Louisiana

Blue Cross and Blue Shield of Louisiana

PROFESSIONAL WORKSHOP

Spring 2022

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

To serve Louisianians as the statewide leader in offering access to affordable health care by improving quality, value and customer experience.

Agenda

Provider Credentialing & Data Management

Vantage Health Managing Blue Cross Credentialing/Recredentialing

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

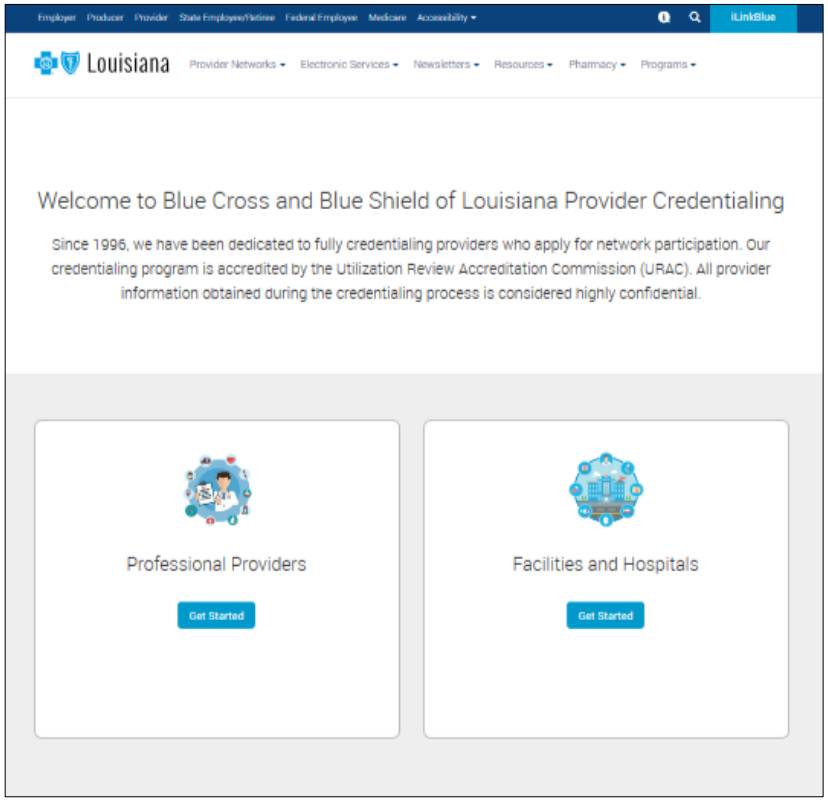
Expanded to include the recredentialing of all Blue Cross professional providers.

Feb. 2022

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

Join Our Networks

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



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

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

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

Credentialing Process

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

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

Credentialing Criteria - Professional

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

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

Reimbursement During Credentialing

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 when all criteria is met.** 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**.

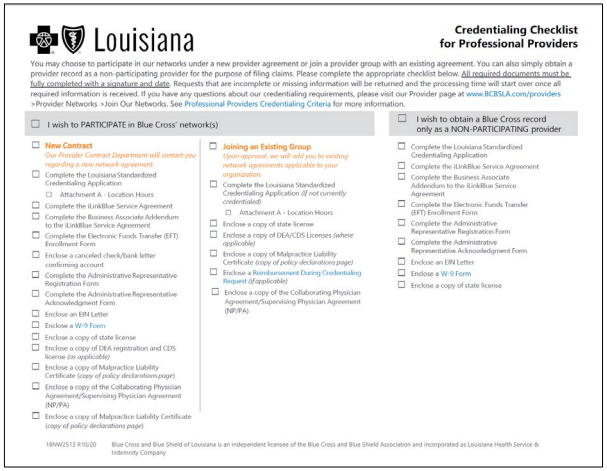
The Reimbursement During Credentialing Instruction Sheet is available online at **www.bcbsla.com/providers** >Resources >Forms.

Initial Credentialing Application

Required Documentation:

- The Professional (initial) credentialing packet includes a checklist of all required documents.
- To **join our networks through a new contract**, or **joining an existing group**, complete the checklist under "I wish to PARTICIPATE in Blue Cross' network(s)."
- If you **want a provider record only for filing claims**, complete the checklist under "I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider."

Blue Cross uses the Louisiana Standardized Credentialing Application (LSCA) for initial credentialing.



Louisiana

Credentialing Checklist for Professional Providers

You may choose to participate in our networks under a new provider agreement or join a provider group with an existing agreement. You can also simply obtain a provider record as a non-participating provider for the purpose of filing claims. Please complete the appropriate checklist below. All required documents must be fully completed with a signature and date. Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received. If you have any questions about our credentialing requirements, please visit our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks. See Professional Providers Credentialing Criteria for more information.

☐ I wish to PARTICIPATE in Blue Cross' network(s)

New Contract

Our Provider Contract Department will contact you regarding a new network agreement.

- ☐ Complete the Louisiana Standardized Credentialing Application
  - ☐ Attachment A - Location Hours
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Enclose a canceled check/bank letter confirming account
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA registration and CDS license *(as applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA)
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*

Joining an Existing Group

Upon approval, we will add you to existing network agreements applicable to your organization.

- ☐ Complete the Louisiana Standardized Credentialing Application *(if not currently credentialed)*
  - ☐ Attachment A - Location Hours
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA/CDS Licenses *(where applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate *(copy of policy declarations page)*
- ☐ Enclose a Reimbursement During Credentialing Request *(if applicable)*
- ☐ Enclose a copy of the Collaborating Physician Agreement/Supervising Physician Agreement (NP/PA)

☐ I wish to obtain a Blue Cross record only as a NON-PARTICIPATING provider

- ☐ Complete the Louisiana Standardized Credentialing Application
- ☐ Complete the iLinkBlue Service Agreement
- ☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement
- ☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form
- ☐ Complete the Administrative Representative Registration Form
- ☐ Complete the Administrative Representative Acknowledgment Form
- ☐ Enclose an EIN Letter
- ☐ Enclose a W-9 Form
- ☐ Enclose a copy of state license

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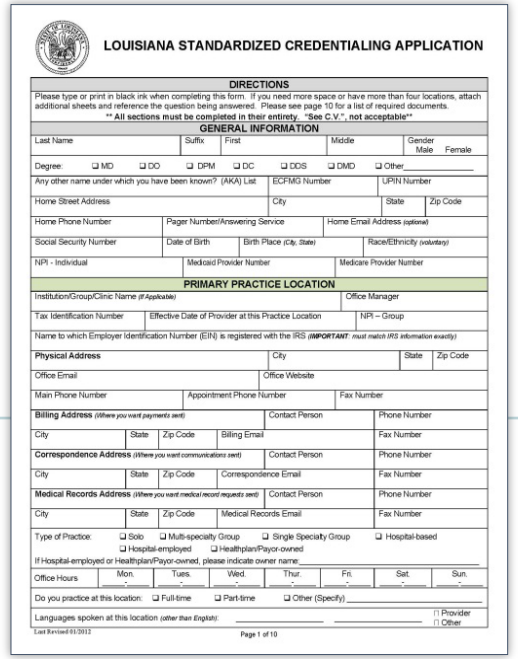

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.
** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address *(optional)*

Social Security Number | Date of Birth | Birth Place *(City, State)* | Race/Ethnicity *(voluntary)*

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)* | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS *(IMPORTANT: must match IRS information exactly)*

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address *(Where you want payments sent)* | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address *(Where you want communications sent)* | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address *(Where you want medical record requests sent)* | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun.

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

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

Last Revised 01/2012

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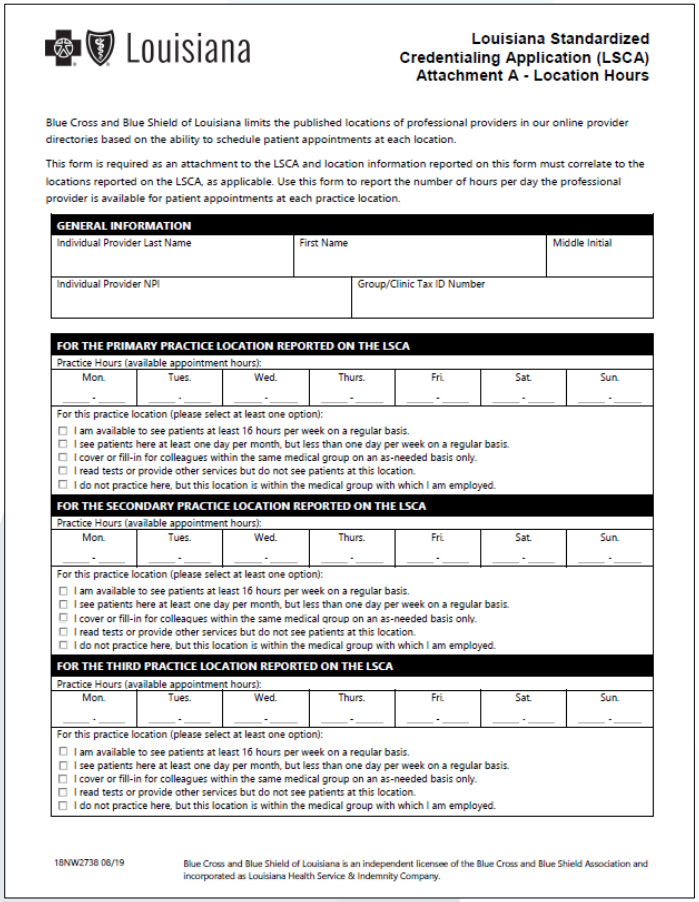
Find our credentialing links at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks.

LSCA Attachment A – Location Hours

- This new form is required as an attachment to the LSCA.
- Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location.
- Location information reported on this form must correlate to the locations reported on the LSCA, as applicable.
- We use the information from this form to determine if the provider meets the qualifications to be listed in our provider directory.



Louisiana

Louisiana Standardized Credentialing Application (LSCA) Attachment A - Location Hours

Blue Cross and Blue Shield of Louisiana limits the published locations of professional providers in our online provider directories based on the ability to schedule patient appointments at each location.

This form is required as an attachment to the LSCA and location information reported on this form must correlate to the locations reported on the LSCA, as applicable. Use this form to report the number of hours per day the professional provider is available for patient appointments at each practice location.

GENERAL INFORMATION

Individual Provider Last Name	First Name	Middle Initial

Individual Provider NPI	Group/Clinic Tax ID Number

FOR THE PRIMARY PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

FOR THE SECONDARY PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

FOR THE THIRD PRACTICE LOCATION REPORTED ON THE LSCA

Practice Hours (available appointment hours):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

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

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.

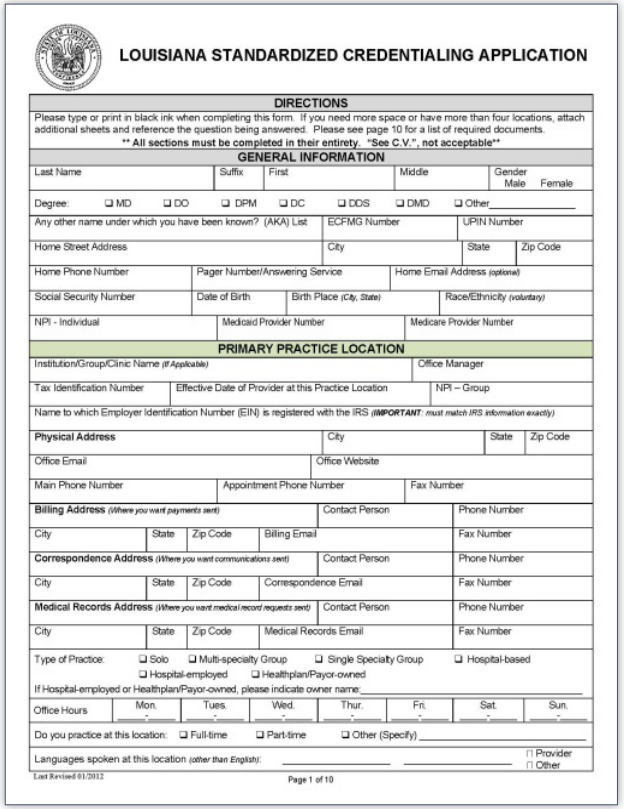
Vantage Health Managing Blue Cross Recredentialing

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 email: **recredentialing@vhpla.com** Vantage by phone: (318) 807-4755

Required Recredentialing Documents

Vantage accepts the LSCA, as well as the CAHQ application.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address (optional)

Social Security Number | Date of Birth | Birth Place (City, State) | Race/Ethnicity (voluntary)

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (If Applicable) | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address (Where you want payments sent) | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address (Where you want communications sent) | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address (Where you want medical record requests sent) | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	--	--	--	--	--	--	--

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

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

Last Revised 01/2012

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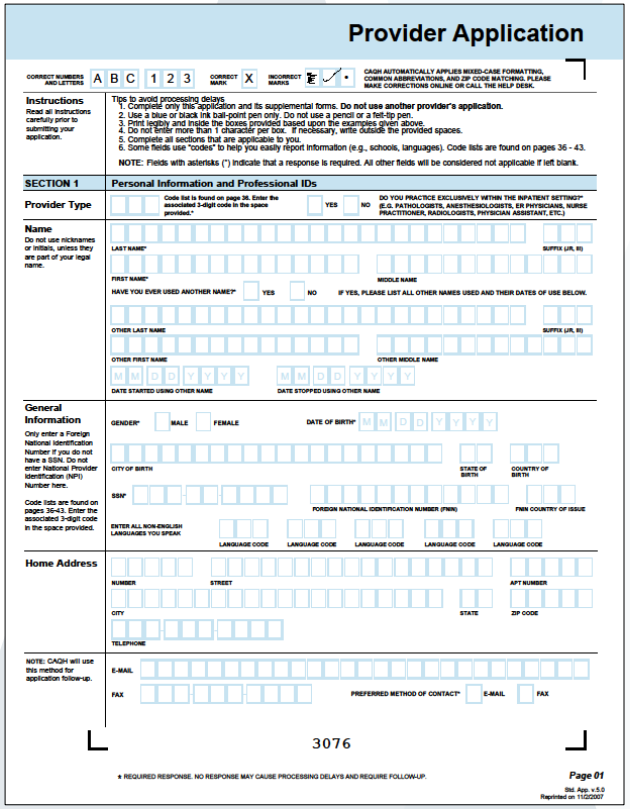


Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ☒ ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays:
1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — **Personal Information and Professional IDs**

Provider Type — Code list is found on page 36. Enter the associated 3-digit code in the space provided.* | YES | NO | DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)

FIRST NAME* | MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) | DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE | DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX | PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 01

Std. App. v.5.0 Reprinted on 11/2/2007

Required Recredentialing Supporting Documentation

The following documents must be submitted with your recredentialing application:

- Copy of state license.
- Copy of DEA registration and CDS license *(as applicable)*.
- Copy of Malpractice Liability Certificate (*copy of policy declarations page*).
- Complete the LSCA Attachment A - Location Hours.
- **Enclose a copy of the Collaborative Physician Agreement/Supervising Physician Agreement for NPs and PAs.**

- **You must complete the applicable checklist and submit all the indicated documents.**
- **Recredentialing packets with incomplete, missing information or submitted incorrectly will be returned. The timeframe starts once all information is submitted.**

Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

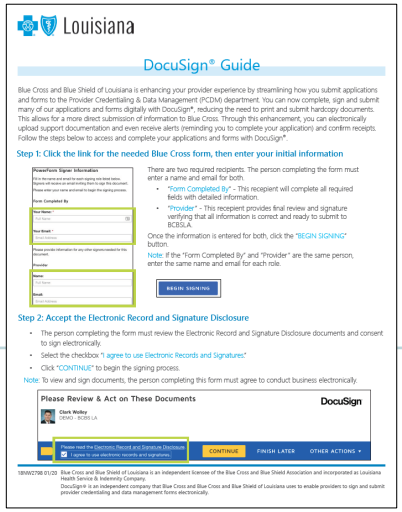
Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign**.

This streamlines submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross.

It allows you to electronically upload support documentation and even receive reminder alerts to complete submission and confirm receipt.

What is DocuSign?

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


Louisiana

DocuSign® Guide

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

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

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

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

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

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

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

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

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

Please Review & Act on These Documents

DocuSign

Clark Walley

DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure

I agree to use electronic records and signatures.

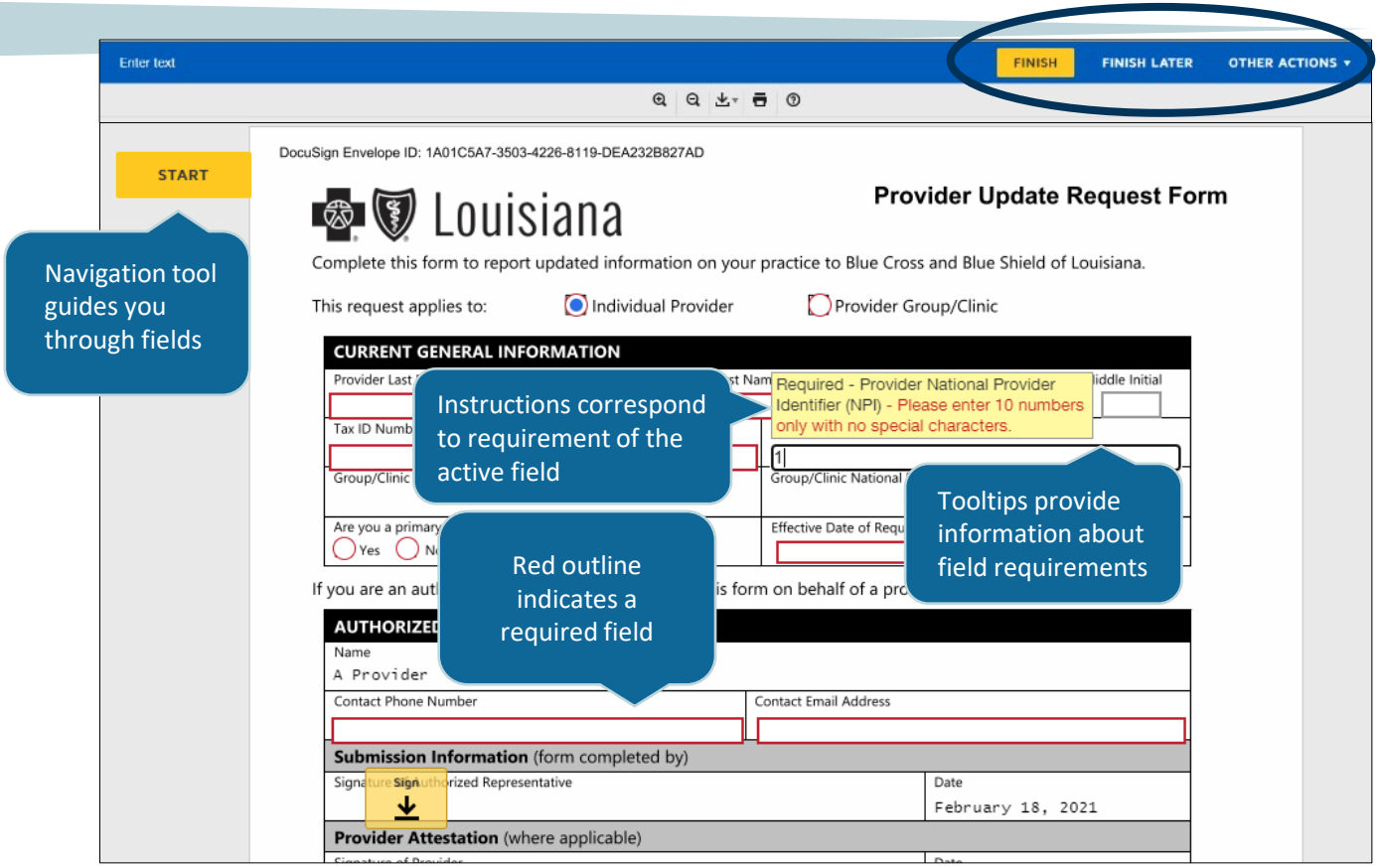
CONTINUE FINISH LATER OTHER ACTIONS

18WZ2708 01/23 Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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

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

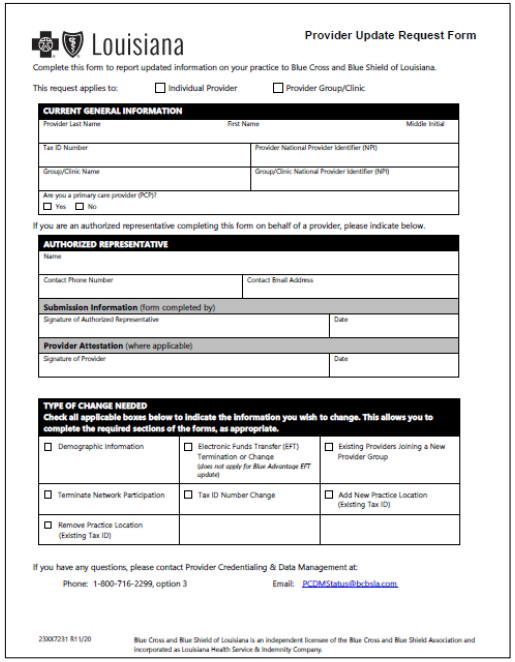
Easily Complete Forms with DocuSign



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

How to Update Your Information

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



Louisiana

Provider Update Request Form

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

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

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

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

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

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

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

Submission Information (form completed by)

Signature of Authorized Representative | Date

Provider Attestation (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

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

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

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

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

23007231 R11/20

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.

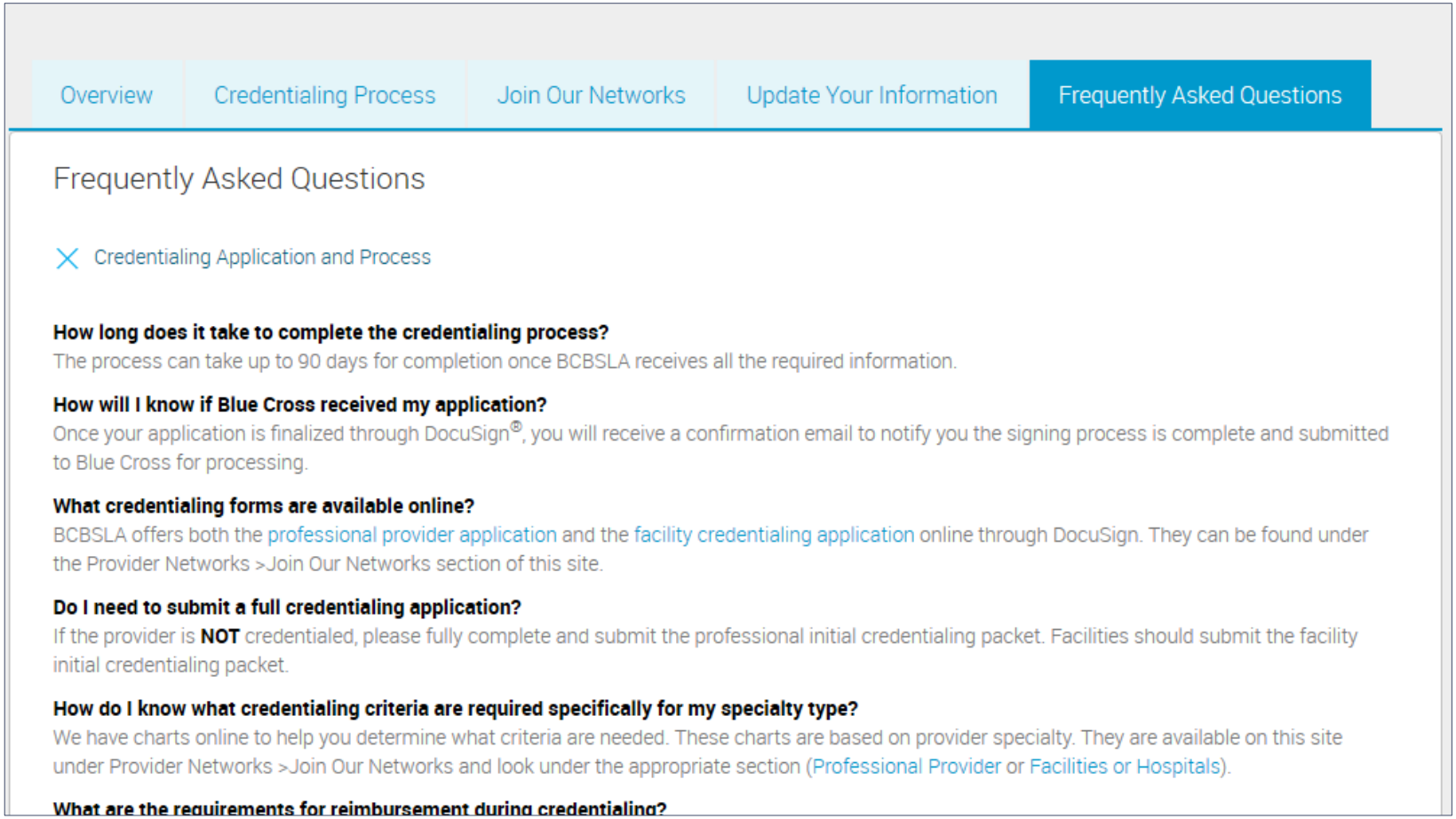
What changes do you need to make?

Provider Update Request Form – to update information such as:

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

Submit these forms online at **www.bcbsla.com/providers** >Provider Networks >Professional Provider >Update Your Information.

Frequently Asked Questions



A list of FAQs are available at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks >Professional Providers >Frequently Asked Questions.

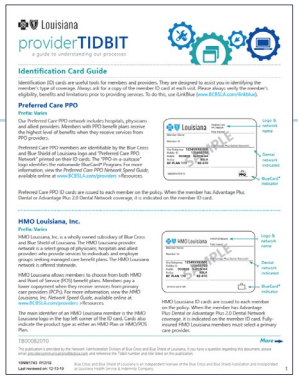
Our Networks

Our Provider Networks

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

Louisiana

HMO Louisiana


Louisiana
providerTIDBIT
a guide for understanding our products

Identification Card Guide

Preferred Care PPO

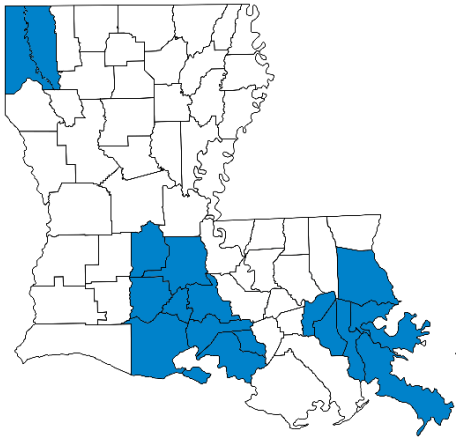
Profile Varies

HMO Louisiana, Inc.

Profile Varies

We have a Provider Tidbit to help identify a member's applicable network when looking at the ID card. *The Identification Card Guide* is available online at **www.bcbsla.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Our Provider Networks



BLUE CONNECT

New Orleans area

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

Lafayette area

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

Shreveport area

Bossier and Caddo parishes

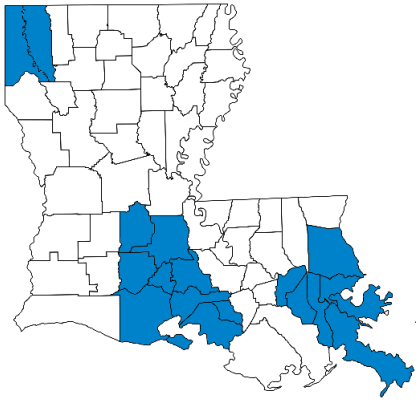
COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks

BLUEHPN



Lafayette area

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

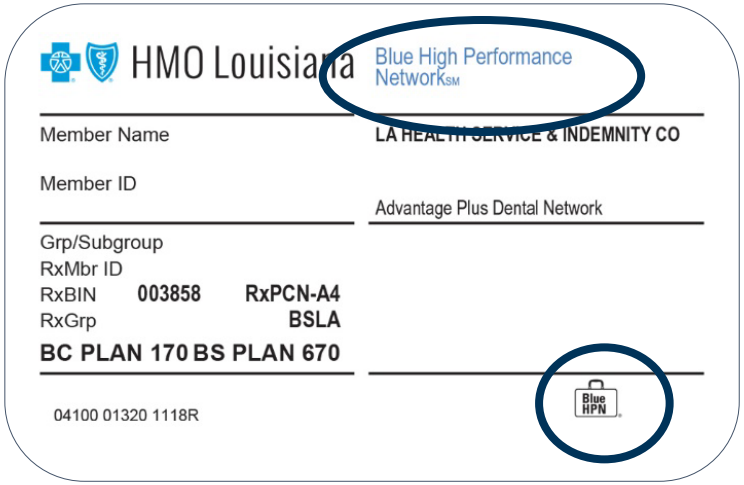
New Orleans area

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

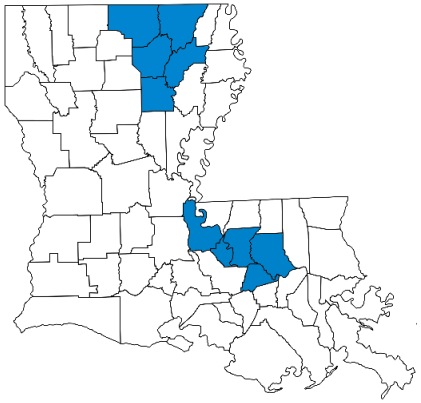
Shreveport area

Bossier and Caddo parishes

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



Our Provider Networks



PRECISION BLUE

Baton Rouge area

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

Greater Monroe/ West Monroe area

Caldwell, Morehouse, Ouachita, Richland and Union parishes

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans parishes

Federal Employee Program

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

STANDARD OPTION

- ✓ In-network
- ✓ Out-of-network

BASIC OPTION

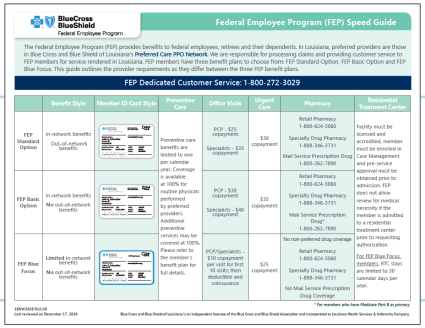
- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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

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

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


BlueCross BlueShield Federal Employee Program

Federal Employee Program (FEP) Speed Guide

The Federal Employee Program (FEP) provides benefits to federal employees, retirees and their dependents. In Louisiana, preferred providers are those in Blue Cross and Blue Shield of Louisiana's **Preferred Care PPO Network**. We are responsible for processing claims and providing customer service to FEP members for service rendered in Louisiana. FEP members have three benefit plans to choose from: FEP Standard Option, FEP Basic Option and FEP Blue Focus. This guide outlines the provider requirements as they differ between the three FEP benefit plans.

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

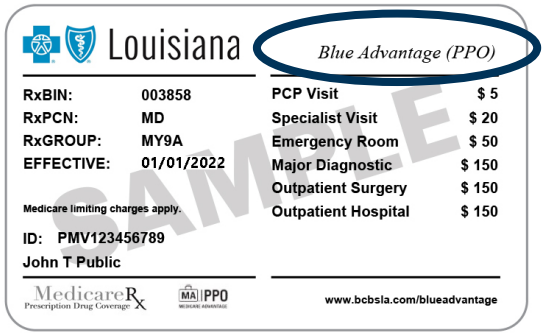
	Benefit Style	Member ID Card Style	Preventive Care	Office Visits	Urgent Care	Pharmacy	Residential Treatment Center
FEP Standard Option	In-network benefits Out-of-network benefits		Preventive care benefits are limited to one per calendar year. Coverage is available at 100% for routine physicals performed by preferred providers. Additional preventive services may be covered at 100%. Please refer to the member's benefit plan for full details.	PCP - $25 copayment Specialists - $35 copayment	$50 copayment	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug 1-800-262-7890	Facility must be licensed and accredited; member must be enrolled in Case Management and pre-service approval must be obtained prior to admission. FEP does not allow review for medical necessity if the member is admitted to a residential treatment center prior to requesting authorization.
FEP Basic Option	In-network benefits No out-of-network benefits			PCP - $30 copayment Specialists - $40 copayment	$35 copayment	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug* 1-800-262-7890	
FEP Blue Focus	Limited in-network benefits No out-of-network benefits			PCP/Specialists - $30 copayment per visit for first 10 visits; then deductible and coinsurance	$35 copayment	No non-preferred drug coverage Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 No Mail Service Prescription Drug Coverage	For FEP Blue Focus members, PPC stays are limited to 30 calendar days per year.

* For members who have Medicare Part B as primary

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

Our Blue Advantage Networks

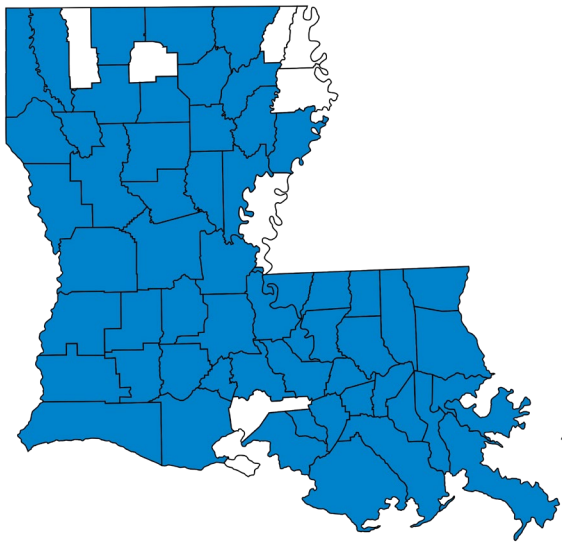
Blue Advantage (HMO) and **Blue Advantage (PPO)** networks are available statewide to Medicare eligible members.



Prefix: PMV

Prefix: MDV

Our Provider Networks



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

HEALTHY BLUE DUAL ADVANTAGE (HMO D-SNP)

Statewide with the exception of the following parishes:

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

Healthy Blue

BlueCard® Program

- BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan service area.
- The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

- The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

- The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

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

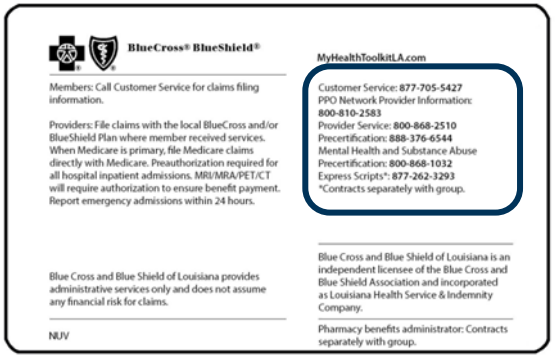
- The BlueHPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (Blue HPN) product.

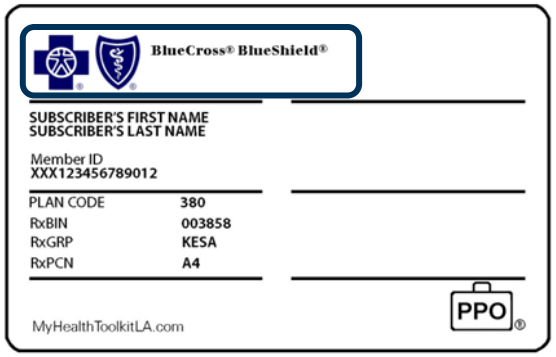
Note: BlueCard authorizations are handled through the members' home plan.

National Alliance

(South Carolina Partnership)

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC).
- Our taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC.
- Claims are processed through the BlueCard program.





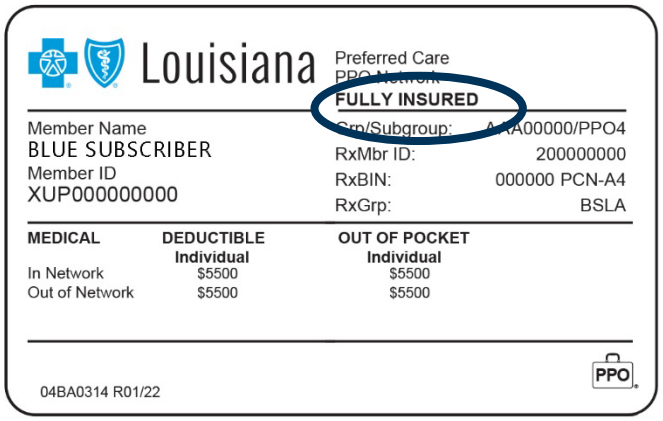
This list of prefixes is available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-funded

Member ID Card Differences

FULLY INSURED

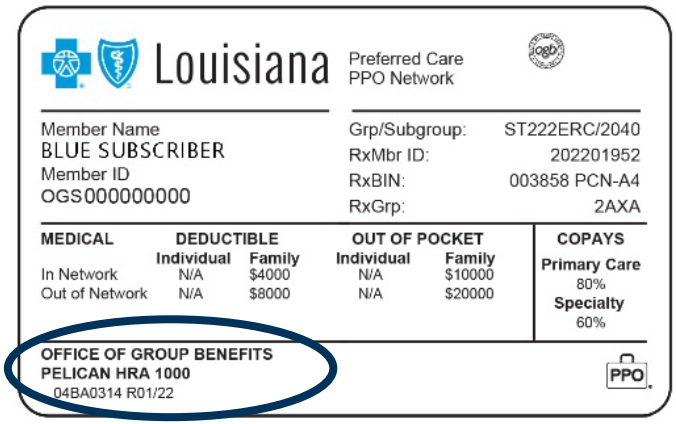
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"Fully Insured" notation

SELF FUNDED

Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA.



- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

The benefit, limitation, exclusion and authorization **requirements often vary for self-funded groups**. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.bcbsla.com/ilinkblue**).

Billing Guidelines

Claims by Provider Types

If Blue Cross offers network participation for a provider type, then that provider is required to file claims under their own name and provider number for services rendered.

For provider types not eligible for network participation, Blue Cross follows CMS incident-to guidelines for processing incident-to claims.

Provider types include:

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

Out-of-network Referrals

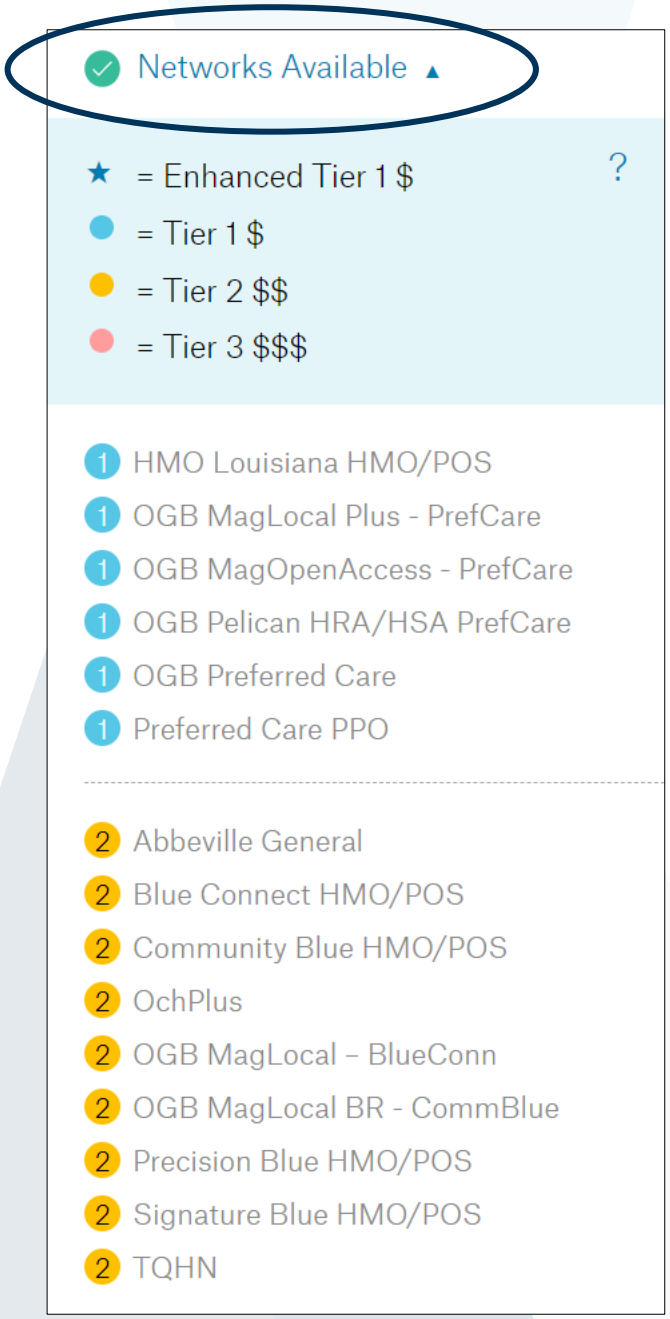
The impact on your patients when you refer Blue Cross members to out-of-network providers:

- Out-of-network member benefits often include higher copayments, coinsurances and deductibles.
- Some members have no benefits for services provided by non-participating providers.
- Non-participating providers can balance bill the member for all amounts not paid by Blue Cross.

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

Network Determination

www.bcbsla.com
>Find a Doctor or Drug
>Local Provider Directory



COVID-19 Treatments

- Effective January 1, 2022, Blue Cross will no longer waive member cost shares for antibody therapies and treatments associated with COVID-19. Claims filed for this treatment will be paid according to the member's contract benefits.
- This includes oral antivirals and the monoclonal antibody COVID-19 infusion for which the FDA issued an emergency use authorization.

Always verify a member's eligibility, benefits and limitations prior to services.

Work Related COVID Testing

- Blue Cross does not cover tests done for public surveillance, or tests that are required to return to work or attend recreational events or groups. This includes, but is not limited to school, camps, sporting events, or any other activity or venue that requires proof of a negative test.

- Do not file work-related COVID testing claims to Blue Cross.

FDA Approved COVID-19 Vaccines

Vaccine	Code Guidelines
Pfizer – vaccine product 91300 (12 years and older)	Dose 1 – 0001A Dose 2 – 0002A Dose 3 – 0003A Booster dose – 0004A
Pfizer – vaccine product 91305, tris-sucrose formulation (12 years and older)	Dose 1 – 0051A Dose 2 – 0052A Dose 3 – 0053A Booster dose – 0054A
Pfizer – vaccine product code 91307, tris-sucrose formulation (Pediatrics ages 5 through 11 years)	Dose 1 – 0071A Dose 2 – 0072A Dose 3 – 0073A
Pfizer vaccine product code – 91308, tris-sucrose formulation (Pediatrics ages 6 months through 4 years)	Dose 1 – 0081A Dose 2 – 0082A
Moderna – vaccine product 91301 (18 years and older)	Dose 1 – 0011A Dose 2 – 0012A Dose 3 – 0013A
Moderna – vaccine product 91306 (specific to booster dose)	Booster dose – 0064A
Jansen (Johnson & Johnson) – vaccine product code 91303 (18 years and older)	Dose 1 – 0031A Booster dose 0034A

At this time, the vaccine itself (five-digit numeric codes) are reimbursed by the federal government, and only the administration codes (ending in "A") should be sent to us for reimbursement.

Lung and Colorectal Screenings Update

2022 Product Enhancement Effective January 1, 2022

- Lung Cancer Screenings – ages 50-80, who have a 20 pack/year smoking history
  - Changed from 55-80, 30 pack/year smoking history
- Colorectal Cancer Screenings – ages 45-75
  - Changed from ages 50-75

This affects fully insured and self-funded groups and individual policies as they renew.

Telehealth New Place of Service Code 10

- Effective for dates of services January 1, 2022, there is a new place of service 10 code established for telehealth provided in a home setting.
- With this new place of service code, Blue Cross is updating the telehealth billing guidelines for direct to consumer (DTC) telehealth services.
- We define DTC telehealth as telehealth services delivered directly between the provider and patient in their home environment (e.g., residence, workplace, personal space, etc.).
- To ensure the appropriate benefits and reimbursement apply, do not bill place of service 02 to Blue Cross for telehealth services. Blue Cross does not consider place of service 02 valid for claims submission and claims billed with place of service 02 may reject.
- Providers should continue to use the appropriate telehealth modifiers to identify telehealth claims, and continue to follow additional guidelines.

For more information about our telemedicine requirements, billing and coding guidelines, see Section 5.37 Telehealth/telemedicine our *Professional Provider Office Manual* at **www.bcbsla.com/providers** >Resources >Manuals.

Provider Directory

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 Highlights

Updated Phone Numbers

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

We no longer use the EDI iLinkBlue phone number (1-800-216-2583). Please begin using **option 3** for EDI services.

Multi-factor Authentication verification for all iLinkBlue Users

- 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 user-friendly self-service interface.
- Choose from various authentication methods, including email, text and smartphone authenticator app.

You will soon receive a guide for how to complete the registration process.

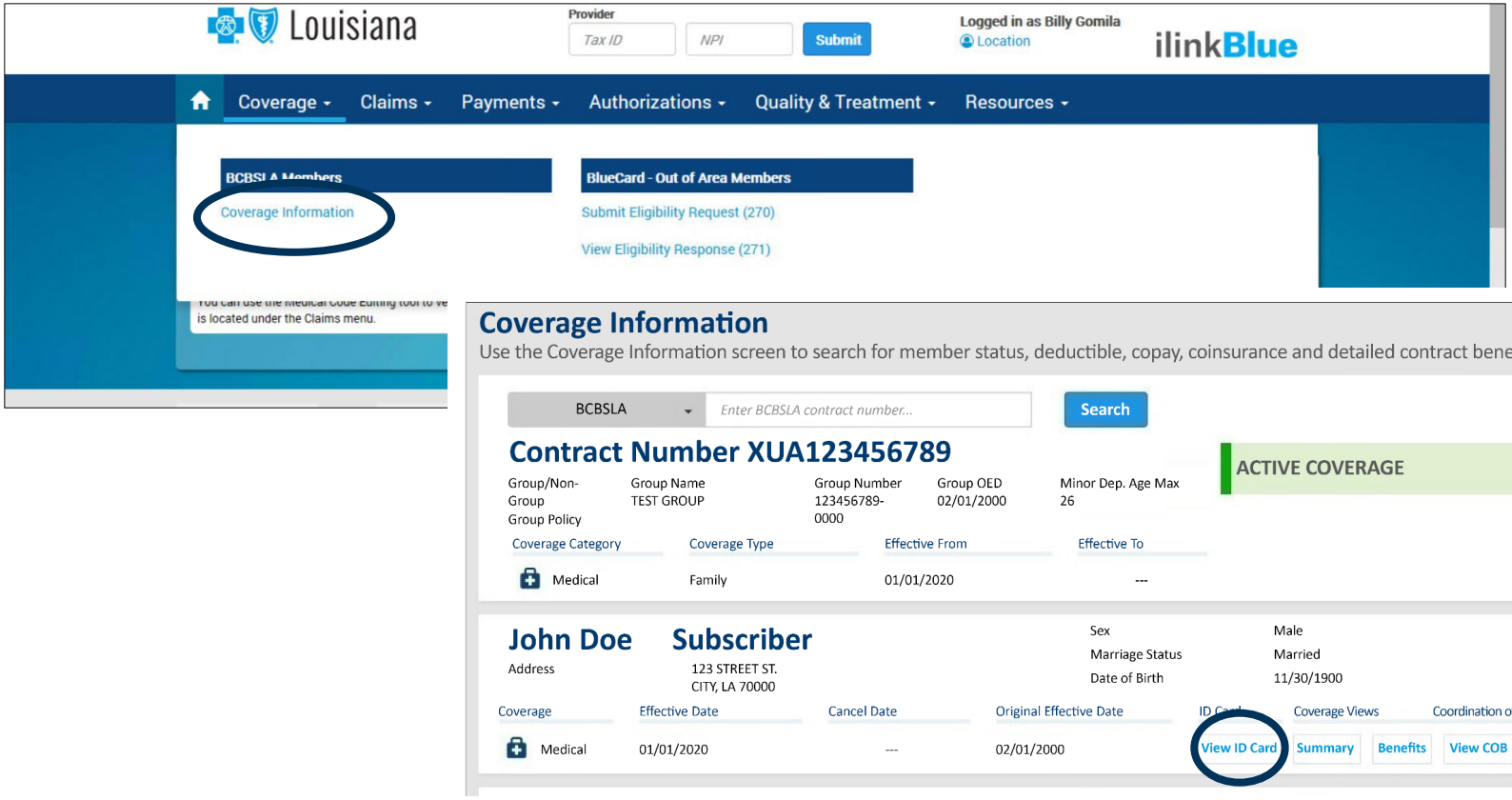
Security Setup Application

- **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**.

Digital ID Cards in iLinkBlue

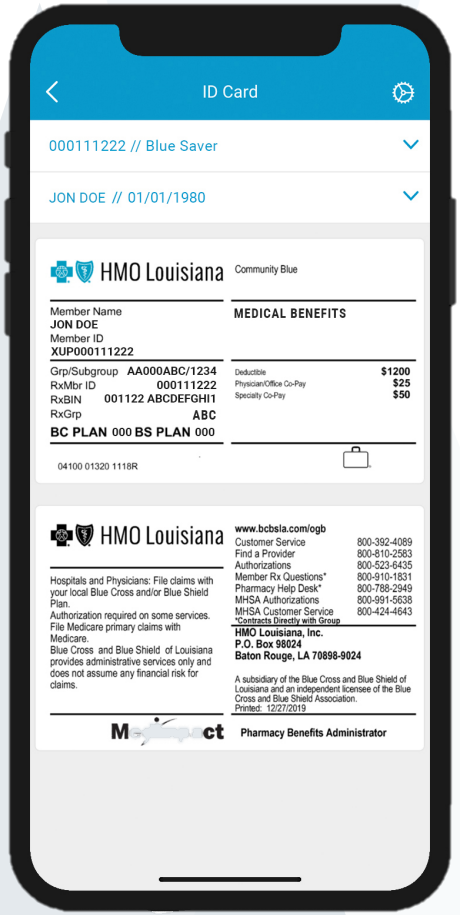
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”



Digital ID Cards

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

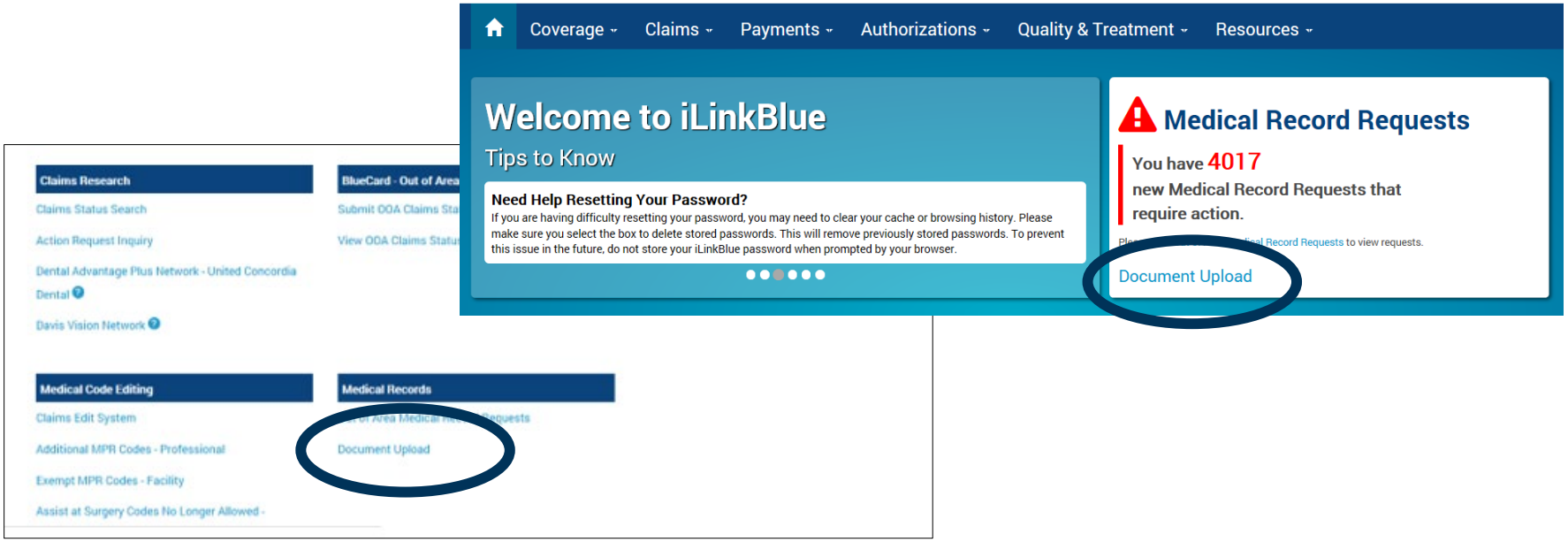
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.
- To access through the Blue Cross member portal, log into the online member account at **www.bcbsla.com**. There, click on “My ID Card” and use the drop-down menu to choose from ID cards available. These cards can be downloaded as PDFs and saved.



Document Upload Feature

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

The new feature is quick, secure and available at any time through the iLinkBlue provider portal.

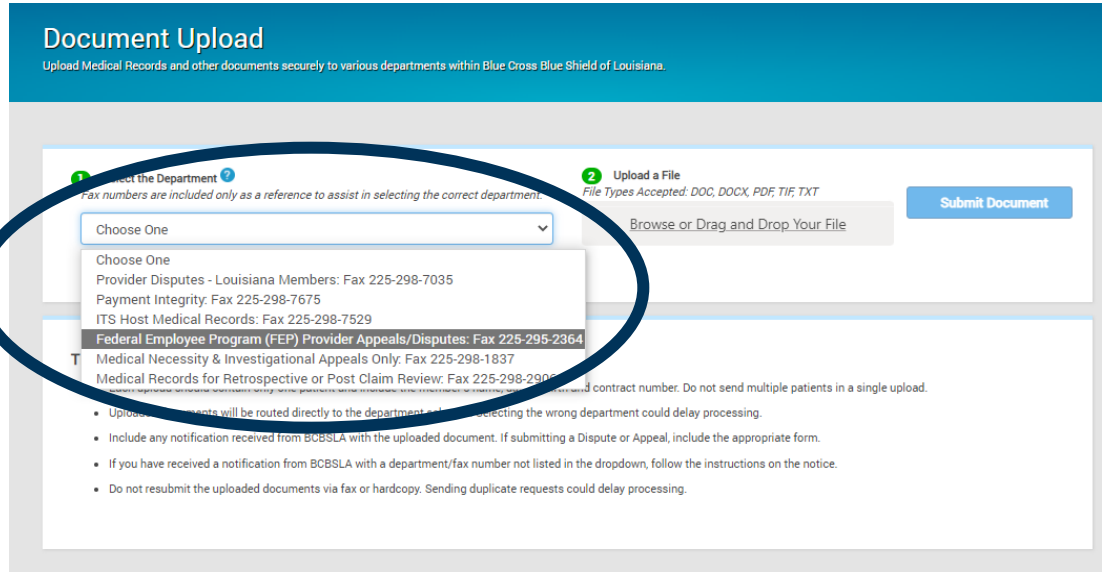


The Document Upload feature can be accessed on iLinkBlue (**www.bcbsla.com/ilinkblue**) or under Claims >Medical Records >Document Upload.

Document Upload Feature

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

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



Document Upload Feature FAQs

What should be included in the uploaded document?

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

What file types are allowed in the upload process?

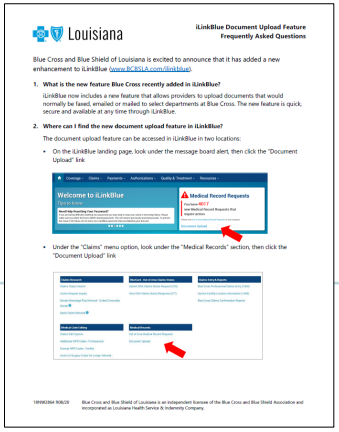
- DOC, DOCX, PDF, TIF, TXT

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

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

Is there a file size limitation?

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


Louisiana

iLinkBlue Document Upload Feature Frequently Asked Questions

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

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

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

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

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

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

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

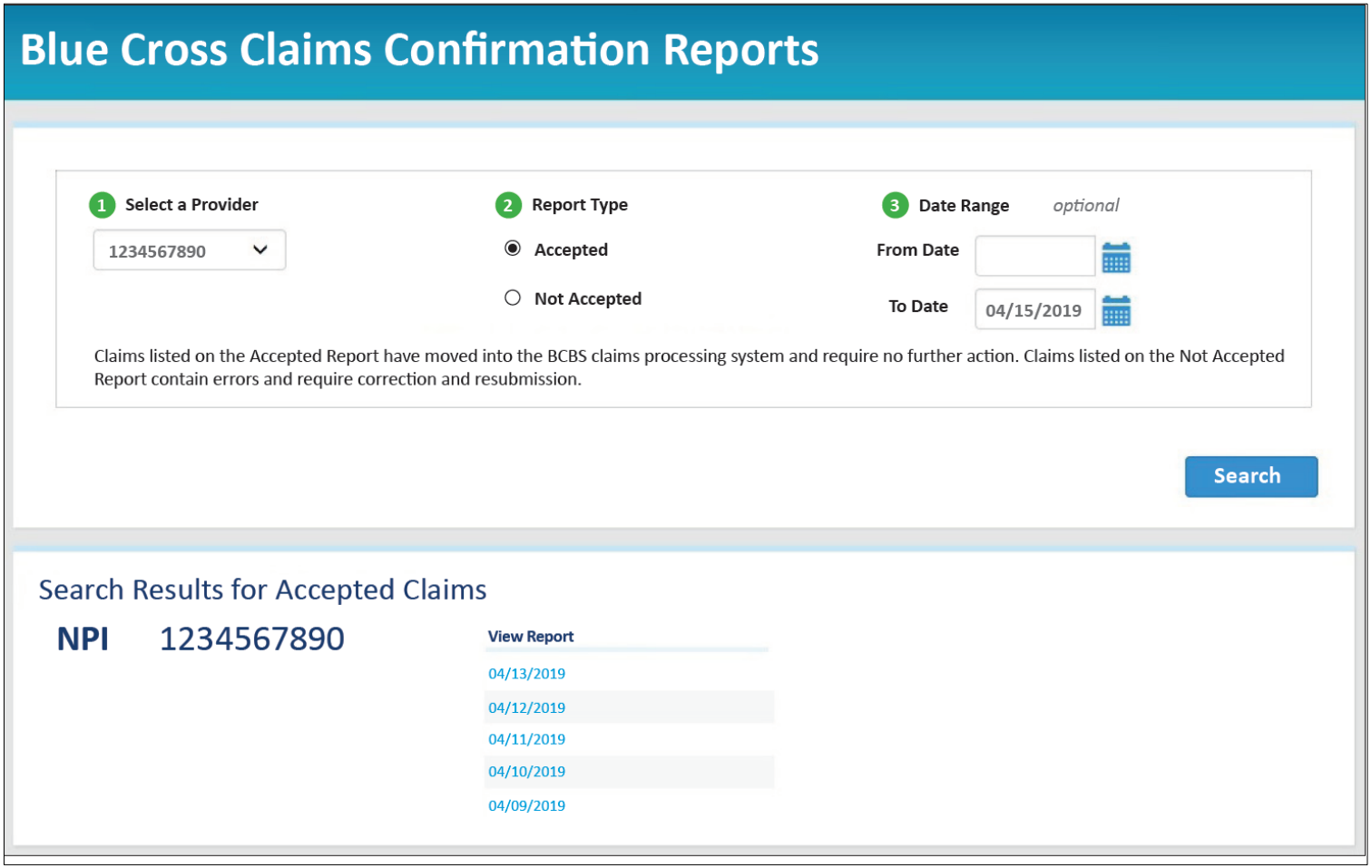
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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

Blue Cross Claims Confirmation Reports

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

Blue Cross Claims Confirmation Reports



Blue Cross Claims Confirmation Reports

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

Accepted Report

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

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

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

PAGE 1

837P ACCEPTED REPORT

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	CH TRACKING NUMBER
L12345678	DOE	JOHN	XUA123458789	040819	040819	125.00	123459876123

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
837P TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS: 1 CLAIMS FOR $125.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
GRAND TOTAL CLAIMS: 1 CLAIMS FOR $125.00

Not Accepted Report

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

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

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

PAGE 1

837P NOT ACCEPTED REPORT

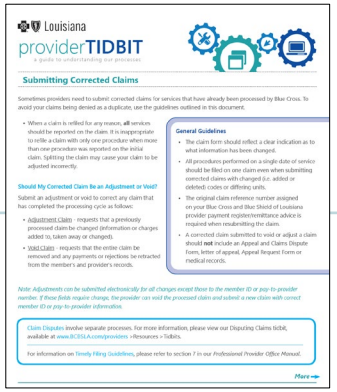
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION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

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

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

Submitting a Corrected Claim

- When a claim is refiled for any reason, all services should be reported on the claim.
- Adjustment Claim – requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim – requests that the entire claim be removed, and any payments or rejections be retracted from the member's and provider's records.
- If submitting a corrected claim through iLinkBlue:
  - In Field 19a, enter the applicable Professional Claim Adjustment/Void Indicator: A (Adjustment Claim) or V (Void Claim)
  - In Field 19b, enter the Internal Control Number (ICN Number which is the original claim number)


Louisiana
providerTIDBIT
a guide to understanding our processes

Submitting Corrected Claims

Sometimes providers need to submit corrected claims for services that have already been processed by Blue Cross. To avoid your claims being denied as a duplicate, use the guidelines outlined in this document.

- When a claim is refiled for any reason, all services should be reported on the claim. It is inappropriate to refile a claim with only one procedure when more than one procedure was reported on the initial claim. Splitting the claim may cause your claim to be adjusted incorrectly.

Should My Corrected Claim Be an Adjustment or Void?

Submit an adjustment or void to correct any claim that has completed the processing cycle as follows:

- Adjustment Claim - requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim - requests that the entire claim be removed and any payments or rejections be retracted from the member's and provider's records.

General Guidelines

- The claim form should reflect a clear indication as to what information has been changed.
- All procedures performed on a single date of service should be filed on one claim even when submitting corrected claims with changed (i.e., added or deleted) codes or differing units.
- The original claim reference number assigned on your Blue Cross and Blue Shield of Louisiana provider payment register/remittance advice is required when resubmitting the claim.
- A corrected claim submitted to void or adjust a claim should **not** include an Appeal and Claims Dispute Form, letter of appeal, Appeal Request Form or medical records.

Note: Adjustments can be submitted electronically for all charges except those to the member ID or pay-to provider number. If these fields require change, the provider can void the processed claim and submit a new claim with correct member ID or pay-to provider information.

Claim Disputes involve separate processes. For more information, please view our Disputing Claims tidbit, available at www.BCBSLA.com/providers >Resources > Tidbits.

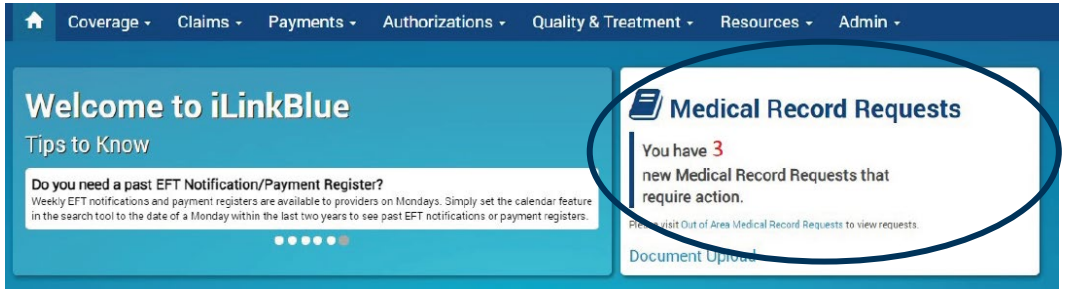
For information on Timely Filing Guidelines, please refer to section 7 in our *Professional Provider Office Manual*.

More

For more information find our Submitting a Corrected Claim Tidbit at **www.bcbsla.com/Providers** >Resources >Tidbits.

BlueCard Medical Record Request

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



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

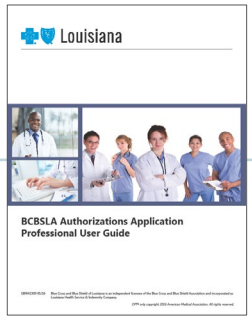
Authorizations

iLinkBlue – Authorizations Mandate

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 application available in iLinkBlue.
- The application allows providers to request authorizations 24 hours a day, seven days a week, in real time.
- **In some cases, the application 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 application, the *BCBSLA Authorizations Applications Professional User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."

Communicating with BCBSLA regarding Authorizations

Creating an "Activity" is the **only** way to communicate with BCBSLA regarding authorizations. Do **not** use the "Notes" tab, as our Authorizations Department will not be notified.

An "Activity" **must** be added to an authorization when attempting to complete any of the following:

- Corresponding with our Authorization Department
- Additional information is being forwarded
- Extending an authorization or adding additional services
- Changing an authorization
- Requesting peer-to-peer review (flag as critical)

The "Activity" must be assigned to: Provider Request Worklist

It is very important to follow this process to ensure authorizations are handled accurately and timely.

Blue Cross requires providers to request prior authorizations through our BCBSLA Authorizations application. It is available online in iLinkBlue (**www.bcbsla.com/ilinkblue**).

Tips for Online Authorizations in iLinkBlue

Troubleshooting tips for navigating BCBSLA Authorizations application:

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

BCBSLA Authorization Application FAQs

What if my request is STAT, am I still required to use the authorization online?

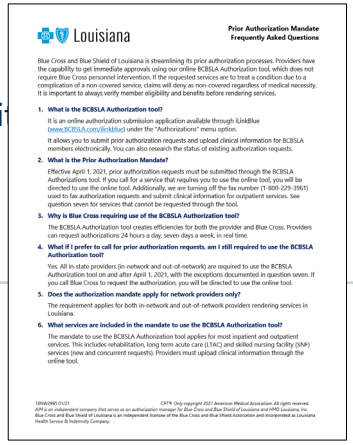
- Yes. Please submit STAT requests through the BCBSLA Authorization application. They will be addressed timely and accordingly.

How do I check the status of my authorization in the BCBSLA Authorization application?

- You may search by the patient's member ID number (found on the member ID card). You may also search by the reference number of the pending request.

How do I submit clinical information to Blue Cross?

- Clinical information can be supplied in one of three ways:
  - Complete criteria review via InterQual (IQ). You may receive an online approval when IQ is completed, and criteria are met. Some services will require additional review, such as a benefit review or a medical policy review regardless of an IQ approval. Completing an IQ review is not required.
  - Upload clinical information to the authorization request through the BCBSLA Authorization application.
  - Document the clinical information in the notes section of the authorization request in the BCBSLA Authorization application. You must then generate an activi within the request. If an activity is not generated, the clinical information will not be available for Blue Cross to review.



Louisiana

Prior Authorization Mandate Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is streamlining its prior authorization processes. Providers have the capability to get immediate approvals using our online BCBSLA Authorization tool, which does not require 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. It is important to always verify member eligibility and benefits before rendering services.

1. **What is the BCBSLA Authorization tool?**

   It is an online authorization submission application available through iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Authorizations" menu option.

   It allows you to submit prior authorization requests and upload clinical information for BCBSLA members electronically. You can also research the status of existing authorization requests.

2. **What is the Prior Authorization Mandate?**

   Effective April 1, 2021, prior authorization requests must be submitted through the BCBSLA Authorizations tool. If you call for a service that requires you to use the online tool, you will be directed to use the online tool. Additionally, we are turning off the fax number (1-800-229-3961) used to fax authorization requests and submit clinical information for outpatient services. See question seven for services that cannot be requested through the tool.

3. **Why is Blue Cross requiring use of the BCBSLA Authorization tool?**

   The BCBSLA Authorization tool creates efficiencies for both the provider and Blue Cross. Providers can request authorizations 24 hours a day, seven days a week, in real time.

4. **What if I prefer to call for prior authorization requests, am I still required to use the BCBSLA Authorization tool?**

   Yes. All in-state providers (in-network and out-of-network) are required to use the BCBSLA Authorization tool on and after April 1, 2021, with the exceptions documented in question seven. If you call Blue Cross to request the authorization, you will be directed to use the online tool.

5. **Does the authorization mandate apply for network providers only?**

   The requirement applies for both in-network and out-of-network providers rendering services in Louisiana.

6. **What services are included in the mandate to use the BCBSLA Authorization tool?**

   The mandate to use the BCBSLA Authorization tool applies for most inpatient and outpatient services. This includes rehabilitation, long term acute care (LTAC) and skilled nursing facility (SNF) services (new and concurrent requests). Providers must upload clinical information through the online tool.

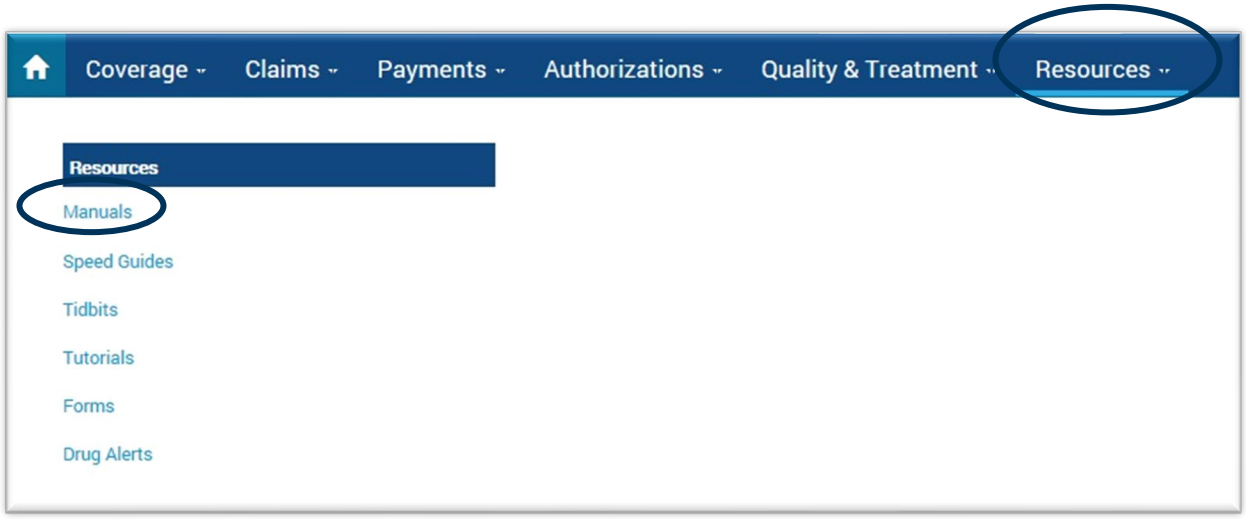
View our Prior Authorization Mandate Frequently Asked Questions at **www.bcbsla.com/providers** >Electronic Services >Authorizations, under the quick links section.

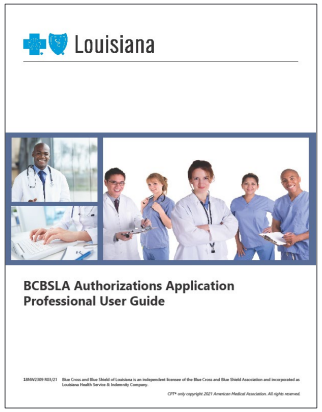
iLinkBlue – Authorizations

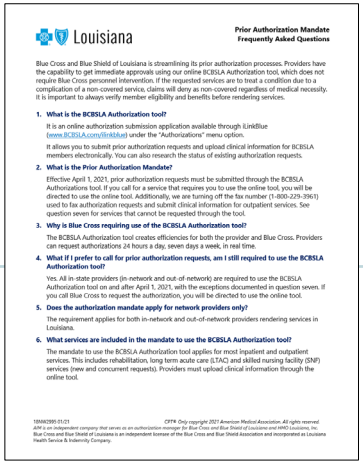
- Use the "Authorizations" menu option to access our authorization applications.
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Out of Area (Pre Service Review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

Authorizations Resources

Use the “Resources” menu option in iLinkBlue to access various provider manuals, including the **BCBSLA Authorization application user guides**.







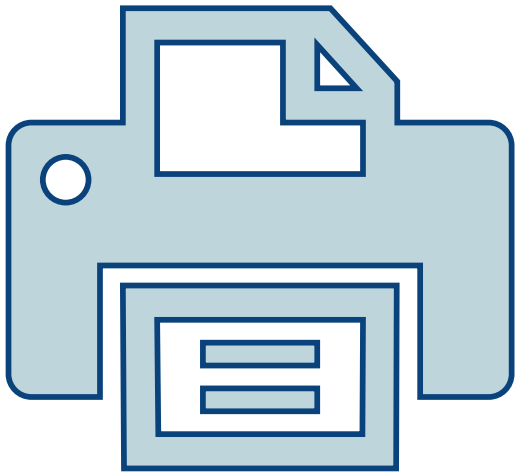
View our Prior Authorization Mandate Frequently Asked Questions at **www.bcbsla.com/providers** >Electronic Services >Authorizations, under the quick links section.

Retrospective Authorization Fax Number

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.
Please instead use the toll-free fax number.

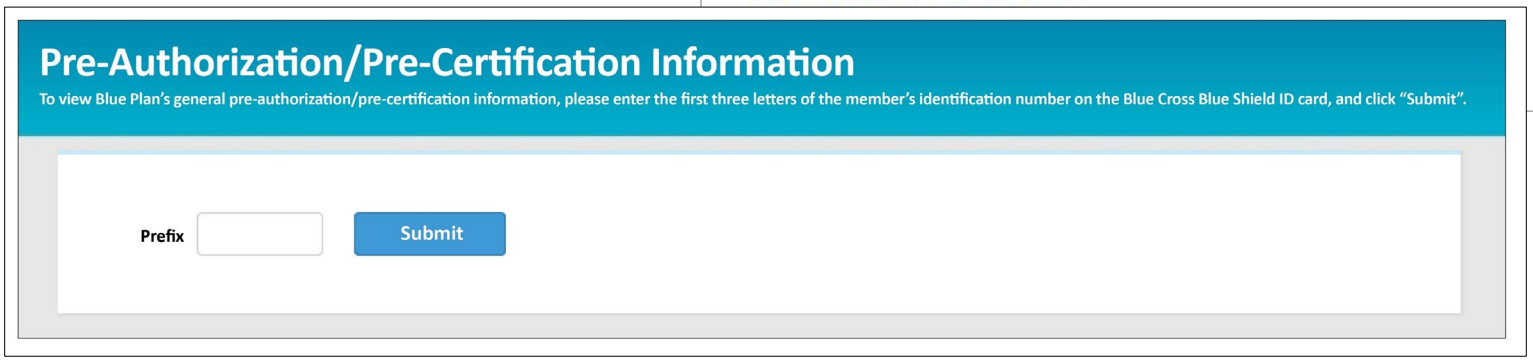


1-800-515-1150

Where to Find Authorization Requirements

Do I need an authorization?

The Authorizations Guidelines application allows providers to research and view authorization requirements for BCBSLA and BlueCard (out-of-area) members.



Simply enter the member's prefix (the first three characters of the member ID number) to access general pre-authorization/pre-certification information.

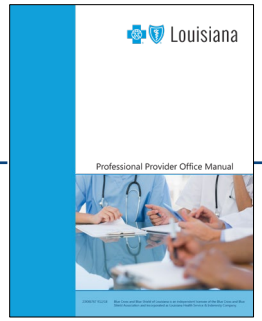
Utilization Management Programs

Blue Cross has several utilization management programs that require prior authorization for select elective services. AIM Specialty Health® (AIM), an independent specialty benefits management company, serves as our authorization manager for these services:

- Cardiology
- High-tech Imaging
- Radiation Oncology
- Musculoskeletal (MSK)
  - Interventional Pain Management
  - Joint Surgery
  - Spine Surgery

Authorization requests may be completed online using the AIM ***Provider****Portal*SM accessed through iLinkBlue. AIM clinical appropriateness guidelines are available at **www.aimspecialtyhealth.com**.

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



Imaging Authorizations

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

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

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

Top reasons for claim denials related to outpatient imaging authorizations:

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

AIM Specialty Health Code Changes

The American Association released CPT code changes in September 2021.

As a result, the following code changes were made to these AIM Specialty Health (AIM) programs, **effective March 13, 2022**.

- Musculoskeletal (MSK) Program
  - Removed from pain management program: 64640
- Radiation Oncology Program
  - Removed codes 46499, 47999, 55899
- High-tech Imaging Program
  - Added codes 0042T, 0648T, 0649T
- Pain Management Program
  - Removed from pain management program: 0228T, 0229T, 0230T, 0231T

For authorization requests or medical necessity review, please access the AIM Provider Portal$_{SM}$ trough iLinkBlue (**www.bcbsla.com/ilinkblue**) under the Authorizations menu option. You may also contact AIM directly at 1-866-455-8416.

Process for Changing an Authorization

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

- There is an approved authorization on file.
- Provider states a claim has not been filed.
- The requested code is surgical or diagnostic.
- The requested code is not on a Blue Cross medical policy or a non-covered benefit.

If the above criteria is met, an authorization can be changed within seven calendar days of the services being rendered. **This can be done by completing an Activity in the BCBSLA Authorization application and uploading medical records and/or adding a note.**

If the procedure being added or changed is on a Blue Cross medical policy or is a non-covered benefit, it cannot be updated on the authorization.

Failure to Obtain an Authorizations

Failure to obtain a prior authorization can result in:

- A 30% penalty imposed on Preferred Care PPO and HMO Louisiana, Inc. network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization.
- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized (Note: some policies contain a different inpatient penalty provision).
- The denial of payment for services for our Office of Group Benefits (OGB) members.
- A $500 penalty applied to inpatient hospital claims for Federal Employee Program (FEP) members with Standard Option, Basic Option and FEP Blue Focus benefits. For select outpatient services, no payment will be made if prior authorization is not obtained. If prior approval is not obtained for certain OP and IP services, a $100 penalty may be applied on Blue Focus.

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

OGB Authorizations

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

OGB PLAN SERVICES REQUIRING AUTHORIZATION

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

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

INPATIENT

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

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

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

STOP

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

OUTPATIENT

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

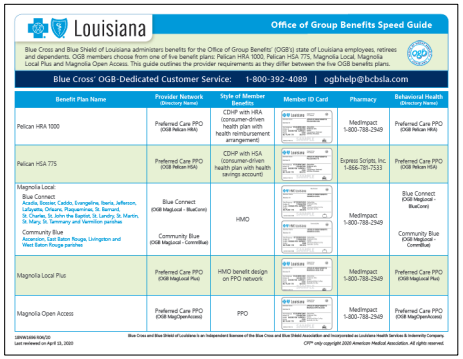
Louisiana

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

4-10
December 2018

The list of OGB authorization requirements can be found in our *Professional Provider Office Manual* located at **www.bcbsla.com/providers** >Resources >Manuals.

The list also appears on the OGB Speed Guide located on **www.bcbsla.com/providers** >Resources.



Louisiana

Office of Group Benefits Speed Guide

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

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

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

LBHW5486-NOV20
Last reviewed on April 15, 2020

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

OptiNet Registration in iLinkBlue

- AIM Specialty Health® offers ***Opti****Net*® an online registration application that gathers information about the technical component capabilities of diagnostic imaging services and calculates provider scores based on self reported information.
- Through this application, we can offer members and their ordering providers the option to "shop" for quality, lower-cost diagnostic imaging services.
- Without an ***Opti****Net*® score, you miss out on this opportunity for exposure to Blue members.

Why Is Your Score So Important?

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

OptiNet Registration in iLinkBlue

How Is Your Score Calculated?

- The site score measures basic performance indicators that are applicable for the facility, such as general site access, quality assurance and staffing.
- The modality specific scoring is based on indicators such as MD certification, technologist certification, modality accreditation and equipment quality.

How to Access OptiNet?

- Log into iLinkBlue (**www.bcbsla.com/ilinkblue**).
- Click on the "Authorizations" menu option Click on the "AIM Specialty Health Authorizations" link; this link takes you to the AIM ***Provider****Portal*$_{SM}$.
- Click on "Access Your OptiNet Registration" on the left menu bar.
- Click the green "Access Your OptiNet Registration" button.

Healthcare Effectiveness Data and Information Set (HEDIS®)

What is HEDIS?

HEDIS is a set of health care performance measures developed by the National Committee for Quality Assurance (NCQA).

- It is used by more than 90% of America's health plans to measure and improve health care quality.
- HEDIS is a retrospective performance review of the prior calendar year and beyond.

Find more information online at **www.ncqa.org/hedis**.

Purpose of HEDIS Results

Health plans use HEDIS performance results to:

- Evaluate quality of care and services.
- Evaluate provider performance.
- Develop performance quality improvement initiatives.
- Perform outreach to members.
- Compare performance with other health plans.

HEDIS Data Collection Methods

HEDIS data is collected in three ways:

- **Administrative Method** - Obtained from our claims database and supplemental data.
- **Hybrid Method** - Obtained from our claims database and medical record reviews.
- **Survey Method** - Obtained from member surveys.

Administrative Method

- **Claims/Encounter data** is essential for measuring and monitoring quality, service utilization and differences in members' health care needs.
- **Correct coding of claims** is also very important. If a service or diagnosis is not coded correctly, the data may not be captured for HEDIS and may not be reflected accurately in the resulting quality scores.

Administrative data and accurate coding help us to better understand and meet the health care needs of our members, your patients.

Administrative Method: Supplemental Data

Standard Supplemental data are electronically generated files that come from service providers.

- Providers can submit data electronically to the health plan using the approved electronic medical record (EMR) Common Clinical Model layout.

Nonstandard supplemental data is used to capture missing service data not received through claims or encounters or in the standard electronically generated files described above.

- May be collected on an irregular basis (sometimes referred to as year-round HEDIS).
- Providers can allow remote access to EMRs.

Hybrid Method

Medical Records: Some HEDIS data cannot be collected through claims or historical data. It is very important that providers document medical records appropriately to abstract this HEDIS data from the medical records.

Medical Record Requests

- Medical record requests are sent to providers from our Blue Cross HEDIS Team. Requests include:
  - Member Name
  - Provider Name
  - A description of the type of medical records and timeframes needed to close the HEDIS gaps.
- The team will coordinate with your office for data collection methods. These options include:
  - Remote Electronic data collection
  - On-site visits
  - Fax
  - Mail
  - Direct upload

Medical Record Requests

Medical Request Reminders:

- Per your Blue Cross network agreement, medical records should be provided at no cost.
- We will work with your copy center or vendor at no cost.
- Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and a release of this information requires no special patient consent or authorization.
- We appreciate your cooperation in sending the requested medical record information in a timely manner (ideally in five to seven business days).

Tips for Improving Quality of Care HEDIS

- Encouraging patients to schedule preventive exams.
- Reminding patients to follow up with ordered tests and procedures.
- Ensure necessary services are being performed in a timely manner.
- Submitting claims with proper codes.
- Accurately documenting all completed services and results in the patient's chart.

When our members/patients are healthy, everyone benefits.

Questions Related to HEDIS

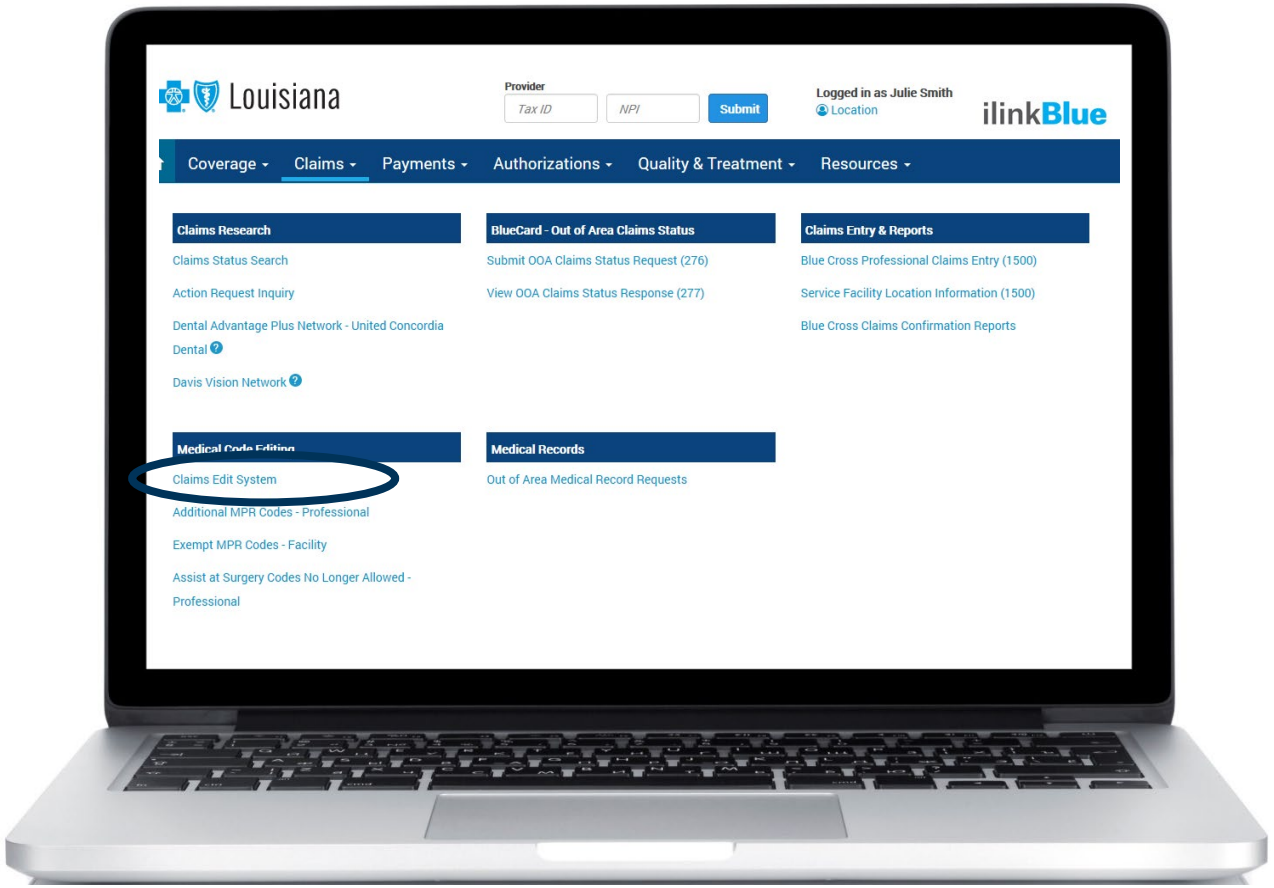
If you have question related to HEDIS measures or medical record collections, please contact the Health and Quality Department.

HEDISTeam@bcbsla.com

Claims Editing

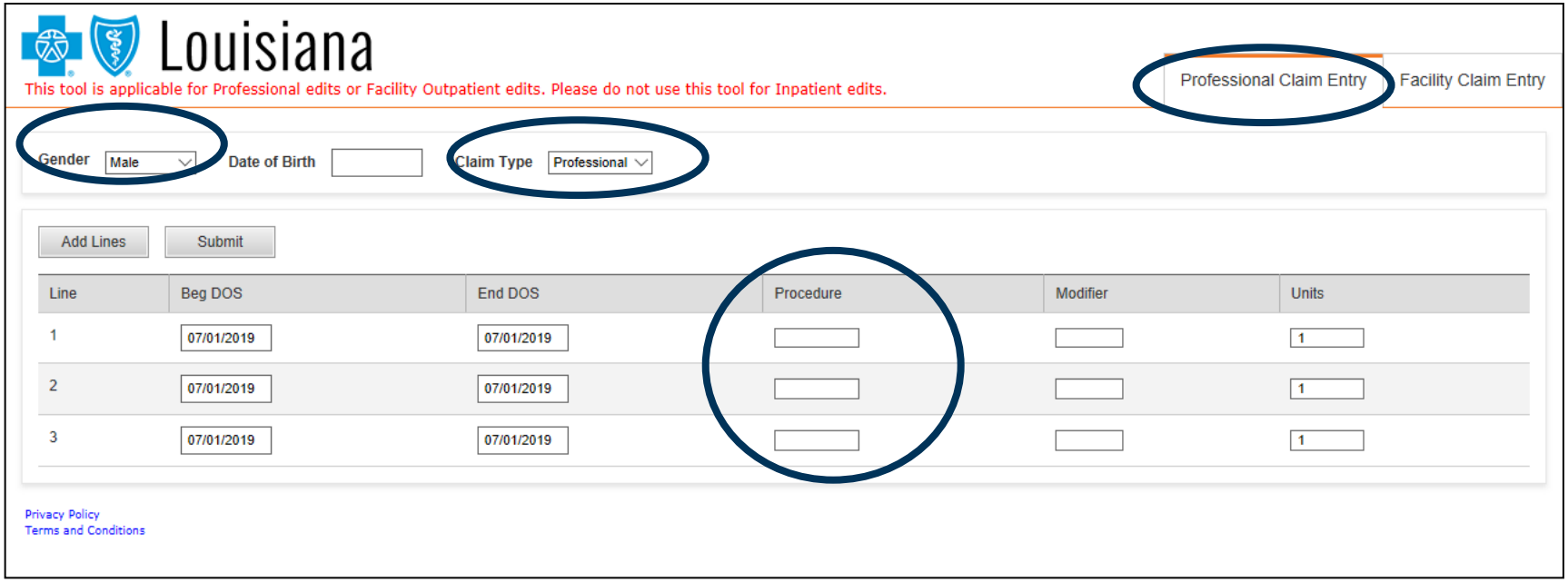
Claims Editing System

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



Claims Editing System

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



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

Claims Resolution

Claims Disputes & Appeals

MEDICAL APPEALS

Involves a denial or partial denial based on:

- Medical necessity, appropriateness, health care setting, level of care or effectiveness.
- Determined to be experimental or investigational.

ADMINISTRATIVE APPEALS & GRIEVANCES

- Claim issue due to the member's contract benefits, limitations, exclusions or cost share.
- When there is a grievance.

PROVIDER DISPUTES

Involves a denial that affects the provider's reimbursement.

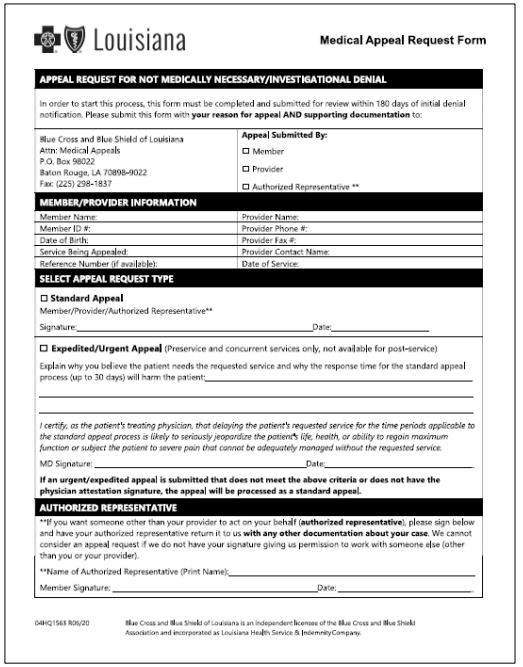
On the next slides, we will detail each of these claims inquiries.

Medical Appeals

Claim denied as investigational or not medically necessary.

MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT.

- Use the Provider Appeal Request Form that was included in the initial denial notice to properly request a review of a medical necessity or investigational denial.
- Be sure to complete all fields in the form and attach to the top of your appeal information. Incomplete information may delay the review.
- Member authorization is required and must be included in the appeal.
- Include rationale and supporting clinical records. Peer-to-peer reviews are **not** available once an appeal has been initiated.
- Physician signature is ONLY required if the request to appeal is expedited.



Louisiana

Medical Appeal Request Form

APPEAL REQUEST FOR NOT MEDICALLY NECESSARY/INVESTIGATIONAL DENIAL

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

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

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

MEMBER/PROVIDER INFORMATION

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

SELECT APPEAL REQUEST TYPE

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

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

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

MD Signature: _____Date:_____

If an urgent/expedited appeal is submitted that does not meet the above criteria or does not have the physician attestation signature, the appeal will be processed as a standard appeal.

AUTHORIZED REPRESENTATIVE

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

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

Member Signature: _____Date: _____

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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.

SEND TO:

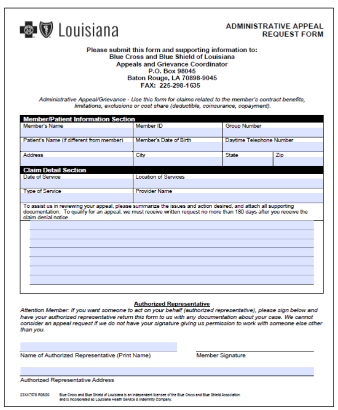
Through iLinkBlue (**www.bcbsla.com/iLinkBlue**), click "Document Upload," then "Provider Disputes" in the drop-down menu.

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

Fax: (225) 298-1837

BCBLSA Administrative Appeals

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



Louisiana

ADMINISTRATIVE APPEAL REQUEST FORM

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

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

Member/Patient Information Section

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

Claim Detail Section

Date of Service	Location of Services
Type of Service	Provider Name

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

Authorized Representative

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

Name of Authorized Representative (Print Name) Member Signature

Authorized Representative Address

23XX7578 R06/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.

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

FAX: 225-298-1635

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

Provider Disputes

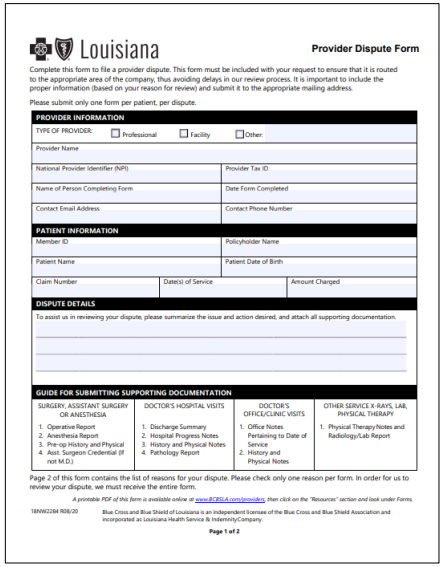
A provider dispute is different than an appeal or grievance. Provider disputes are defined as written requests from our participating network providers (Network Providers ONLY) questioning (or disputing) their allowable charge of a processed claim. Disputes could involve the following:

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

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

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

FAX: (225) 298-7035



Louisiana

Provider Dispute Form

Complete this form to file a provider dispute. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

Contact Email Address | Contact Phone Number

PATIENT INFORMATION

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

Claim Number | Date(s) of Service | Amount Charged

DISPUTE DETAILS

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

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-op History and Physical 4. Asst. Surgeon Credential (if not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

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

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Page 1 of 2

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

Disputes Process for Claims

SECOND (STAFF) LEVEL REVIEW

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

Disputes Process for Claims

THIRD (MANAGEMENT) LEVEL REVIEW

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

Quality Blue 3.0

Quality Blue Update

We have streamlined our provider communications for Quality Blue providers. Effective April 1, 2022, the **clinicalpartnerships@bcbsla.com** email address will no longer be available.

New contact information:

Beginning April 1, 2022, for any general questions or contracting questions related to the QB Program, please email our Provider Relations Department at **provider.relations@bcbsla.com**.

Lab Benefit Management Program

Laboratory Benefit Management Program

Effective **May 15, 2022**, Blue Cross will partner with Avalon Healthcare Solutions to offer 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.

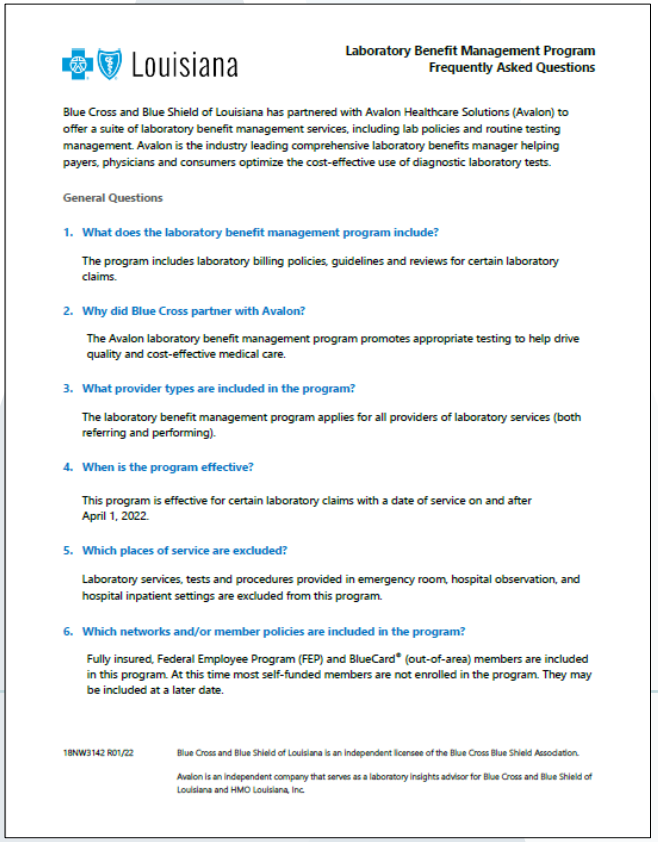
Blue Cross will apply Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

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.

Laboratory Benefit Management Program Frequently Asked Questions

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.

18NW3142 R01/22

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

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

Find our recent Laboratory Benefit Management webinar online at **www.bcbsla.com/providers**, under the "Resources" section.

Resources

Future Webinars

- Administrative Representative Application
  - April 26-28, May 3, 2022
- BlueCard
  - August 25, 2022
- Behavioral Health
  - August 8-10, 2022
- Provider Credentialing & Data Management
  - September 14, 2022

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

Provider Relations

Provider Education & Outreach

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

Michelle Hunt
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

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

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

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Patricia O'Gwynn
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll, Acadia

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

Paden Mouton, Supervisor

Provider Contracting

Jason Heck, Director, Provider Networks – **jason.heck@bcbsla.com**
Shreveport and Monroe Markets

Senior Network Development Representatives

Cora LeBlanc, cora.leblanc@bcbsla.com
Baton Rouge and Houma/Thibodaux Markets

Dayna Roy, dayna.roy@bcbsla.com
Alexandria, Lafayette and Lake Charles Markets

Jill Taylor, jill.taylor@bcbsla.com
New Orleans and Northshore Markets

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

Doreen Prejean **Mary Landry** **Karen Armstrong**

Provider Credentialing & Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Anne Monroe provider information supervisor – **anne.monroe@bcbsla.com**

If you would like to check the status on your credentialing application or provider data change or update, please contact the Provider Credentialing & Data Management.

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

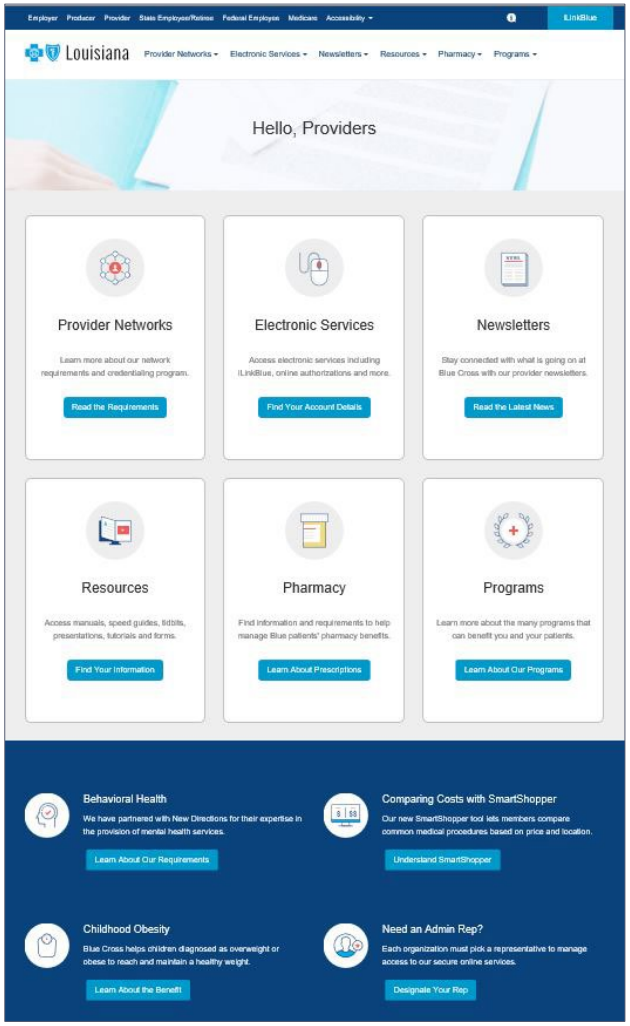
Annual Provider Survey

Please remember to take our Provider Survey later this year!

Your opinions and feedback are very important and helps us better understand your challenges and/or needs.

Questions?

Provider Page



www.bcbsla.com/providers

The Provider page is home to online resources such as:

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

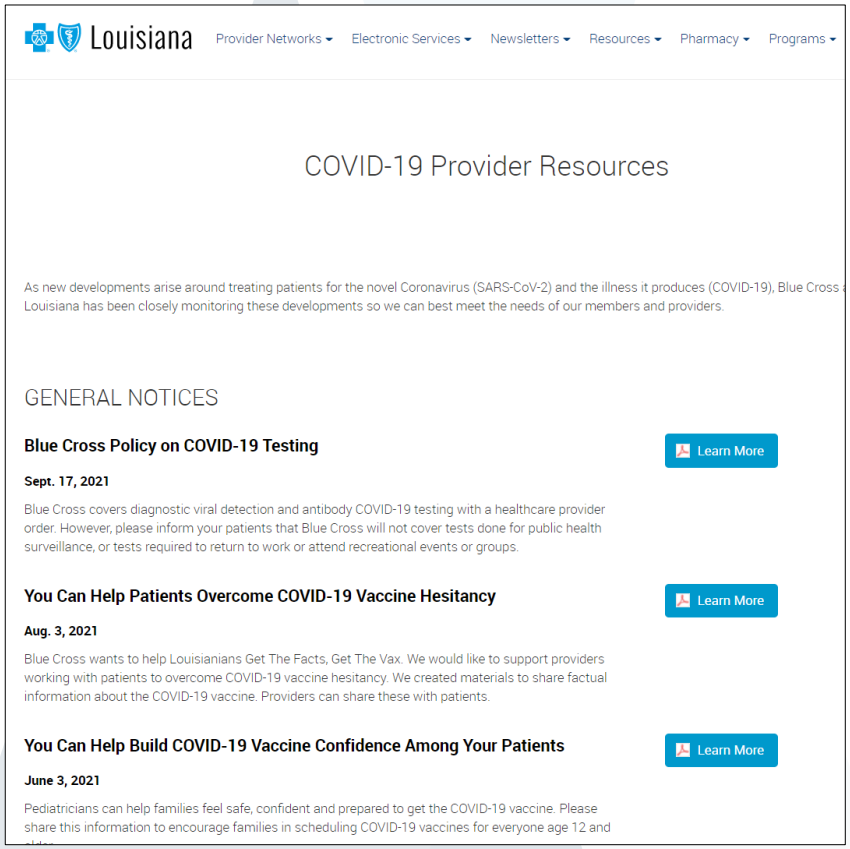
COVID-19 Provider Resources Page

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

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

- Authorizations
- Telehealth
- Billing & Coding Guidelines
- Credentialing & Provider Data Management

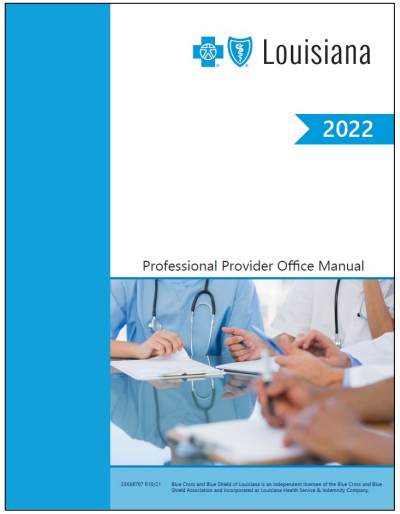
Check this page often for updated information.



Manuals & Newsletters

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

www.bcbsla.com/providers >Resources



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

www.bcbsla.com/providers >Newsletters

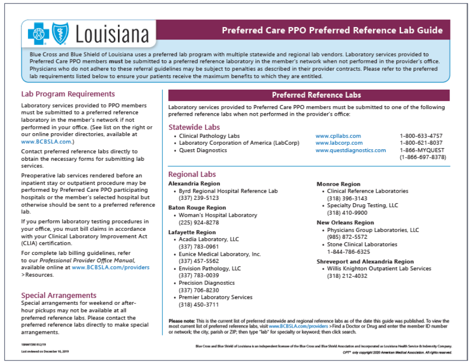
Not Getting Our Newsletters?

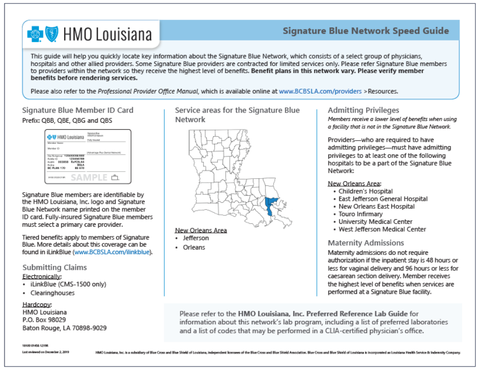
Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

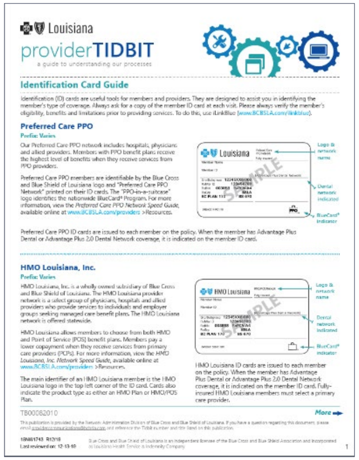
Speed Guides & Tidbits

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

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







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

www.bcbsla.com/providers
>Resources >Tidbits

Call Centers

Customer Care Center	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-866-508-7145**

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