# Welcome to the Blue Cross Network

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

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

**How to submit questions:**

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

Louisiana

# Welcome to the Blue Cross Network – *Professional Webinar*

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

August 2022

# Our Networks

# Network Overview

Blue Cross has comprehensive provider networks.

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

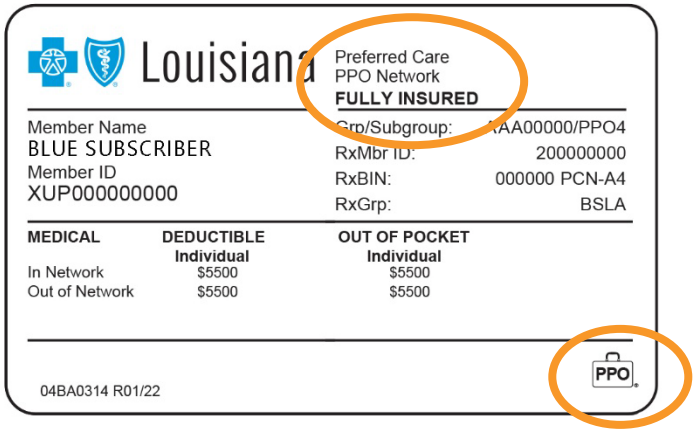
- Preferred Care PPO
- HMO Louisiana, Inc.
- Blue Connect
- BlueHPN
- Community Blue
- Precision Blue
- Signature Blue
- Blue Advantage (HMO) | Blue Advantage (PPO)

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

# Preferred Care PPO

## Prefix Varies

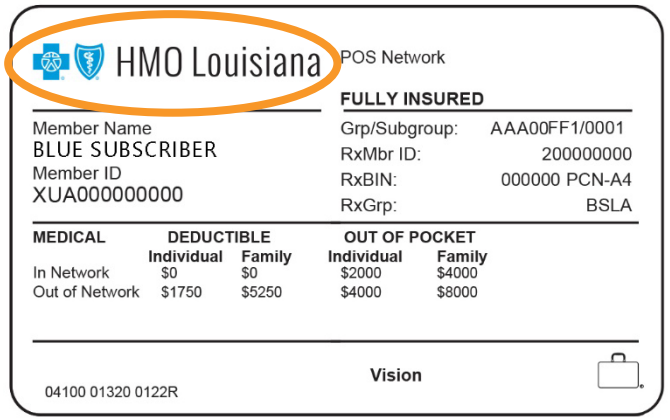
- Our Preferred Care PPO Network is available statewide.
- Members with PPO benefits receive the **highest level of benefits** when they receive services from PPO providers.
- Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network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




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

## Prefix Varies

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

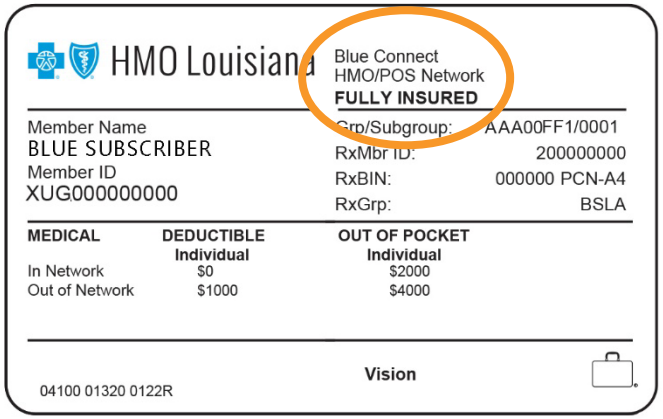


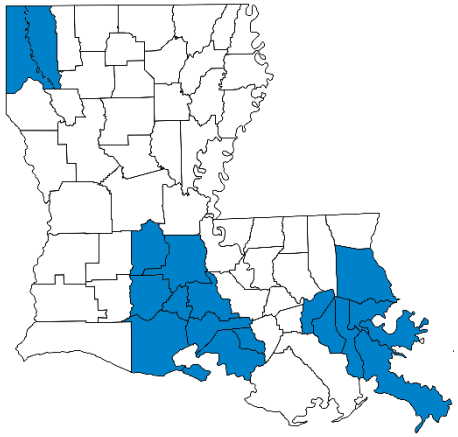

For more information, view the *HMO Louisiana Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

# Blue Connect

## Prefixes: XUF, XUG, XUU and XUV

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



### New Orleans area

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

### Shreveport area

Bossier and Caddo parishes

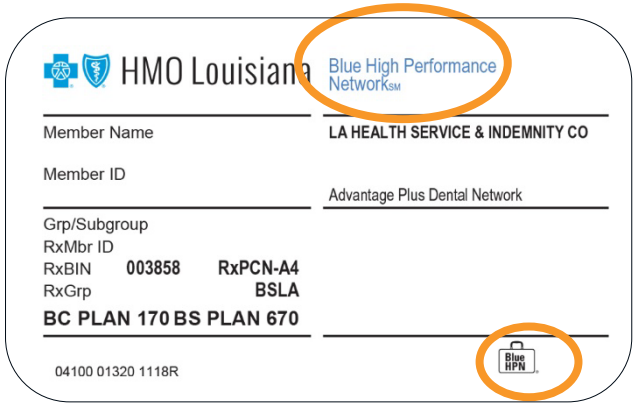
### Lafayette area

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

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

# BlueHPN

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




### Lafayette area

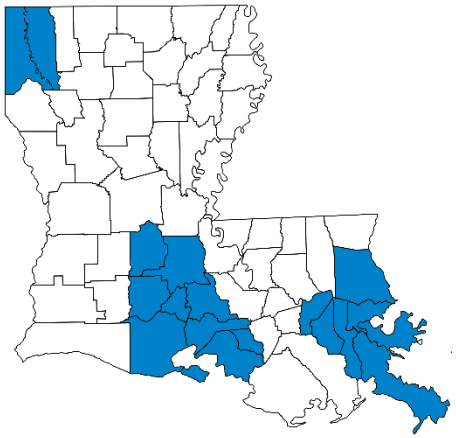
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

### New Orleans area

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

### Shreveport area

Bossier and Caddo parishes



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

Blue HPN

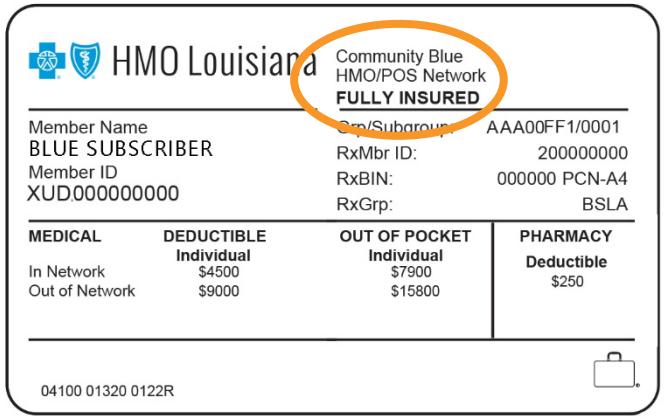
For more information, view the *BlueHPN Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

## Prefixes: XUD, XUJ and XUT

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

### Baton Rouge area:

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


HMO Louisiana
Community Blue
HMO/POS Network
FULLY INSURED
Member Name
BLUE SUBSCRIBER
Member ID
XUD000000000
Grp/Subgroup: AAA00FF1/0001
RxMbr ID: 200000000
RxBIN: 000000 PCN-A4
RxGrp: BSLA

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

04100 01320 0122R

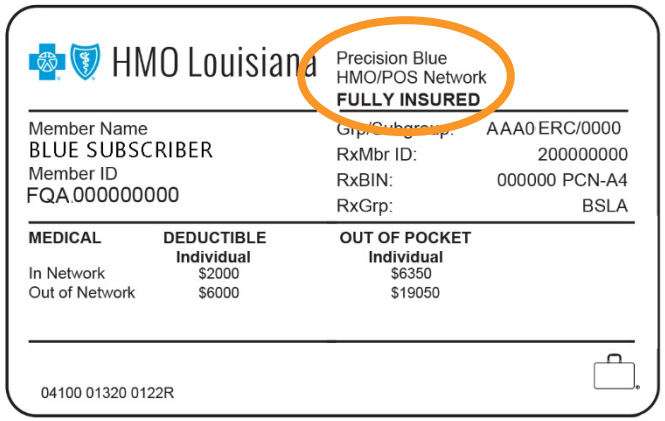
Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Community Blue Network.

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

# Precision Blue

## Prefixes: FQA, FQT or FQW

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

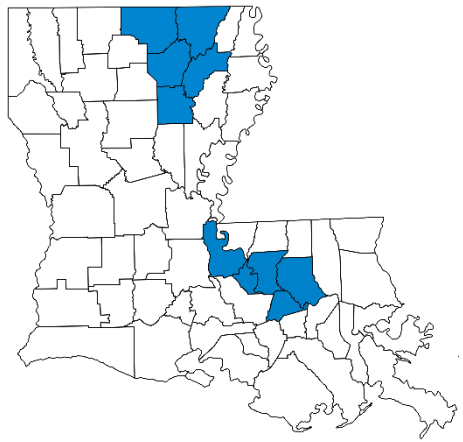



### Baton Rouge area:

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

### Greater Monroe/West Monroe area:

Caldwell, Morehouse, Ouachita, Richland, Union parishes

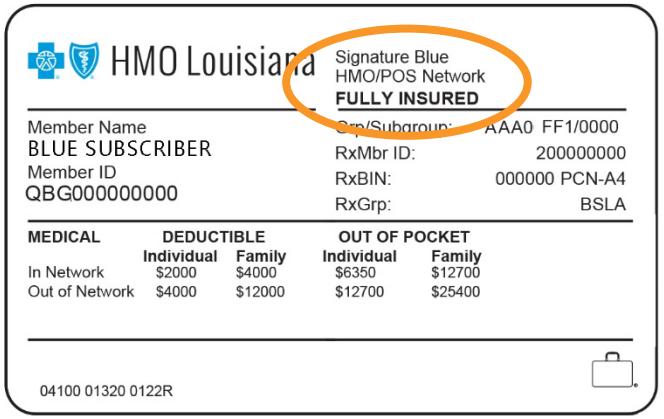


Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Precision Blue Network.

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

## Prefixes: QBB, QBE, QBG and QBS

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


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

### New Orleans area:

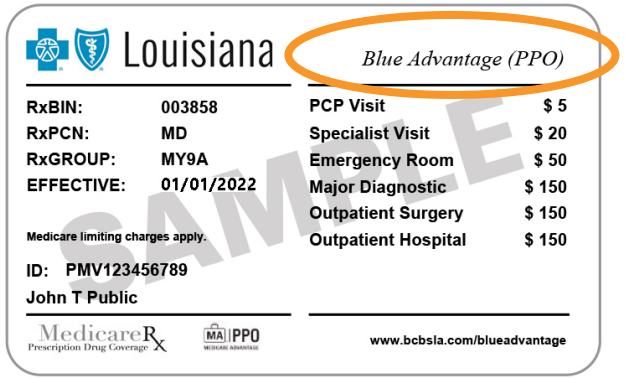
Jefferson and Orleans parishes

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

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

## Prefixes: PMV and MDV

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




**Prefix: PMV**


**Prefix: MDV**

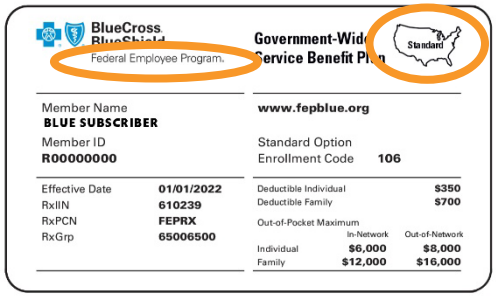
# Federal Employee Program

## Prefix: R (followed by 8 digits)

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

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

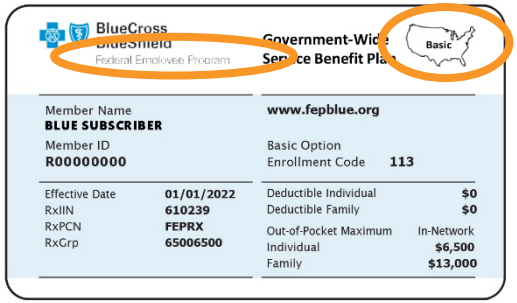
### Standard




✓ In-network

✓ Out-of-network

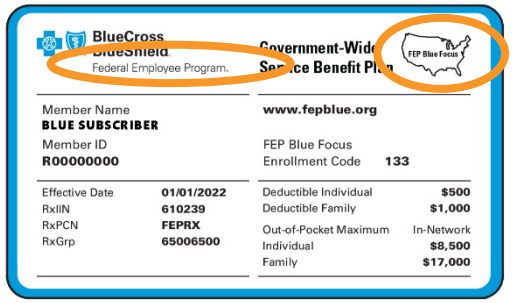
### Basic




✓ In-network

X Out-of-network

### FEP Blue Focus




✓ **LIMITED** in-network

X Out-of-network

# Office of Group Benefits (OGB) Benefit Plans

## Prefixes: OGS, LZB or LXS

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

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

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

**Pelican HRA 775** (Active Employees Only)

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

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

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

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

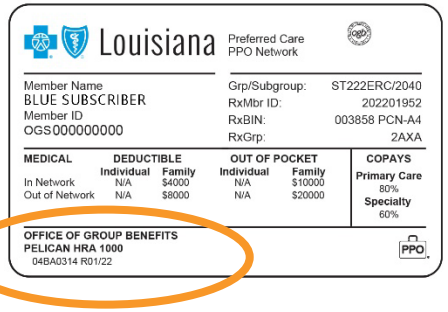
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

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

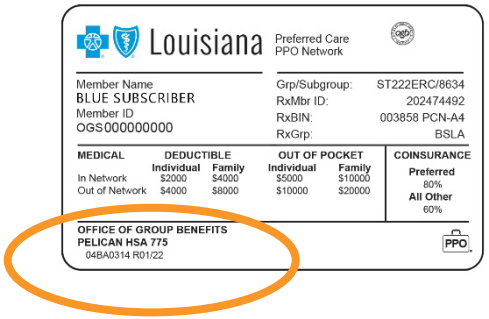
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

# OGB Sample Member ID Cards

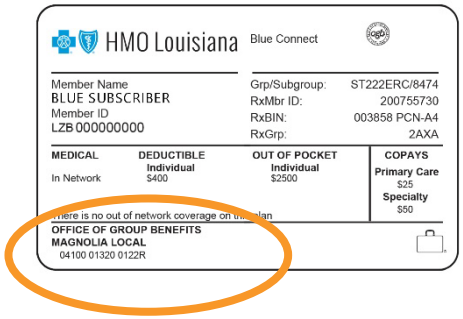
## Pelican HRA 1000



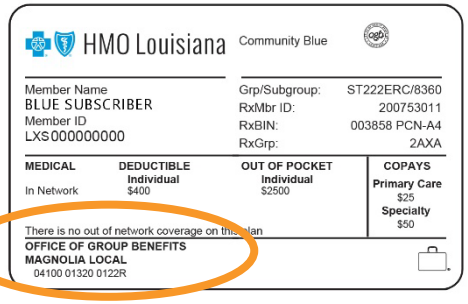

## Pelican HRA 775



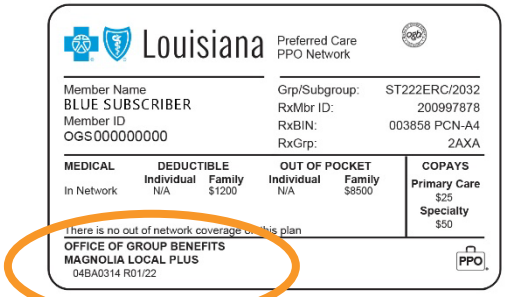

## Magnolia Local Blue Connect



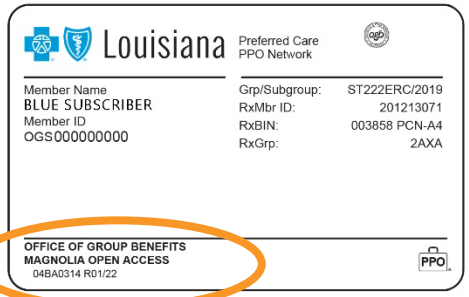

## Magnolia Local Community Blue




## Magnolia Local Plus




## Magnolia Open Access




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

# BlueCard® Program

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

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


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


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

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


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

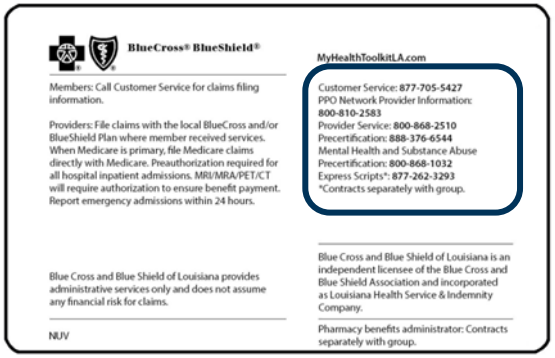
**Note: BlueCard authorizations are handled through the members' home plan.**

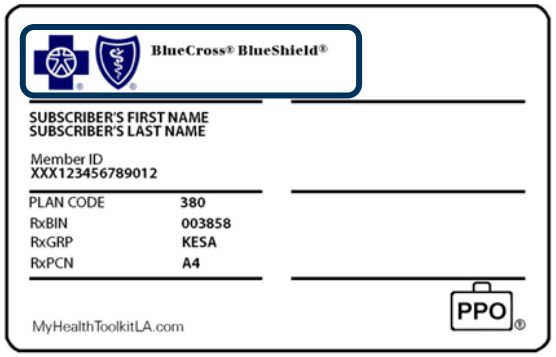
You can find additional BlueCard guidelines in the *BlueCard Program Provider Manual*, available online at **www.bcbsla.com/providers** >Resources >Manuals.

# National Alliance

*(South Carolina Partnership)*

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




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

# Medicare Advantage PPO Network Sharing

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

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

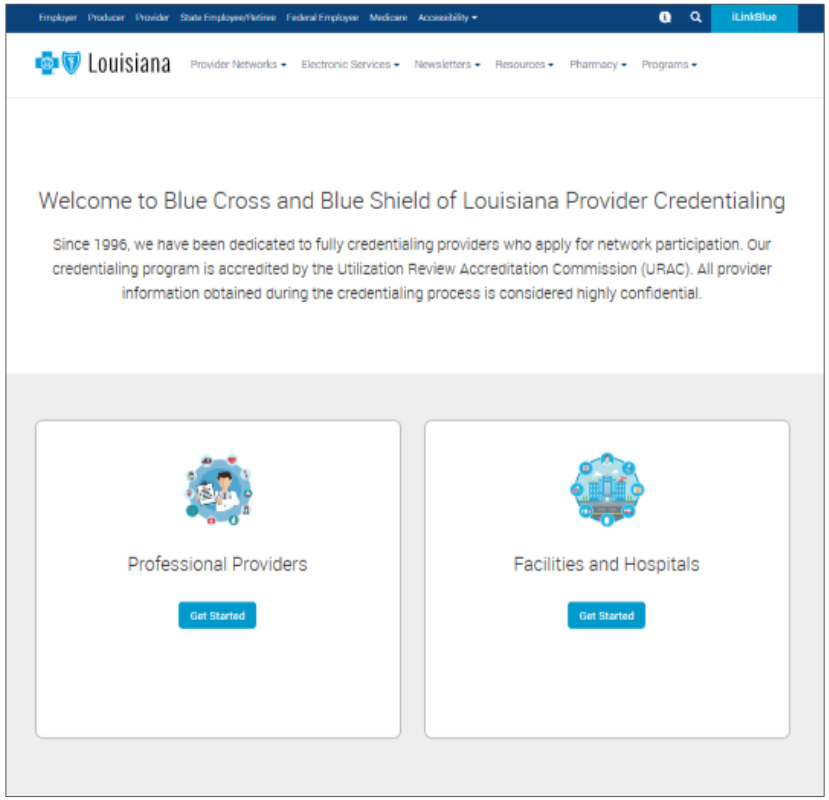
MA | PPO
MEDICARE ADVANTAGE

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

# Provider Credentialing & Data Management

# Join Our Networks Webpage

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




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

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

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

# Credentialing Process

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

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

# Vantage Health Managing Blue Cross Credentialing/Recredentialing

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

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

**Nov. 2021** — Expanded to include the recredentialing of all Blue Cross professional providers.

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

# Effective Dates

## For participating providers:

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

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

# Reimbursement During Credentialing

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

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

This provision does not apply for solo practitioners.

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

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

# Vantage Health Managing Blue Cross Recredentialing

Use the chart below for the new recredentialing process:

| | |
|---|---|
| Process initiated by: | Vantage |
| Form(s) to complete for professional provider recredentialing: | CAQH Application or Louisiana Standardized Credentialing Application (LSCA). |
| Form(s) to complete for facility reverification: | Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments. |
| Where to submit forms: | To Vantage based on instructions included with recredentialing form. |
| Verification Process: | Vantage |
| Who to contact: | Vantage:<br>recredentialing@vhpla.com or (318) 807-4755 |

# Incomplete Credentialing Applications

Below are the most common reasons credentialing applications are returned:

- Incomplete or expired supporting documents.
- No effective date listed.
- Professional provider did not submit the current version of the **Louisiana Standardized Credentialing Application**.

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

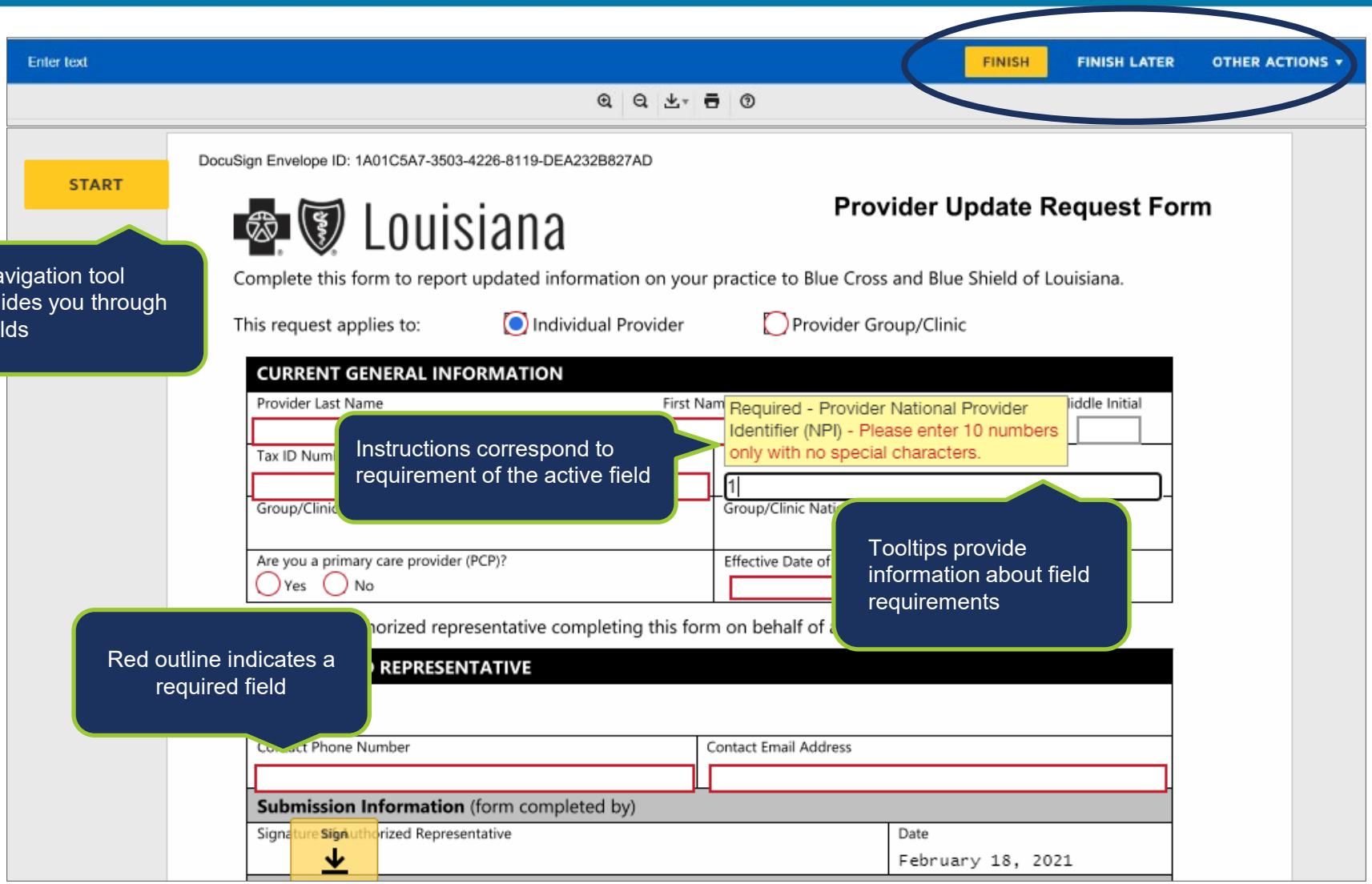
# Credentialing Criteria for Professional Providers

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

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

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

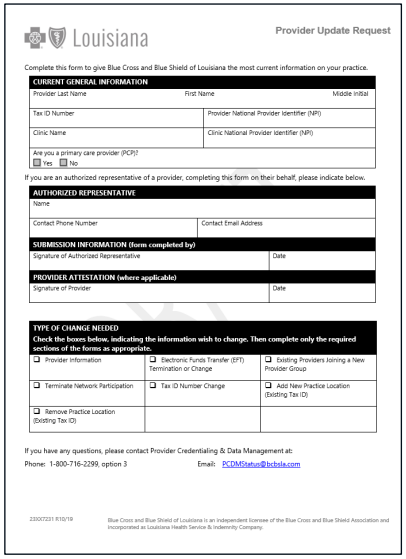
# Easily Complete Forms with DocuSign




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

# How to Update Your Information

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



Louisiana

Provider Update Request

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

**CURRENT GENERAL INFORMATION**

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

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

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

**AUTHORIZED REPRESENTATIVE**

Name

Contact Phone Number | Contact Email Address

**SUBMISSION INFORMATION (form completed by)**

Signature of Authorized Representative | Date

**PROVIDER ATTESTATION (where applicable)**

Signature of Provider | Date

**TYPE OF CHANGE NEEDED**
**Check the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.**

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

If you have any questions, please contact Provider Credentialing & Data Management at:
Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

23307231 R10/19

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

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

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

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

# Provider Directory

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

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

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

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

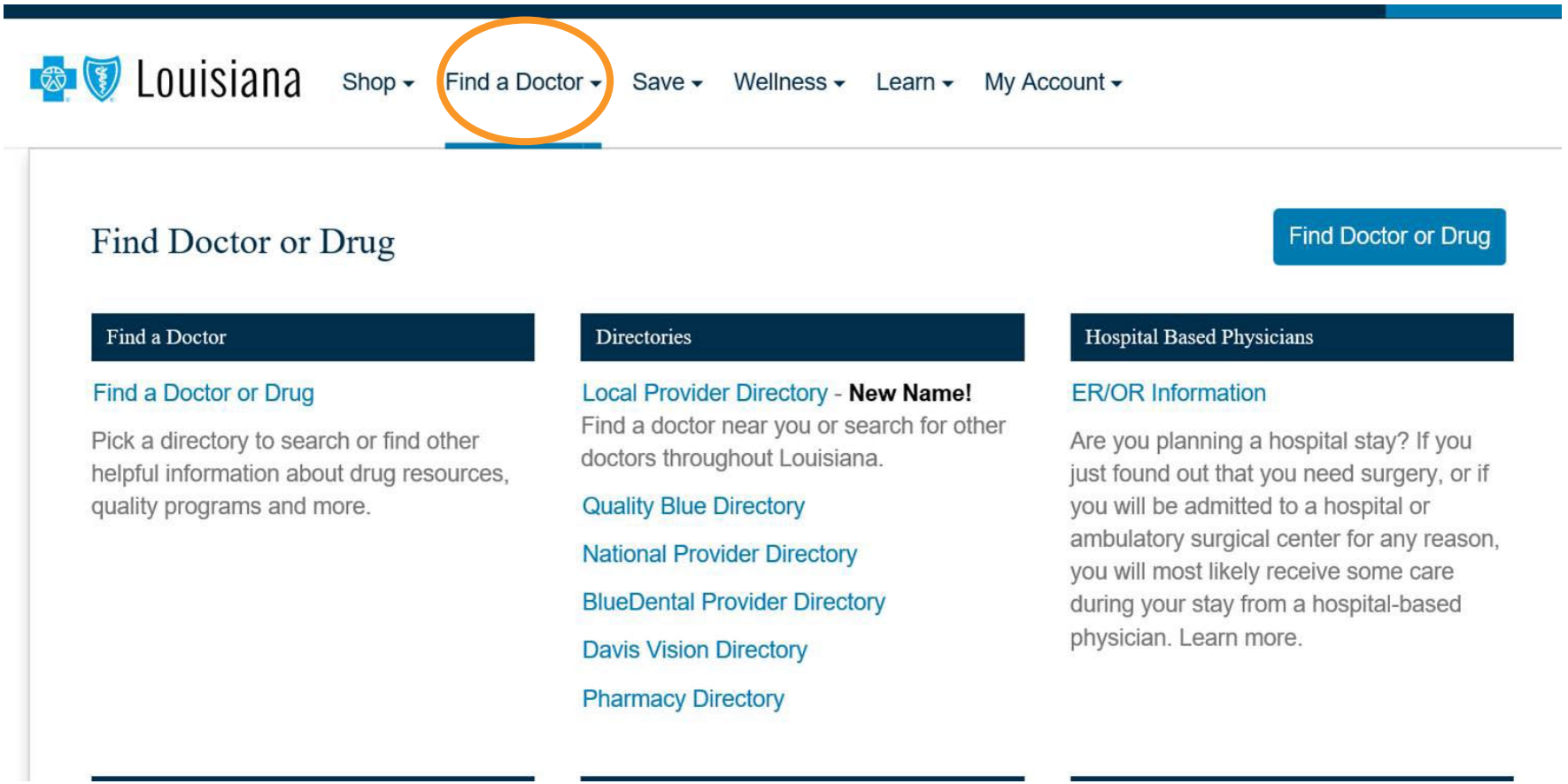
To improve the accuracy of our online provider directory, we are making changes in accordance with the CAA Mandate to help create the most accurate directory for our members. Provider Attestation forms will be emailed to you quarterly to confirm your demographic information is accurate.

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

Telehealth attestation forms will be emailed to providers soon to identify whether your office offers telehealth services.

# Finding Participating Providers

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



# iLinkBlue Application Packet

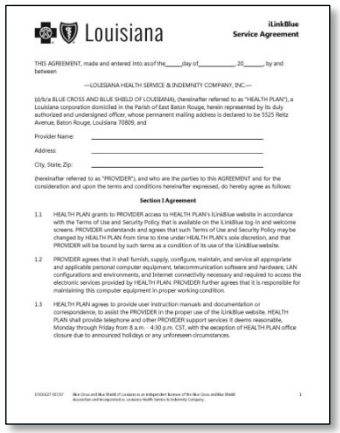
iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions.

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

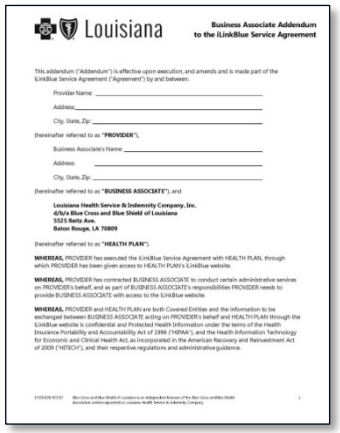
## ALWAYS include NPI/Tax ID on:

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

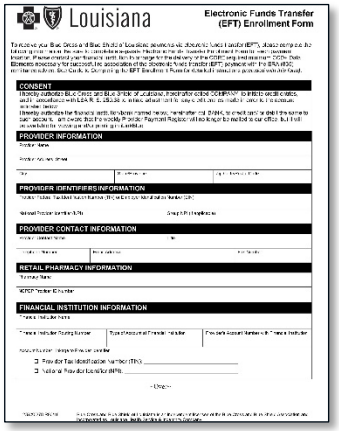
These four documents are included in the initial credentialing packets and are required to access iLinkBlue:


Louisiana
iLinkBlue Service Agreement

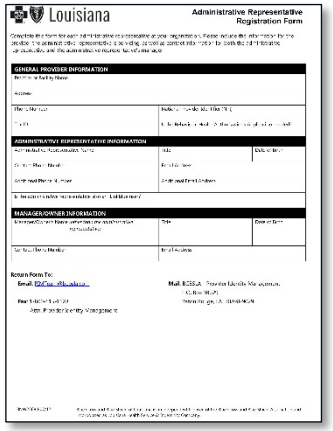
iLinkBlue Service Agreement


Louisiana
Business Associate Addendum to the iLinkBlue Service Agreement

Business Associate Addendum


Louisiana
Electronic Funds Transfer (EFT) Enrollment Form

Electronic Funds Transfer Enrollment Form


Louisiana
Administrative Representative Registration Form

Administrative Representative Registration Form

# Claims

# Electronic Claims

## Electronic Data Interchange (EDI)

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

## Electronic Transaction Exchange

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

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

# Electronic Payment Registers

## HIPAA 835 Transaction

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

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

# Hardcopy Claims

## CMS-1500 (professional)


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

## Mailing Addresses

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

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

**For FEP Claims:**

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

**For BlueHPN Claims:**

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

**For Blue Advantage Claims:**

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

The fastest method of claim submission and payment is electronic submission.

# Timely Filing Requirements

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

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

**FEP:**

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

**Blue Advantage:**

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

**OGB:**

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

**Self-funded & BlueCard:**

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

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

# National Drug Code (NDC) Required on Drug Claims

Use the following billing guidelines to report required NDCs on professional CMS-1500 claims:

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

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

# Reporting NDCs on Professional Claims

## For Hardcopy Claims

On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A. We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.

## For Electronic Claims 837P

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

## For iLinkBlue Claims (Professional Only)

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

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

# Reporting NDCs on Professional Claims

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

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

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

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

# Closed Formulary

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

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

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

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

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

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

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

# Submitting Action Requests

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

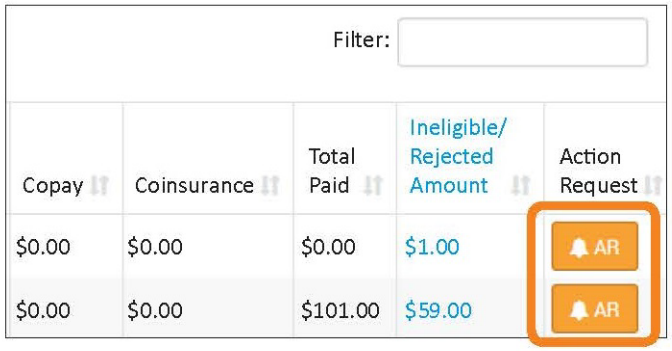
## Common reasons to submit an Action Request

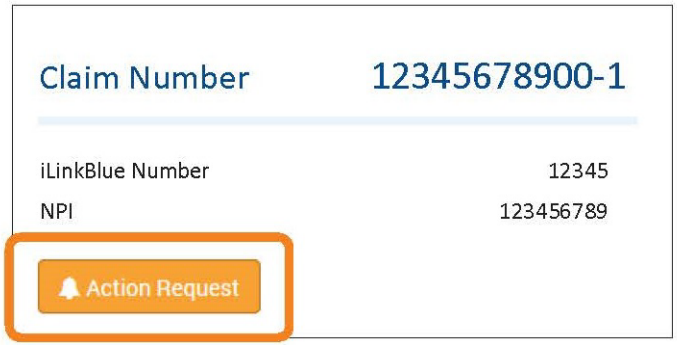
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No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

**Action requests are NOT available for Blue Advantage.**

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

# Submitting Action Requests



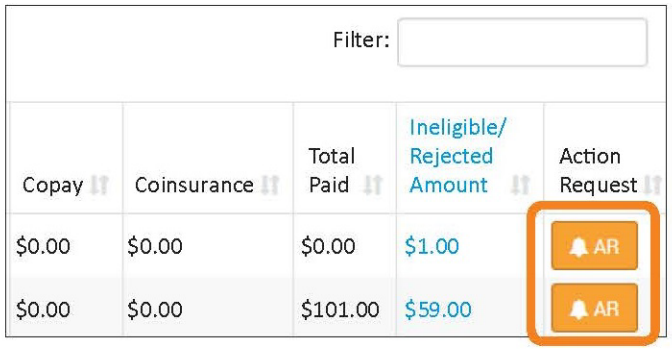



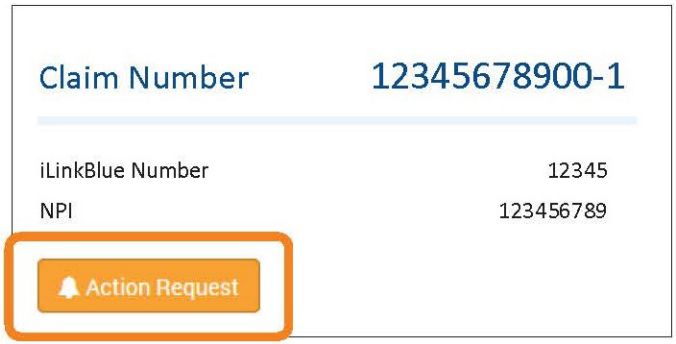

Submit an Action Request through iLinkBlue (**www.bcbsla.com/ilinkblue**).

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

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

# Submitting Action Requests



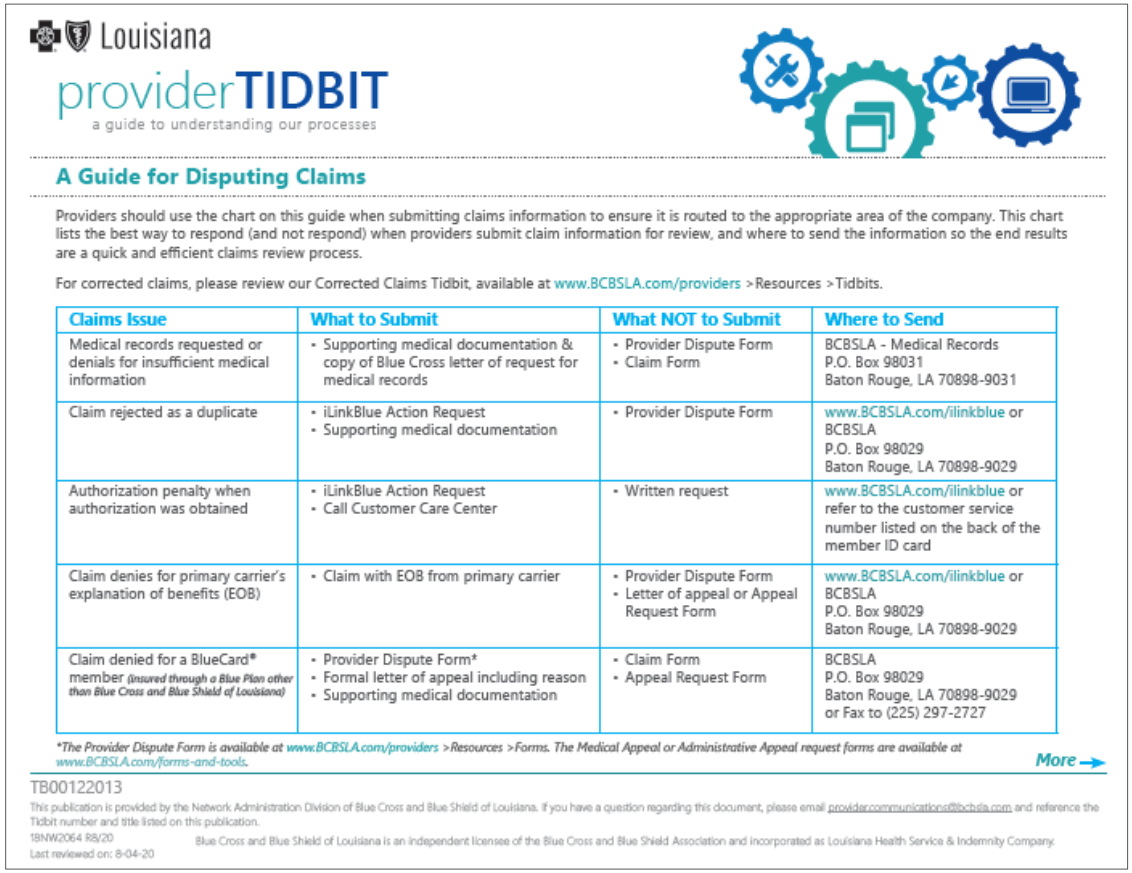

- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 business days for first request.
- Check iLinkBlue for a claims resolution.
- Submit a second action request for a review.
- Allow 10-15 business days for second request.

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

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

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

# A Guide for Disputing Claims



Louisiana

providerTIDBIT

a guide to understanding our processes

## A Guide for Disputing Claims

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

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

| Claims Issue | What to Submit | What NOT to Submit | Where to Send |
|---|---|---|---|
| Medical records requested or denials for insufficient medical information | • Supporting medical documentation & copy of Blue Cross letter of request for medical records | • Provider Dispute Form<br>• Claim Form | BCBSLA - Medical Records<br>P.O. Box 98031<br>Baton Rouge, LA 70898-9031 |
| Claim rejected as a duplicate | • iLinkBlue Action Request<br>• Supporting medical documentation | • Provider Dispute Form | www.BCBSLA.com/ilinkblue or<br>BCBSLA<br>P.O. Box 98029<br>Baton Rouge, LA 70898-9029 |
| Authorization penalty when authorization was obtained | • iLinkBlue Action Request<br>• 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<br>• Letter of appeal or Appeal Request Form | www.BCBSLA.com/ilinkblue or<br>BCBSLA<br>P.O. Box 98029<br>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*<br>• Formal letter of appeal including reason<br>• Supporting medical documentation | • Claim Form<br>• Appeal Request Form | BCBSLA<br>P.O. Box 98029<br>Baton Rouge, LA 70898-9029<br>or Fax to (225) 297-2727 |

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

More →

TB00122013

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

18NW2064 R8/20

Last reviewed on: 8-04-20

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

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

# Claims Disputes & Appeals

## MEDICAL APPEALS

Involves a denial or partial denial based on:

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

## ADMINISTRATIVE APPEALS & GRIEVANCES

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

## PROVIDER DISPUTES

Involves a denial that affects the provider's reimbursement.

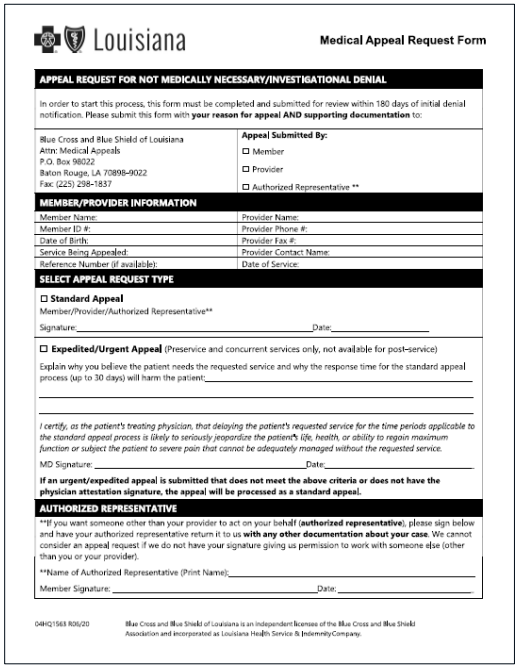
Please refer to Section 8 of the Provider Manual for more information.

# Medical Appeals

***Claim denied as investigational or not medically necessary.***

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

- Use the Medical Appeals Request Form that was included in the initial denial notice to properly request a review of a medical necessity or investigational denial.
- Be sure to complete all fields in the form and attach to the top of your appeal information. Incomplete information may delay the review.
- Member authorization is required and must be included in the appeal.
- Include rationale and supporting clinical records. Peer-to-peer reviews are **not** available once an appeal has been initiated.
- Physician signature is ONLY required if the request to appeal is expedited.
- If upheld and member still disagrees, they must request an external appeal within 120 days handled by an IRO and that will be the final decision.



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**Medical Appeal Request Form**

**APPEAL REQUEST FOR NOT MEDICALLY NECESSARY/INVESTIGATIONAL DENIAL**

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

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

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

**MEMBER/PROVIDER INFORMATION**

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

**SELECT APPEAL REQUEST TYPE**

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

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

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

MD Signature: _____Date:_____

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

**AUTHORIZED REPRESENTATIVE**

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

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

Member Signature: _____Date: _____

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

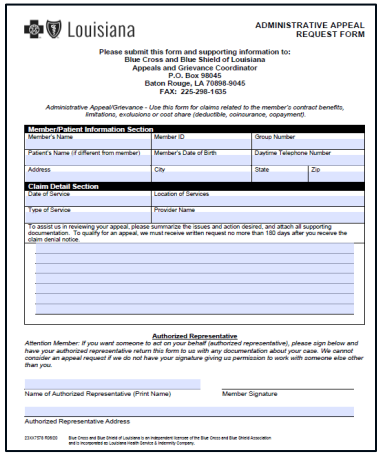
**SEND TO:**
Through iLinkBlue (**www.bcbsla.com/iLinkBlue**), click "Document Upload," then "Provider Disputes" in the drop-down menu.

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

Fax: (225) 298-1837

# BCBSLA Administrative Appeals

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



Louisiana

ADMINISTRATIVE APPEAL REQUEST FORM

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

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

**Member/Patient Information Section**

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

**Claim Detail Section**

| Date of Service | Location of Services |
|---|---|
| Type of Service | Provider Name |

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

**Authorized Representative**

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

Name of Authorized Representative (Print Name) Member Signature

Authorized Representative Address

**SEND TO:**

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

FAX: 225-298-1635

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

# Provider Disputes

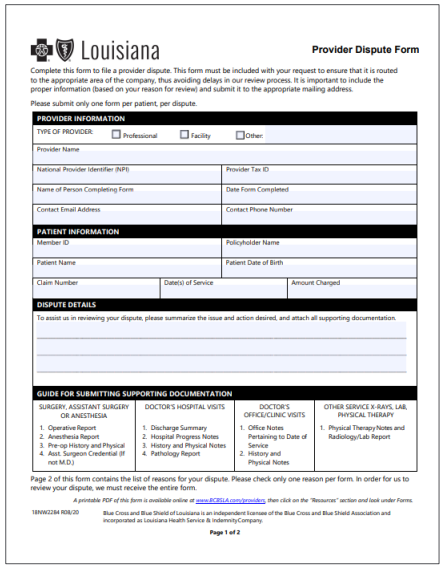
*A provider dispute is different than an appeal or grievance*. Provider disputes are defined as written requests from our participating network providers (***Network Providers ONLY***) questioning (or disputing) their allowable charge of a processed claim. Disputes could involve the following:

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

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

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

FAX: (225) 298-7035



Louisiana

**Provider Dispute Form**

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

Please submit only one form per patient, per dispute.

**PROVIDER INFORMATION**

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

Contact Email Address | Contact Phone Number

**PATIENT INFORMATION**

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

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

**DISPUTE DETAILS**

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

**GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION**

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

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

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

18NW2284 R08/20

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Page 1 of 2

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

# FIRST LEVEL REVIEW

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

## SECOND (STAFF) LEVEL REVIEW

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

## THIRD (MANAGEMENT) LEVEL REVIEW

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

# Helpful Reminders

# Benefits of Proper Clinical Documentation

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

# Provider's Role in Documenting

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

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

# Coding to the Highest Level of Specificity

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

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

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

# Medical Record Requests

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

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

# Network providers should **always** refer members to other **network** providers

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

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

# Laboratory Referrals

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

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

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

The In-office Lab List is available in our *HMO Preferred Reference Lab Guide* which is available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

# Behavioral Health Referrals

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


Behavioral health services that require an authorization:

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

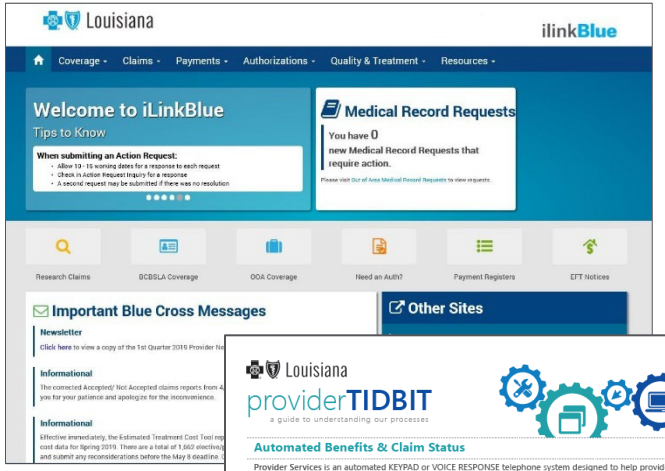
For more information, view the *Behavioral Health Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

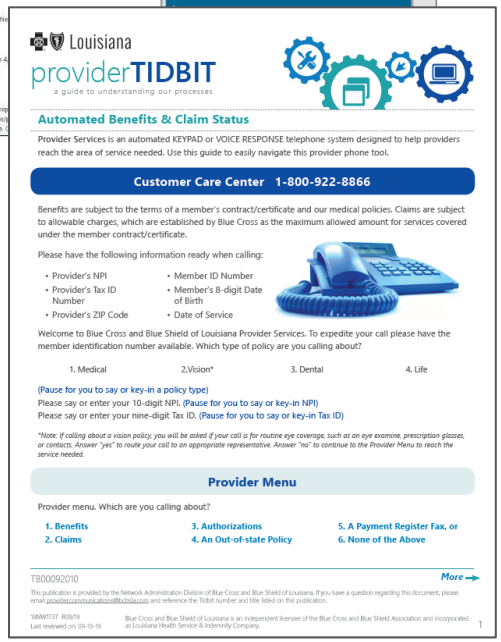
# Provider Self-service Initiative

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

- Member eligibility
- Claim status inquiries
- Professional allowable searches
- Medical policy searches

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




## Self-service tools available to providers:

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

# Laboratory Benefit Management Program

# Laboratory Benefit Management Program

Effective **May 15, 2022**, Blue Cross in partnership with Avalon Healthcare Solutions, implemented a new laboratory benefit management program.

Avalon provides:

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

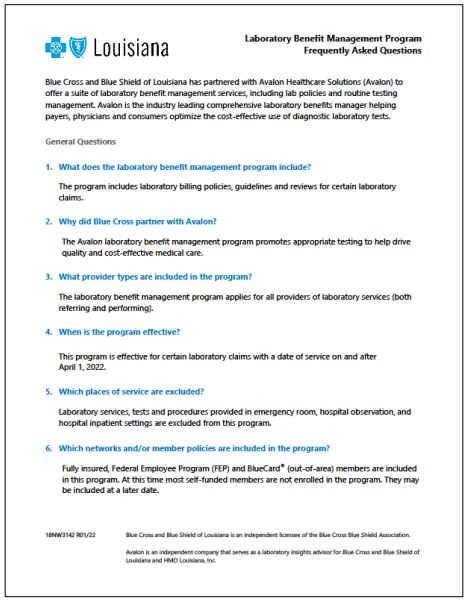
Blue Cross applies Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

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

Providers can now review and research the billing policies and guidelines on iLinkBlue (**www.bcbsla.com/ilinkblue**) under Authorizations, then Lab Reimbursement Policies.

# Laboratory Benefit Management Program

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



Louisiana

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

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

General Questions

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

   The program includes laboratory billing policies, guidelines and reviews for certain laboratory claims.

2. **Why did Blue Cross partner with Avalon?**

   The Avalon laboratory benefit management program promotes appropriate testing to help drive quality and cost-effective medical care.

3. **What provider types are included in the program?**

   The laboratory benefit management program applies for all providers of laboratory services (both referring and performing).

4. **When is the program effective?**

   This program is effective for certain laboratory claims with a date of service on and after April 1, 2022.

5. **Which places of service are excluded?**

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

6. **Which networks and/or member policies are included in the program?**

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

18NW3142 R01/22

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

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

# iLinkBlue

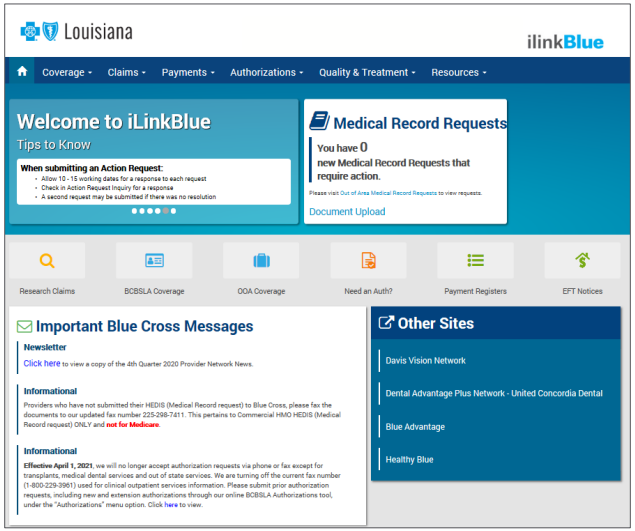
# iLinkBlue

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

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

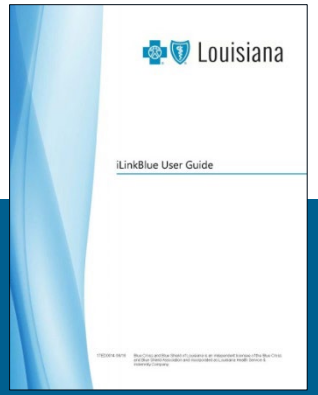
**ilinkBlue**

**www.bcbsla.com/ilinkblue**




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

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



# The Administrative Representative Role

## What is an Administrative Representative?

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

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

# Multi-factor Authentication Soon to be Required for iLinkBlue Access

COMING SOON

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

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

- email
- text
- voice call
- smartphone app

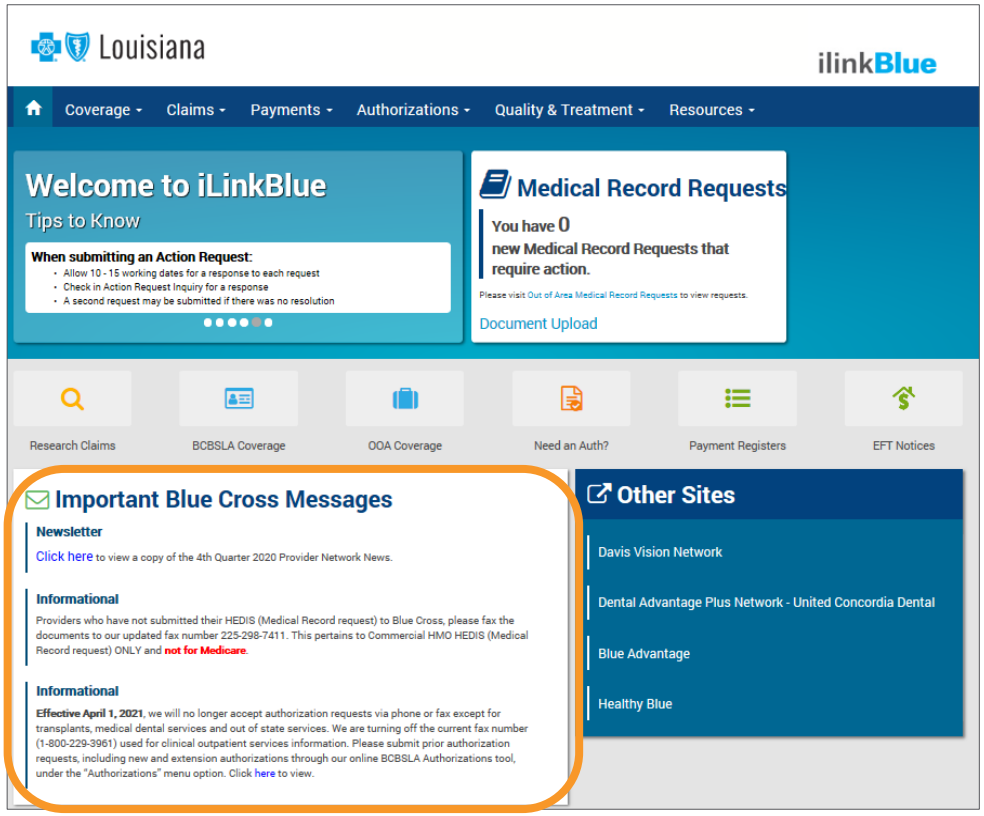
Our step-by-step instruction guide for MFA registration is available at **www.bcbsla.com/providers** >Resources >Speed Guides.

# Security Setup Tool Update


- **September 2022**, we are introducing a new Security Setup Application for administrative representatives called Delegated Access. It will be available through iLinkBlue only.
  - Replaces the existing Sigma Security Setup Tool used today.
  - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality.
- We will migrate the data housed in the current tool for your provider organization to the new application.
- You will not need to reload information into the new application. The goal is to create a seamless transition.

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

# iLinkBlue Message Board




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

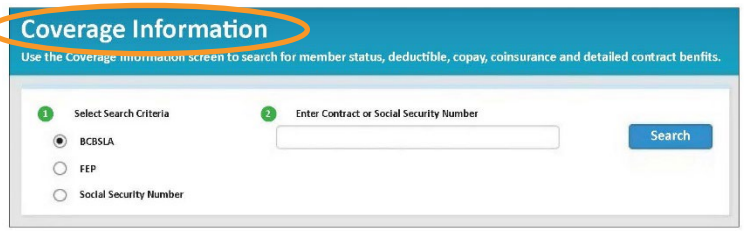
This area contains posts for:

- Upcoming events
- New features
- System outages
- Holiday notices
- And other important bulletins

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

# Coverage and Eligibility in iLinkBlue

1

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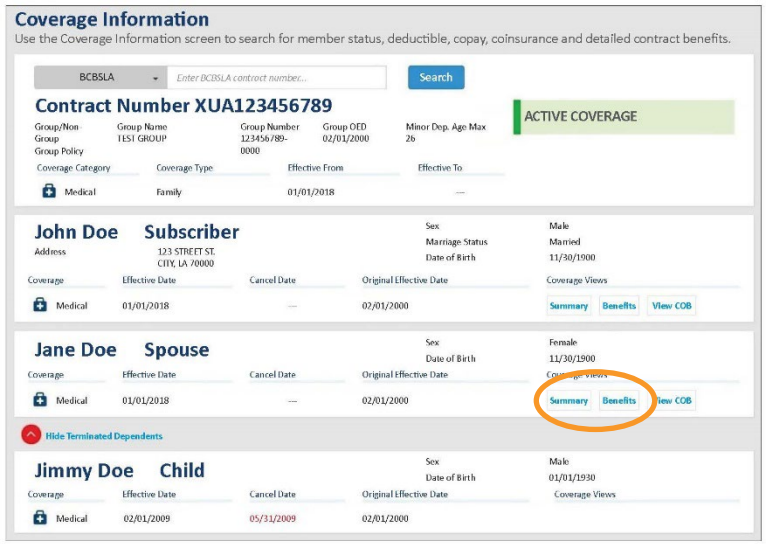


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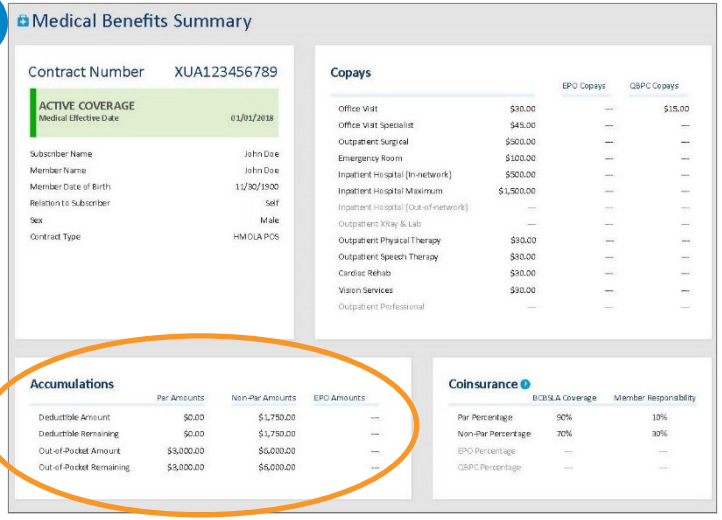



Use the “Coverage” menu option to research Blue Cross and Federal Employee Program (FEP) member eligibility, copays, deductibles and detailed contract information.

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

# Claims Information in iLinkBlue


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

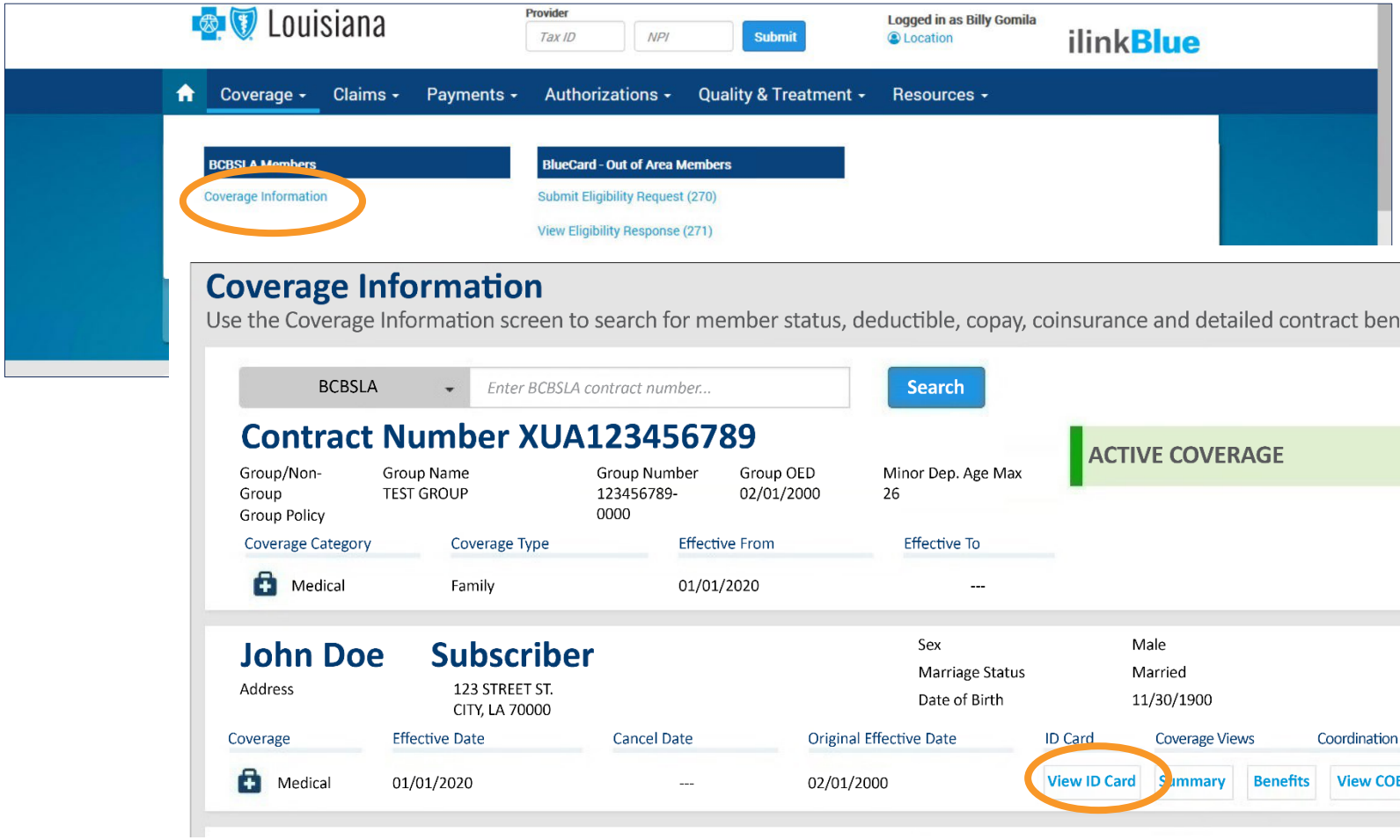
- File CMS-1500 claims electronically using the **Blue Cross Professional Claims Entry** tool.
- Perform **Claims Research** on claims that were submitted for processing.
- Submit **BlueCard - Out of Area Claims Status** inquiries for BlueCard (out-of-area) members.
- Check status of claims that were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

# FEP Medical Policy Guidelines in iLinkBlue

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

# Digital ID Cards on iLinkBlue

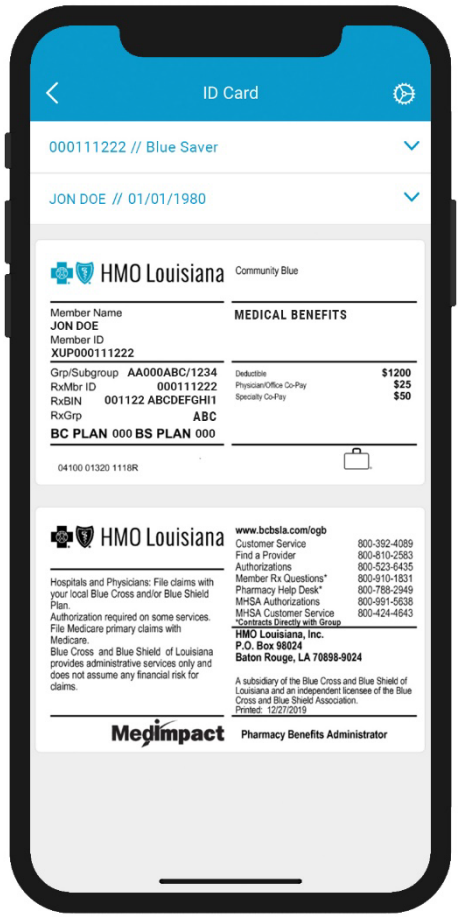
Digital ID cards are accessible through iLinkBlue as a downloadable PDF. Click the "Coverage Information" menu option, enter the member contract number in the search bar and then click “ID Card.”



# Members Can Access Their Digital ID Cards

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

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

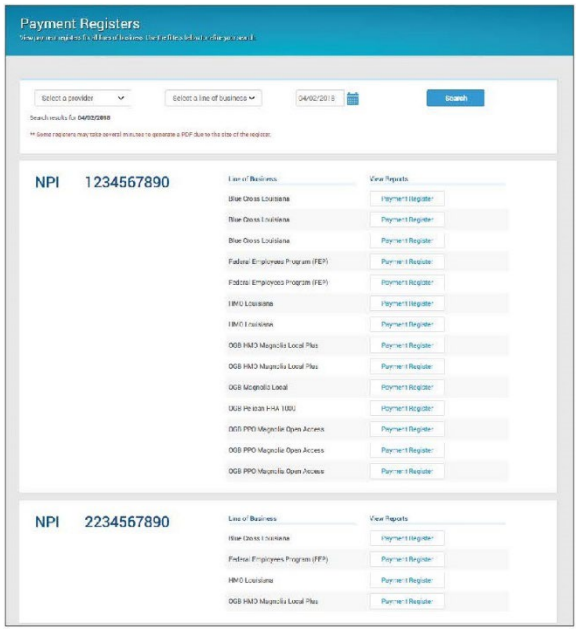


# Payments Information in iLinkBlue

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

1.


2.

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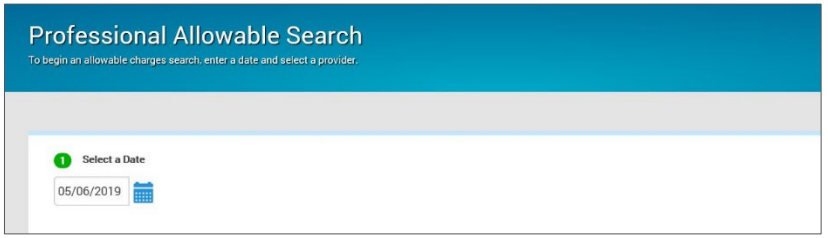
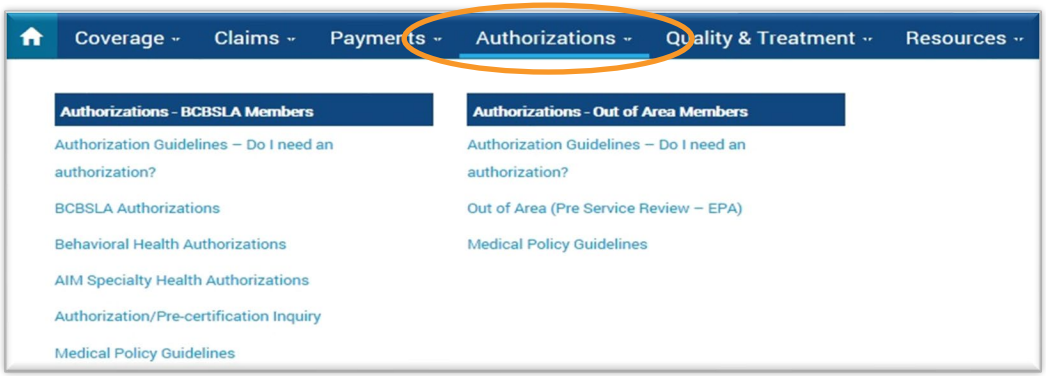


# Authorization Requests Through iLinkBlue




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

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

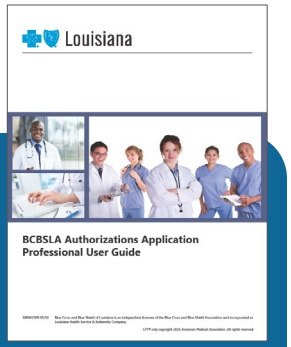
# Authorization Portal Mandate

## We have streamlined the process for requesting prior authorizations

- Blue Cross no longer accepts authorization requests via phone or fax, with a few exceptions including transplants, dental services covered under medical and out-of-state services.
- Prior authorization requests, including new and extension authorizations, must be submitted through our online BCBSLA Authorizations application available in iLinkBlue.
- The application allows providers to request authorizations 24 hours a day, seven days a week, in real time.
- **In some cases, the tool allows for immediate approval without Blue Cross personnel intervention.**

- **If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity.**
- **Providers are responsible for checking member eligibility and benefits.**

For more information on how to use our BCBSLA Authorizations application, the *BCBSLA Authorizations Applications Facility User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."

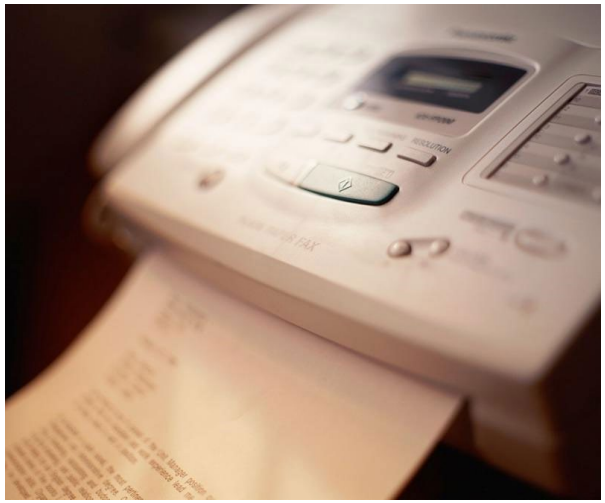


# Please Discontinue Use of our Local Retrospective Authorization Fax Number

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

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

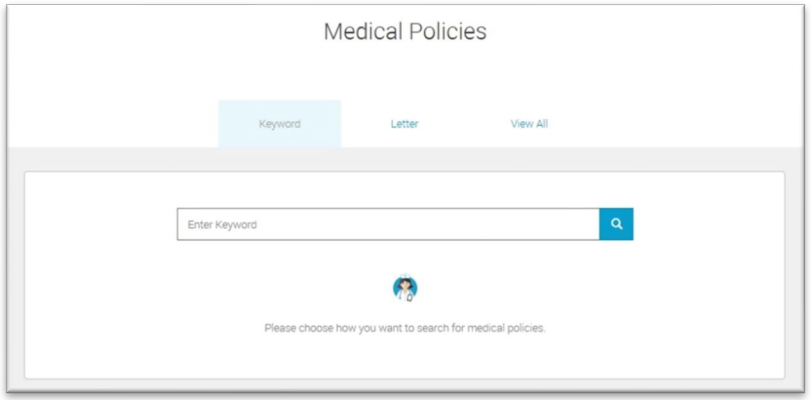
**1-800-515-1150**



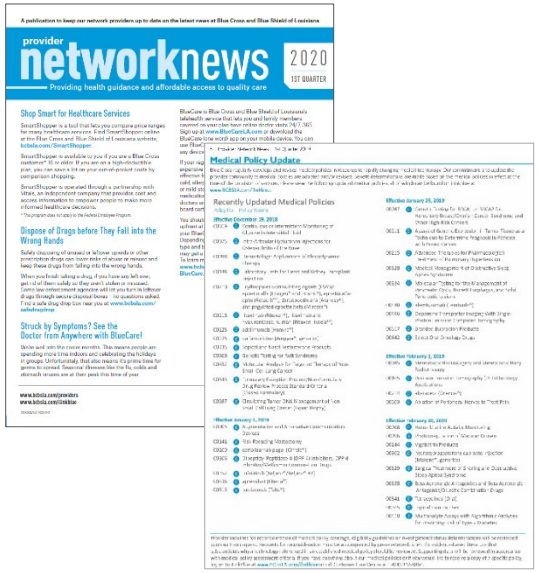
# Accessing Medical Policies in iLinkBlue

1.


2.




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




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

# Claims Editing

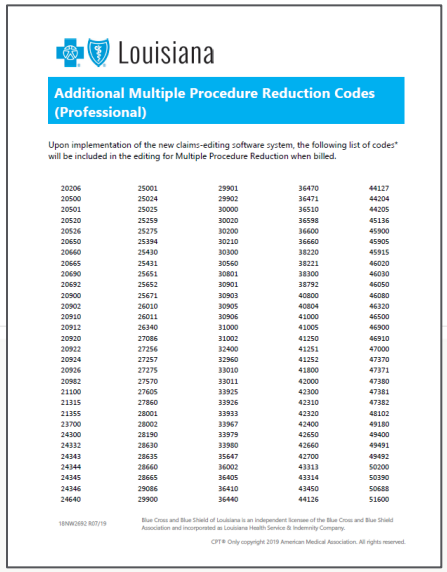
# Claims Editing Software

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

# Multiple Procedure Reduction

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

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



Louisiana

**Additional Multiple Procedure Reduction Codes (Professional)**

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

| | | | | |
|---|---|---|---|---|
| 20206 | 25001 | 29901 | 36470 | 44127 |
| 20500 | 25024 | 29902 | 36471 | 44204 |
| 20501 | 25025 | 30000 | 36510 | 44205 |
| 20520 | 25259 | 30020 | 36598 | 45136 |
| 20526 | 25275 | 30200 | 36600 | 45900 |
| 20650 | 25394 | 30210 | 36660 | 45905 |
| 20660 | 25430 | 30300 | 38220 | 45915 |
| 20665 | 25431 | 30560 | 38221 | 46020 |
| 20690 | 25651 | 30801 | 38300 | 46030 |
| 20692 | 25652 | 30901 | 38792 | 46050 |
| 20900 | 25671 | 30903 | 40800 | 46080 |
| 20902 | 26010 | 30905 | 40804 | 46320 |
| 20910 | 26011 | 30906 | 41000 | 46500 |
| 20912 | 26340 | 31000 | 41005 | 46900 |
| 20920 | 27086 | 31002 | 41250 | 46910 |
| 20922 | 27256 | 32400 | 41251 | 47000 |
| 20924 | 27257 | 32960 | 41252 | 47370 |
| 20926 | 27275 | 33010 | 41800 | 47371 |
| 20982 | 27570 | 33011 | 42000 | 47380 |
| 21100 | 27605 | 33925 | 42300 | 47381 |
| 21315 | 27860 | 33926 | 42310 | 47382 |
| 21355 | 28001 | 33933 | 42320 | 48102 |
| 23700 | 28002 | 33967 | 42400 | 49180 |
| 24300 | 28190 | 33979 | 42650 | 49400 |
| 24332 | 28630 | 33980 | 42660 | 49491 |
| 24343 | 28635 | 35647 | 42700 | 49492 |
| 24344 | 28660 | 36002 | 43313 | 50200 |
| 24345 | 28665 | 36405 | 43314 | 50390 |
| 24346 | 29086 | 36410 | 43450 | 50688 |
| 24640 | 29900 | 36440 | 44126 | 51600 |

18NW2692 R07/19

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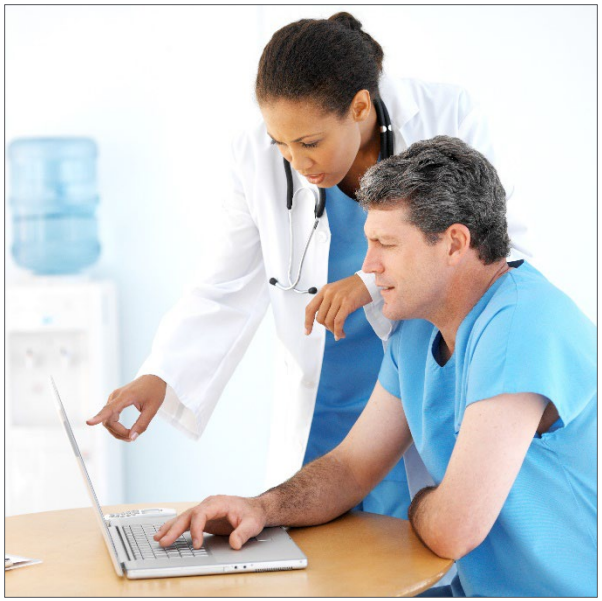
# Not Separately Reimbursable



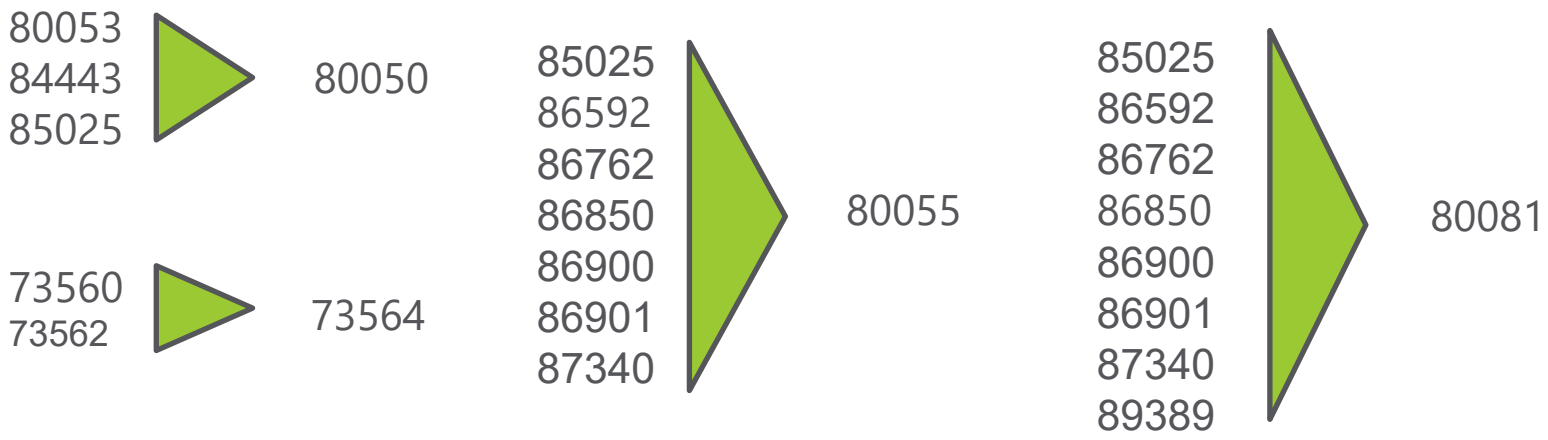
Certain codes will be denied because the services should be included with other services billed on the same day.

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

# Rebundles

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

**Examples:**



# Important Things to Remember

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

*With the exception of **multiple procedure reductions**.

# Troubleshooting

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

## Step 1

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

## Step 2

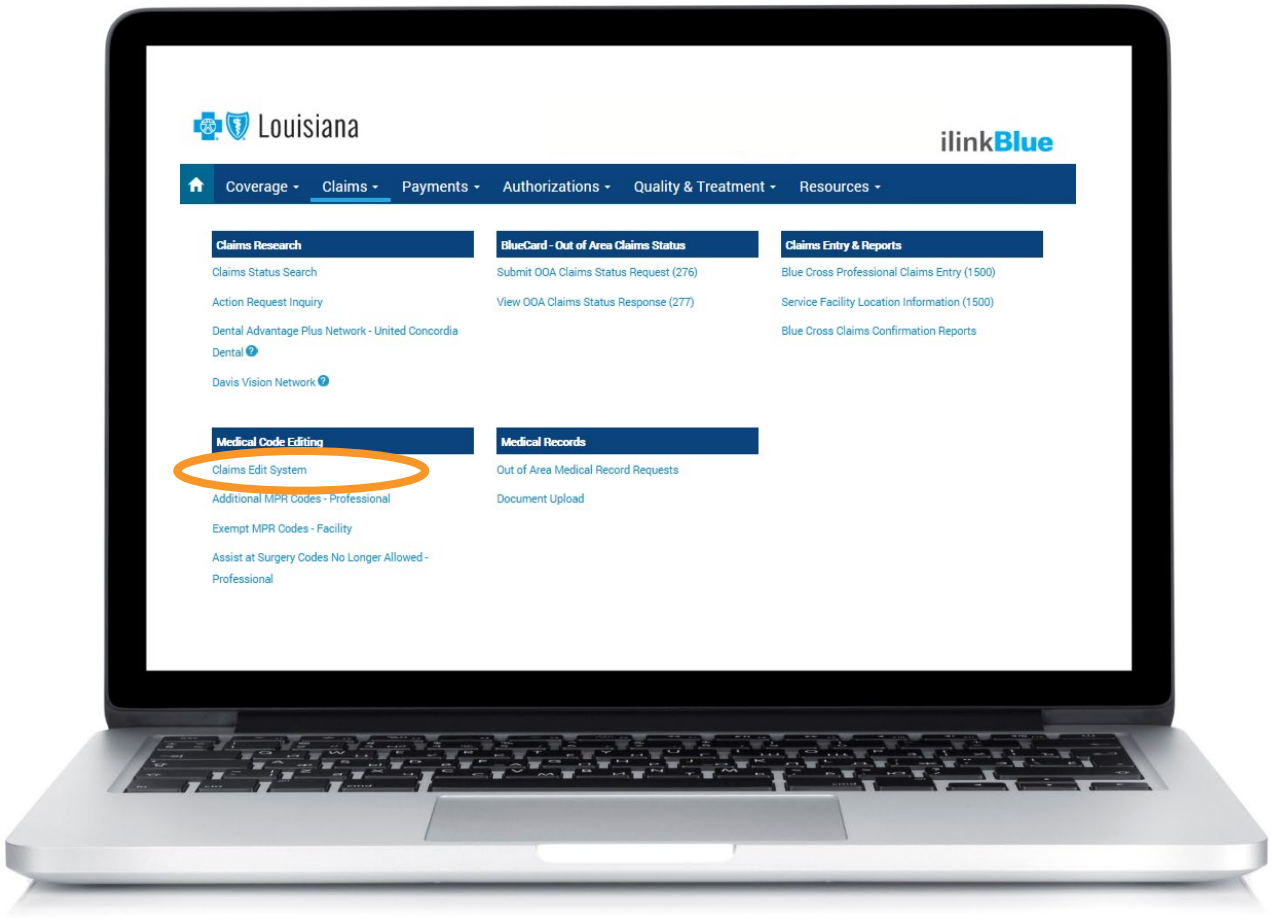
- Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code.
- This tool is located at **www.bcbsla.com/ilinkblue** >Claims >Claims Edit System.
- CES edits will appear in lower case.

## Step 3

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

# Claims Editing System Tool

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



# Claims Editing System Tool

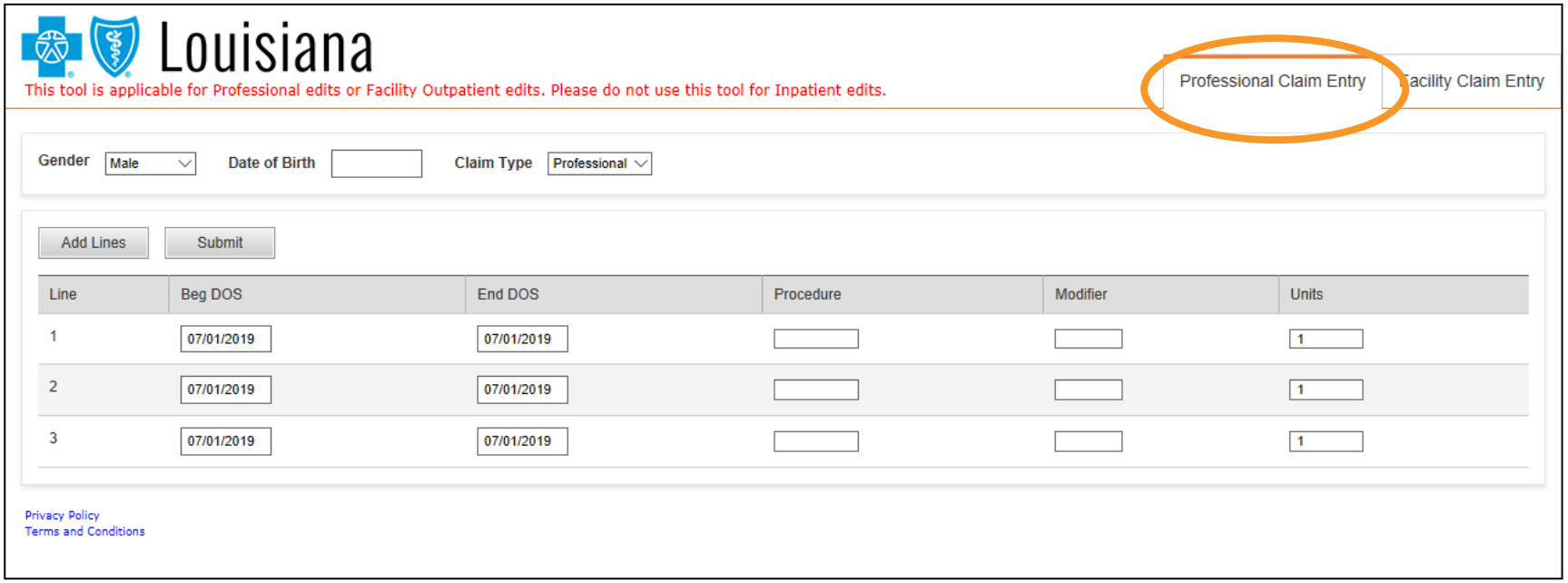
This tool applies to **professional** claims and does not guarantee claims payment.

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

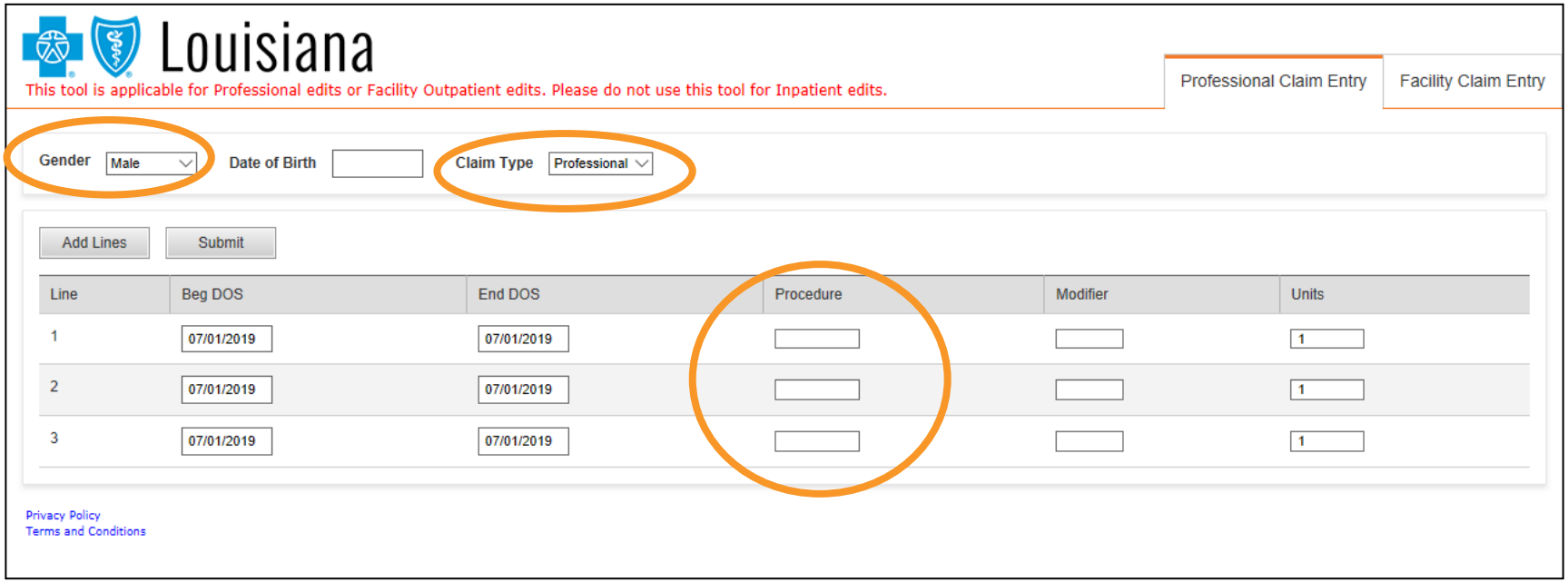
- Historical claims previously billed
- Units billed
- Global day edits for procedures
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits

# Claims Editing System Tool

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

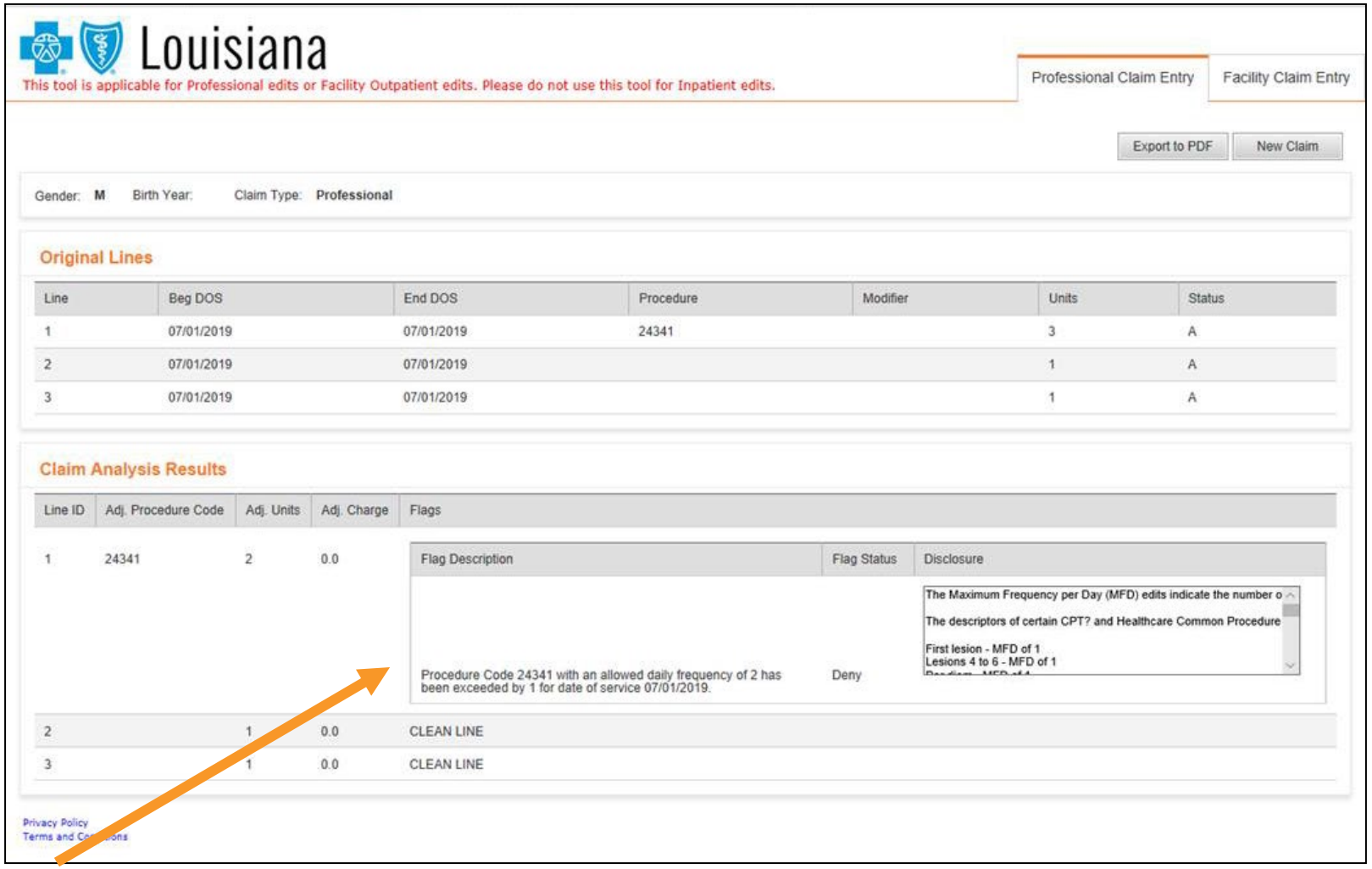


# CES Tool Mandatory Fields



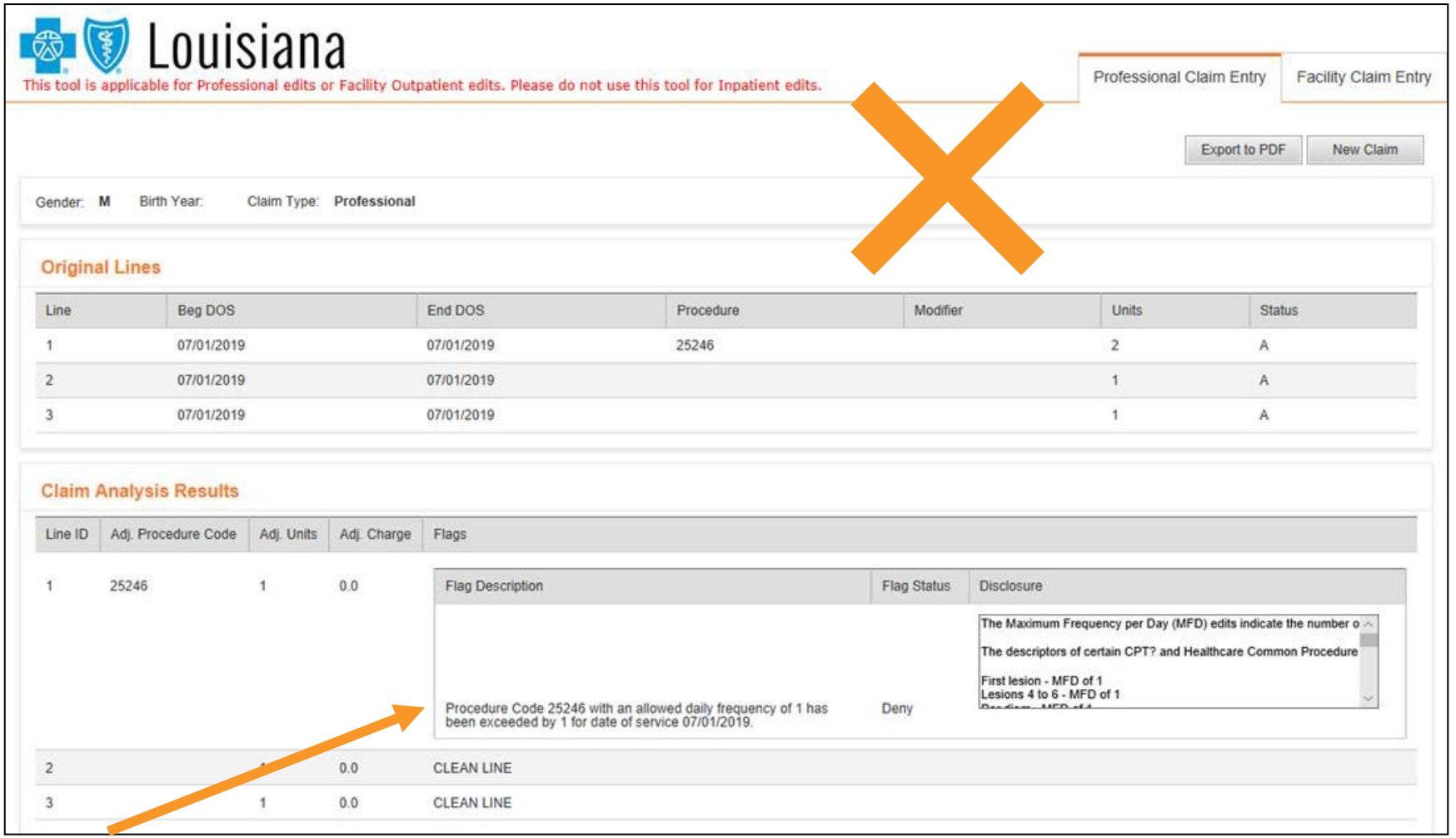

**NOTE**: If you do not enter the Statement From or Through dates, no edits will be returned, so the dates are necessary.

# CES Tool Outputs



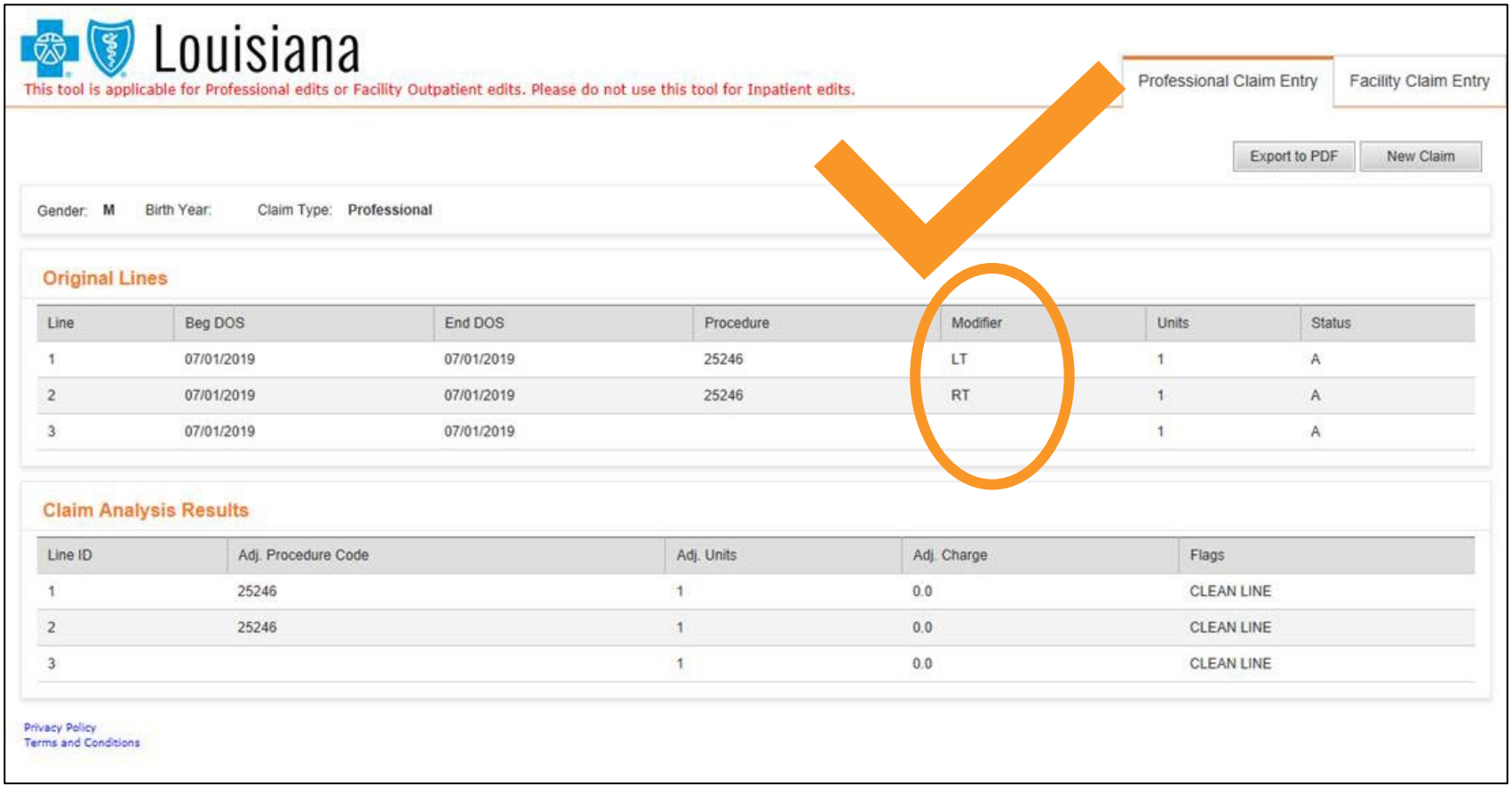

CPT Code 24341 – Repair, tendon or muscle, upper arm or elbow daily max frequency limit of 2 units. Code on one line with 3 units – 2 units will pay, 1 unit will deny.

# CES Tool Outputs




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

# CES Tool Outputs



Louisiana

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

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: M Birth Year: Claim Type: Professional

**Original Lines**

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

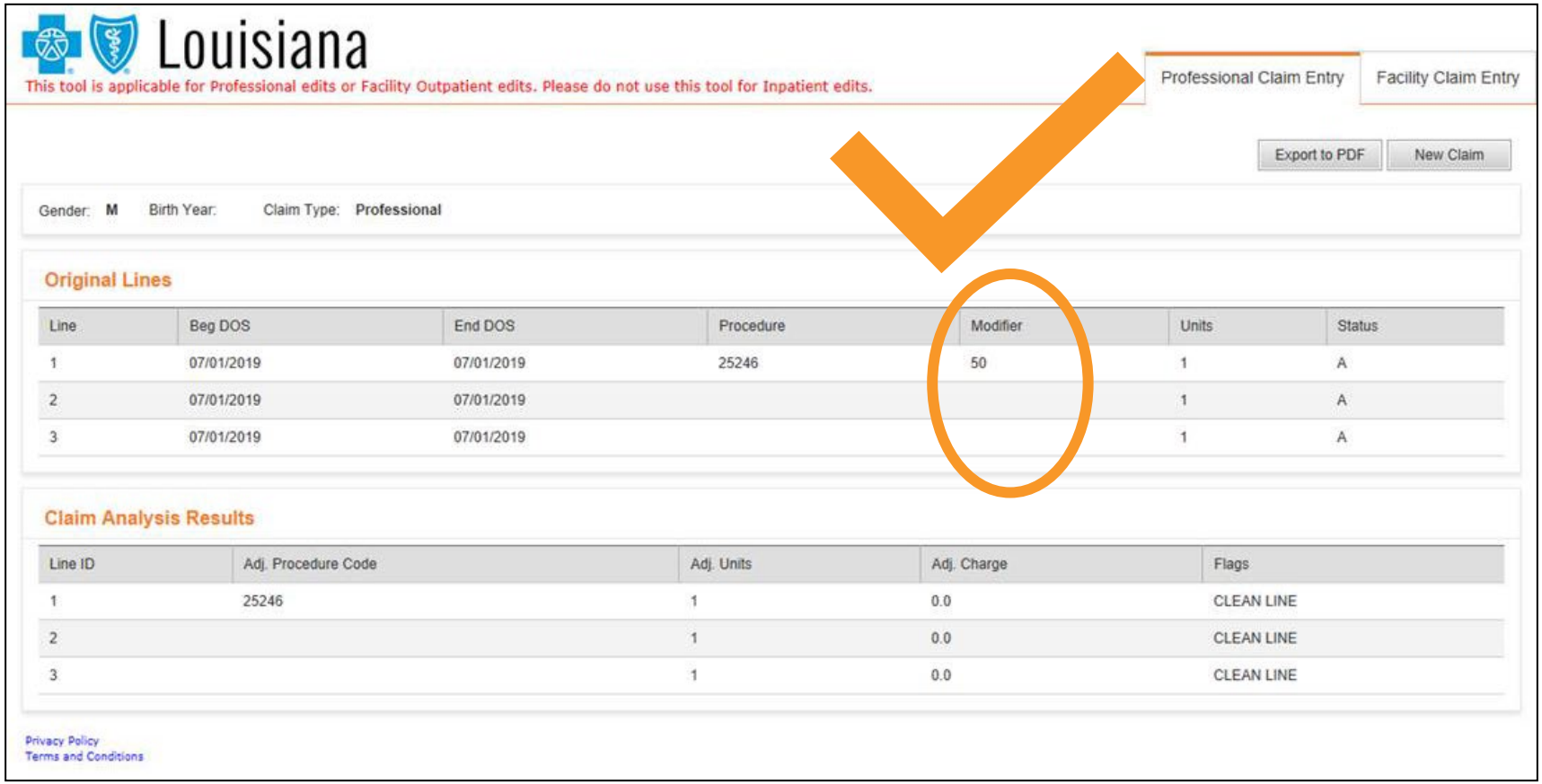
**Claim Analysis Results**

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

Privacy Policy
Terms and Conditions

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

# CES Tool Outputs



Louisiana

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

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: M Birth Year: Claim Type: Professional

**Original Lines**

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

**Claim Analysis Results**

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

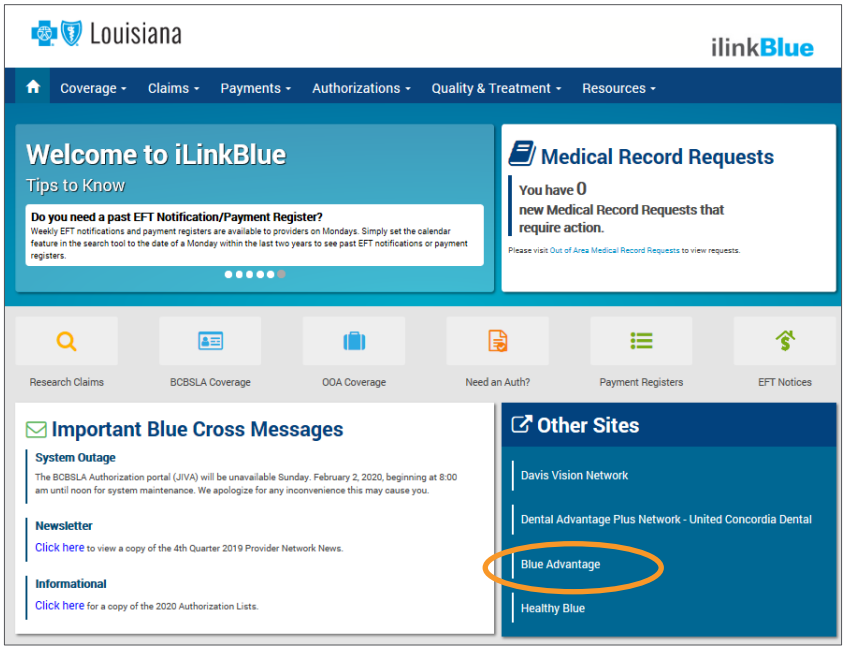
Privacy Policy
Terms and Conditions

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

# Blue Advantage

# Accessing the Blue Advantage Provider Portal

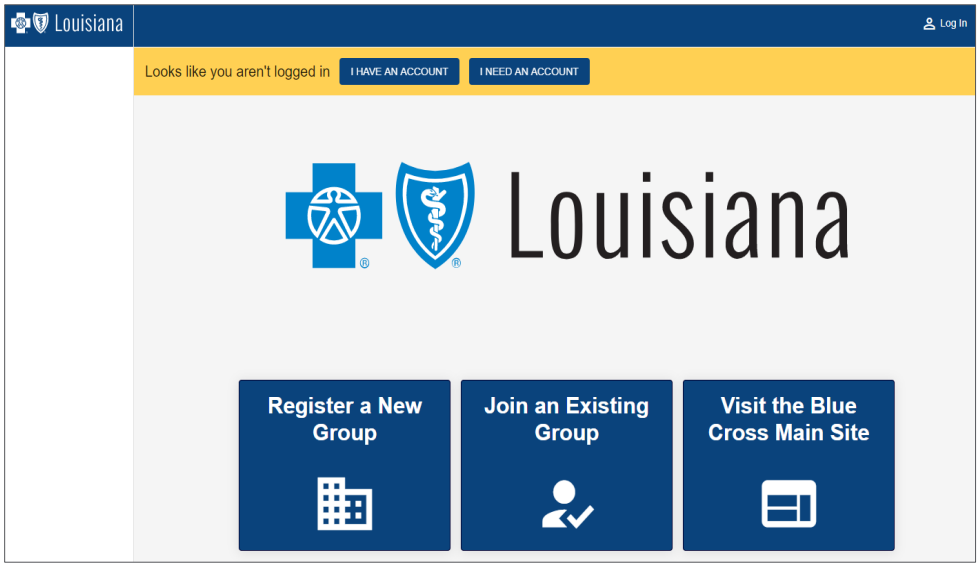
- The processes for Blue Advantage (HMO)/Blue Advantage (PPO) differ from our other provider network processes.
- There is a separate portal for these contracted providers to access needed information.
- You can access the Blue Advantage Provider Portal through iLinkBlue (**www.bcbsla.com/iLinkBlue.com**),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



# The Blue Advantage Provider Portal

The Blue Advantage Provider Portal offers resources such as:

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

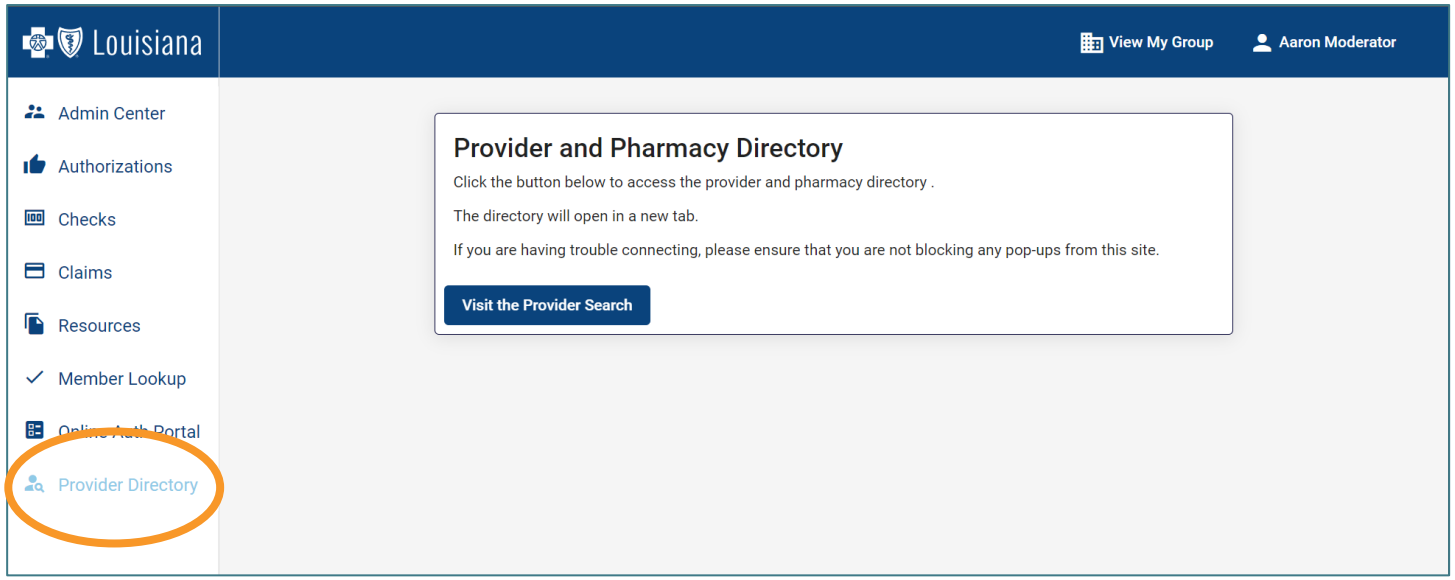



*These resources are also available on the Blue Advantage Resources page at **www.bcbsla.com/providers**.

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

# Finding Blue Advantage Providers & Lab Services

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




Preferred laboratories for all specimens for the Blue Advantage network:

- Clinical Pathology Labs (CPL)
- Quest Diagnostics
- Lab Corp

# Blue Advantage – Administered by Vantage Health Plan

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

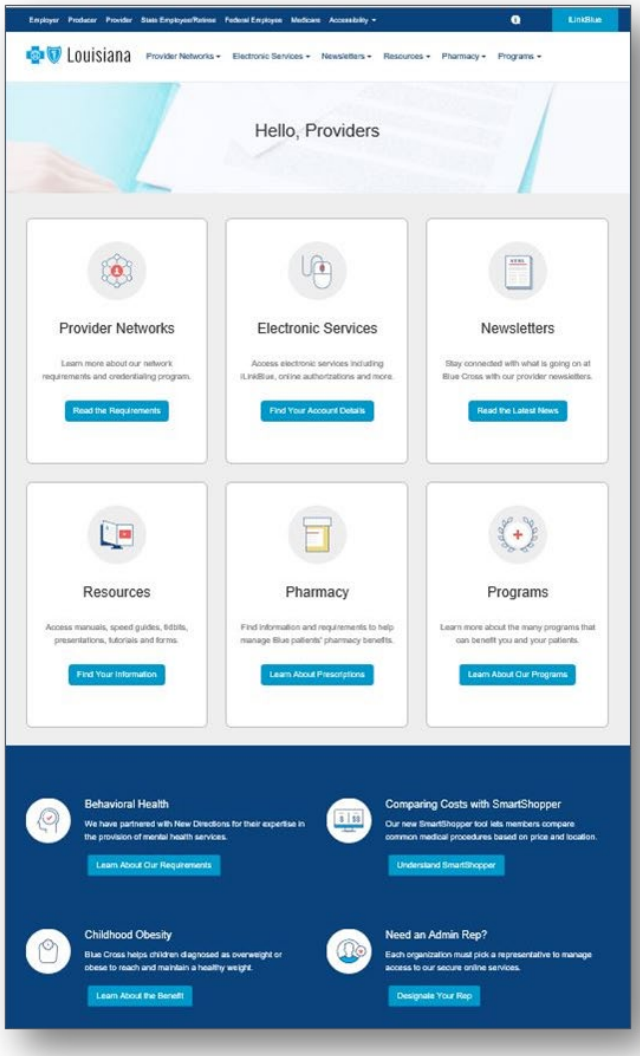
**Submit claims to Vantage Health Plan**
**(Payor ID 72107)**

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

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

# Resources

# The Provider Page

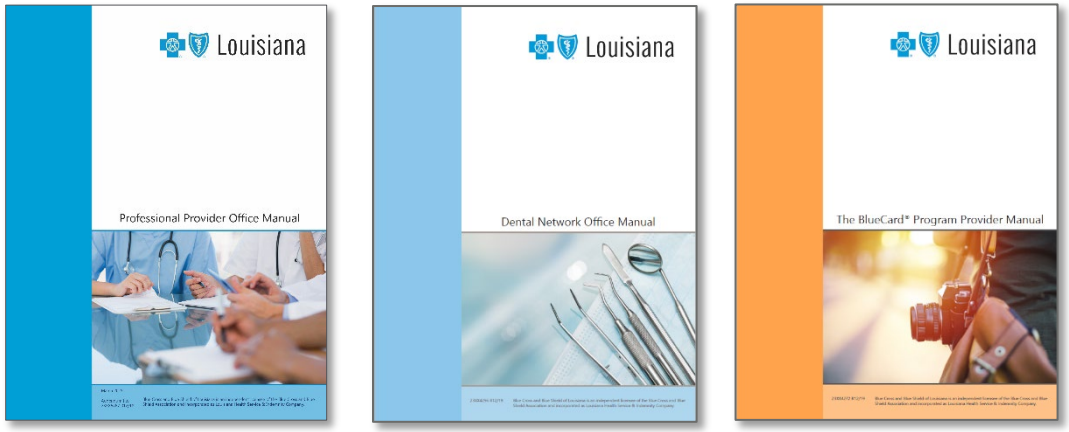



The Provider Page is home to online resources such as:

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

**www.bcbsla.com/providers**

# Provider Manuals




**www.bcbsla.com/providers** >Resources >Manuals

Our manuals are an extension of your member provider agreement.

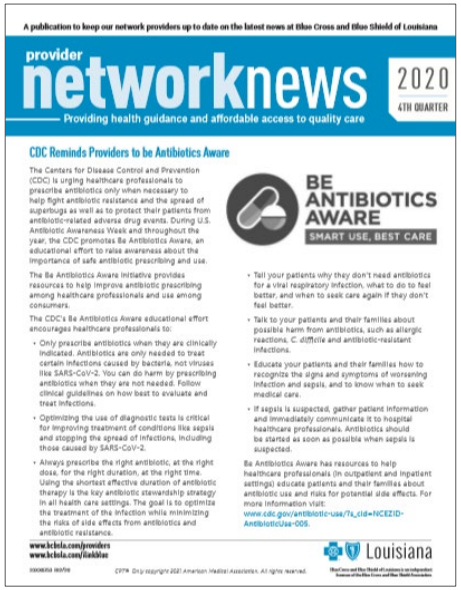
The manuals include the information you need as a participant in our networks:

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

# Newsletters

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

**www.bcbsla.com/providers** >Newsletters




**Network News**
Our quarterly newsletter for network providers.


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

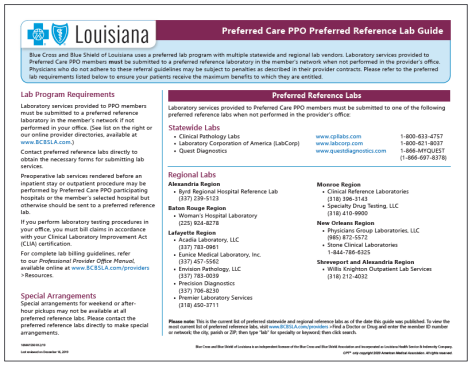
## Not Getting Our Newsletters?

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

# Speed Guides & 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.cplabsc.com — 1-800-633-4757
- Laboratory Corporation of America (LabCorp) — www.labcorp.com — 1-800-821-8037
- 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) 783-0961
- Eunice Medical Laboratory, Inc. (337) 457-5582
- Envision Pathology, LLC (337) 783-0039
- Precision Diagnostics (337) 706-8230
- Premier Laboratory Services (318) 450-3711

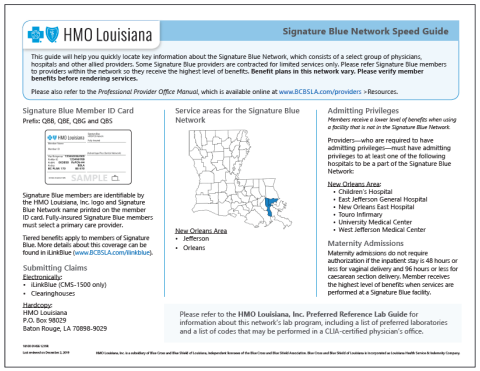
**Monroe Region**
- Clinical Reference Laboratories (318) 396-3143
- Specialty Drug Testing, LLC (318) 410-9660

**New Orleans Region**
- Physicians Group Laboratories, LLC (985) 872-5572
- Stonx Clinical Laboratories 1-844-786-6925

**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.




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: QB8, QBE, QBG and QBS

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/linkblue).

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:

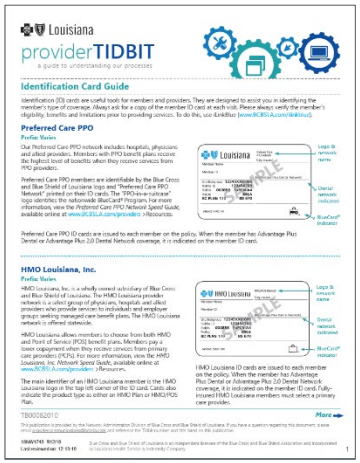
New Orleans Area:
- Children's Hospital
- East Jefferson General Hospital
- New Orleans East Hospital
- Touro Infirmary
- University Medical Center
- West Jefferson Medical Center

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.




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/linkblue).

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-cutout" logo identifies the nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

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 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

TB00062010




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 10-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 examine, 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

TB00062010



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

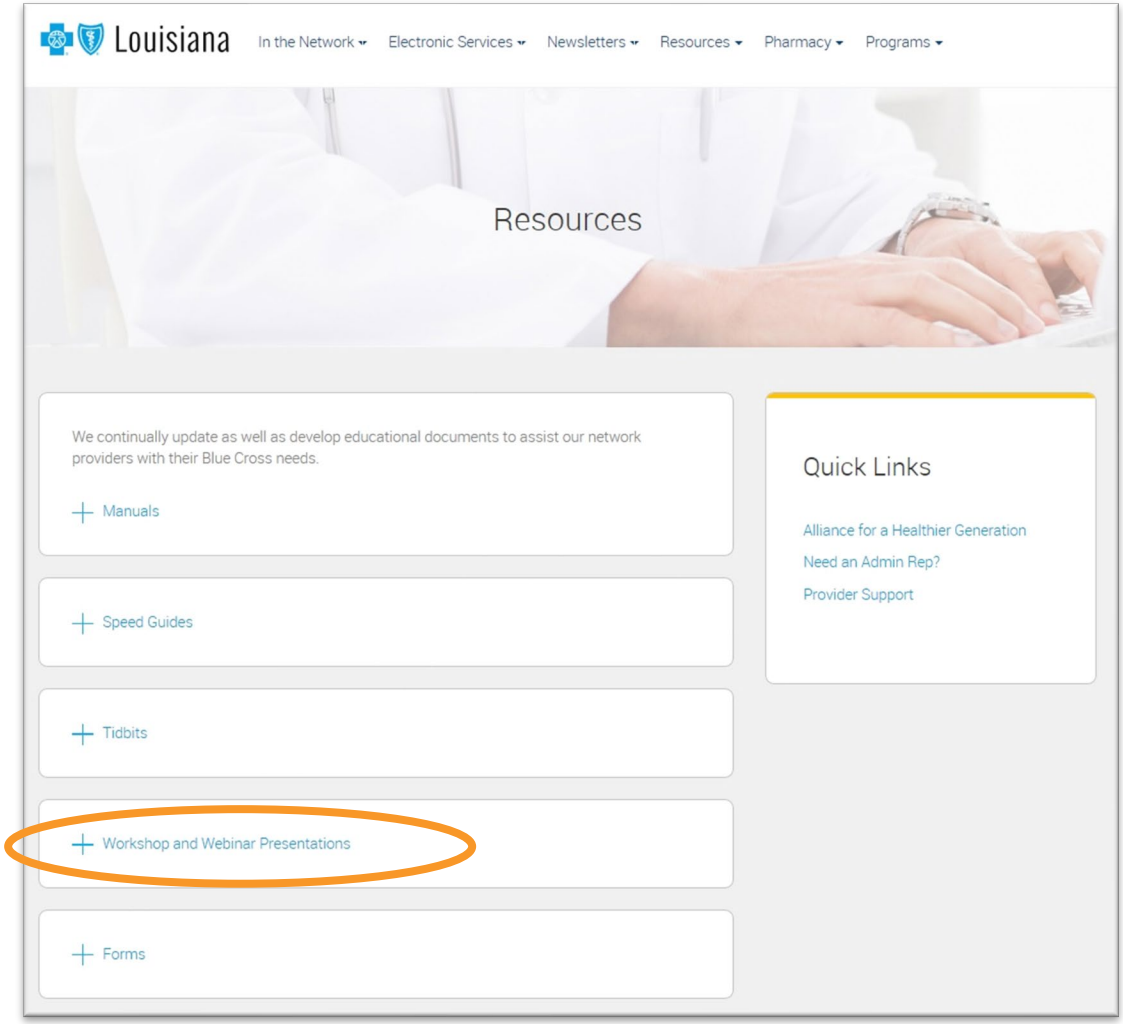
**www.bcbsla.com/providers**
>Resources >Tidbits

# Workshops and Webinars

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

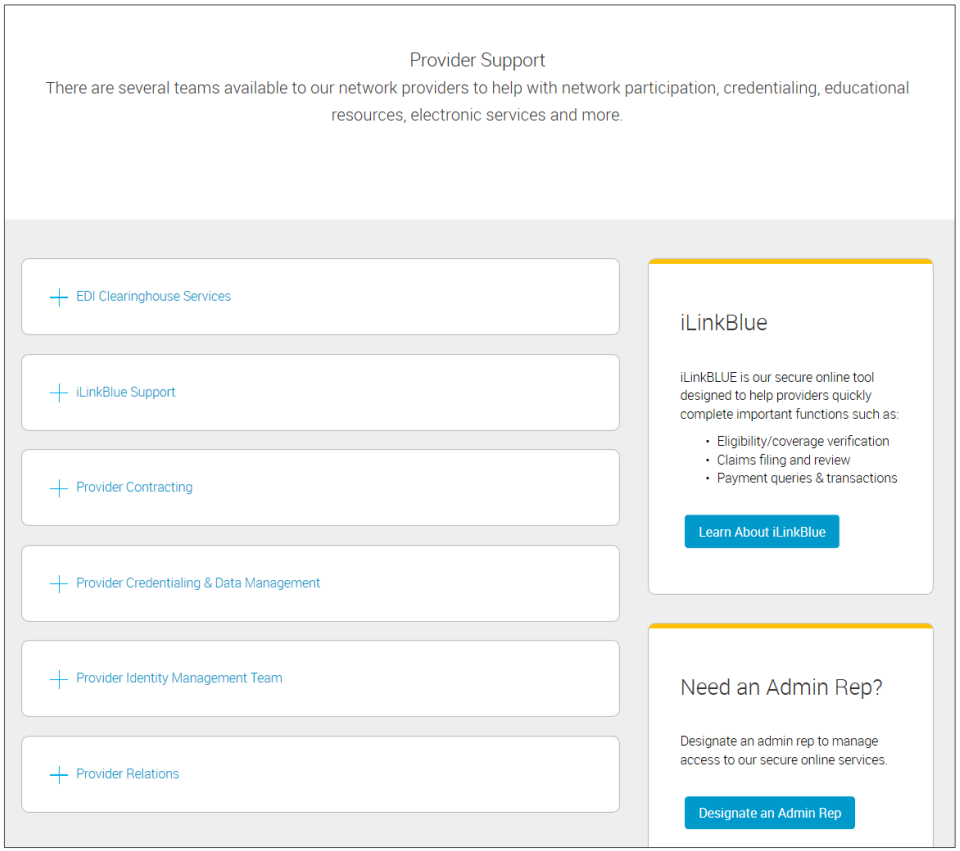
Invites to attend these events are sent to the providers' correspondence email address.

PDF copies of our workshops and webinars are available online.




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

# Provider Support




We believe supporting our network providers is important.

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

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

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

# Customer Care Center

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

**For information NOT available on iLinkBlue**

## Other Provider Phone Lines

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

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

**Health Services Division** – 1-800-716-2299

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

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