Louisiana

Blue Cross and Blue Shield of Louisiana

FACILITY WORKSHOP

FALL 2022

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

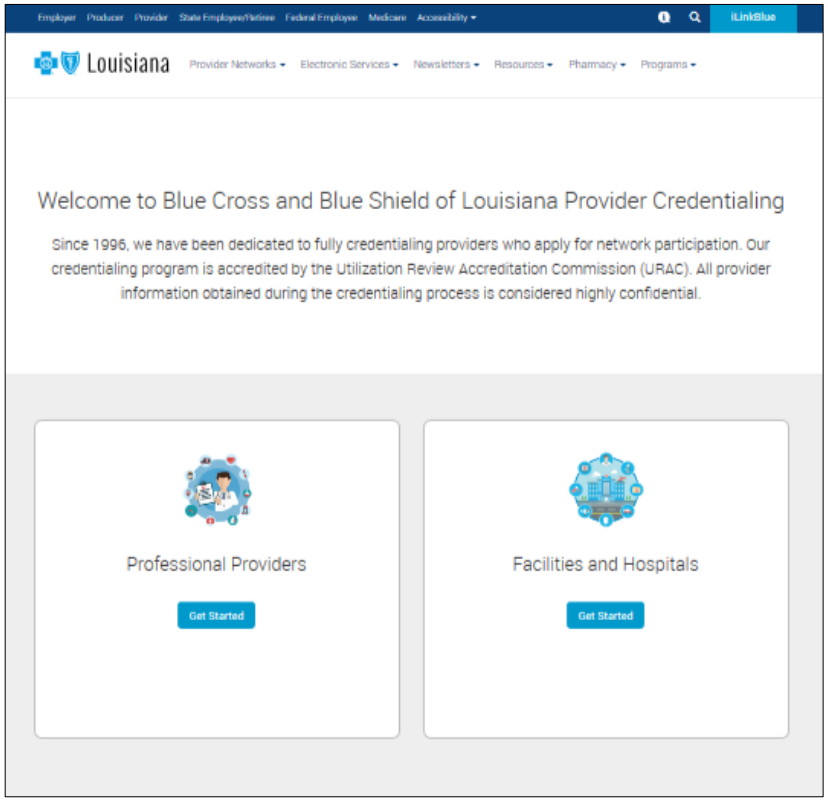
Our Vision

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

Provider Credentialing & Data Management

Join Our Networks

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



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

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

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

Credentialing Criteria - Facility

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

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

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

Credentialing Process

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

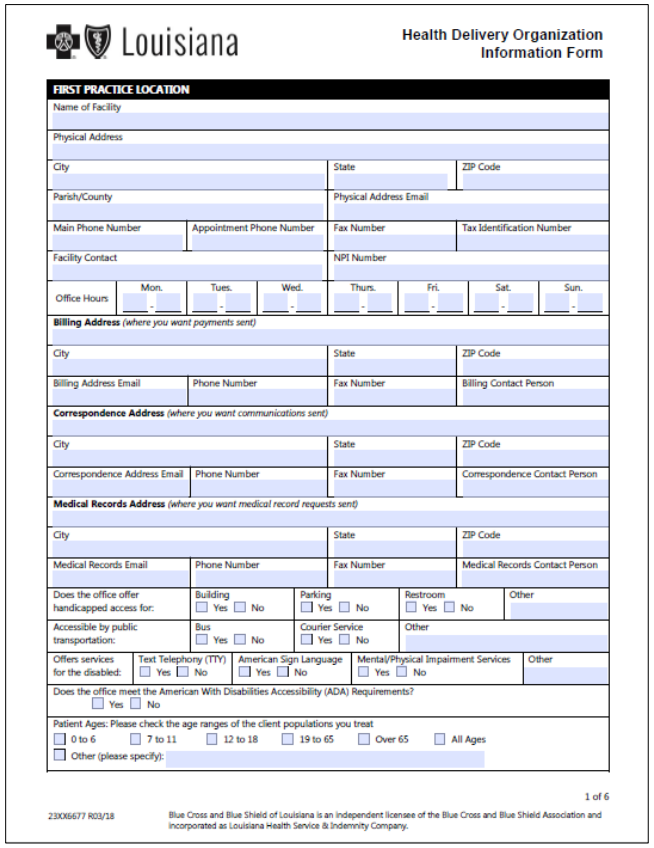
You may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **PCDMStatus@bcbsla.com**.

Credentialing Application

Each packet includes a checklist of all required documents. Please follow the checklist to ensure all information is included with the submission of your application.

Some of the required credentialing supporting documentation for Facilities and Hospitals includes:

- Health Delivery Organization (HDO) Form
- HDO Attachment, as applicable
- State License
- Malpractice Liability Certificate (copy of declarations page)



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Health Delivery Organization Information Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours: Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun.

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

Patient Ages: Please check the age ranges of the client populations you treat

☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages

☐ Other (please specify):

1 of 6

23XX6677 R03/18

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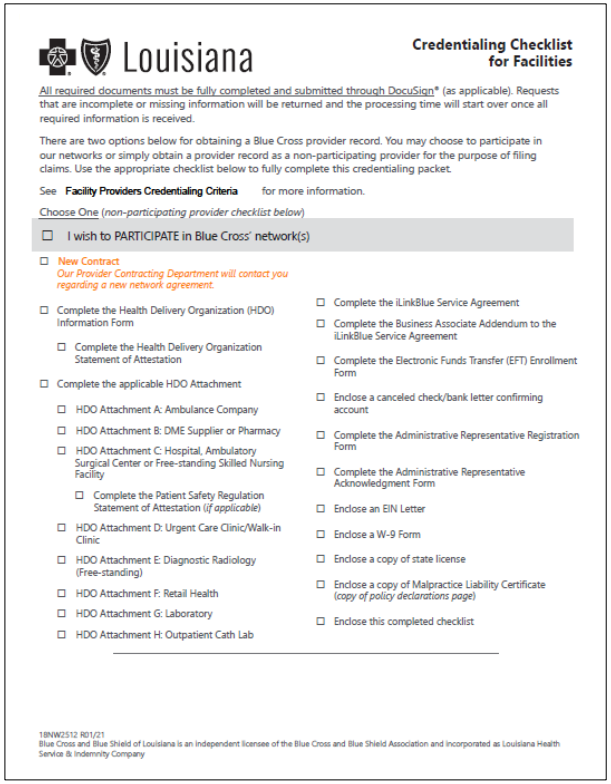
Facility Initial Credentialing Packets can be found online at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks >Facilities and Hospitals.

Required Recredentialing Documents

Recredentialing packet includes a checklist and all applicable forms.



Louisiana

Credentialing Checklist for Facilities

All required documents must be fully completed and submitted through DocuSign* (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

There are two options below for obtaining a Blue Cross provider record. You may choose to participate in our networks or simply obtain a provider record as a non-participating provider for the purpose of filing claims. Use the appropriate checklist below to fully complete this credentialing packet.

See **Facility Providers Credentialing Criteria** for more information.

Choose One (*non-participating provider checklist below*)

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

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

☐ Complete the Health Delivery Organization (HDO) Information Form
- ☐ Complete the Health Delivery Organization Statement of Attestation

☐ Complete the applicable HDO Attachment
- ☐ HDO Attachment A: Ambulance Company
- ☐ HDO Attachment B: DME Supplier or Pharmacy
- ☐ HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
  - ☐ Complete the Patient Safety Regulation Statement of Attestation (*if applicable*)
- ☐ HDO Attachment D: Urgent Care Clinic/Walk-in Clinic
- ☐ HDO Attachment E: Diagnostic Radiology (Free-standing)
- ☐ HDO Attachment F: Retail Health
- ☐ HDO Attachment G: Laboratory
- ☐ HDO Attachment H: Outpatient Cath Lab

☐ Complete the iLinkBlue Service Agreement

☐ Complete the Business Associate Addendum to the iLinkBlue Service Agreement

☐ Complete the Electronic Funds Transfer (EFT) Enrollment Form

☐ Enclose a canceled check/bank letter confirming account

☐ Complete the Administrative Representative Registration Form

☐ Complete the Administrative Representative Acknowledgment Form

☐ Enclose an EIN Letter

☐ Enclose a W-9 Form

☐ Enclose a copy of state license

☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)

☐ Enclose this completed checklist

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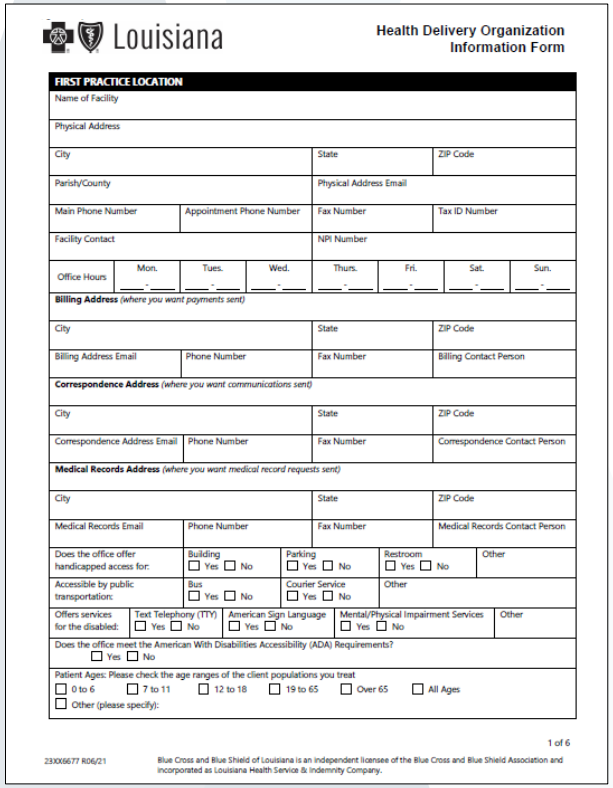

Louisiana

Health Delivery Organization Information Form

FIRST PRACTICE LOCATION

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

1 of 6

23XX6677 R06/21
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Required Recredentialing Supporting Documentation

The following documents must be submitted with your recredentialing application:

- Accrediting entity certification (JCAHO, CHAP, etc.)
- License (State, Occupational, CLIA, etc.)
- Medicare Participation Letter (if applicable)
- Professional Liability Insurance Certificate or Products Liability Insurance Certificate (DME Providers)
- Louisiana Patients' Compensation Fund Certificate (if applicable)
- If your organization is a(n):
  - Ambulance company, complete attachment A
  - DME supplier, complete attachment B
  - Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility, complete attachment C
  - Urgent Care/Walk-In Clinic, complete attachment D
  - Free-standing Diagnostic Radiology Center, complete attachment E
  - Retail Health Clinic, complete attachment F
  - Laboratory (free-standing), complete attachment G
  - Outpatient Cath Lab with Accreditation, complete attachment H
- EIN Letter and W-9
- EFT, iLinkBlue and Business Associate Agreement
- Health Plan Agreement (if applicable)

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

Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

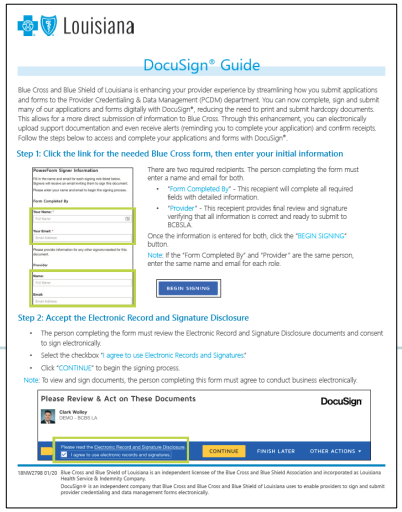
Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign**.

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

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

What is DocuSign?

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


Louisiana

DocuSign® Guide

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

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

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

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

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

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

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

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

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

Please Review & Act on These Documents

DocuSign

Clark Wolley

DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure

I agree to use electronic records and signatures.

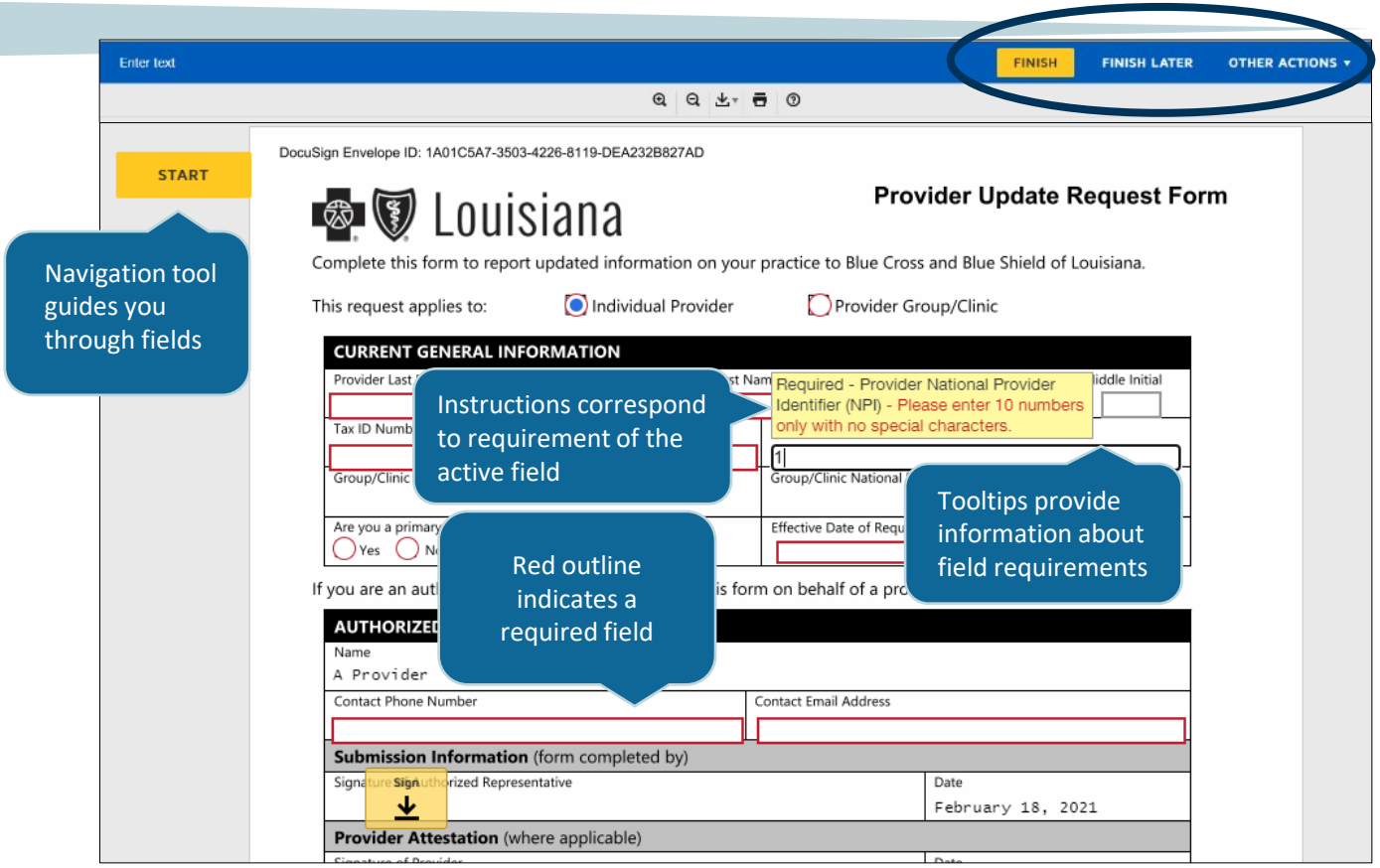
CONTINUE FINISH LATER OTHER ACTIONS

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

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

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

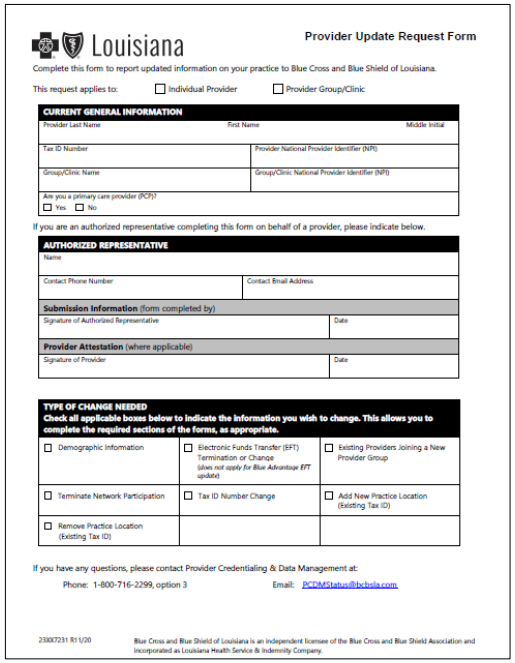
Easily Complete Forms with DocuSign



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

How to Update Your Information

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



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Provider Update Request Form

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

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

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

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

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

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

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

Submission Information (form completed by)

Signature of Authorized Representative | Date

Provider Attestation (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

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

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

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

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

23007231 R11/20

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

What changes do you need to make?

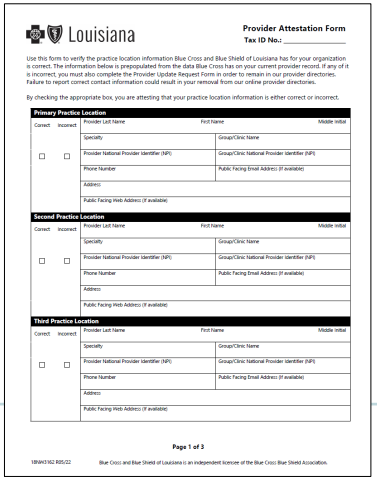
Provider Update Request Form – to update information such as:

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

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

Provider Attestation Form

- Due to requirements of the federal Consolidated Appropriation Acts (CAA) 2021, our PCDM Department is sending a Provider Attestation Form every 90 days to all providers listed in our online provider directories to review their information as it appears in our directories.
- If any of your information is not correct, there will be an option within the Provider Attestation Form to complete and return our Provider Update Request Form. This allows us to update the information we publish in our directories.
- The form is emailed in a DocuSign format, prepopulated with the information we have on file. The provider must verify and attest to the accuracy of the information.



Louisiana

Provider Attestation Form

Tax ID No.: _____

Use this form to verify the practice location information Blue Cross and Blue Shield of Louisiana has for your organization is correct. The information below is prepopulated from the data Blue Cross has on your current provider record. If any of it is incorrect, you must also complete the Provider Update Request Form in order to remain in our provider directories. Failure to report correct contact information could result in your removal from our online provider directories.

By checking the appropriate box, you are attesting that your practice location information is either correct or incorrect.

Primary Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

Second Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

Third Practice Location

Correct	Incorrect	Provider Last Name	First Name	Middle Initial
☐	☐	Specialty		Group/Clinic Name
		Provider National Provider Identifier (NPI)		Group/Clinic National Provider Identifier (NPI)
		Phone Number		Public Facing Email Address: (if available)
		Address:		
		Public Facing Web Address: (if available)		

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1BWH3162 R05/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

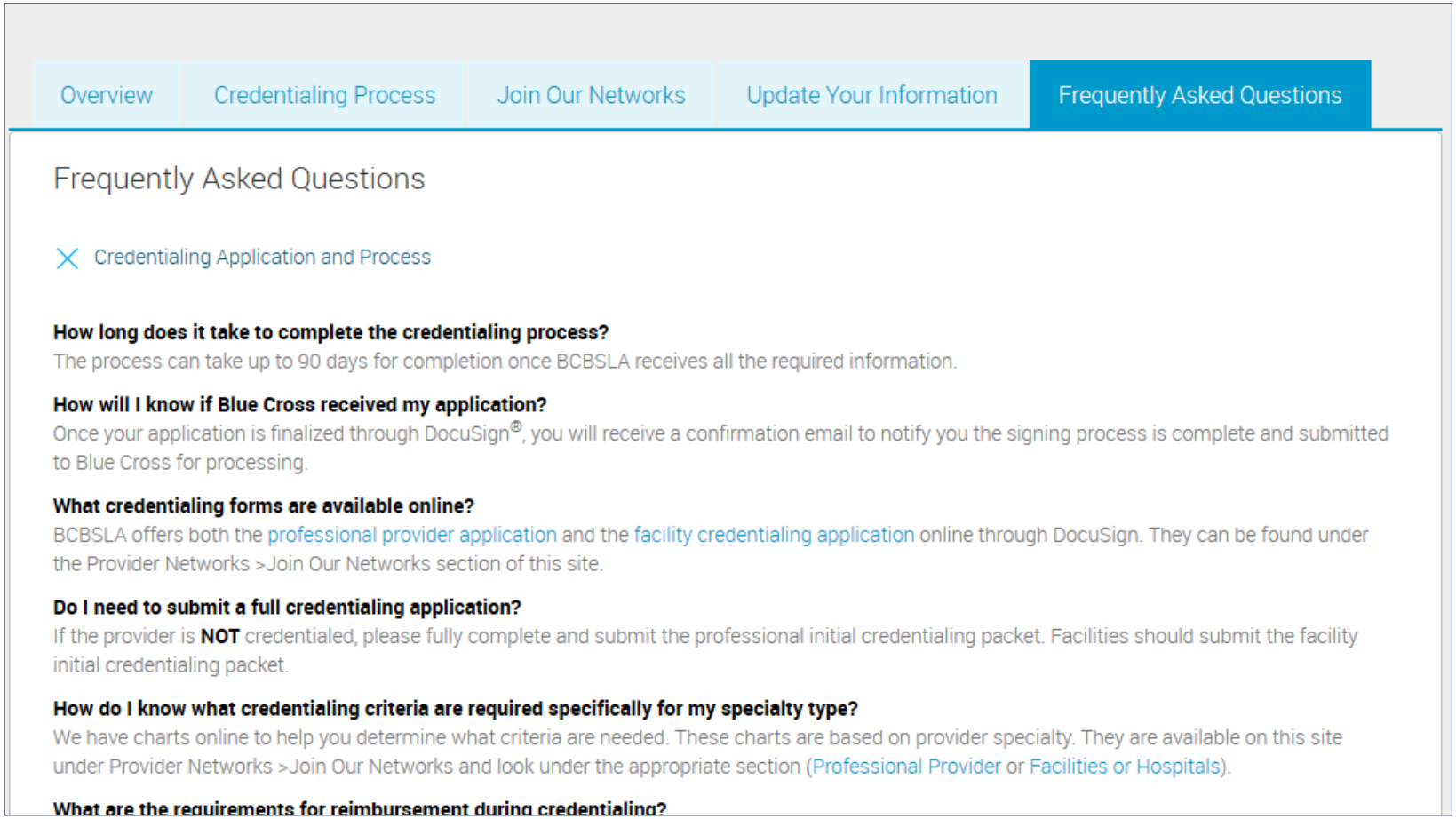
Providers who do not complete attestation of their information will be removed from our online provider directories.

Vantage Health Managing Blue Cross Recredentialing

Use the chart below for the new recredentialing process:

Process initiated by:	Vantage
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments.
Where to submit forms:	To Vantage based on instructions included with recredentialing form.
Verification Process:	Vantage
Who to contact:	Vantage by email: **recredentialing@vhpla.com** Vantage by phone: (318) 807-4755

Frequently Asked Questions



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

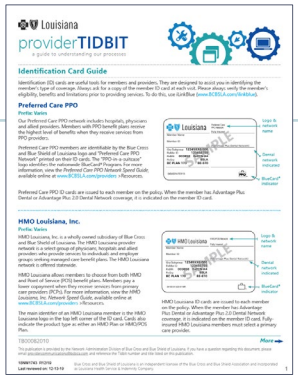
Our Networks

Our Provider Networks

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

Louisiana

HMO Louisiana


Louisiana
providerTIDBIT
a guide for understanding our products

Identification Card Guide

Preferred Care PPO

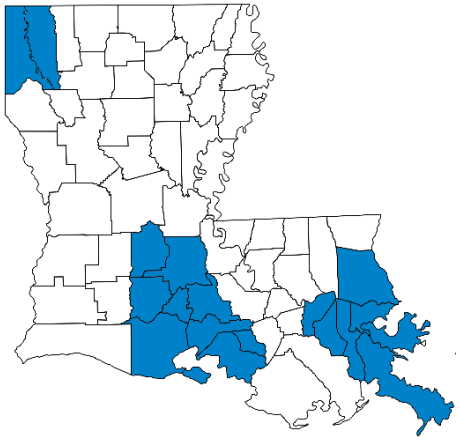
Profile Varies

HMO Louisiana, Inc.

Profile Varies

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

Our Provider Networks



BLUE CONNECT

New Orleans area

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

Lafayette area

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

Shreveport area

Bossier and Caddo parishes

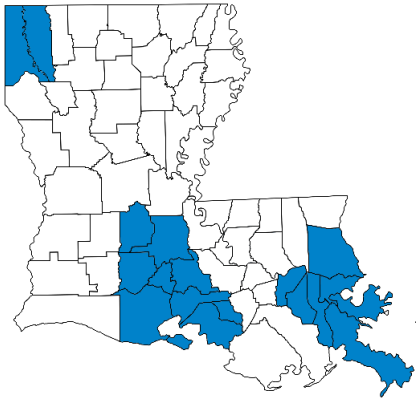
COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks

BLUEHPN



Lafayette area

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

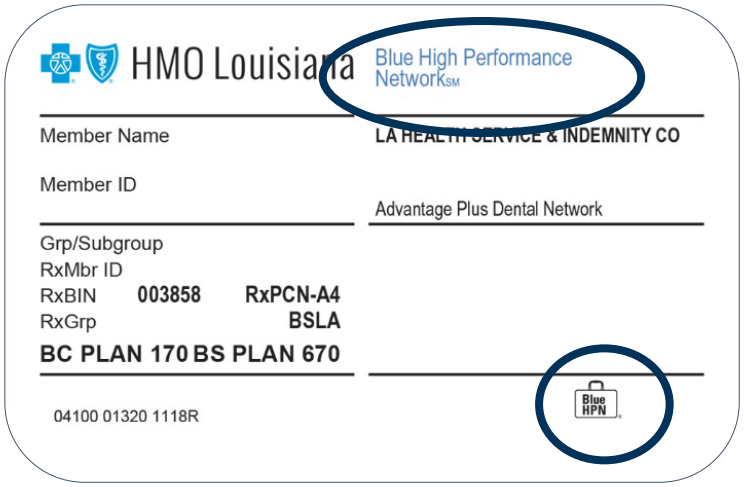
New Orleans area

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

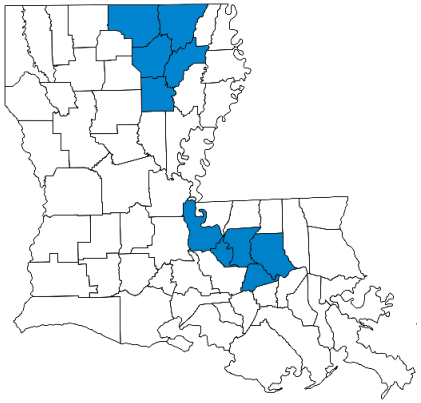
Shreveport area

Bossier and Caddo parishes

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



Our Provider Networks



PRECISION BLUE

Baton Rouge area

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

Greater Monroe/ West Monroe area

Caldwell, Morehouse, Ouachita, Richland and Union parishes

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans parishes

Federal Employee Program

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

STANDARD OPTION

- ✓ In-network
- ✓ Out-of-network

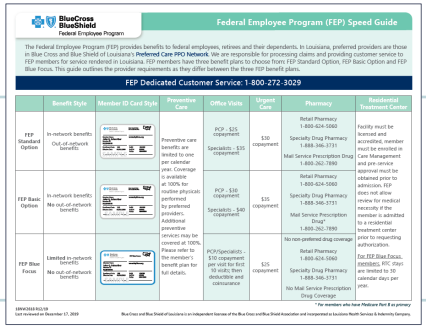
BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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

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


BlueCross BlueShield
Federal Employee Program

Federal Employee Program (FEP) Speed Guide

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

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

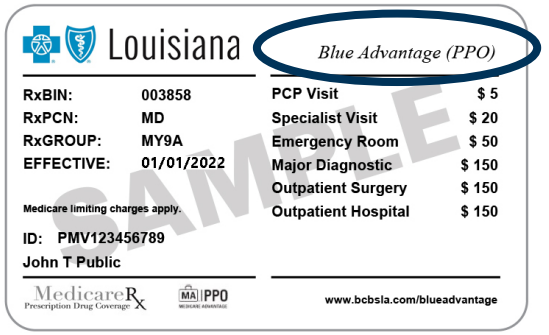
	Benefit Style	Member ID Card Style	Preventive Care	Office Visits	Urgent Care	Pharmacy	Residential Treatment Center
FEP Standard Option	In-network benefits Out-of-network benefits		Preventive care benefits are limited to one per calendar year. Coverage is available at 100% for routine physicals performed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

* For members who have Medicare Part B as primary

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

Our Blue Advantage Networks

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



Prefix: PMV

Prefix: MDV

BlueCard® Program

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

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

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

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

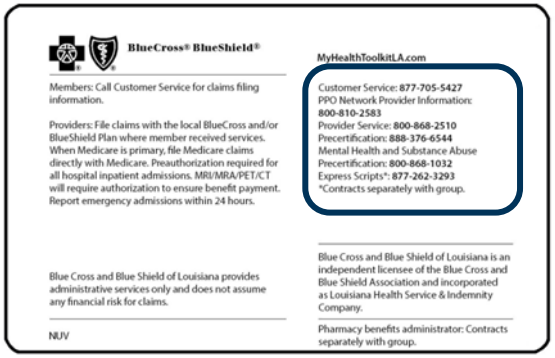
- The BlueHPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) product.

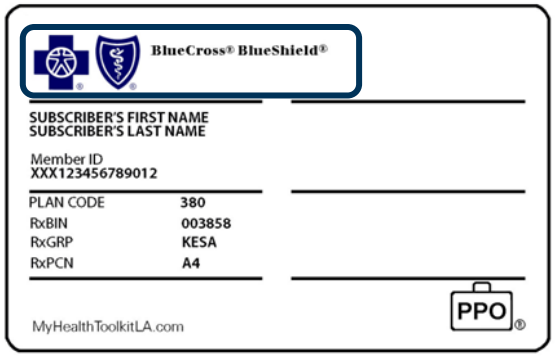
Note: BlueCard authorizations are handled through the members' home plan.

National Alliance

(South Carolina Partnership)

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





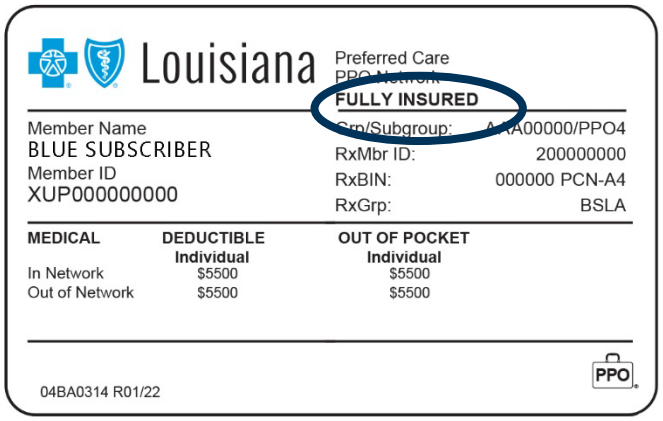
This list of prefixes is available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-funded

Member ID Card Differences

FULLY INSURED

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


Louisiana Preferred Care PPO Network

FULLY INSURED

Member Name
BLUE SUBSCRIBER
Member ID
XUP000000000

Grp/Subgroup: A[illegible]A00000/PPO4
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA

MEDICAL	DEDUCTIBLE Individual	OUT OF POCKET Individual
In Network	$5500	$5500
Out of Network	$5500	$5500

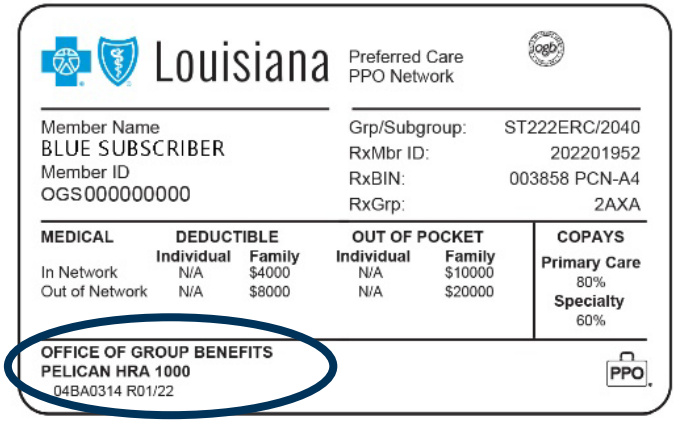
04BA0314 R01/22

PPO

"Fully Insured" notation

SELF FUNDED

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


Louisiana Preferred Care PPO Network

Member Name
BLUE SUBSCRIBER
Member ID
OGS000000000

Grp/Subgroup: ST222ERC/2040
RxMbr ID: 202201952
RxBIN: 003858 PCN-A4
RxGrp: 2AXA

MEDICAL	DEDUCTIBLE Individual	DEDUCTIBLE Family	OUT OF POCKET Individual	OUT OF POCKET Family
In Network	N/A	$4000	N/A	$10000
Out of Network	N/A	$8000	N/A	$20000

COPAYS
Primary Care 80%
Specialty 60%

OFFICE OF GROUP BENEFITS
PELICAN HRA 1000
04BA0314 R01/22

PPO

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

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

Out-of-network Referrals

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

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

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

Billing Requirements

Timely Filing

Blue Cross, HMO Louisiana, Blue Connect, Community Blue, BlueHPN, 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:

- Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the service were provided.

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.
- Claims 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. 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.

Ordering/Referring Policy

The ordering/referring providers first name, last name and NPI are **required** on all claims for the following provider types:

- Diagnostic Radiology Center
- Durable Medical Equipment Supplier
- Infusion Therapy
- Laboratory
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy

Claims received without the ordering/referring provider's first name, last name and NPI will be returned, and the claim must be refiled with the requested information. The ordering/referring provider should not be the same as the rendering provider.

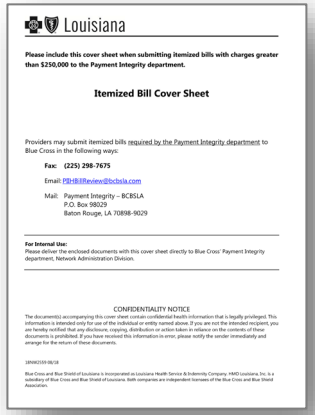
Please enter the ordering/referring provider's information for paper and electronic claims as indicated below:

Paper Claims	• CMS-1500 Health Insurance Claim Form: Block 17B
Electronic 837P, Professional Claims	• Referring Provider - Claim Level: 2310A loop, NM1 Segment • Referring Provider - Line Level: 2420F loop, NM1 Segment • Ordering Provider - Line Level: 2420E loop, NM1 Segment

Pre-pay Itemized Bill Review

$100,000 minimum, please follow these guidelines:

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


Louisiana

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

Itemized Bill Cover Sheet

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

Fax: (225) 298-7675

Email: PIIHBillReview@bcbsla.com

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

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

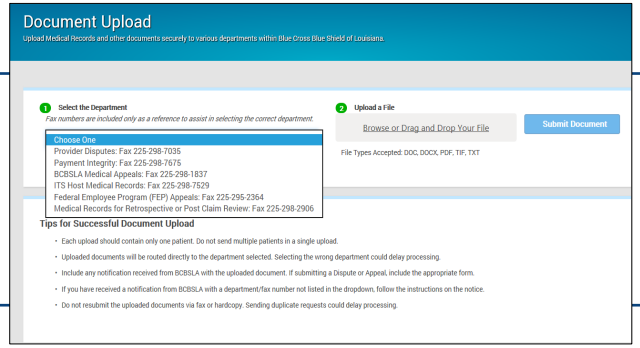
CONFIDENTIALITY NOTICE

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

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

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

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


Document Upload

Upload Medical Records and other documents securely to various departments within Blue Cross Blue Shield of Louisiana.

1 Select the Department

Fax numbers are included only as a reference to assist in selecting the correct department.

Choose One
Provider Disputes: Fax 225-298-7035
Payment Integrity: Fax 225-298-7675
BCBSLA Medical Appeals: Fax 225-298-1837
ITS Host Medical Records: Fax 225-298-7529
Federal Employee Program (FEP) Appeals: Fax 225-295-2364
Medical Records for Retrospective or Post Claim Review: Fax 225-298-2906

2 Upload a File

Browse or Drag and Drop Your File

Submit Document

File Types Accepted: DOC, DOCX, PDF, TIF, TXT

Tips for Successful Document Upload

- Each upload should contain only one patient. Do not send multiple patients in a single upload.
- Uploaded documents will be routed directly to the department selected. Selecting the wrong department could delay processing.
- Include any notification received from BCBSLA with the uploaded document. If submitting a Dispute or Appeal, include the appropriate form.
- If you have received a notification from BCBSLA with a department/fax number not listed in the dropdown, follow the instructions on the notice.
- Do not resubmit the uploaded documents via fax or hardcopy. Sending duplicate requests could delay processing.

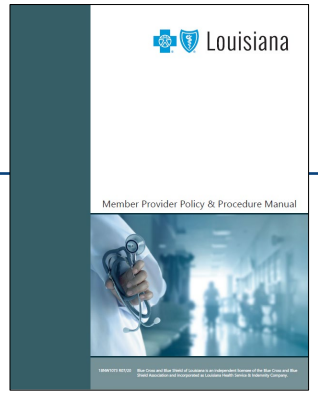
Inpatient Unbundling Policy

The inpatient unbundling policy is effective for all inpatient acute care claims.

- The policy identifies supplies, items and services that should bundle with room and board charges in an inpatient setting, according to CMS guidelines. The services and supplies identified in the inpatient unbundling policy are not separately reimbursable by Blue Cross and are not billable to our members.
- All Blue Cross inpatient acute care claims and itemized bills could be subject to review under this policy. Upon discovery of a supply, item or service identified by the policy, the associated charge will be deemed non-covered/ineligible. Should an adjustment be required to your claim, it will be reflected on your remittance advice.
- EXCD codes related to our provider integrity audits will appear on the payment register for the BCBSLA (excludes FEP and BlueCard claims) members only. Inpatient unbundling will be identified by the code "VAS."

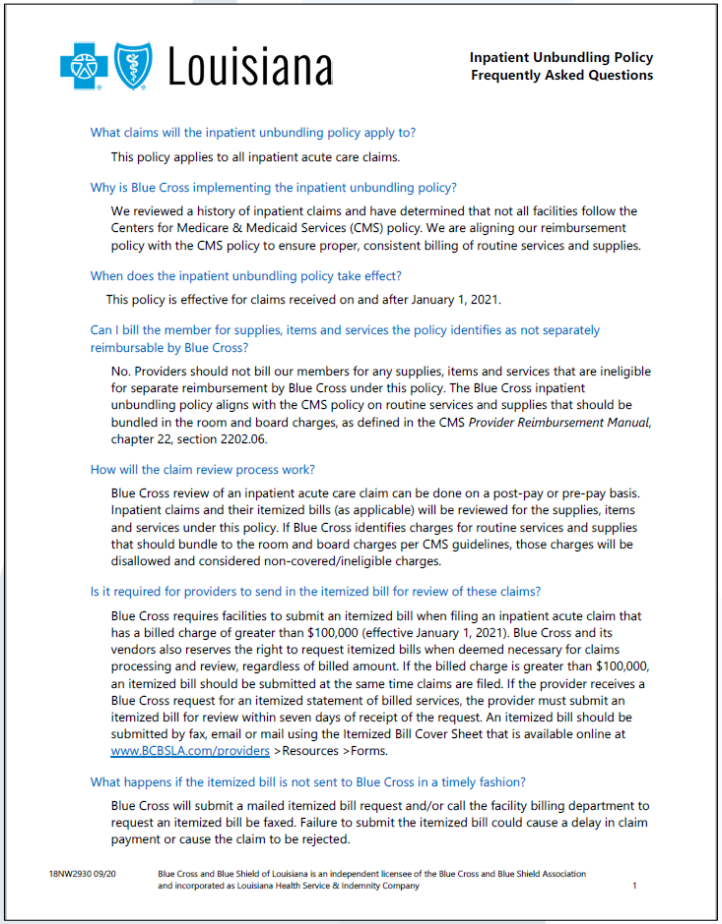
Effective for claims received on or after April 1, 2022. Blue Cross will not separately reimburse for over-the-counter medications that are part of inpatient acute-care claims.

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



Inpatient Unbundling Policy FAQs

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



Louisiana

Inpatient Unbundling Policy Frequently Asked Questions

What claims will the inpatient unbundling policy apply to?

This policy applies to all inpatient acute care claims.

Why is Blue Cross implementing the inpatient unbundling policy?

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

When does the inpatient unbundling policy take effect?

This policy is effective for claims received on and after January 1, 2021.

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

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

How will the claim review process work?

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

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

Blue Cross requires facilities to submit an itemized bill when filing an inpatient acute claim that has a billed charge of greater than $100,000 (effective January 1, 2021). Blue Cross and its vendors also reserves the right to request itemized bills when deemed necessary for claims processing and review, regardless of billed amount. If the billed charge is greater than $100,000, an itemized bill should be submitted at the same time claims are filed. If the provider receives a Blue Cross request for an itemized statement of billed services, the provider must submit an itemized bill for review within seven days of receipt of the request. An itemized bill should be submitted by fax, email or mail using the Itemized Bill Cover Sheet that is available online at www.BCBSLA.com/providers >Resources >Forms.

What happens if the itemized bill is not sent to Blue Cross in a timely fashion?

Blue Cross will submit a mailed itemized bill request and/or call the facility billing department to request an itemized bill be faxed. Failure to submit the itemized bill could cause a delay in claim payment or cause the claim to be rejected.

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1

Readmissions Policy

- Readmissions to the same or an affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed.
- The first admission payment will encompass full reimbursement for treatment of the condition and/or any related complications.
- Providers cannot bill members for service recouped as a result of this policy.
- EXCD codes related to our provider integrity audits will appear on the payment register for the BCBSLA (excludes FEP and BlueCard claims) members only. Readmissions will be identified by the code "VT8."

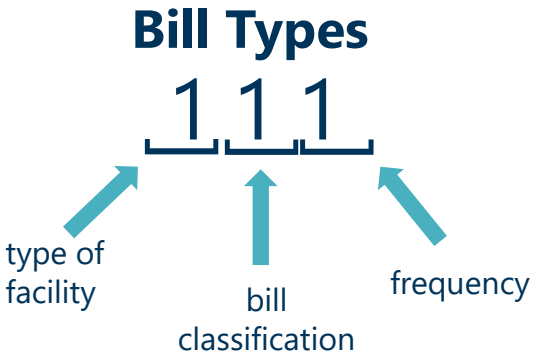
To view the full Blue Cross readmissions policy, refer to *our Member Provider Procedure & Policies Manual*, available in iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" menu option.

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.

Submitting a Corrected Claim

When a claim is refiled for any reason, all services should be reported on the claim.

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

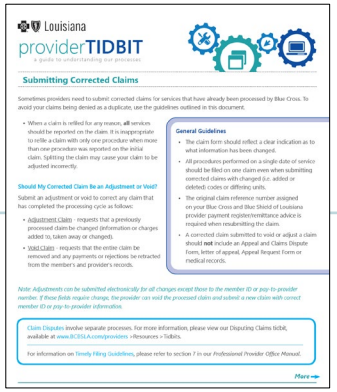
Corrected claims submitted in the 837 format should include the following:

- In Loop 2300 Segment CLM05-03, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Loop 2300 in the REF segment, use "F8" as the qualifier and enter the original claim reference number.

Corrected claims submitted on a UB-04:

- In Block 4, Type of Bill, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Block 64, Document Control Number, enter the original claim reference number.

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


Louisiana
providerTIDBIT
a guide to understanding our processes

Submitting Corrected Claims

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

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

Should My Corrected Claim Be an Adjustment or Void?

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

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

General Guidelines

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

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

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

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

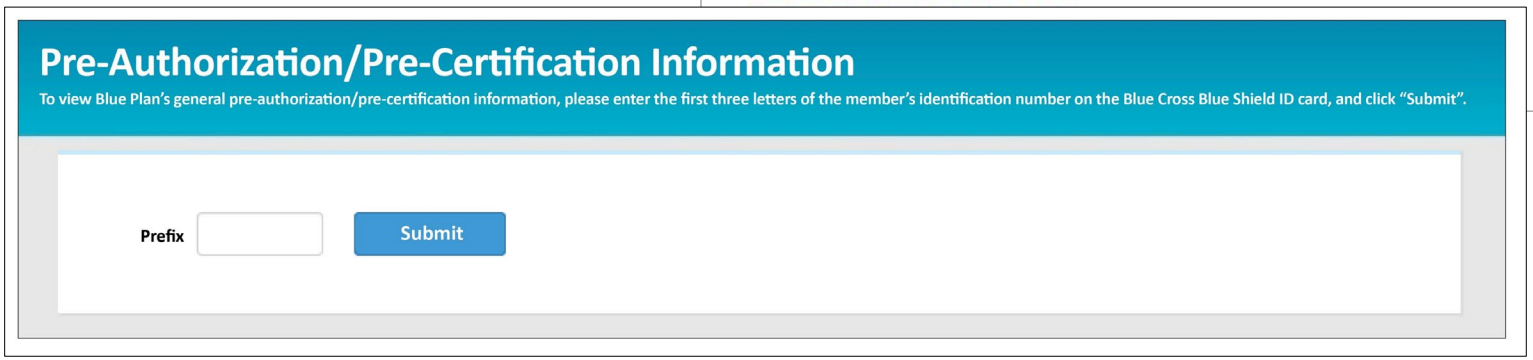
More

Authorizations

Where to Find Authorization Requirements

Do I need an authorization?

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



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

Failure to Obtain an Authorizations

Failure to obtain a prior authorization can result in:

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

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

OGB Authorizations

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

Section 4: Medical Management

OGB PLAN SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required for occupational therapy greater than 50 visits, physical therapy greater than 50 visits and bariatric surgery benefit (enrollment and surgery). Failure to obtain prior authorization for these services will result in the denial of payment for services.

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

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

OUTPATIENT
- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bariatric Benefit (enrollment & surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Infusion Therapy – Includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Insulin Pumps (initial, replacement, supplies & accessories)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300)
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.BCBSLA.com/providers >Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplant
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations tools that are available on iLinkBlue (www.BCBSLA.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations tool.

* High tech imaging & utilization management program services are authorized through the AIM *ProviderPortal*$_{SM}$ by clicking the "AIM Specialty Health Authorizations" link.

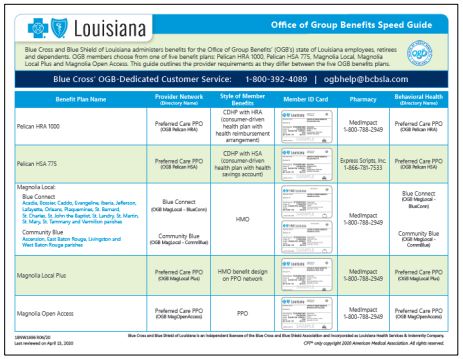
** Behavioral health services are authorized through the New Directions WebPass Portal by clicking the "Behavioral Health Authorizations" link.

For OGB members, failure to obtain prior authorization, when required, will result in the denial of payments for services.

Louisiana — Blue Cross and Blue Shield of Louisiana Professional Provider Office Manual — 4-12 January 2022

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

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



Louisiana — Office of Group Benefits Speed Guide

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

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

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

LBHW5686-NSA/20
Last reviewed on April 15, 2020

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

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

iLinkBlue – Authorizations

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

Tips for Online Authorizations in iLinkBlue

Troubleshooting tips for navigating BCBSLA Authorizations application:

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

BCBSLA Authorization Application FAQs

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

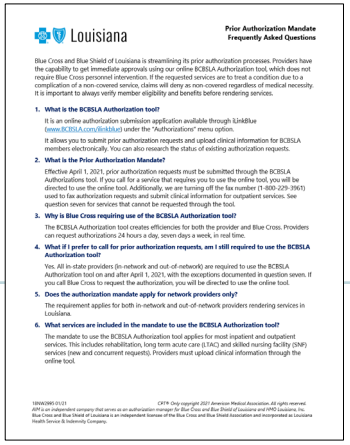
- Yes. Please submit STAT requests through the BCBSLA Authorization application. They will be addressed timely and accordingly.

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

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

How do I submit clinical information to Blue Cross?

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



Louisiana

Prior Authorization Mandate Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is streamlining its prior authorization processes. Providers have the capability to get immediate approvals using our online BCBSLA Authorization tool, which does not require Blue Cross personnel intervention. If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity. It is important to always verify member eligibility and benefits before rendering services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Communicating with BCBSLA regarding Authorizations

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

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

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

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

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

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

Process for Changing a BCBSLA Authorization

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

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

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

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

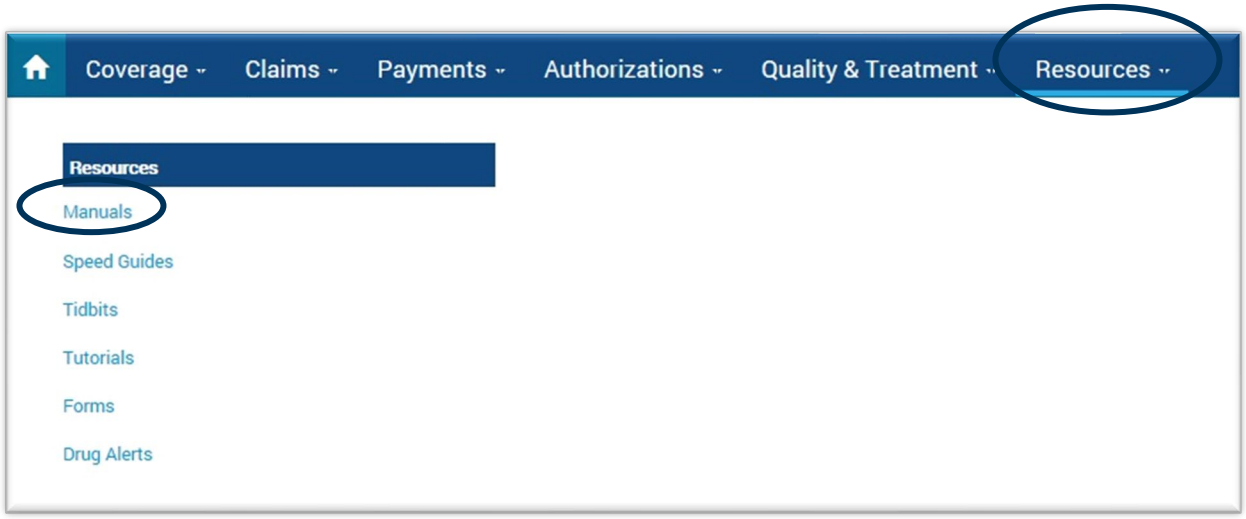
Retrospective Authorization Fax Number

Medical Management Department retrospective authorization fax number:

1-800-515-1150

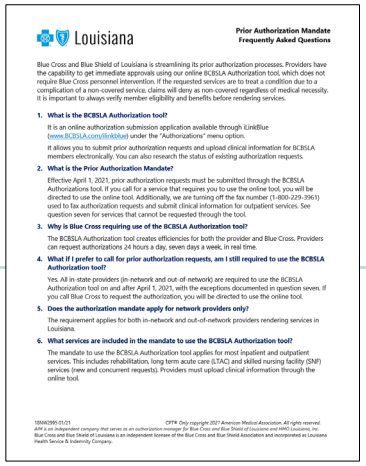
Authorizations Resources

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




Louisiana

BCBSLA Authorizations Application Facility User Guide


Louisiana

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10MM2595-01/21 CPT® Only copyright 2021 American Medical Association. All rights reserved.
AIM is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. 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.

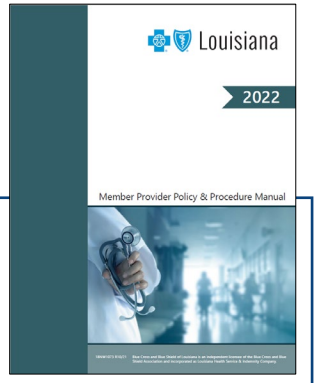
View our Prior Authorization Mandate Frequently Asked Questions at **www.bcbsla.com/providers** >Electronic Services >Authorizations, under the quick links section.

Utilization Management Programs

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

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

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



Additional information can be found in the ***Member Provider Policy & Procedural Manual.*** Find it online at **www.bcbsla.com/providers** >Resources >Manuals**.**

Imaging Authorizations

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

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

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

Top reasons for claim denials related to outpatient imaging authorizations:

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

AIM Specialty Health Code Changes

The American Association released CPT code changes in September 2021.

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

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

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

AIM's Guidelines for Changing Authorization

- AIM allows seven days post the service (retro) for the provider to call and update the original request for MSK program.
- All other programs allows two days, with the exception of some cardiac services that allow 10 days post service.

OptiNet Registration in iLinkBlue

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

Why Is Your Score So Important?

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

OptiNet Registration in iLinkBlue

How Is Your Score Calculated?

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

How to Access OptiNet?

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

Blue Distinction

Blue Distinction Specialty Care Centers

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.

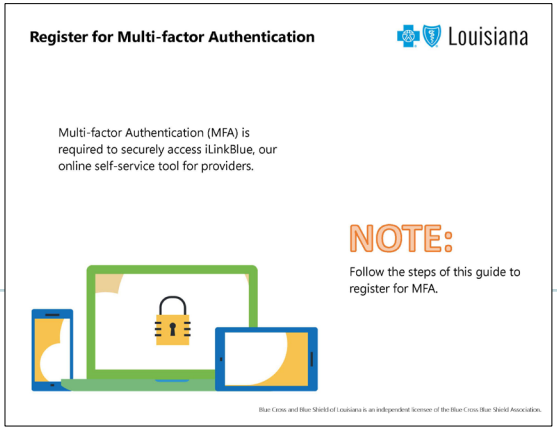
Blue Distinction Level Comparison

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		✓

iLinkBlue Highlights

Multi-factor Authentication verification for all iLinkBlue Users

- Multi-factor Authentication (MFA) is a simplified, convenient and user-friendly self-service interface.
- Effective September 9, 2022, all iLinkBlue users were required to complete additional verification steps before entering iLinkBlue. Choose from various authentication methods, including email, text and smartphone authenticator app. Users must be registered with at least two methods.
- If you previously registered with PING for MFA verification, you do not have to register again.



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

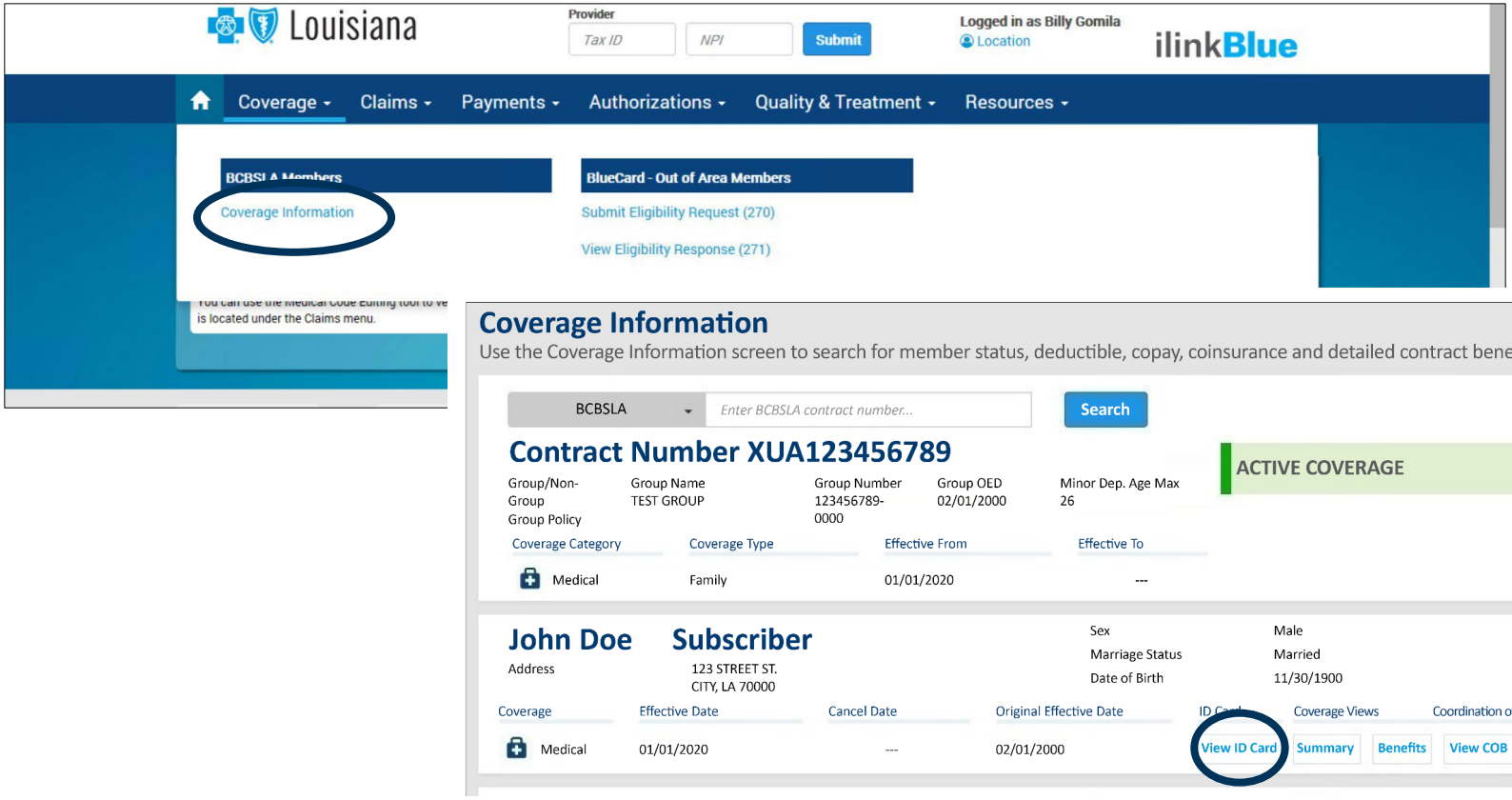
Security Setup Application

- We have introduced a new Security Setup Application for administrative representatives called Delegated Access. It is available through iLinkBlue only.
  - Replaces the existing Sigma Security Setup Tool we previously used.
  - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality.
- We have migrated the data housed in the old tool for your provider organization to the new application.
- You do not need to reload information into the new application. The goal was to create a seamless transition.

If you have questions about these changes, please contact our Provider Relations Department at **provider.relations@bcbsla.com**.

Digital ID Cards in iLinkBlue

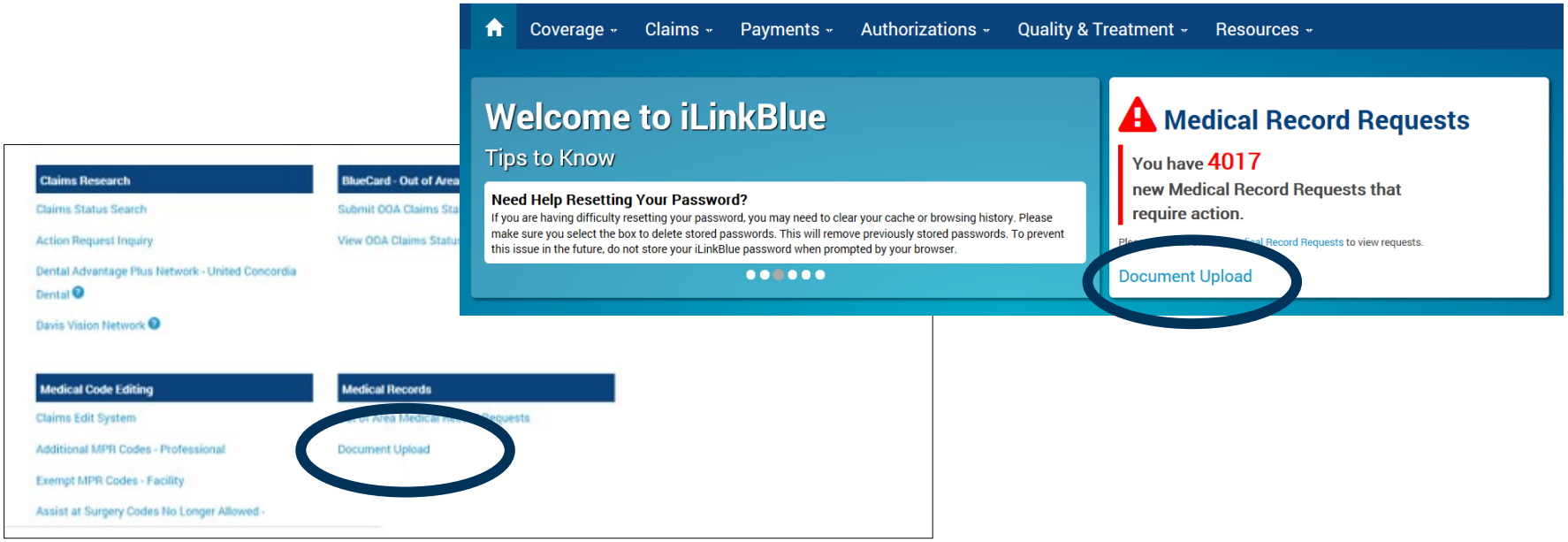
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”



Document Upload Feature

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

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

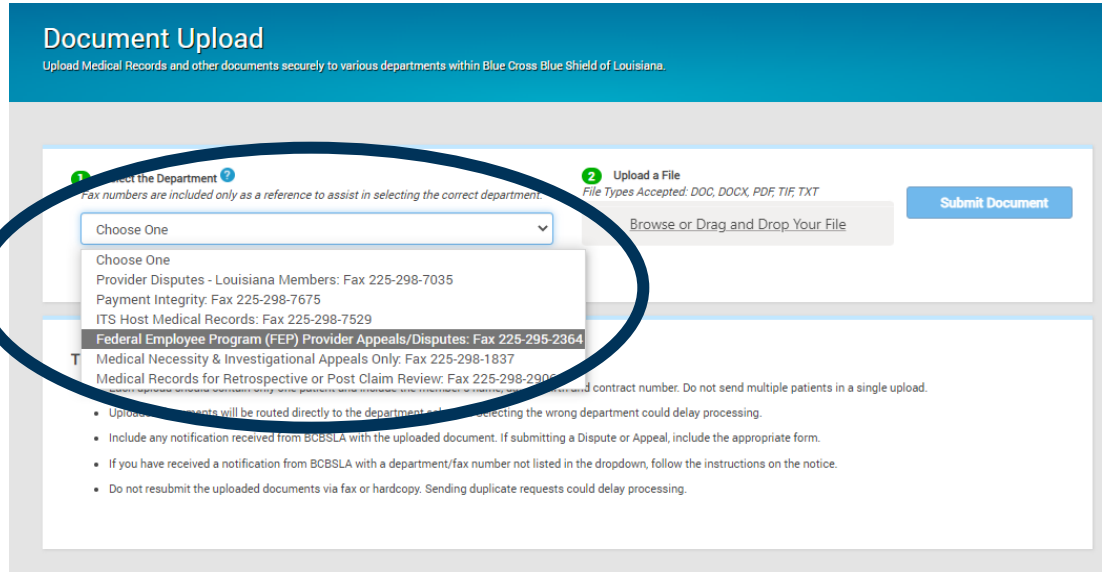


The Document Upload feature can be accessed on iLinkBlue (**www.bcbsla.com/ilinkblue**) or under Claims >Medical Records >Document Upload.

Document Upload Feature

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

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



Document Upload Feature FAQs

What should be included in the uploaded document?

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

What file types are allowed in the upload process?

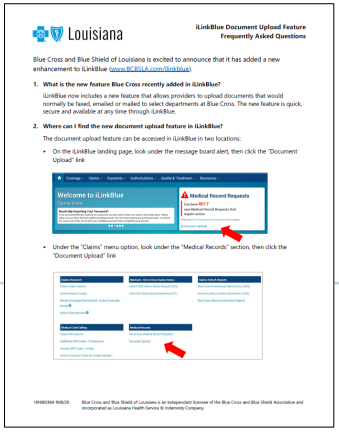
- DOC, DOCX, PDF, TIF, TXT

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

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

Is there a file size limitation?

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


Louisiana

iLinkBlue Document Upload Feature Frequently Asked Questions

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

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

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

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

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

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

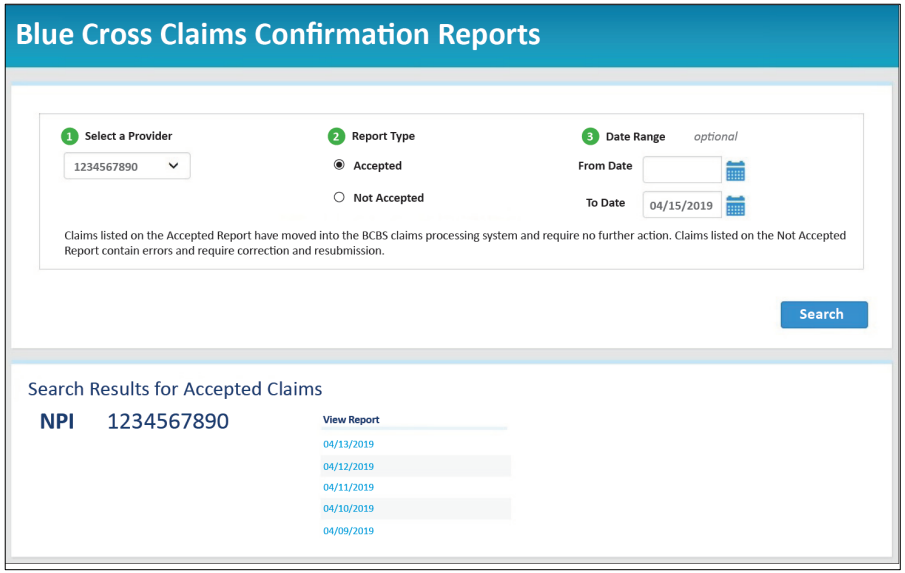
   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

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

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

Blue Cross Claims Confirmation Reports

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



Blue Cross Claims Confirmation Reports

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

Accepted Report

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

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

SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL

PROCESSING DATE: 04-12-19

PAGE 1

837P ACCEPTED REPORT

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

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

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

Not Accepted Report

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

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

SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL

PROCESSING DATE: 04-12-19

PAGE 1

837P NOT ACCEPTED REPORT

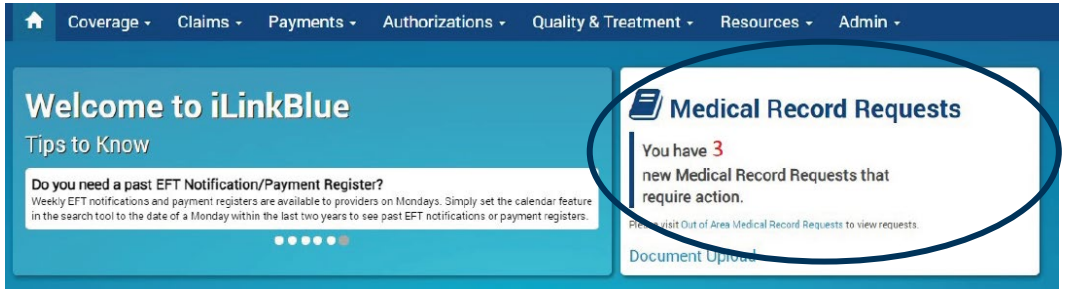
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION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

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

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

BlueCard Medical Record Request

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



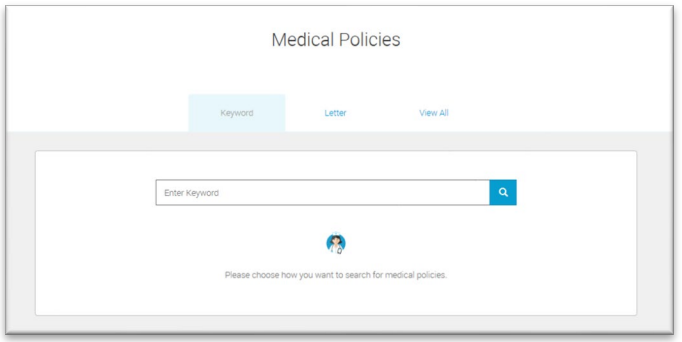
For more information find our Medical Record Guidelines for BlueCard tidbit at **www.bcbsla.com/providers** >Resources >Tidbits.

Accessing Our Medical Policies

- From the iLinkBlue menu, select “Authorizations” then “Medical Policy Guidelines” to open the **Medical Policy Index**.
- Policies are listed in alpha order, or you may search by keyword, procedure code, policy name or policy number.

1.

2.



Medical policies are reviewed, updated and developed every month. We publish these updates in our quarterly *Provider Network News* newsletters, available online at **www.bcbsla.com/providers** >Newsletters.

Our medical policies include: coverage eligibility, background information related to technology, devices and treatments, technology assessments, literature sources and the rationale for coverage determinations.

FEP Medical Policy Guidelines

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

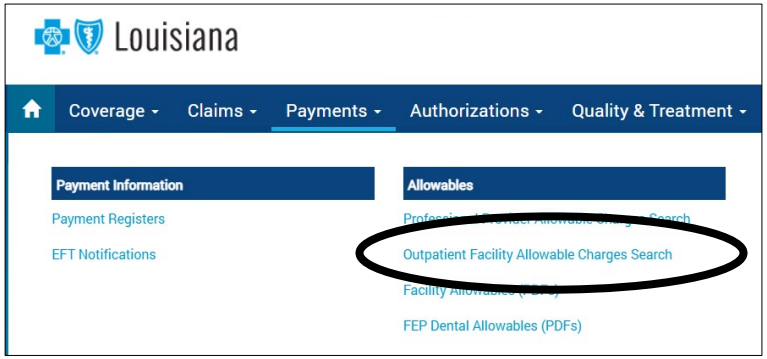
Downloadable Facility Fee Schedules Now Available

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

Important facts to know about this enhancement:

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

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



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

Healthcare Effectiveness Data and Information Set (HEDIS®)

What is HEDIS?

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

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

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

Purpose of HEDIS Results

Health plans use HEDIS performance results to:

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

HEDIS Data Collection Methods

HEDIS data is collected in three ways:

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

Medical Record Requests

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

Medical Record Requests

Medical Request Reminders:

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

Tips for Improving Quality of Care HEDIS

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

When our members/patients are healthy, everyone benefits.

Questions Related to HEDIS

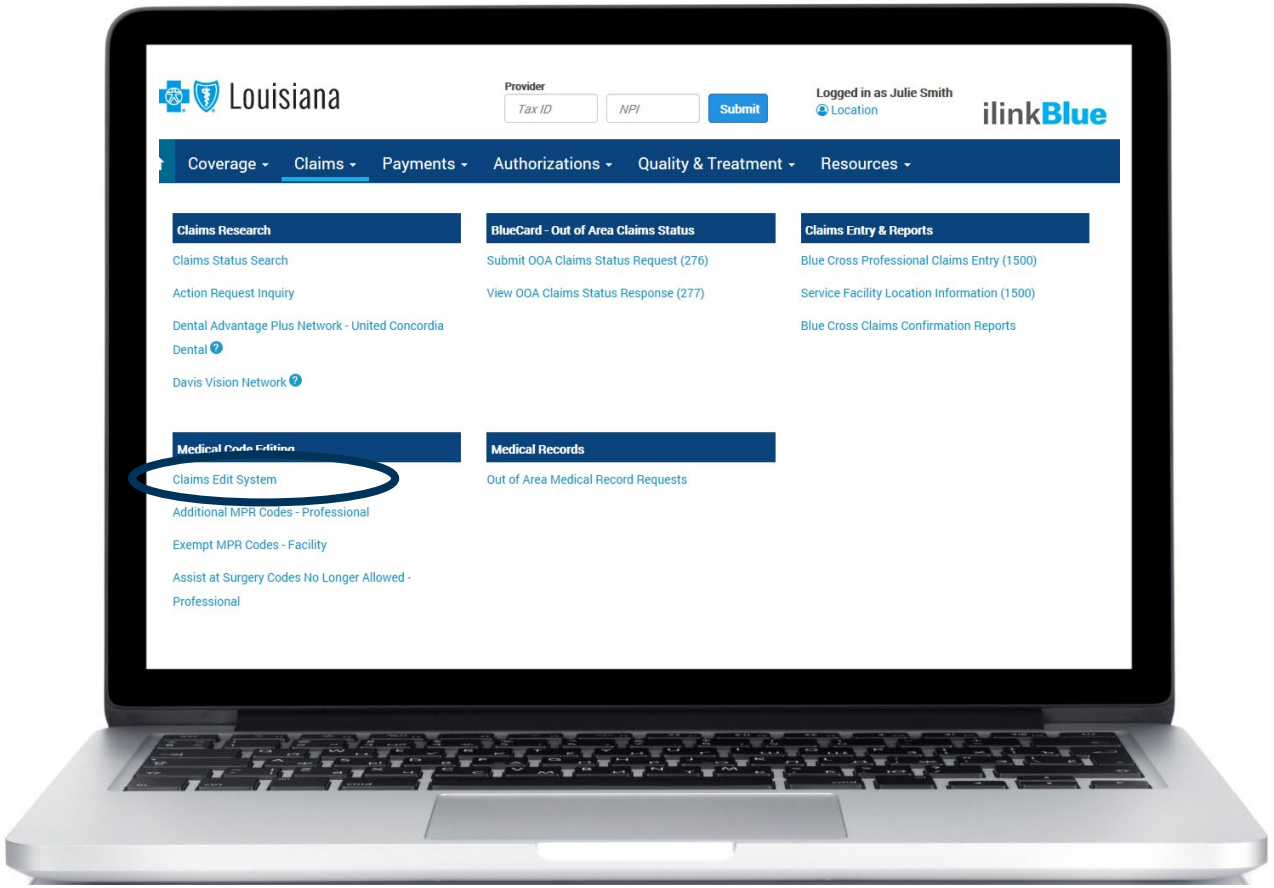
If you have question related to HEDIS measures or medical record collections, please contact the Health and Quality Department.

HEDISTeam@bcbsla.com

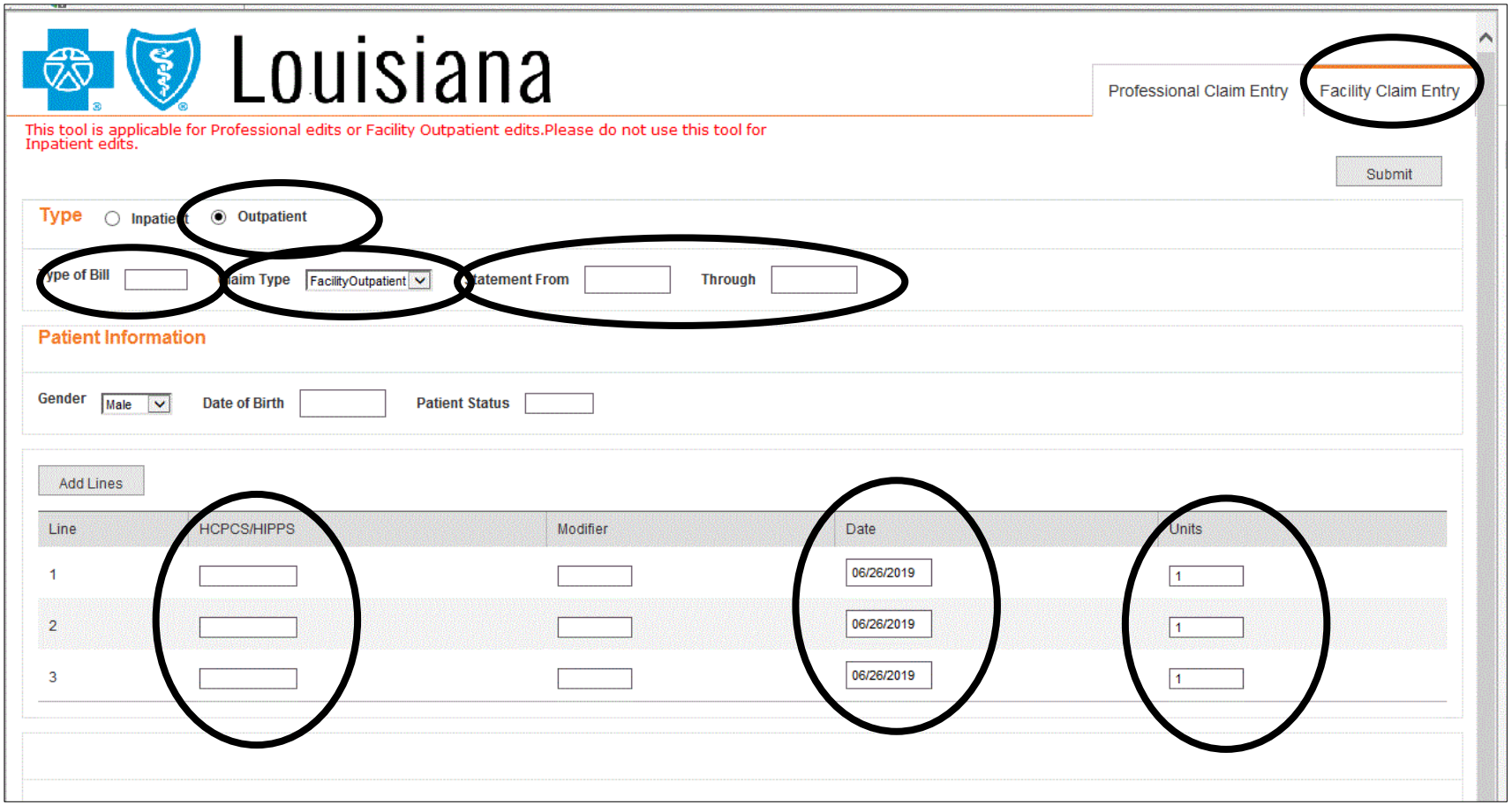
Claims Editing

Claims Editing System

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



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.

Claims Resolution

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 (AR)
- Provider Disputes
- Medical Appeals
- Administrative Appeals & Grievances *(for members)*

Submitting an Action Request is a great option for getting a quick and accurate resolution for your claims issues and:

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

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

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

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: Only complete 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

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.

- 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.

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

Authorizations and claims denied as investigational or not medically necessary ONLY.

To properly request a review of a medical necessity or investigational denial, submit the Medical Appeal Request Form that was included in the initial denial notice.

- Include rationale and supporting clinical records.
- Physician signature is ONLY required if the request to appeal is expedited.
- Peer-to-peer reviews are **not** available once an appeal has been initiated.

Expedited/Urgent Appeals

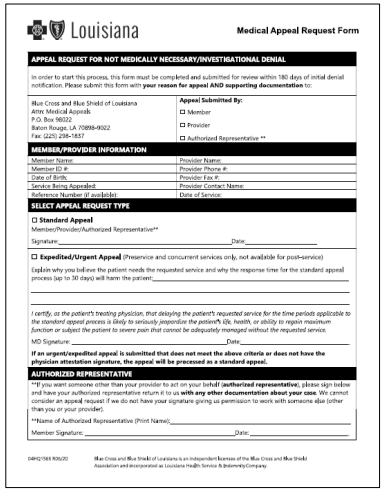
- Only available if services have not yet been rendered.
- Can be requested verbally or in writing.
- Must be completed within 72 hours of receipt.

Standard First Level Appeals

- Must be in writing.
- First level internal appeals must be received within 180 days of *initial* denial. (COVID timeframe extension may be applicable.)

Second Level/External Appeals

- Timeframes and external review eligibility are dependent on the member's contract.
- Appeals eligible for external review through IRO **must include** External Appeal form signed by the member or authorized representative. This form will be included with the first level appeal decision when eligible.



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:_____

04HQ1569 R09/20 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.

SEND TO:
Through iLinkBlue (**www.bcbsla.com/iLinkBlue**), click "Document Upload," then "Medical Necessity & Investigational Appeals Only" in the drop-down menu.

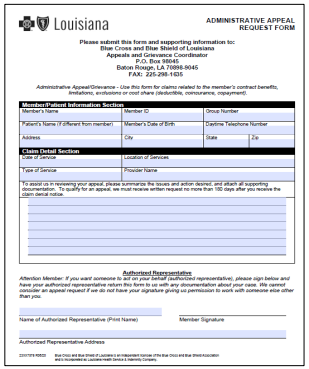
Blue Cross and Blue Shield of Louisiana
Attn: Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

Fax: (225) 298-1837

. This form can also be found online by going to **www.bcbsla.com** >Helpful Links >Forms and Tools.

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 2nd level appeal rights, they have 60 days to submit.



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ADMINISTRATIVE APPEAL REQUEST FORM

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

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

Member/Patient Information Section

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

Claim Detail Section

Date of Service	Location of Services
Type of Service	Provider Name

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

Authorized Representative

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

Name of Authorized Representative (Print Name) Member Signature

Authorized Representative Address

SEND TO:

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

Fax: 225-298-1635

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

Provider Disputes

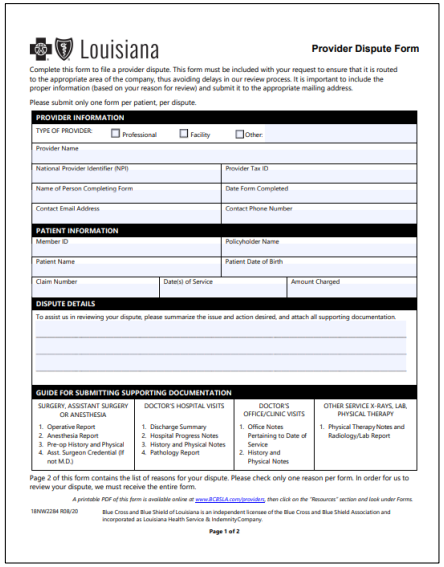
A provider dispute is different than an appeal or grievance. Provider disputes are defined as written requests from our participating network providers (**Network Providers ONLY**) questioning (or disputing) their allowable charge of a processed claim. Disputes could involve the following:

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

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

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

Fax: (225) 298-7035



Louisiana

Provider Dispute Form

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

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

Contact Email Address | Contact Phone Number

PATIENT INFORMATION

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

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

DISPUTE DETAILS

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

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

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

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

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

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Page 1 of 2

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

Disputes Process for Claims

FIRST LEVEL REVIEW

- Once a refund letter is sent, the provider has 30 days to respond and request a first-level dispute.
- If no refund is requested, provider has 15 months to dispute.
- Blue Cross has 60 days to review and respond in writing with a decision to the provider.

Disputes Process for Claims

SECOND (STAFF) LEVEL REVIEW

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

Disputes Process for Claims

THIRD (MANAGEMENT) LEVEL REVIEW

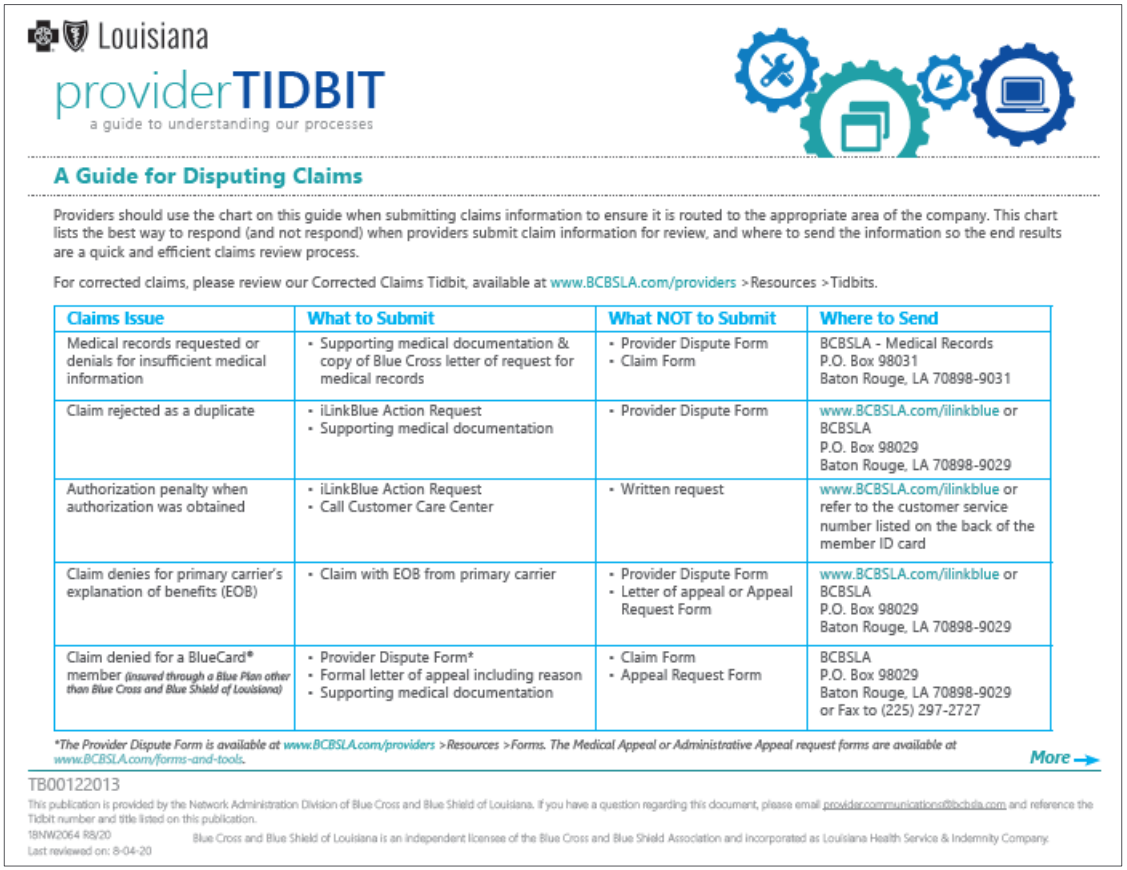
- Once a decision letter is sent, provider has 30 days to respond in writing to request a third-level review (management-level review).
- Case is presented and decision is made by management.

Disputes Process for Claims

ARBITRATION

- Once a decision letter is sent, the provider has the right to request arbitration.
- Arbitration is the final resolution and handled by an external arbiter.

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 providercommunications@bcbsla.com and reference the Tidbit number and title listed on this publication.

18NW2064 RB/20

Last reviewed on: 8-04-20

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www.bcbsla.com/providers >Resources >Tidbits

Lab Benefit Management Program

Laboratory Benefit Management Program

Effective **May 15, 2022**, Blue Cross partnered with Avalon Healthcare Solutions to offer a new laboratory benefit management program.

Avalon provides:

- Routine testing management services to ensure enforcement of laboratory policies.
- Automated review of high-volume, low-cost laboratory claims.

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

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 Lab Reimbursement Policies. Go to **www.bcbsla.com** and look under the "Helpful Links" section at the bottom of the page.

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	**1-877-250-9167**

For information NOT available on iLinkBlue

Other Provider Phone Lines

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

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

Network Administration – **1-800-716-2299**

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding provider credentialing and data managment
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding administrative representative setup

Updated Phone Numbers

Health Services Division – 1-800-716-2299

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

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

Provider Relations

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

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

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

Yolanda Trahan
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Marie Davis
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll, Acadia

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

Paden Mouton, Supervisor

Provider Contracting

Jason Heck*, Director – jason.heck@bcbsla.com

Cora LeBlanc, Sr. Provider Network Development Representative – **cora.leblanc@bcbsla.com**
St. John The Baptist, Terrebonne, Lafourche, St. Charles, St. James, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula, Lasalle parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@bcbsla.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension, Assumption, Iberville, Caddo, Bossier, Webster, Claiborne parishes

Dayna Roy, Sr. Provider Network Development Representative – **dayna.roy@bcbsla.com**
Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Rapides, St. Landry, St. Martin, Vermilion, Vernon parishes

Diana Bercaw, Sr. Provider Network Development Representative – **diana.bercaw@bcbsla.com**
Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangipahoa, Washington parishes

*Jason Heck works with providers in the following parishes: Desoto, Red River, Bienville, Sabine, Natchitoches, Winn, Jackson and Lincoln

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

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

Provider Credentialing & Data Management

Vielka Valdez, Director, Provider Network Operations
vielka.valdez@bcbsla.com

Venessa Williams, Manager, Provider Information
venessa.williams@bcbsla.com

Anne Monroe, Supervisor, Provider Information
anne.monroe@bcbsla.com

Mallory Trant, Supervisor, Provider Information (Credentialing)
mallory.trant@bcbsla.com

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Provider Credentialing & Data Management Department.

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

Your Feedback is Important to Us!

Have you completed the Provider Engagement Survey? By completing the survey, you could win a gift card. The top prize is $500!

If you have not received the survey link, email **provider.communications@bcbsla.com** with "Provider Engagement Survey" in the subject line.

Questions?

Appendix

Updated Outpatient Code Ranges

We updated the Outpatient Procedure Services and Diagnostic and Therapeutic Services code ranges based on reviews of the 2022 CPT® and HCPCS codes. As a result of our most recent review, we are adding the following codes, effective July 1, 2022.

Diagnostic and Therapeutic Services code range:

90584	0330U	0729T	C9095	J2779
0323U	0331U	0731T	C9096	J2998
0324U	0716T	0732T	C9097	J3299
0325U	0721T	0733T	C9098	J9331
0326U	0722T	0734T	J0739	J9332
0327U	0723T	A9596	J1306	Q4259
0328U	0724T	A9601	J1551	Q4260
0329U	0728T	C9094	J2356	Q4261

Outpatient Procedure Services code range:

0714T	0727T
0715T	0730T
0717T	0735T
0718T	0736T
0719T	0737T
0720T	G0308
0725T	G0309
0726T	

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

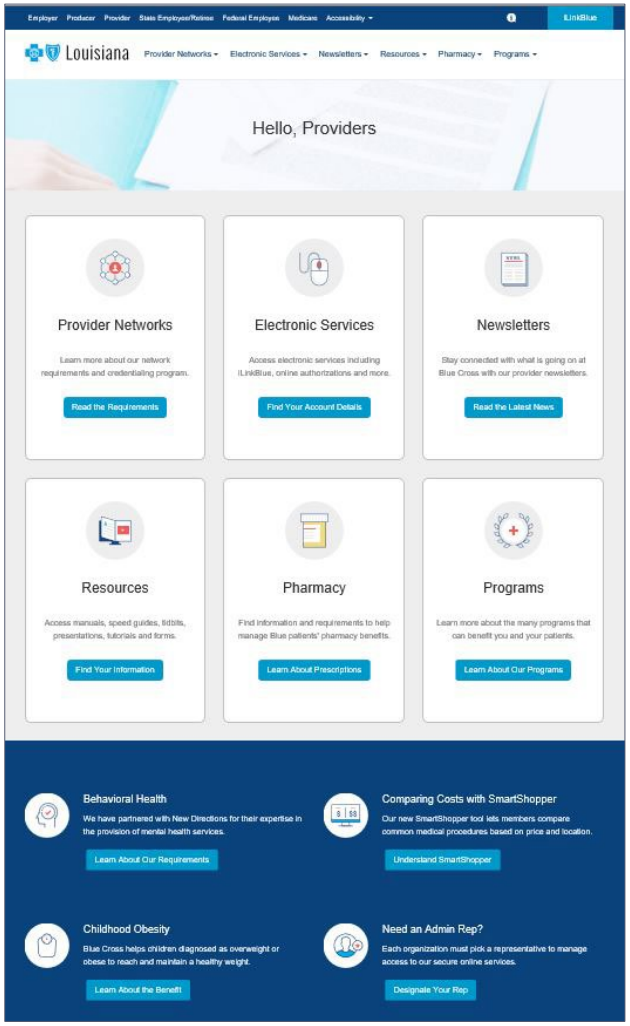
Updated Facility Drug Allowable Supplemental Listing

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

As a result of that review the following HCPCS codes were added to our system, effective July 1, 2022:

A9596	J0739	J3299
A9601	J1306	J9331
C9094	J1551	J9332
C9095	J2356	Q4259
C9096	J2779	Q4260
C9097	J2998	Q4261

Provider Page



www.bcbsla.com/providers

The Provider page is home to online resources such as:

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

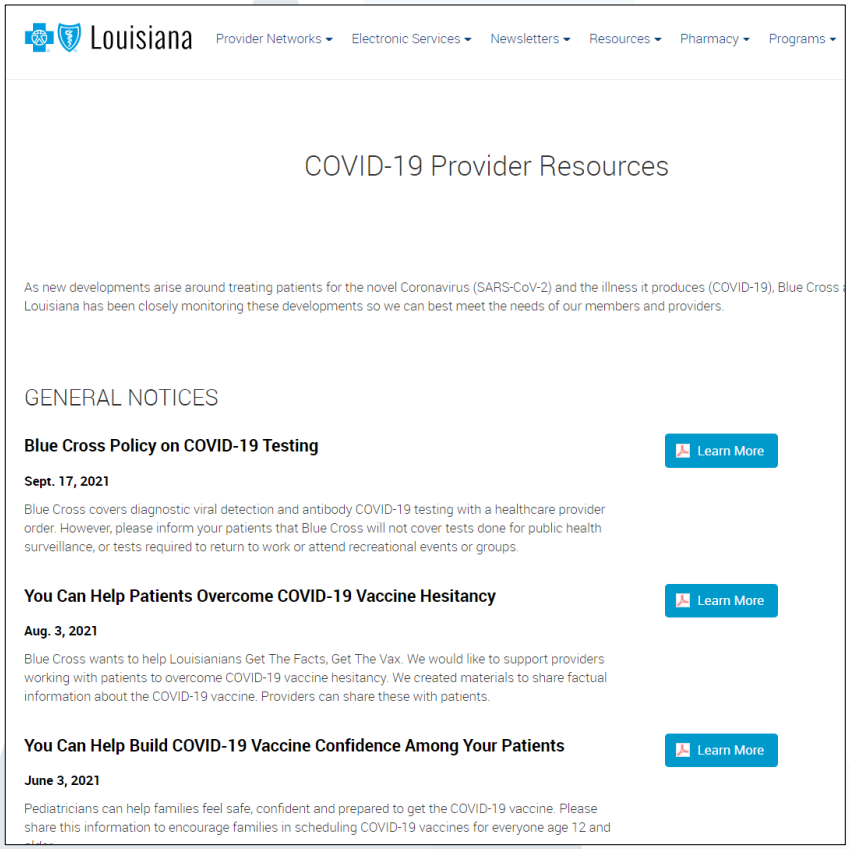
COVID-19 Provider Resources Page

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

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

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

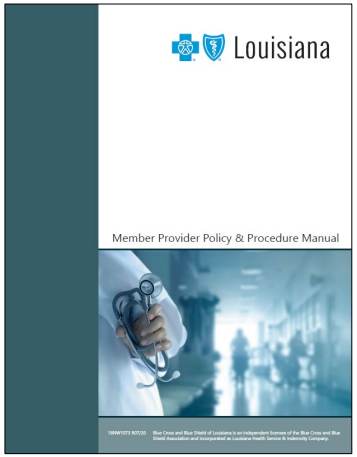
Check this page often for updated information.

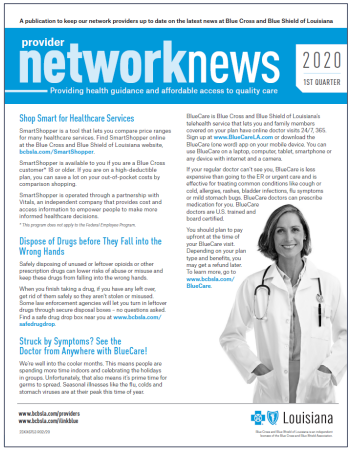


Manuals & Newsletters

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

www.bcbsla.com/providers >Resources





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

www.bcbsla.com/providers >Newsletters

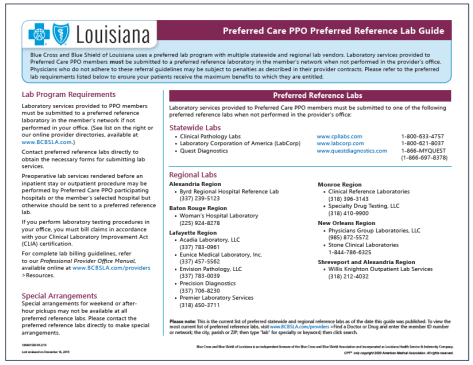
Not Getting Our Newsletters Electronically?

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

Speed Guides & Tidbits

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

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


Louisiana
Preferred Care PPO Preferred Reference Lab Guide

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

Lab Program Requirements

Laboratory services provided to PPO members must be submitted to a preferred reference laboratory in the member's network if not performed in your office. (See list on the right or our online provider directories, available at www.BCBSLA.com.)

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services.

Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO participating hospitals or the member's selected hospital but otherwise should be sent to a preferred reference lab.

If you perform laboratory testing procedures in your office, you must bill claims in accordance with your Clinical Laboratory Improvement Act (CLIA) certification.

For complete lab billing guidelines, refer to our *Professional Provider Office Manual*, available online at www.BCBSLA.com/providers >Resources.

Special Arrangements

Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

Preferred Reference Labs

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

Statewide Labs

- Clinical Pathology Labs — www.cplabs.com — 1-800-633-4757
- Laboratory Corporation of America (LabCorp) — www.labcorp.com — 1-800-621-8007
- Quest Diagnostics — www.questdiagnostics.com — 1-866-MYQUEST (1-866-697-8378)

Regional Labs

Alexandria Region
- Byrd Regional Hospital Reference Lab (337) 239-5123

Baton Rouge Region
- Woman's Hospital Laboratory (225) 924-8278

Lafayette Region
- Acadia Laboratory, LLC (337) 783-0981
- Eunice Medical Laboratory, Inc. (337) 457-5562
- Envision Pathology, LLC (337) 783-0039
- Precision Diagnostics (337) 706-8230
- Premier Laboratory Services (318) 450-3711

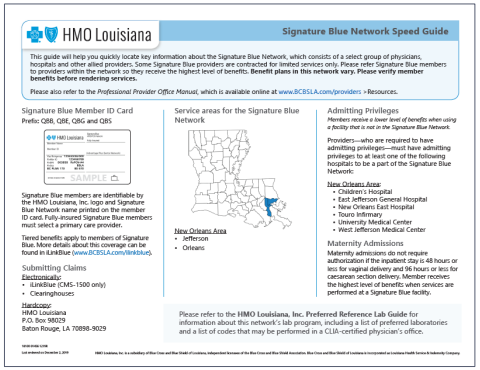
Monroe Region
- Clinical Reference Laboratories (318) 396-3143
- Specialty Drug Testing, LLC (318) 410-9000

New Orleans Region
- Physicians Group Laboratories, LLC (985) 872-5572
- Stone Clinical Laboratories 1-844-786-6325

Shreveport and Alexandria Region
- Willis Knighton Outpatient Lab Services (318) 212-4032

Please note: This is the current list of preferred statewide and regional reference labs as of the date this guide was published. To view the most current list of preferred reference labs, visit www.BCBSLA.com/providers >Find a Doctor or Drug and enter the member ID number or network, the city, parish or ZIP. Then type "lab" for specialty or keyword, then click search.

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.


HMO Louisiana
Signature Blue Network Speed Guide

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

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

Signature Blue Member ID Card

Prefix: QBB, QBE, QBG and QBS

SAMPLE

Signature Blue members are identifiable by the HMO Louisiana, Inc. logo and Signature Blue Network name printed on the member ID card. Fully-insured Signature Blue members must select a primary care provider.

Tiered benefits apply to members of Signature Blue. More details about this coverage can be found in iLinkBlue (www.BCBSLA.com/ilinkblue).

Submitting Claims

Electronically:
- iLinkBlue (CMS-1500 only)
- Clearinghouses

Hardcopy:
HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Service areas for the Signature Blue Network

New Orleans Area
- Jefferson
- Orleans

Admitting Privileges

Members receive a lower level of benefits when using a facility that is not in the Signature Blue Network.

Providers—who are required to have admitting privileges—must have admitting privileges to at least one of the following hospitals to be a part of the Signature Blue Network:

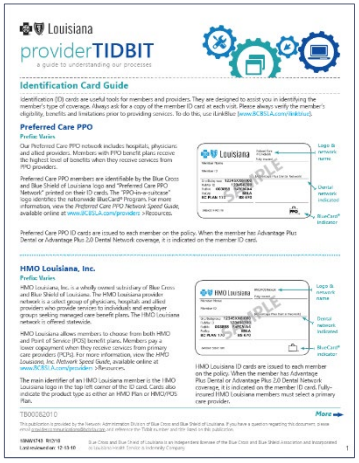
New Orleans Area:
- Children's Hospital
- East Jefferson General Hospital
- New Orleans East Hospital
- Touro Infirmary
- University Medical Center
- West Jefferson Medical Center

Maternity Admissions

Maternity admissions do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery. Member receives the highest level of benefits when services are performed at a Signature Blue facility.

Please refer to the **HMO Louisiana, Inc. Preferred Reference Lab Guide** for information about this network's lab program, including a list of preferred laboratories and a list of codes that may be performed in a CLIA-certified physician's office.

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


Louisiana
providerTIDBIT
a guide to understanding our processes

Identification Card Guide

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

Preferred Care PPO

Prefix: Varies

Our Preferred Care PPO network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.

Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and "Preferred Care PPO Network" printed on their ID cards. The "PPO-in-a-suitcase" logo identifies this nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

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

HMO Louisiana, Inc.

Prefix: Varies

HMO Louisiana, Inc. is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. The HMO Louisiana provider network is a select group of physicians, hospitals and allied providers who provide services to individuals and employer groups in seeking managed care benefit plans. The HMO Louisiana network is offered statewide.

HMO Louisiana allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a lower copayment when they receive services from primary care providers (PCPs). For more information, view the *HMO Louisiana, Inc. Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

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

HMO Louisiana ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card. Fully-insured HMO Louisiana members must select a primary care provider.

More

TBDOCBL2010

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 providernetworkadmin@bcbsla.com and reference the Tidbit number and title listed on the publication.

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Louisiana
providerTIDBIT
a guide to understanding our processes

Automated Benefits & Claim Status

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

Customer Care Center 1-800-922-8866

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

Please have the following information ready when calling:

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

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

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

(Pause for you to say or key-in a policy type)

Please say or enter your 16-digit NPI. (Pause for you to say or key-in NPI)

Please say or enter your nine-digit Tax ID. (Pause for you to say or key-in Tax ID)

*Note: If calling about a vision policy you will be asked if your call is for routine eye coverage, such as an eye exam/eye prescription glasses, or contacts. Answer "yes" to route your call to an appropriate representative. Answer "no" to continue to the Provider Menu to reach the service needed.

Provider Menu

Provider menu. Which are you calling about?

1. Benefits
2. Claims
3. Authorizations
4. An Out-of-state Policy
5. A Payment Register Fax, or
6. None of the Above

More

TBCOSSCI2010

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 providernetworkadmin@bcbsla.com and reference the Tidbit number and title listed on the publication.

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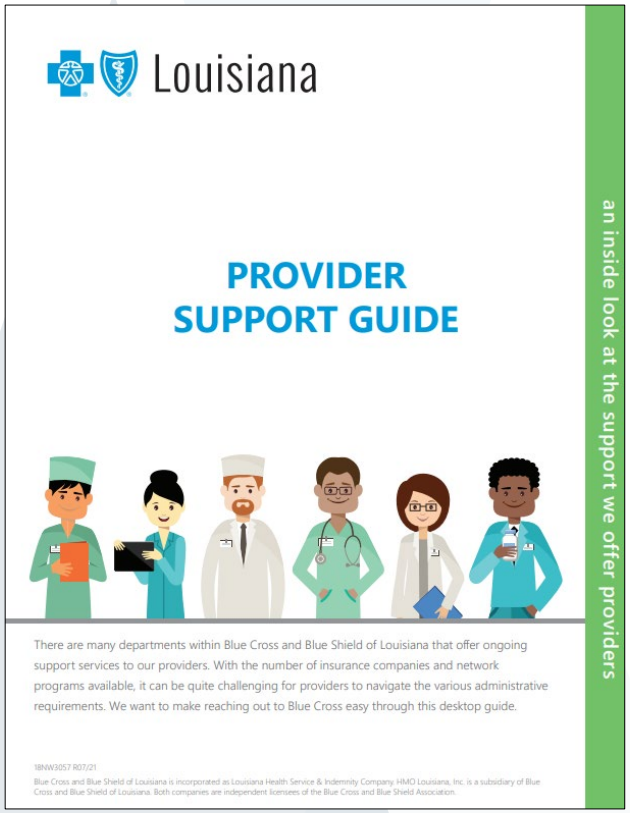
Provider Tidbits are quick guides designed to help you with our current business processes.

www.bcbsla.com/providers
>Resources >Tidbits

Provider Resource Guide

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



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