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 Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."

- Once your question is answered, it will appear in the "Answered" tab.

- All questions will be answered by the end of the webinar.

Welcome to the
Blue Cross Network –
Facility Webinar

February 2022

Presented by Lisa Roth
Provider Relations Department
Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

AIM is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

New Directions is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Avalon is an independent company that serves as a laboratory insights advisor for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

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

Our Networks

Blue Cross has comprehensive provider networks.

Included on the next slides are brief overviews of our networks and large employee groups so you can better understand your patients' coverage:
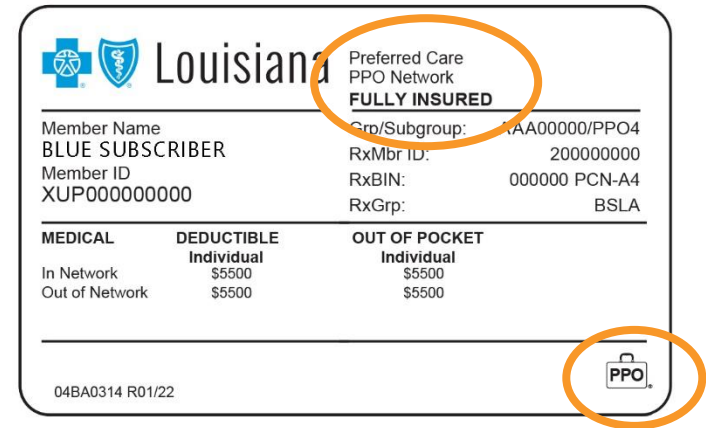
- Preferred Care PPO

- HMO Louisiana, Inc.

- Blue Connect

- Community Blue

- BlueHPN

- Precision Blue

- Signature Blue

- Blue Advantage (HMO) | Blue Advantage (PPO)

- Healthy Blue Dual Advantage (HMO D-SNP)

- Ochsner Health Network

Always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.BCBSLA.com/ilinkblue**) or call the number on the member ID card.

Prefix Varies

- Our Preferred Care PPO Network is available statewide.

- Members with PPO benefits receive the **highest level of benefits** when they receive services from PPO providers.

- Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on member ID cards.

- The "PPO" in a suitcase logo identifies the nationwide BlueCard® Program.

For more information, view the *Preferred Care PPO Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefix Varies

- Our HMO Louisiana Network is available statewide.

- HMO Louisiana members have one of two styles of benefits: HMO or HMO Point of Service (POS).

- HMO members receive **no benefits** while HMO POS members receive a **lower level** of benefits when using providers not in the HMO Louisiana Network.

- The main identifier of an HMO Louisiana member is the HMO Louisiana logo in the top left corner of the member ID card. Cards also indicate the product type as either an HMO or HMO/POS Plan.

For more information, view the *HMO Louisiana Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefixes: XUF, XUG, XUU and XUV

- Blue Connect is an HMO POS product currently available to groups and individuals residing in 17 parishes.

- Members may **not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Blue Connect Network.
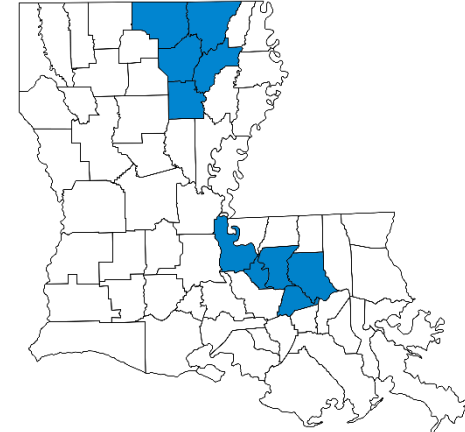

New Orleans area

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

Shreveport area

Bossier and Caddo parishes

Lafayette area

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

For more information, view the *Blue Connect Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefixes: XUD, XUJ and XUT

Community Blue is an HMO POS product currently available to groups and individuals residing in four parishes.

Baton Rouge area:

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

Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Community Blue Network.

For more information, view the *Community Blue Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

BlueHPN is an HMO product currently available to groups and individuals residing in the following parishes:

Lafayette area

Acadia, Evangeline, Iberia, Jefferson, Lafayette 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

Shreveport area

Bossier and Caddo parishes

BlueHPN members are identifiable by the BlueHPN **suitcase logo** in the bottom right-hand corner of the card.
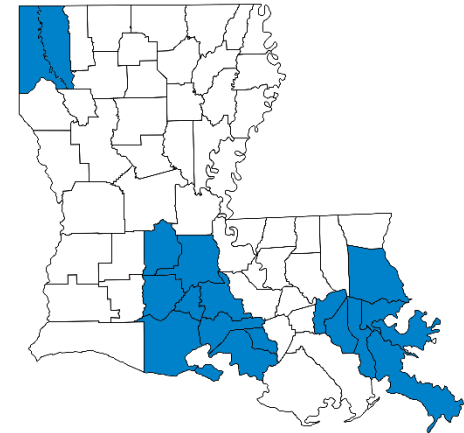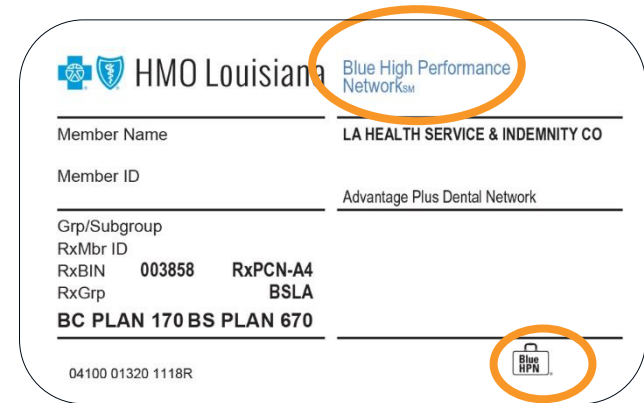
For more information, view the *BlueHPN Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefixes: FQA, FQT or FQW

Precision Blue is an HMO POS product currently available to groups and individuals residing in 10 parishes.

Baton Rouge area:

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

Greater Monroe/West Monroe area:

Caldwell, Morehouse, Ouachita, Richland, Union parishes

Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Precision Blue Network.

For more information, view the *Precision Blue Network Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefixes: QBB, QBE, QBG and QBS
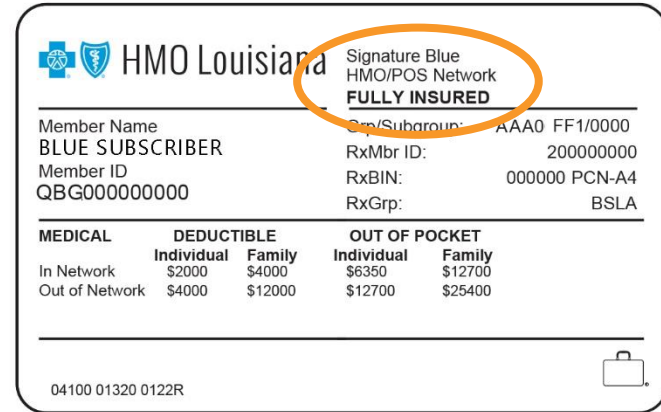
Signature Blue is an HMO POS product that is available to groups and individuals residing in two parishes.

New Orleans area:

Jefferson and Orleans parishes

Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Signature Blue Network.

For more information, view the *Signature Blue Network Speed Guide,* available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Prefixes: PMV and MDV

- Blue Advantage (HMO) and Blue Advantage (PPO) are our Medicare Advantage products currently available to Medicare-eligible members statewide.

- Blue Advantage members **must use** Blue Advantage network providers except for select situations such as emergency care.

Prefix: PMV

Prefix: MDV

Blue Advantage (HMO) | Blue Advantage (PPO)

Prefix: JLA

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

Statewide with the exception of the following parishes:

Concordia	Madison
East Carroll	Webster
Iberia	West Carroll
Lincoln	
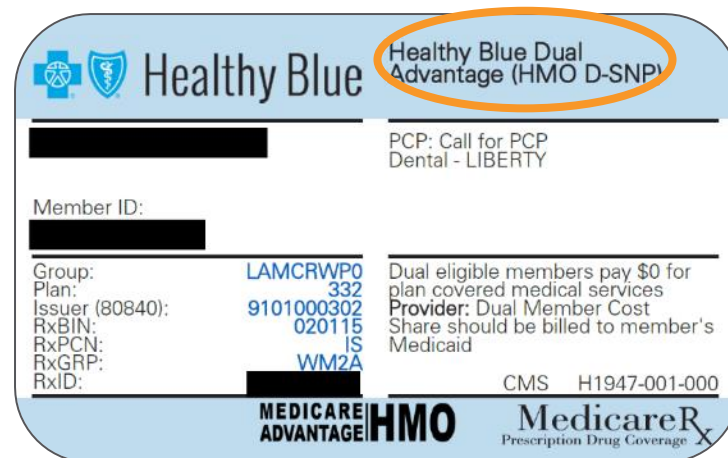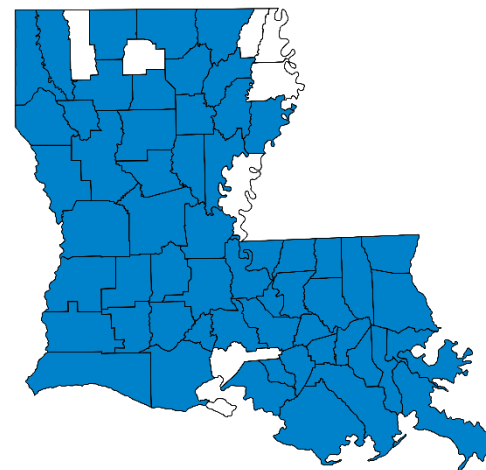
For more information, go to **www.BCBSLA.com/ilinkblue** >Other Sites >Healthy Blue.

Prefix: JLA

Effective January 1, 2022, for BCBSLA members.

Ochsner Health Network (OHN) is available statewide to eligible members. This is a select network in which BCBSLA partners with Ochsner Health Plan to manage.

Prefix: OCF

Prefix: R (followed by 8 digits)

The **Federal Employee Program (FEP)** provides benefits to federal employees and their dependents. These members use the Preferred Care PPO Network.

FEP members have three benefit plan options: Standard Option, Basic Option and FEP Blue Focus.

Standard	Basic	FEP Blue Focus

Standard	Basic	FEP Blue Focus
✓ In-network	✓ In-network	✓ **LIMITED** in-network
✓ Out-of-network	✗ Out-of-network	✗ Out-of-network

Prefixes: OGS, LZB or LXS

Blue Cross administers benefits for Office of Group Benefits (OGB) state of Louisiana employees, retirees and dependents. There are five member-benefit plans currently available to OGB members:

Pelican HRA 1000 (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- Consumer-driven health plan with health reimbursement arrangement.
- Uses our OGB Preferred Care PPO provider network.

Pelican HRA 775 (Active Employees Only)
- Prefix: OGS
- Consumer-driven health plan with health savings account.
- Uses our OGB Preferred Care PPO provider network.

Magnolia Local (Active Employees & Retirees with and without Medicare)
- Uses our Blue Connect (prefix: LZB) or Community Blue (prefix: LXS) provider networks.
- HMO POS
- There are no benefits for services performed by out-of-network providers.

Magnolia Local Plus (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

Magnolia Open Access (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

Pelican HRA 1000

Pelican HRA 775

Magnolia Local Blue Connect

Magnolia Local Community Blue

Magnolia Local Plus

Magnolia Open Access

For more information about our OGB benefit plans as well as important plan requirements, view the *OGB Speed Guide*, available at **www.BCBSLA.com/providers** >Resources >Speed Guides.

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

Note: BlueCard authorizations are handled through the members' home plan.

You can find additional BlueCard guidelines in the *BlueCard Program Provider Manual*, available online at **www.BCBSLA.com/providers** >Resources >Manuals.

(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.

Medicare Advantage PPO Network Sharing

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

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

MA | PPO
MEDICARE ADVANTAGE

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

Provider Credentialing & Data Management

Join Our Networks Webpage

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.
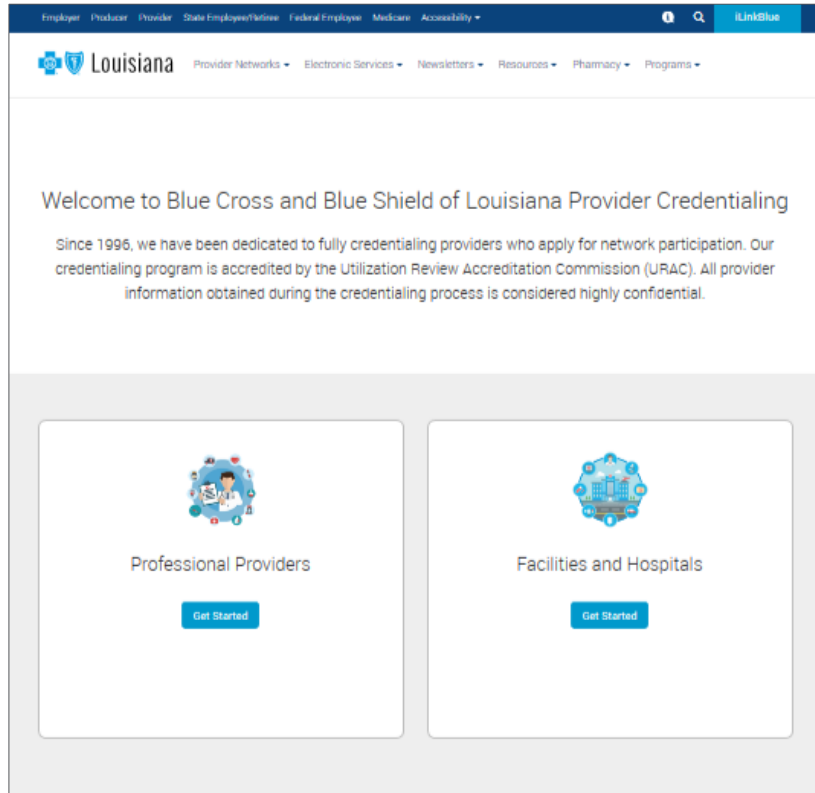
Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:

- Credentialing packets

- Quick links to the Provider Update Request Form

- Credentialing criteria for professional, facility and hospital-based providers

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 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.

You may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **pcdmstatus@bcbsla.com**.

Blue Cross is pleased to announce its partnership with Vantage Health Plan, Inc. to recredential our network providers. This move will simplify the recredentialing experience for many of our providers.

Aug. 2021 — Recredentialing for professional providers participating in both the Blue Cross and Vantage networks.

Nov. 2021 — Expanded to include the recredentialing of <u>all</u> Blue Cross professional providers.

Feb. 2022 — Expanded to include initial credentialing for professional providers and initial and recredentialing for Blue Cross facility providers.

Use the chart below for the new recredentialing process:

Process initiated by:	Vantage
Form(s) to complete for professional provider recredentialing:	CAQH Application or Louisiana Standardized Credentialing Application (LSCA)
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments
Where to submit forms:	To Vantage based on instructions included with recredentialing form
Verification Process:	Vantage
Who to contact:	Vantage by emailing recredentialing@vhpla.com

Below are the most common reasons credentialing applications are returned:

- Incomplete or expired supporting documents.

- No effective date listed.

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

- An alternative application was submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*.

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

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

- Ambulance Service
- Ambulatory Surgical Center
- Birthing Centers
- Cardiac Cath Lab (Outpatient)
- Diagnostic Services
- Dialysis Facility
- DME Supplier
- Emergency Medicine Physician Groups
- Home Health Agency
- Home Infusion
- Hospice
- Hospitals
- IOP/PHP Psych/CDU
- Laboratory
- Lithotripsy/Orthotripsy
- Nursing Home
- Radiation Center

- Residential Treatment
- Retail Health Clinic
- Skilled Nursing Facility
- Sleep Lab/Center
- Specialty Pharmacy
- Urgent Care Clinic

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

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

Credentialing packets:

- Professional (initial)
- Facility (initial)

Forms:

- **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
- **EFT Enrollment Form** – to begin receiving payments via electronic funds transfer (EFT)

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

www.BCBSLA.com/providers >Provider Networks
>Join Our Networks >Facilities and Hospitals

Easily Complete Forms with DocuSign

Navigation tool guides you through fields

Instructions correspond to requirement of the active field
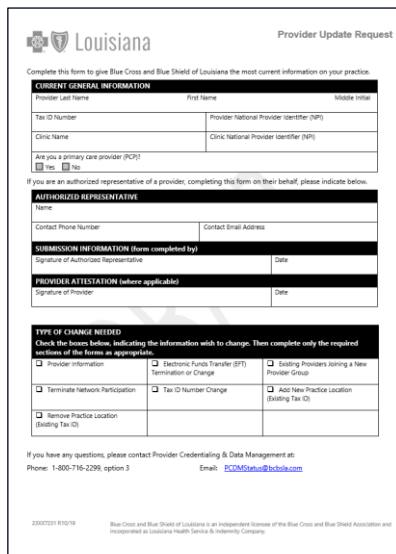
Tooltips provide information about field requirements

Red outline indicates a required field

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

It is important that we always have your most current information. Our revised **Provider Update Request Form** now accommodates all your change requests, which are handled directly by our Provider Data Management team.

When you access the form, check the appropriate box to indicate the type of change needed. You may select more than one option.

- **Demographic Information** allows you to update your address, phone, fax, email address, hours of operation and more.

- **EFT Termination or Change** option is to update your EFT information.

- **Existing Providers Joining a New Provider Group** is used to link an individual provider to an existing provider group or clinic.

- **Terminate Network Participation** is to request termination from one or more of our networks.

- **Tax ID Number Change** is to report a change in your Tax ID number.

- **Add a New Practice Location** is for when a provider is adding practice location(s) on an existing Tax ID.

- **Remove Practice Location** is for when a provider is removing a practice location(s) on an existing Tax ID.

Complete these via a DocuSign link at
www.BCBSLA.com/providers >Resources >Forms.

iLinkBlue Application Packet

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions.

The **iLinkBlue Application Packet** is available in DocuSign format at **www.BCBSLA.com/providers** >Resources >Forms.

ALWAYS include NPI/Tax ID on:

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

These four documents are included in the initial credentialing packets and are required to access iLinkBlue:

iLinkBlue Service Agreement

Business Associate Addendum

Electronic Funds Transfer Enrollment Form

Administrative Representative Registration Form

Administrative Representatives

What is an Administrative Representative?

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online tools.

- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.

- Your administrative representative must grant a user access to the following applications:

  - BCBSLA Authorizations

  - Behavioral Health Authorizations

  - Blue Advantage Provider Portal

  - Pre-Service Review

- One administrative representative is required to self-manage user access to our secure online services, but we recommend each organization assign more than one.

If you do not have an administrative representative registered with Blue Cross, please fill out and submit the Administrative Representative Registration Packet, which can be found on our Provider page (**www.BCBSLA.com/providers**).

We are committed to providing the highest level of protection when accessing our secure online services.

Adding administrative representatives was the first step in placing our online services under a higher level of security. Our next step was to add multi-factor authentication (MFA) for administrative representatives when they log into the Security Setup Tool.

- MFA is a security feature that delivers a unique identifier via email, text and other formats. The administrative representatives must enter this identifier as a first step in the logon process in the Security Setup Tool.

- It provides improved security and privacy.

- Administrative representatives can contact **1-800-716-2299, option 5** or **PIMTeam@bcbsla.com** for MFA assistance or questions.

Administrative representatives have the option of using PingID to authenticate their identity through their mobile device.

Ping iD

COMING SOON

- **May 2022**, we are introducing a new Security Setup Application for administrative representatives that will be available through iLinkBlue only.

    - Replaces the existing Sigma Security Setup Tool used today

    - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality

- We will migrate the data housed in the current tool for your provider organization to the new application.

- You will not need to reload information into the new application. The goal is to create a seamless transition.

We will provide more details as we get closer to May 2022. At that time, if you have questions about these changes, please contact our Provider Relations Department at **provider.relations@bcbsla.com**.

Miscellaneous

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

Two designation levels:

Blue Distinction® Center   **Blue Distinction® Center+**

The current programs are:

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

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

Questions related to Blue Distinction?

Contact Sheldon Evans at **shelton.evans@bcbsla.com**.

Blue Distinction Level Comparison

Evaluation Criteria for Participation Focused on:

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

Hospital-based Providers

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

- Anesthesia

- Emergency Medicine

- Neonatology

- Pathology

- Radiology

According to the legislation, facilities must notify health plans of any changes made to this information within 30 days of the change.

This information is presented to our members on our hospital-based physician reports, available at **www.BCBSLA.com** >Find A Doctor >ER/OR Information >Hospital-based Physician Providers.

- Blue Cross asks that network facilities submit changes on the **Consumer's Right to Know Facility Reporting Form** every time there is a change in hospital-based physician for any specialties listed previously.

- Return completed forms to our Provider Credentialing Department at **provider.contracting@bcbsla.com**.

The Consumer's Right to Know Facility Reporting Form is located at **www.BCBSLA.com/providers** >Resources >Forms.

Claims

Electronic Claims

Electronic Data Interchange (EDI)

- The fastest, most efficient way to exchange eligibility information, payment information and claims.

- Blue Cross' experienced EDI staff is ready to assist in determining the best electronic solution for your needs.

Electronic Transaction Exchange

- Various healthcare transactions can be submitted electronically to the Blue Cross clearinghouse in a system-to-system arrangement.

- Blue Cross does not charge a fee for electronic transactions.

- You can send your transactions to Blue Cross via indirect submission through a clearinghouse or through direct submission to the Blue Cross EDI Clearinghouse.

For more information about system-to-system electronic transactions, please contact EDI Services at **EDIServices@bcbsla.com** or **1-800-716-2299, option 3.**

HIPAA 835 Transaction

- Providers who submit claims electronically can receive an electronic file containing their weekly Provider Remittance Advice/Payment Register (ERA).

- The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.

- ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an upfront fee from your billing system vendor for programming.

- From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge.

For more information, please contact Blue Cross EDI Services at **EDIServices@bcbsla.com** or **1-800-716-2299, option 3.**

UB-04 (facility)

- If it is necessary to file a hardcopy claim, we only accept the original **RED** claim forms.

- We no longer accept faxed claims.

Mailing Addresses

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue, Signature Blue & OGB Claims:

BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898

For FEP Claims:

BCBSLA
P.O. Box 98028
Baton Rouge, LA 70898

For BlueHPN Claims:

HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898

For Blue Advantage Claims:

Blue Cross and Blue Shield
of Louisiana/HMO Louisiana
130 DeSiard St, Ste 322
Monroe, LA 71201

For Healthy Blue Dual Advantage (D-SNP):

Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

The fastest method for claim processing and payment is electronic submission.

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

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

Bill Types

1 1 1

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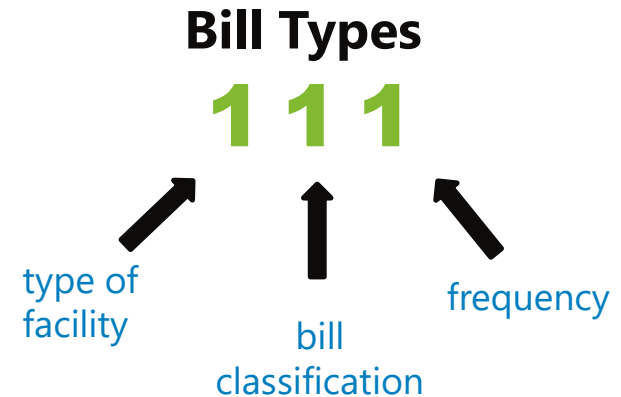
Frequency Code	Description	Blue Cross Acceptance Rule
Non-interim Claims		
1	Admit Through Discharge Claim	Accepted
Interim Claims		
2	Interim (First Claim)	We accept interim claims only when the total charge is $800,000 or greater **and** the length of stay is at least 60 days of service
3	Interim (Continuing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

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

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

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

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

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

- **Effective January 1, 2021**, the period from discharge was extended to **30 days**.

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

Blue Cross, HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue & Signature Blue:
– Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.

FEP:
– Preferred Providers have within 15 months of the date of service to file claim.
– Members and non preferred providers must be filed by December 31 of the year after the year service was rendered.

Blue Advantage:
– Providers have 12 months from the date of service to file an initial claim.
– Providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim.

OGB:
– Claim must be filed within 12 months of the date of service.
– Claim reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim.

Self-funded & BlueCard:
– Timely filing standards may vary so always verify the member's benefits, including timely filing standards, through iLinkBlue.

Healthy Blue Dual Advantage (HMO D-SNP):
– Claim must be filed within 12 months of the date of service.

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

National Drug Code (NDC) Required on Drug Claims

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

- NDC code editing will apply to any clinician-administered drugs billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").

- Each clinician-administered drug must be billed on a separate line item.

- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.

- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.

- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:

  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

Failure to report NDCs on claims will result in automatic rejections.

For Hardcopy Claims

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

For Electronic Claims 837I

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

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

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

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

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

For claims submitted on a UB-04:

We require that providers report an NDC when billing revenue codes 25X (excluding revenue code 258).

We also ask that you report the corresponding HCPCS/CPT® code for the billed drug. It should be included on the line item in addition to the NDC.

For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) **that line will not be reimbursed**.

- Most of our members follow a Covered Drug List. Covered Drug Lists include thousands of generic and brand drugs, but not all drugs.

- **Please consider prescribing drugs that are covered** or have lower out-of-pocket costs when you believe it is appropriate. If members fill a prescription drug that is not on the covered drug list, they could have to pay the full cost of the drug out of pocket.

- **You may ask for a clinical review** (similar to prior authorization) if your patient has a medically necessary need for a *non-formulary* drug. Find information about submitting a prior authorization at **www.BCBSLA.com** >Provider >Pharmacy. This is not available for drugs excluded from coverage.

You and your patients can check the Covered Drug List and find up-to-date information about drug coverage at **www.BCBSLA.com/covereddrugs**.

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

- Provider 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 Action Request response.

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

Common reasons to submit an Action Request:

- Claim status (detailed denials)

- Claim denied for coordination of benefits

- Claim denied as duplicate

- Claim denied for no authorization (but there is a matching authorization on file)

- Information needed from member (coordination of benefits, subrogation)

- Questioning non-covered charges

- No record of membership (effective and term date)

- Medical records receipt

- Recoupment request

- Status of an appeal

- Status of a grievance

Action requests are NOT available for Blue Advantage.

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

Submitting Action Requests

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

- On each claim, providers have the option to submit an Action Request review for correct processing.

- Click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim.

- Please include your contact information.

- NOTE: You only have to do one AR per claim; not one AR per line item of the claim.

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

- 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.

Helpful Reminders

- Allows identification of high-risk patients.

- Allows opportunities to engage patients in care management programs and care prevention initiatives.

- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross.

- Reduces costs associated with submitting corrected claims.

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

- Each page of the patient's medical records should include the following for hospital encounters and progress notes:
  - Patient name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials).
- Report ALL applicable diagnoses on claims and report at the highest level of specificity (UB-04 Claim Form).
- Include all related diagnoses, including chronic conditions you are treating.
- Medical records **must support ALL** diagnosis codes on claims.

- Include chronic conditions in documentation.

- Code to the highest specificity.

- Monitored, Evaluated, Assessed or Treated (MEAT) should be noted.

- Clarify whether a condition is **chronic** or **acute**.

- Clarify whether a condition as **controlled** or **uncontrolled**.

- Clarify the **type of diabetes**.

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

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

Medical Record Requests

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

- Per your Blue Cross network agreement, **providers are not to charge a fee** for providing medical records to Blue Cross or agencies acting on our behalf.

- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge.

- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.

- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee.

Network providers should always refer members to other network providers.

- Referrals to out-of-network providers result in significantly higher cost shares (deductibles, coinsurance and copayments) for our members and is a breach of your Blue Cross provider agreement.

- **Providers who consistently refer to out-of-network providers will be audited and may be subject to a reduction in their network reimbursement.**

Laboratory Referrals

- All of our network providers should refer members to preferred reference lab vendors when lab services are needed and are not performed in the facility.

- Blue Cross discourages hospital billing for services as a reference lab when they are not contracted as a reference lab with us.

- Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by an in-network hospital.

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

- UB-04: Block 78

- 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

For more information, view the *HMO Preferred Reference Lab Guide* and the *PPO Preferred Reference Lab Guide*, which are both available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

- Please make sure when referring your patients to behavioral health providers that they are in their behavioral health network.

- We have partnered with New Directions for their expertise in the provision of behavioral health services.

- New Directions manages authorizations for our members, performs all utilization and case management activities, as well as ABA case management.

- Request authorizations online through iLinkBlue using the **Behavioral Health Authorizations** application.

- New Directions' team of behavioral health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.

- For more information, such as medical necessity criteria, visit the **www.ndbh.com**.
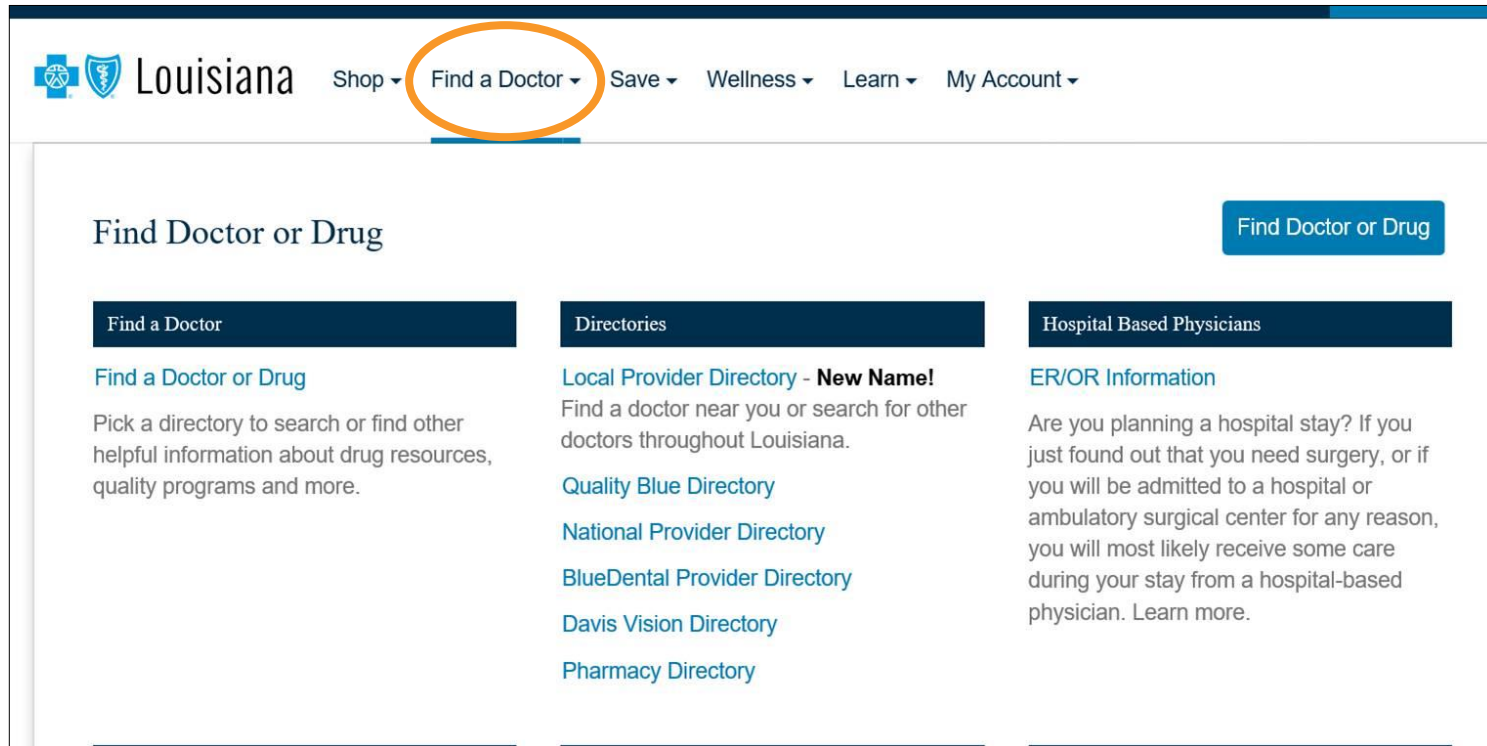
Behavioral health services that require an authorization:

- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP) - excluding FEP
- Partial Hospitalization Program (PHP) - excluding FEP
- Residential Treatment Center (RTC)
- FEP Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA)

For more information, view the *Behavioral Health Speed Guide*, available online at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Finding Participating Providers
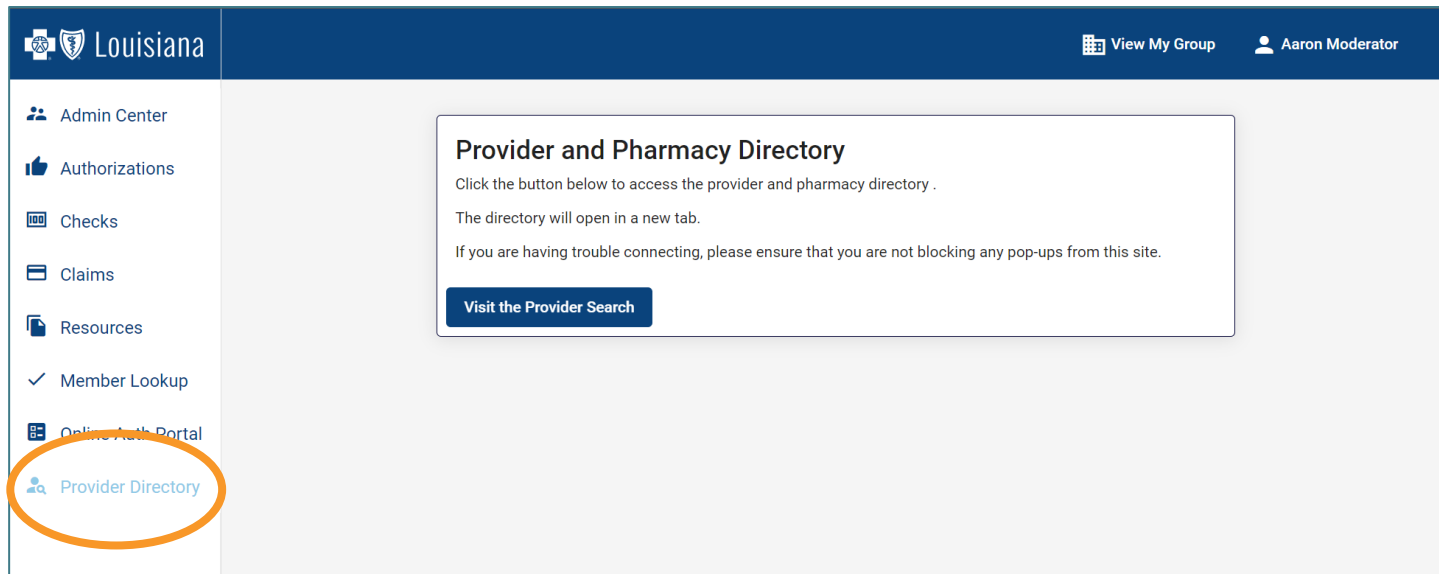
Find network providers in our online provider directories at
www.BCBSLA.com >Find a Doctor.

To refer Blue Advantage (HMO) | Blue Advantage (PPO) members to other providers, use the "Find a Provider" feature on the Blue Advantage Provider Portal (accessed through iLinkBlue).

Preferred laboratories for all specimens for the Blue Advantage network:

Clinical Pathology Labs (CPL)

Quest Diagnostics

Lab Corp

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

- Member eligibility

- Claim status inquiries

- Outpatient facility allowable searches

- Medical policy searches

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

Self-service tools available to providers:

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

- Interactive Voice Recognition (IVR) (1-800-922-8866)

  – The Automated Benefits & Claim Status (IVR Navigation Guide) Tidbit will help you navigate the IVR system and is available at **www.BCBSLA.com/providers** >Resources >Tidbits.

- HIPAA 27x transactions

Laboratory Benefit Management Program

COMING SOON
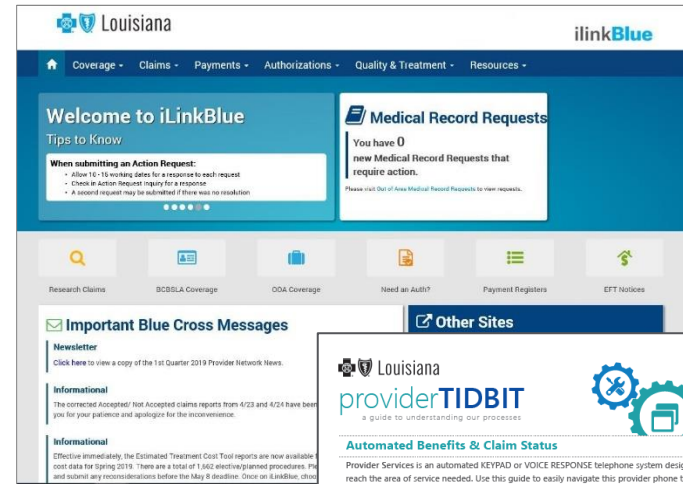
Effective **April 1, 2022**, Blue Cross in partnership with Avalon Healthcare Solutions, is implementing a new laboratory benefit management program.

Avalon provides:

- routine testing management services to ensure enforcement of laboratory policies

- automated review of high-volume, low-cost laboratory claims.

Blue Cross will apply Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

Note: Laboratory services, tests and procedures provided in emergency room, hospital observation, and hospital inpatient settings are excluded from this program.

Providers can now review and research the billing policies and guidelines. Go to **www.BCBSLA.com** and look under the Helpful Links section at the bottom of the page.

We have previously sent out a Laboratory Benefit Management Program Frequently Asked Questions, If you would like a copy, please email **provider.relations@bcbsla.com**.

In April, we will be hosting an educations webinar about this new program. Look for an email invitation or email **provider.relations@bcbsla.com** for registration information.

Authorizations

We have streamlined the process for requesting prior authorizations

- Blue Cross no longer accept authorization requests via phone or fax, with a few exceptions including transplants, dental services covered under medical and out-of-state services.

- Prior authorization requests, including new and extension authorizations, must be submitted through our online BCBSLA Authorizations tool available in iLinkBlue.

- The tool allows providers to request authorizations 24 hours a day, seven days a week, in real time.

- **In some cases, the tool allows for immediate approval without Blue Cross personnel intervention.**

- **If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity.**

- **Providers are responsible for checking member eligibility and benefits.**
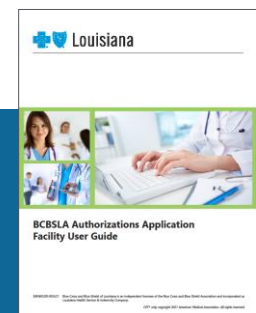
For more information on how to use our BCBSLA Authorizations Tool, the *BCBSLA Authorizations Applications Facility User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."

Our Medical Management Department has a toll-free retrospective authorization fax number; 1-800-515-1150.

The department also has a local fax number (225-298-2906). **On May 1, 2022, this local fax number will no longer be in service**. Please discontinue using the local number. If you are using the local number, please instead use the toll-free fax number.
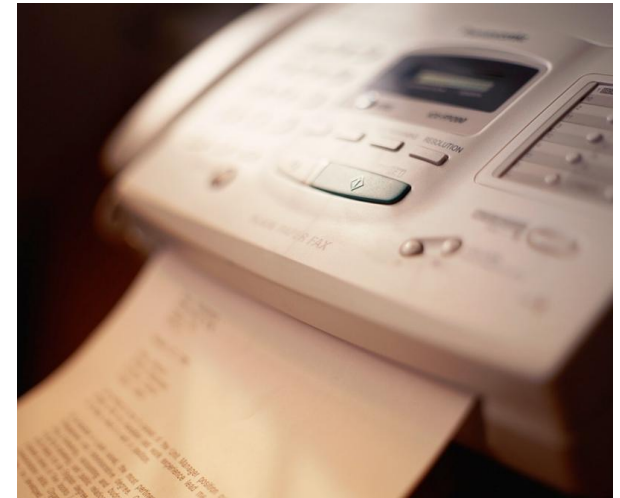
1-800-515-1150

iLinkBlue

iilinkBlue

www.BCBSLA.com/ilinkblue

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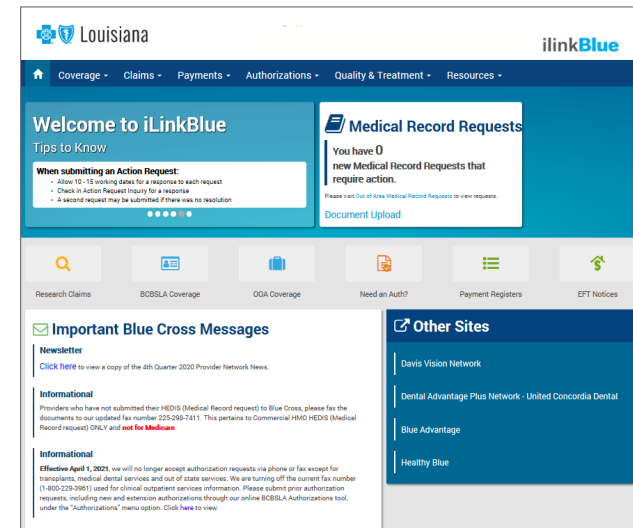
For iLinkBlue training and education, contact provider.relations@bcbsla.com.

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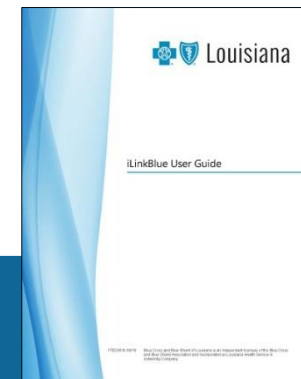
COMING SOON

- In **May 2022**, all iLinkBlue users will be required to complete several verification steps before entering iLinkBlue (**www.BCBSLA.com/ilinkblue**).

- Multi-factory Authentication (MFA) will be in a simplified, convenient and userfriendly self-service interface.

- Choose from various authentication methods, including email, text and smartphone authenticator app.

We will soon provide a a guide for how to complete the registration process.

iLinkBlue has a message board that appears on the main landing page.

This area contains posts for:

- Upcoming Events
- New Features
- System Outages
- Holiday Notices
- And other important bulletins

The main landing page also alerts you when there are BlueCard® (out-of-area) medical record requests for your patients.

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

Note: Blue Advantage (HMO) | Blue Advantage (PPO) member coverage and eligibility must be verified through the Blue Advantage Provider Portal.

Claims Information in iLinkBlue

Use the "Claims" menu option to find online tools to:
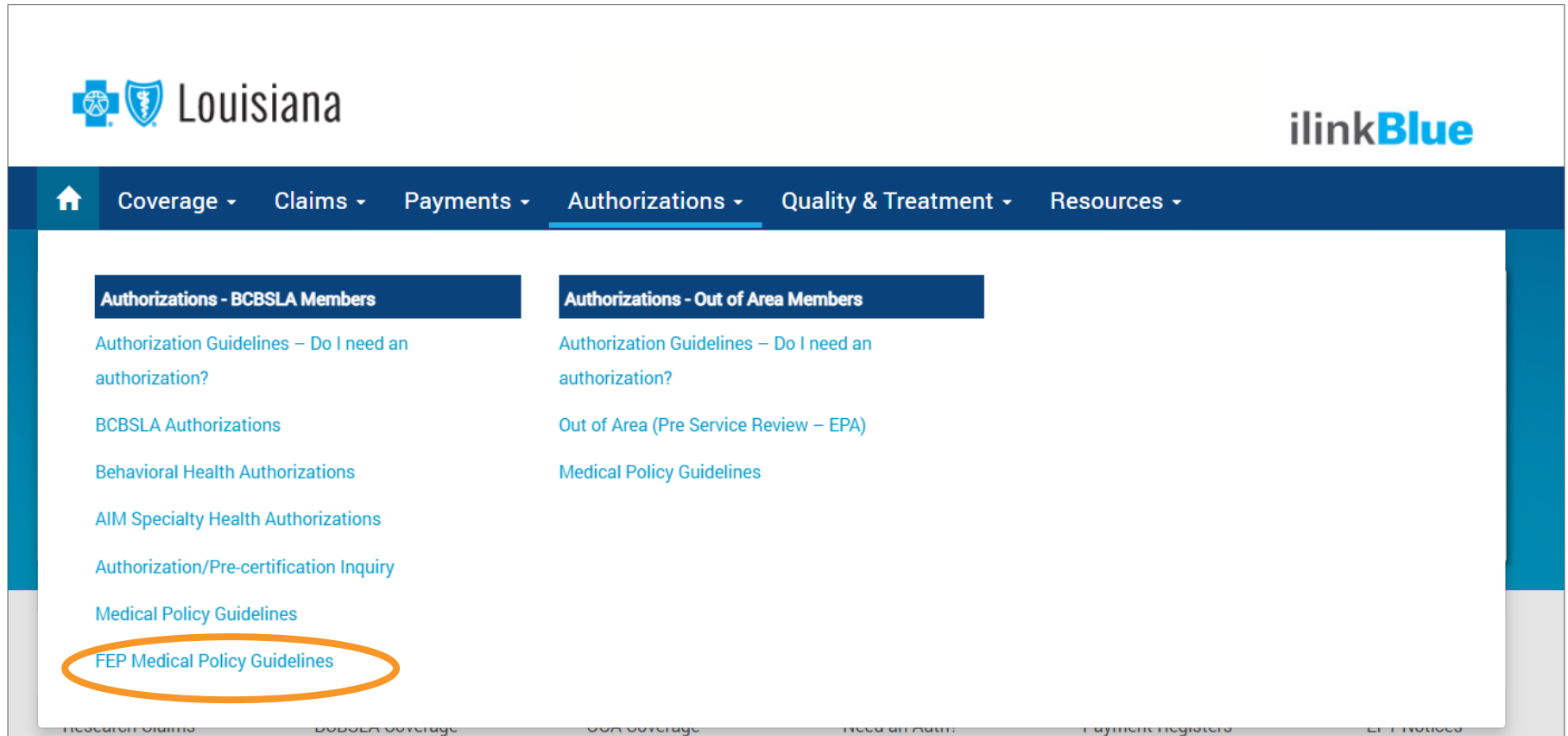
- Perform **Claims Research** on claims that were submitted for processing,

- Submit **BlueCard - Out of Area Claims Status** inquiries for BlueCard (out-of-area) members,

- Check status of claims that were filed electronically (even if they were filed through a clearinghouse) using the **Blue Cross Claims Confirmation Reports** tool and/or

- View medical record requests for your BlueCard (out-of-area) patients in our **Medical Records** section.

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

Digital ID Cards on iLinkBlue

Digital ID cards are accessible through iLinkBlue as a downloadable PDF. Click the "Coverage Information" menu option, enter the member contract number in the search bar and then click "ID Card."

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

- 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.

- Blue Cross member portal: Log into the online member account at **www.BCBSLA.com**, then 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.

Payments Information in iLinkBlue
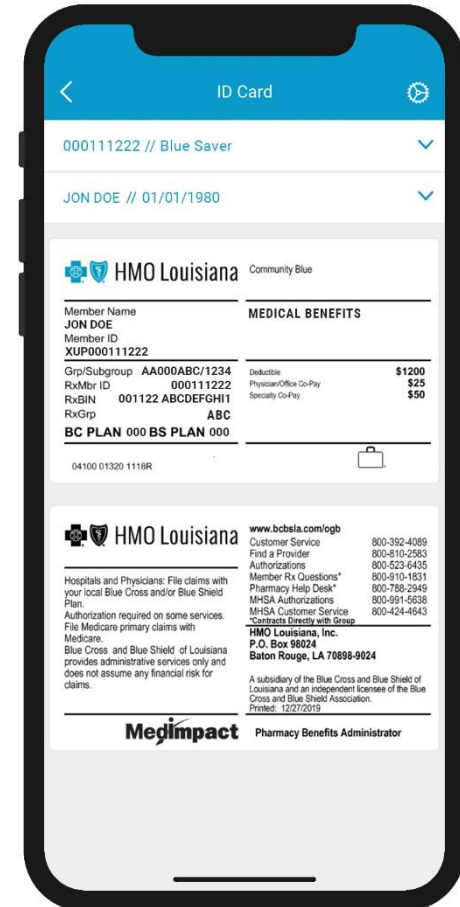
Use the "Payments" menu option to view payment registers, EFT notifications and research allowables.

Use the "Authorizations" menu option to access online authorization tools:

- The **BCBSLA Authorizations** tool allows you to submit and research authorizations for BCBSLA members.

- Behavioral health providers must use the New Directions Webpass Portal application, located in the **Behavioral Health Authorizations** link, to submit authorization requests for behavioral 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

- Our network providers can access pre-service information offered by other Blue Plans for BlueCard® (out-of-area) members in the **Out of Area (Pre-service Review - EPA)** application.

Accessing Medical Policies in iLinkBlue
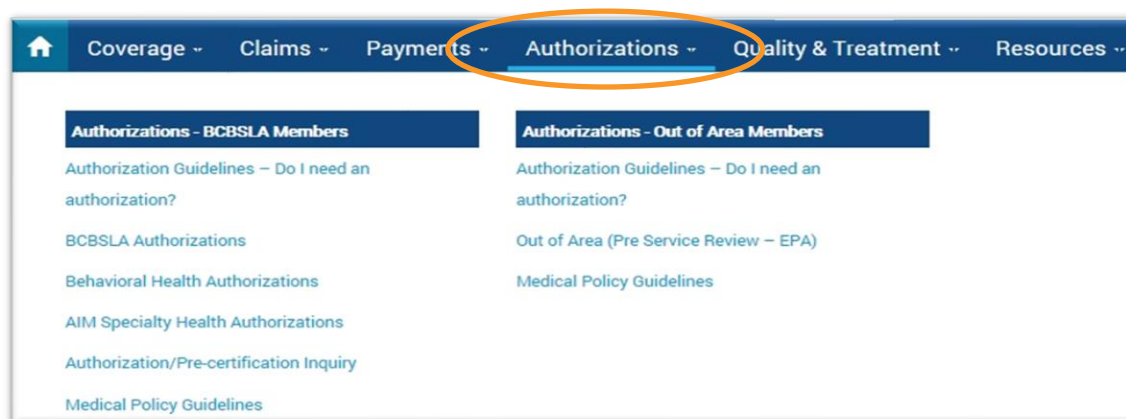
- Use the "Authorizations" menu option to access our **Medical Policy Index**.

- Policies are listed in alpha order or you may search by policy number or procedure code.

1
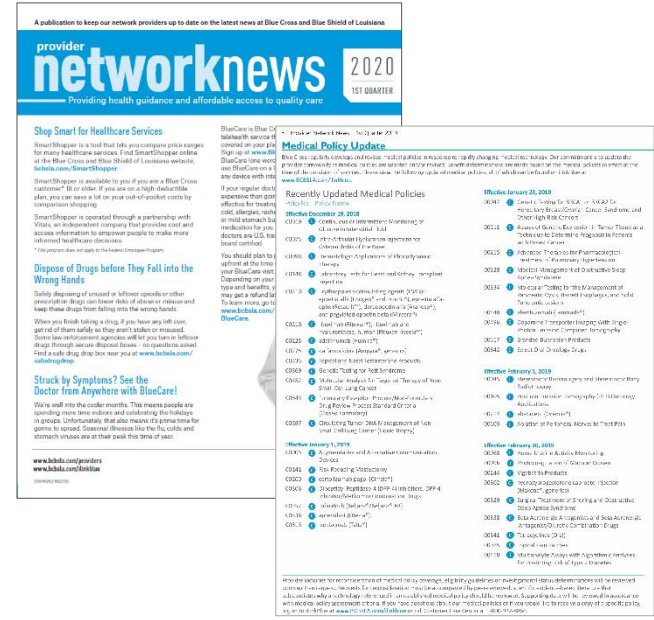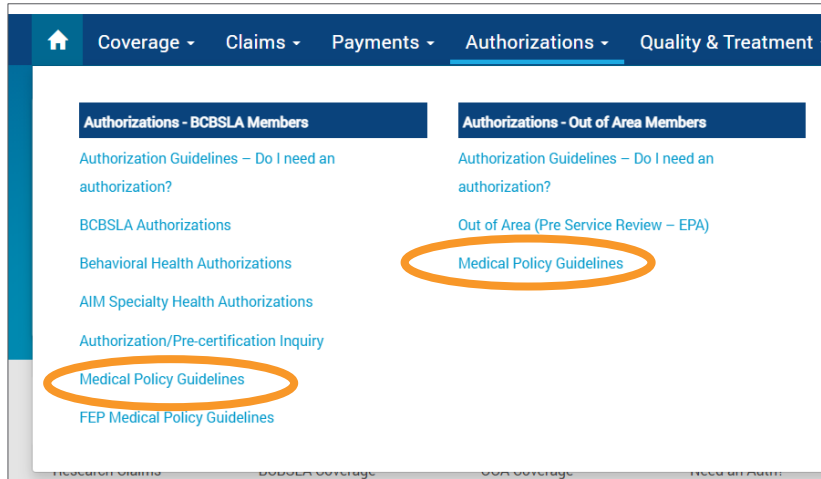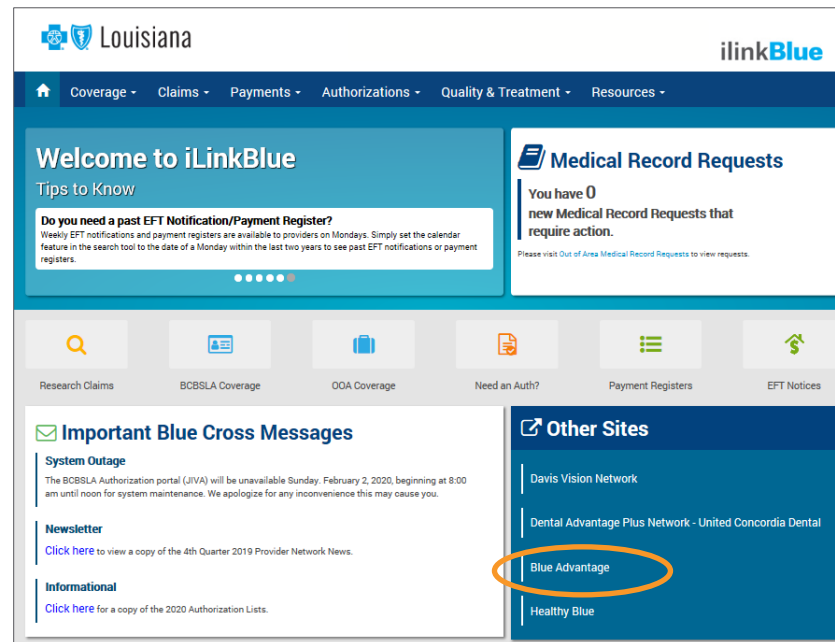
2
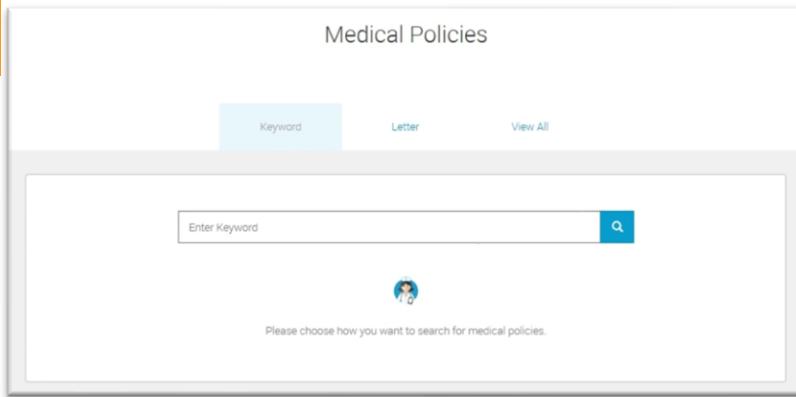
Medical policies are reviewed annually and are updated throughout the year as needed. We publish these updates in our quarterly *Provider Network News* newsletters, available online at **www.BCBSLA.com/providers** >Newsletters.

Blue Advantage

- The processes for Blue Advantage (HMO)/Blue Advantage (PPO) differ from our other provider network processes.

- There is a separate portal for these contracted providers to access needed information.

- You can access the Blue Advantage Provider Portal through iLinkBlue (**www.BCBSLA.com/iLinkBlue.com**), under "Other Sites," click "Blue Advantage."

- Access to the Blue Advantage Provider Portal requires a higher level of security that must be assigned to users by your organization's security administrative representative.

The Blue Advantage Provider Portal offers resources such as:

- Office Manuals*

- Guides*

- Forms*

- Eligibility

- Claims & Authorization Inquiries

- Provider & Pharmacy Search feature to refer members to other Blue Advantage network providers
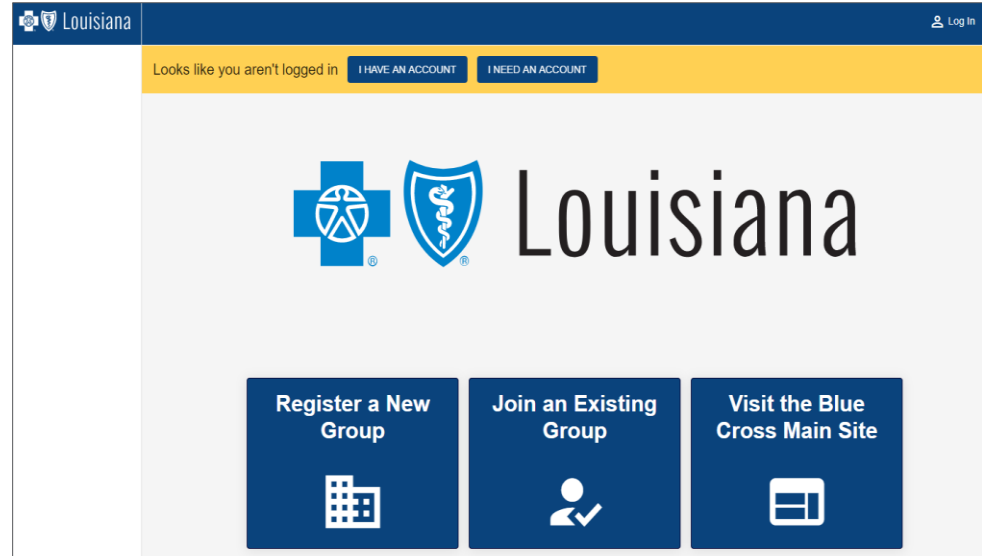
*These resources are also available on the Blue Advantage Resources page at **www.BCBSLA.com/providers**.

Registration is required to gain access to the Blue Advantage Provider Portal. If you need access, please contact your Group Moderator.

Blue Advantage – Administered by Vantage Health Plan

Effective **January 1, 2021**, we transitioned our Blue Advantage primary service administrator to **Vantage Health Plan**, a Louisiana-based company.

Submit claims to Vantage Health Plan
(Payor ID 72107)

Blue Cross Blue Shield of Louisiana/HMO Louisiana, Inc.
130 DeSiard St. Ste 322
Monroe, LA 71201

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).

Claims Editing

- Applies edits to incoming claims to ensure proper coding and billing based on:

  – Reimbursement

  – Medical policy

  – Benefit rules

  – Industry standard and coding guidelines

- It promotes accurate and consistent payments.

- Manages compliance with standard coding and billing practice between various types of services, such as:

  – Medical

  – Surgical

  – Lab and radiology

Effective May 1, 2022, codes exempt from multiple procedure reduction have been updated.

A listing of the codes exempt from Multiple Procedure Reduction can be found on iLinkBlue (**www.BCBSLA.com/ilinkblue** >Claims >Exempt MPR Codes - Facility).
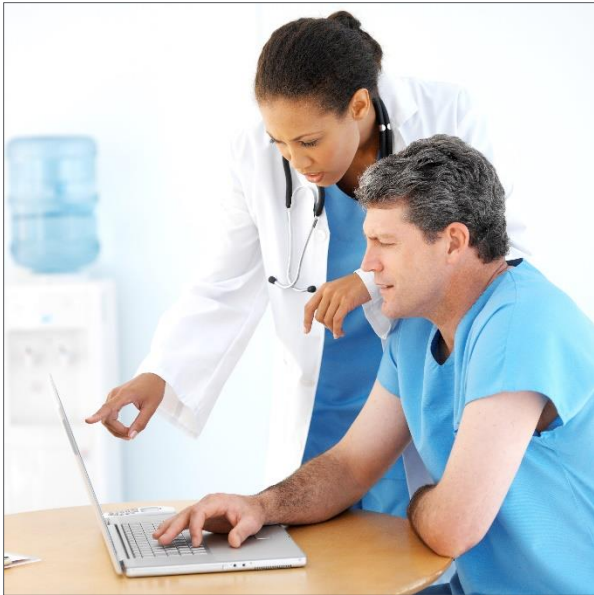
Certain codes will be denied because the services should be included with other services billed on the same day.

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

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

Examples:

80053 84443 85025	▶	80050

73560 73562	▶	73564

85025 86592 86762 86850 86900 86901 87340	▶	80055

85025 86592 86762 86850 86900 86901 87340 89389	▶	80081

- Most edits are based on date processed, **not** date of service.*

- Any claim adjustments processed **after the implementation date** of the new CES system are subject to edits in the new system.

- **Explanation codes and descriptions** on payment register may be different in the new system.

- CARC codes on the 835 may be different. Example: Where you previously saw **CARC 97** for mutually exclusive, incidental and unbundle edits, you will now see CARC 97 for Incidental **AND** Unbundle and 231 for Mutually Exclusive.

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

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

Step 1

- Check that you are following the proper billing guidelines. Refer to resources in your:
    - Provider Manual
    - Code Book
    - Lists provided on iLinkBlue (You can locate these lists at **www.BCBSLA.com/ilinkblue** >Claims then look under the "Medical Code Editing" section).

Step 2

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

Step 3

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

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

www.BCBSLA.com/providers >Resources >Tidbits

With the implementation of the new CES system, we have a new tool in iLinkBlue for providers to calculate claim-edit outcomes.
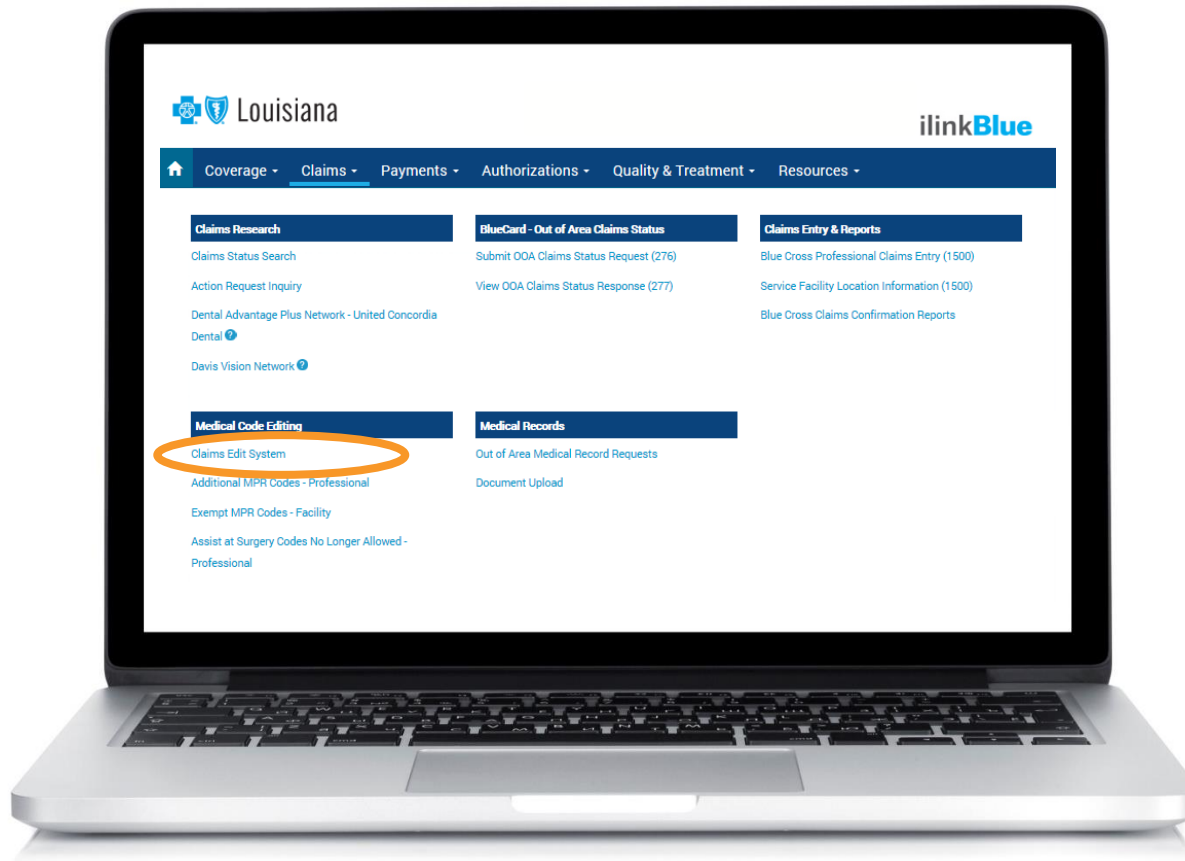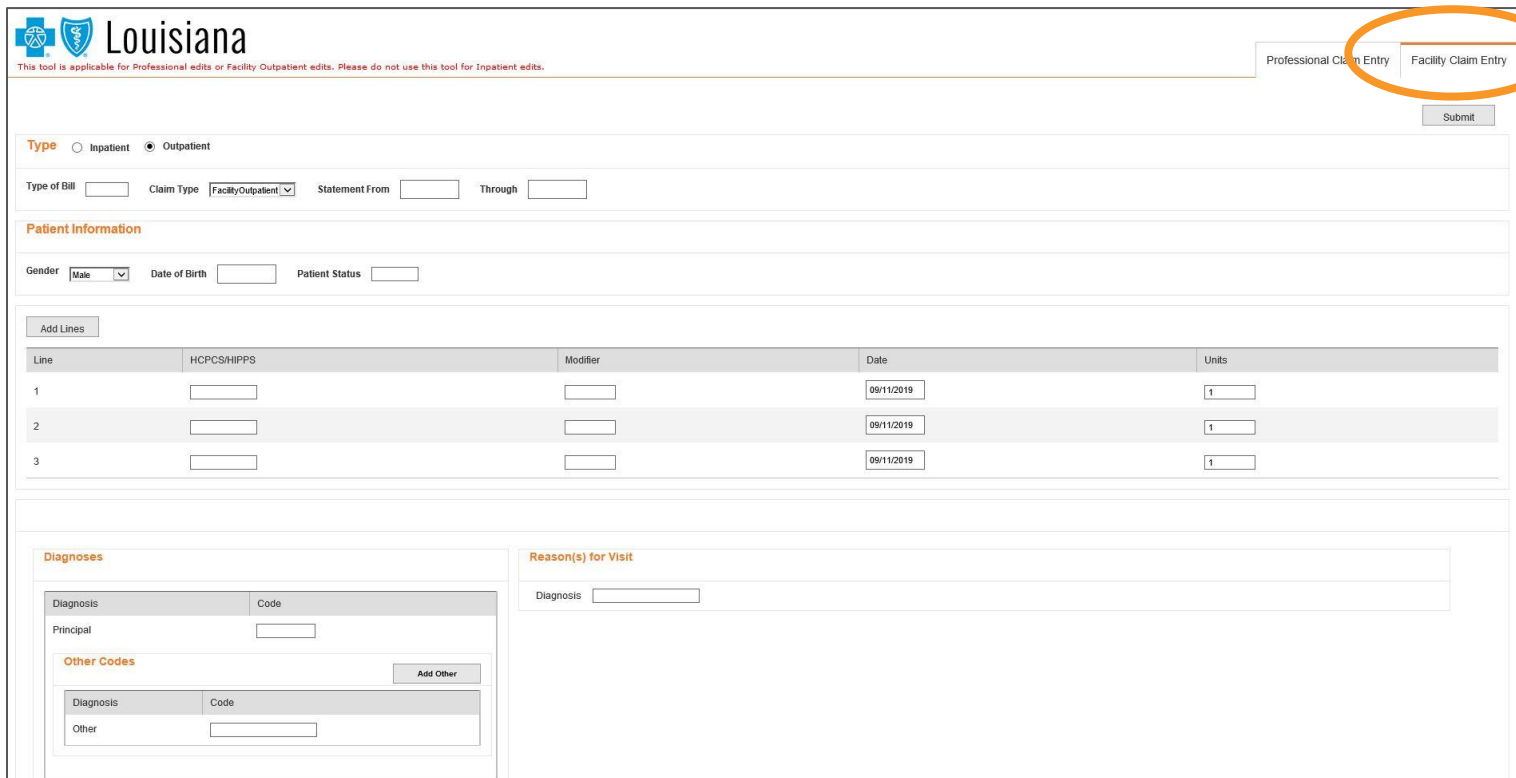
This tool applies to **hospital outpatient & ambulatory surgery center claims only** and does not guarantee claims payment.

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

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

Claims Editing System Tool

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

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

Bilateral procedure (92250) billed with 2 units.

G0463 not separately reimbursable.

Resources

The Provider Page

The Provider Page is home to online resources such as:

- Provider manuals
- Network speed guides
- Newsletters
- Provider forms
- And more
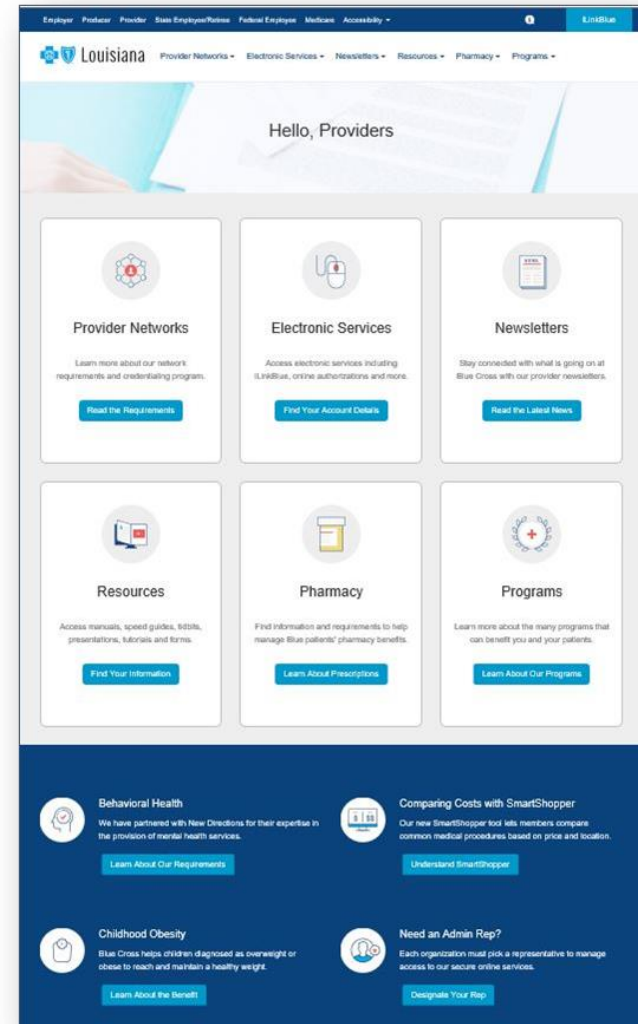
www.BCBSLA.com/providers

Our manuals are an extension of your member provider agreement.

The manuals include the information you need as a participant in our networks:

- Reimbursement Information
- Claims Submission
- Billing Guidelines
- Medical Management
- Appeals and Disputes
- Network Overviews
- Authorization Requirements
- And much more

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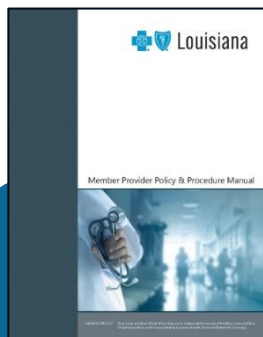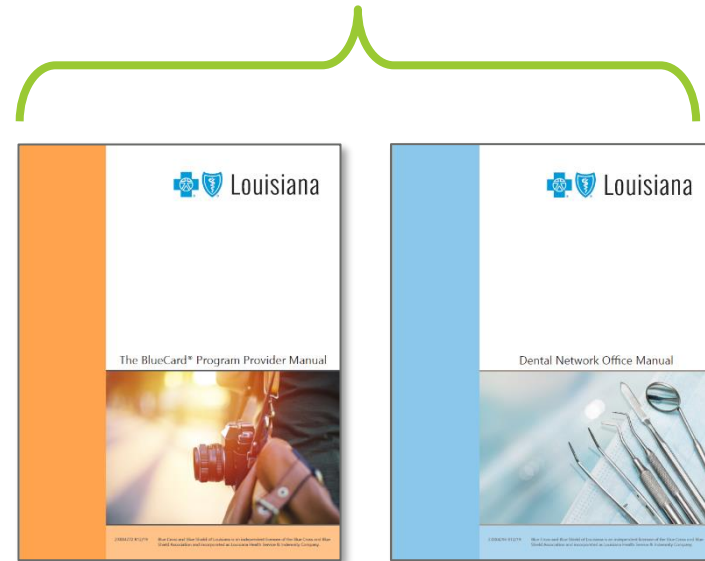
The *Member Provider Policy & Procedure Manual* (our facility manual) is located only in iLinkBlue at **www.BCBSLA.com/ilinkblue** >Resources.

Stay connected with what is going on at Blue Cross with our **provider newsletters**.

www.BCBSLA.com/providers > Newsletters

Network News
Our quarterly newsletter for network providers.

Blue Advantage Insight
Our newsletter for our Blue Advantage (HMO) and Blue Advantage (PPO) network providers.

Not Getting Our Newsletters?

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 and Tidbits

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

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

www.BCBSLA.com/providers > Resources

- **Provider Workshops and Webinars** are held throughout the year to offer training and updates on Blue Cross policies and procedures.

- Invites to attend these events are sent to providers' correspondence email address.

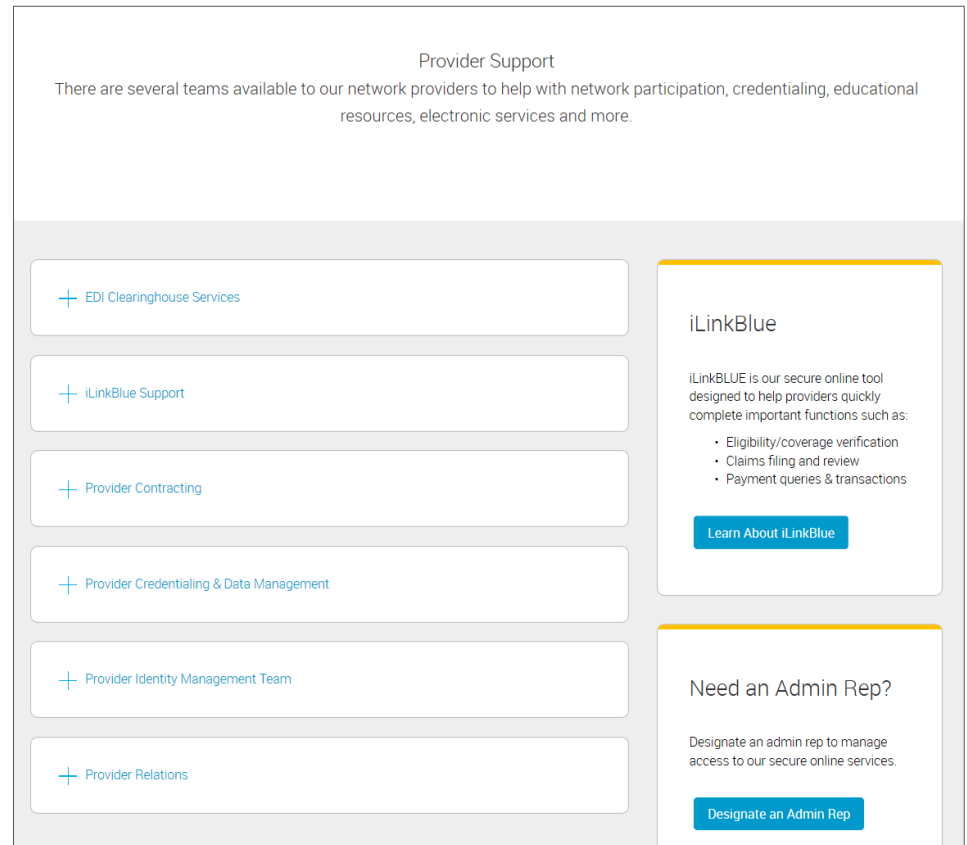- PDF copies of our workshops and webinars are available online.
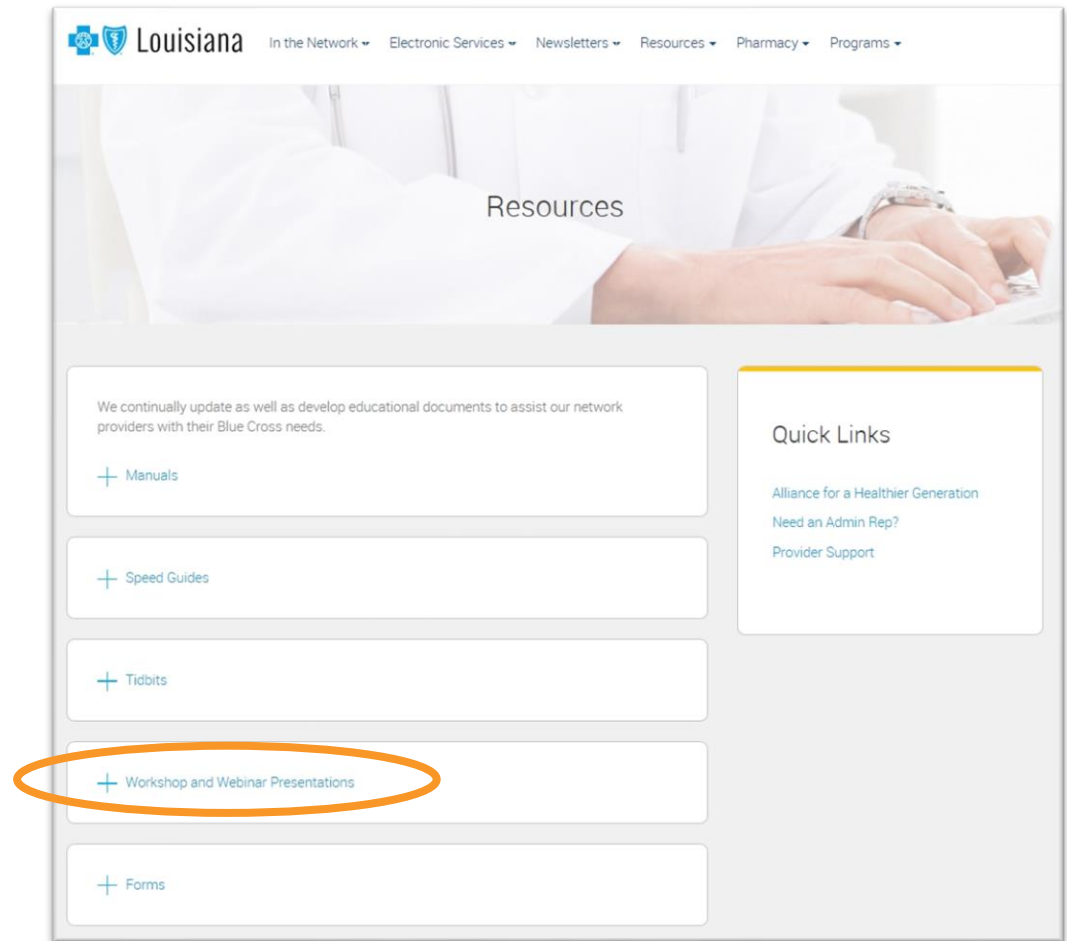
www.BCBSLA.com/providers >Resources >Workshop and Webinar Presentations

Provider Support

We believe supporting our network providers is important.

Our **Provider Support** page can help you find your:

- Provider Credentialing Representative

- Provider Relations Representative

- PCDM assistance with credentialing or demographic changes

- Electronic services support

www.BCBSLA.com/providers >Provider Networks >Provider Support

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   **1-866-508-7145**

Healthy Blue Dual Advantage   **1-844-209-5406**
**   (HMO) D-SNP**

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

Health Services Division – 1-800-716-2299
  option 1 – for questions regarding provider contracts
  option 2 – for questions regarding credentialing and provider record information
  option 3 – for questions regarding iLinkBlue and clearinghouse information
  option 4 – for questions regarding provider relations
  option 5 – for questions regarding security access to online services

At this time, we will address the questions you submitted electronically through the webinar platform.