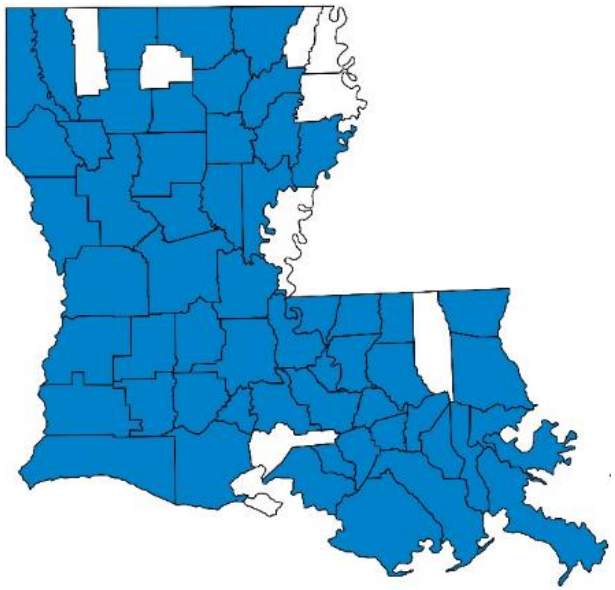
Our Provider Networks

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)

Statewide with the exception of the following parishes:

- Concordia
- East Carroll
- Iberia
- Lincoln
- Madison
- Tangipahoa
- Webster
- West Carroll



Healthy Blue

Healthy Blue contact:
Provider Relations Hotline: **1-504-836-8888**
Provider Relations Inbox: **LAinterPR@HealthyBlueLA.com**

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.

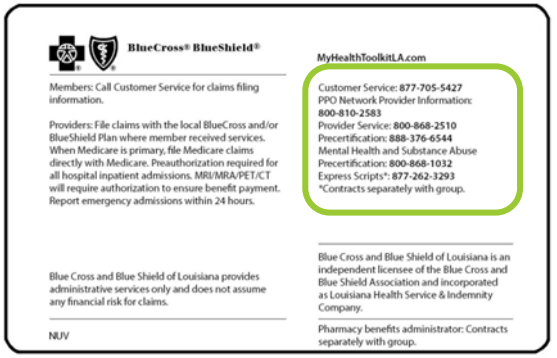
- The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

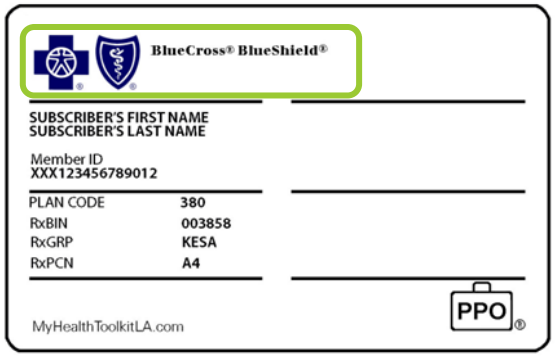
- The HPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) product.

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.





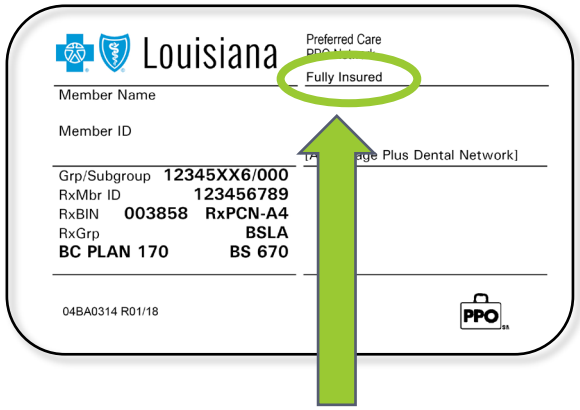
This list of prefixes is available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-funded

Member ID Card Differences

FULLY INSURED

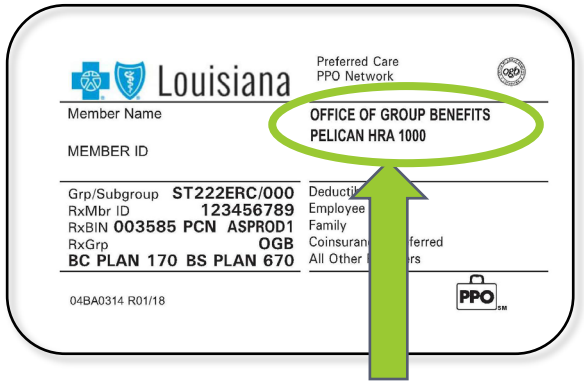
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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**).

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 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.

If a provider continues to refer patients to out-of-network providers, their entire fee schedule could be reduced.

New Billing Requirements

COVID-19 Vaccination Billing

- Administration costs for the COVID-19 vaccines listed below are eligible for Blue Cross payment.
- Properly billed multiple dose vaccinations should include the first and second administration code.
- Providers should not bill Blue Cross for CPT® codes 91300, 91301, 91302 and 91303. The federal government covers these COVID-19 vaccines.

Vaccine	Code Guidelines
Pfizer	• 91300 – vaccine • 0001A – first administration • 0002A – second administration • 0003A – third administration
Moderna	• 91301 – vaccine • 0011A – first administration • 0012A – second administration • 0013A – third administration
AstraZeneca	• 91302 – vaccine • 0021A – first administration • 0022A – second administration
Janssen (Johnson & Johnson)	• 91303 – vaccine • 0031A – administration (single dose)

Work Related COVID Testing

- Blue Cross covers diagnostic viral detection and antibody COVID-19 testing with a healthcare provider order. Without a medical order, the member has to pay out of pocket for the test.
- Blue Cross does **not** cover tests done for public health surveillance, or tests required to return to work or attend recreational events or groups. This includes, but is not limited to school, camps sporting events, or any other activity or venue that requires proof of a negative test.
- Do not bill Blue Cross for tests performed for elective reasons.
- If you are reading this, be the first to type “Bingo” in the chat section to win a prize.

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.

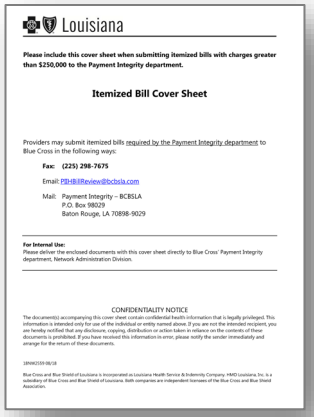
Please enter the ordering/referring provider's information for paper and electronic claims as indicated below:

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

Pre-pay Itemized Bill Review

Effective **January 1, 2021**, this limit changed to a $100,000 minimum, please follow these guidelines:

- File the claim using your usual process for filing claims; in addition, please submit an itemized bill and include the Itemized Bill Cover Sheet.
- If the itemized bill is sent via fax or email, you will receive an acknowledgement of receipt.
- We highly recommended that you send itemized bills immediately after filing the claim or before filing the claim. Claims received with a billed amount of greater than $100,000 without itemized bill information may be denied or result in delayed reimbursement.
- The itemized bill must list each service and item supplied to the member and match the dollar amount and dates of service.
- If you have questions about this claim review process, please email the Payment Integrity department at **PIIHBillReview@bcbsla.com**.


Louisiana

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

Itemized Bill Cover Sheet

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

Fax: (225) 298-7675

Email: PIIHBillReview@bcbsla.com

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

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

CONFIDENTIALITY NOTICE

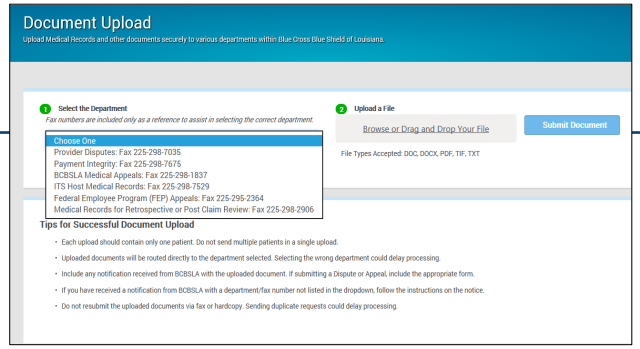
The document(s) accompanying this cover sheet contain confidential health information that is legally privileged. This information is intended only for use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution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

18NN2359-08/18

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

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

Submit your Itemized Bill Cover Sheet via the Document Upload feature on iLinkBlue **(www.BCBSLA.com/ilinkblue).**


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.

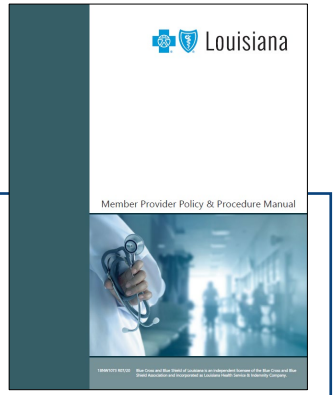
Inpatient Unbundling Policy

The inpatient unbundling policy is effective for all inpatient acute care claims received on and after January 1, 2021.

- The policy identifies supplies, items and services that should bundle with room and board charges in an inpatient setting, according to CMS guidelines. The services and supplies identified in the inpatient unbundling policy are not separately reimbursable by Blue Cross and are not billable to our members.

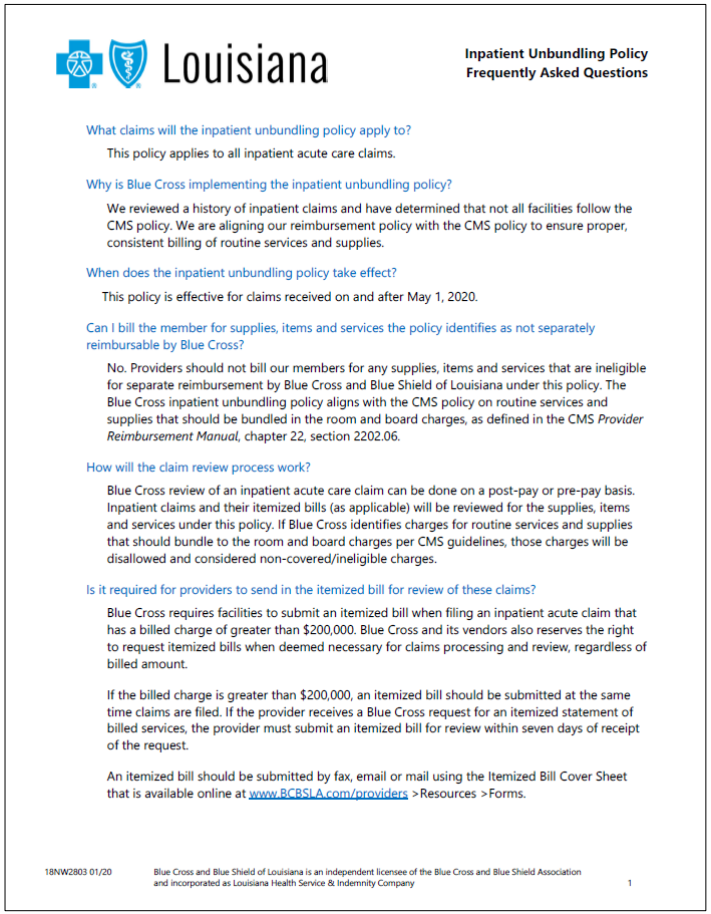
- All Blue Cross inpatient acute care claims and itemized bills could be subject to review under this policy. Upon discovery of a supply, item or service identified by the policy, the associated charge will be deemed non-covered/ineligible. Should an adjustment be required to your claim, it will be reflected on your remittance advice.

The full policy is available in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.BCBSLA.com/ilinkblue**, click on "Resources," then "Manuals"



Inpatient Unbundling Policy FAQs

For a copy of our **Inpatient Unbundling Policy Frequently Asked Questions** email **provider.relations@bcbsla.com**.



Louisiana

Inpatient Unbundling Policy Frequently Asked Questions

What claims will the inpatient unbundling policy apply to?

This policy applies to all inpatient acute care claims.

Why is Blue Cross implementing the inpatient unbundling policy?

We reviewed a history of inpatient claims and have determined that not all facilities follow the CMS policy. We are aligning our reimbursement policy with the CMS policy to ensure proper, consistent billing of routine services and supplies.

When does the inpatient unbundling policy take effect?

This policy is effective for claims received on and after May 1, 2020.

Can I bill the member for supplies, items and services the policy identifies as not separately reimbursable by Blue Cross?

No. Providers should not bill our members for any supplies, items and services that are ineligible for separate reimbursement by Blue Cross and Blue Shield of Louisiana under this policy. The Blue Cross inpatient unbundling policy aligns with the CMS policy on routine services and supplies that should be bundled in the room and board charges, as defined in the CMS *Provider Reimbursement Manual*, chapter 22, section 2202.06.

How will the claim review process work?

Blue Cross review of an inpatient acute care claim can be done on a post-pay or pre-pay basis. Inpatient claims and their itemized bills (as applicable) will be reviewed for the supplies, items and services under this policy. If Blue Cross identifies charges for routine services and supplies that should bundle to the room and board charges per CMS guidelines, those charges will be disallowed and considered non-covered/ineligible charges.

Is it required for providers to send in the itemized bill for review of these claims?

Blue Cross requires facilities to submit an itemized bill when filing an inpatient acute claim that has a billed charge of greater than $200,000. Blue Cross and its vendors also reserves the right to request itemized bills when deemed necessary for claims processing and review, regardless of billed amount.

If the billed charge is greater than $200,000, an itemized bill should be submitted at the same time claims are filed. If the provider receives a Blue Cross request for an itemized statement of billed services, the provider must submit an itemized bill for review within seven days of receipt of the request.

An itemized bill should be submitted by fax, email or mail using the Itemized Bill Cover Sheet that is available online at www.BCBSLA.com/providers >Resources >Forms.

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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

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Blue Advantage Changes

BA Transition to Vantage Health Plan

- Effective **January 1, 2021**, we transitioned our Blue Advantage primary service administrator from Lumeris Healthcare Outcomes to **Vantage Health Plan**, a Louisiana-based company.
- This new partnership allows 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.

Registration is required to gain access to the Blue Advantage Provider Portal. If you need access to the Blue Advantage Provider Portal, please reach out to your Group Moderator (Admin Rep).

Blue Advantage Claims Filing Guidelines

Date of Service	Submit to Vantage (Payor ID 72107) Blue Cross Blue Shield of Louisiana/HMO Louisiana, Inc. 130 DeSiard St. Ste 322 Monroe, LA 71201
All 2021 dates of services AND 2020 dates of service.	✓

All electronic claims must be received via Change Healthcare. Blue Advantage is unable to receive claims filed directly from any other source. Blue Advantage Customer Service 1-866-508-7145.

ASC Converting to CMS-1500 Claim form for Blue Advantage Claims

Effective October 1, 2020, submit Blue Advantage Ambulatory Surgery Center claims on a CMS-1500 claim form.

NOTE: ASC claims for non-Blue Advantage members should still be billed on a UB-04 claim form.

COVID member cost share

COVID-19 Member Cost Shares

For dates of service on or after January 1, 2021, member cost shares for our **fully insured members** was reinstituted for visits associated with the treatment of COVID-19 for all places of service.

Member cost share will continue to be waived for the following services until the applicable time periods defined in the respective state and federal laws have concluded.

Service	Requirement
Applicable for diagnosis codes U07.1, Z03.818 and Z20.822	
COVID-19 Testing (viral detection and antibody testing)	With a provider order and excluding public health, school-related and return to work testing
Office Visit	When COVID-19 testing is performed during the same visit
Urgent Care Visit	
Emergency Room Visit	
Telehealth Visit	

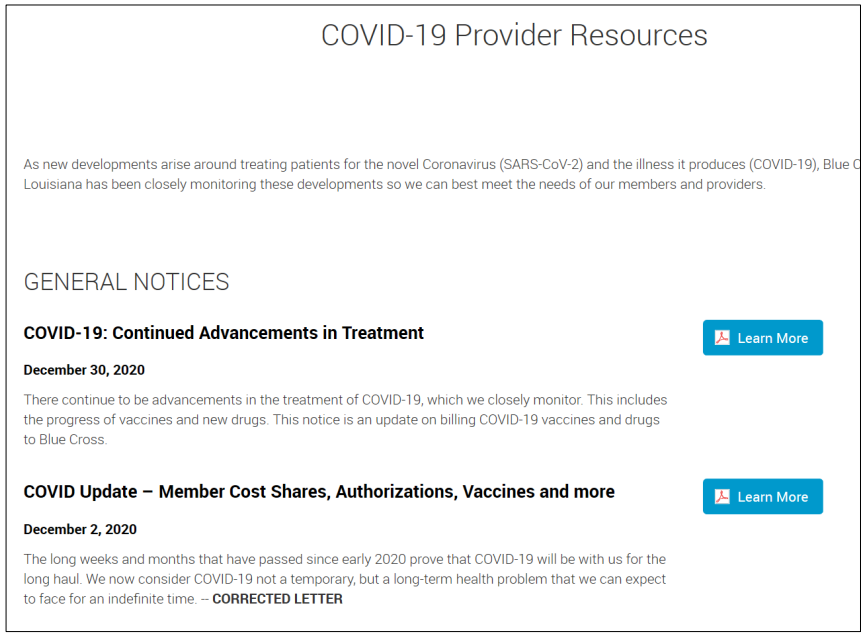
COVID-19 Provider Resources Page

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 for updated information.



Readmissions Policy

Readmissions Policy

Effective January 1, 2021, we have implemented the second phase of our readmissions policy.

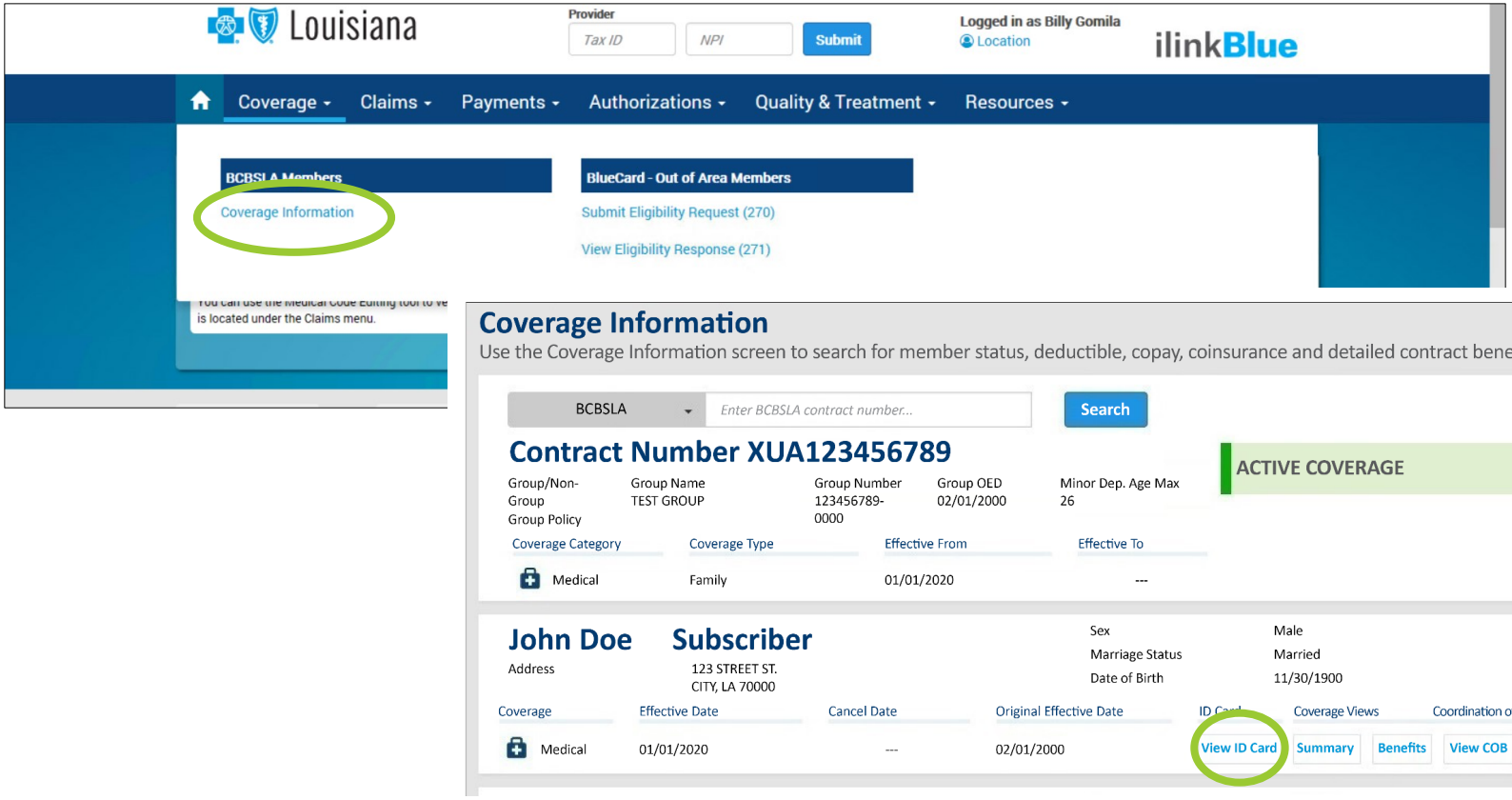
- Readmissions to the same or an affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed.
- The first admission payment will encompass full reimbursement for treatment of the condition and/or any related complications.
- Providers cannot bill members for service recouped as a result of this policy.

To view the full Blue Cross readmissions policy, refer to *our Member Provider Procedure & Policies Manual*, available in iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" menu option.

iLinkBlue Highlights

Digital ID Cards in iLinkBlue

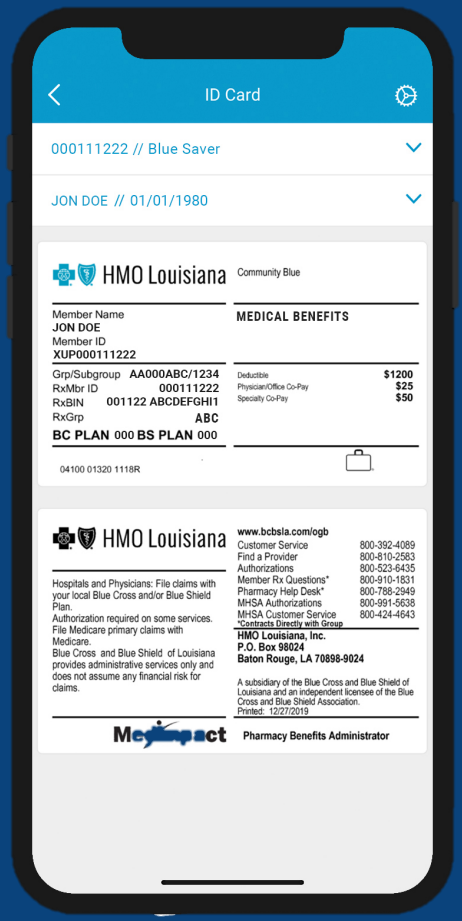
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”



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:

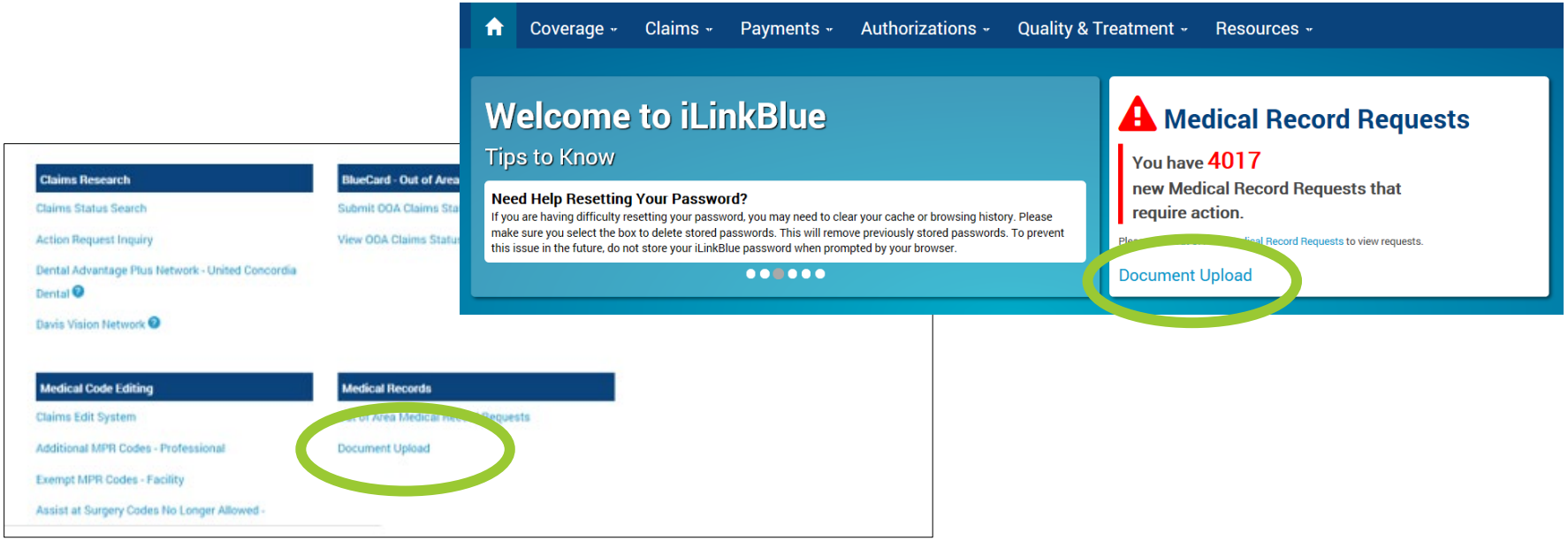
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.
- To access through the Blue Cross member portal, log into the online member account at **www.BCBSLA.com**. There, click on “My ID 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.

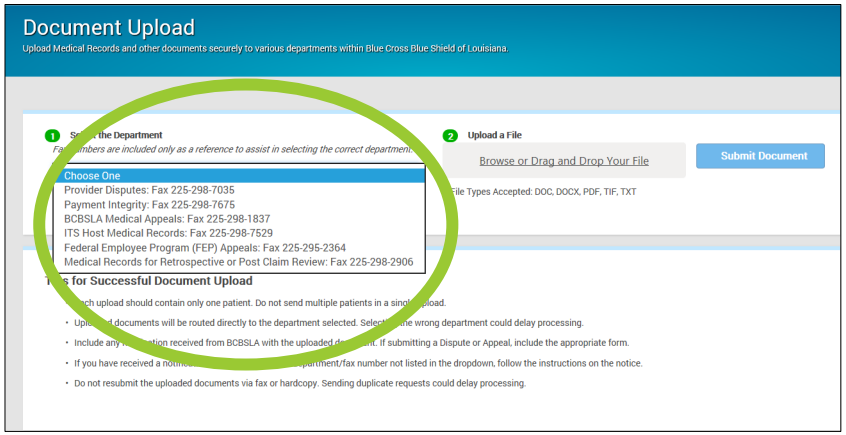


The Document Upload feature can be accessed on iLinkBlue (**www.BCBSLA.com/ilinkblue**) or under Claims >Medical Records >Document Upload.

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 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?

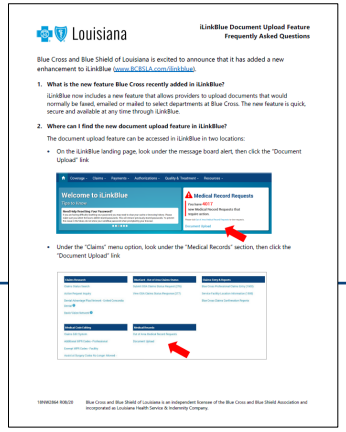
- DOC, DOCX, PDF, TIF, TXT

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.

Is there a file size limitation?

- Flies that are over 10MB in size will not be accepted for upload. Documents that exceed this limit will need to be faxed or mailed to BCBSLA.


Louisiana

iLinkBlue Document Upload Feature
Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is excited to announce that it has added a new enhancement to iLinkBlue (www.BCBSLA.com/iLinkBlue).

1. **What is the new feature Blue Cross recently added in iLinkBlue?**

   iLinkBlue now includes a new feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments at Blue Cross. The new feature is quick, secure and available at any time through iLinkBlue.

2. **Where can I find the new document upload feature in iLinkBlue?**

   The document upload feature can be accessed in iLinkBlue in two locations:

   - On the iLinkBlue landing page, look under the message board alert, then click the "Document Upload" link

   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

For a copy of the Document Upload Feature FAQs send an email to **provider.relations@bcbsla.com**.

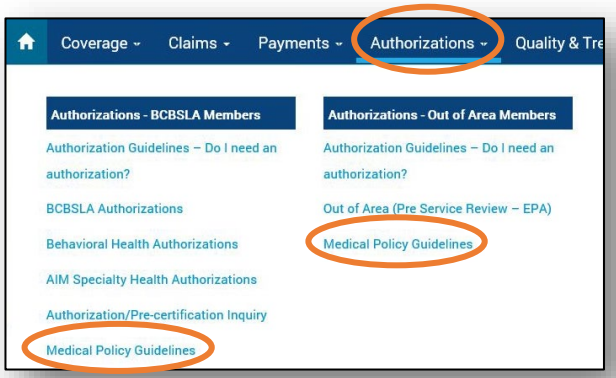
FEP Medical Policy Guidelines

FEP Medical Policy Guidelines can now be found on iLinkBlue (**www.BCBSLA.com/ilinkblue**), under Authorizations.

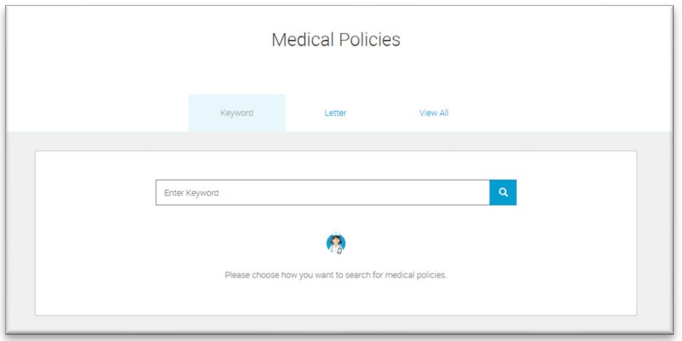
Accessing Our Medical Policies

- 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.

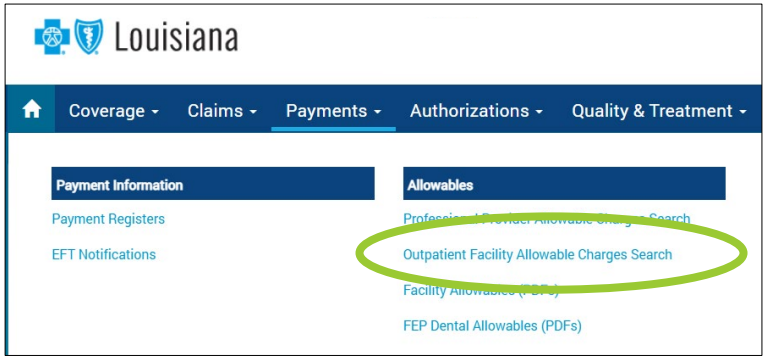
Downloadable Facility Fee Schedules Now Available

Our secure online tool now includes the ability to request allowable charge listings for outpatient facility providers. This functionality replaces the full fee schedule notifications that have been mailed hardcopy in the past.

Important facts to know about this enhancement:

- The display grid will retain the completed requests for 10 business days, after which it will be automatically deleted.
- Since the fee schedules are by provider network, users will need to request a full schedule for each network they are affiliated with.
- Fee schedules will be available for up to two years prior to the current date.

On future allowable update notification, we will no longer enclose listings of allowable charges for facilities since this information is now fully available on iLinkBlue.

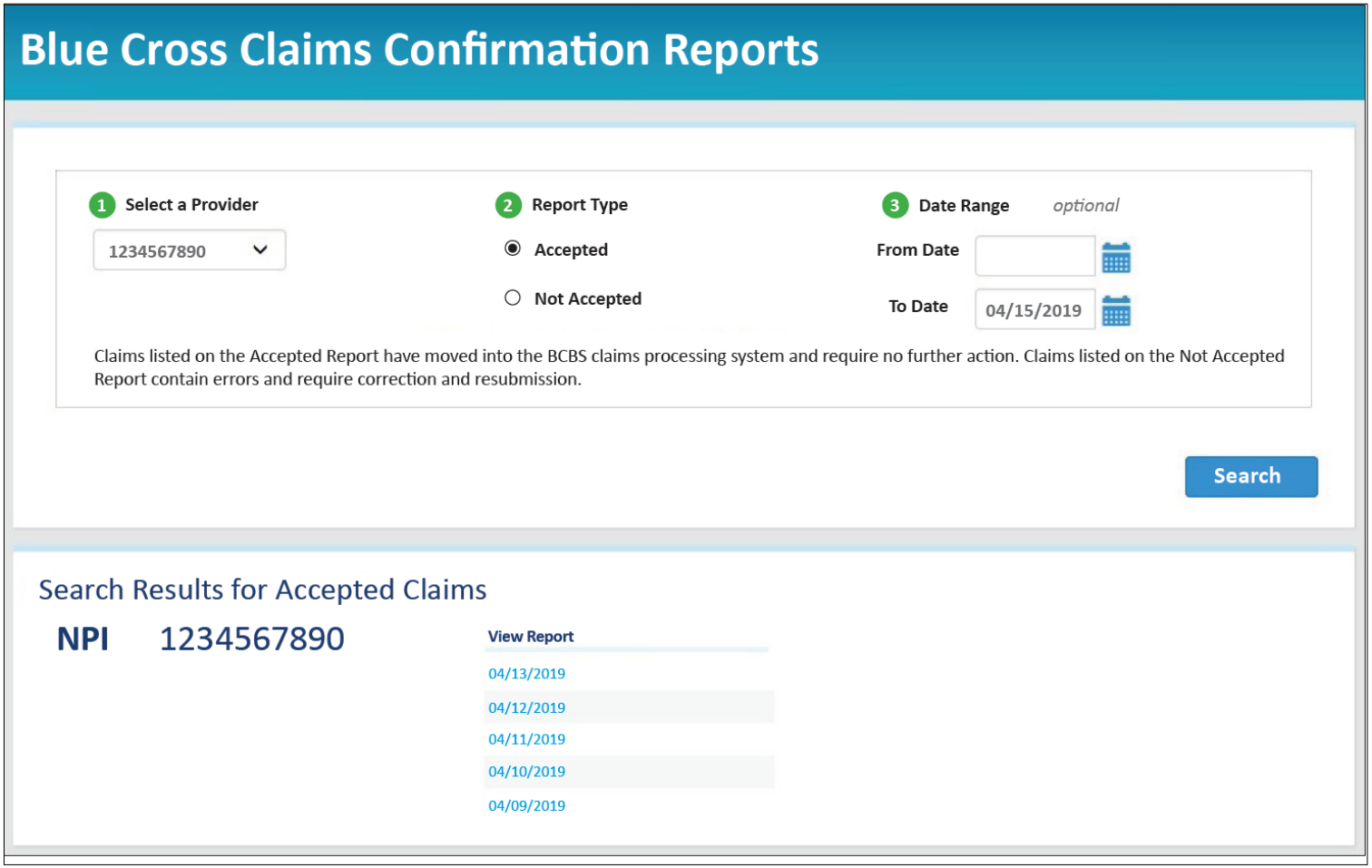


The current allowable search tool is available under the “Payments” menu option, then click the “Outpatient Facility Allowable Charges Search” link under the “Allowables” section. The enhanced search tool now includes a tab labeled “Fee Schedule Request.”

Blue Cross Claims Confirmation Reports

- Provide detailed claim information on transactions that were accepted or not accepted by Blue Cross for processing.
- You may access these reports via iLinkBlue (Claims >Blue Cross Claims Confirmation Reports).
- Reports are available up to 120 days.
- The reports include claims that are submitted in iLinkBlue as well as through a clearinghouse or billing agency.

Blue Cross Claims Confirmation Reports



Blue Cross Claims Confirmation Reports

Confirmation Reports indicate detailed claim information on transactions that were accepted or not accepted for processing. Providers are responsible for reviewing these reports and correcting claims appearing on the “Not Accepted” report.

Not Accepted Report

Blue Cross and Blue Shield of Louisiana
837 Accepted / Not Accepted / Warning Report
Professional Claims Report

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z
BC ID # T5678
RECEIVE DATE: 04-12-19
NPI# 1234567891

SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 04-12-19

PAGE 1

837P NOT ACCEPTED REPORT

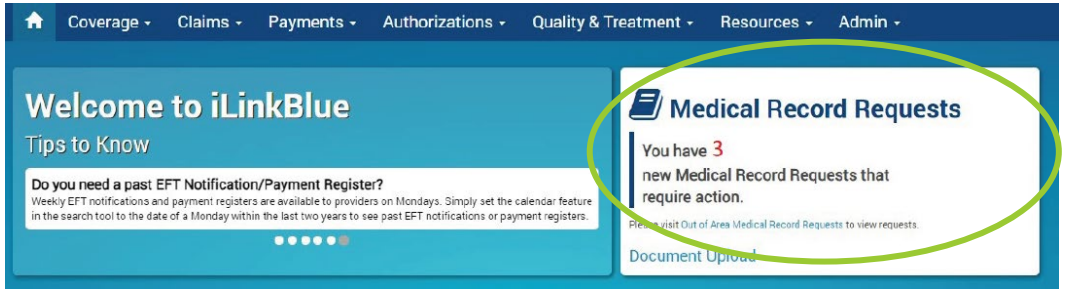
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION IRS CONFLICT	987654321

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
837P TOTAL CLAIMS: 2 CLAIMS FOR $412.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
GRAND TOTAL CLAIMS: 2 CLAIMS FOR $412.00

BlueCard Medical Record Request

- **Effective April 15, 2021**, providers will no longer receive hardcopy letters for BlueCard medical record requests. Instead, Blue Cross will only alert providers through iLinkBlue.
- This change does not affect non-BlueCard medical record requests. Blue Cross will continue to send hardcopy requests for non-BlueCard members.



For more information find our Medical Record Guidelines for BlueCard tidbit at **www.BCBSLA.com/Providers** >Resources >Tidbits.

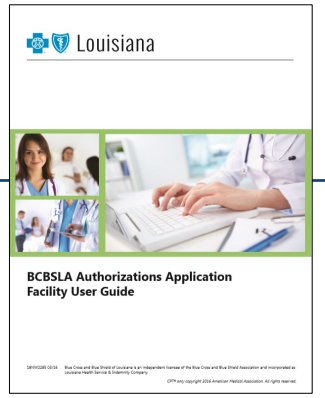
Authorizations

Authorization Portal Mandate

BCBSLA is requiring all prior authorization requests to be submitted exclusively through our online BCBSLA Authorizations tool.

- Authorization requests will no longer be taken via phone or fax.
- Providers must use the BCBSLA Authorization Tool to start and complete the process for all requests. This online tool allows providers to request authorizations for services 24 hours a day, seven days a week, in real time.
- We will continue to fax approval letters to your facility for every member reviewed.

For more information on how to use our BCBSLA Authorizations Tool, the *BCBSLA Authorizations Applications Facility User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."



Temporary Transfer Authorization Requirements Policy

We understand that there may be a growing need to transfer patients for continued medical services. To help ease our hospitals' administrative burdens, we are implemented the following temporary authorization requirement provisions in accordance with the Louisiana Department of Insurance Emergency Rule 46.[1]

- For all acute inpatient admission transfers for dates of service on and after August 9, 2021, Blue Cross is suspending the requirement to obtain prior authorization to move patients from an acute care inpatient setting to a LTACH, SNF or inpatient rehabilitation facility setting. The following applies:
  - The receiving facility should notify Blue Cross of the admission within 24 hours. We will automatically approve a 3-day stay for the receiving facility.
  - Blue Cross will work with the receiving facility to perform a concurrent review by day 4. We will authorize appropriate continued stay based on medical necessity of the continued treatment of the underlying condition.
- We are allowing in-network level benefits to apply for all in-state and out-of-state inpatient admission transfers for our Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members. This applies even if the facility is not specifically in the member's network.
- This change does not apply for our Blue Advantage HMO and Blue Advantage PPO members.

[1]Emergency Rule 46: www.doa.la.gov/media/beudsiyz/2108emr028.pdf

Additional COVID-19 Authorization Waivers

Effective August 20, ending September 30, 2021.

- **Urgent Inpatient Admissions and Stays:**
  - All diagnoses for emergent/urgent stays will be approved.
  - Facilities must still notify Blue Cross of stay; however, medical review activities throughout stay are not required. In-network benefits apply for participating providers.
  - Exception does not apply for elective, scheduled admissions or transplants.
  - Exception does not apply to out-of-state or non-participating providers/facilities.
- **Outpatient Services and Durable Medical Equipment (DME) Services:**
  - For COVID-19 diagnoses only. Providers must still notify Blue Cross of services; however, medical review activities are not required.
  - In-network benefits apply for participating providers.
  - Exception does not apply to out-of-state or non-participating providers/facilities.

Tips for Online Authorizations in ILinkblue

Blue Cross requires providers to request prior authorizations through our BCBSLA Authorizations tool. It is available online in iLinkBlue (**www.BCBSLA.com/ilinkblue**). Here are some trouble-shooting tips for navigating aspects of the tool:

- Recurrent/Ongoing Services: Use the initial authorization when the requested service code (CPT/HCPC) and provider(s) are the same, even if a break in service has occurred. Do NOT create a new authorization. New authorizations will be voided in the system and moved to the initial authorization. Please add a note with documentation of what you are requesting and create an activity on the initial authorization request.
- Member Search: When searching for a member, enter the numbers following the alpha prefix. Do not enter the three letters in front of the member number on the ID card. The only instance where you would enter a letter in front of member ID number is if the member number starts with an "R." The member ID number should be entered in the "Subscriber ID" field, not the "Member ID" field.
- Overdue Tasks: These tasks will not be visible on the "My Tasks" tab. To see your overdue tasks/activities, click on the "Overdue" tab.
- Provider Access: Users should use their own individual iLinkBlue login information to view authorizations. Provider groups with multiple iLinkBlue users should not log in with the same user information.

Tips for Online Authorizations in Ilinkblue

- Provider Attachment to Authorizations: To view an existing authorization, a user must log in under the provider that is attached to the authorization. Otherwise, they will not be able to view the authorization in the tool. If a user removes the provider and attaches a different provider to an existing authorization, they will receive a "no results found" when searching for that authorization.
- Members Accessible Via the BCBSLA Online Tool: Only Blue Cross and Blue Shield of Louisiana members will display. Blue Advantage members will not display in the online tool.
- Copy & Paste: When using copy/paste in the search fields make sure there is no space before or after the information in the field, or the search will not yield a result.

Tips for Online Authorizations in Ilinkblue

- Activity Assignment: All activities that require action on Blue Cross' part should be assigned to "Provider Requests." Do not assign these activities to yourself. The date on these activities should be the date they did the activity, not a future date.

- Closed Episodes: Once an authorization request has been closed, providers do not have the ability to re-open it themselves. They must generate an activity to Blue Cross within the closed request, with a note explaining the action being requested to the health plan.

- Authorization Requirements & Services Affiliated with Medical Policy: View a member's specific schedule of benefits to determine if a prior authorization is required for a specific service. The medical policy database should be used to determine if a service is affiliated with a medical policy.

Extending Services for Inpatient Cases when the Case is closed

When it is necessary to extend services listed under an inpatient authorization request through our online BCBSLA Authorizations tool, the status of the case will determine the process.

If the episode status on the authorization is listed as “Open Request,” then the “Extension” and “Discharge” buttons remain available under the “UM Service” tab, and you may press “Extension.”

- Once a request is closed, the extension button for concurrent review is no longer available. If a request is closed but the member did not discharge, take the following steps to access the extension button:
  - Under the UM Service tab, under the “Actions,” section, click on the discharge icon.
  - Under the “Discharge section,” change “Yes” to “No” and then click save.
  - On the UM Services line, the extension button will now be available, and you may perform the concurrent review. Once you submit the extension, the concurrent review activity will generate on the Provider Requests worklist. However, the case will remain in closed status until Blue Cross re-opens the case to review the concurrent request.

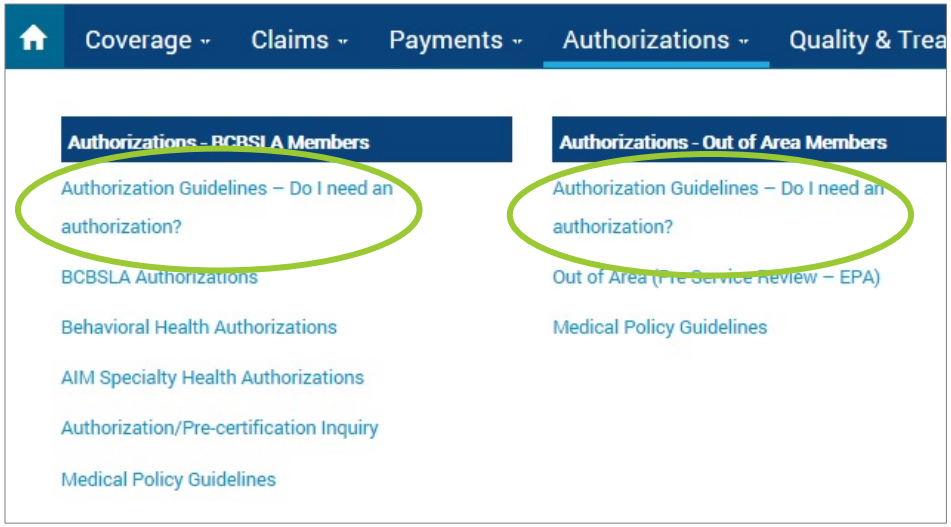
iLinkBlue - Authorizations

- 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)

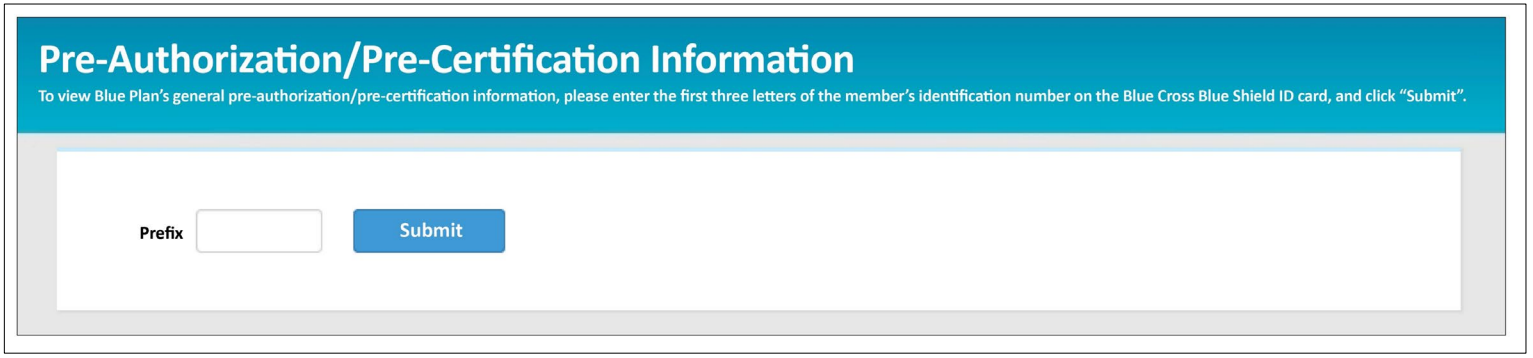
Where to Find Authorization Requirements

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.

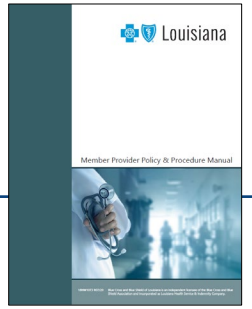


AIM Utilization Management Programs

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**.



The full policy is available in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.BCBSLA.com/ilinkblue**, click on "Resources," then "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 all services.

If you are reading this, be the first to type "Bingo" in the chat section to win a prize.

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.
  - Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations tool. Exceptions to this process include transplants, dental services covered under medical and out-of-state services. Providers should call the authorizations phone number on the back of the members ID card for these services.

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 a BCBSLA 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. **This can be done by completing an Activity in the BCBSLA Authorization tool and uploading medical records and/or adding a note.**

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.

Failure to Obtain an Authorization

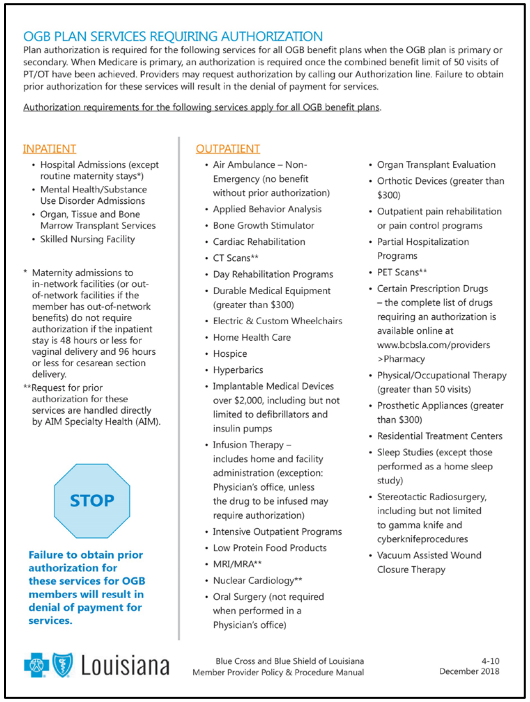
Failure to obtain a prior authorization can result in:

- A 30% up to "no payment" 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.**



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).

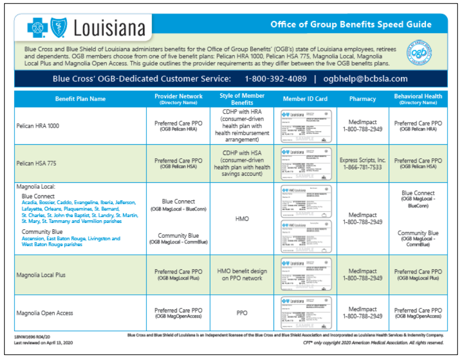
Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

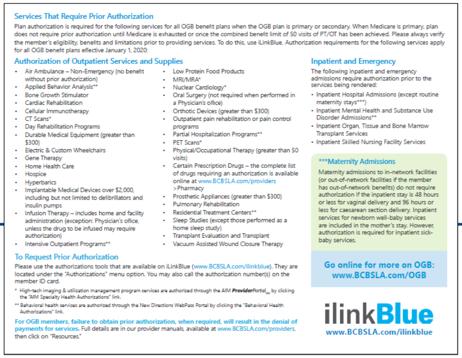
OUTPATIENT

- 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.





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.

*Opti*Net Registration Tool in iLinkBlue

- AIM Specialty Health® offers ***Opti****Net*® 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 ***Opti****Net* 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 *Opti*Net?

- 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 ***Opti****Net* Registration" on the left menu bar.
- Click the green "Access Your ***Opti****Net* Registration" button.

Claims Resolutions

Resolving Claims Issues

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

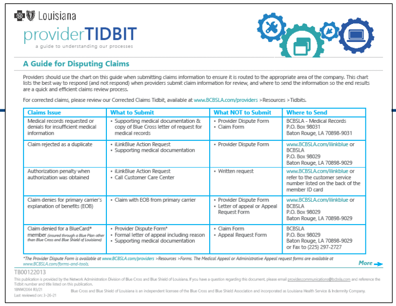
Depending on the type of claim issue, there are multiple ways to submit claims reviews that we will outline in this section:

- 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 claim's 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.

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



Louisiana

providerTIDBIT

a guide to understanding our processes

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	• Provider 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	• Provider Dispute 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	• Provider 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)*	• Provider 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 Provider Dispute Form is available at www.BCBSLA.com/providers >Resources >Forms. The Medical Appeal or Administrative Appeal request forms are available at www.BCBSLA.com/forms-and-tools.*

More →

TB00122013

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this document, please email provider.communications@bcbsla.com and reference the Tidbit number and title listed on this publication.

18NW2064 R3/21

Last reviewed on: 3-26-21

Submitting Action Requests

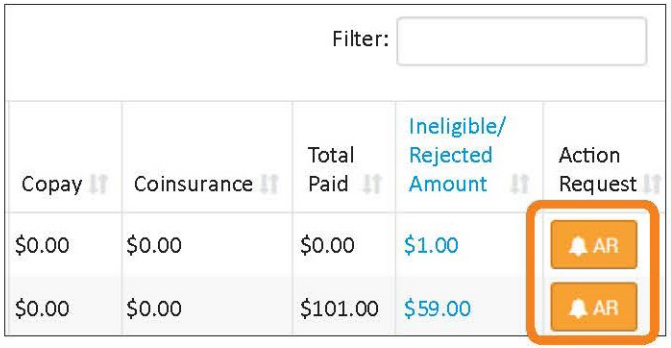
Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim (**www.BCBSLA.com/ilinkblue**).

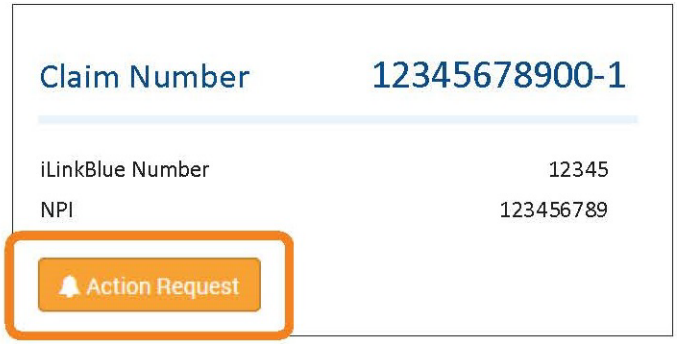
Common reasons to submit an Action Request:

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

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

Submitting Action Requests





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

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

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

- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) 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.

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.

PROVIDER DISPUTES

Involves a denial that affects the provider's reimbursement.

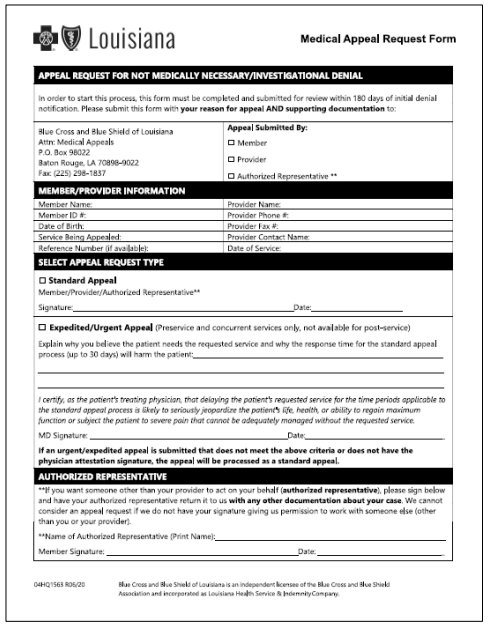
On the next slides, we will detail each of these claims inquiries.

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.



Louisiana

Medical Appeal Request Form

APPEAL REQUEST FOR NOT MEDICALLY NECESSARY/INVESTIGATIONAL DENIAL

In order to start this process, this form must be completed and submitted for review within 180 days of initial denial notification. Please submit this form with **your reason for appeal AND supporting documentation** to:

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

Appeal Submitted By:
☐ Member
☐ Provider
☐ Authorized Representative **

MEMBER/PROVIDER INFORMATION

Member Name:	Provider Name:
Member ID #:	Provider Phone #:
Date of Birth:	Provider Fax #:
Service Being Appealed:	Provider Contact Name:
Reference Number (if available):	Date of Service:

SELECT APPEAL REQUEST TYPE

☐ **Standard Appeal**
Member/Provider/Authorized Representative**
Signature:_____Date:_____

☐ **Expedited/Urgent Appeal** (Preservice and concurrent services only, not available for post-service)
Explain why you believe the patient needs the requested service and why the response time for the standard appeal process (up to 30 days) will harm the patient:_____

I certify, as the patient's treating physician, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health, or ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed without the requested service.

MD Signature: _____Date:_____

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.

AUTHORIZED REPRESENTATIVE

If you want someone other than your provider to act on your behalf (authorized representative**), please sign below and have your authorized representative return it to us **with any other documentation about your case**. We cannot consider an appeal request if we do not have your signature giving us permission to work with someone else (other than you or your provider).

**Name of Authorized Representative (Print Name):_____

Member Signature: _____Date:_____

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SEND TO:
Blue Cross and Blue Shield of Louisiana
Attn: Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

Fax: (225) 298-1837

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.

Peer-to-peer reviews are not available once an appeal has been initiated.

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 Medical Appeals Request Form. More information can be found on the "Guide For Disputing Claims" Tidbit, available at **www.BCBSLA.com/providers** >Resources >Tidbits.
- Expedited appeals are **not** available if services have been rendered.

Administrative Appeals & Grievances

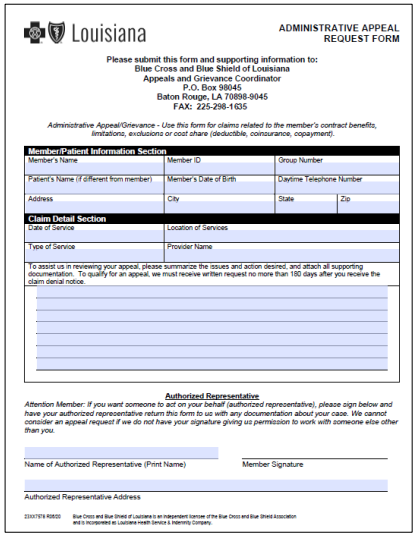
- Administrative appeals involve contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), with the member's authorization.
- A grievance is a written expression of dissatisfaction with BCBSLA or a provider's services. Typically, grievances do not involve denied claims.

The top reasons for administrative appeals are:

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

BCBSLA Administrative Appeals

- Administrative appeals involve member's contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), **with the member's authorization**.
- A written request must be submitted within 180 days following the member's receipt of an initial adverse benefit determination. Requests submitted to us after 180 days of our initial determination will not be considered.



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ADMINISTRATIVE APPEAL REQUEST FORM

Please submit this form and supporting information to:
Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Coordinator
P.O. Box 98045
Baton Rouge, LA 70898-9045
FAX: 225-298-1635

Administrative Appeal/Grievance - Use this form for claims related to the member's contract benefits, limitations, exclusions or cost share (deductible, coinsurance, copayment).

Member/Patient Information Section

Member's Name	Member ID	Group Number	
Patient's Name (if different from member)	Member's Date of Birth	Daytime Telephone Number	
Address	City	State	Zip

Claim Detail Section

Date of Service	Location of Services
Type of Service	Provider Name

To assist us in reviewing your appeal, please summarize the issues and action desired, and attach all supporting documentation. To qualify for an appeal, we must receive written request no more than 180 days after you receive the claim denial notice.

Authorized Representative

Attention Member: If you want someone to act on your behalf (authorized representative), please sign below and have your authorized representative return this form to us with any documentation about your case. We cannot consider an appeal request if we do not have your signature giving us permission to work with someone else other than you.

Name of Authorized Representative (Print Name)

Member Signature

Authorized Representative Address

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SEND TO:

Blue Cross and Blue Shield of Louisiana
Attn: Appeals and Grievance Coordinator
P.O. Box 98045
Baton Rouge, LA 70898-9045

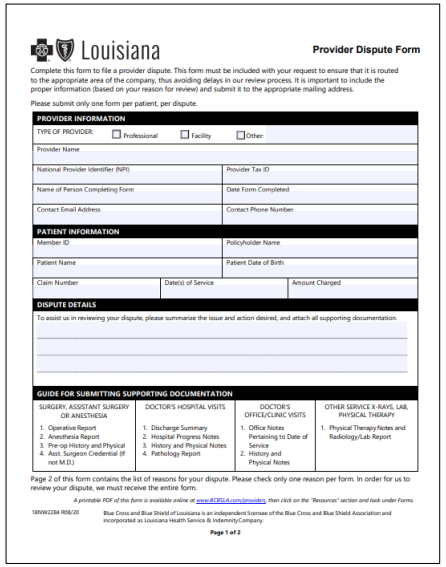
FAX: 225-298-1635

The Administrative Appeal Request Form can be found online at **www.BCBSLA.com** >Helpful Links >Forms and Tools.

Provider Disputes

A provider dispute is different than an appeal or grievance. Provider disputes are defined as written requests from our participating network providers (In Network Providers ONLY) questioning (or disputing) their allowable charge of a processed claim. Disputes could involve the following:

- Reimbursement concerns
  - Allowable disputes **(must include breakdown, fee schedule)**
  - Bundling issues (note: must always have medical records attached)
- Authorization issues
  - Penalties where the **provider** is liable for the amount
  - Failed to obtain authorization denials **(reason auth not obtained)**
- Refund Disputes
- Maximum daily benefit denials
- Timely Filing denials



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Provider Dispute Form

Complete this form to file a provider dispute. 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 include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

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

DISPUTE DETAILS

To assist us in reviewing your dispute, please summarize the issue and action desired, and attach all supporting documentation.

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 dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

A printable PDF of this form is available online at www.BCBSLA.com/providers, then click on the "Resources" section and look under Forms.

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Page 1 of 2

SEND TO:
Blue Cross and Blue Shield of Louisiana
Attn: Provider Disputes
P.O. Box 98021
Baton Rouge, LA 70898-9021

FAX: (225) 298-7035

Through iLinkBlue (**www.BCBSLA.com/iLinkBlue**), click "Document Upload," then "Provider Disputes" in the drop-down menu.

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

Disputes Process for BCBSLA Claims

FIRST (ADMINISTRATIVE) LEVEL REVIEW

- Must be submitted in writing, using Claims Dispute Form attached and all supporting documentation.
- Provider will be sent an acknowledgement letter.
- BCBSLA has 60 days to review and respond.

Disputes Process for BCBSLA Claims

SECOND (STAFF) LEVEL REVIEW

- Once a resolution letter is sent, the provider has 30 days to respond and request a second level review (staff level review).
- For second level review, the provider must submit additional information. The review will be conducted by a different specialist.
- For the second level review, BCBSLA has 60 days to review and respond.

Disputes Process for BCBSLA Claims

THIRD (MANAGEMENT) LEVEL REVIEW

- Once a resolution letter is sent, provider has 30 days to respond in writing to request a third level review (management level review).
- Case is presented and decision is made by managers.
- Providers are notified of the decision and has the right to request arbitration.
- Arbitration is the final resolution.

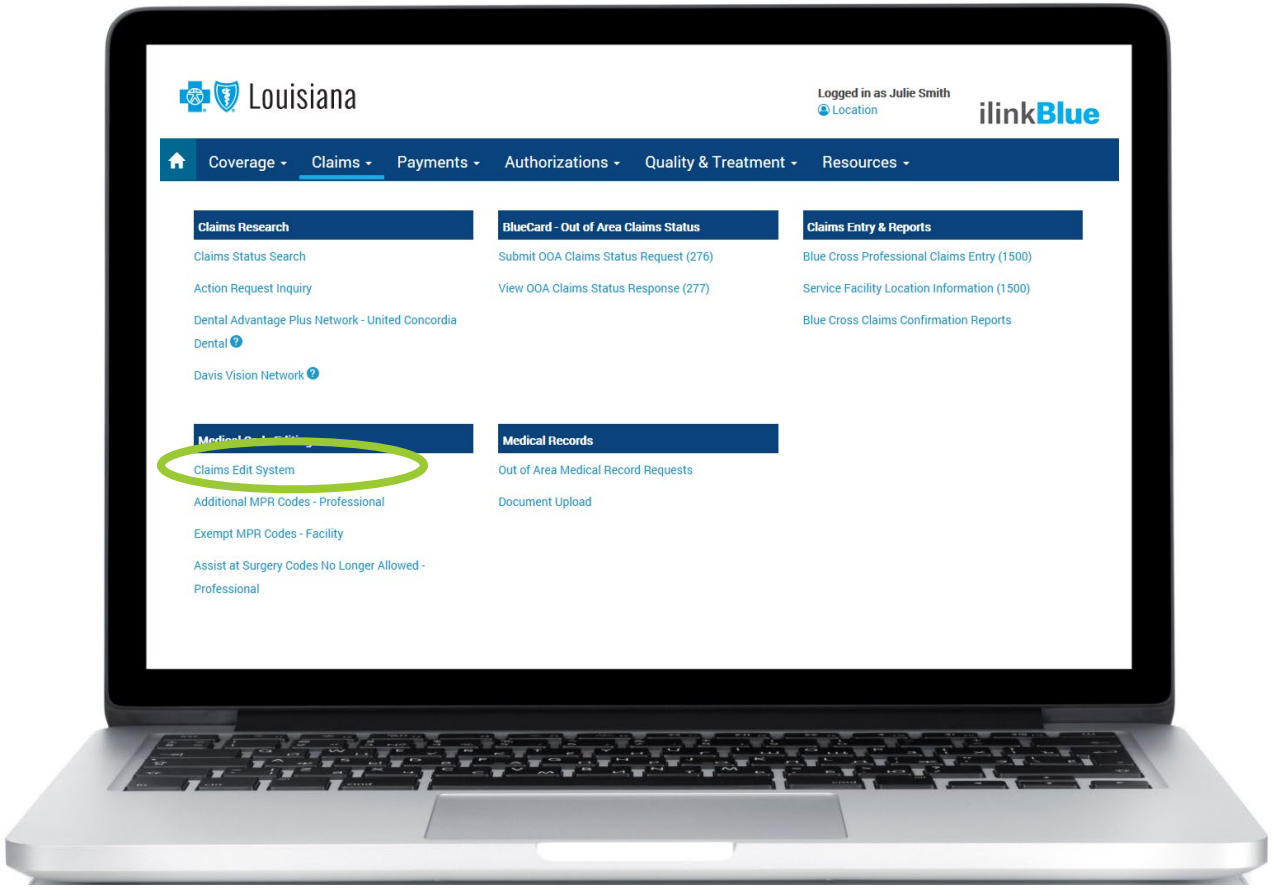
Claims Editing System

Claims Editing Software

- 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 System Tool

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



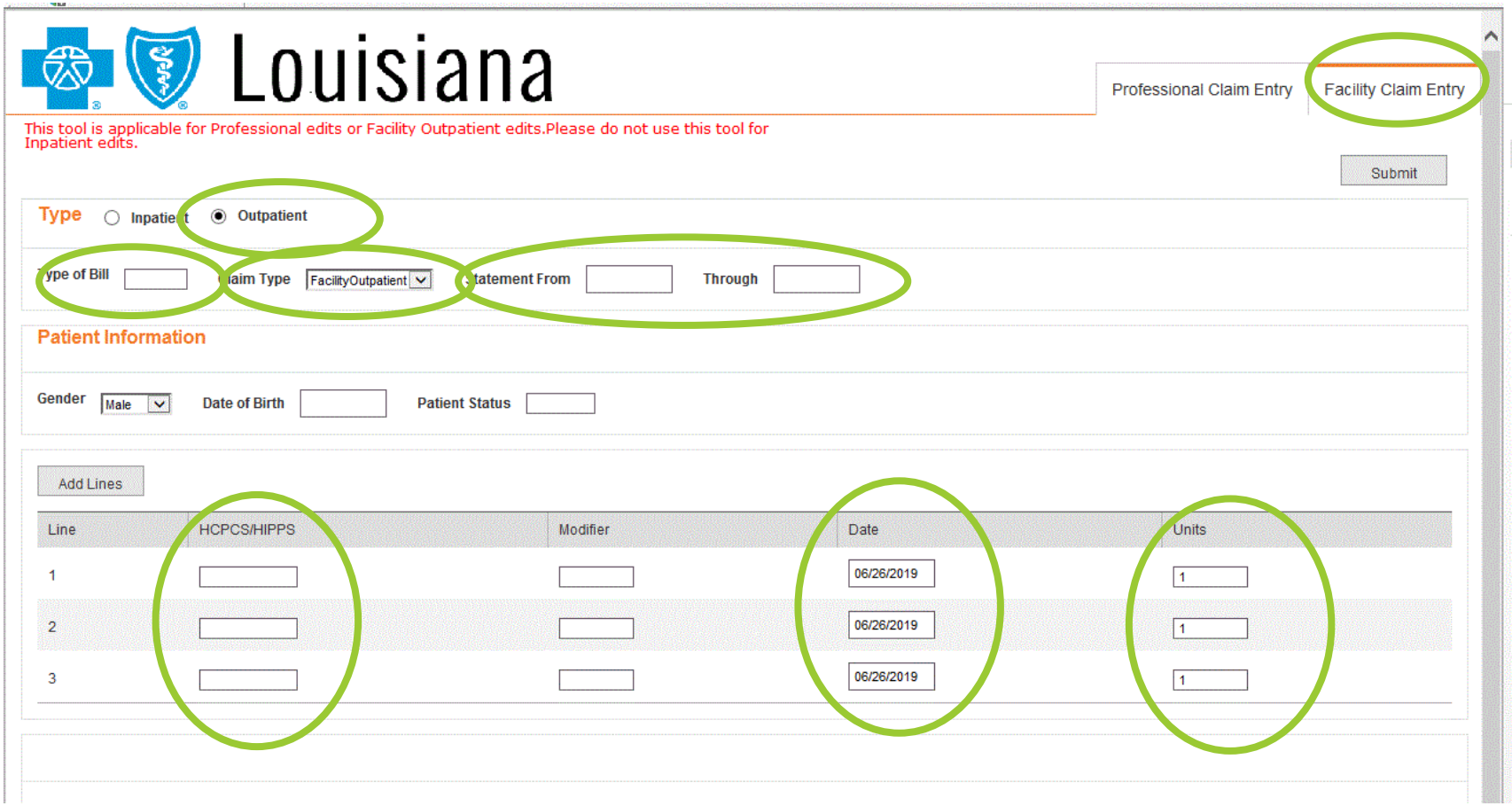
Claims Editing System Tool

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

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.

Annual Provider Survey

Thank you to those who took our recent survey. If you haven't responded, there is still time. We greatly value your input!

- Did not receive an email invitation? Email **provider.communications@bcbsla.com** with "Provider Engagement Survey" in the subject line. Win one of 26 American Express gift cards. Top prize is $500.
- We have received positive feedback regarding this initiative and look forward to hearing your additional ideas.

Questions?

Appendix

Future Webinars

- BlueCard®
  - October 20, 2021
- Blue Advantage Behavioral Health
  - November 11, 2021

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

Updated Outpatient Code Ranges

We updated the Outpatient Procedure Services and Diagnostic and Therapeutic Services code ranges based on reviews of the 2021 CPT® and HCPCS codes. As a result of our most recent review, we are adding the following codes, effective July 1, 2021.

Diagnostic and Therapeutic Services code range:

0248U	0641T	0663T	C9075	J1951
0249U	0642T	90626	C9076	J7168
0250U	0648T	90627	C9077	J9348
0251U	0649T	90671	C9078	J9353
0252U	0650T	90677	C9079	Q5123
0253U	0651T	90758	C9080	
0254U	0658T	A9593	G0327	
0640T	0662T	A9594	J0224	

Outpatient Procedure Services code range:

0643T	0655T	0666T
0644T	0656T	0667T
0645T	0657T	0668T
0646T	0659T	0669T
0647T	0660T	0670T
0652T	0661T	C1761
0653T	0664T	C9778
0654T	0665T	

These changes do not affect existing codes and allowables. They allow our system to accept these codes appropriately for claims adjudication.

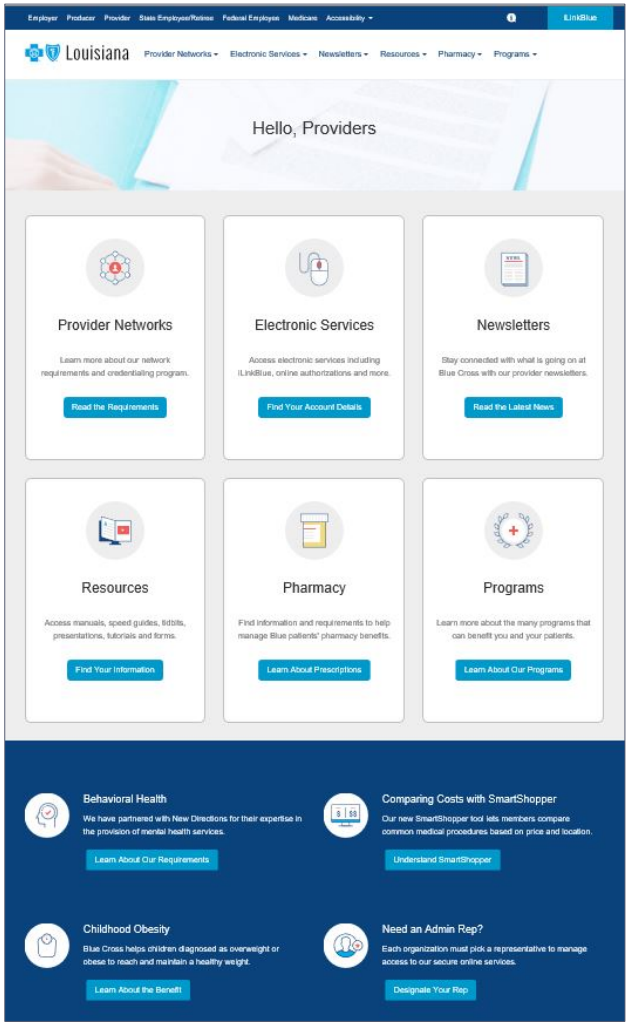
Updated Facility Drug Allowable Supplemental Listing

We conduct a biannual review of our drug and drug administration code pricing. In addition to the biannual review, we also add new drug codes to our system as they come out and apply reimbursement, as applicable.

As a result of that review the following HCPCS codes were added to our system, effective July 1, 2021:

C9075	C9080	J9348
C9077	J0224	J9353
C9078	J1951	Q5123
C9079	J7168	

Provider Page



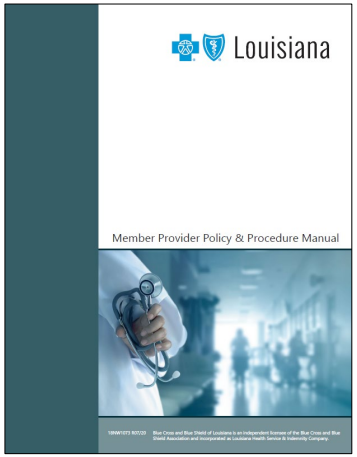
www.BCBSLA.com/providers

The Provider Page is home to online resources such as:

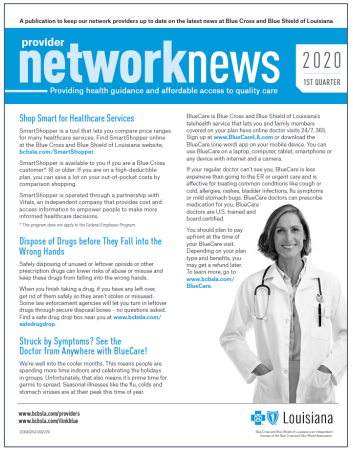
- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more

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

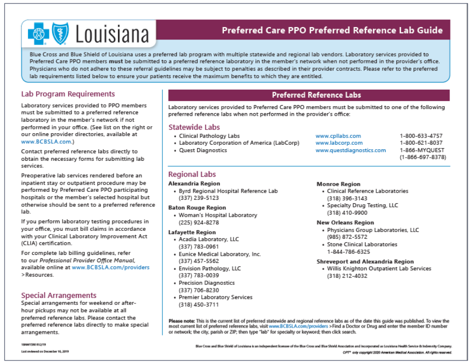
Not Getting Our Newsletters Electronically?

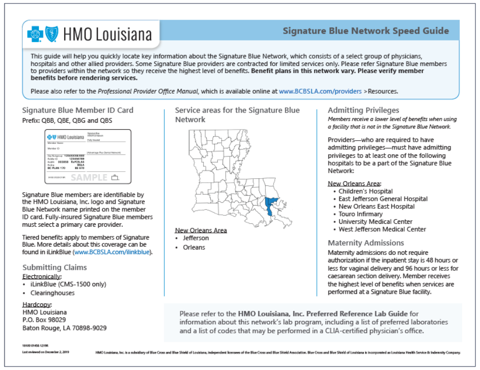
Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

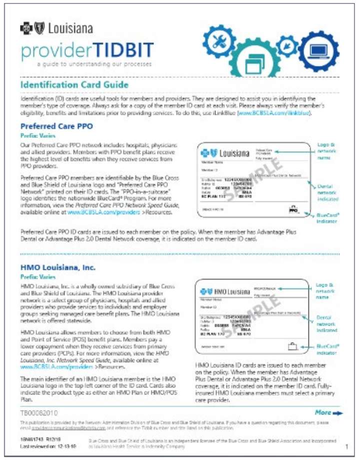
Speed Guides & Tidbits

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

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





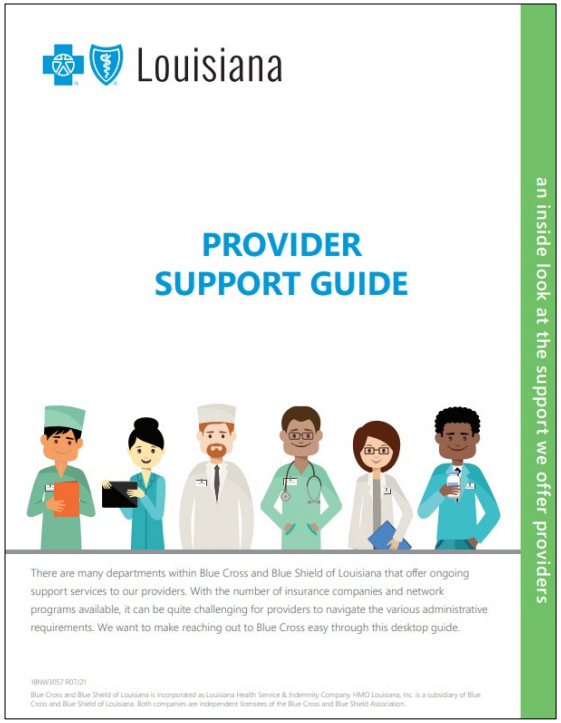


Provider Tidbits are quick guides designed to help you with our current business processes.

www.BCBSLA.com/providers
>Resources >Tidbits

Provider Resource Guide

There are many departments within Blue Cross and Blue Shield of Louisiana that offer ongoing support services to our providers. With the number of insurance companies and network programs available, it can be quite challenging for providers to navigate the various administrative requirements. We want to make reaching out to Blue Cross easy through this desktop guide.



Find a copy of the Provider Support Guide at **www.BCBSLA.com/providers** >Resources, under the Quick Links section.

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 provider data record
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **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, Iberville

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn, Jefferson Davis, St. Landry, Vermilion

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

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana, Livingston, Pointe Coupee, St. Martin

Melonie Martin
East Baton Rouge, Ascension, West 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. Acadia

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

Jennifer Aucoin **Angela Jackson** **Paden Mouton** **Brittany Thompson**

Provider Contracting

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

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

Danielle Jackson manager – **danielle.jackson@bcbsla.com**

Ashley Wilson – **ashley.wilson@bcbsla.com**
Northshore

Cora LeBlanc – **cora.leblanc@bcbsla.com**
Houma, Thibodeaux

Dayna Roy – **dayna.roy@bcbsla.com**
Alexandria, Lake Charles

Jason Heck – **jason.heck@bcbsla.com**
Shreveport

Jill Taylor – **jill.taylor@bcbsla.com**
New Orleans

Mica Toups – **mica.toups@bcbsla.com**
Lafayette

Sue Condon – **sue.condon@bcbsla.com**
Baton Rouge

Shannon Taylor – **shannon.taylor@bcbsla.com**
Monroe

provider.contracting@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**.

1-800-716-2299, option 2 | **PCDMstatus@bcbsla.com**