Welcome to the Blue Cross Network

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

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

How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

Louisiana

Welcome to the Blue Cross Network –

Facility Webinar

August 2022

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

Our Networks

Network Overview

Blue Cross has comprehensive provider networks.

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

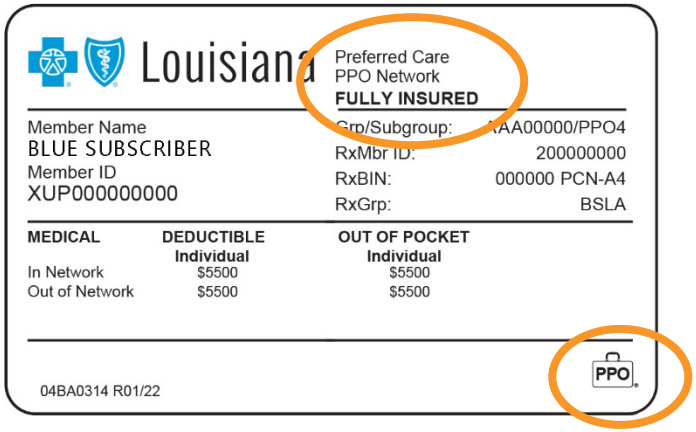
- Preferred Care PPO
- HMO Louisiana, Inc.
- Blue Connect
- BlueHPN
- Community Blue
- Precision Blue
- Signature Blue
- Blue Advantage (HMO) | Blue Advantage (PPO)

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

Preferred Care PPO

Prefix Varies

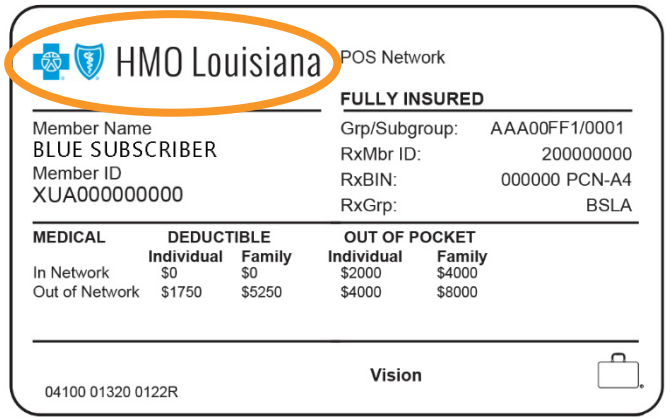
- Our Preferred Care PPO Network is available statewide.
- Members with PPO benefits receive the **highest level of benefits** when they receive services from PPO providers.
- Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on member ID cards.
- The "PPO" in a suitcase logo identifies the nationwide BlueCard® Program.



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

Prefix Varies

- Our HMO Louisiana Network is available statewide.
- HMO Louisiana members have one of two styles of benefits: HMO or HMO Point of Service (POS).
- HMO members receive **no benefits** while HMO POS members receive a **lower level** of benefits when using providers not in the HMO Louisiana Network.
- The main identifier of an HMO Louisiana member is the HMO Louisiana logo in the top left corner of the member ID card. Cards also indicate the product type as either an HMO or HMO/POS Plan.

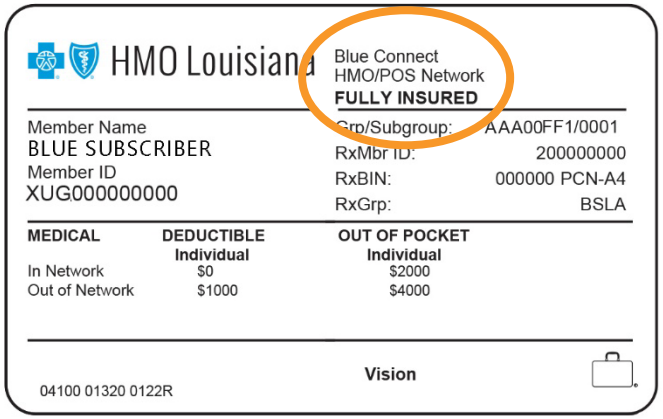


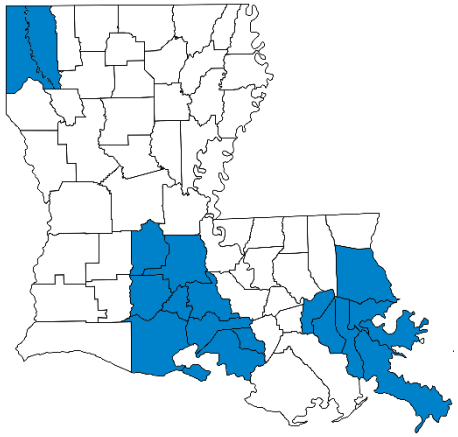
For more information, view the *HMO Louisiana Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Blue Connect

Prefixes: XUF, XUG, XUU and XUV

- Blue Connect is an HMO POS product currently available to groups and individuals residing in 17 parishes.
- Members may **not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Blue Connect Network.





New Orleans area

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

Shreveport area

Bossier and Caddo parishes

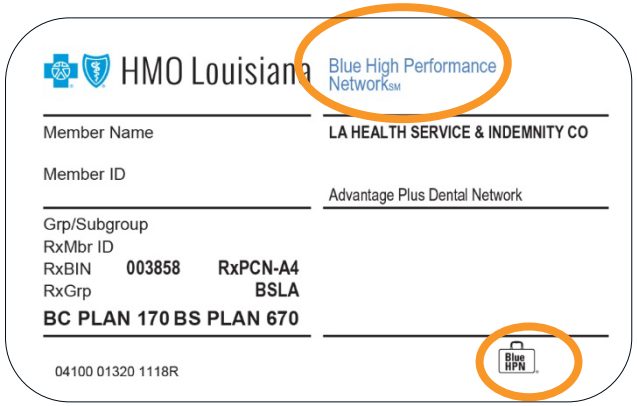
Lafayette area

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

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

BlueHPN

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



Lafayette area

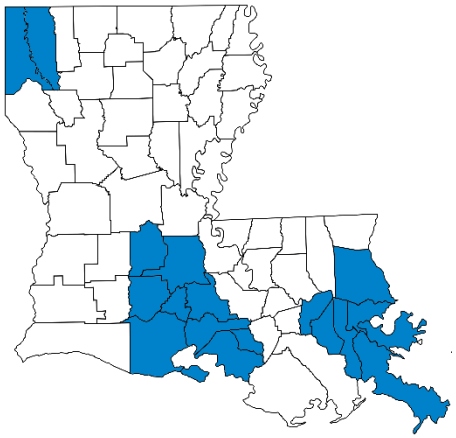
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

New Orleans area

Jefferson, 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 **suitcase logo** in the bottom right-hand corner of the card.

Blue HPN

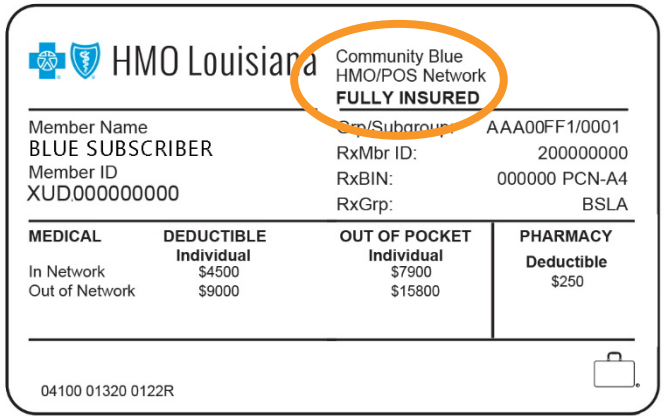
For more information, view the *BlueHPN Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Prefixes: XUD, XUJ and XUT

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

Baton Rouge area:

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



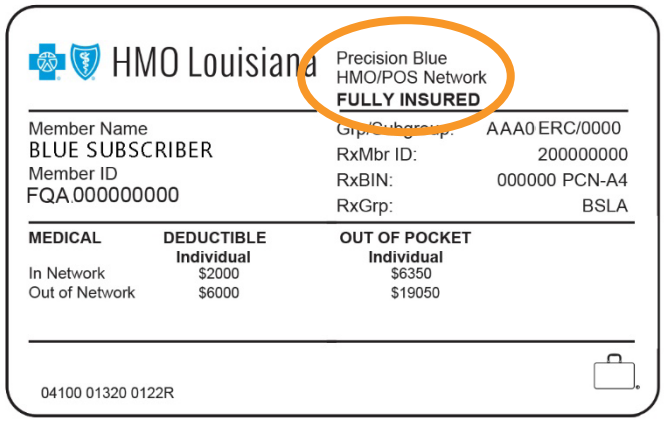
Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Community Blue Network.

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

Precision Blue

Prefixes: FQA, FQT or FQW

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

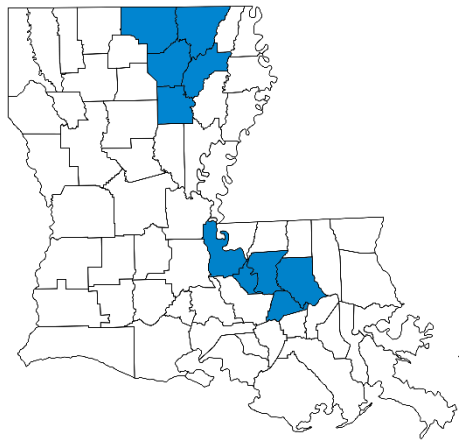


Baton Rouge area:

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

Greater Monroe/West Monroe area:

Caldwell, Morehouse, Ouachita, Richland, Union parishes

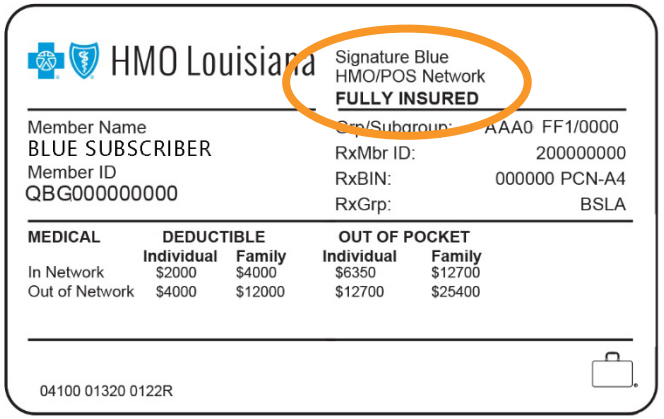


Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Precision Blue Network.

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

Prefixes: QBB, QBE, QBG and QBS

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


HMO Louisiana
Signature Blue
HMO/POS Network
FULLY INSURED
Member Name
BLUE SUBSCRIBER
Member ID
QBG000000000
Grp/Subgroup: AAA0 FF1/0000
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA
MEDICAL DEDUCTIBLE OUT OF POCKET
Individual Family Individual Family
In Network $2000 $4000 $6350 $12700
Out of Network $4000 $12000 $12700 $25400
04100 01320 0122R

New Orleans area:

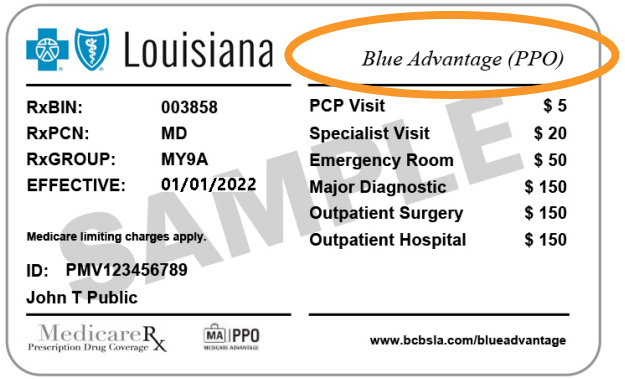
Jefferson and Orleans parishes

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

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

Prefixes: PMV and MDV

- Blue Advantage (HMO) and Blue Advantage (PPO) are our Medicare Advantage products currently available to Medicare-eligible members statewide.
- Blue Advantage members **must use** Blue Advantage network providers except for select situations such as emergency care.



Prefix: PMV

Prefix: MDV

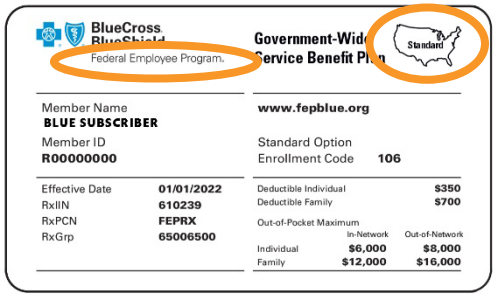
Federal Employee Program

Prefix: R (followed by 8 digits)

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

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

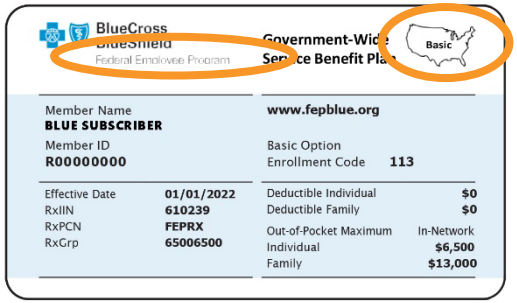
Standard



✓ In-network

✓ Out-of-network

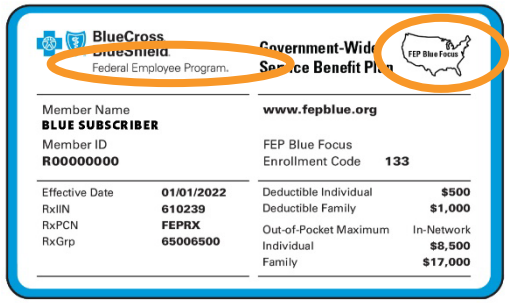
Basic



✓ In-network

X Out-of-network

FEP Blue Focus



✓ **LIMITED** in-network

X Out-of-network

Office of Group Benefits (OGB) Benefit Plans

Prefixes: OGS, LZB or LXS

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

Pelican HRA 1000 (Active Employees & Retirees with and without Medicare)

- Prefix: OGS
- Consumer-driven health plan with health reimbursement arrangement.
- Uses our OGB Preferred Care PPO provider network.

Pelican HRA 775 (Active Employees Only)

- Prefix: OGS
- Consumer-driven health plan with health savings account.
- Uses our OGB Preferred Care PPO provider network.

Magnolia Local (Active Employees & Retirees with and without Medicare)

- Uses our Blue Connect (prefix: LZB) or Community Blue (prefix: LXS) provider networks.
- HMO POS
- There are no benefits for services performed by out-of-network providers.

Magnolia Local Plus (Active Employees & Retirees with and without Medicare)

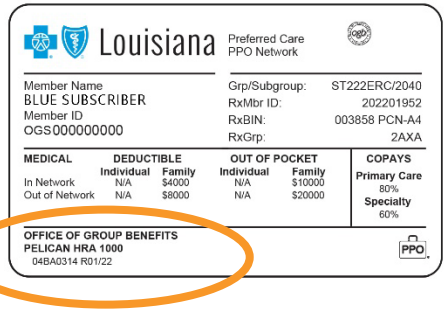
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

Magnolia Open Access (Active Employees & Retirees with and without Medicare)

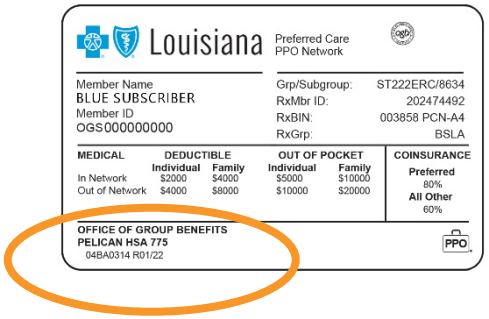
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

OGB Sample Member ID Cards

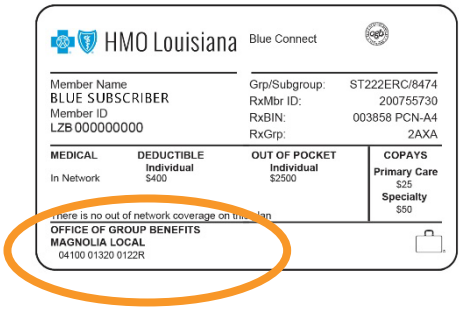
Pelican HRA 1000



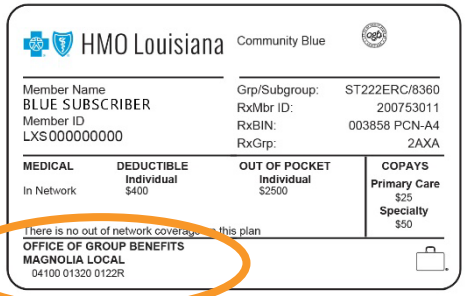
Pelican HRA 775



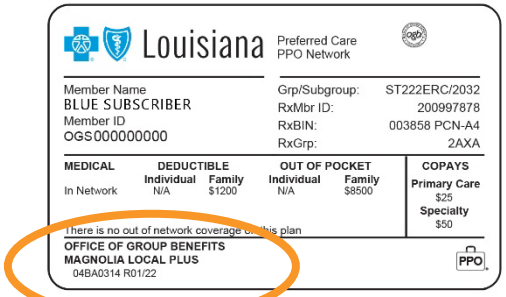
Magnolia Local Blue Connect



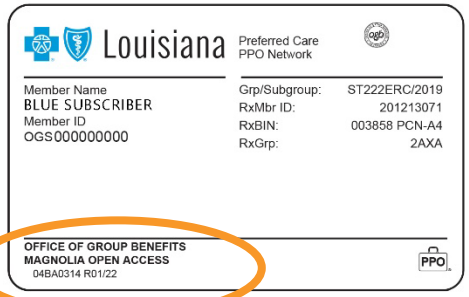
Magnolia Local Community Blue



Magnolia Local Plus



Magnolia Open Access



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

BlueCard® Program

- **BlueCard®** is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area.

- The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

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

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

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

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

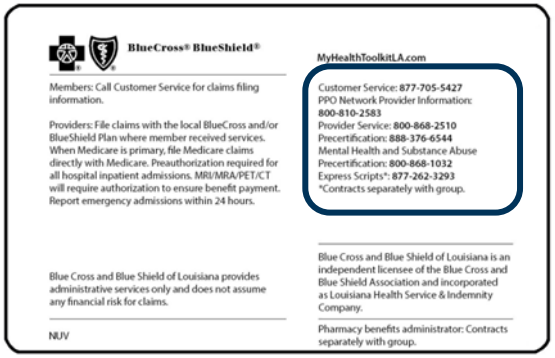
Note: BlueCard authorizations are handled through the members' home plan.

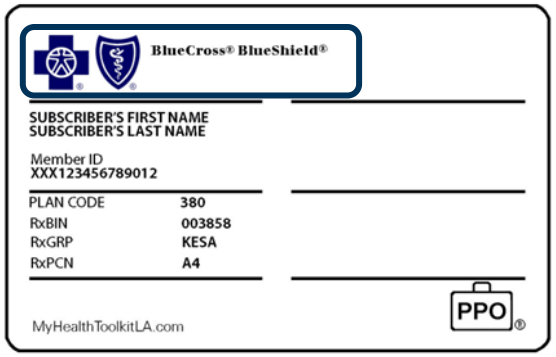
You can find additional BlueCard guidelines in the *BlueCard Program Provider Manual*, available online at **www.bcbsla.com/providers** >Resources >Manuals.

National Alliance

(South Carolina Partnership)

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





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

Medicare Advantage PPO Network Sharing

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

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

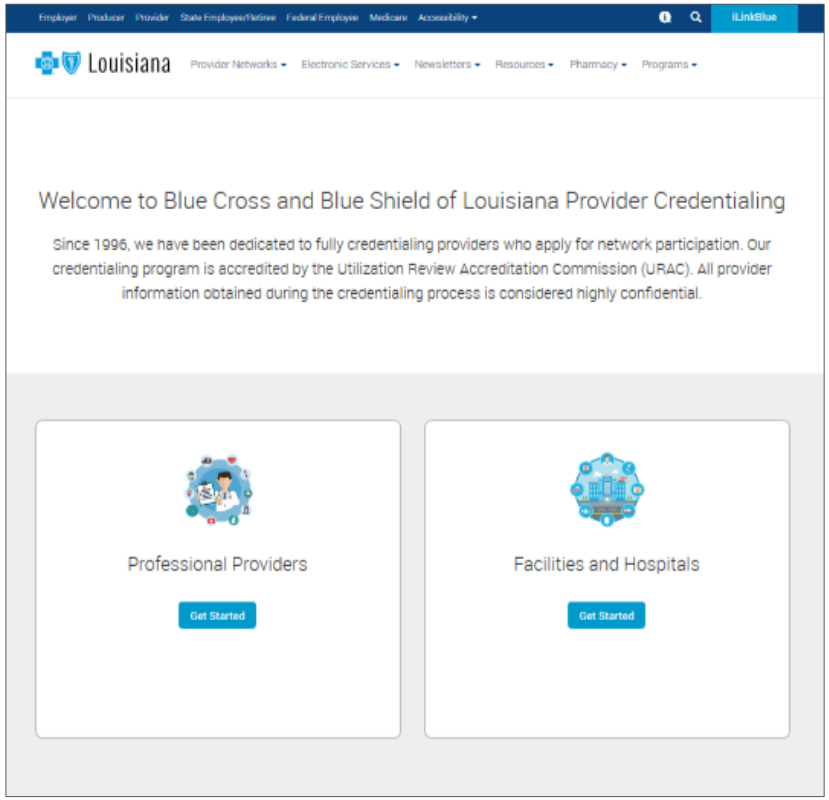
MA | PPO
MEDICARE ADVANTAGE

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

Provider Credentialing & Data Management

Join Our Networks Webpage

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



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

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

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

Credentialing Process

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

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

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.

Effective Dates

For participating providers:

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

Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director.	If you are not eligible for reimbursement during credentialing, then it is the approval date of your executed network agreement **AFTER** your credentialing committee approval.	If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is within 90 days of the calendar date, then it will be that date, but not before the group's effective date. If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is greater than 90 days of the calendar date, then it will be 90 days from the day the information was received, but not before the group's effective date.

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: recredentialing@vhpla.com or (318) 807-4755

Incomplete Credentialing Applications

Below are the most common reasons credentialing applications are returned:

- Incomplete or expired supporting documents.
- No effective date listed.
- Professional provider did not submit the current version of the **Louisiana Standardized Credentialing Application**.
- An alternative application was submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*.

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

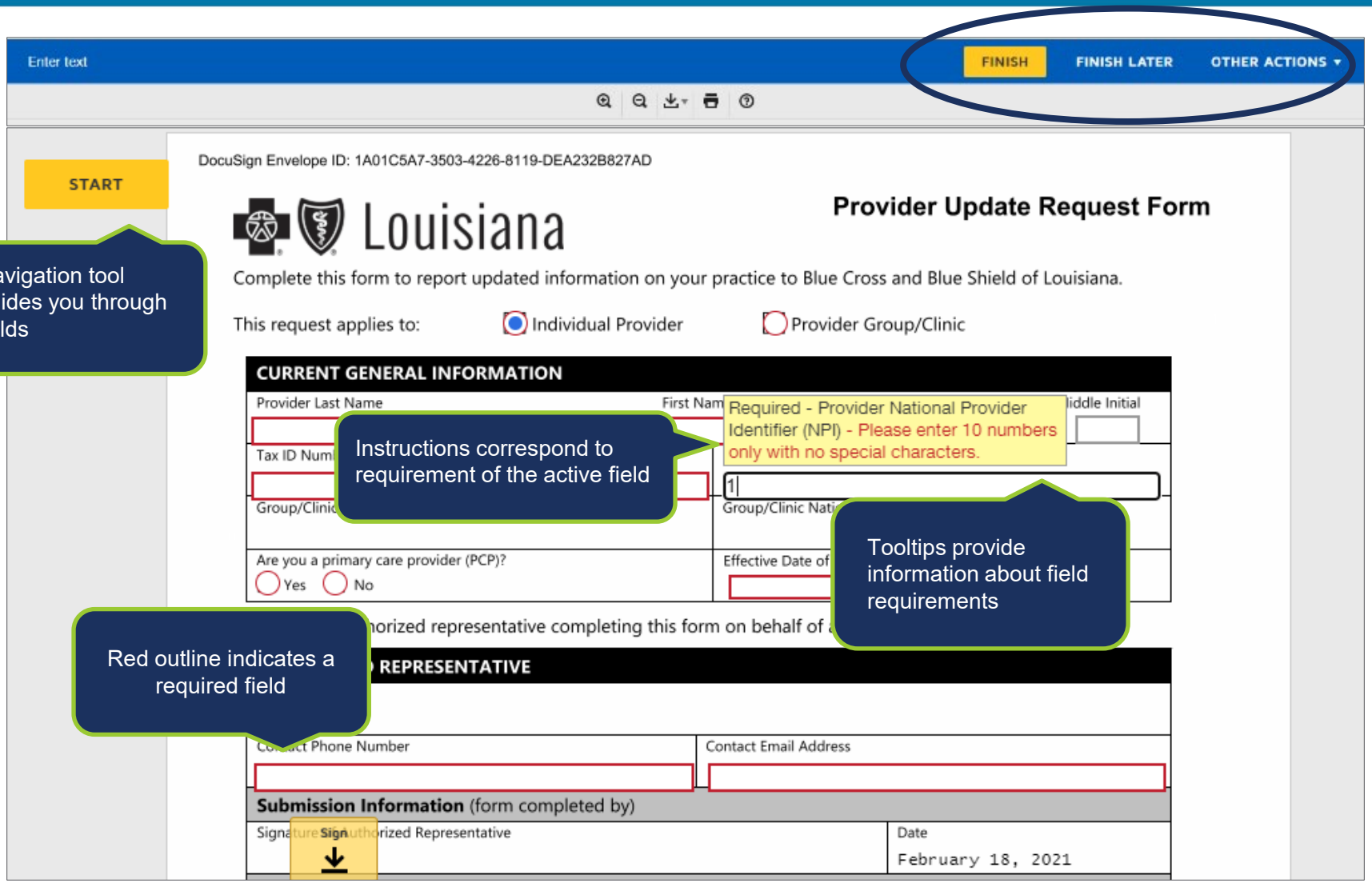
Credentialing Criteria for Facility Provider Types

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

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

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

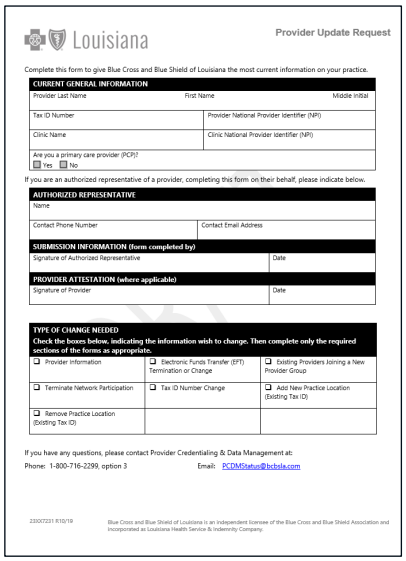
Easily Complete Forms with DocuSign



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

How to Update Your Information

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



Louisiana

Provider Update Request

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice.

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

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

If you are an authorized representative of a provider, completing this form on their behalf, 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 the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.

☐ Provider Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ 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

23307231 R10/19

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.

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

- **Demographic Information** allows you to update your address, phone, fax, email address, hours of operation and more.
- **EFT Termination or Change** option is to update your EFT information.
- **Existing Providers Joining a New Provider Group** is used to link an individual provider to an existing provider group or clinic.
- **Terminate Network Participation** is to request termination from one or more of our networks.
- **Tax ID Number Change** is to report a change in your Tax ID number.
- **Add a New Practice Location** is for when a provider is adding practice location(s) on an existing Tax ID.
- **Remove Practice Location** is for when a provider is removing a practice location(s) on an existing Tax ID.

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

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 in accordance with the CAA Mandate to help create the most accurate directory for our members. Provider Attestation forms will be emailed to you quarterly to confirm your demographic information is accurate.

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

iLinkBlue Application Packet

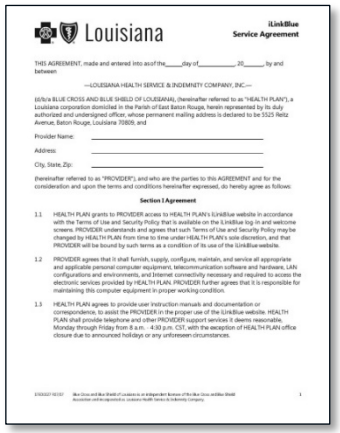
iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions.

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

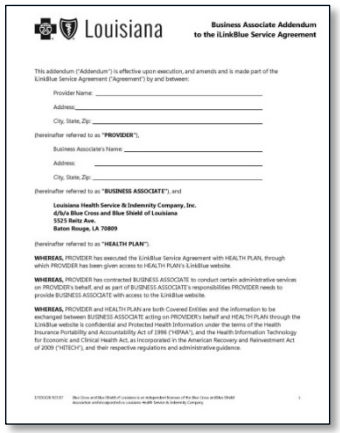
ALWAYS include NPI/Tax ID on:

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

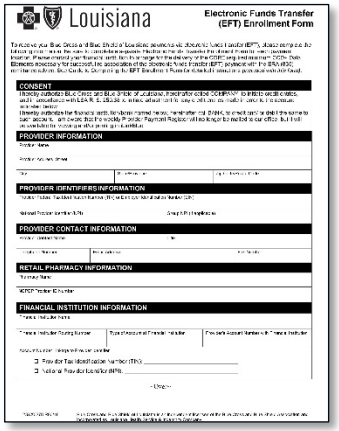
These four documents are included in the initial credentialing packets and are required to access iLinkBlue:


Louisiana
iLinkBlue Service Agreement

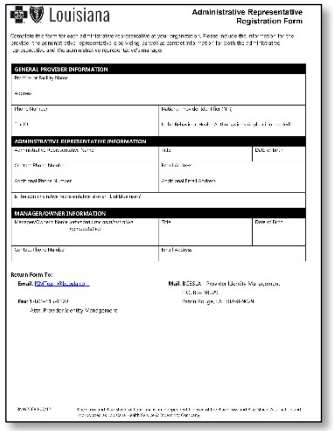
iLinkBlue Service Agreement


Louisiana
Business Associate Addendum to the iLinkBlue Service Agreement

Business Associate Addendum


Louisiana
Electronic Funds Transfer (EFT) Enrollment Form

Electronic Funds Transfer Enrollment Form


Louisiana
Administrative Representative Registration Form

Administrative Representative Registration Form

Miscellaneous

Blue Distinction Specialty Care

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

Two designation levels:

Blue Distinction® Center

Blue Distinction® Center+

The current programs are:

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

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

Blue Distinction Level Comparison

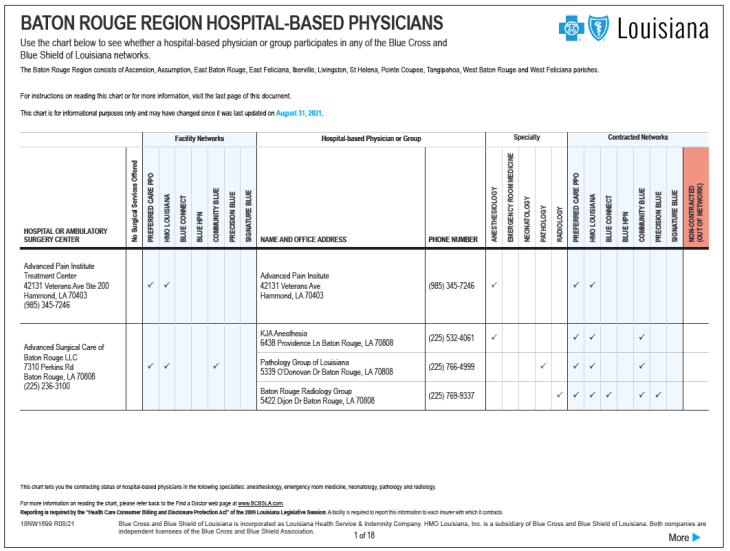
Evaluation Criteria for Participation Focused on:	Blue Distinction® Center Healthcare facilities recognized for their **expertise** in delivering specialty care	Blue Distinction® Center+ Healthcare facilities recognized for their **expertise** and **efficiency** in delivering specialty care
Identifying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

Hospital-based Providers

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

- Anesthesia
- Emergency Medicine
- Neonatology
- Pathology
- Radiology

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



BATON ROUGE REGION HOSPITAL-BASED PHYSICIANS

Louisiana

Use the chart below to see whether a hospital-based physician or group participates in any of the Blue Cross and Blue Shield of Louisiana networks.

The Baton Rouge Region consists of Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Livingston, St Helena, Pointe Coupee, Tangipahoa, West Baton Rouge and West Feliciana parishes.

For instructions on reading this chart or for more information, visit the last page of this document.

This chart is for informational purposes only and may have changed since it was last updated on August 31, 2021.

		Facility Networks								Hospital-based Physician or Group		Specialty				Contracted Networks							
HOSPITAL OR AMBULATORY SURGERY CENTER	No Surgical Services Offered	PREFERRED CARE PPO	HMO LOUISIANA	BLUE CONNECT	BLUE HPN	COMMUNITY BLUE	PRECISION BLUE	SIGNATURE BLUE		NAME AND OFFICE ADDRESS	PHONE NUMBER	ANESTHESIOLOGY	EMERGENCY ROOM MEDICINE	NEONATOLOGY	PATHOLOGY	RADIOLOGY	PREFERRED CARE PPO	HMO LOUISIANA	BLUE CONNECT	BLUE HPN	COMMUNITY BLUE	PRECISION BLUE	SIGNATURE BLUE	NON-CONTRACTED (OUT OF NETWORK)
Advanced Pain Institute Treatment Center 42131 Veterans Ave Ste 200 Hammond, LA 70403 (985) 345-7246		✓	✓							Advanced Pain Institute 42131 Veterans Ave Hammond, LA 70403	(985) 345-7246	✓					✓	✓						
Advanced Surgical Care of Baton Rouge LLC 7310 Perkins Rd Baton Rouge, LA 70808 (225) 236-3100		✓	✓			✓				KJA Anesthesia 6438 Providence Ln Baton Rouge, LA 70808	(225) 532-4061	✓					✓	✓			✓			
										Pathology Group of Louisiana 5335 O'Donovan Dr Baton Rouge, LA 70808	(225) 766-4999				✓		✓	✓			✓			
										Baton Rouge Radiology Group 5422 Dijon Dr Baton Rouge, LA 70808	(225) 769-9337					✓	✓	✓	✓		✓	✓		

This chart tells you the contracting status of hospital-based physicians in the following specialties: anesthesiology, emergency room medicine, neonatology, pathology and radiology.

For more information on reading the chart, please refer back to the Find a Doctor web page at www.BCBSLA.com.

Reporting is required by the "Health Care Consumer Billing and Disclosure Protection Act" of the 2009 Louisiana Legislative Session. A facility is required to report this information to each insurer with which it contracts.

18NW1690 RDB/21

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

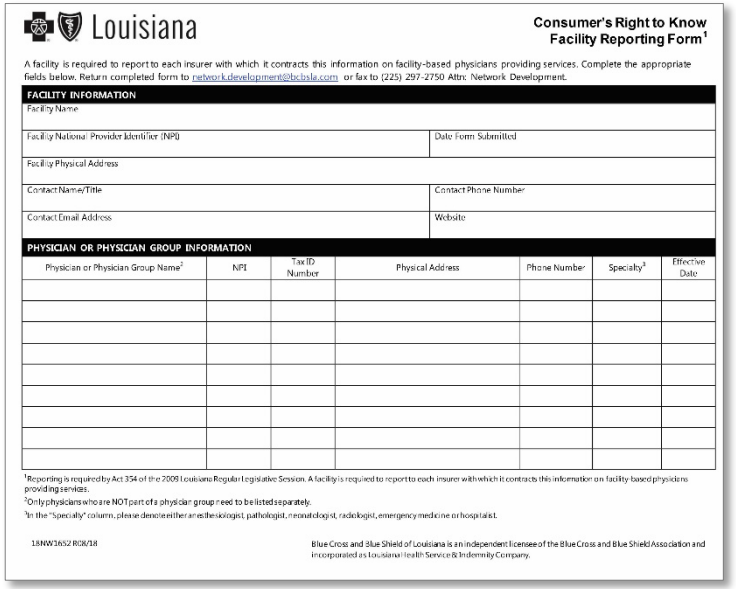
1 of 18

More ▶

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

Submitting Hospital-based Providers Changes

- Blue Cross asks that network facilities submit changes on the **Consumer's Right to Know Facility Reporting Form** every time there is a change in hospital-based physician for any specialties listed previously.
- Return completed forms to our Provider Credentialing Department at **provider.contracting@bcbsla.com**.



Louisiana

Consumer's Right to Know Facility Reporting Form[1]

A facility is required to report to each insurer with which it contracts this information on facility-based physicians providing services. Complete the appropriate fields below. Return completed form to network.development@bcbsla.com or fax to (225) 297-2750 Attn: Network Development.

FACILITY INFORMATION

Facility Name	
Facility National Provider Identifier (NPI)	Date Form Submitted
Facility Physical Address	
Contact Name/Title	Contact Phone Number
Contact Email Address	Website

PHYSICIAN OR PHYSICIAN GROUP INFORMATION

Physician or Physician Group Name[2]	NPI	Tax ID Number	Physical Address	Phone Number	Specialty[3]	Effective Date

[1] Reporting is required by Act 354 of the 2009 Louisiana Regular Legislative Session. A facility is required to report to each insurer with which it contracts this information on facility-based physicians providing services.

[2] Only physicians who are NOT part of a physician group need to be listed separately.

[3] In the "Specialty" column, please denote either anesthesiologist, pathologist, neonatologist, radiologist, emergency medicine or hospitalist.

18NW1652 R08/18

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

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

Claims

Electronic Claims

Electronic Data Interchange (EDI)

- The fastest, most efficient way to exchange eligibility information, payment information and claims.
- Blue Cross' experienced EDI staff is ready to assist in determining the best electronic solution for your needs.

Electronic Transaction Exchange

- Various healthcare transactions can be submitted electronically to the Blue Cross clearinghouse in a system-to-system arrangement.
- Blue Cross does not charge a fee for electronic transactions.
- You can send your transactions to Blue Cross via indirect submission through a clearinghouse or through direct submission to the Blue Cross EDI Clearinghouse.

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

Electronic Payment Registers

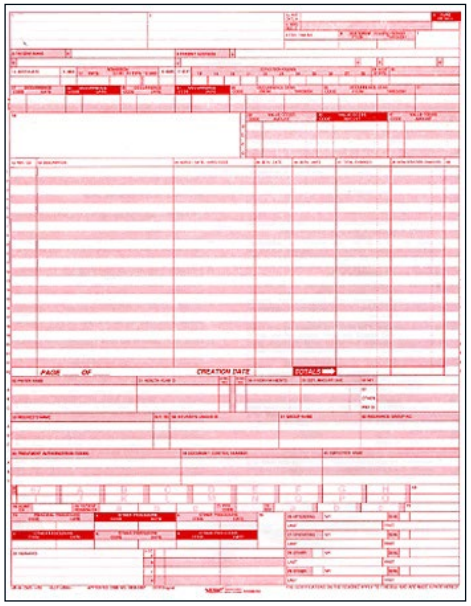
HIPAA 835 Transaction

- Providers who submit claims electronically can receive an electronic file containing their weekly Provider Remittance Advice/Payment Register (ERA).
- The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.
- ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an upfront fee from your billing system vendor for programming.
- From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge.

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

Hardcopy Claims

UB-04 (facility)



- If it is necessary to file a hardcopy claim, we only accept the original **RED** claim forms.
- We no longer accept faxed claims.

Mailing Addresses

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

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

For FEP Claims:

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

For BlueHPN Claims:

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

For Blue Advantage Claims:

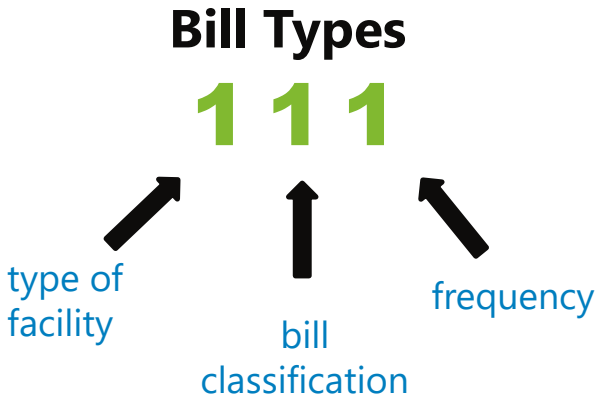
Blue Cross and Blue Shield
of Louisiana/HMO Louisiana
130 DeSiard St, Ste 322
Monroe, LA 71201

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

Facility Billing Guidelines

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

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



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

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

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

Readmissions Policy

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

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

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

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

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

Timely Filing Requirements

Blue Cross, HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue & Signature Blue:

- Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.

FEP:

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

Blue Advantage:

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

OGB:

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

Self-funded & BlueCard:

- Timely filing standards may vary so always verify the member's benefits, including timely filing standards, through iLinkBlue.

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

National Drug Code (NDC) Required on Drug Claims

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

- NDC code editing will apply to any clinician-administered drugs billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician-administered drug must be billed on a separate line item.
- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.
- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

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

Reporting NDCs on Facility Claims

For Hardcopy Claims

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

For Electronic Claims 837I

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

Reporting NDCs on Facility Claims

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

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

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

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

Revenue Code 250 Requirements

For claims submitted on a UB-04:

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

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

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

Closed Formulary

- Most of our members follow a Covered Drug List. Covered Drug Lists include thousands of generic and brand drugs, but not all drugs.
- **Please consider prescribing drugs that are covered** or have lower out-of-pocket costs when you believe it is appropriate. If members fill a prescription drug that is not on the covered drug list, they could have to pay the full cost of the drug out of pocket.
- **You may ask for a clinical review** (similar to prior authorization) if your patient has a medically necessary need for a *non-formulary* drug. Find information about submitting a prior authorization at **www.bcbsla.com** >Provider >Pharmacy. This is not available for drugs excluded from coverage.

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

Resolving Claims Issues

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

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

- Action Requests
- Provider Disputes
- Medical Appeals
- Administrative Appeals & Grievances

Submitting an Action Request is a great option for getting a quick and accurate resolution for your claim's issues. Action Requests:

- Reduce the time it takes for providers to receive a response from Blue Cross.
- Allow providers to see responses directly from the adjustments team after review.
- Allow providers to submit additional questions once they have reviewed the Action Request response.

Submitting Action Requests

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

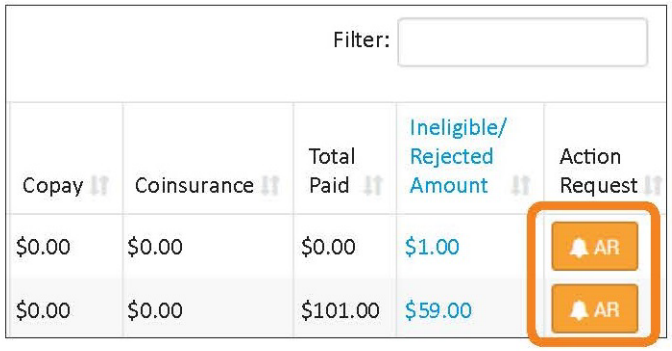
Common reasons to submit an Action Request:

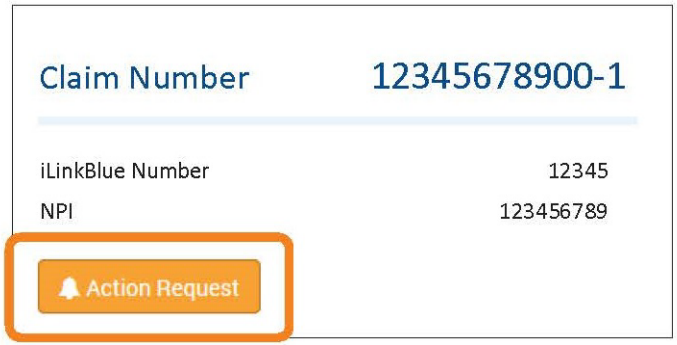
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No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

Action requests are NOT available for Blue Advantage.

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

Submitting Action Requests



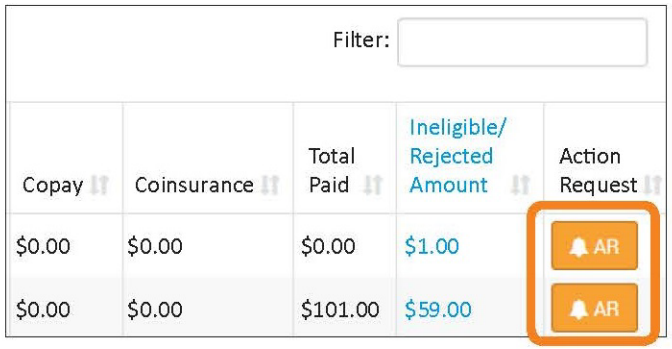


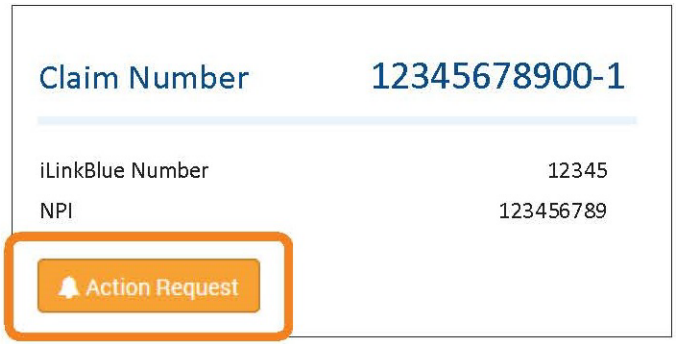
Submit an Action Request through iLinkBlue (**www.bcbsla.com/ilinkblue**).

- On each claim, providers have the option to submit an Action Request review for correct processing.
- Click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim.
- Please include your contact information.
- NOTE: You only have to do one AR per claim; not one AR per line item of the claim.

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

Submitting Action Requests





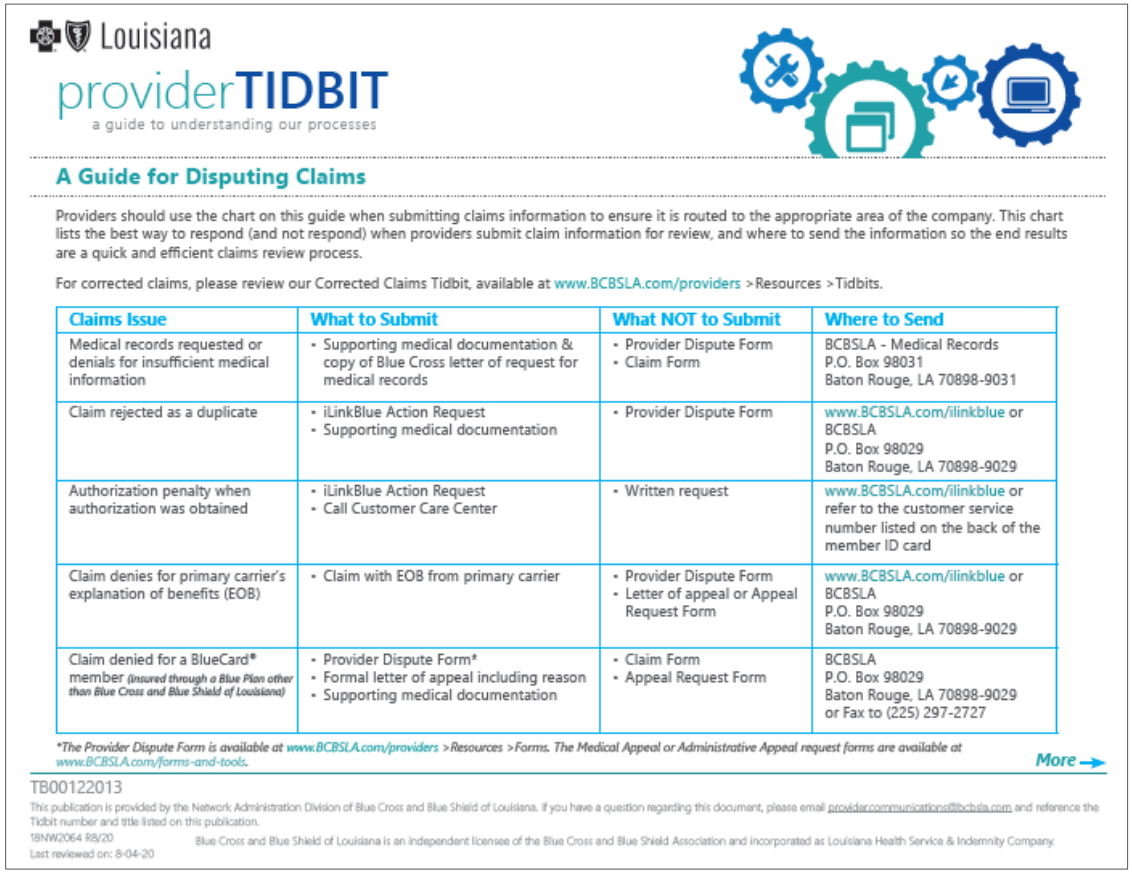
- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 business days for first request.
- Check iLinkBlue for a claims resolution.
- Submit a second action request for a review.
- Allow 10-15 business days for second request.

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

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

- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) and have allowed 10-15 business days after second request, or
- It is a system issue affecting multiple claims.

A Guide for Disputing Claims



Louisiana

providerTIDBIT

a guide to understanding our processes

A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denials for insufficient medical information	• Supporting medical documentation & copy of Blue Cross letter of request for medical records	• Provider Dispute Form • Claim Form	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	• iLinkBlue Action Request • Supporting medical documentation	• Provider Dispute Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	• iLinkBlue Action Request • Call Customer Care Center	• Written request	www.BCBSLA.com/ilinkblue or refer to the customer service number listed on the back of the member ID card
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Provider Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denied for a BlueCard® member *(insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)*	• Provider Dispute Form* • Formal letter of appeal including reason • Supporting medical documentation	• Claim Form • Appeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

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

More →

TB00122013

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

18NW2064 R8/20

Last reviewed on: 8-04-20

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.

A Guide for Disputing Claims Tidbit can be found online at **www.bcbsla.com/providers** >Resources >Tidbits.

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.

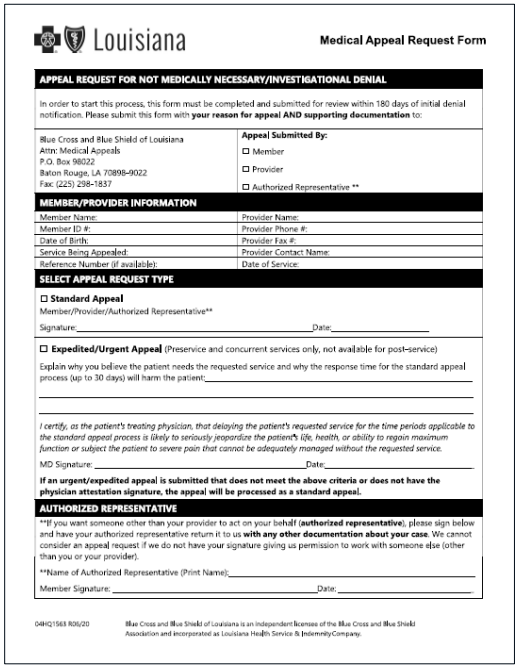
Please refer to Section 8 of the Provider Manual for more information.

Medical Appeals

Claim denied as investigational or not medically necessary.

MUST BE COMPLETED WITHIN 180 DAYS. Blue Cross will respond within 30 days

- Use the Medical Appeals 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.
- If upheld and member still disagrees, they must request an external appeal within 120 days handled by an Independent Review Organization and that will be the final decision.



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: _____

04HQ1568 R06/20

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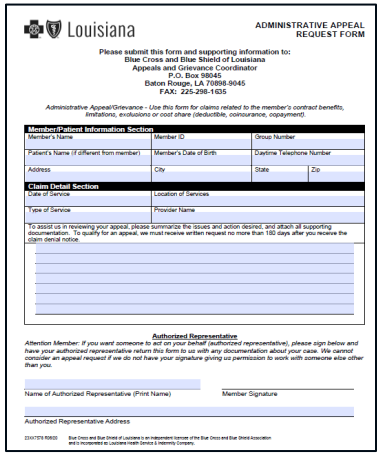
SEND TO:
Through iLinkBlue (**www.bcbsla.com/iLinkBlue**), click "Document Upload," then "Provider Disputes" in the drop-down menu.

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

Fax: (225) 298-1837

BCBSLA Administrative Appeals

- Administrative appeals involve member's contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), **with the member's authorization**.
- A written request must be submitted within 180 days following the member's receipt of an initial adverse benefit determination. Requests submitted to us after 180 days of our initial determination will not be considered. Blue Cross has 30 days to respond.
- If the member has second-level appeal rights, they have 60 days to submit.



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 _____

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:

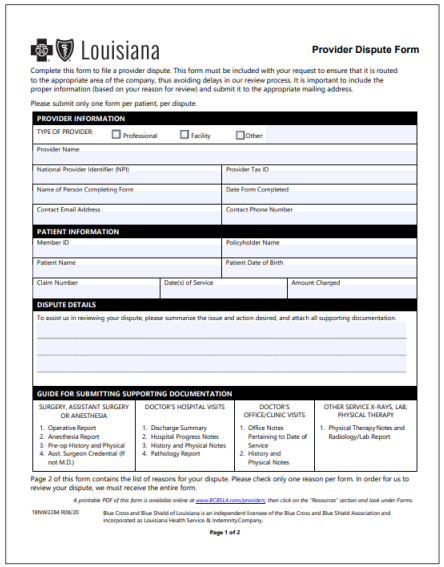
- Allowable disputes (**must include breakdown, fee schedule**)
- Bundling issues (note: must always have medical records attached)
- Authorization issues - Penalties where the **provider** is liable for the amount
- Failed to obtain authorization denials (**reason auth not obtained**)
- Refund Disputes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

18NW2284 R08/20

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Page 1 of 2

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

FIRST LEVEL REVIEW

- Once claim(s) receive a denial reflected on the payment register (i.e., authorization, bundling, etc.), providers may submit a first-level dispute for review.
- First-level disputes must be submitted within 24 months of the date claim(s) were processed.
- If a refund letter is sent, the provider has 30 days to respond and request a first-level dispute.
- Blue Cross has 60 days to review disputes and respond in writing with a decision to the provider.

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.

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.

Helpful Reminders

Benefits of Proper Clinical Documentation

- Allows identification of high-risk patients.
- Allows opportunities to engage patients in care management programs and care prevention initiatives.
- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross.
- Reduces costs associated with submitting corrected claims.

Provider's Role in Documenting

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

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

Coding to the Highest Level of Specificity

- Include chronic conditions in documentation.
- Code to the highest specificity.
- Monitored, Evaluated, Assessed or Treated (MEAT) should be noted.
- Clarify whether a condition is **chronic** or **acute**.
- Clarify whether a condition as **controlled** or **uncontrolled**.
- Clarify the **type of diabetes**.

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

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

Medical Record Requests

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

- Per your Blue Cross network agreement, **providers are not to charge a fee** for providing medical records to Blue Cross or agencies acting on our behalf.
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge.
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee.

Member Referrals

Network providers should always refer members to other network providers.

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

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

Laboratory Referrals

- All of our network providers should refer members to preferred reference lab vendors when lab services are needed and are not performed in the facility.
- Blue Cross discourages hospital billing for services as a reference lab when they are not contracted as a reference lab with us.
- Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by an in-network hospital.

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

- UB-04: Block 78
- 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

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

Behavioral Health Referrals

- Please make sure when referring your patients to behavioral health providers that they are in their behavioral health network.
- We have partnered with New Directions for their expertise in the provision of behavioral health services.
- New Directions manages authorizations for our members, performs all utilization and case management activities, as well as ABA case management.
- Request authorizations online through iLinkBlue using the **Behavioral Health Authorizations** application.
- New Directions' team of behavioral health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.
- For more information, such as medical necessity criteria, visit the **www.ndbh.com**.

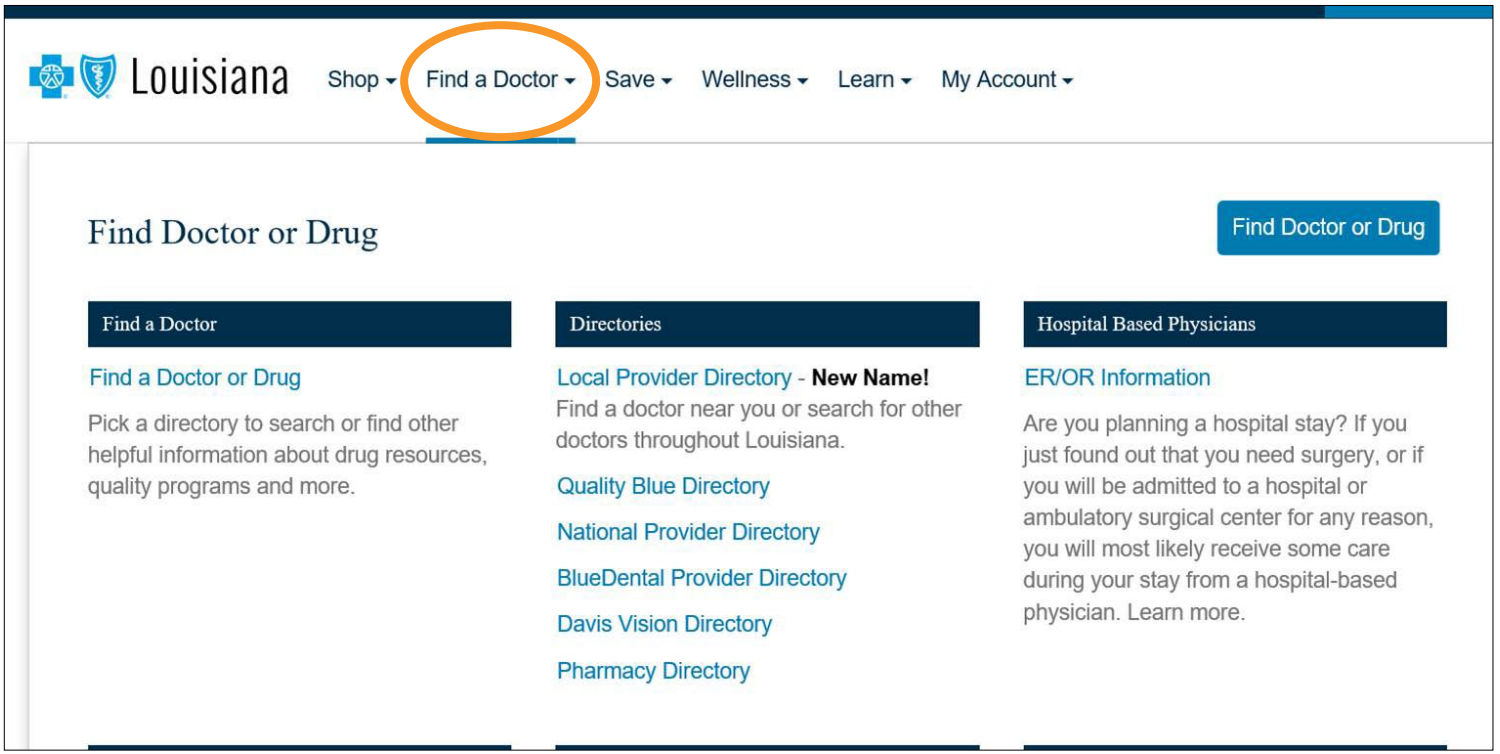
Behavioral health services that require an authorization:

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

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

Finding Participating Providers

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

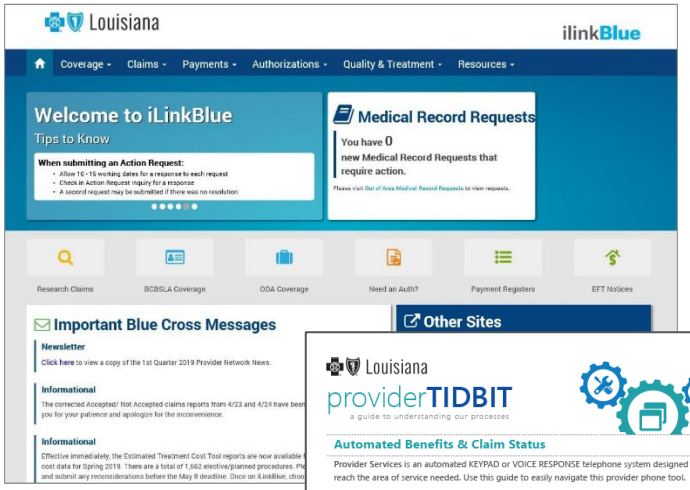


Provider Self-service Initiative

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

- Member eligibility
- Claim status inquiries
- Outpatient facility allowable searches
- Medical policy searches

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



Self-service tools available to providers:

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

Laboratory Benefit Management Program

Laboratory Benefit Management Program

Effective **May 15, 2022**, Blue Cross in partnership with Avalon Healthcare Solutions, implemented 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.

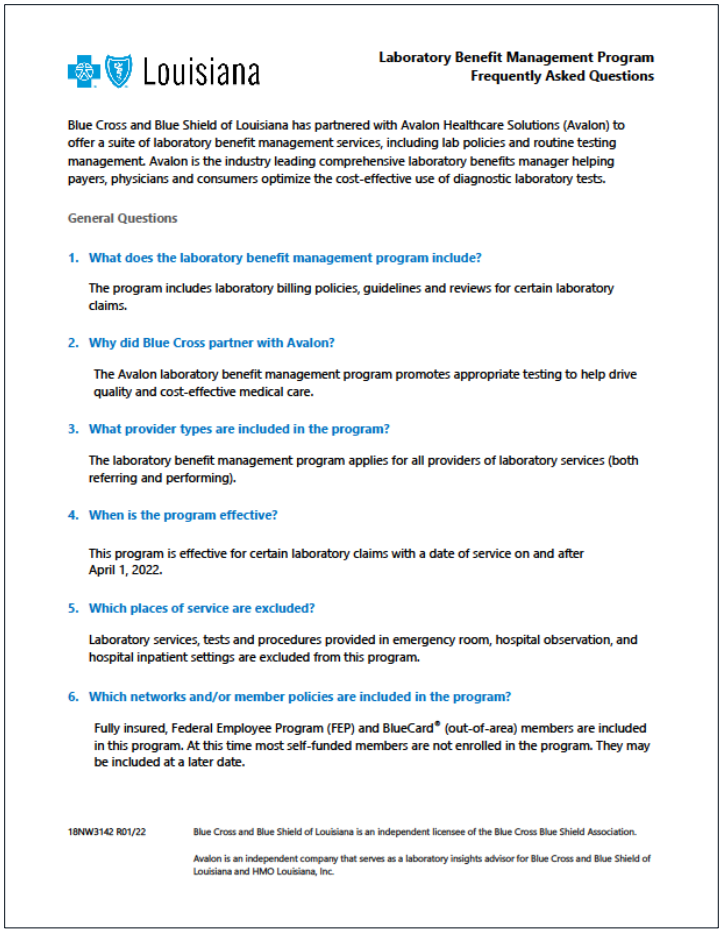
Blue Cross applies Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

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 on iLinkBlue (**www.bcbsla.com/ilinkblue**) under Authorizations, then Lab Reimbursement Policies.

Laboratory Benefit Management Program

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.

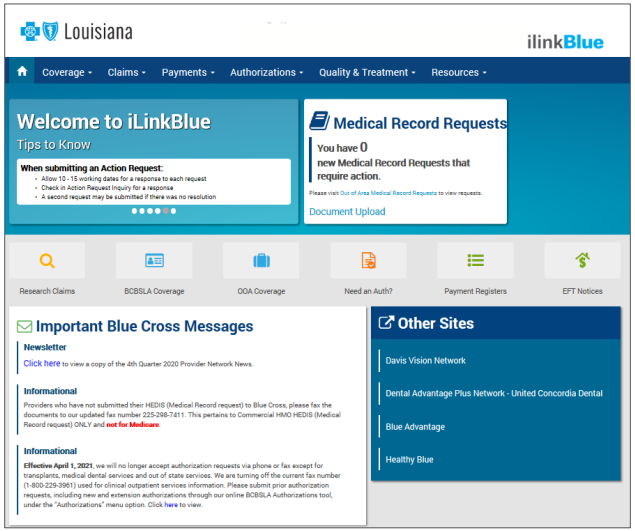
iLinkBlue

iLinkBlue

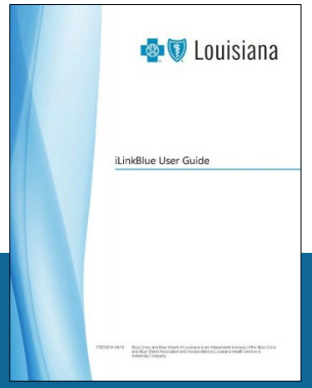
- iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:
  - Coverage & Eligibility
  - Benefits
  - Coordination of Benefits (COB)
  - Claims Status (BCBSLA, FEP and Out of Area)
  - Medical Code Editing
  - Payment Registers/EFT Notifications
  - Allowables Search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

ilinkBlue

www.bcbsla.com/ilinkblue



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



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

The Administrative Representative Role

What is an Administrative Representative?

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online tools.
- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.
- Your administrative representative must grant a user access to the following applications:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Blue Advantage Provider Portal
  - Pre-Service Review
- One administrative representative is required to self-manage user access to our secure online services, but we recommend each organization assign more than one.

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

Multi-factor Authentication Soon to be Required for iLinkBlue Access

COMING SOON

Beginning September 2022, multi-factor authentication (MFA) verification will be required for iLinkBlue users to securely access iLinkBlue.

MFA is a security feature that authenticates who you are when logging in. You must preregister **at least two methods** of verification.

- email
- text
- voice call
- smartphone app

Our step-by-step instruction guide for MFA registration is available at **www.bcbsla.com/providers** >Resources >Speed Guides.

Security Setup Tool Update

- **September 2022**, we are introducing a new Security Setup Application for administrative representatives called Delegated Access. It 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.

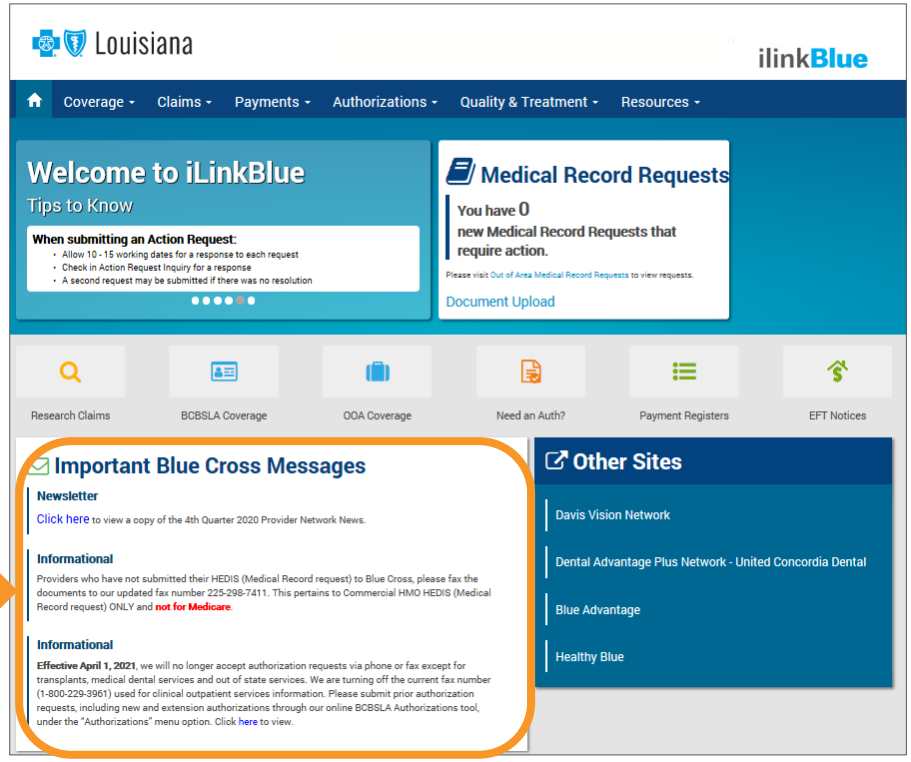
We will provide more details soon. If you have questions about these changes, please contact our Provider Relations Department at **provider.relations@bcbsla.com**.

iLinkBlue Message Board

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

This area contains posts for:

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

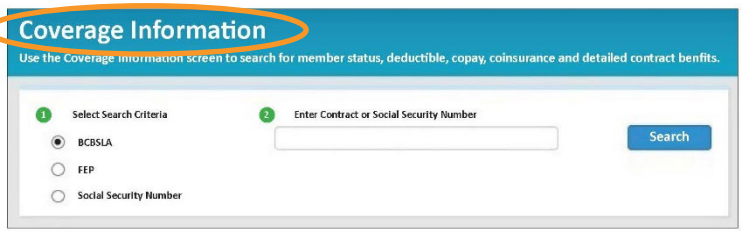


The main landing page also alerts you when there are BlueCard® (out-of-area) medical record requests for your patients.

Coverage and Eligibility in iLinkBlue

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

1



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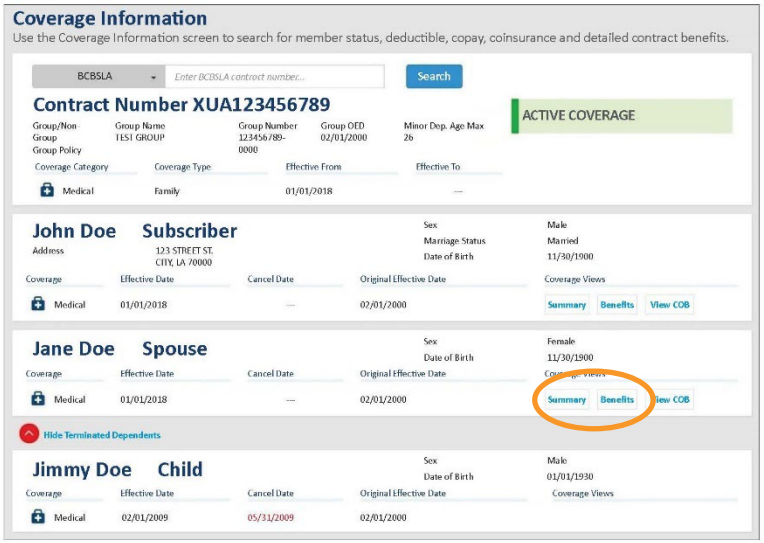

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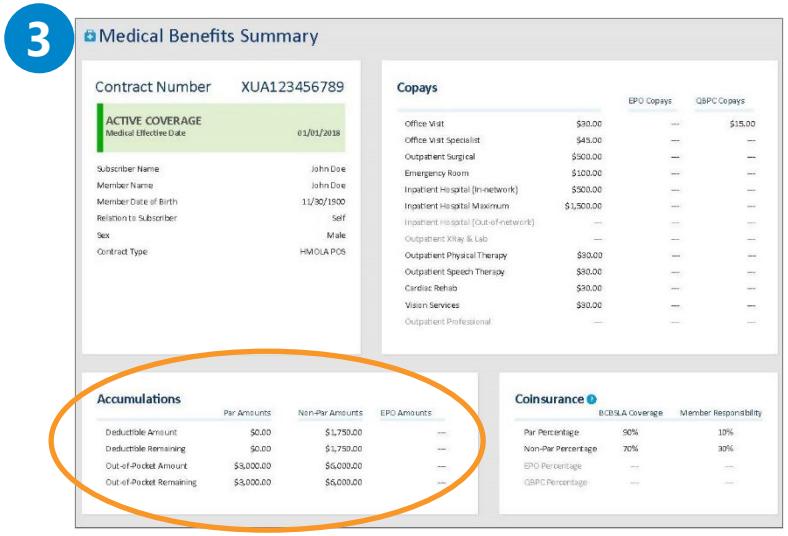


Note: Blue Advantage (HMO) | Blue Advantage (PPO) member coverage and eligibility must be verified through the Blue Advantage Provider Portal.

Claims Information in iLinkBlue

Use the "Claims" menu option to find online tools to:

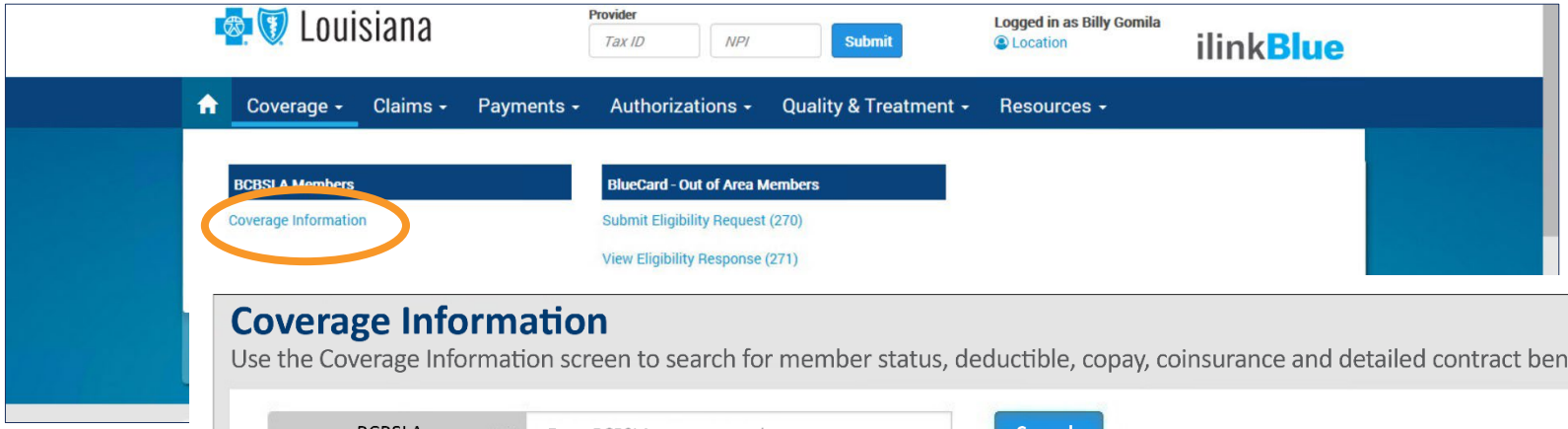
- Perform **Claims Research** on claims that were submitted for processing,
- Submit **BlueCard - Out of Area Claims Status** inquiries for BlueCard (out-of-area) members,
- Check status of claims that were filed electronically (even if they were filed through a clearinghouse) using the **Blue Cross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

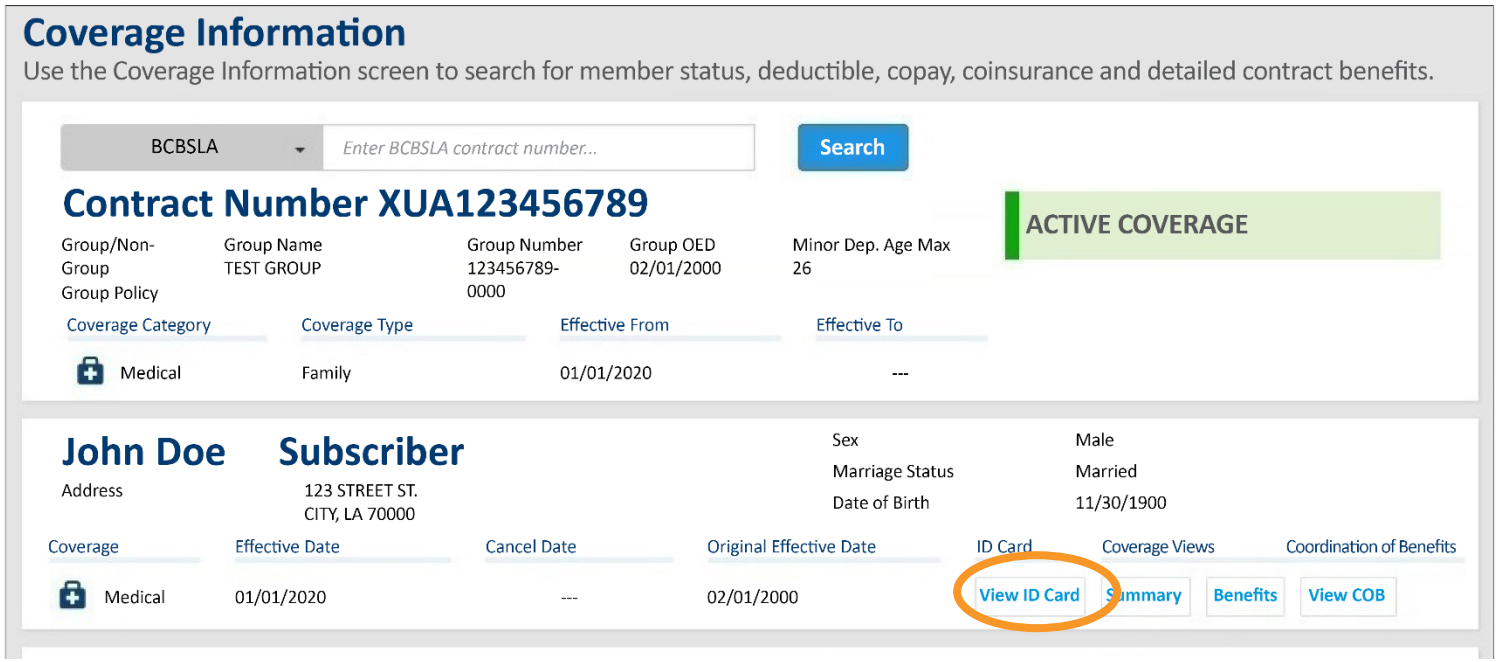
FEP Medical Policy Guidelines in iLinkBlue

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

Digital ID Cards on iLinkBlue

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

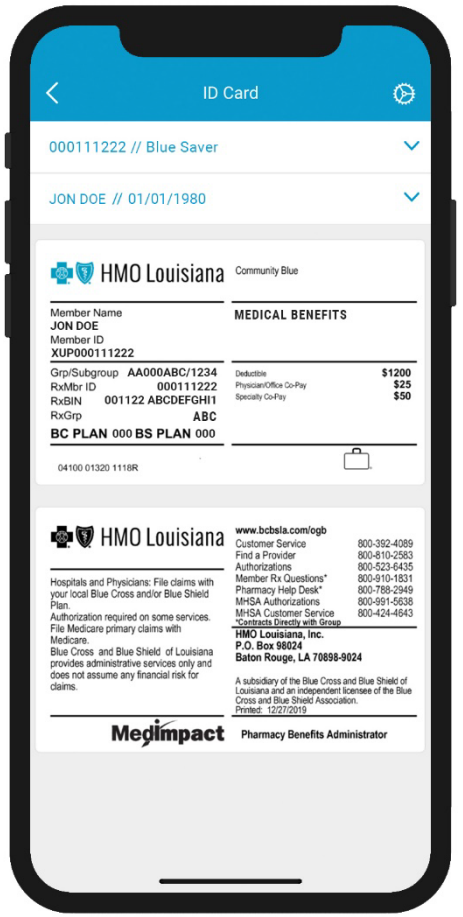




Members Can Access Their Digital ID Cards

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

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

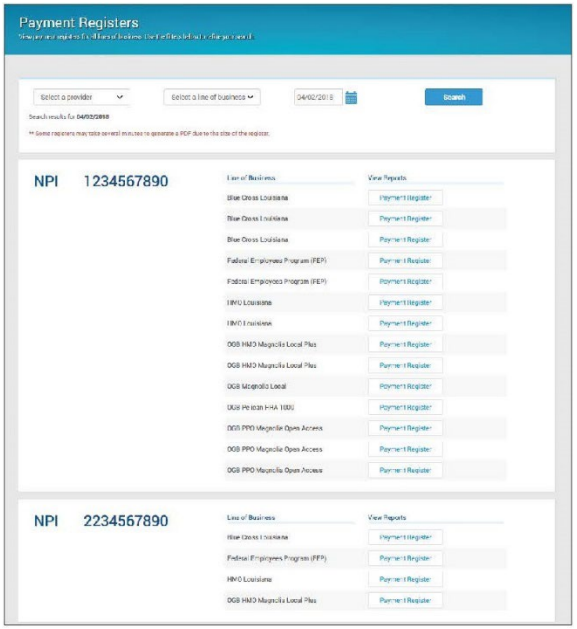


Payments Information in iLinkBlue

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

1

2



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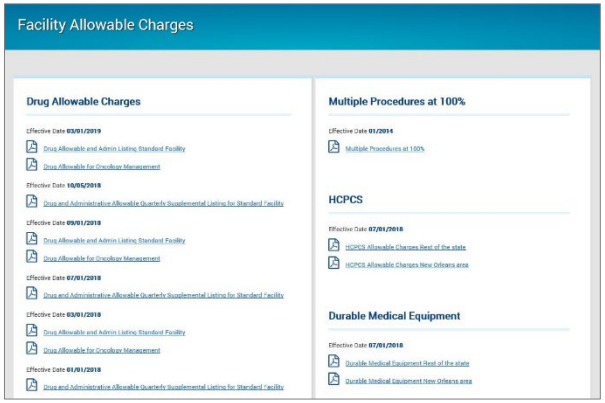

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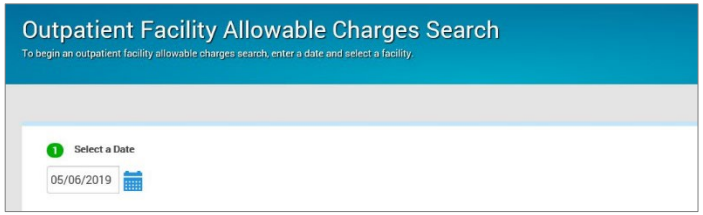
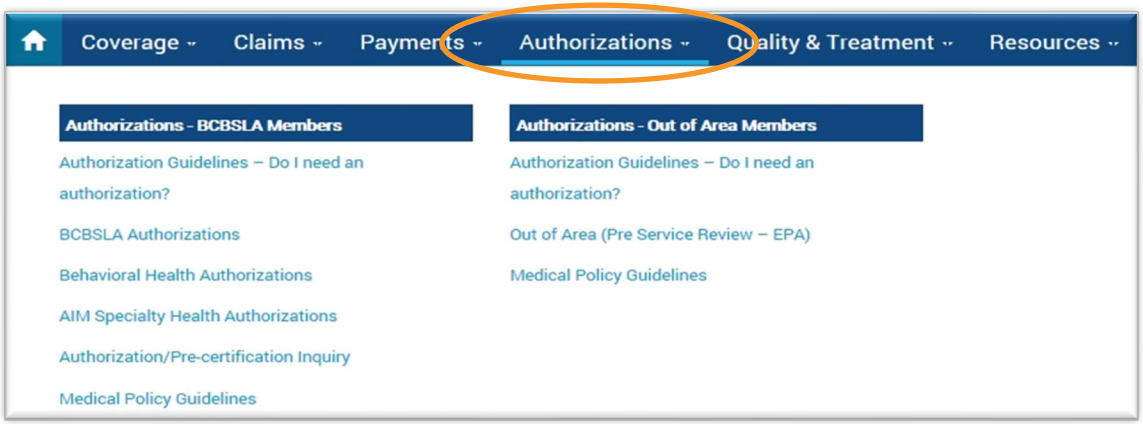


Authorization Requests Through iLinkBlue

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

- The **BCBSLA Authorizations** application allows you to submit and research authorizations for BCBSLA members.
- Behavioral health providers must use the New Directions WebPass Portal application, located in the **Behavioral Health Authorizations** link, to submit authorization requests for behavioral services.
- **AIM Specialty Health® (AIM)**, an independent specialty benefits management company, serves as our authorization manager for these services:
  - Cardiology
  - High-tech Imaging
  - Radiation Oncology
  - Musculoskeletal (MSK)
    - ✓ Interventional Pain Management
    - ✓ Joint Surgery
    - ✓ Spine Surgery
- Our network providers can access pre-service information offered by other Blue Plans for BlueCard® (out-of-area) members in the **Out of Area (Pre-service Review - EPA)** application.

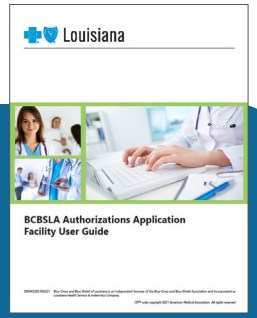


Prior Authorizations

- Blue Cross no longer accept authorization requests via phone or fax, with a few exceptions including transplants, dental services covered under medical and out-of-state services.
- Prior authorization requests, including new and extension authorizations, must be submitted through our online BCBSLA Authorizations 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 Facility User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."

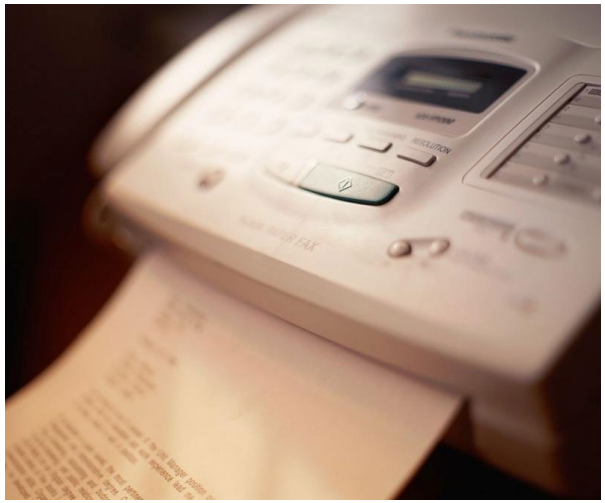


Please Discontinue Use of our Local Retrospective Authorization Fax Number

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

The department also had a local fax number (225-298-2906) **that is no longer in service**. Please discontinue using the local number. If you are using the local number, please instead use the toll-free fax number.

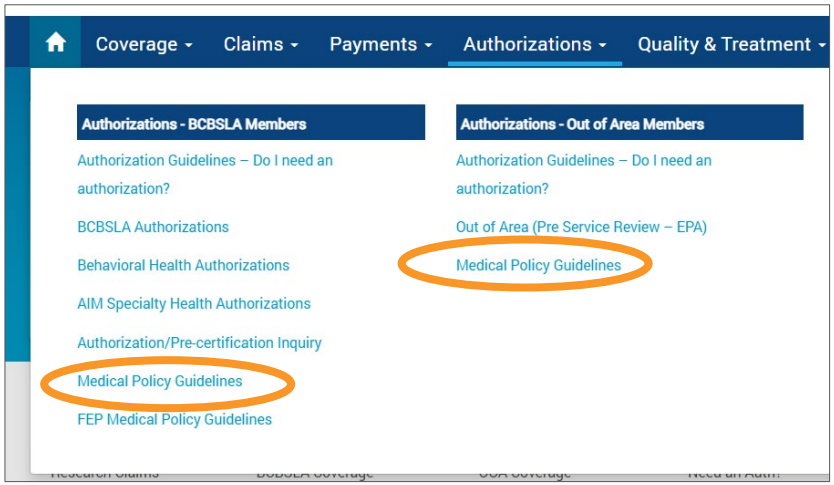
1-800-515-1150

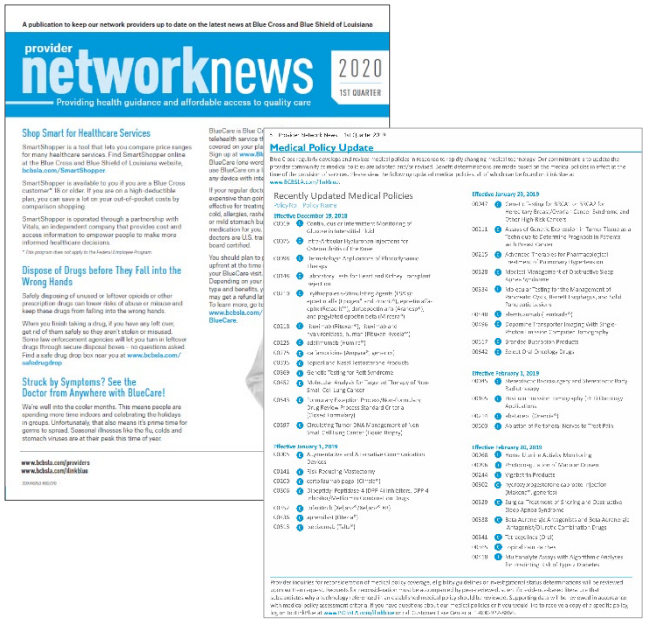


Accessing Medical Policies in iLinkBlue

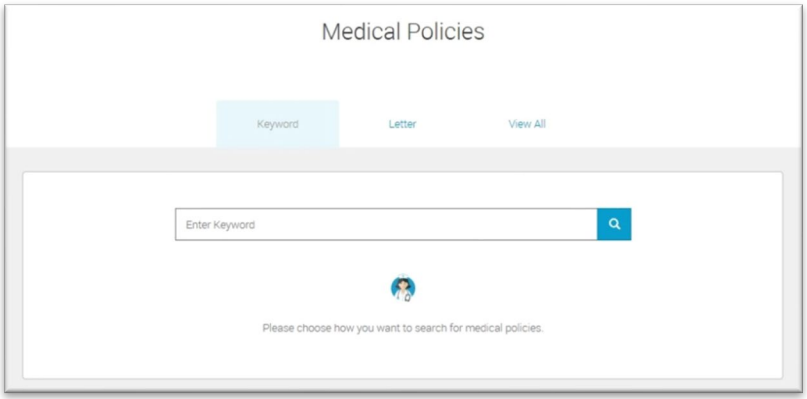
- Use the "Authorizations" menu option to access our **Medical Policy Index**.
- Policies are listed in alpha order or you may search by policy number or procedure code.

1





2



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

Claims Editing

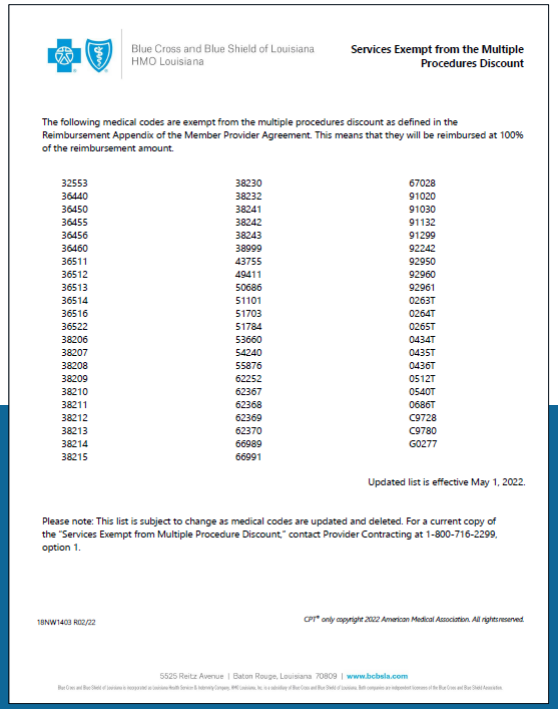
Claims Editing Software

- Applies edits to incoming claims to ensure proper coding and billing based on:
  - Reimbursement
  - Medical policy
  - Benefit rules
  - Industry standard and coding guidelines
- It promotes accurate and consistent payments.
- Manages compliance with standard coding and billing practice between various types of services, such as:
  - Medical
  - Surgical
  - Lab and radiology

Multiple Procedure Reduction

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

A listing of the codes exempt from Multiple Procedure Reduction can be found on in the *Member Provider Policy & Procedure Manual* (our facility manual) is located only in iLinkBlue at **www.bcbsla.com/ilinkblue** >Resources.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Services Exempt from the Multiple Procedures Discount

The following medical codes are exempt from the multiple procedures discount as defined in the Reimbursement Appendix of the Member Provider Agreement. This means that they will be reimbursed at 100% of the reimbursement amount.

32553	38230	67028
36440	38232	91020
36450	38241	91030
36455	38242	91132
36456	38243	91299
36460	38999	92242
36511	43755	92950
36512	49411	92960
36513	50686	92961
36514	51101	0263T
36516	51703	0264T
36522	51784	0265T
38206	53660	0434T
38207	54240	0435T
38208	55876	0436T
38209	62252	0512T
38210	62367	0540T
38211	62368	0686T
38212	62369	C9728
38213	62370	C9780
38214	66989	G0277
38215	66991	

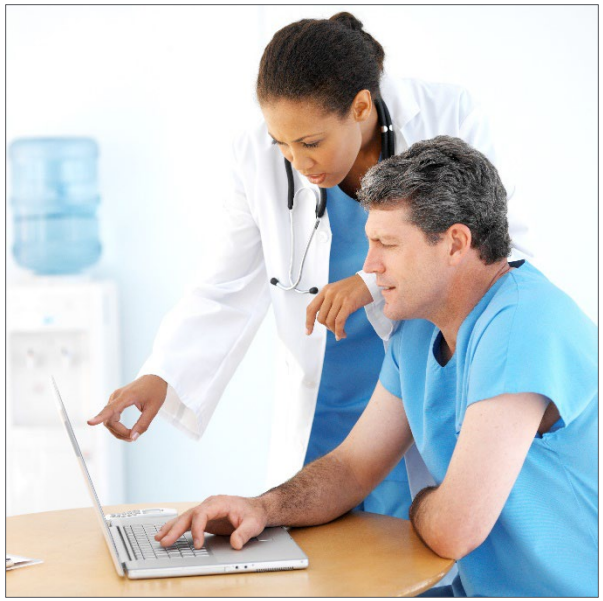
Updated list is effective May 1, 2022.

Please note: This list is subject to change as medical codes are updated and deleted. For a current copy of the "Services Exempt from Multiple Procedure Discount," contact Provider Contracting at 1-800-716-2299, option 1.

18NW1403 R02/22

5525 Reitz Avenue | Baton Rouge, Louisiana 70809 | www.bcbsla.com

Not Separately Reimbursable



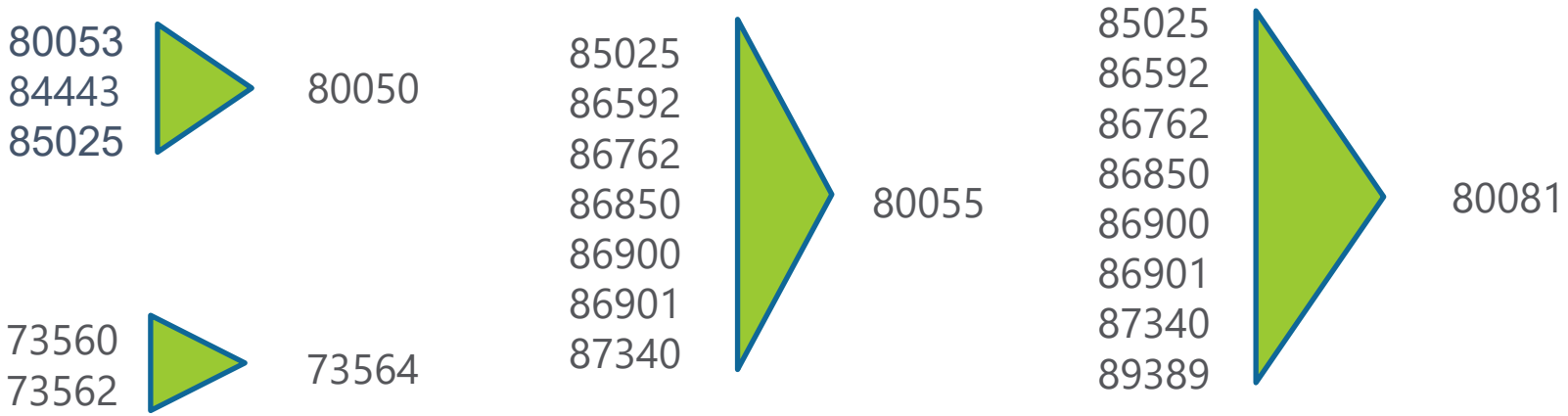
Certain codes will be denied because the services should be included with other services billed on the same day.

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

Rebundles

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

Examples:



Important Things to Remember

- Most edits are based on date processed, **not** date of service.*
- Any claim adjustments processed **after the implementation date** of the new CES system are subject to edits in the new system.
- **Explanation codes and descriptions** on payment register may be different in the new system.
- CARC codes on the 835 may be different. Example: Where you previously saw **CARC 97** for mutually exclusive, incidental and unbundle edits, you will now see CARC 97 for Incidental **AND** Unbundle and 231 for Mutually Exclusive.

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

Troubleshooting

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

Step 1

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

Step 2

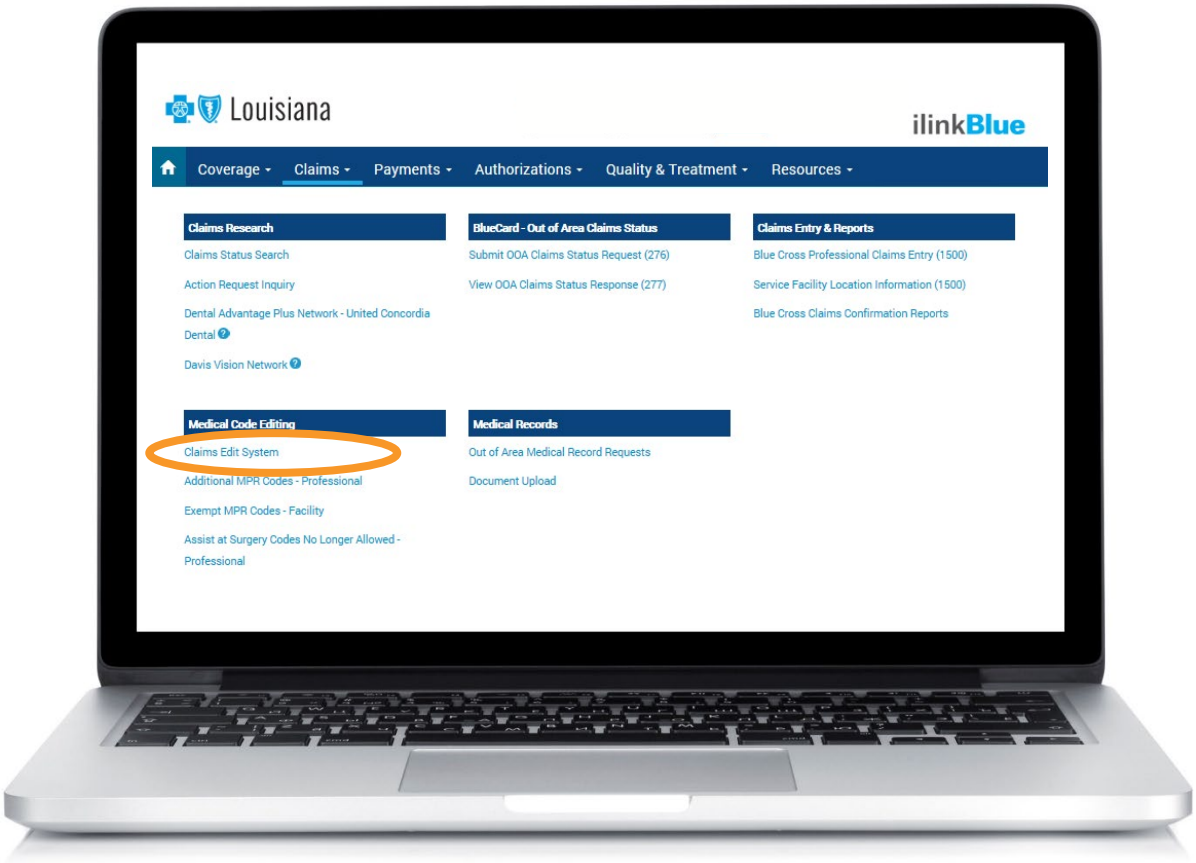
- Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code.
- This tool is located at **www.bcbsla.com/ilinkblue** >Claims >Claims Edit System.
- CES edits will appear in lower case.

Step 3

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

Claims Editing System Tool

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



Claims Editing System Tool

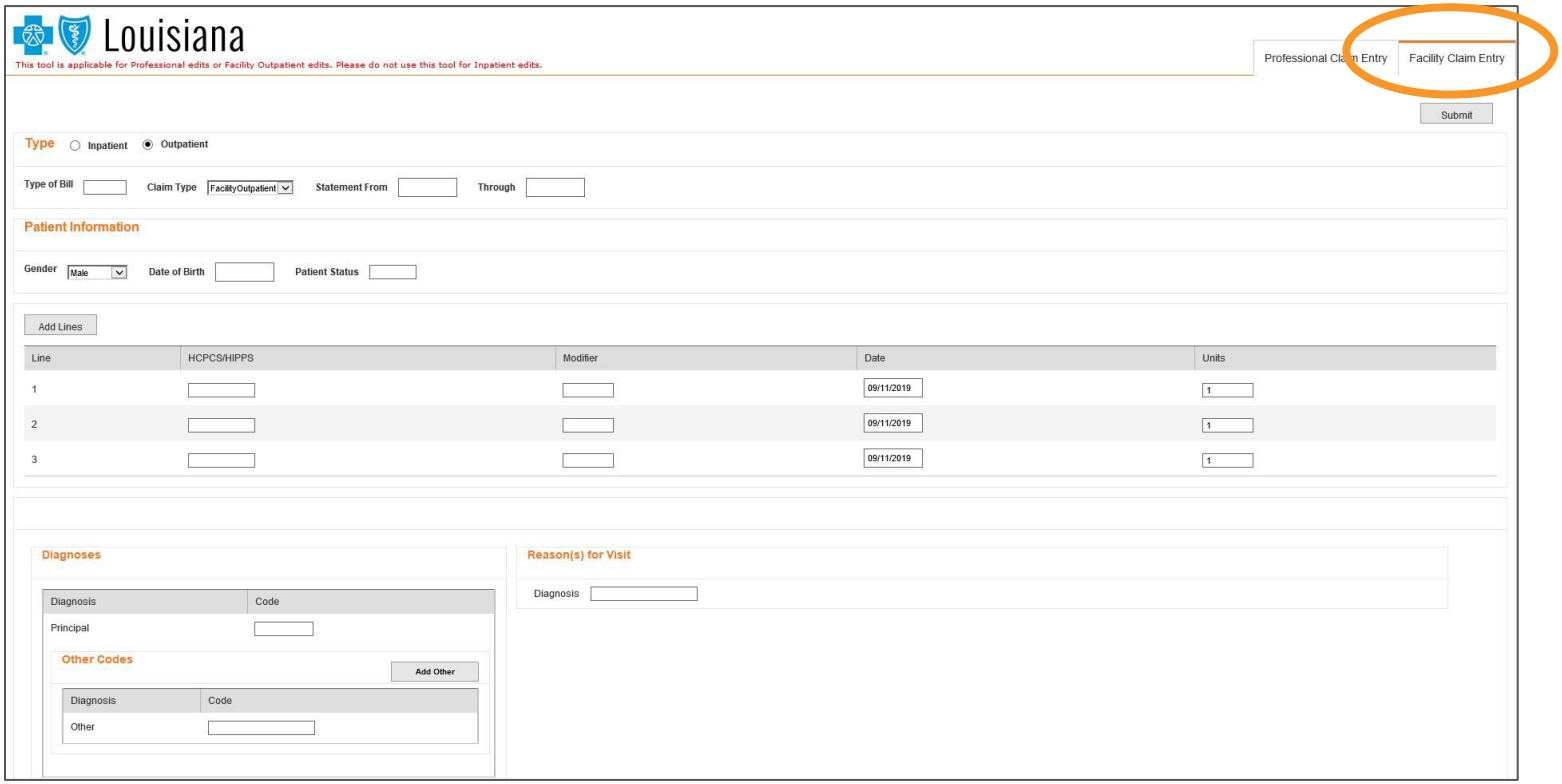
This tool applies to **hospital outpatient & ambulatory surgery center claims only** and does not guarantee claims payment.

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

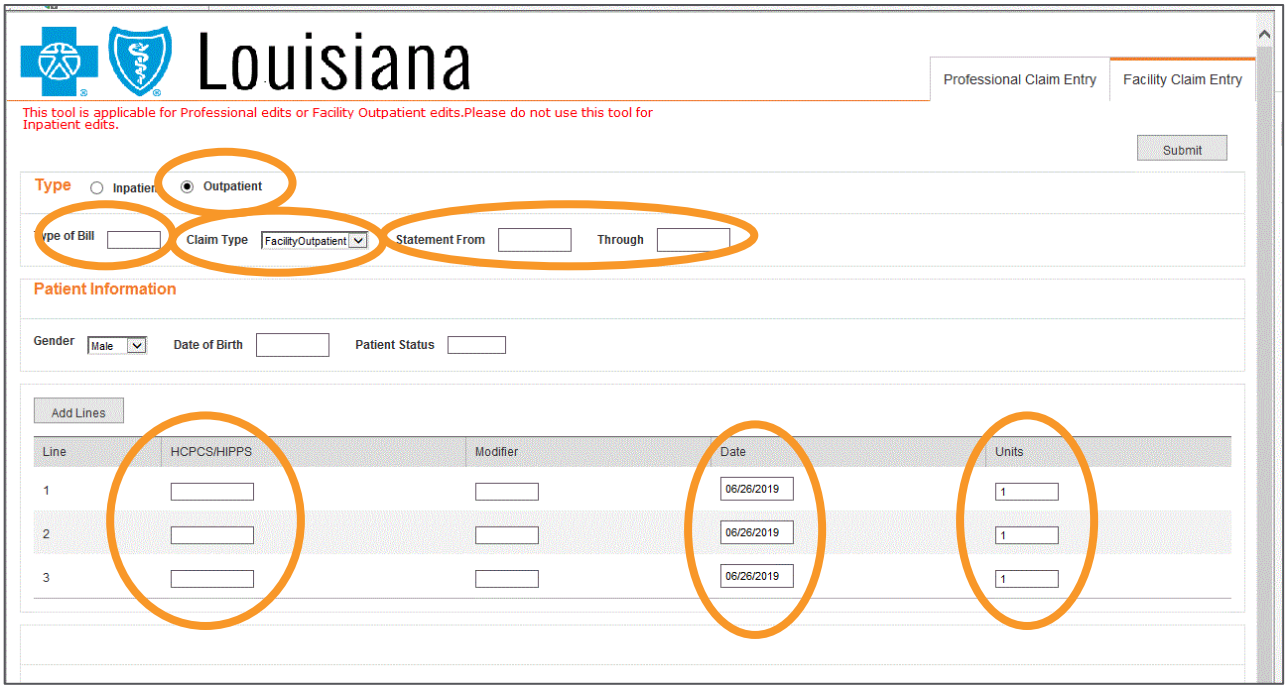
- Historical claims previously billed
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits
- Max frequency edits

Claims Editing System Tool

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

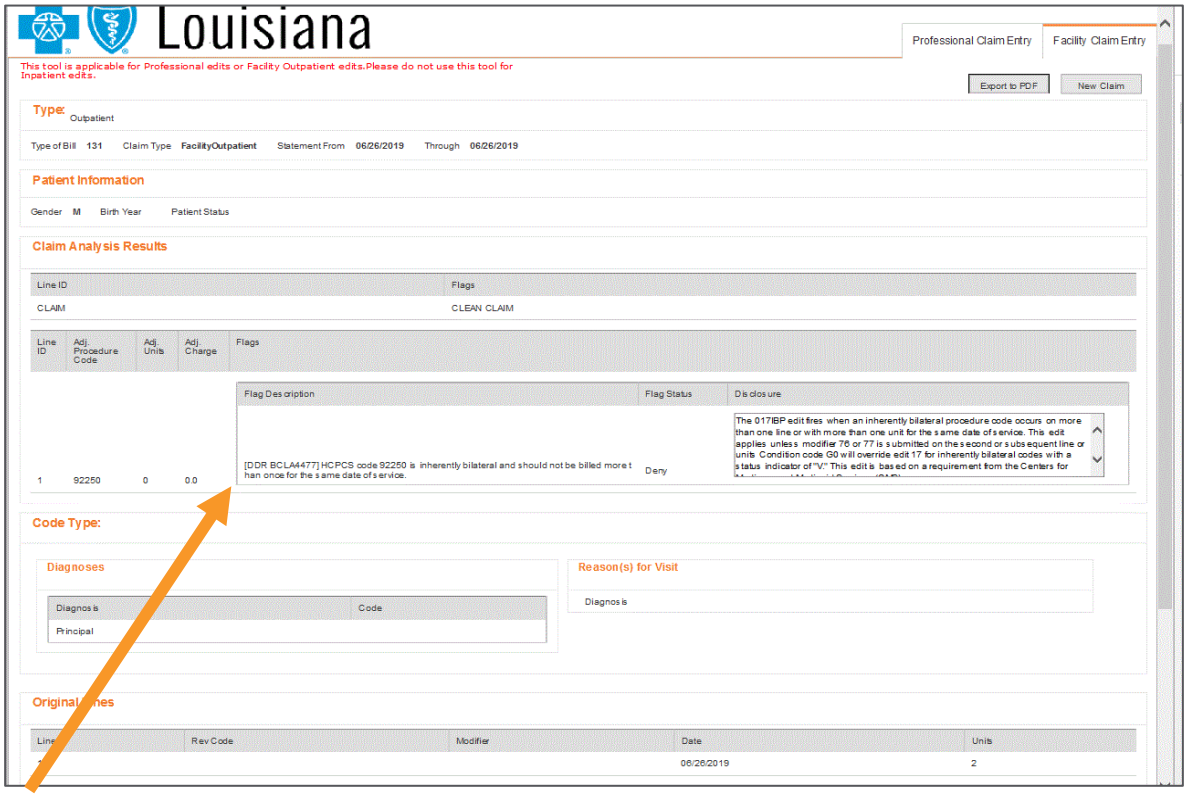


CES Tool Mandatory Fields



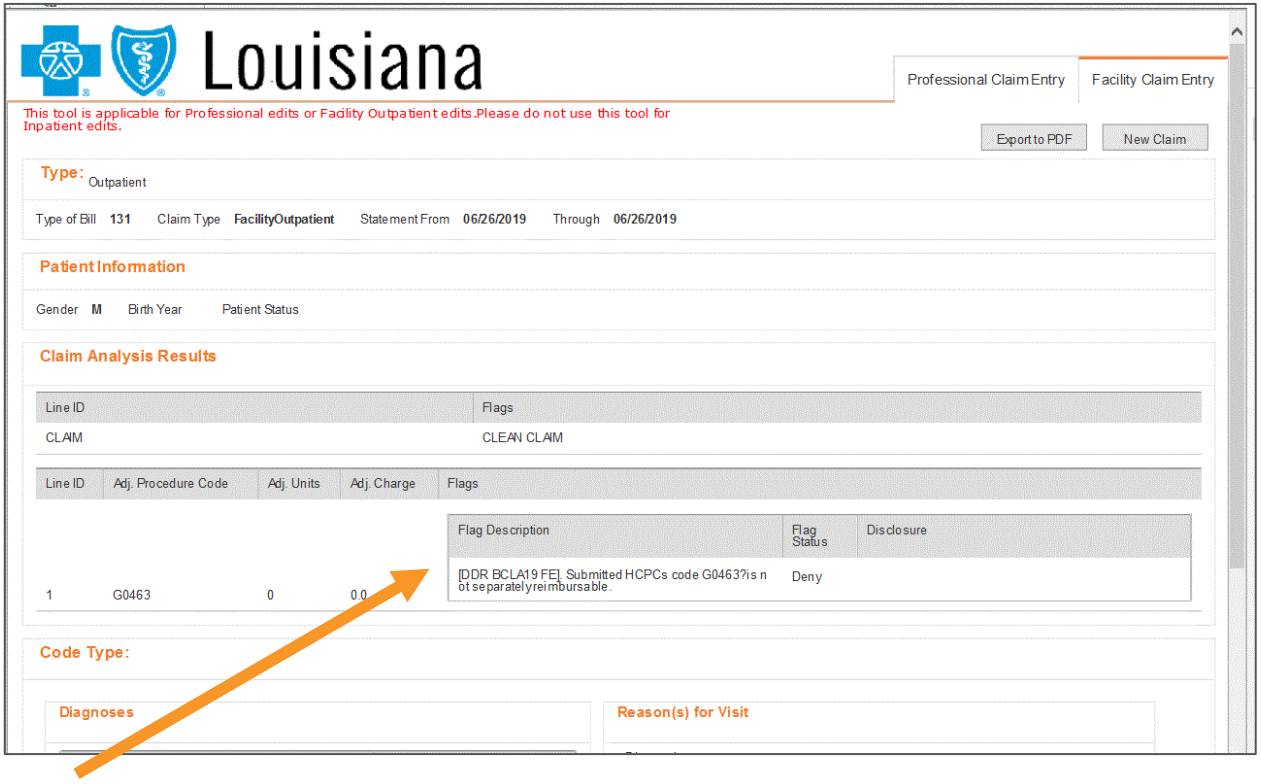
NOTE: If you do not enter the Statement From or Through dates, no edits will be returned, so the dates are necessary.

CES Tool Outputs



Bilateral procedure (92250) billed with 2 units.

CES Tool Outputs

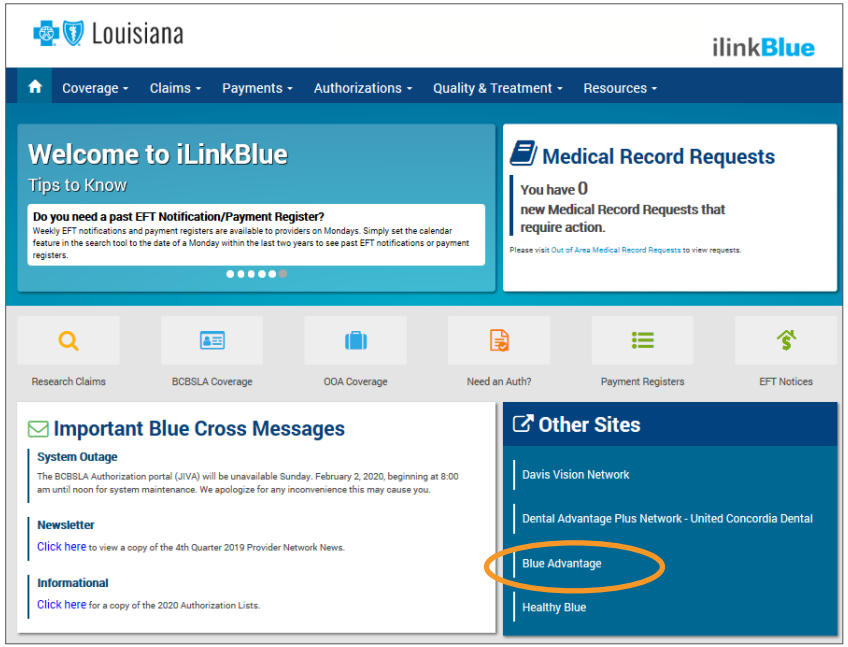


G0463 not separately reimbursable.

Blue Advantage

Accessing the Blue Advantage Provider Portal

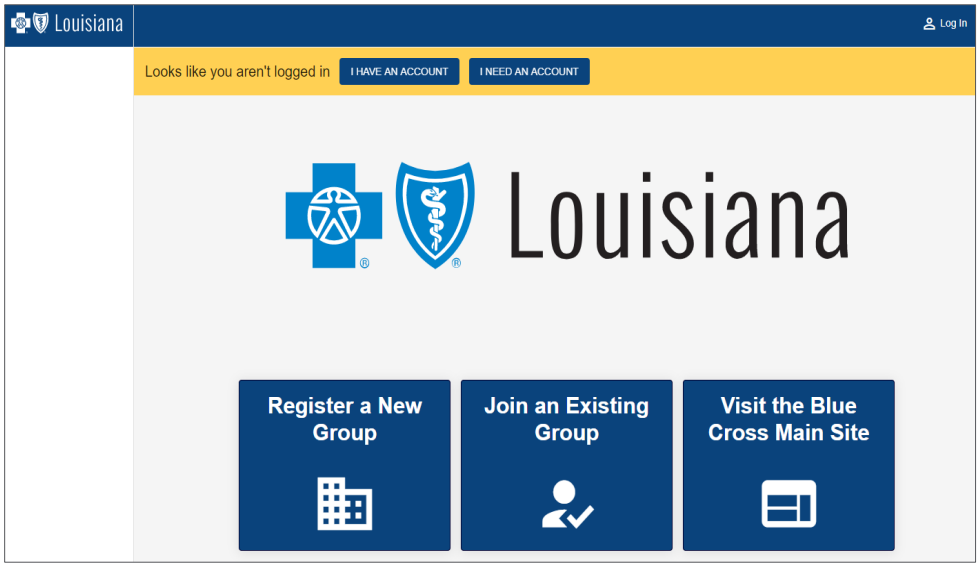
- The processes for Blue Advantage (HMO)/Blue Advantage (PPO) differ from our other provider network processes.
- There is a separate portal for these contracted providers to access needed information.
- You can access the Blue Advantage Provider Portal through iLinkBlue (**www.bcbsla.com/iLinkBlue.com**), under “Other Sites,” click “Blue Advantage.”
- Access to the Blue Advantage Provider Portal requires a higher level of security that must be assigned to users by your organization's security administrative representative.



The Blue Advantage Provider Portal

The Blue Advantage Provider Portal offers resources such as:

- Office Manuals*
- Guides*
- Forms*
- Eligibility
- Claims & Authorization Inquiries
- Provider & Pharmacy Search feature to refer members to other Blue Advantage network providers

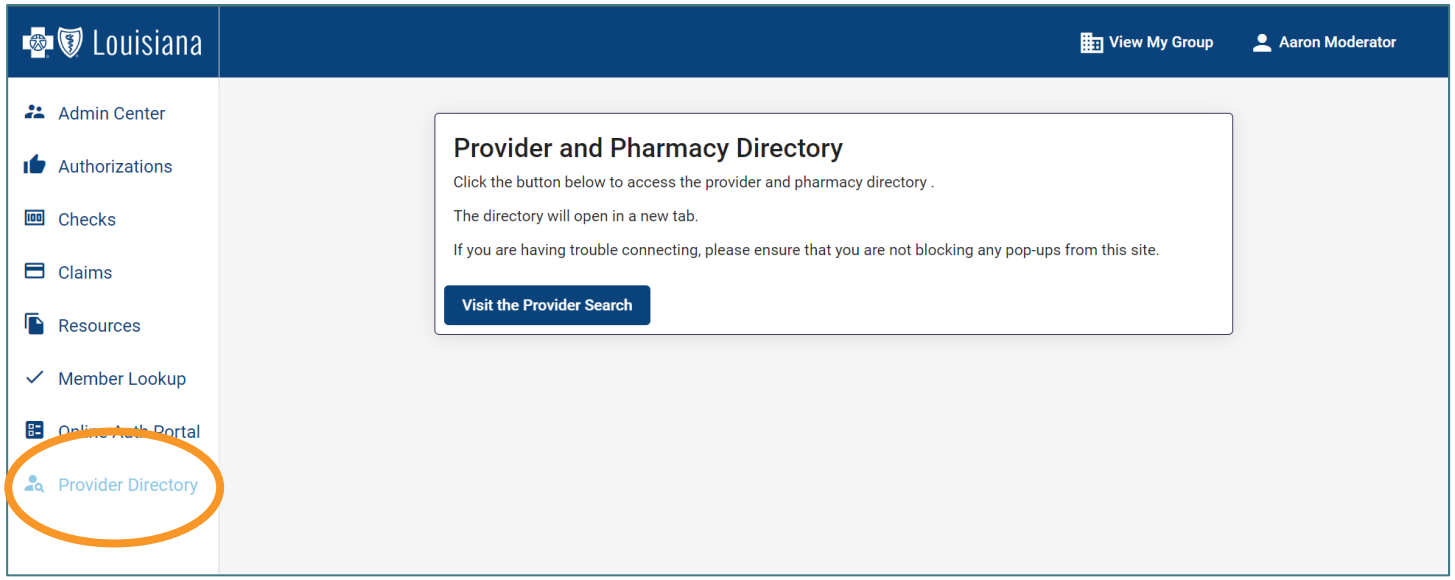


*These resources are also available on the Blue Advantage Resources page at **www.bcbsla.com/providers**.

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

Finding Blue Advantage Providers & Lab Services

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



Preferred laboratories for all specimens for the Blue Advantage network:

Clinical Pathology Labs (CPL)

Quest Diagnostics

Lab Corp

Blue Advantage – Administered by Vantage Health Plan

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

Submit claims to Vantage Health Plan (Payor ID 72107)

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

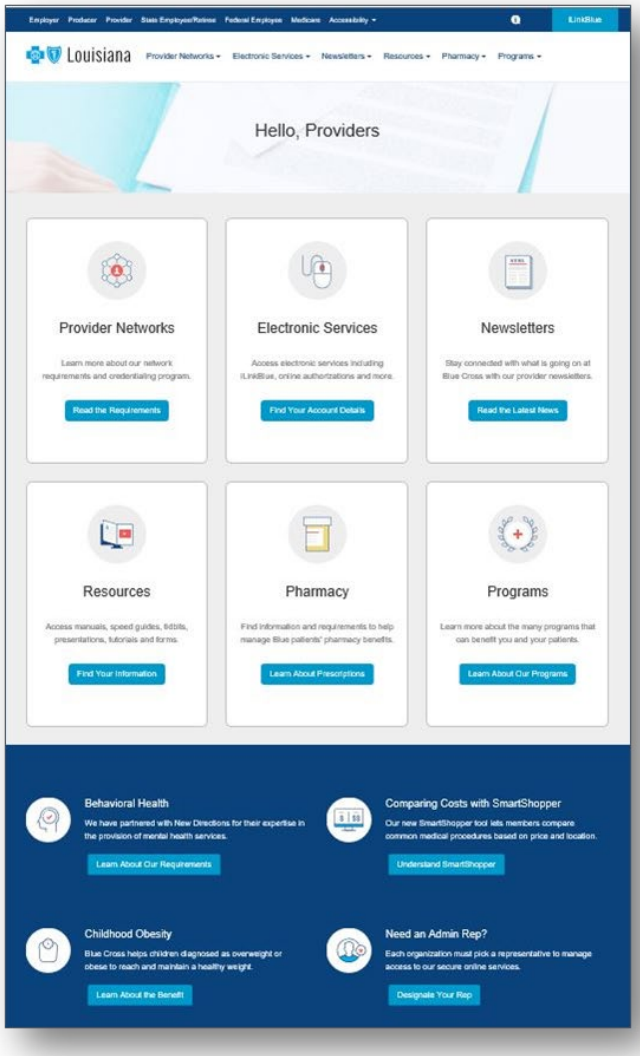
Registration is required to gain access to the Blue Advantage Provider Portal. If you need access to the Blue Advantage Provider Portal, please reach out to your Group Moderator (Admin Rep).

Resources

The Provider Page

The Provider Page is home to online resources such as:

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



www.bcbsla.com/providers

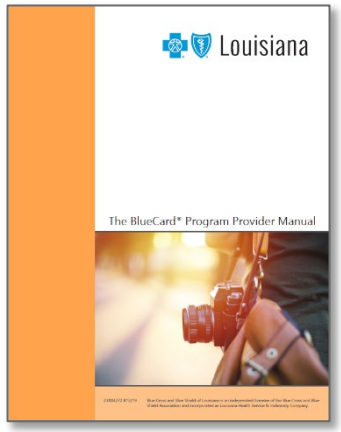
Provider Manuals

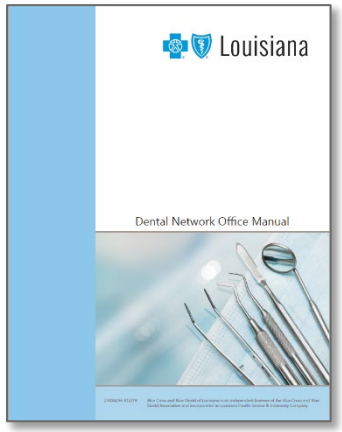
Our manuals are an extension of your member provider agreement.

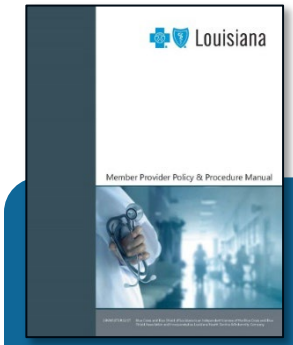
The manuals include the information you need as a participant in our networks:

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

www.bcbsla.com/providers
>Resources >Manuals





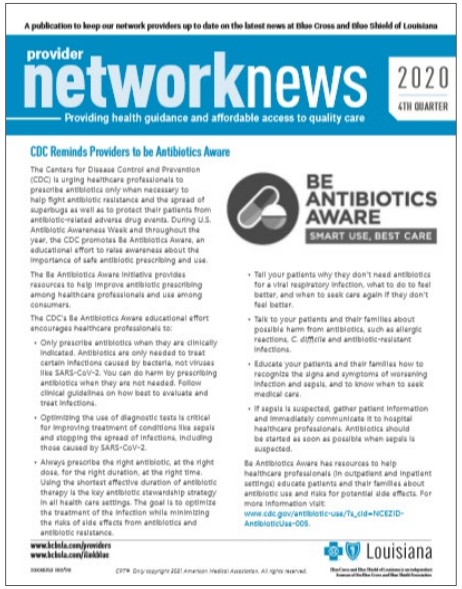


The *Member Provider Policy & Procedure Manual* (our facility manual) is located only in iLinkBlue at **www.bcbsla.com/ilinkblue** >Resources.

Newsletters

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

www.bcbsla.com/providers >Newsletters


A publication to keep our network providers up to date on the latest news at Blue Cross and Blue Shield of Louisiana

provider networknews 2020 4TH QUARTER

Providing health guidance and affordable access to quality care

CDC Reminds Providers to be Antibiotics Aware

The Centers for Disease Control and Prevention (CDC) is urging healthcare professionals to prescribe antibiotics only when necessary to help fight antibiotic resistance and the spread of superbugs as well as to protect their patients from antibiotic-related adverse drug events. During U.S. Antibiotic Awareness Week and throughout the year, the CDC promotes Be Antibiotics Aware, an educational effort to raise awareness about the importance of safe antibiotic prescribing and use.

The Be Antibiotics Aware initiative provides resources to help improve antibiotic prescribing among healthcare professionals and use among consumers.

The CDC's Be Antibiotics Aware educational effort encourages healthcare professionals to:

- Only prescribe antibiotics when they are clinically indicated. Antibiotics are only needed to treat certain infections caused by bacteria, not viruses like SARS-CoV-2. You can do harm by prescribing antibiotics when they are not needed. Follow clinical guidelines on how best to evaluate and treat infections.
- Optimizing the use of diagnostic tests is critical for improving treatment of conditions like sepsis and stopping the spread of infections, including those caused by SARS-CoV-2.
- Always prescribe the right antibiotic, at the right dose, for the right duration, at the right time. Using the shortest effective duration of antibiotic therapy is the key antibiotic stewardship strategy in all health care settings. The goal is to optimize the treatment of the infection while minimizing the risks of side effects from antibiotics and antibiotic resistance.

BE ANTIBIOTICS AWARE
SMART USE, BEST CARE

- Tell your patients why they don't need antibiotics for a viral respiratory infection, what to do to feel better, and when to seek care again if they don't feel better.
- Talk to your patients and their families about possible harm from antibiotics, such as allergic reactions, *C. difficile* and antibiotic-resistant infections.
- Educate your patients and their families how to recognize the signs and symptoms of worsening infection and sepsis, and to know when to seek medical care.
- If sepsis is suspected, gather patient information and immediately communicate it to hospital healthcare professionals. Antibiotics should be started as soon as possible when sepsis is suspected.

Be Antibiotics Aware has resources to help healthcare professionals (in outpatient and inpatient settings) educate patients and their families about antibiotic use and risks for potential side effects. For more information visit: www.cdc.gov/antibiotic-use/?s_cid=NCEZID-AntibioticUse-005.

www.bcbsla.com/providers
www.bcbsla.com/linkblue

Louisiana


A publication to keep our network providers informed on the latest Blue Advantage (HMO) | Blue Advantage (PPO) news

Blue Advantage Insight Newsletter

February 2021

In this edition:

page	article
2	Help Your Patients Start the Year Off Well!
2	Primary Care Provider Selection
3	Important Authorization Reminders
3	Filing Blue Advantage Claims
4	NEW Provider Portal Features
4	Things to Remember When Using the Blue Advantage Provider Portal
5	MIPS on Blue Advantage Claims
5	Reimbursement During Credentialing
6	Be Aware of COVID-19 Vaccine Fraud
7	Do We Have Your Current Contact Information?
7	Provider Pay Disputes

Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Network News
Our quarterly newsletter for network providers.

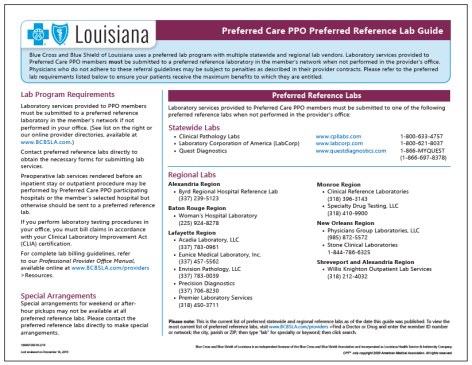
Blue Advantage Insight
Our newsletter for our Blue Advantage (HMO) and Blue Advantage (PPO) network providers.

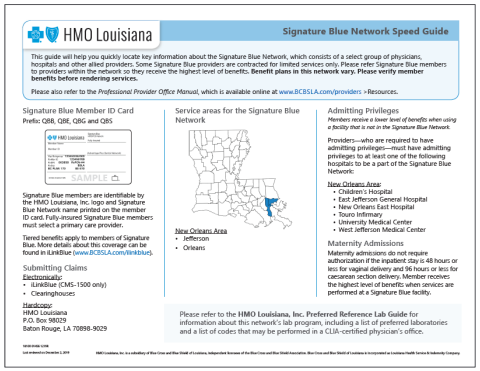
Not Getting Our Newsletters?

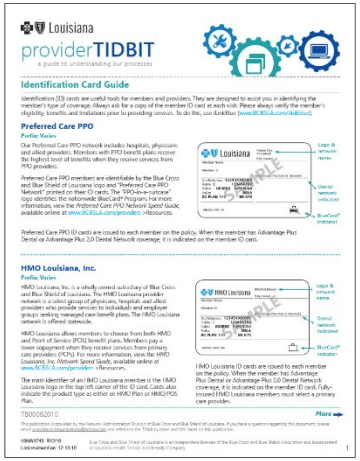
Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

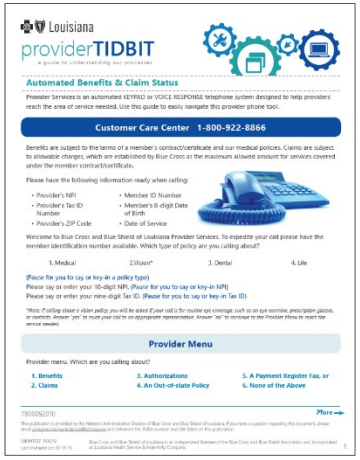
Speed Guides and Tidbits

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







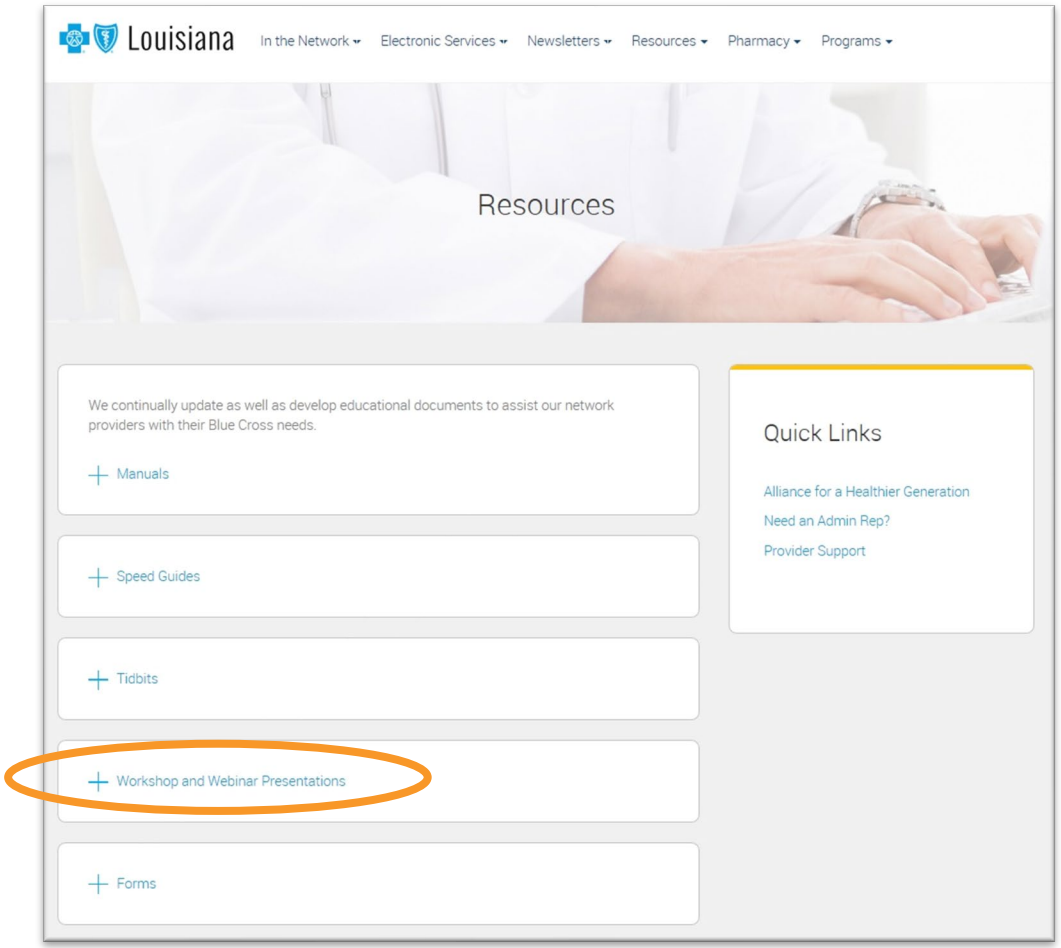


Provider Tidbits are quick guides designed to help you stay informed of our current business processes.

www.bcbsla.com/providers >Resources

Workshops and Webinars

- **Provider Workshops and Webinars** are held throughout the year to offer training and updates on Blue Cross policies and procedures.
- Invites to attend these events are sent to providers' correspondence email address.
- PDF copies of our workshops and webinars are available online.



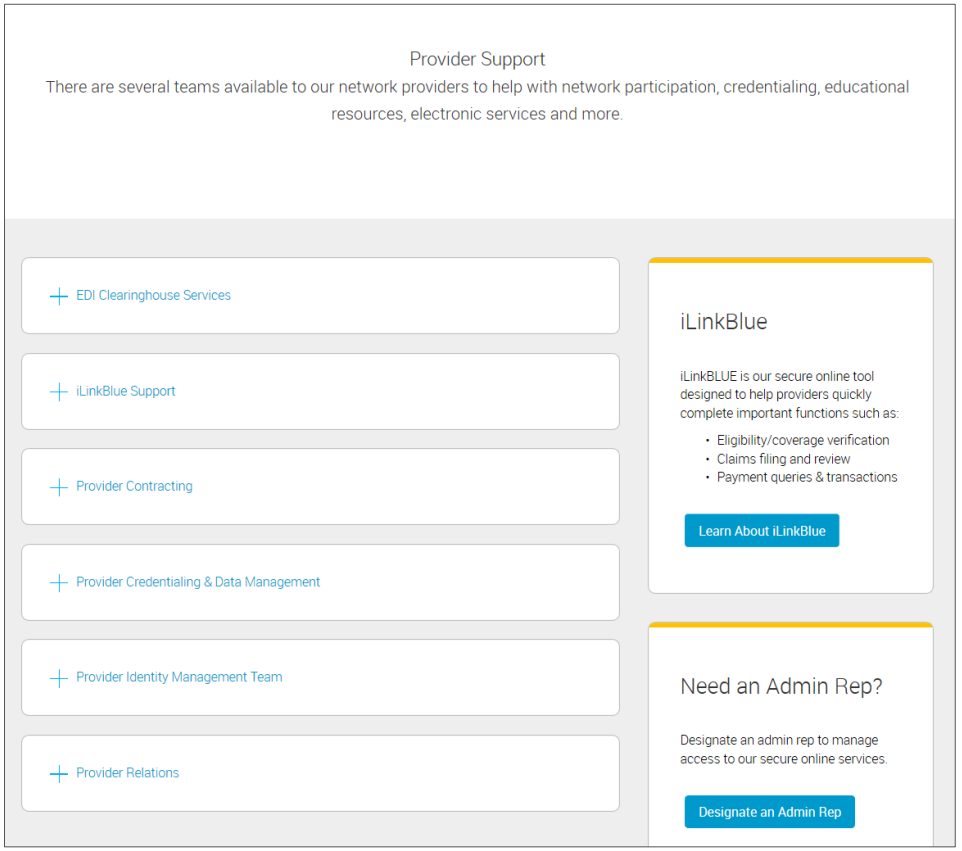
www.bcbsla.com/providers >Resources >Workshop and Webinar Presentations

Provider Support

We believe supporting our network providers is important.

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

- Provider Credentialing Representative
- Provider Relations Representative
- PCDM assistance with credentialing or demographic changes
- Electronic services support



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

Call Centers

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

For information NOT available on iLinkBlue

Other Provider Phone Lines

BlueCard Eligibility Line – 1-800-676-BLUE (1-800-676-2583)
for out-of-state member eligibility and benefits information

Fraud & Abuse Hotline – 1-800-392-9249
Call 24/7 and you can remain anonymous as all reports are confidential

Health Services Division – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing and provider record information
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding security access to online services

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