

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.



Louisiana

Welcome to the Blue Cross Network – *Professional Webinar*



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

February 2022

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.





	Louisiana	Preferred Care PPO Network FULLY INSURED
Member Name BLUE SUBSCRIBER	Member ID XUP000000000	Grp/Subgroup: RAA00000/PPO4
		RxMbr ID: 200000000
		RxBIN: 000000 PCN-A4
		RxGrp: BSLA
MEDICAL	DEDUCTIBLE	OUT OF POCKET
	Individual	Individual
In Network	\$5500	\$5500
Out of Network	\$5500	\$5500
04BA0314 R01/22		
		

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.

 HMO Louisiana		POS Network
FULLY INSURED		
Member Name BLUE SUBSCRIBER	Grp/Subgroup: AAA00FF1/0001	
Member ID XUA000000000	RxMbr ID: 200000000	
	RxBIN: 000000 PCN-A4	
	RxGrp: BSLA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET
	Individual Family	Individual Family
In Network	\$0 \$0	\$2000 \$4000
Out of Network	\$1750 \$5250	\$4000 \$8000
04100 01320 0122R		Vision 




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

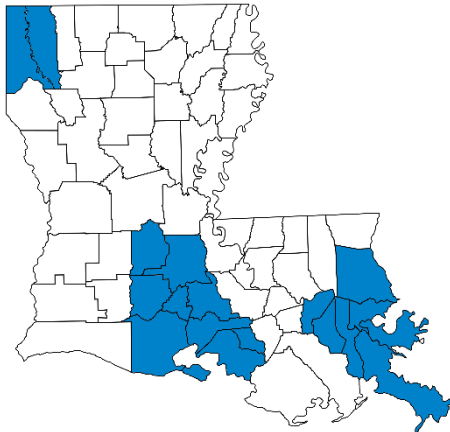
Prefixes: XUF, XUG, XUU and XUV

- 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.

MEDICAL		DEDUCTIBLE	OUT OF POCKET
		Individual	Individual
In Network		\$0	\$2000
Out of Network		\$1000	\$4000

04100 01320 0122R

Vision 



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

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



MEDICAL		DEDUCTIBLE	OUT OF POCKET	PHARMACY
		Individual	Individual	Deductible
In Network		\$4500	\$7900	\$250
Out of Network		\$9000	\$15800	

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

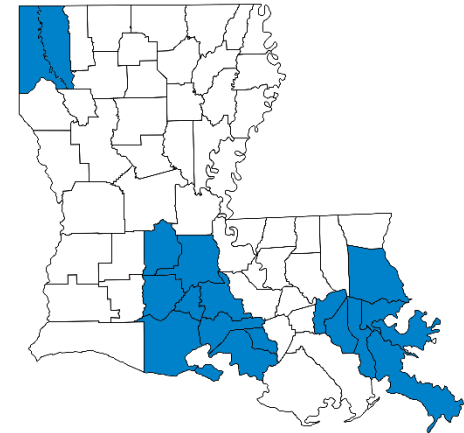
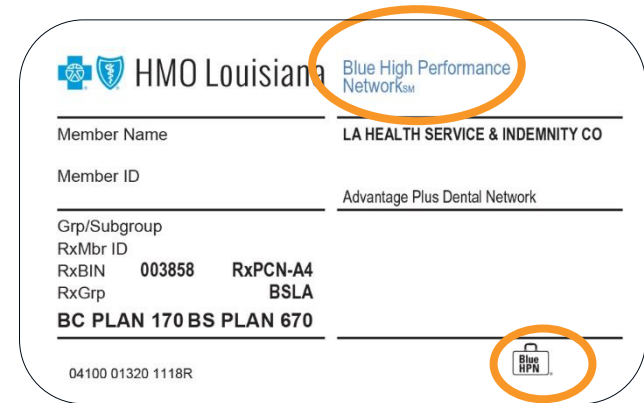
New Orleans area

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.

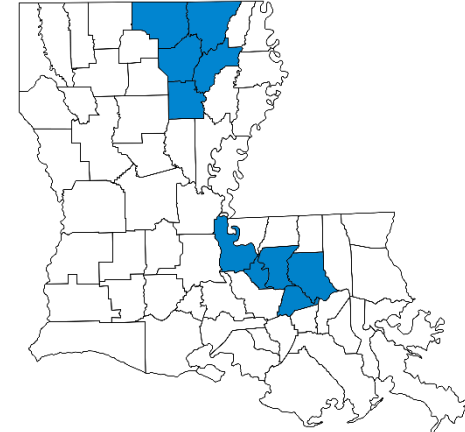
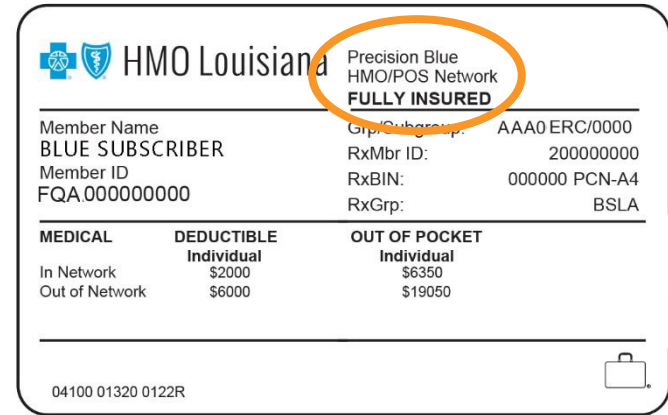
Baton Rouge area:

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

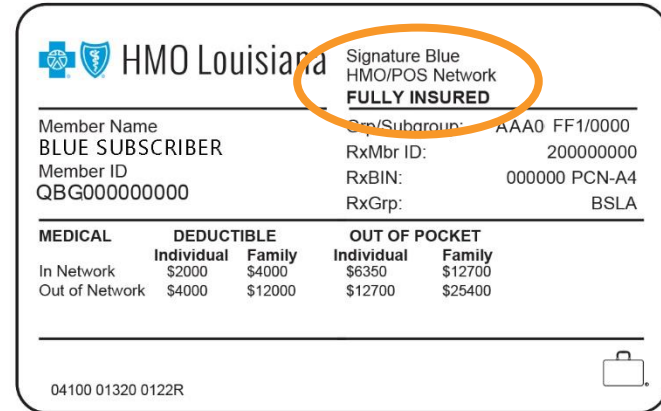
Signature Blue is an HMO POS product that is available to groups and individuals residing in two parishes.

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.



Signature Blue HMO/POS Network
FULLY INSURED

Member Name: BLUE SUBSCRIBER
Member ID: QBG000000000

Corp/Subgroup: AAA0 FF1/0000
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA

MEDICAL	DEDUCTIBLE		OUT OF POCKET	
	Individual	Family	Individual	Family
In Network	\$2000	\$4000	\$6350	\$12700
Out of Network	\$4000	\$12000	\$12700	\$25400

04100 01320 0122R

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.



Louisiana

Blue Advantage (PPO)

RxBIN:	003858	PCP Visit	\$ 5
RxPCN:	MD	Specialist Visit	\$ 20
RxGROUP:	MY9A	Emergency Room	\$ 50
EFFECTIVE:	01/01/2022	Major Diagnostic	\$ 150
		Outpatient Surgery	\$ 150
		Outpatient Hospital	\$ 150

Medicare limiting charges apply.

ID: PMV123456789
John T Public

Prescription Drug Coverage
 MEDICARE ADVANTAGE

www.bcbsla.com/blueadvantage

Prefix: PMV

Louisiana

Blue Advantage (HMO)

RxBIN:	003858	PCP Visit	\$
RxPCN:	MD	Specialist Visit	\$
RxGROUP:	MY9A	Emergency Room	\$
EFFECTIVE:	01/01/2022	Major Diagnostic	\$
		Outpatient Surgery	\$
		Outpatient Hospital	\$

ID: MDV123456789
John T Public

Prescription Drug Coverage
 MEDICARE ADVANTAGE

www.bcbsla.com/blueadvantage

Prefix: MDV



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

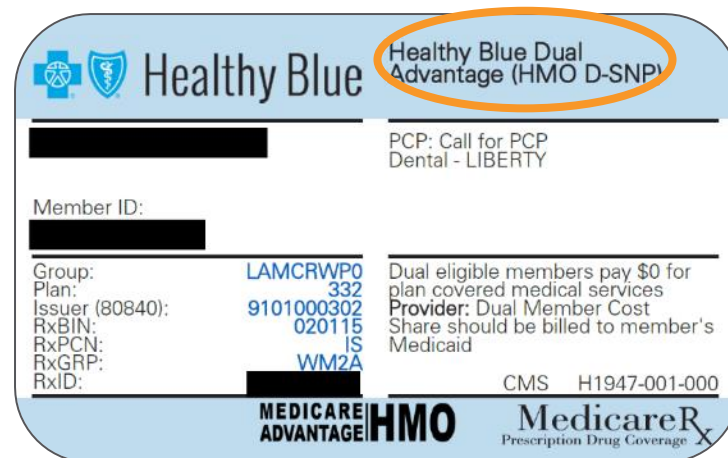


Prefix: JLA

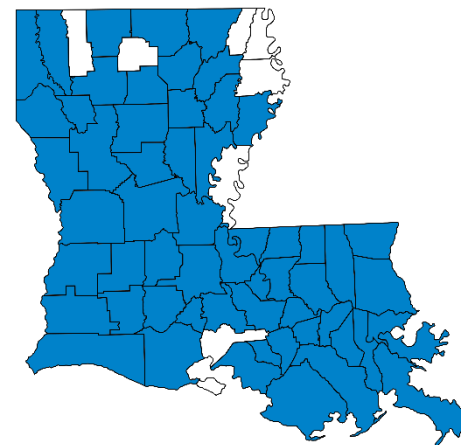
Healthy Blue Dual Advantage (HMO D-SNP) is our Medicare/Medicaid Dual Advantage special needs product currently available to Medicare/Medicaid-eligible members.

Statewide with the exception of the following parishes:

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



Prefix: JLA





For more information, go to www.BCBSLA.com/ilinkblue > Other Sites > Healthy Blue.

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.



 **Louisiana** Preferred Care PPO Network 

Member Name: BLUE SUBSCRIBER Grp/Subgroup: 78T04ERC/0000
Member ID: OCF000000000

MEDICAL	DEDUCTIBLE		OUT OF POCKET		Tier 1 COPAYS After Deductible Primary Care Specialty
	Individual	Family	Individual	Family	
OchPlus	\$0	\$0	\$3000	\$9000	\$25 \$45
BCBSLA PPO	\$5000	\$14000	\$7000	\$14000	
Out of network	\$5000	\$14000	Unlimited	Unlimited	

OCHSNER HEALTH 

04BA0314 R01/22

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

		Government-Wide Service Benefit Plan						
Member Name BLUE SUBSCRIBER		www.fepblue.org						
Member ID R00000000		Standard Option Enrollment Code 106						
Effective Date	01/01/2022	Deductible Individual	\$350					
RxIIN	610239	Deductible Family	\$700					
RxPCN	FEPRX	Out-of-Pocket Maximum						
RxGrp	65006500	<table border="0"> <tr> <td>In-Network</td> <td>Out-of-Network</td> </tr> <tr> <td>Individual</td> <td>\$6,000</td> </tr> <tr> <td>Family</td> <td>\$12,000</td> </tr> </table>	In-Network	Out-of-Network	Individual	\$6,000	Family	\$12,000
In-Network	Out-of-Network							
Individual	\$6,000							
Family	\$12,000							

✓ In-network

✓ Out-of-network

Basic

		Government-Wide Service Benefit Plan						
Member Name BLUE SUBSCRIBER		www.fepblue.org						
Member ID R00000000		Basic Option Enrollment Code 113						
Effective Date	01/01/2022	Deductible Individual	\$0					
RxIIN	610239	Deductible Family	\$0					
RxPCN	FEPRX	Out-of-Pocket Maximum						
RxGrp	65006500	<table border="0"> <tr> <td>In-Network</td> <td>Out-of-Network</td> </tr> <tr> <td>Individual</td> <td>\$6,500</td> </tr> <tr> <td>Family</td> <td>\$13,000</td> </tr> </table>	In-Network	Out-of-Network	Individual	\$6,500	Family	\$13,000
In-Network	Out-of-Network							
Individual	\$6,500							
Family	\$13,000							

✓ In-network

✗ Out-of-network

FEP Blue Focus

		Government-Wide Service Benefit Plan						
Member Name BLUE SUBSCRIBER		www.fepblue.org						
Member ID R00000000		FEP Blue Focus Enrollment Code 133						
Effective Date	01/01/2022	Deductible Individual	\$500					
RxIIN	610239	Deductible Family	\$1,000					
RxPCN	FEPRX	Out-of-Pocket Maximum						
RxGrp	65006500	<table border="0"> <tr> <td>In-Network</td> <td>Out-of-Network</td> </tr> <tr> <td>Individual</td> <td>\$8,500</td> </tr> <tr> <td>Family</td> <td>\$17,000</td> </tr> </table>	In-Network	Out-of-Network	Individual	\$8,500	Family	\$17,000
In-Network	Out-of-Network							
Individual	\$8,500							
Family	\$17,000							

✓ **LIMITED** in-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

Louisiana Preferred Care PPO Network			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/2040	RxMbr ID: 202201952	
Member ID OGS000000000	RxBIN: 003858 PCN-A4	RxGrp: 2AXA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COPAYS
In Network	Individual N/A	Individual N/A	Primary Care 80%
Out of Network	Family \$4000	Family \$10000	Specialty 60%
	Individual N/A	Individual N/A	
	Family \$8000	Family \$20000	
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS PELICAN HRA 1000 04BA0314 R01/22			

Pelican HRA 775

Louisiana Preferred Care PPO Network			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/8634	RxMbr ID: 202474492	
Member ID OGS000000000	RxBIN: 003858 PCN-A4	RxGrp: BSLA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COINSURANCE
In Network	Individual \$2000	Individual \$5000	Preferred 80%
Out of Network	Family \$4000	Family \$10000	All Other 60%
	Individual \$4000	Individual \$2000	
	Family \$8000	Family \$20000	
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS PELICAN HSA 775 04BA0314 R01/22			

Magnolia Local Blue Connect

HMO Louisiana Blue Connect			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/8474	RxMbr ID: 200755730	
Member ID LZB000000000	RxBIN: 003858 PCN-A4	RxGrp: 2AXA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COPAYS
In Network	Individual \$400	Individual \$2500	Primary Care \$25
			Specialty \$50
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS MAGNOLIA LOCAL 04100 01320 0122R			

Magnolia Local Community Blue

HMO Louisiana Community Blue			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/8360	RxMbr ID: 200753011	
Member ID LXS000000000	RxBIN: 003858 PCN-A4	RxGrp: 2AXA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COPAYS
In Network	Individual \$400	Individual \$2500	Primary Care \$25
			Specialty \$50
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS MAGNOLIA LOCAL 04100 01320 0122R			

Magnolia Local Plus

Louisiana Preferred Care PPO Network			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/2032	RxMbr ID: 200997878	
Member ID OGS000000000	RxBIN: 003858 PCN-A4	RxGrp: 2AXA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COPAYS
In Network	Individual N/A	Individual N/A	Primary Care \$25
	Family \$1200	Family \$8500	Specialty \$50
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS MAGNOLIA LOCAL PLUS 04BA0314 R01/22			

Magnolia Open Access

Louisiana Preferred Care PPO Network			
Member Name BLUE SUBSCRIBER	Grp/Subgroup: ST222ERC/2019	RxMbr ID: 201213071	
Member ID OGS000000000	RxBIN: 003858 PCN-A4	RxGrp: 2AXA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET	COPAYS
In Network	Individual N/A	Individual N/A	Primary Care \$25
	Family N/A	Family N/A	Specialty \$50
There is no out of network coverage on this plan. OFFICE OF GROUP BENEFITS MAGNOLIA OPEN ACCESS 04BA0314 R01/22			

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 NetworkSM (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.



BlueCross® BlueShield®

Members: Call Customer Service for claims filing information.

Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. When Medicare is primary, file Medicare claims directly with Medicare. Preauthorization required for all hospital inpatient admissions, MRI/MRA/PET/CT will require authorization to ensure benefit payment. Report emergency admissions within 24 hours.

Blue Cross and Blue Shield of Louisiana provides administrative services only and does not assume any financial risk for claims.


NUV

MyHealthToolkitLA.com

Customer Service: 877-705-5427
PPO Network Provider Information: 800-810-2583
Provider Service: 800-868-2510
Precertification: 888-376-6544
Mental Health and Substance Abuse Precertification: 800-868-1032
Express Scripts®: 877-262-3293
*Contracts separately with group.

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.

Pharmacy benefits administrator: Contracts separately with group.




BlueCross® BlueShield®

SUBSCRIBER'S FIRST NAME _____
SUBSCRIBER'S LAST NAME _____

Member ID
XXX123456789012

PLAN CODE	380	
RxBIN	003858	
RxGRP	KESA	
RxPCN	A4	

MyHealthToolkitLA.com



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

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...

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.

If you are NOT a participating provider in our MA PPO network...

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.

If your practice is closed to new members...

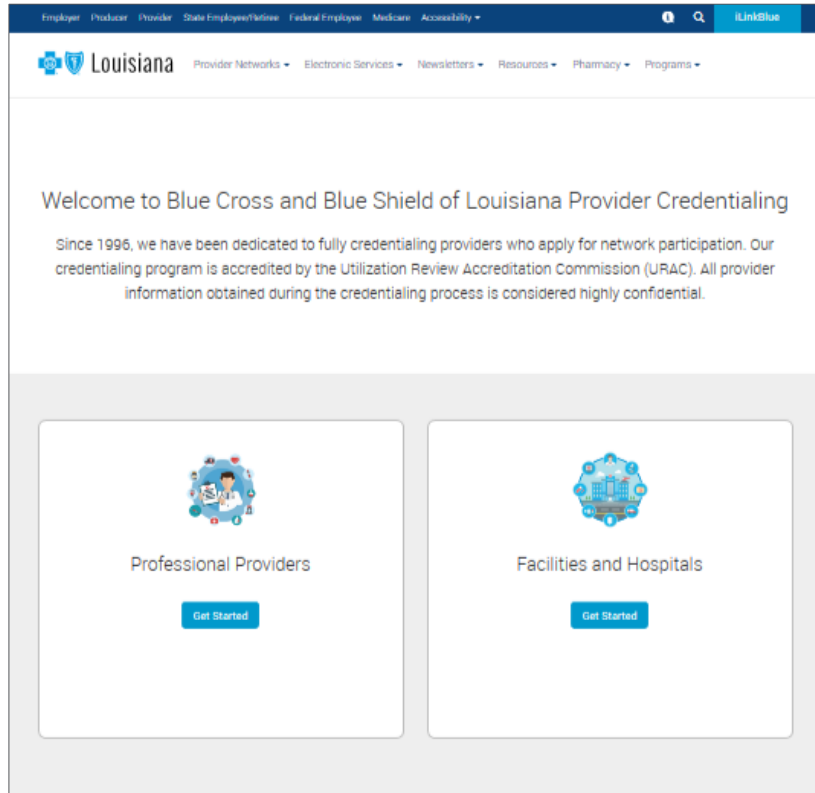
you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members.



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

Provider Credentialing & Data Management

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



- 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 all Blue Cross professional providers.

**Feb.
2022**



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



For participating providers:

We cannot retroactively allow network participation prior to a provider’s credentialing date. Our accrediting organization strictly prohibits it. Effective dates are based on:

Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director	If you are eligible for reimbursement during credentialing (joining an existing contracted group), then it is one month prior to the date of receipt of application; OR If you are not eligible for reimbursement during credentialing, then it is the approved date by the Credentialing Committee AND the execution of your network agreement.	If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is within 90 days of the calendar date, then it will be that date, but not before the group’s effective date. If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is greater than 90 days of the calendar date, then it will be 90 days from the day the information was received, but not before the group’s effective date.

Louisiana law allows professional provider types to request that Blue Cross reimburse claims during the credentialing process as if a network provider. This special provision effective date can be retroactive up to one month from the date we received the application and request. **The next slide includes new updates to this provision.**

The Consolidated Appropriations Act (CAA) 2021 includes new guidelines, effective January 1, 2022, for Reimbursement During Credentialing as it applies to all professional providers. Blue Cross already offered this expanded level to our providers.

Reimbursement During Credentialing will be granted to all professional providers **joining an existing contracted provider group**. This allows for in-network reimbursement on submitted claims during the credentialing process.

This provision does not apply for solo practitioners.



Providers should not file/submit claims until receiving a provider number letter from our PCDM Department notifying you of the Reimbursement During Credentialing effective date. If you have any questions about the Reimbursement During Credentialing Process, contact PCDM at 1-800-716-2299, option 2 or PCDMStatus@bcbsla.com.

More information can be found on our guide at www.BCBSLA.com/providers >Resources >Forms > How to Request Reimbursement During Credentialing.

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.
- Professional provider did not submit the current version of the **Louisiana Standardized Credentialing Application**.
- 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 professional provider types must meet certain criteria to participate in our networks:

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



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

Enter text

FINISH **FINISH LATER** **OTHER ACTIONS**

START

DocuSign Envelope ID: 1A01C5A7-3503-4226-8119-DEA232B827AD

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	Required - Provider National Provider Identifier (NPI) - Please enter 10 numbers only with no special characters.	Middle Initial
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tax ID Number	Group/Clinic Name		
<input type="text"/>	<input type="text"/>		
Group/Clinic	Are you a primary care provider (PCP)?	Effective Date of	
<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	

Authorized representative completing this form on behalf of a

AUTHORIZED REPRESENTATIVE	
Contact Phone Number	Contact Email Address
<input type="text"/>	<input type="text"/>

Submission Information (form completed by)	
Signature Authorized Representative	Date
<input type="text"/>	February 18, 2021

Navigation tool guides you through fields

Instructions correspond to requirement of the active field

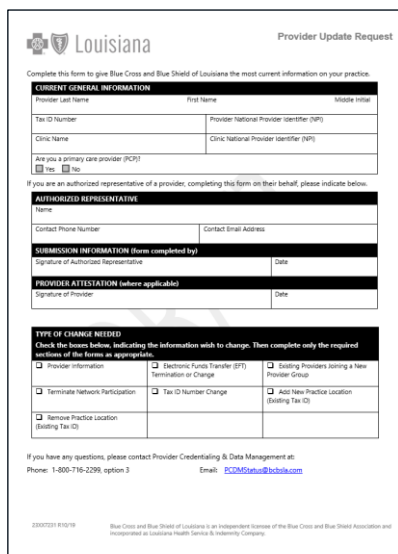
Tooltips provide information about field requirements

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.



The screenshot shows the 'Provider Update Request' form from Blue Cross and Blue Shield of Louisiana. The form is divided into several sections: 'CURRENT GENERAL INFORMATION' with fields for last name, first name, middle initial, tax ID number, provider national identifier (NPI), clinic name, and clinic national provider identifier (NPI); 'AUTHORIZED REPRESENTATIVE' with fields for name, contact phone number, and contact email address; 'SUBMISSION INFORMATION (Items completed by)' with fields for signature and date of the authorized representative; 'PROVIDER ATTESTATION (where applicable)' with fields for signature and date of the provider; and 'TYPE OF CHANGE NEEDED' with a grid of checkboxes for: Provider Information, Electronic Funds Transfer (EFT) Termination or Change, Existing Providers Joining a New Provider Group, Terminate Network Participation, Tax ID Number Change, Add New Practice Location (Existing Tax ID), and Remove Practice Location (Existing Tax ID). At the bottom, there is contact information for the Provider Credentialing & Data Management team.

- **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 forms via a DocuSign link at www.BCBSLA.com/providers >Resources >Forms.

Keeping your information up to date with us is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at www.BCBSLA.com.

It is the contractual responsibility of all participating providers to contact Provider Credentialing & Data Management to update your information as soon as it changes. This includes:

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
 - In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 8 hours per week at the location listed.

To improve the accuracy of our online provider directory, we are making changes to help create the most accurate directory for our members.

Our Provider Credentialing & Data Management team will be working with you to help ensure your information is current and accurate.



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.

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

The form is titled "Louisiana iLinkBlue Service Agreement". It contains a preamble, a section for provider information, and a section for agreement terms. The agreement terms include: 1. HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of the use of the iLinkBlue website. 2. PROVIDER agrees that it will furnish, supply, configure, maintain, and service all appropriate and applicable personal computer hardware, operating systems, software, network LAN configuration and equipment, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining the computer equipment in proper working condition. 3. HEALTH PLAN agrees to provide user instruction, training and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN will provide telephone and other PROVIDER support services to assist in resolving issues through hours from 8:00 a.m. - 4:00 p.m. CST with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

iLinkBlue Service Agreement

The form is titled "Louisiana Business Associate Addendum to the iLinkBlue Service Agreement". It contains a preamble, a section for business associate information, and a section for agreement terms. The agreement terms include: WHEREAS, PROVIDER has entered the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website; WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER'S behalf and as part of BUSINESS ASSOCIATE'S responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website; WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE as set forth in PROVIDER'S behalf and HEALTH PLAN through the iLinkBlue website is confidential and protected health information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act as implemented by the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidelines.

Business Associate Addendum

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

The form is titled "Louisiana Electronic Funds Transfer (EFT) Enrollment Form". It contains a preamble, a consent section, and several information sections: PROVIDER INFORMATION, PROVIDER CONTACT INFORMATION, FINANCIAL INSTITUTION INFORMATION, and FINANCIAL INSTITUTION INFORMATION. The consent section states: "I, the undersigned, hereby authorize Louisiana Health Service Association, Inc. to debit my bank account for the payment of my bills. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills." The financial institution information section includes fields for bank name, account number, routing number, and account type.

Electronic Funds Transfer Enrollment Form

The form is titled "Louisiana Administrative Representative Registration Form". It contains a preamble, a consent section, and several information sections: GENERAL PROVIDER INFORMATION, ADMINISTRATIVE REPRESENTATIVE INFORMATION, MANAGER INFORMATION, and FINANCIAL INSTITUTION INFORMATION. The consent section states: "I, the undersigned, hereby authorize Louisiana Health Service Association, Inc. to register me as an administrative representative. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills. I understand that this authorization is irrevocable and that I will be responsible for the payment of my bills." The administrative representative information section includes fields for name, address, and contact information.

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.





- **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.

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 at 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 at 1-800-716-2299, option 3.



CMS-1500 (professional)

- 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 of claim submission and payment is electronic submission.

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.



Use the following billing guidelines to report required NDCs on professional CMS-1500 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 CMS-1500 claim form, report the NDC in the shaded area of Box 24A. 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 837P

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. 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.

For iLinkBlue Claims (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement:

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity.
- Measurement: Select the appropriate measurement from the drop-down menu.
 - F2 – International Unit
 - GR – Gram
 - ME – Milligram
 - ML – Milliliter
 - UN – 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.

- 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.

Filter:

Copay	Coinsurance	Total Paid	Ineligible/ Rejected Amount	Action Request
\$0.00	\$0.00	\$0.00	\$1.00	
\$0.00	\$0.00	\$101.00	\$59.00	

Claim Number 12345678900-1

iLinkBlue Number 12345
NPI 123456789



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**.

Filter:

Copay	Coinsurance	Total Paid	Ineligible/ Rejected Amount	Action Request
\$0.00	\$0.00	\$0.00	\$1.00	
\$0.00	\$0.00	\$101.00	\$59.00	

Claim Number **12345678900-1**

iLinkBlue Number 12345
NPI 123456789

Action Request

- 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 a face-to-face visit:
 - Patient name
 - Date of birth or other unique identifier
 - Date of service including the year
- Provider signature (must be legible and include credentials).
- Report ALL applicable diagnoses on claims and report at the highest level of specificity (CMS-1500 claim forms can accommodate up to 12 diagnosis codes).
- Include all related diagnoses, including chronic conditions you are treating.
- Medical records **must support ALL** diagnosis codes on claims.



- 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 is **controlled** or **uncontrolled**.
- Clarify the **type of diabetes** (if applicable).

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.

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.**



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

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

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

The In-office Lab List is available in our *HMO Preferred Reference Lab Guide* which is 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.

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



Louisiana

Shop ▾

Find a Doctor ▾

Save ▾

Wellness ▾

Learn ▾

My Account ▾

Find Doctor or Drug

Find Doctor or Drug

Find a Doctor

[Find a Doctor or Drug](#)

Pick a directory to search or find other helpful information about drug resources, quality programs and more.

Directories

[Local Provider Directory - **New Name!**](#)

Find a doctor near you or search for other doctors throughout Louisiana.

[Quality Blue Directory](#)

[National Provider Directory](#)

[BlueDental Provider Directory](#)

[Davis Vision Directory](#)

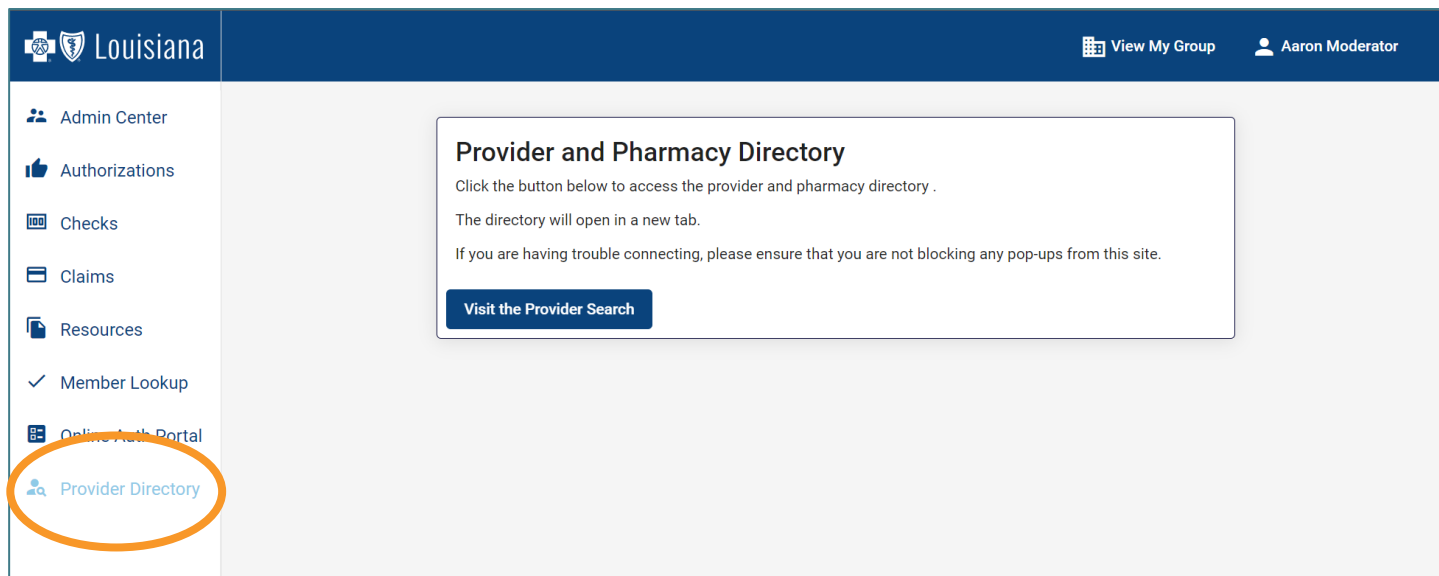
[Pharmacy Directory](#)

Hospital Based Physicians

[ER/OR Information](#)

Are you planning a hospital stay? If you just found out that you need surgery, or if you will be admitted to a hospital or ambulatory surgical center for any reason, you will most likely receive some care during your stay from a hospital-based physician. Learn more.

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
- Professional allowable searches
- Medical policy searches

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

Self-service tools available to providers:

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



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.

**Louisiana****Laboratory Benefit Management Program
Frequently Asked Questions**

Blue Cross and Blue Shield of Louisiana has partnered with Avalon Healthcare Solutions (Avalon) to offer a suite of laboratory benefit management services, including lab policies and routine testing management. Avalon is the industry leading comprehensive laboratory benefits manager helping payers, physicians and consumers optimize the cost-effective use of diagnostic laboratory tests.

General Questions

- 1. What does the laboratory benefit management program include?**

The program includes laboratory billing policies, guidelines and reviews for certain laboratory claims.
- 2. Why did Blue Cross partner with Avalon?**

The Avalon laboratory benefit management program promotes appropriate testing to help drive quality and cost-effective medical care.
- 3. What provider types are included in the program?**

The laboratory benefit management program applies for all providers of laboratory services (both referring and performing).
- 4. When is the program effective?**

This program is effective for certain laboratory claims with a date of service on and after April 1, 2022.
- 5. Which places of service are excluded?**

Laboratory services, tests and procedures provided in emergency room, hospital observation, and hospital inpatient settings are excluded from this program.
- 6. Which networks and/or member policies are included in the program?**

Fully insured, Federal Employee Program (FEP) and BlueCard® (out-of-area) members are included in this program. At this time most self-funded members are not enrolled in the program. They may be included at a later date.

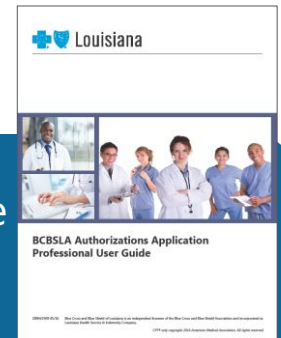
10NW3142 R01/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

In April, we will be hosting an education 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 accepts 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

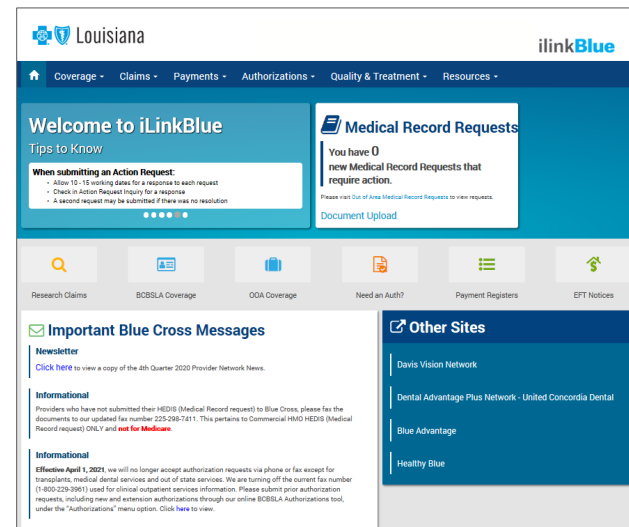
iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:

- Coverage & Eligibility
- Benefits
- Coordination of Benefits (COB)
- Claims Status (BCBSLA, FEP and Out of Area)
- Medical Code Editing
- Payment Registers/EFT Notifications
- Allowables Search
- Authorizations
- Medical Policy
- 1500 Claims Entry

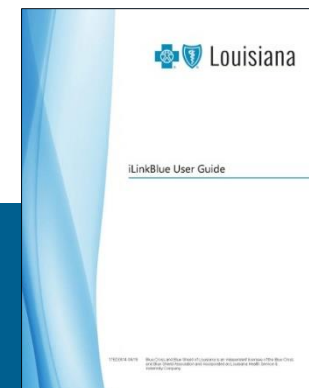
For iLinkBlue training and education, contact provider.relations@bcbsla.com.

iLinkBlue

www.BCBSLA.com/ilinkblue



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

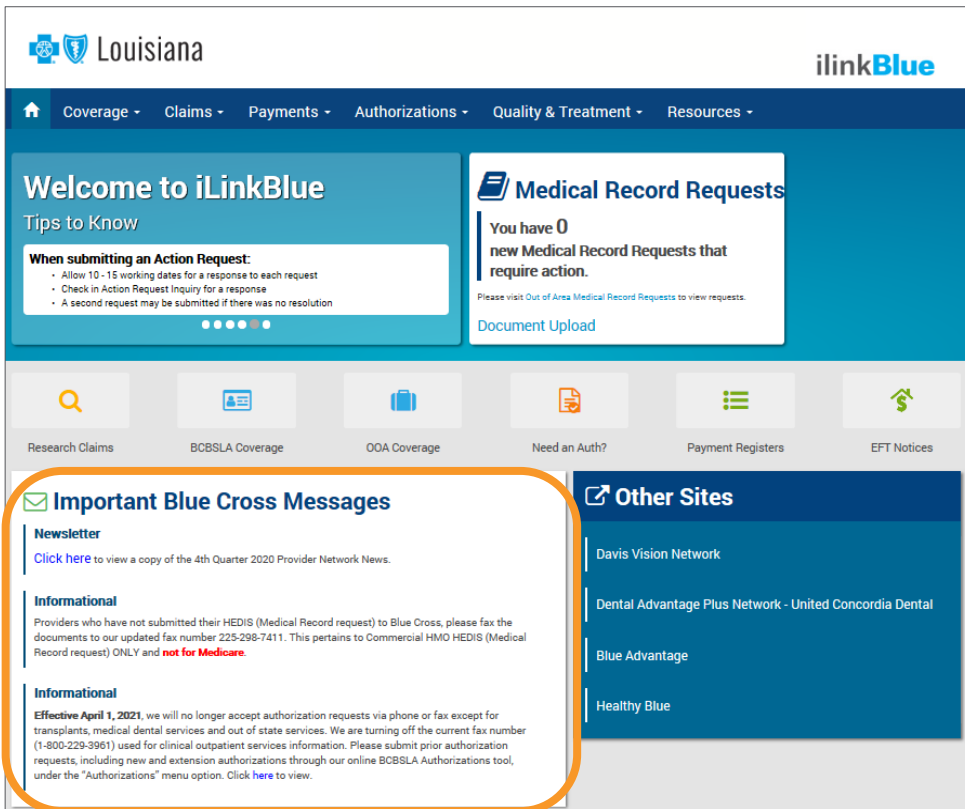




COMING
SOON

- In **May 2022**, all iLinkBlue users will be required to complete several verification steps before entering iLinkBlue (www.BCBSLA.com/ilinkblue).
- Multi-factor 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 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 gives you an alert message when there are BlueCard[®] (out-of-area) medical record requests for your patients.



1 Coverage Information
Use the Coverage Information screen to search for member status, deductible, copay, coinsurance and detailed contract benefits.

1 Select Search Criteria 2 Enter Contract or Social Security Number

BCBSLA

FEP

Social Security Number

2 Coverage Information
Use the Coverage Information screen to search for member status, deductible, copay, coinsurance and detailed contract benefits.

BCBSLA Enter BCBSLA contract number...

Contract Number XUA123456789 **ACTIVE COVERAGE**

Group/Non Group	Group Name	Group Number	Group OED	Minor Dep. Age Max
1ES1 GROUP	1ES1 GROUP	223456789-0000	02/01/2000	26

Coverage Category	Coverage Type	Effective From	Effective To
Medical	Family	01/01/2018	---

John Doe Subscriber Sex: Male Married 11/30/1900

Address: 123 STREET ST, CITY, LA 70000

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	01/01/2018	---	02/01/2000	Summary Benefits View COB

Jane Doe Spouse Sex: Female 11/30/1900

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	01/01/2018	---	02/01/2000	Summary Benefits View COB

Hide Terminated Dependents

Jimmy Doe Child Sex: Male 01/01/1930

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	02/01/2009	05/31/2009	02/01/2000	

3 Medical Benefits Summary

Contract Number XUA123456789

ACTIVE COVERAGE
Medical Effective Date: 01/01/2018

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

Copays	EPO Copays	GBPC Copays
Office Visit	\$10.00	---
Office Visit specialist	\$45.00	---
Outpatient Surgical	\$500.00	---
Emergency Room	\$100.00	---
Inpatient Hospital (In-network)	\$500.00	---
Inpatient Hospital Maximum	\$1,500.00	---
Inpatient Hospital (Out-of-network)	---	---
Outpatient X-ray & Lab	---	---
Outpatient Physical Therapy	\$10.00	---
Outpatient Speech Therapy	\$30.00	---
Cardiac Rehab	\$30.00	---
Vision Services	\$30.00	---
Outpatient Professional	---	---

Accumulations	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	\$0.00	\$1,750.00	---
Deductible Remaining	\$0.00	\$1,750.00	---
Out-of-Pocket Amount	\$5,000.00	\$6,000.00	---
Out-of-Pocket Remaining	\$5,000.00	\$6,000.00	---

Coinsurance	BCBSLA Coverage	Member Responsibility
Par Percentage	50%	10%
Non-Par Percentage	70%	30%
EPO Percentage	---	---
GBPC Percentage	---	---

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

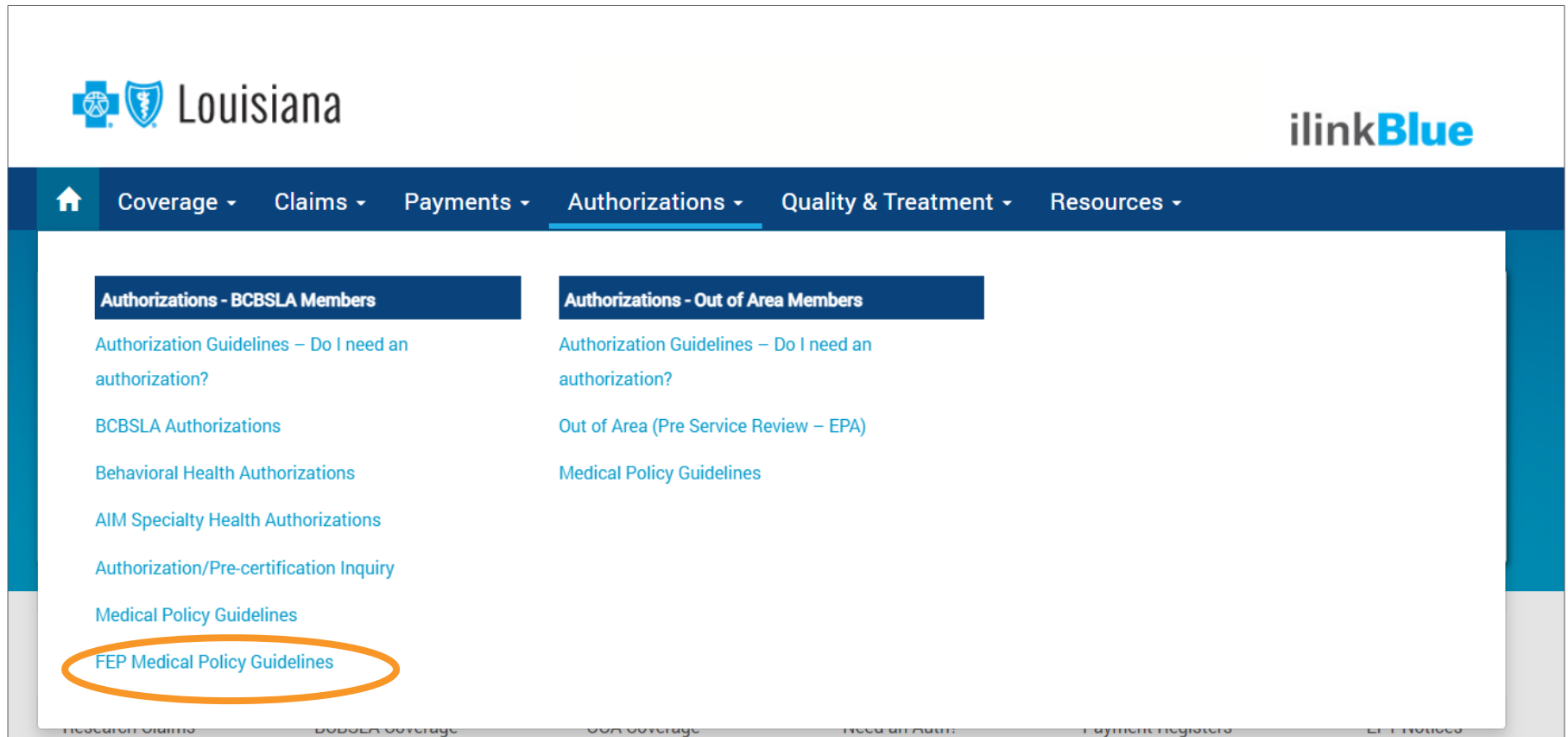
Note: Blue Advantage (HMO) | Blue Advantage (PPO) member coverage and eligibility must be verified through the Blue Advantage Provider Portal.



Use the “Claims” menu option to find online tools to:

- File CMS-1500 claims electronically using the **Blue Cross Professional Claims Entry** tool.
- Perform **Claims Research** on claims that were submitted for processing.
- Submit **BlueCard - Out of Area Claims Status** inquiries for BlueCard (out-of-area) members.
- Check status of claims that were filed electronically (even if they were filed through a clearinghouse) using the **Blue Cross Claims Confirmation Reports** tool.
- View medical record requests for your BlueCard (out-of-area) patients in our **Medical Records** section.

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



The screenshot shows the iLinkBlue website interface. At the top left is the Louisiana logo with the text "Louisiana". At the top right is the "iLinkBlue" logo. Below the logo is a dark blue navigation bar with a home icon and the following menu items: "Coverage", "Claims", "Payments", "Authorizations", "Quality & Treatment", and "Resources". The "Authorizations" menu is expanded, showing two columns of links. The left column is titled "Authorizations - BCBSLA Members" and includes links for "Authorization Guidelines – Do I need an authorization?", "BCBSLA Authorizations", "Behavioral Health Authorizations", "AIM Specialty Health Authorizations", "Authorization/Pre-certification Inquiry", "Medical Policy Guidelines", and "FEP Medical Policy Guidelines". The "FEP Medical Policy Guidelines" link is circled in orange. The right column is titled "Authorizations - Out of Area Members" and includes links for "Authorization Guidelines – Do I need an authorization?", "Out of Area (Pre Service Review – EPA)", and "Medical Policy Guidelines".

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."

Louisiana **ilinkBlue**

Provider: Tax ID, NPI, Submit. Logged in as Billy Gomila, Location.

Navigation: Coverage, Claims, Payments, Authorizations, Quality & Treatment, Resources.

BCBSLA Members: Coverage Information (circled in orange)

BlueCard - Out of Area Members: Submit Eligibility Request (270), View Eligibility Response (271)

Coverage Information

Use the Coverage Information screen to search for member status, deductible, copay, coinsurance and detailed contract benefits.

BCBSLA Search

Contract Number XUA123456789

ACTIVE COVERAGE

Group/Non-Group	Group Name	Group Number	Group OED	Minor Dep. Age Max
Group Policy	TEST GROUP	123456789-0000	02/01/2000	26

Coverage Category	Coverage Type	Effective From	Effective To
Medical	Family	01/01/2020	---

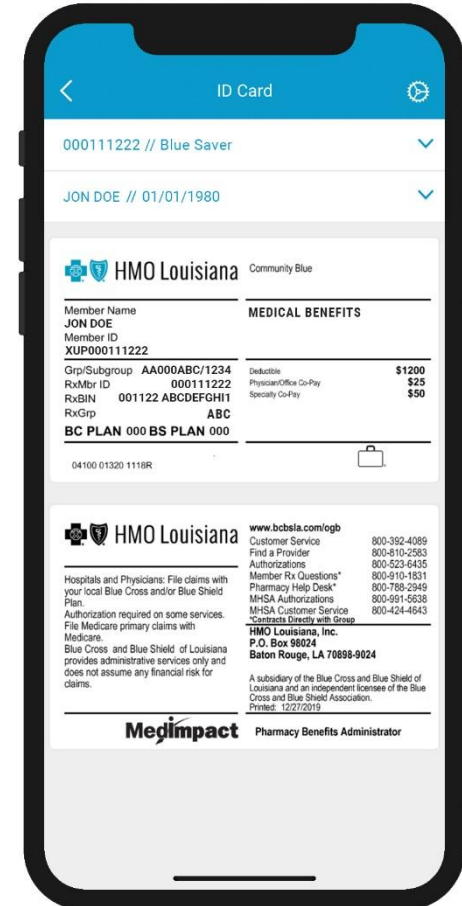
John Doe Subscriber

Address	123 STREET ST. CITY, LA 70000	Sex	Male
		Marriage Status	Married
		Date of Birth	11/30/1900

Coverage	Effective Date	Cancel Date	Original Effective Date	ID Card	Coverage Views	Coordination of Benefits
Medical	01/01/2020	---	02/01/2000	View ID Card (circled in orange)	Summary	Benefits View COB

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.

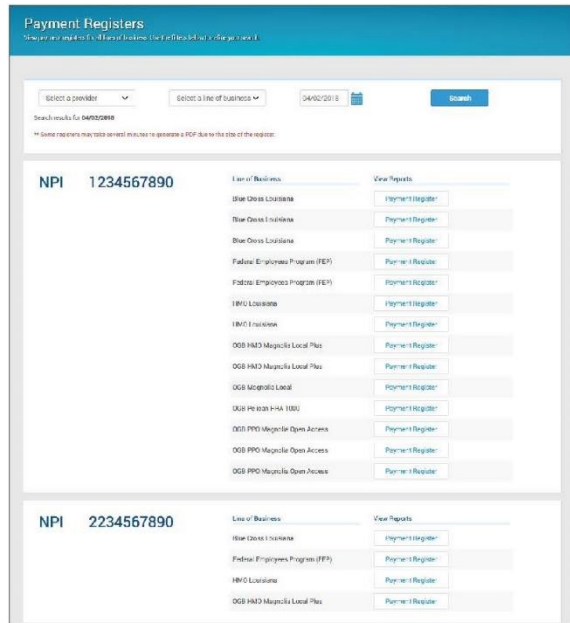


Use the “Payments” menu option to view payment registers, EFT notifications and research allowables.

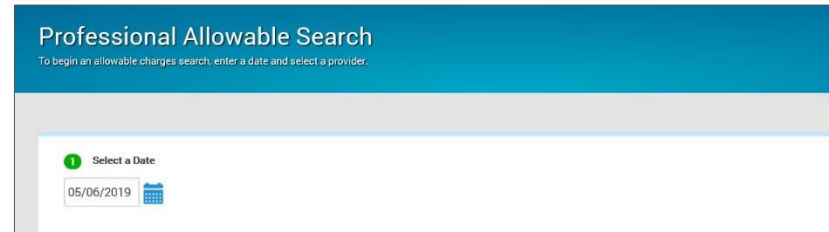
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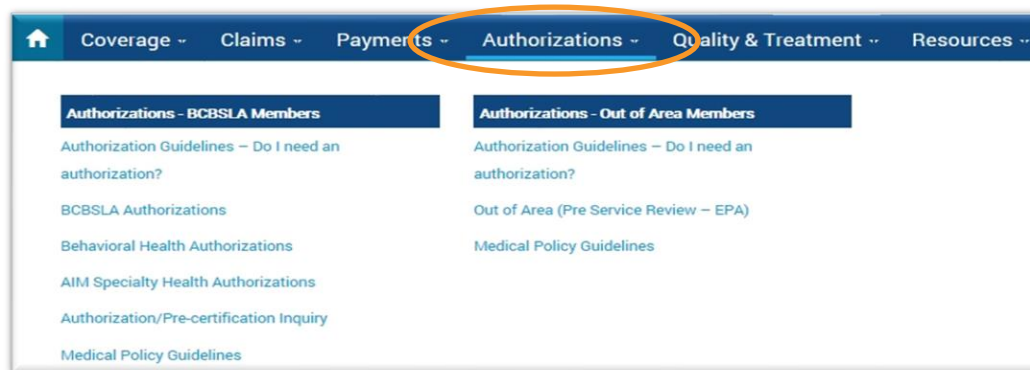


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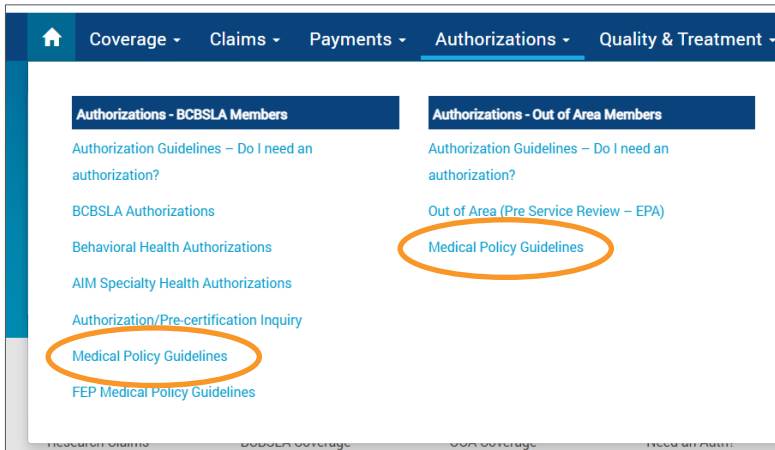


Use the “Authorizations” menu option to access online authorization tools:

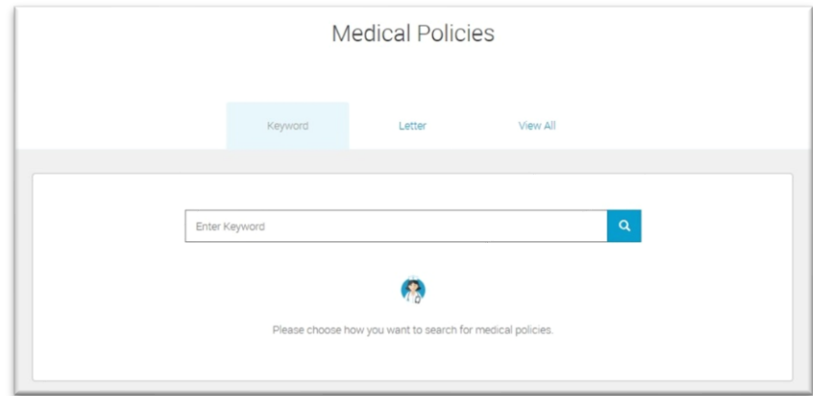
- The **BCBSLA Authorizations** tool allows you to submit and research authorizations for BCBSLA members.
- Behavioral health providers must use the New Directions Webpass Portal application, located in the **Behavioral Health Authorizations** link, to submit authorization requests for behavioral services.
- **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.



1.



2.



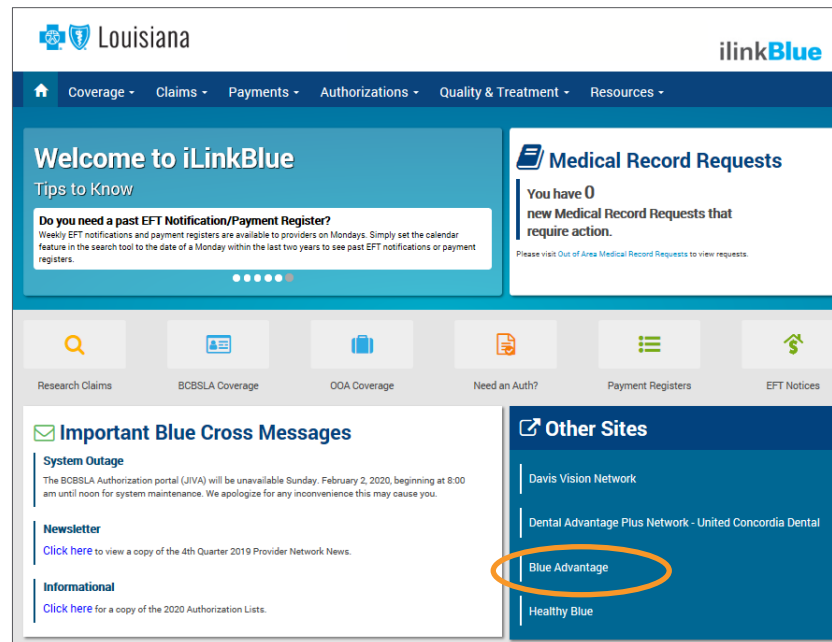
- Also use the “Authorizations” menu option to access our **Medical Policy Index**.
- Policies are listed in alpha order or you may search by policy number or procedure code.

Medical policies are reviewed annually and 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.

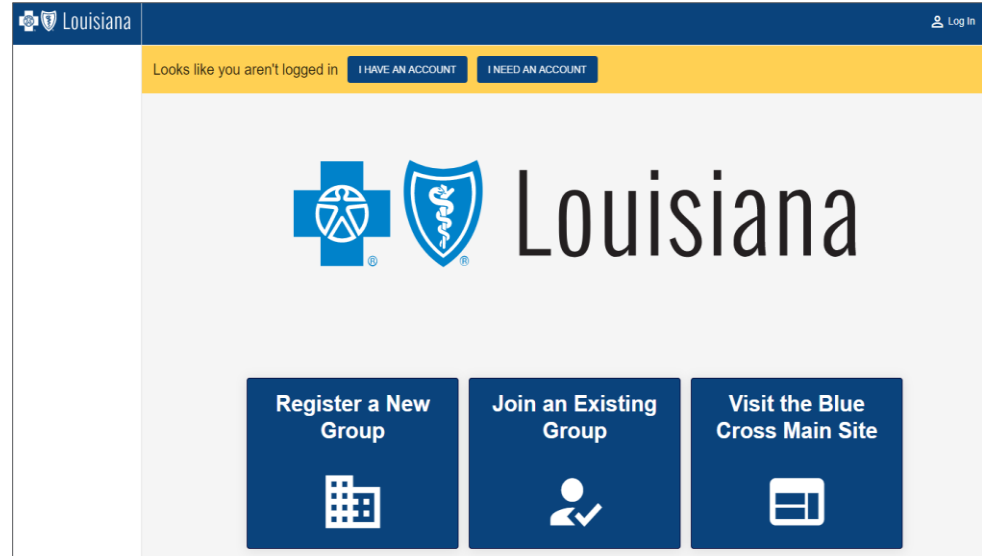


The screenshot displays the iLinkBlue provider portal for Louisiana. The top navigation bar includes links for Coverage, Claims, Payments, Authorizations, Quality & Treatment, and Resources. The main content area is divided into several sections:

- Welcome to iLinkBlue:** A section with a "Tips to Know" box. The tip states: "Do you need a past EFT Notification/Payment Register? Weekly EFT notifications and payment registers are available to providers on Mondays. Simply set the calendar feature in the search tool to the date of a Monday within the last two years to see past EFT notifications or payment registers."
- Medical Record Requests:** A section indicating "You have 0 new Medical Record Requests that require action." Below this, it says "Please visit Out of Area Medical Record Requests to view requests."
- System Outage:** A message stating "The BCBSLA Authorization portal (JIVA) will be unavailable Sunday, February 2, 2020, beginning at 8:00 am until noon for system maintenance. We apologize for any inconvenience this may cause you."
- Newsletter:** A link to "view a copy of the 4th Quarter 2019 Provider Network News."
- Informational:** A link to "view a copy of the 2020 Authorization Lists."
- Other Sites:** A list of links to other provider networks: Davis Vision Network, Dental Advantage Plus Network - United Concordia Dental, **Blue Advantage** (circled in orange), and Healthy Blue.

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 to the Blue Advantage Provider Portal, please reach out to your Group Moderator.



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



An additional multiple procedure reduction codes list can be found on iLinkBlue.

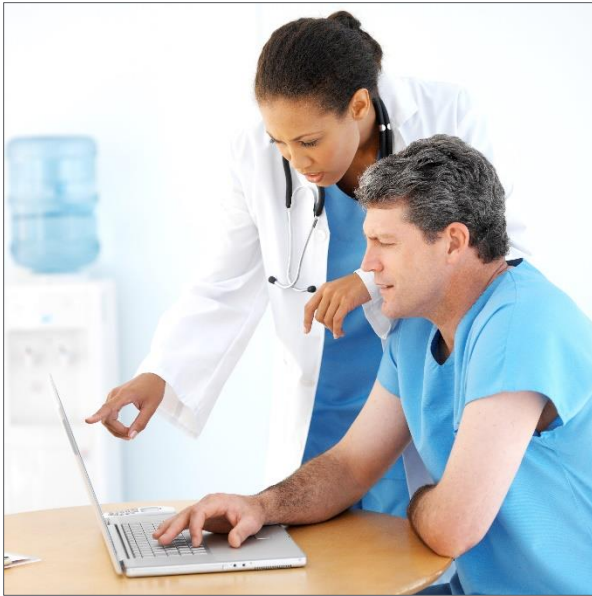
A listing of the additional Multiple Procedure Reduction codes can be found on iLinkBlue (www.BCBSLA.com/ilinkblue > Claims > Additional MPR Codes – Professional).

Louisiana
Additional Multiple Procedure Reduction Codes (Professional)

Upon implementation of the new claims-editing software system, the following list of codes* will be included in the editing for Multiple Procedure Reduction when billed.

20206	25001	29901	36470	44127
20500	25024	29921	36471	44204
20501	25025	30000	36510	44205
20520	25259	30020	36598	45138
20526	25275	30220	36600	45900
20650	25384	30210	36660	45905
20660	25430	30300	38220	45915
20665	25431	30560	38221	46020
20690	25651	30801	38300	46030
20692	25652	30901	38792	46050
20900	25671	30903	40800	46080
20902	26010	30905	40804	46330
20910	26011	30906	41000	46500
20912	26340	31000	41005	46900
20920	27086	31002	41250	46910
20922	27256	32400	41251	47000
20924	27257	32860	41252	47370
20926	27275	33010	41800	47371
20982	27570	33011	42000	47380
21100	27605	33915	42300	47381
21115	27860	33926	42310	47382
21355	28001	33933	42320	48102
23700	28002	33967	42400	48100
24300	28150	33979	42650	49400
24332	28630	33980	42660	49491
24340	28635	33987	42700	49492
24344	28660	36002	43113	50300
24345	28665	36405	43114	50390
24346	29066	36410	43400	50508
24640	29900	36440	44126	51600

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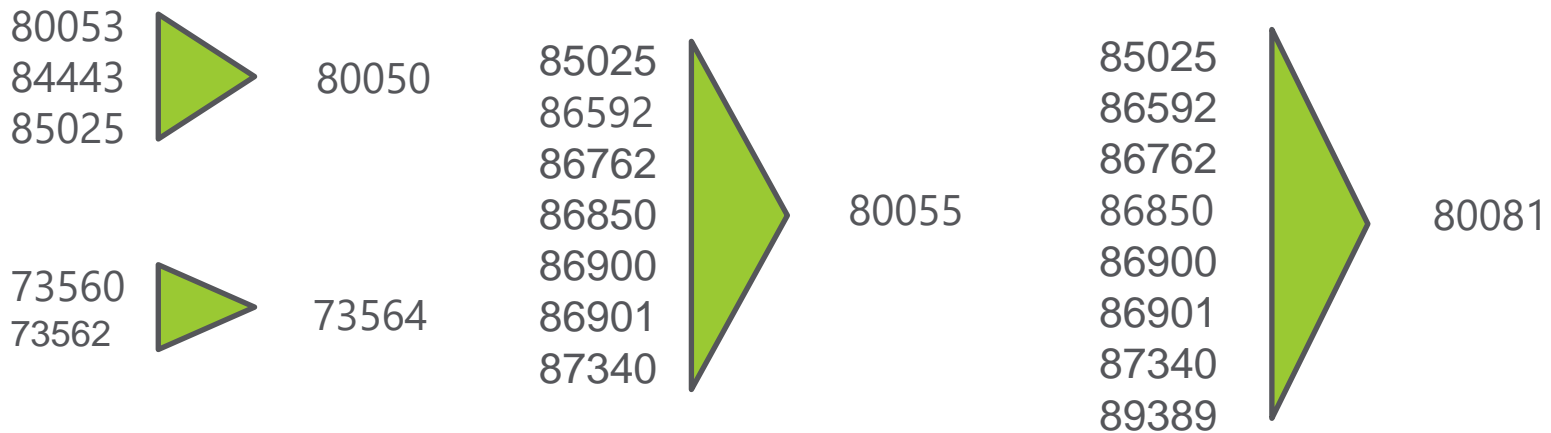


Certain codes will be denied because the services should be included with other services billed on the same day.

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:





- 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**.

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.



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.

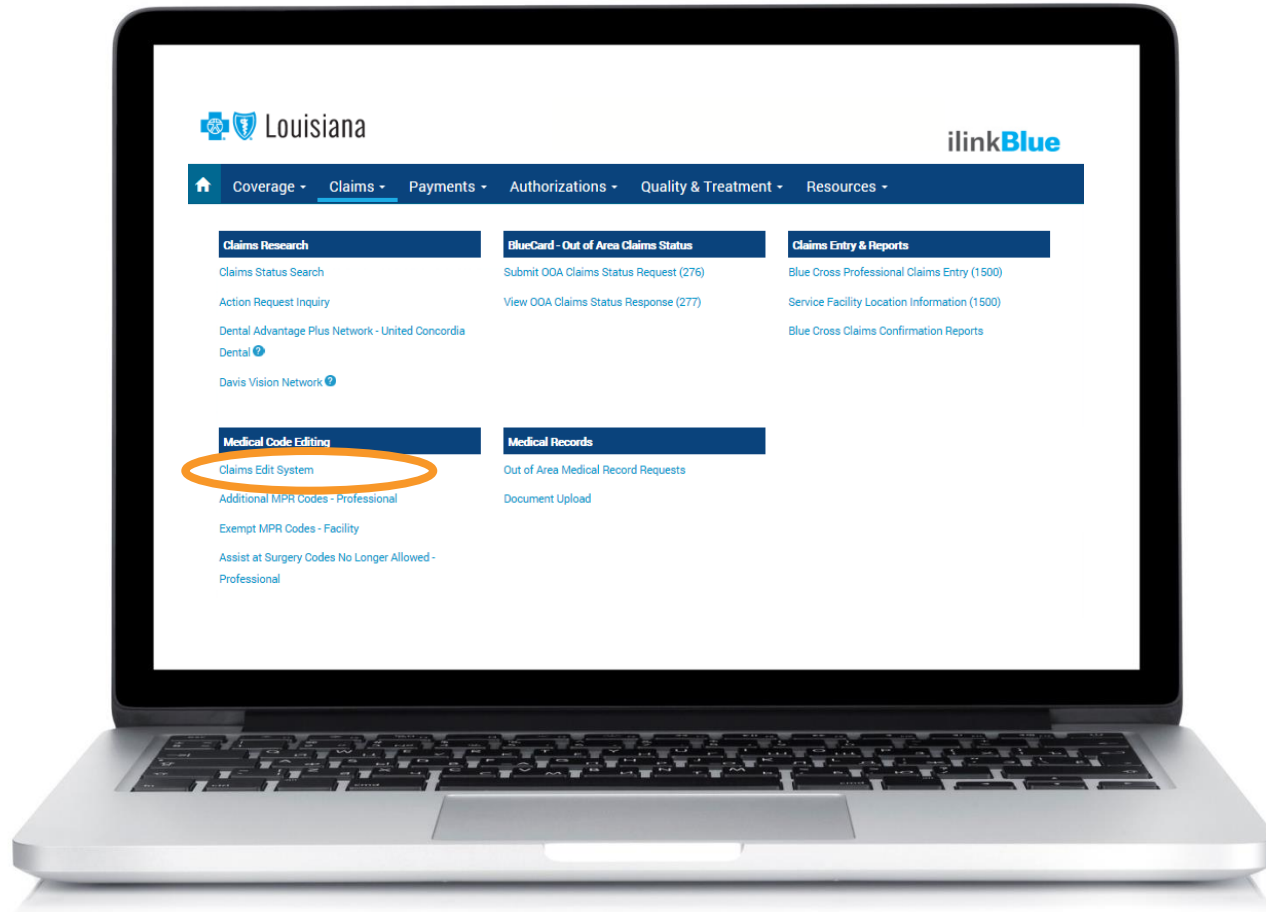
Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denials for insufficient medical information	<ul style="list-style-type: none"> Supporting medical documentation & copy of Blue Cross letter of request for medical records 	<ul style="list-style-type: none"> Provider Dispute Form Claim Form 	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	<ul style="list-style-type: none"> iLinkBlue Action Request Supporting medical documentation 	<ul style="list-style-type: none"> Provider Dispute Form 	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	<ul style="list-style-type: none"> iLinkBlue Action Request Call Customer Care Center 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Claim with EOB from primary carrier 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Provider Dispute Form* Formal letter of appeal including reason Supporting medical documentation 	<ul style="list-style-type: none"> 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 providercommunications@bcbsla.com, and reference the Tidbit number and title listed on this publication.
18NW2004 R8/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
Last reviewed on: 8-04-20

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 **professional** claims 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
- Units billed
- Global day edits for procedures
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits



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.



Louisiana


This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Gender: Date of Birth: Claim Type:

Line	Beg DOS	End DOS	Procedure	Modifier	Units
1	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>
2	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>
3	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>

[Privacy Policy](#)
[Terms and Conditions](#)



Louisiana

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.


Professional Claim Entry Facility Claim Entry

Gender Date of Birth Claim Type

Line	Beg DOS	End DOS	Procedure	Modifier	Units
1	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>
2	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>
3	<input type="text" value="07/01/2019"/>	<input type="text" value="07/01/2019"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>

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



Louisiana

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: **M** Birth Year: Claim Type: **Professional**

Original Lines

Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	24341		3	A
2	07/01/2019	07/01/2019			1	A
3	07/01/2019	07/01/2019			1	A

Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags						
1	24341	2	0.0	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Flag Description</th> <th>Flag Status</th> <th>Disclosure</th> </tr> </thead> <tbody> <tr> <td>Procedure Code 24341 with an allowed daily frequency of 2 has been exceeded by 1 for date of service 07/01/2019.</td> <td>Deny</td> <td> The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Second - MFD of 1 </td> </tr> </tbody> </table>	Flag Description	Flag Status	Disclosure	Procedure Code 24341 with an allowed daily frequency of 2 has been exceeded by 1 for date of service 07/01/2019.	Deny	The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Second - MFD of 1
Flag Description	Flag Status	Disclosure								
Procedure Code 24341 with an allowed daily frequency of 2 has been exceeded by 1 for date of service 07/01/2019.	Deny	The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Second - MFD of 1								
2		1	0.0	CLEAN LINE						
3		1	0.0	CLEAN LINE						

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CPT Code 24341 – Repair, tendon or muscle, upper arm or elbow daily max frequency limit of 2 units. Code on one line with 3 units – 2 units will pay, 1 unit will deny.

Louisiana

Professional Claim Entry
Facility Claim Entry

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Export to PDF
New Claim

Gender: **M** Birth Year: Claim Type: **Professional**

Original Lines


Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	25246		2	A
2	07/01/2019	07/01/2019			1	A
3	07/01/2019	07/01/2019			1	A

Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags						
1	25246	1	0.0	<table border="1" style="width: 100%; border-collapse: collapse; text-align: left;"> <thead> <tr style="background-color: #f2f2f2;"> <th>Flag Description</th> <th>Flag Status</th> <th>Disclosure</th> </tr> </thead> <tbody> <tr> <td style="font-size: x-small;">Procedure Code 25246 with an allowed daily frequency of 1 has been exceeded by 1 for date of service 07/01/2019.</td> <td style="text-align: center;">Deny</td> <td style="font-size: x-small;"> The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Revision MFD of 1 </td> </tr> </tbody> </table>	Flag Description	Flag Status	Disclosure	Procedure Code 25246 with an allowed daily frequency of 1 has been exceeded by 1 for date of service 07/01/2019.	Deny	The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Revision MFD of 1
Flag Description	Flag Status	Disclosure								
Procedure Code 25246 with an allowed daily frequency of 1 has been exceeded by 1 for date of service 07/01/2019.	Deny	The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1 Revision MFD of 1								
2		1	0.0	CLEAN LINE						
3		1	0.0	CLEAN LINE						



CPT Code 25246 – Injection procedure for wrist daily max frequency limit of 1 unit. Code on one line with 2 units – 1 unit will pay and one unit will deny.



Louisiana

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry Facility Claim Entry

Export to PDF New Claim

Gender: **M** Birth Year: Claim Type: **Professional**

Original Lines


Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	25246	LT	1	A
2	07/01/2019	07/01/2019	25246	RT	1	A
3	07/01/2019	07/01/2019			1	A

Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	25246	1	0.0	CLEAN LINE
2	25246	1	0.0	CLEAN LINE
3		1	0.0	CLEAN LINE

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CPT 25246 (injection procedure) – billed correctly with Modifiers LT, RT and one unit, it will pay correctly.

 **Louisiana**
This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry Facility Claim Entry

Export to PDF New Claim

Gender: **M** Birth Year: Claim Type: **Professional**

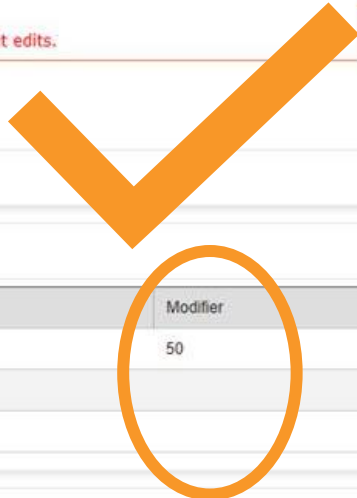
Original Lines

Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	25246	50	1	A
2	07/01/2019	07/01/2019			1	A
3	07/01/2019	07/01/2019			1	A

Claim Analysis Results

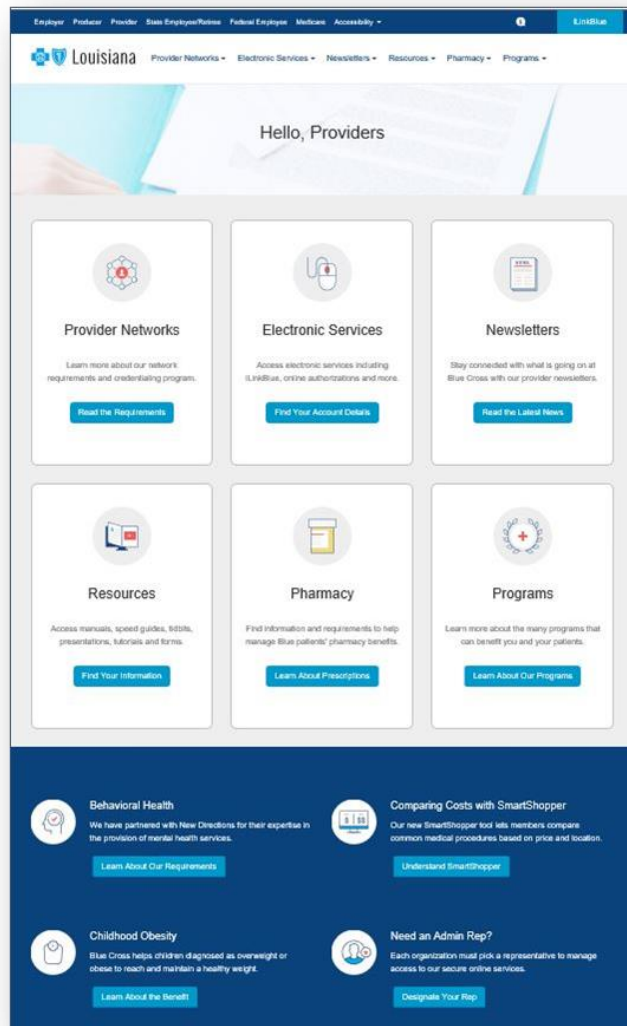
Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	25246	1	0.0	CLEAN LINE
2		1	0.0	CLEAN LINE
3		1	0.0	CLEAN LINE

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CPT 25246 (injection procedure) – billed correctly with Modifier 50.

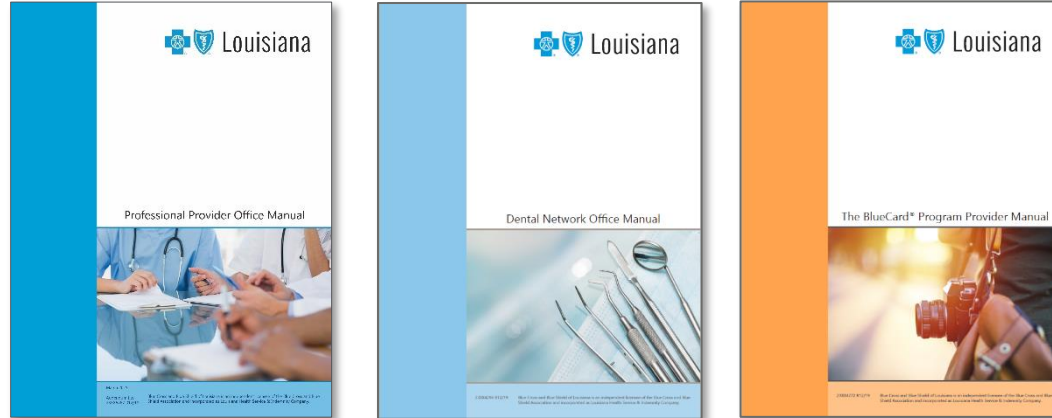
Resources



The Provider Page is home to online resources such as:

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

www.BCBSLA.com/providers



www.BCBSLA.com/providers > Resources > Manuals

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
- Provider Disputes
- Network Overviews
- Authorization Requirements
- And much more

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 providercommunications@bcbsla.com. Put "newsletter" in the subject line. Please include your name, organization name and contact information.



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

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

Louisiana Preferred Care PPO Preferred Reference Lab Guide

Blue Cross and Blue Shield of Louisiana uses a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Preferred Care PPO members must be submitted to a preferred reference laboratory in the member's network when not performed in the provider's office. Physicians who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts. Please refer to the preferred lab requirements listed below to ensure your patients receive the maximum benefits to which they are entitled.

Lab Program Requirements
 Laboratory services provided to PPO members must be submitted to a preferred reference laboratory in the member's network if not performed in your office. Use the on the right or our online provider directory, available at www.BCBSLA.com.
 Contact preferred reference labs directly to obtain the necessary forms for submitting lab services.
 Preoperative lab services rendered before an outpatient surgery or outpatient procedure that is performed by Preferred Care PPO participating hospitals or the member's selected hospital but otherwise should be sent to a preferred reference lab.
 If you perform laboratory testing procedures in your office, you must bill claims in accordance with your Clinical Laboratory Improvement Accreditation (CLIA) certification.
 For complete lab billing guidelines, refer to your Professional Provider Office Manual, available online at www.BCBSLA.com/providers.
Special Arrangements
 Special arrangements for weekend or after-hour service may be available at a preferred reference lab. Please contact the preferred reference lab directly to make special arrangements.

Preferred Reference Labs
 Laboratory services provided to Preferred Care PPO members must be submitted to one of the following preferred reference labs when not performed in the provider's office.

Statewide Labs	Website	Phone
• Clinical Reference Labs	www.crlabs.com	1-800-433-4747
• LabCorp	www.labcorp.com	1-800-421-6037
• Quest Diagnostics	www.questdiagnostics.com	1-888-MYQUC337 (1-888-897-8378)

Regional Labs

Region	Lab Name	Phone
Atchafalaya Region	• Bay Regional Hospital Reference Lab	(337) 728-9123
	• Weyer's Hospital Laboratory	(225) 824-4278
Lafayette Region	• Acacia Laboratory, LLC	(225) 782-0461
	• Eureka Medical Laboratory, Inc.	(225) 453-5843
Metairie Region	• Eureka Pathology, LLC	(504) 788-9029
	• Precision Pathology	(504) 408-3771
Monroe Region	• Clinical Reference Laboratories	(504) 388-2143
	• Specialty Drug Testing, LLC	(504) 433-8800
New Orleans Region	• Precision Clinical Laboratories, LLC	(504) 877-5572
	• Quest Diagnostics	1-844-788-8222
Shreveport and Alexandria Region	• Mills Logistics Outpatient Lab Services	(504) 224-4032
	• Premier Laboratory Services	(318) 408-3771

Please note: This is the current list of preferred statewide and regional reference labs as of the date this guide was published. To view the most current list of preferred reference labs, visit www.BCBSLA.com/providers. There is a charge to print and mail this guide or network, the city, parish or ZIP code "tab" for quickly to request this web link search.

Louisiana Signature Blue Network Speed Guide

This guide will help you quickly locate key information about the Signature Blue Network, which consists of a select group of physicians, hospitals and other allied providers. Some Signature Blue providers are contracted for limited services only. Please refer to Signature Blue members to providers within the network to verify the highest level of benefits. Benefits plans in the network vary. Please verify member benefits before rendering services.

Please also refer to the Professional Provider Office Manual, which is available online at www.BCBSLA.com/providers.

Signature Blue Member ID Card
 Provider: CMS, CMS and CMS

Service areas for the Signature Blue Network

New Orleans Area

- Jefferson
- Orleans

Admitting Privileges
 Member must have admitting privileges to the facility where care is rendered in the Signature Blue Network.
 Provider who are required to have admitting privileges must have admitting privileges to the best use of the following hospitals to be a part of the Signature Blue Network.

New Orleans Area

- Children's Hospital
- East Jefferson General Hospital
- New Orleans East Hospital
- North Jefferson Medical Center
- University Medical Center
- West Jefferson Medical Center

Maternity Admissions
 Maternity admissions do not require authorization in the Signature Blue Network. Maternity admissions do not require authorization in the Signature Blue Network. Maternity admissions do not require authorization in the Signature Blue Network. Maternity admissions do not require authorization in the Signature Blue Network.

Submitting Claims
 Claims should be submitted to the member's preferred reference lab. Claims should be submitted to the member's preferred reference lab. Claims should be submitted to the member's preferred reference lab.

Exclusions

- Louisiana CMS-1500 only
- Out-of-network

PLEASE REFER TO THE HMO LOUISIANA, INC. PREFERRED REFERENCE LAB GUIDE FOR INFORMATION ABOUT THIS NETWORK'S LAB PROGRAM, INCLUDING A LIST OF PREFERRED LABORATORIES AND A LIST OF CODES THAT MAY BE PERFORMED IN A CLIA-CERTIFIED PHYSICIAN'S OFFICE.

Louisiana providerTIDBIT

a guide to understanding our processes

Identification Card Guide

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

Preferred Care PPO

Plan Name: Preferred Care PPO
Plan Type: PPO
Network: Preferred Care PPO network includes hospitals, physicians and allied providers. Members with Preferred Care PPO plan 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 Preferred Care PPO Member's printed on their ID cards. The "PPO as a customer" logo indicates the member's Preferred Care PPO membership. For more information, visit the Preferred Care PPO Network Speed Guide, available online at www.BCBSLA.com/providers.

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

HMO Louisiana, Inc.

Plan Name: HMO Louisiana, Inc.
Plan Type: HMO
Network: HMO Louisiana, Inc. is a fully insured subsidiary of Blue Cross and Blue Shield of Louisiana. The HMO Louisiana provides network to a select group of physicians, hospitals, and allied providers who provide services to individual and employer groups under managed care benefit plans. The HMO Louisiana network is offered statewide.
HMO Louisiana allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a co-pay when they receive services from providers who are not in the HMO Louisiana network. For more information, visit the HMO Louisiana Network Speed Guide, available online at www.BCBSLA.com/providers.

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

TRIGGERED BY:
 This document is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. It is a customer supporting document. For more information, visit www.BCBSLA.com/providers or contact the Network Administration Division at (504) 388-2143.

ISSUED BY: HMO Louisiana, Inc. (504) 388-2143
LAST REVISED: 12/18/2015

Louisiana providerTIDBIT

a guide to understanding our processes

Automated Benefits & Claim Status

Provider Services is an automated KEYPAD or VOICE RESPONSE telephone system designed to help providers reach the area of service needed. Use this guide to easily navigate this provider phone tool.

Customer Care Center 1-800-922-8866

Benefits are subject to the terms of a member's contract/contract and our medical policies. Claims are subject to allowable charges, which are established by Blue Cross at the maximum allowed amount for services covered under the member contract/benefit.

Please have the following information ready when calling:

- Provider's NPI
- Member ID Number
- Provider's Tax ID Number
- Member's 8-digit Date of Birth
- Provider's ZIP Code
- Date of Service

Welcome to Blue Cross and Blue Shield of Louisiana Provider Services. To expedite your call please have the member identification number available. Which type of policy are you calling about?

1. Medical 2. Dental 3. Dental 4. Life

(Please fill you say or key in a policy type)
 Please say or enter your 10-digit NPI. Please fill you say or key in NPI.
 Please say or enter your 8-digit Tax ID. Please fill you say or key in Tax ID.
 *Note: Policy type is not applicable for all services. Please say or key in the appropriate response. Answer "no" to continue to the Provider Services menu.

Provider Menu

Provider Menu: Which are you calling about?

1. Benefits
2. Claims
3. Authorizations
4. An Out-of-State Policy
5. A Payment Request for a
6. None of the Above

TRIGGERED BY:
 This document is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. It is a customer supporting document. For more information, visit www.BCBSLA.com/providers or contact the Network Administration Division at (504) 388-2143.

ISSUED BY: Provider Services (504) 388-2143
LAST REVISED: 12/18/2015

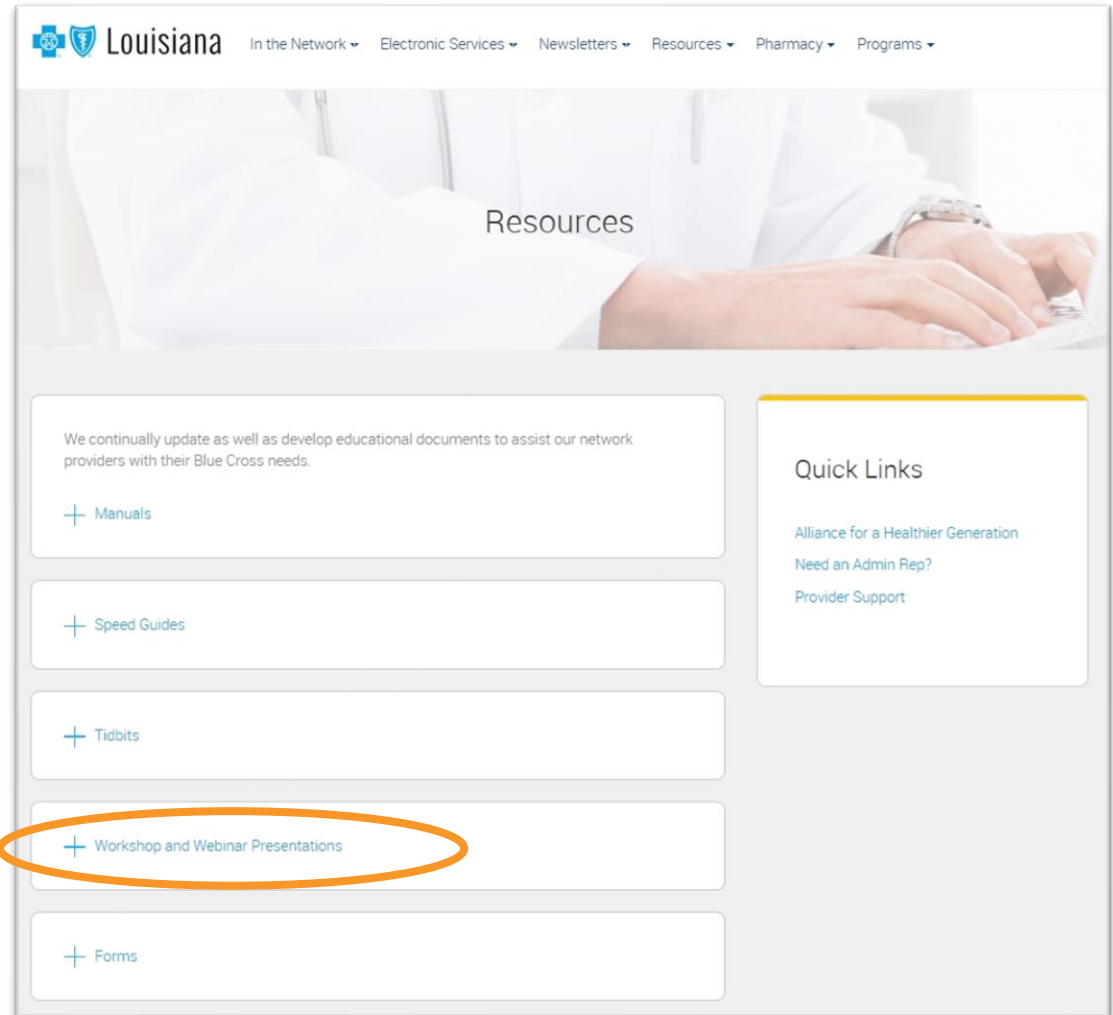
Provider Tidbits are quick guides designed to help you with our current business processes.

www.BCBSLA.com/providers
 >Resources >Tidbits

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 the 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

There are several teams available to our network providers to help with network participation, credentialing, educational resources, electronic services and more.

- + EDI Clearinghouse Services
- + iLinkBlue Support
- + Provider Contracting
- + Provider Credentialing & Data Management
- + Provider Identity Management Team
- + Provider Relations

iLinkBlue

iLinkBLUE is our secure online tool designed to help providers quickly complete important functions such as:

- Eligibility/coverage verification
- Claims filing and review
- Payment queries & transactions

[Learn About iLinkBlue](#)

Need an Admin Rep?

Designate an admin rep to manage access to our secure online services.

[Designate an Admin Rep](#)

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

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 (HMO) D-SNP	1-844-209-5406

**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.

