Facility Workshop

Fall 2024

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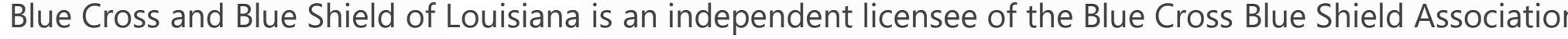
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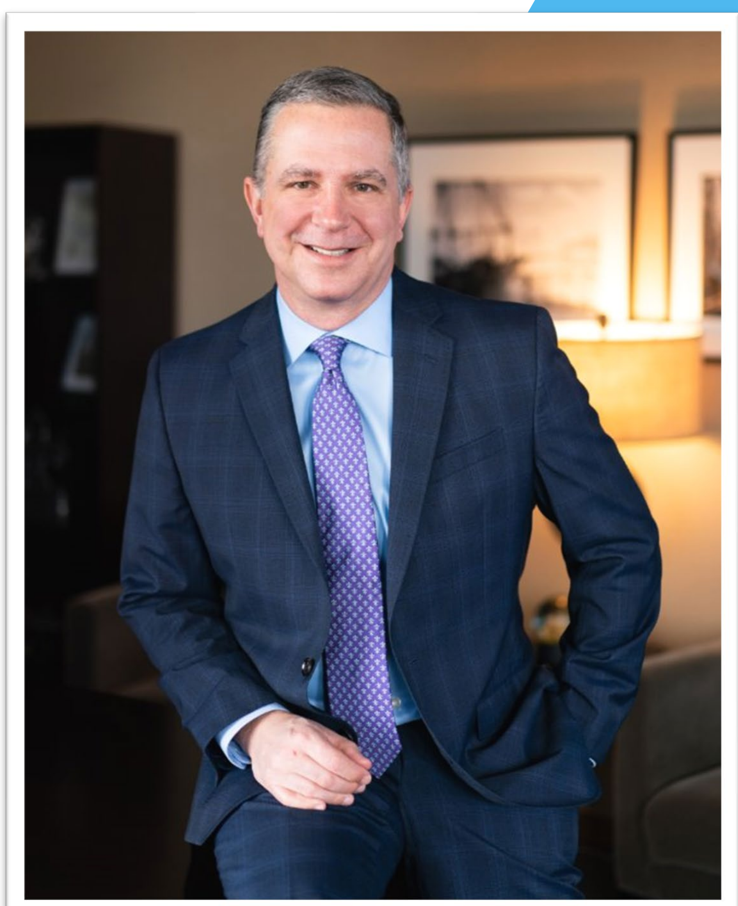
Introducing…

Louisiana Blue's new

President and CEO

Bryan Camerlinck



Our New Brand

Blue Cross and Blue Shield of Louisiana is introducing ***Louisiana Blue***.

We now have:

- a new name - Louisiana Blue
- a new logo:

www.lablue.com

Louisiana Blue

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Welcome

Today we will review the following:

- ✓ Being in the Network
- ✓ Identifying Your Patients
- ✓ Verifying Your Patient's Benefits
- ✓ Authorizations
- ✓ Policies and Procedures
- ✓ Blue Distinction
- ✓ Billing Guidelines
- ✓ Claims
- ✓ iLinkBlue
- ✓ Medical Records
- ✓ Supporting Your Needs

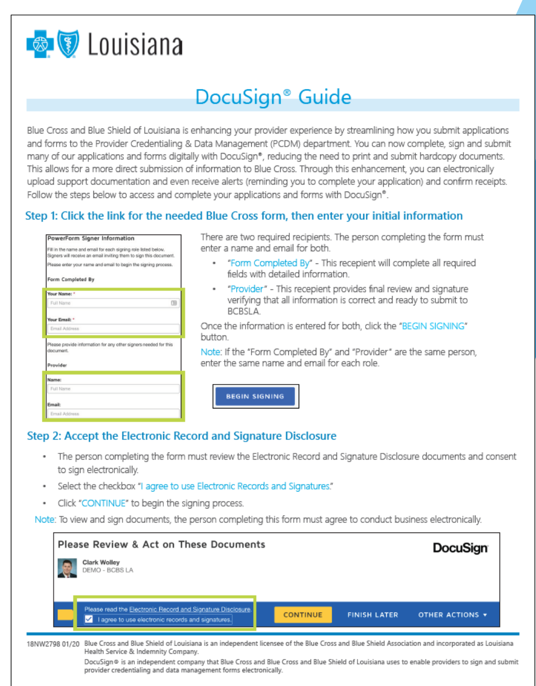
CREDENTIALING

Digitally Submitting Applications & Forms with DocuSign®

Complete, sign and submit applications and forms to the Provider Credentialing & Data Management (PCDM) Department digitally with **DocuSign**.

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

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



Louisiana

DocuSign® Guide

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

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

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

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

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

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

Step 2: Accept the Electronic Record and Signature Disclosure

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

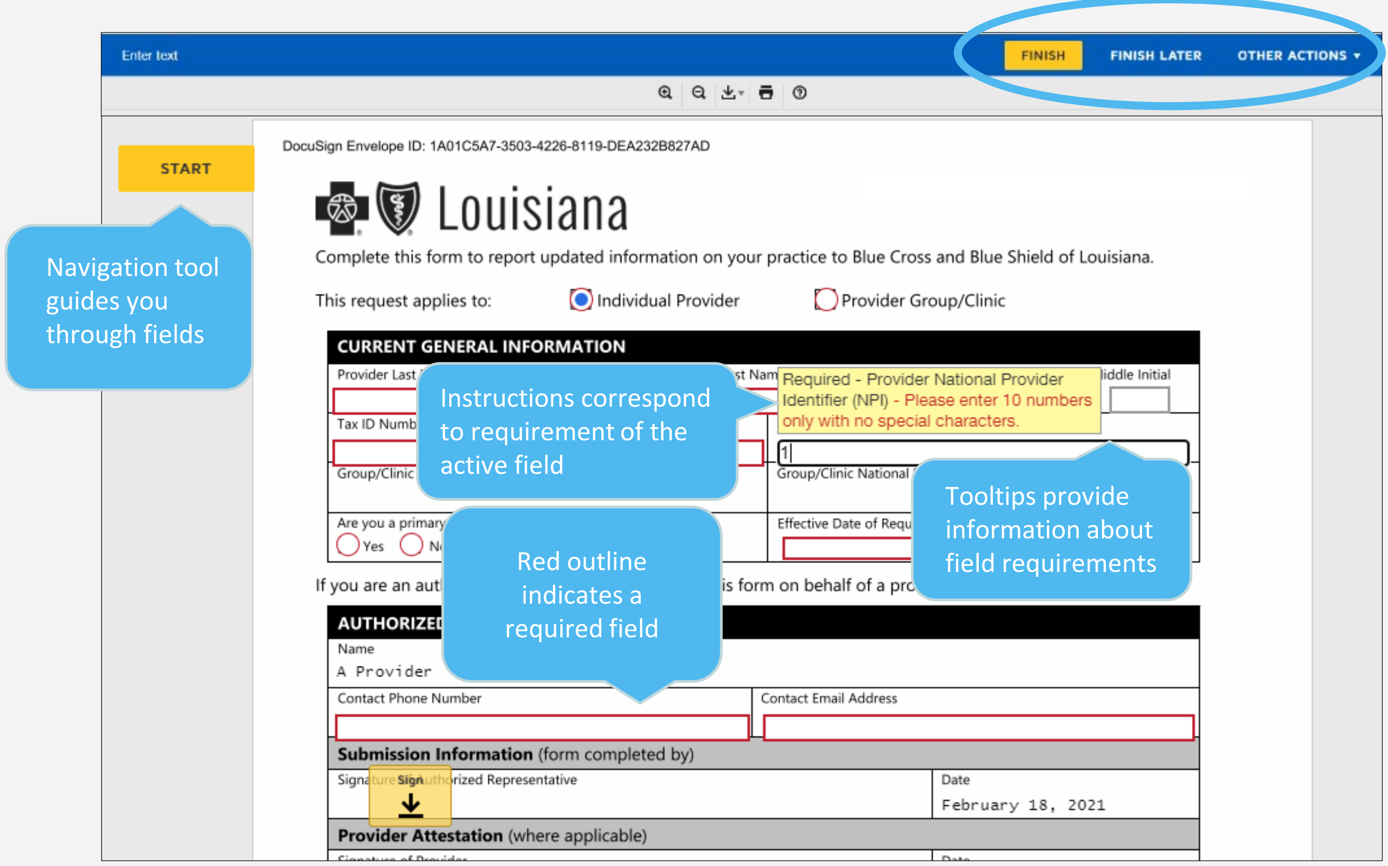
Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

18NW2798 01/20 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.

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

A DocuSign guide is available online at **www.lablue.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals, then look under the "Join Our Networks" tab.

Easily Complete Forms with DocuSign



Find our *DocuSign Guide* at **www.lablue.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Join Our Networks.

Credentialing Process

Since 1996, we have been dedicated to fully credentialing providers who apply for network participation.

Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC).

To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Louisiana Blue.

Providers will remain non-participating in our networks until a signed agreement is received by our contracting department.

The credentialing committee approves credentialing twice per month.

Inquire about your initial credentialing status by contacting our Provider Credentialing & Data Management (PCDM) Department at **PCDMstatus@bcbsla.com**.

Facility Network Availability

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

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

View the *Credentialing Criteria* for these facility types at **www.lablue.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Credentialing Process.

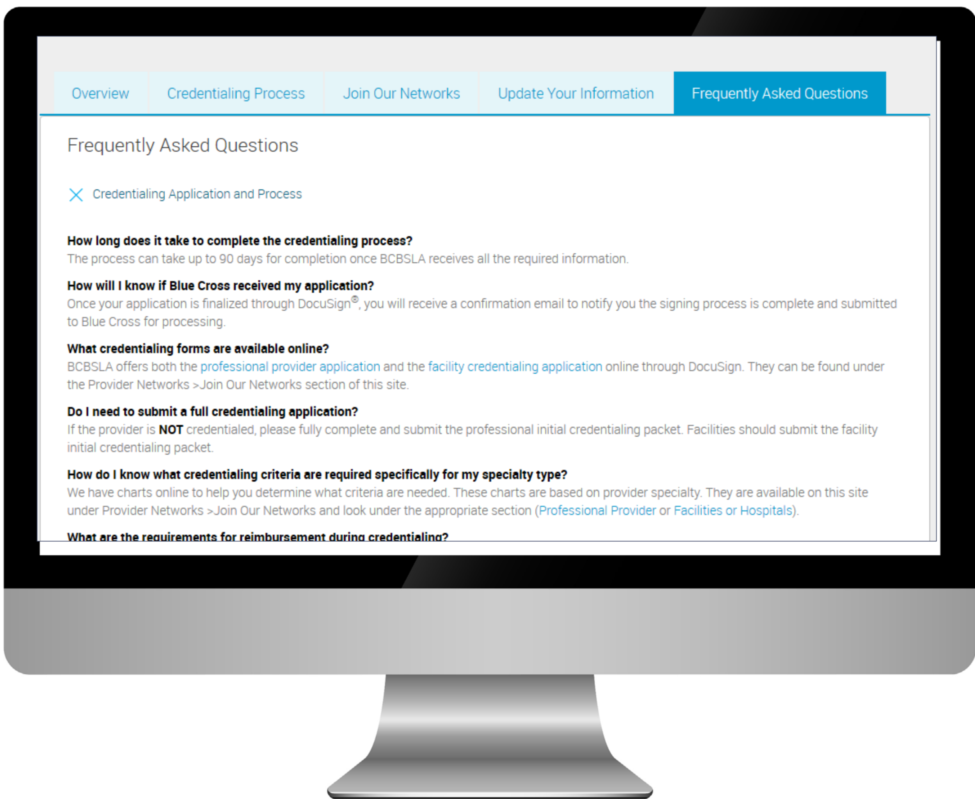
Hospital Based Providers

A hospital-based provider is defined as a provider that **only** sees patients as a result of their being admitted or directed to the hospital.

- The classification as a hospital-based provider applies for the hospital location only and NOT for any other practice locations outside the hospital.
- Hospital-based providers can be allowed to participate in our networks without credentialing requirements. We do not list those providers in the directory and allow the hospital's credentialing to stand.

A provider is **NOT considered hospital-based** if they have patients referred directly to them from another physician or organization or if the member can make an appointment with the physician.

Frequently Asked Questions



A list of FAQs is available at **www.lablue.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Frequently Asked Questions.

RECREDENTIALING

Louisiana Blue Recredentialing Process

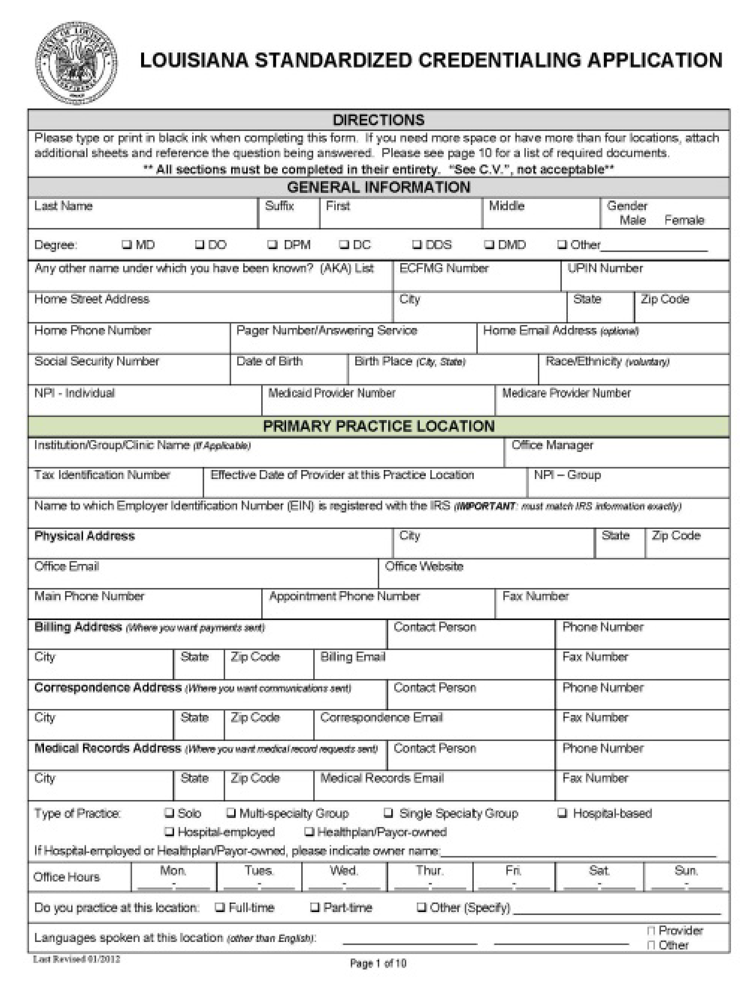
- Network providers must be approved through our **recredentialing** process **every three years** from the last credentialing acceptance date.
- Louisiana Blue sends* recredentialing applications to providers approximately six months prior to the recredentialing due date.
- Instructions are included on how to return completed forms. Louisiana Blue will complete the verification process.
- The Credentialing Committee reviews all recredentialing applications.

**The provider's correspondence record information is used when sending recredentialing applications.*

If you have questions during the process, you may email **recredentialing@bcbsla.com** or call (318) 807-4755.

Required Recredentialing Documents

The Louisiana Standardized Credentialing Application (LSCA) Application is accepted for recredentialing facilities.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

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

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

GENERAL INFORMATION

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

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

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

Home Street Address | City | State | Zip Code

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

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

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

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

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

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

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

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

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

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

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

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

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

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

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

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

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

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

Last Revised 01/2012

Page 1 of 10

Required Recredentialing Supporting Documentation for Facilities

The following documents must be submitted with your recredentialing application:

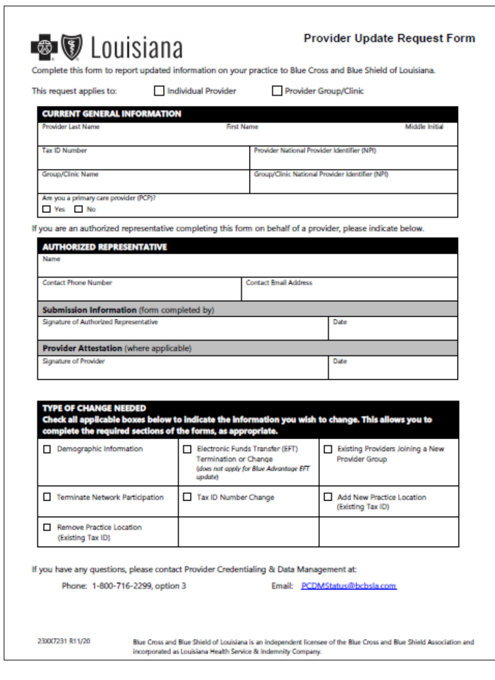
- Completed credentialing form
- Completed attachment(s), as applicable
- Copy of state license
- Copy of W-9
- Copy of Malpractice Liability Certificate (copy of policy declarations page)

If information is missing from submitted recredentialing application, the provider is then contacted by a recredentialing specialist with a deadline to return the needed information. If not received timely, then provider may be terminated from the network.

DATA MANAGEMENT

How to Update Your Information

This allows us to keep our directories current, contact you when needed as well as disperse payments. These forms are in DocuSign format, allowing you to easily submit them to Louisiana Blue electronically.



Louisiana

Provider Update Request Form

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

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

CURRENT GENERAL INFORMATION		
Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Group/Clinic Name	Group/Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? ☐ Yes ☐ No		

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

AUTHORIZED REPRESENTATIVE	
Name	
Contact Phone Number	Contact Email Address
Submission Information (form completed by)	
Signature of Authorized Representative	Date
Provider Attestation (where applicable)	
Signature of Provider	Date

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

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

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

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

23XX7231 R11/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

Provider Update Request Form – to update information such as:

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

Submit these forms online at **www.lablue.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Update Your Information.

Provider Update Request Form

- Indicate on the Provider Request Form the type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Filling out the entire form is not required.

TYPE OF CHANGE **Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.**		
☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change (*does not apply for Blue Advantage EFT update*)	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

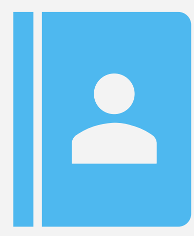
Provider Directory

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.lablue.com** under the "Find a Doctor or Drug" menu.

- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.



It is the contractual responsibility of all participating providers keep their information current with Louisiana Blue. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

Provider Attestation Form

The Provider Attestation Form is prepopulated with the information we have on file. Providers must verify and attest to the accuracy of the information.

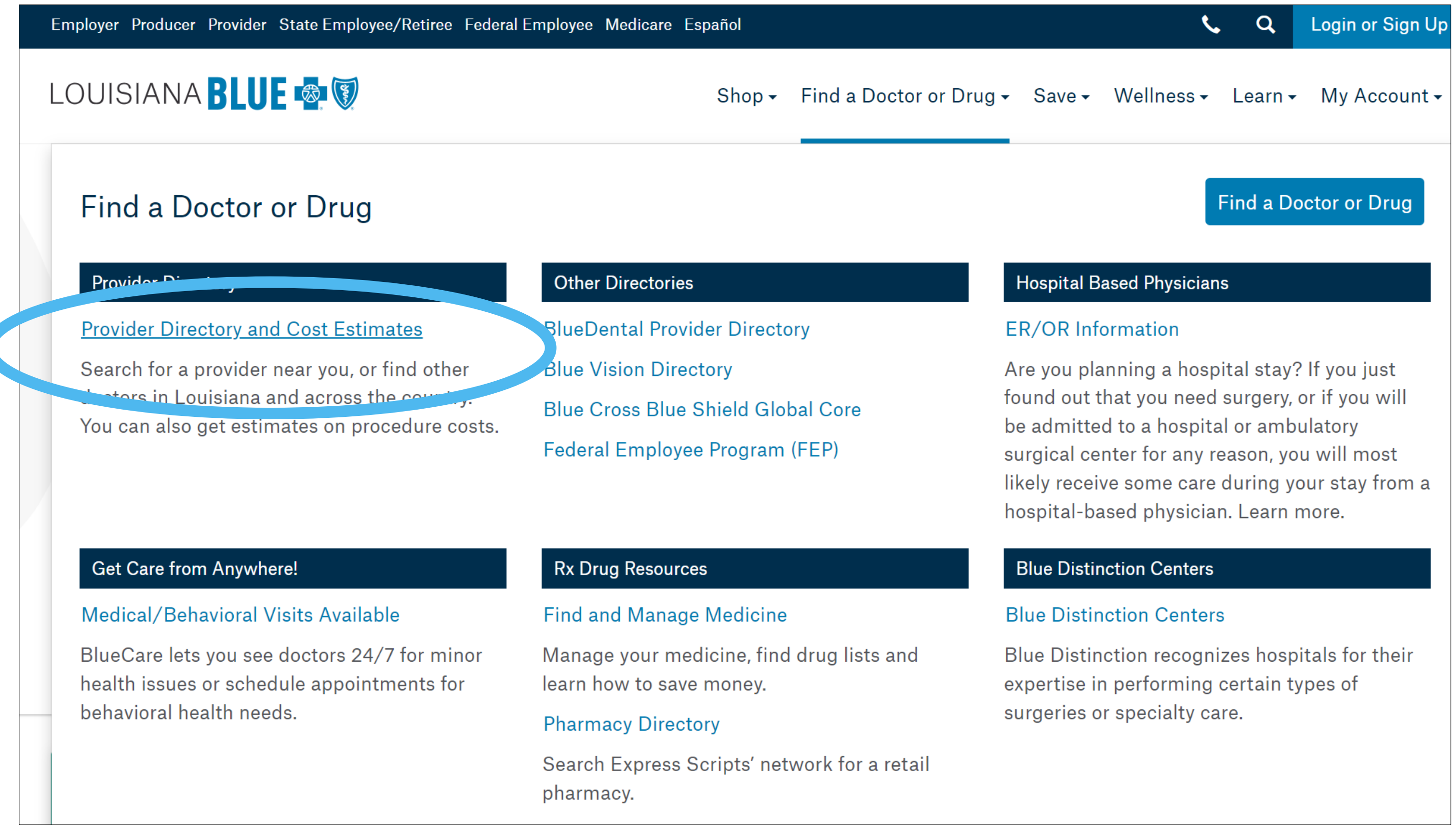
- In compliance with the federal Consolidated Appropriation Acts (CAA), our PCDM Department sends out a Provider Attestation Form every 90 days to all providers listed in our online provider directories. Providers must review their information as it appears in our directories and attest that it is still accurate.
- If any information is incorrect, you must complete and return our Provider Update Request Form. This allows us to update your published information in our directories. A link to the update form is included within the attestation form.

Providers who do not complete and submit the attestation form will be removed from our online provider directories.

IDENTIFYING YOUR PATIENTS

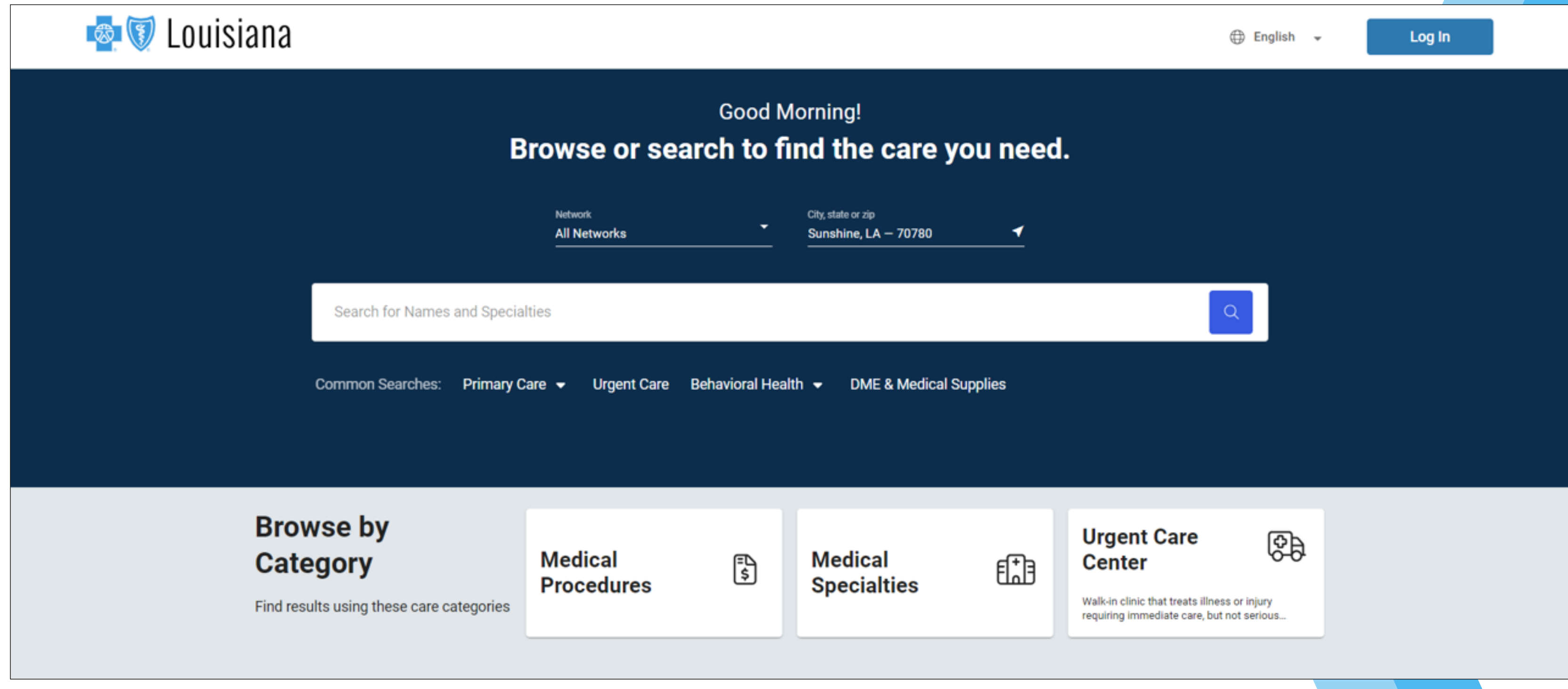
Knowing Your Networks

Louisiana Blue offers many networks. All providers do not participate in all networks. In order to maximize benefits for your patients, you need to know which networks you participate in. This information can be found online at **www.lablue.com** >Find a Doctor or Drug >Provider Directory and Cost Estimates.



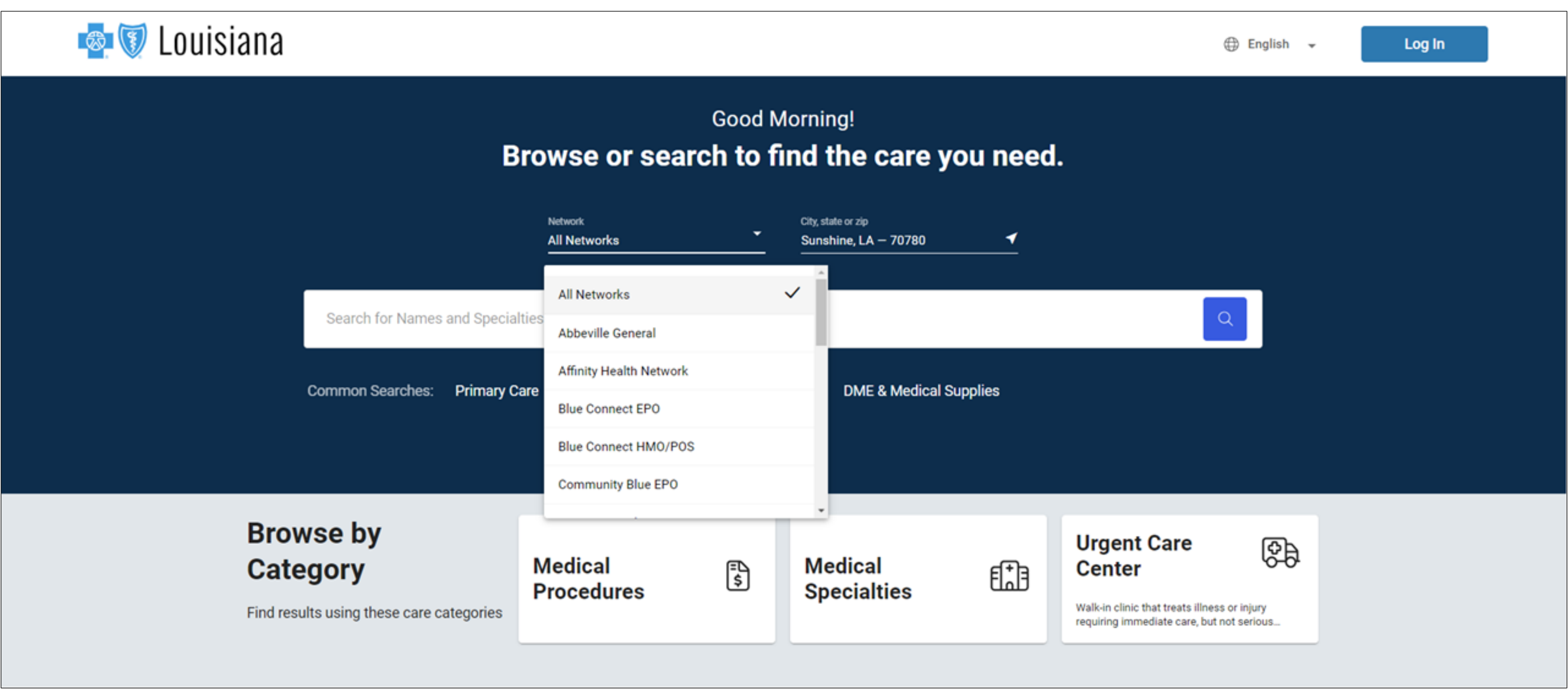
Provider Directory

- You can search for a provider by name or specialty.
- To refine your search, select a **Network** and/or enter your location in the **city, state or ZIP** field. You can skip this by logging in to your account, so that your network and location are automatically selected.



Provider Directory

- To find a provider in a particular network, select a network from the **Network** dropdown menu.
- The networks are listed in alphabetical order, or you can search "All Networks."
- If you log in to your account, you can skip this step because your network and location will be automatically selected.



Provider Directory

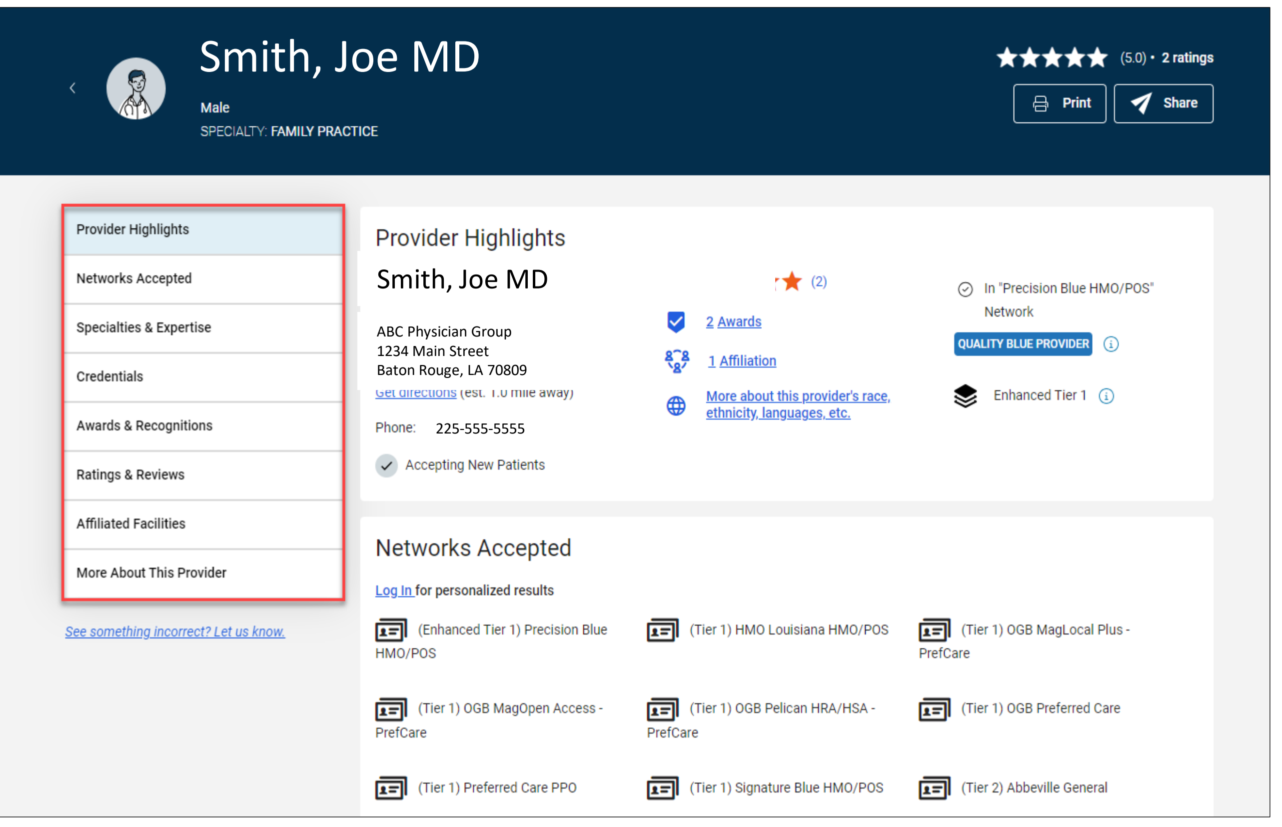
- To search by medical specialty, type in a specialty or term in the search bar box, and then click the result for which you're searching in the dropdown menu.
- If you do not see the specialty you need in the dropdown menu, then click the blue magnifying glass button to the far right of the search bar to get more search results.

Louisiana
English
Log In
Good Morning!
Browse or search to find the care you need.
Network
Preferred Care PPO
City, state or zip
Sunshine, LA – 70780
family
I'm looking for...
All Results
Names
Specialties
Specialties
Family Medicine
Diagnose and treat a wide variety of typical diseases and conditions, usually in a primary care capacity.
Marriage and Family Counselor
Works with couples and families to solve problems with talk therapy.
General Practice
Diagnose and treat a wide variety of typical diseases and conditions, often in a primary care capacity.

Provider Directory

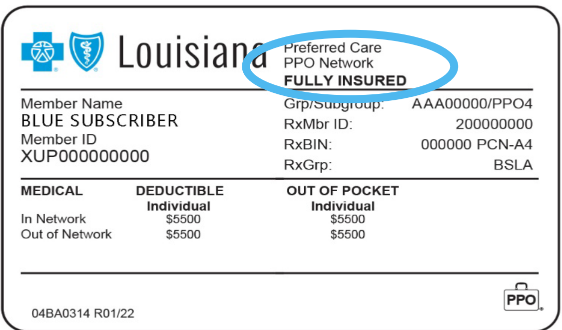
Each provider has a page with links:

- Provider Highlights
- Networks Accepted
- Specialties & Expertise
- Credentials
- Awards & Recognitions
- Ratings & Reviews
- Affiliated Facilities
- More About This Provider

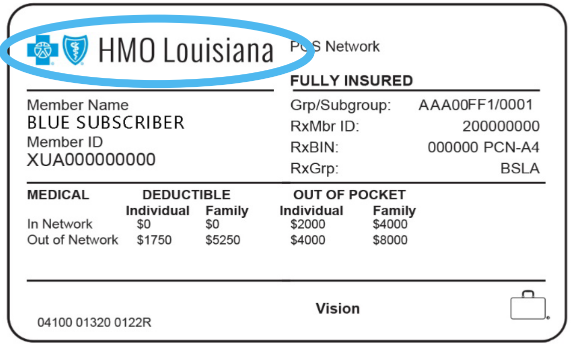


PPO and HMO Available Statewide

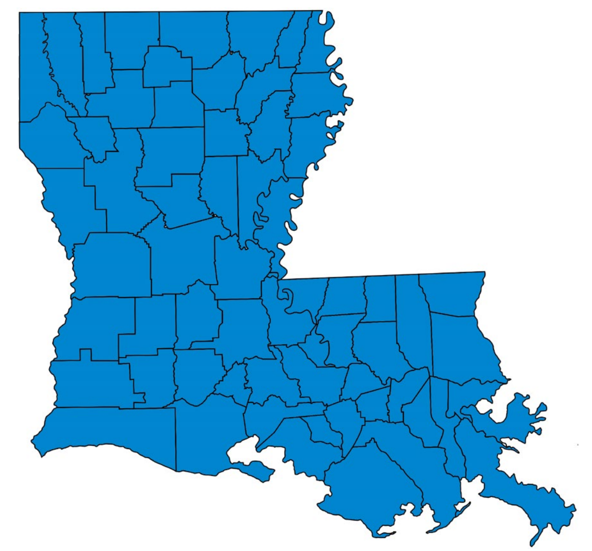
Preferred Care PPO



HMO Louisiana, Inc.



Our Preferred Care PPO and HMO Louisiana, Inc. networks are available statewide.



Office of Group Benefits

Prefixes: OGS, LZB or LXS

Louisiana Blue 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)

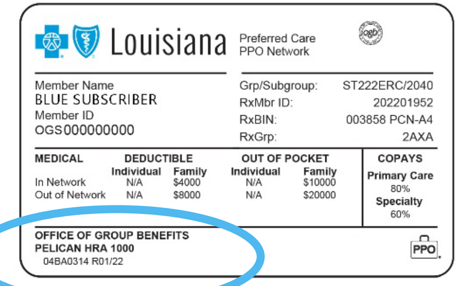
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

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

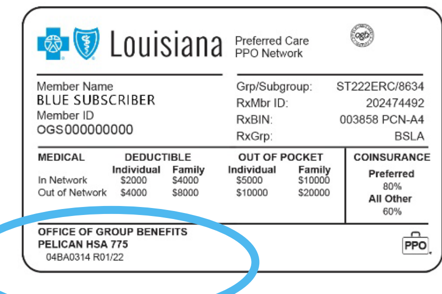
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

Sample OGB Member ID Cards

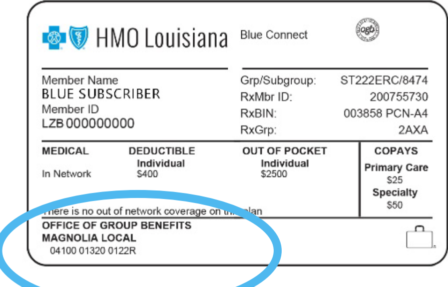
Pelican HRA 1000



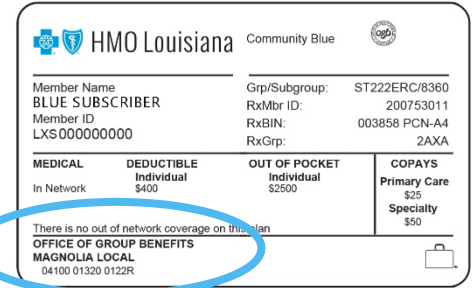
Pelican HRA 775



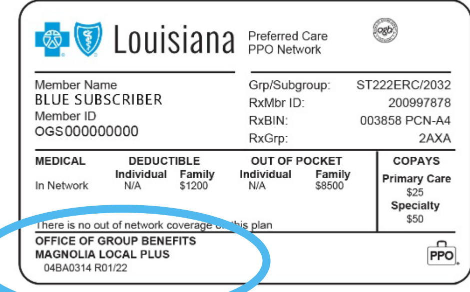
Magnolia Local Blue Connect



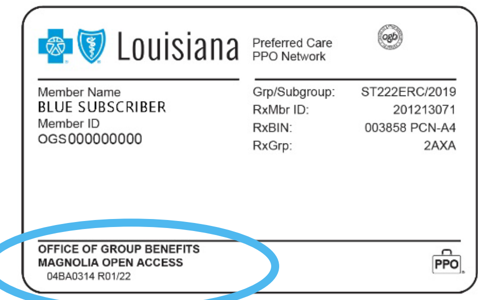
Magnolia Local Community Blue



Magnolia Local Plus



Magnolia Open Access

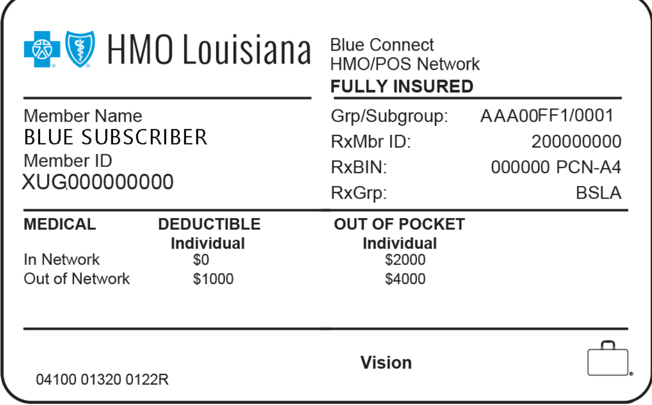


For more information about our OGB benefit plans as well as important plan requirements, view the *OGB Speed Guide*, available at **www.lablue.com/providers** >Resources >Speed Guides.

Blue Connect

HMO/POS Product

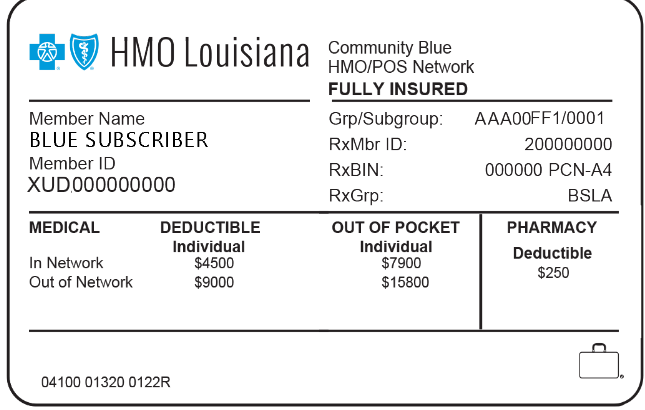
- **Prefixes XUF, XUG, XUU and XUV**
- Blue Connect is an HMO POS product currently available to groups and individuals residing in 17 parishes.
- Members may **not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Blue Connect Network.



Community Blue

HMO/POS Product

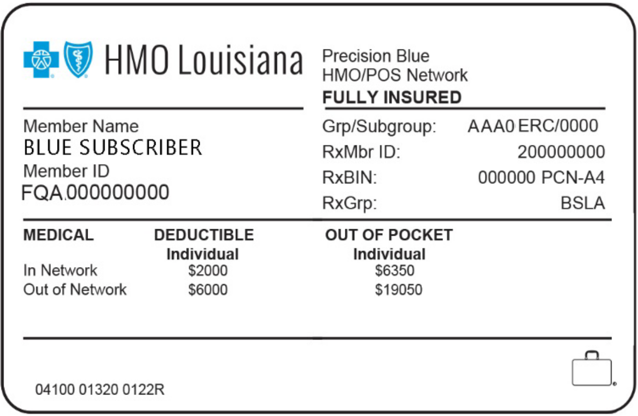
- **Prefixes XUD, XUJ and XUT**
- Community Blue is an HMO POS product currently available to groups and individuals residing in four parishes.
- Members may **not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Community Blue Network.



Precision Blue

HMO/POS Product

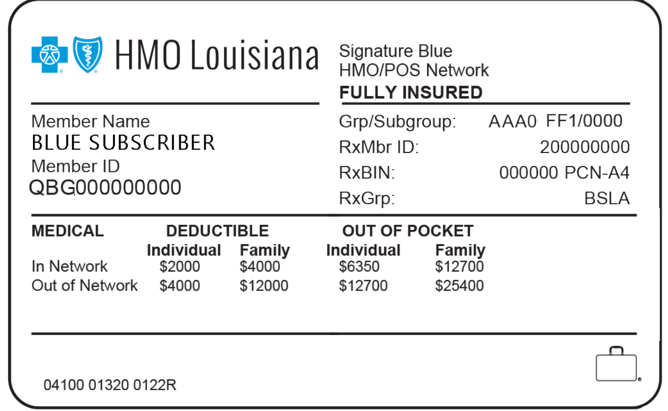
- **Prefixes: FQA, FQT or FQW**
- Precision Blue is an HMO POS product currently available to groups and individuals residing in 10 parishes.



Signature Blue

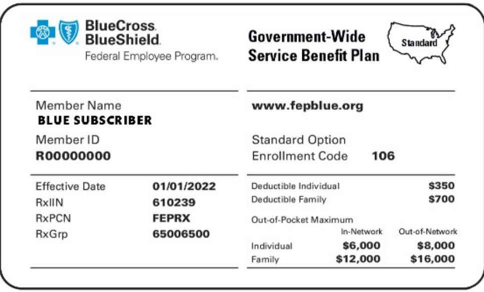
HMO/POS Product

- **Prefixes: QBB, QBE, QBG and QBS**
- Signature Blue is an POS product currently available to groups and individuals residing in Jefferson, Orleans and St. Tammany parishes.

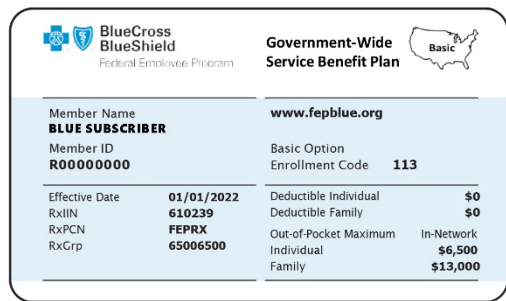


Federal Employee Program

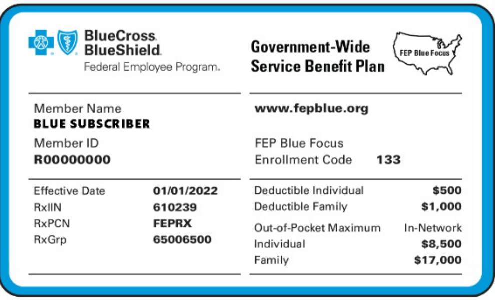
- **Prefix: R (followed by 8 digits)**
- The **Federal Employee Program (FEP)** provides benefits to federal employees and their dependents. These members use the Preferred Care PPO Network.



Standard
In-network benefit
Out-of-network benefits



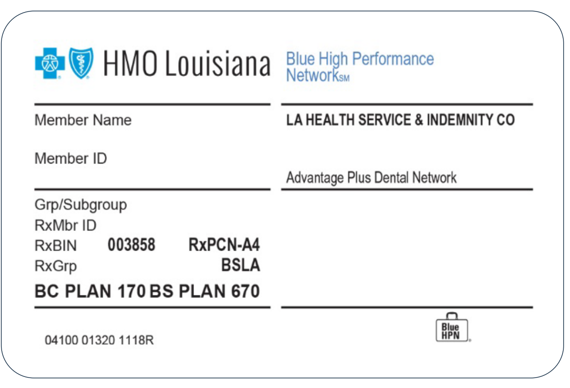
Basic
In-network benefits
No out-of-network benefits

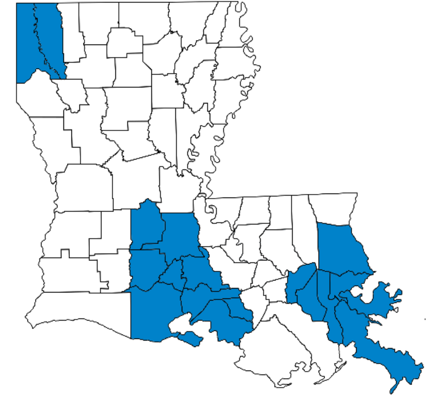


Blue Focus
Limited in-network benefits
No out-of-network benefits

Blue High-Performance Network

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

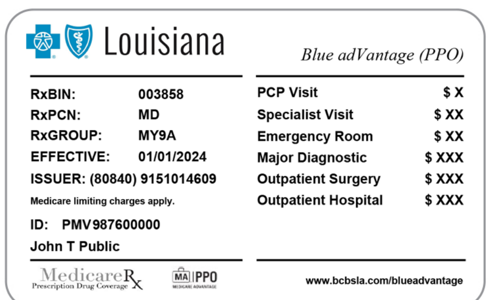
Shreveport area

Bossier and Caddo parishes

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

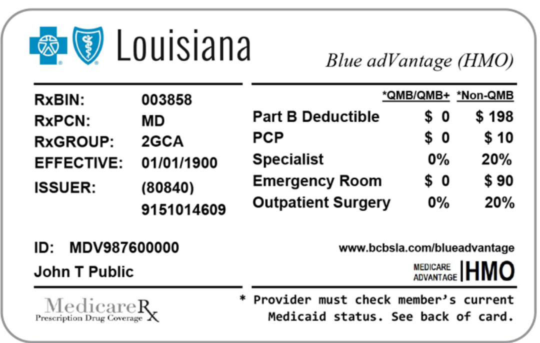
Blue Advantage

- **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.



D-SNP

- **Prefixes: MDV**
- Dual eligible special needs plans (D-SNPs) are a type of Medicare Advantage plan designed to meet the specific needs of dually eligible members currently available to Medicare-eligible members statewide.
- D-SNP members must use Blue Advantage network providers except for select situations such as emergency care.



BlueCard® Program

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

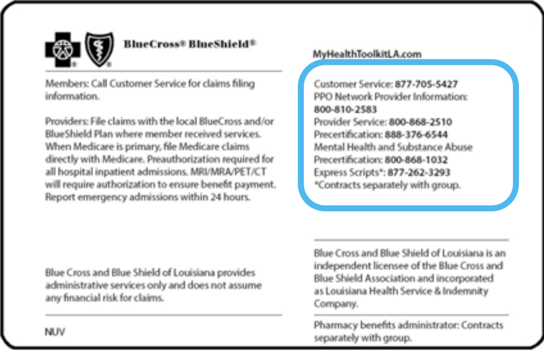
- The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.
- The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.
- The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.
- The BlueHPN suitcase logo indicates the member is enrolled in a BlueHPN product.

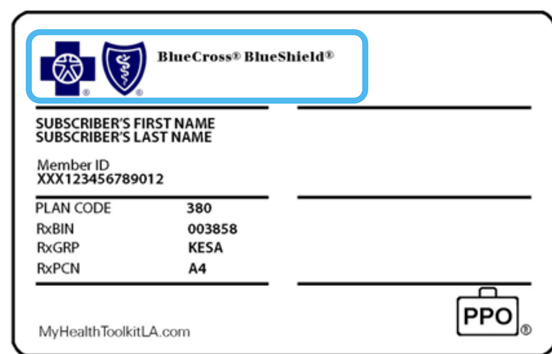
Note: BlueCard authorizations are handled through each member's home plan.

National Alliance

(South Carolina Partnership)

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



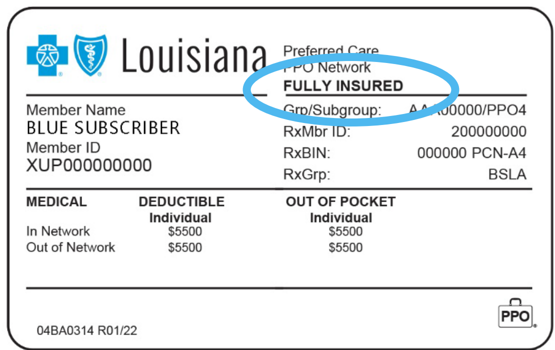


This list of prefixes is available on iLinkBlue (**www.lablue.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-funded

FULLY INSURED

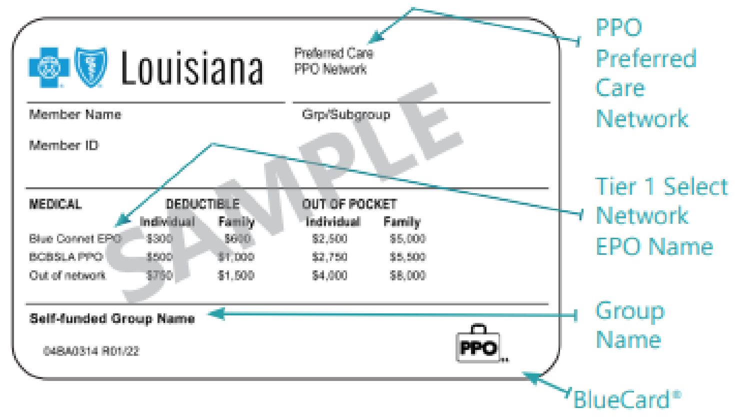
Group and individual policies issued by Louisiana Blue/HMOLA and claims are funded by Louisiana Blue/HMOLA.



"Fully Insured" notation

SELF FUNDED

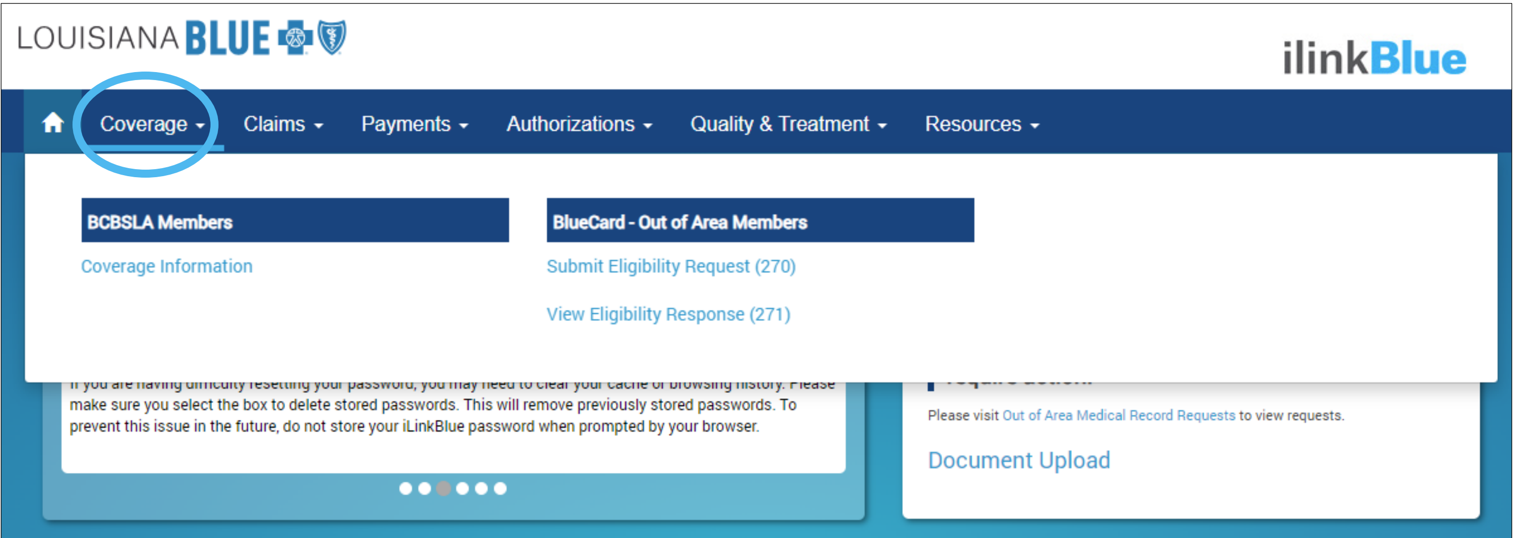
Group policies issued by Louisiana Blue/HMOLA but claims payments are funded by the employer group, not Louisiana Blue/HMOLA.



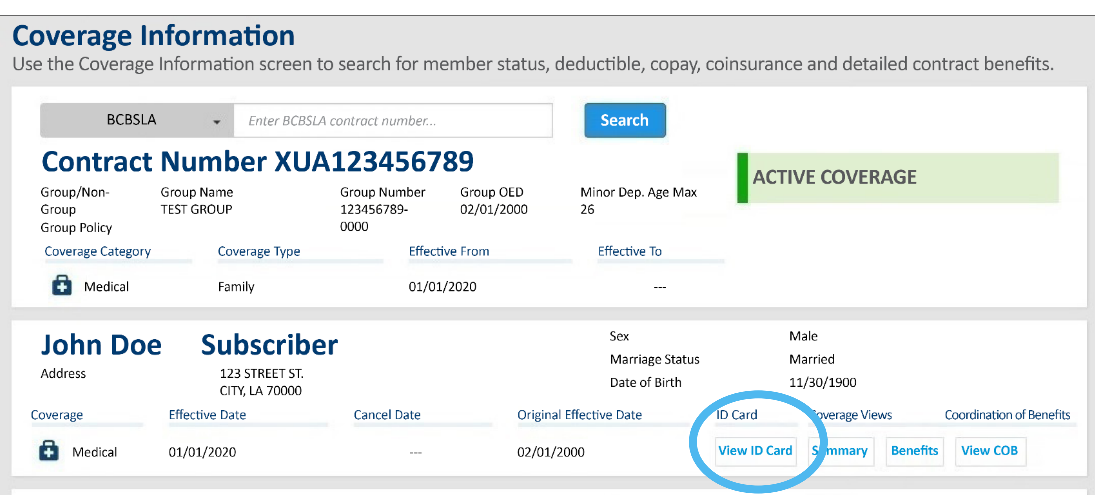
- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

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

Digital ID Cards in iLinkBlue



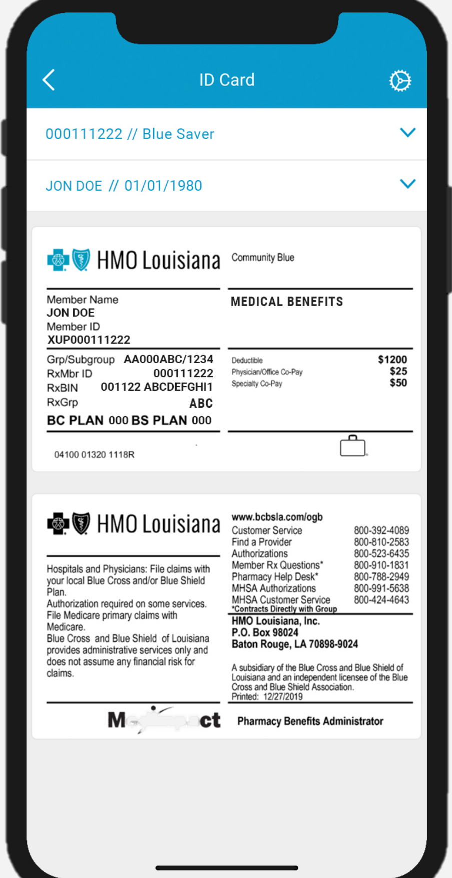
Digital ID cards can be accessed through iLinkBlue (**www.lablue.com/ilinkblue**) under the "Coverage Information" menu option, then click "View ID Card."



Digital ID Cards

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

- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available. Then download to their phone’s wallet. This eliminates the need to log into their Louisiana Blue account to view it.
- To access through the Louisiana Blue member portal, log into the online member account at **www.lablue.com**. There, click on “My ID Card” and use the drop-down menu to choose from ID cards available. These cards can be downloaded as PDFs and saved.



VERIFYING YOUR PATIENTS' BENEFITS

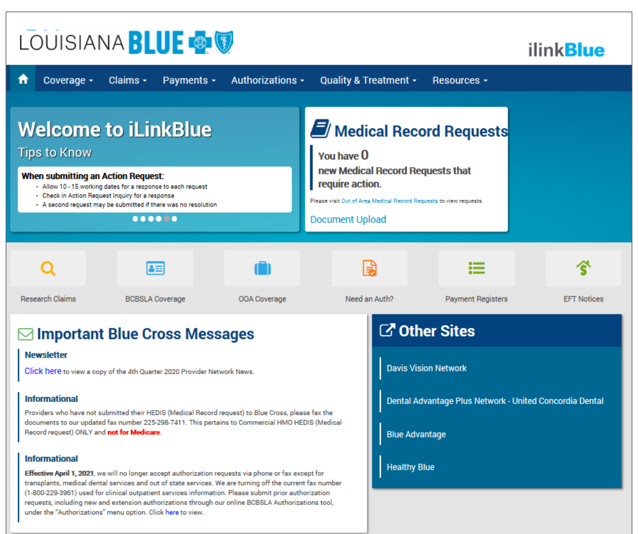
iLinkBlue

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

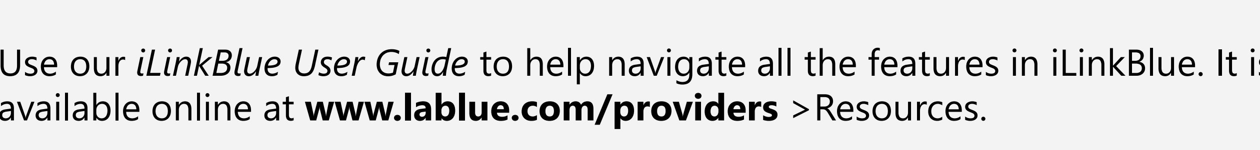
- Coverage & Eligibility
- Benefits
- Coordination of Benefits (COB)
- Claims Status (Louisiana Blue, FEP and Out of Area)
- Medical Code Editing
- Payment Registers/EFT Notifications
- Allowables Search
- Authorizations
- Medical Policy
- 1500 Claims Entry

ilinkBlue

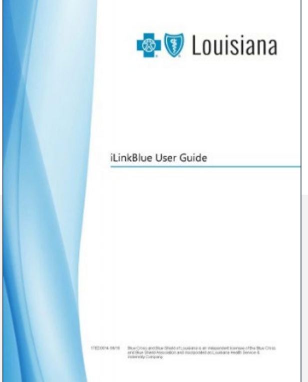
www.lablue.com/ilinkblue



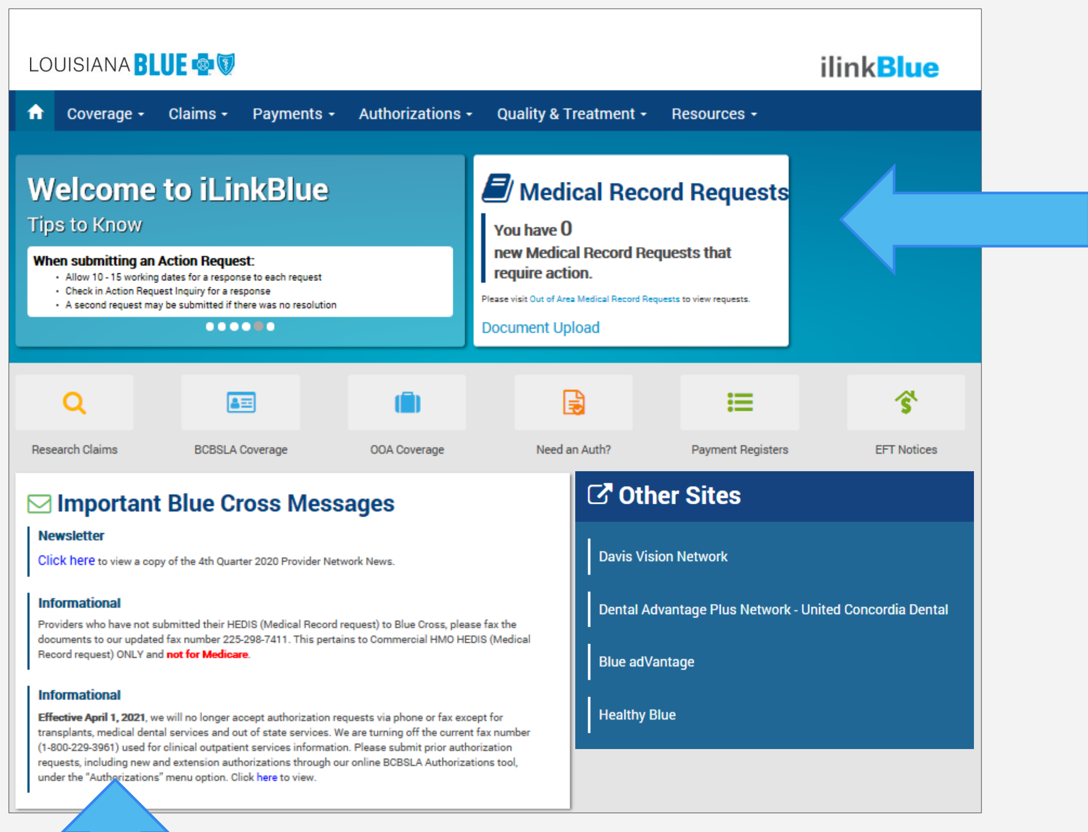
For iLinkBlue training and education, contact **provider.relations@bcbsla.com**.



Use our *iLinkBlue User Guide* to help navigate all the features in iLinkBlue. It is available online at **www.lablue.com/providers** >Resources.



iLinkBlue Landing Page

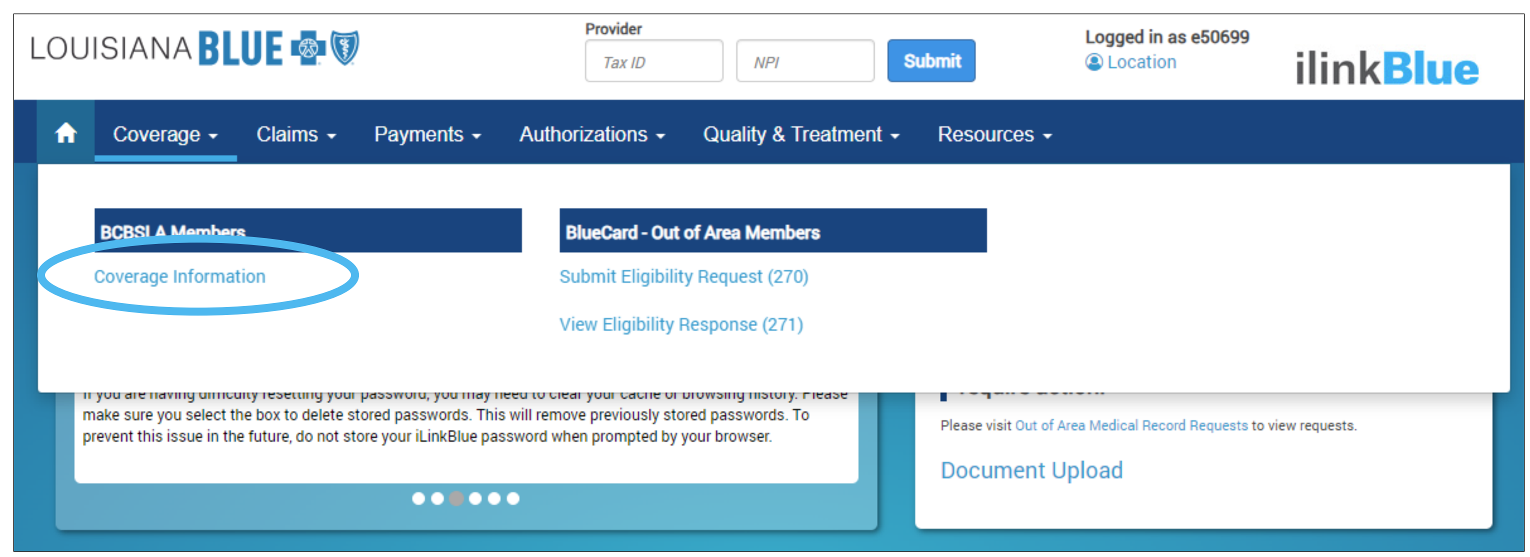


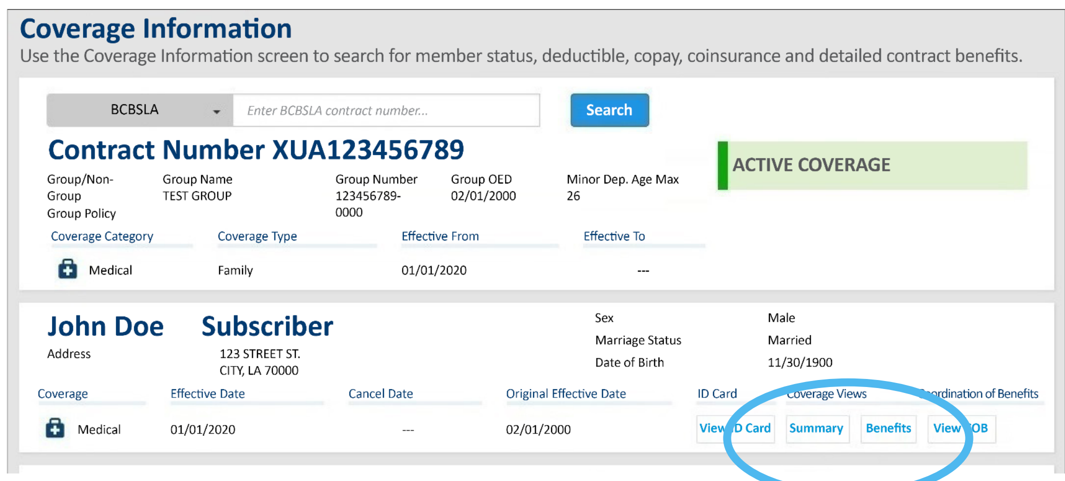
The main landing page has an alert box for when there are BlueCard® (out-of-area) medical record requests for your patients.

There is a message board on the main landing page. This area contains informational and alert posts such as:

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

Verifying Benefits in iLinkBlue





Easily verify your patient's benefits using iLinkBlue. Go to **www.lablue.com/ilinkblue** >Coverage >Coverage Information, then click on "Summary" and/or "Benefits."

Summary of Benefits - Copays

On the Summary page you will see a list of your patient's different copays.

- Office Visits
- Office Visit Specialist
- Emergency Room
- Inpatient Hospital (in-network)
- Inpatient Hospital Maximum
- High-Tech Imaging
- Outpatient Physical Therapy
- Outpatient Speech Therapy
- Cardiac Rehab
- Vision Services

Copays

		EPO Copays	QB Copays
Office Visit	$25.00	---	---
Office Visit Specialist	$50.00	---	---
Outpatient Surgical	---	---	---
Emergency Room	$200.00	---	---
Inpatient Hospital (In-network)	$100.00	---	---
Inpatient Hospital Maximum	$300.00	---	---
Inpatient Hospital (Out-of-network)	---	---	---
High-Tech Imaging	$50.00	---	---
Outpatient XRay & Lab	---	---	---
Outpatient Physical Therapy	$25.00	---	---
Occupational Therapy	---	---	---
Outpatient Speech Therapy	$25.00	---	---
Cardiac Rehab	$25.00	---	---
Vision Services	$25.00	---	---
Outpatient Professional	---	---	---

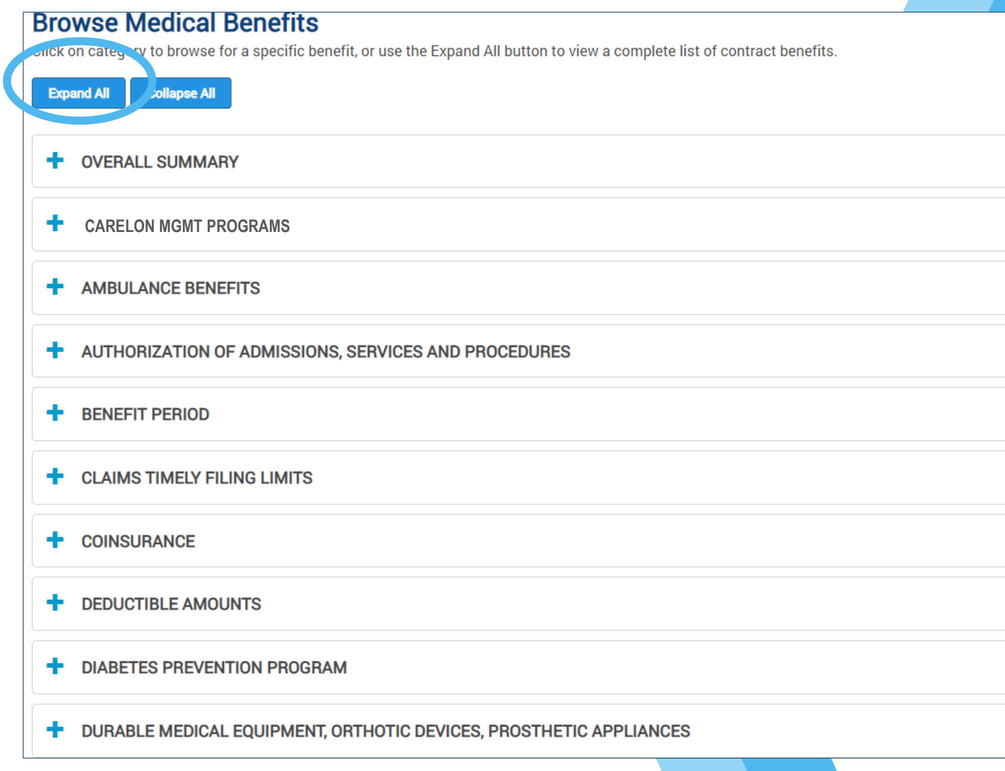
*For a complete listing of services that are subject to copays, please view the 'Contract Benefits' section of iLinkBlue. In addition to copays, deductible and coinsurance may apply.

Go to **www.lablue.com/ilinkblue** >Coverage >Coverage Information, then click on "Benefits."

Benefits

It is important to understand your patient's medical benefits. The Benefits page shows different types of benefits, including:

- Overall Summary
- Carelon Mgmt Programs
- Ambulance Benefits
- Authorizations
- Benefit Period
- Claims Timely Filing Limits
- Coinsurance
- Deductible Amounts
- Diabetes Prevention Program
- Durable Medical Equipment
- Office Copays
- Etc.



Go to **www.lablue.com/ilinkblue** >Coverage >Coverage Information, then click on "Benefits."

Additional Copays

Depending on the member's policy, there may be multiple tabs where copayments are listed. These can be found on under the Coverage menu, under Coverage Information, then Benefits.

X-RAY AND LABORATORY COPAYMENT

COPAYMENTS and COINSURANCE

*ACTIVE EMPLOYEES AND RETIREES WITH OR WITHOUT MEDICARE
- NETWORK PROVIDERS
* X-ray and Laboratory Services 100%
* Sonogram and Ultrasound (professional and outpatient facility) Copayment - $50
* MRA, MRI, CAT,PET, SPECT Scans (professional and outpatient facility) Copayment- $50
* Nuclear Cardiology (professional and outpatient facility) Copayment- $50

*ACTIVE EMPLOYEES AND RETIREES WITH OR WITHOUT MEDICARE
- NON-NETWORK PROVIDERS
* No Coverage

LOW TECH IMAGING AND LAB CLAIMS:
* 100% of the allowed amount when performed in a Physician's Office (place of treatment 11), Free Standing Independent Diagnostic Testing Facility (place of treatment 11) or a contracted Reference Lab (place of treatment 81). Urgent Care Centers should be treated like (place of treatment 11 (office).

Deductible and Coinsurance applies based on the allowed amount in a Hospital Based Lab (place of treatment 22).

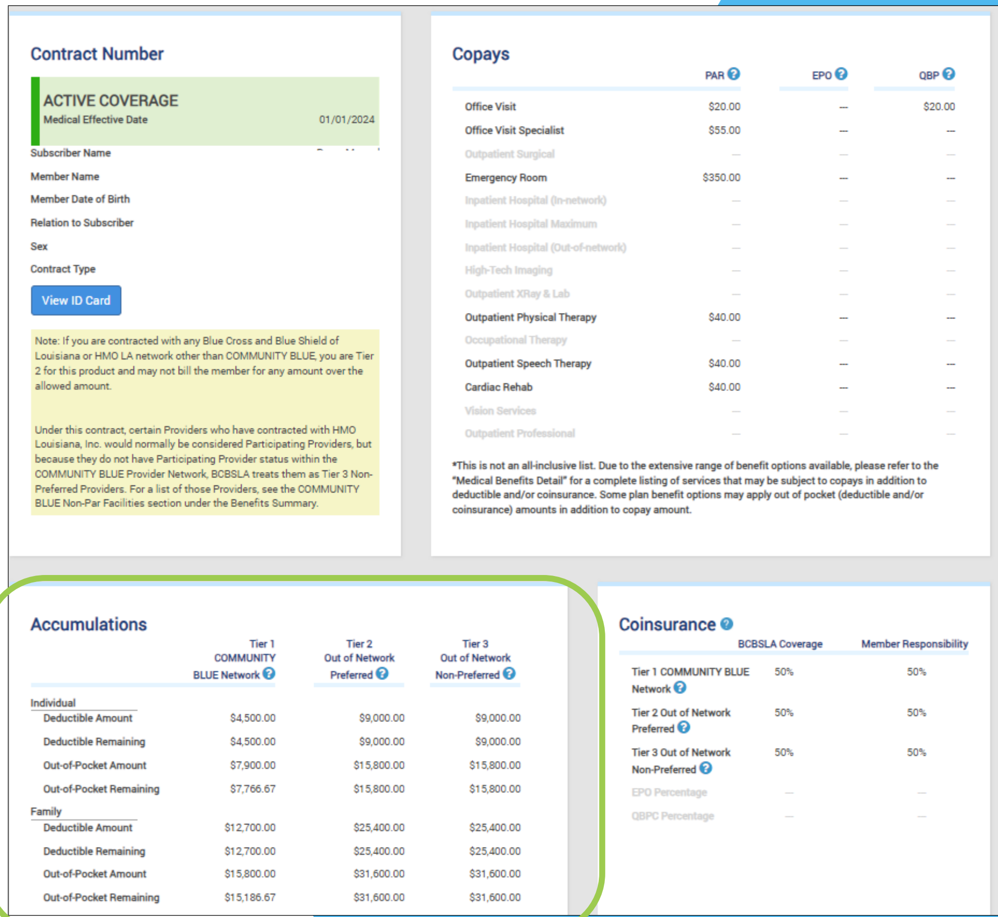
OTHER COPAYS

COPAYMENTS for NETWORK PROVIDERS
Ground Ambulance Services Copayment - $50 per day per Provider
Ambulatory Surgical Center and Outpatient Surgical Facility Copayment - $100 per surgical visit
Autism Spectrum Disorders (ASD) - $25 PCP / $50 Specialist
Bariatric Surgery Facility - $2,500 Facility Copayment
Cardiac Rehabilitation Copayment - $25 PCP / $50 Specialist
Cardiac Rehabilitation Outpatient Facility Copayment - $50 per visit
Chemotherapy Radiation Therapy Office Copayment - $25 per visit
Day Rehabilitation Programs Copayment - $25 per visit
Diabetic / Nutritional Counseling Copayment (Clinics and Outpatient Facilities) - $25 per visit
High-Tech Imaging Outpatient Copayment - $50 per visit
Inpatient Facility Copayment - $100 per day, $300 maximum per Admission
Massage Therapy (Outpatient) Copayment - $25 per visit
Mental Health / Substance Use Inpatient Treatment and Intensive Outpatient Programs Copayment - $100 per day, $300 maximum per Admission
Mental Health /Substance Use Disorder Outpatient Treatment Copayment - $25 per visit
Newborn (III / Sick) Facility Copayment - $100 per day, $300 maximum per Admission
Nurse Practitioner Copayment - $25 per visit
Occupational Therapy (Outpatient) Copayment - $25 per visit
Office Primary Care Physician Copayment - $25 per visit
Office Specialist Copayment - $50 per visit
Physical Therapy (Outpatient) Copayment - $25 per visit
Pregnancy Care Copayment - $90 per pregnancy
Retail Health Clinic Copayment - $25 per visit
Skilled Nursing Facility Copayment - $100 Copayment per day, $300 maximum per Admission
Sonograms and Ultrasounds (Outpatient) Copayment - $50 per visit
Speech Therapy (Outpatient) Copayment - $25 per visit
Urgent Care Center Copayment - $50 per visit
Vision Care (Non-Routine) Exam Copayment - $25 PCP / $50 Specialist

ALL PROVIDERS
Air Ambulance Services Copayment - $250 per day per Provider
Emergency Ground Ambulance Services Copayment - $50 per day per Provider (Emergency Medical Transportation only)
Emergency Medical Services Copayment (Hospital / Facility charge) - $200 per visit

Tiered Benefits

Some members' benefits include **tiered benefit levels**. Accumulations will show deductibles and coinsurance depending on the provider's network participation. The provider must participate in the member specific select network to be considered a Tier 1 provider.



Contract Number

ACTIVE COVERAGE
Medical Effective Date 01/01/2024

Subscriber Name
Member Name
Member Date of Birth
Relation to Subscriber
Sex
Contract Type

View ID Card

Note: If you are contracted with any Blue Cross and Blue Shield of Louisiana or HMO LA network other than COMMUNITY BLUE, you are Tier 2 for this product and may not bill the member for any amount over the allowed amount.

Under this contract, certain Providers who have contracted with HMO Louisiana, Inc. would normally be considered Participating Providers, but because they do not have Participating Provider status within the COMMUNITY BLUE Provider Network, BCBSLA treats them as Tier 3 Non-Preferred Providers. For a list of those Providers, see the COMMUNITY BLUE Non-Par Facilities section under the Benefits Summary.

Copays

	PAR	EPO	QBP
Office Visit	$20.00	—	$20.00
Office Visit Specialist	$55.00	—	—
Outpatient Surgical	—	—	—
Emergency Room	$350.00	—	—
Inpatient Hospital (In-network)	—	—	—
Inpatient Hospital Maximum	—	—	—
Inpatient Hospital (Out-of-network)	—	—	—
High-Tech Imaging	—	—	—
Outpatient XRay & Lab	—	—	—
Outpatient Physical Therapy	$40.00	—	—
Occupational Therapy	—	—	—
Outpatient Speech Therapy	$40.00	—	—
Cardiac Rehab	$40.00	—	—
Vision Services	—	—	—
Outpatient Professional	—	—	—

*This is not an all-inclusive list. Due to the extensive range of benefit options available, please refer to the "Medical Benefits Detail" for a complete listing of services that may be subject to copays in addition to deductible and/or coinsurance. Some plan benefit options may apply out of pocket (deductible and/or coinsurance) amounts in addition to copay amount.

Accumulations

	Tier 1 COMMUNITY BLUE Network	Tier 2 Out of Network Preferred	Tier 3 Out of Network Non-Preferred
Individual			
Deductible Amount	$4,500.00	$9,000.00	$9,000.00
Deductible Remaining	$4,500.00	$9,000.00	$9,000.00
Out-of-Pocket Amount	$7,900.00	$15,800.00	$15,800.00
Out-of-Pocket Remaining	$7,766.67	$15,800.00	$15,800.00
Family			
Deductible Amount	$12,700.00	$25,400.00	$25,400.00
Deductible Remaining	$12,700.00	$25,400.00	$25,400.00
Out-of-Pocket Amount	$15,800.00	$31,600.00	$31,600.00
Out-of-Pocket Remaining	$15,186.67	$31,600.00	$31,600.00

Coinsurance

	BCBSLA Coverage	Member Responsibility
Tier 1 COMMUNITY BLUE Network	50%	50%
Tier 2 Out of Network Preferred	50%	50%
Tier 3 Out of Network Non-Preferred	50%	50%
EPO Percentage	—	—
QBPC Percentage	—	—

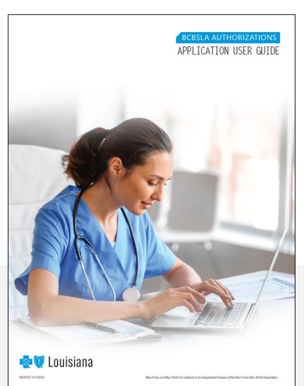
Tiered Benefits

Enhanced Tier 1 In-network Preferred	Tier 1 In-network Preferred	Tier 2 Out-of-network Preferred	Tier 3 Out-of-network Non-Preferred
Select providers in the Precision Blue network.	Providers in the member's network.	Providers participating with Louisiana Blue but NOT in the member's network.	Non-participating providers (do not participate in any Louisiana Blue network).
Member Benefit Plan:			
Precision Blue Only	• Blue Connect • Community Blue • Precision Blue • Signature Blue	• Blue Connect • Community Blue • Precision Blue • Signature Blue	• Blue Connect • Community Blue • Precision Blue • Signature Blue
Example Scenarios:			
• Precision Blue member sees a **select** Precision Blue network provider. • The accumulations and copayments identified as Enhanced Tier 1 are applied. • Provider may not bill the member for any amount over the allowed amount.	• Community Blue member sees a Community Blue network provider. • The accumulations, copayments and coinsurance identified as Tier 1 apply. • Provider may not bill the member for any amount over the allowed amount.	• A Community Blue member sees a Signature Blue network provider. • The accumulations, copayments and coinsurance identified as Tier 2 apply. • Provider may not bill the member for any amount over the allowed amount.	• A Community Blue member sees a non-participating provider. • The accumulations, copayments and coinsurance identified as Tier 3 apply. • Provider can bill the member for any amount over the allowed amount.

AUTHORIZATIONS

iLinkBlue Authorizations Application

- Louisiana Blue replaced the BCBSLA Authorizations application in iLinkBlue. The new application is powered by **Epic Systems Corporation** (Epic) and designed to be more user friendly and efficient for providers and their staff.
- The application allows providers to request authorizations 24 hours a day, seven days a week, in real time.
- **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 in iLinkBlue.**
- Louisiana Blue no longer accepts authorization requests via phone or fax, with a few exceptions including transplants, dental medical and out-of-state services.



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

BCBSLA Authorizations Application FAQs

How do we notify Louisiana Blue if the case is stat or urgent?

- For urgent requests that will occur within 72 hours choose the “Urgent/Preservice” Priority type when submitting the authorization request. If the request is within 24 hours, then also use the Add Referral Note feature in the application and enter “STAT NOTE" in the summary field.

When logged into the BCBSLA Authorizations application, can you change providers without exiting completely out of the program?

- Yes, users may view and load authorizations for multiple providers during a single session. The provider NPI:Tax ID must be linked to your iLinkBlue user account for this option.

How will I access authorization determination (approval/denial) letters in the new BCBSLA Authorizations application?

- The new BCBSLA Authorizations application includes an In Basket feature that allows the Referred to Location/POS and Referred To providers access determination letters. All providers attached to the case can find the determination letters in the Referral details screen.

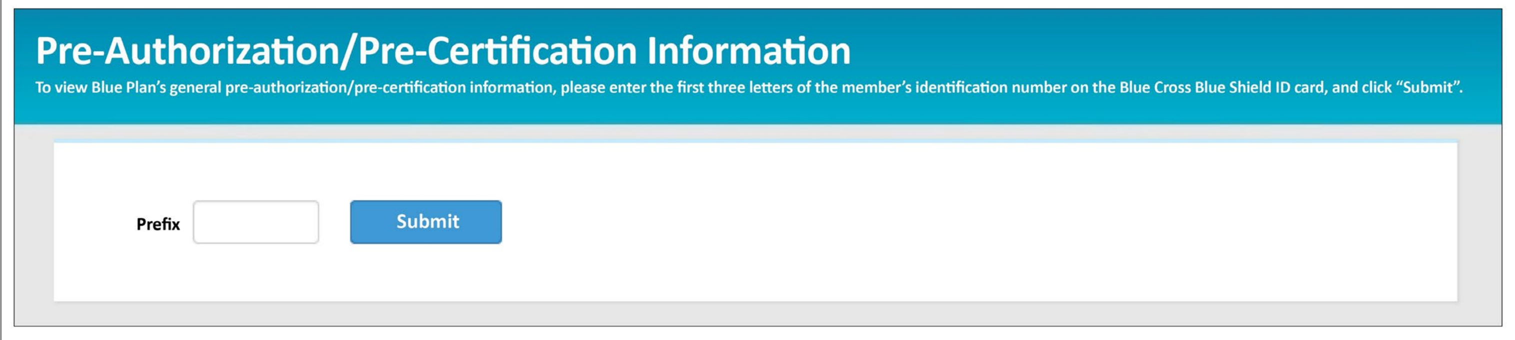
View Frequently Asked Questions at **www.lablue.com/providers** >Electronic Services >Authorizations, under the quick links section.

Where to Find Authorization Requirements

Do I need an authorization?

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

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

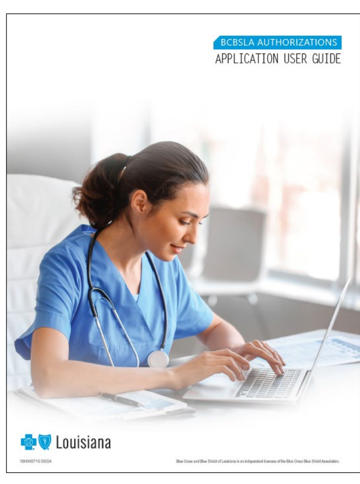


Requesting Authorizations thru iLinkBlue

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

Authorizations Resources

Use the "Resources" menu option in iLinkBlue to access various provider manuals, including the **BCBSLA Authorizations Application User Guide**.



The following can also be found on are also available on iLinkBlue at **www.lablue.com/ilinkblue** >Manuals: *Blue Cross and Blue Shield of Louisiana Member Provider Policy & Procedure Manual, iLinkBlue User Guide* as well as Inpatient and outpatient authorizations how to videos.

Adding Notes to an Authorization Request

Adding notes to your authorization request/referral is not mandatory. In fact, adding notes when not needed may cause delays to your request.

- Notes are not mandatory in the BCBSLA Authorizations application. Only add a note if you have pertinent information to share.
  - For example, you do not have to send a note indicating clinicals will follow.
  - Notes are not needed for requests that are automatically approved or when no authorization is required. To see the status of your submission, refresh the Referral Details page. The record is usually updated instantly but could take up to three minutes for providers to receive the case pending, automatic approval or no authorization is required.
- The BCBSLA Authorizations application does not interface with a provider's Epic-powered EMR system.
  - Please do not add notes instructing us to reference MRN numbers as the application does not utilize MRN numbers.

For more information about adding notes, review Page 50 of the *BCBSLA Authorizations Application User Guide,* found on iLinkBlue (**www.lablue.com/ilinkblue**), under Resources, then Manuals.

Provider Note Type

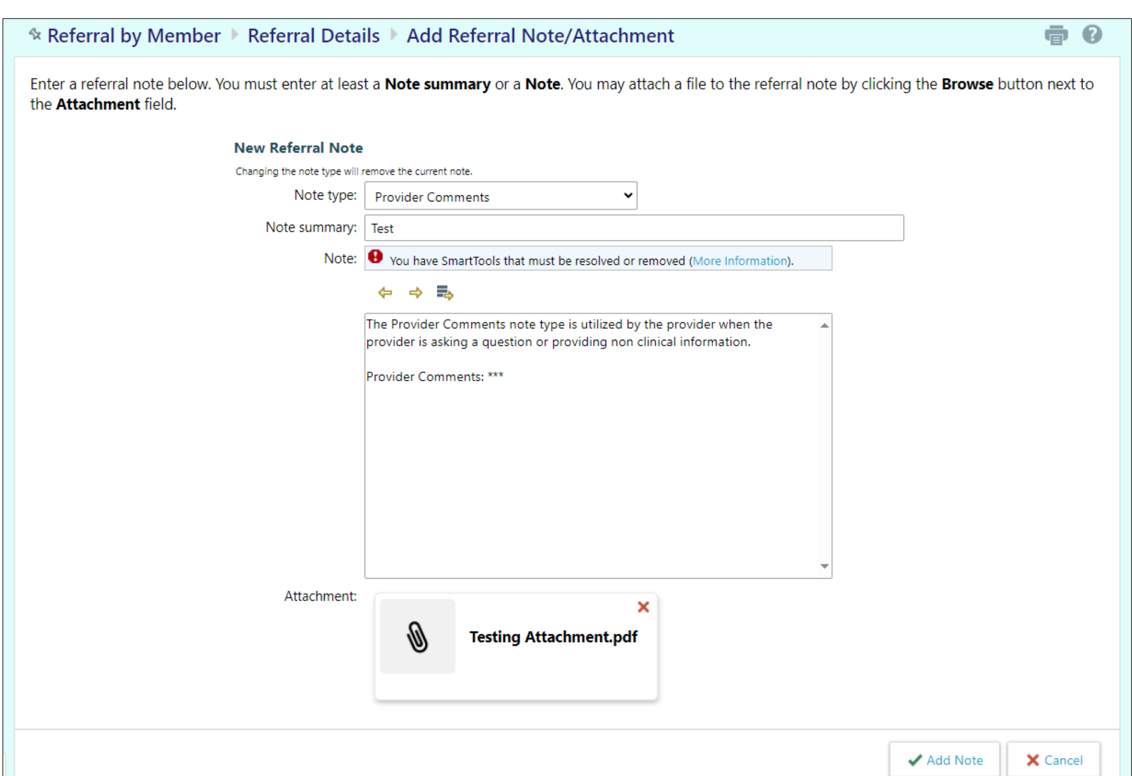
When adding a note, select the appropriate Note Type that fits your need. Selecting the incorrect type can delay processing of your authorization request.

- **Provider Non-clinical Comments**: Select when asking a question, providing a non-clinical information or sending a non-medical record communication to Louisiana Blue that is not one of the below options.
- **Provider IQ Note**: Select when submitting an InterQual (IQ) review via notes.
- **Provider IP Extension/Concurrent Request**: Select when requesting additional inpatient bed days only. This is not for outpatient services.
- **Provider Clinical Information**: Select when submitting medical records and additional clinical information for review.
- **Provider Peer to Peer**: Select when requesting a peer-to-peer review after a service has been denied.
- **Provider Reconsideration Request**: Select when submitting additional information for review after a service has been denied.
- **Provider IP Discharge Notification**: Select to submitting an inpatient discharge date and discharge disposition.
- **Provider Additional Service Request**: Select when the provider is requesting additional units/visits/hours/days on present outpatient services or requesting additional service codes for either inpatient or outpatient.

Adding Notes to an Authorization Request

The **Note** text field will allow you to enter a message and select an attachment.

If you need to include additional attachments, create a new note for each attachment.



Failure to Obtain an Authorizations

Failure to obtain a prior authorization can result in:

- A 30% penalty imposed on Preferred Care PPO and HMO Louisiana, Inc. network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization.

- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized (Note: some policies contain a different inpatient penalty provision).

- The denial of payment for services for our Office of Group Benefits (OGB) members.

- A $500 penalty applied to inpatient hospital claims for Federal Employee Program (FEP) members with Standard Option, Basic Option and FEP Blue Focus benefits. For select outpatient services, no payment will be made if prior authorization is not obtained. If prior approval is not obtained for certain OP and IP services, a $100 penalty may be applied on Blue Focus.

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

Process for Changing a Louisiana Blue Authorization

You can add a note and/or attachment to change or add a code to an already approved authorization when **all of the following** conditions are met:

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

If the above criteria is met, an authorization can be changed within seven calendar days of the services being rendered.

Adding a note and/or attachment to the request in the BCBSLA Authorizations application will allow providers to:

- Correspond with the Louisiana Blue Authorization Department
- Add additional information
- Extend an authorization or add additional services
- Change an authorization
- Requesting peer-to-peer review (flag as critical)
- Close or cancel an authorization created in error

Gold Card Program

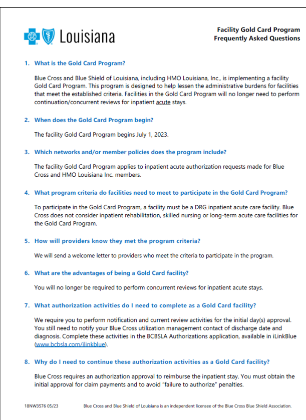
Facilities that meet the program criteria are enrolled in the Gold Card Program and receive the following benefits:

Provider Type	Gold Card Program Benefit	Participation Criteria
Facilities	Will no longer need to perform continuation/concurrent reviews for acute inpatient stays.	• Is a DRG inpatient acute care facility; or • Is an inpatient acute care facility that has a percent of billed charges agreement with Louisiana Blue

Louisiana Blue does not consider the following facilities for the Gold Card Program:

- Per diem inpatient acute care
- Inpatient rehabilitation
- Skilled nursing
- Long-term acute care

If you have questions or would like to request the Gold Card Program FAQs email **provider.relations@bcbsla.com**.



Louisiana

Facility Gold Card Program
Frequently Asked Questions

1. **What is the Gold Card Program?**

   Blue Cross and Blue Shield of Louisiana, including HMO Louisiana, Inc., is implementing a facility Gold Card Program. This program is designed to help lessen the administrative burdens for facilities that meet the established criteria. Facilities in the Gold Card Program will no longer need to perform continuation/concurrent reviews for inpatient acute stays.

2. **When does the Gold Card Program begin?**

   The facility Gold Card Program begins July 1, 2023.

3. **Which networks and/or member policies does the program include?**

   The facility Gold Card Program applies to inpatient acute authorization requests made for Blue Cross and HMO Louisiana Inc. members.

4. **What program criteria do facilities need to meet to participate in the Gold Card Program?**

   To participate in the Gold Card Program, a facility must be a DRG inpatient acute care facility. Blue Cross does not consider inpatient rehabilitation, skilled nursing or long-term acute care facilities for the Gold Card Program.

5. **How will providers know they met the program criteria?**

   We will send a welcome letter to providers who meet the criteria to participate in the program.

6. **What are the advantages of being a Gold Card facility?**

   You will no longer be required to perform concurrent reviews for inpatient acute stays.

7. **What authorization activities do I need to complete as a Gold Card facility?**

   We require you to perform notification and current review activities for the initial day(s) approval. You still need to notify your Blue Cross utilization management contact of discharge date and diagnosis. Complete these activities in the BCBSLA Authorizations application, available in iLinkBlue (www.bcbsla.com/ilinkblue).

8. **Why do I need to continue these authorization activities as a Gold Card facility?**

   Blue Cross requires an authorization approval to reimburse the inpatient stay. You must obtain the initial approval for claim payments and to avoid "failure to authorize" penalties.

18NW3576 05/23

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

CARELON AUTHORIZATIONS

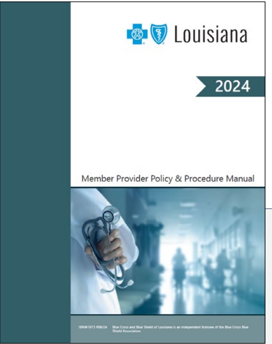
Utilization Management Programs

Louisiana Blue has several utilization management programs that require prior authorization for select elective services. Carelon Medical Benefits Management, an independent specialty benefits management company, serves as our authorization manager for these services:

- Cardiology
- High-tech Imaging
- Genetic Testing
- Sleep Study
- Radiation Oncology
- Musculoskeletal (MSK)
    - Interventional Pain Management, Joint Surgery and Spine Surgery

Authorization requests may be completed online using the Carelon MBM Provider Portal accessed through iLinkBlue. Carelon clinical appropriateness guidelines are available at **https://guidelines.carelonmedicalbenefitsmanagement.com**.

NOTE: When medical requests are requested by Carelon, please forward the records to them instead of Louisiana Blue.

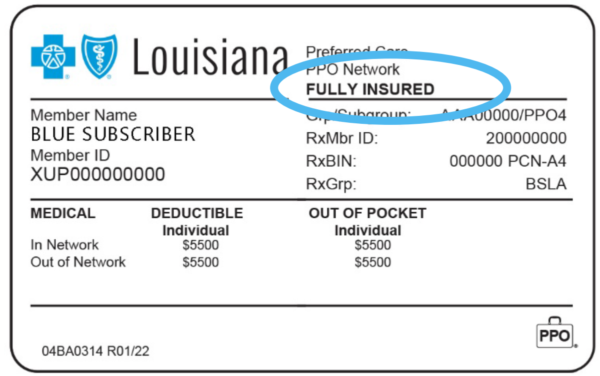


Additional information can be found in the *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.lablue.com/ilinkblue**, click on "Resources," then "Manuals."

Which Members Are in the Carelon Program?

Below are general guidelines to help identify the members that are a part of our utilization management programs. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

- Fully insured members are a part of all programs. Fully insured members can be identified by the words "Fully Insured" on the member ID card.
- Self-funded members (ASO plans) have an option to be in these programs. Self-funded member ID cards will include the group name but will NOT include the words "Fully Insured."



- Small Business Funded (SBF) members are a part of all programs. SBF members have "SBF" in the group number in the Group/Subgroup section of their member ID card.
- Office of Group Benefits (OGB) members are a part of all programs, except the Sleep Management Program.

Carelon Authorizations

When an authorization is required, please refer to members' benefits in iLinkBlue to determine where to obtain an authorization, (Carelon or the BCBSLA Authorizations application). Fully insured members are in all Carelon programs. This can also be viewed under the Benefits tab.

CARE - CARELON PROGRAMS

Group DOES participate with CARELON PROGRAMS
1.866.455.8416 x4842

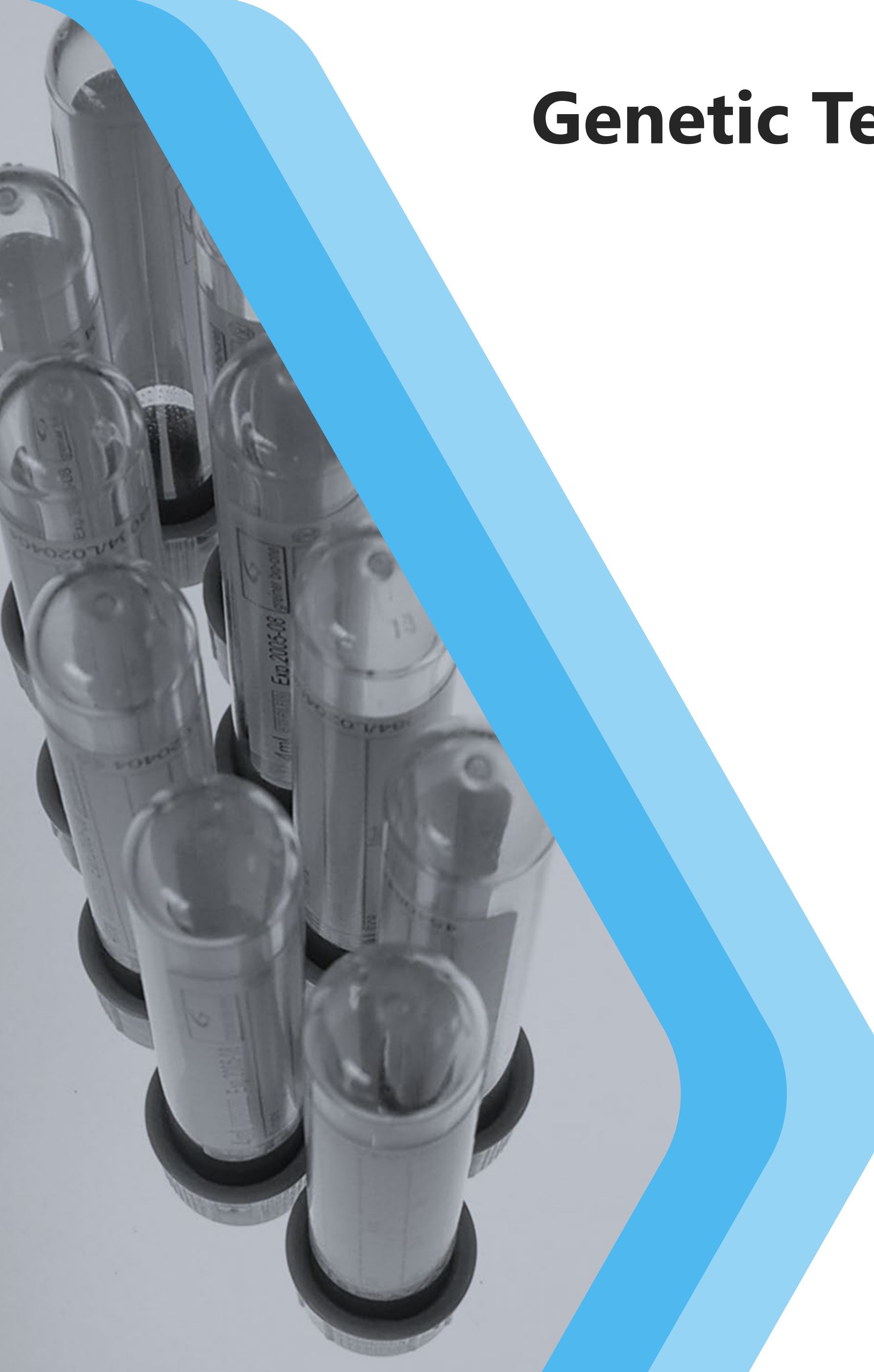
Program Participation:
- High-Tech Imaging
- Musculoskeletal Care Management Program
- Cardiac Diagnostic & Interventional Services
- Radiation Oncology Program

Example: member's authorizations through Carelon for these services.

CARE - CARELON PROGRAMS

Group DOES NOT participate with CARELON PROGRAMS

Example: authorization would be entered in BCBSLA Authorizations



Genetic Testing Program

We have transitioned the review of genetic testing to Carelon for dates of services on and after July 1, 2024.

- As a provider of genetic testing, Louisiana Blue requires that you participate in the new program.
- The ordering physician must submit prior authorization reviews to Carelon for all outpatient genetic testing.
- This program is for all fully insured and self-funded members, including Office of Group Benefits (OGB) members. At this time, Federal Employee Program (FEP) members are not included in the program.

Carelon Guidelines for Changing Authorizations

- Carelon allows **seven** days post the service (retro) for the provider to call and update the original request for MSK program.

- All other programs allows **two** days, with the exception of some cardiac services that allow 10 days post service.

POLICIES AND PROCEDURES

Changes to E&M Coding Policy for ED Claims

Effective November 1, 2024, Louisiana Blue will begin using the Optum Emergency Department Claim (EDC) Analyzer™ tool to determine appropriate E&M coding levels for outpatient facility ED claims.

The EDC Analyzer tool determines appropriate E&M coding levels based on data from the patient's claim including the following:

- Patient's presenting problem
- Diagnostic services performed during the visit
- Any patient complicating conditions

To learn more about the EDC Analyzer tool, please visit https://EDCAnalyzer.com.

Changes to E&M Coding Policy for ED Claims

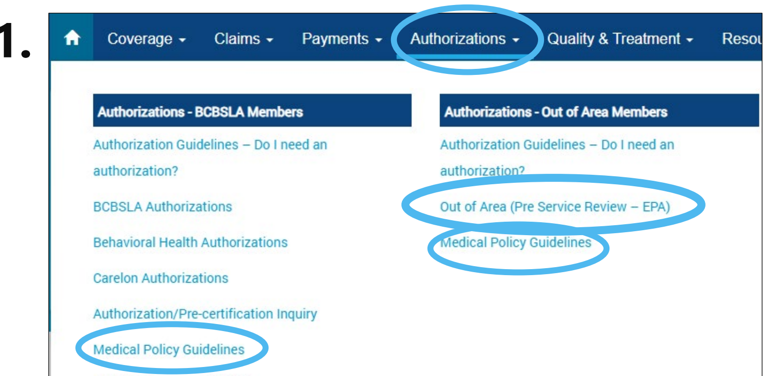
This policy applies to facilities, including freestanding facilities (with exceptions of ASO groups that DO NOT opt in, which includes OGB). Criteria that may exclude outpatient facility claims from these policies include, but are not limited to:

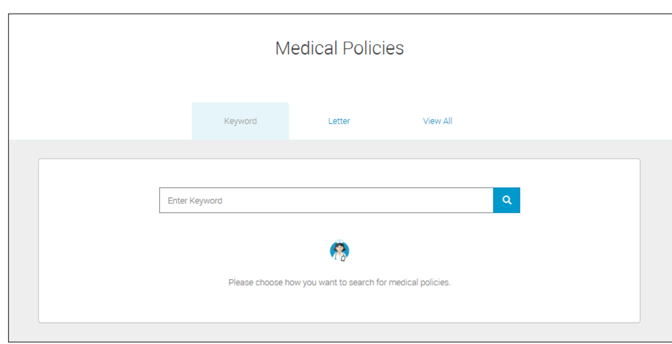
- Claims for patients who were admitted from the emergency department or transferred to another healthcare setting (skilled nursing facility, long-term care hospital, etc.)
- Claims for patients who received critical care services (99291, 99292)
- Claims for patients under the age of 2 years
- Claims with certain diagnosis codes that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Claims for patients who expired in the ED

Facilities submitting claims for ED E&M codes may experience adjustments to reflect an appropriate level E&M code or may receive a denial, based on the reimbursement structure set forth in the applicable Louisiana Blue network agreement.

Accessing Our Medical Policies

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

1. 

2. 

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

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

FEP Medical Policy Guidelines

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

Laboratory Benefit Management Program

Louisiana Blue has partnered with Avalon Healthcare Solutions to offer a 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.

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

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

Providers can now review and research the lab policies and guidelines.
Go to **www.lablue.com/providers** >Medical Management >Lab Management.

Lab Reimbursement Policies

Coverage ▾ | Claims ▾ | Payments ▾ | Authorizations ▾ | Quality & Treatment ▾ | Resources ▾

Authorizations Guidelines

Do I need an authorization?

Authorizations - BCBSLA Members

BCBSLA Authorizations

Behavioral Health Authorizations

Carelon Authorizations

Authorization/Pre-certification Inquiry

Medical Policy Guidelines

Lab Reimbursement Policies

FEP Medical Policy Guidelines

Authorizations - Out of Area Members

Out of Area (Pre Service Review – EPA)

Medical Policy Guidelines

Our medical policies can also be found online at **www.lablue.com/provider** >Medical Management >Medical Policies.

Laboratory Policies

Blue Cross and Blue Shield of Louisiana Health Laboratory Testing Policies

Blue Cross and Blue Shield of Louisiana (BCBSLA) has partnered with Avalon Healthcare Solutions for Laboratory Benefits Management (LBM) in order to administer Avalon's Routine Testing Management (RTM), a post-service pre-payment clinical claim editing program. The laboratory testing policies for the RTM program are accessible through the links below. These policies are specific to BCBSLA network and product requirements and in alignment with its policies, rules, and/or state and federal contracts. In the event of a conflict, BCBSLA's policies, rules, and/or state and federal contracts will take precedence.

The RTM policies below are effective for claims with a date of service of May 15th, 2022, and later.

Search...

- F2019: Flow Cytometry
- G2002: Cervical Cancer Screening
- G2005: Vitamin D Testing
- G2006: Diabetes Mellitus Testing
- G2007: Prostate Biopsies
- G2008: Prostate Specific Antigen (PSA) Testing
- G2009: Preventive Screening in Adults
- G2011: Diagnostic Testing of Iron Hemostasis and Metabolism
- G2013: Testosterone

Laboratory Benefit Management Denials

- If services were denied due to an Avalon policy, the policy number will appear on the provider payment register.
- You can then access our policies and procedures, put the policy number in the search field and it will display the policy and criteria.

SUBSCRIBER, JOE XUP20000000 1 7/2/2022 7/2/2022 220000080061 $137.98 $137.98 $0.00

Lab Policy #G2050, Procedure Code: 80061, Decision: D06R - 1 per 1 Yr

Providers can now review and research the lab policies and guidelines.
Go to **www.lablue.com/providers** >Medical Management >Lab Management.

Laboratory Benefit Management Denials

- If you are billing in accordance with how the policy reads and you feel there is a systemic or configuration issue present that caused the claim to deny you may submit your findings to **provider.relations@bcbsla.com** for review.

- If you believe our published policy does not indicate coverage for your claim and/or you are disputing the policy itself, submit your case using our Provider Dispute Form. Please include clinically published documentation. Louisiana Blue will not process dispute cases submitted without published documentation.

The Provider Disputes Form can be found on our Provide page at **www.lablue/providers** >Resources >Forms.

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Intra-operative Monitoring Services

We require all intra-operative monitoring (IOM) services to be contracted with Louisiana Blue.

- When our members receive care provided in your facility by a non-contracted IOM, the members have higher out-of-pocket costs.
- When approached by an IOM to request privileges at your facility, please verify that they are in network with Louisiana Blue.

Provider Contracting Team

1-800-716-2299, option 1

provider.contracting@bcbsla.com

BLUE DISTINCTION

Blue Distinction Specialty Care Centers

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

Two designation levels:

Blue Distinction® Center

Blue Distinction® Center+

The current programs are:

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

The Specialty Program selection criteria is available at **www.lablue.com** >About Us >Capabilities & Initiatives >Blue Distinction >Blue Distinction Specialty Care.

Blue Distinction Level Comparison

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

BILLING GUIDELINES

Timely Filing

Louisiana Blue, HMO Louisiana, Blue Connect, Community Blue, BlueHPN, Precision Blue & Signature Blue	Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.
FEP	Louisiana Blue FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the service were provided.
Blue Advantage	• Providers have 12 months from the date of service to file an initial claim. • Providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim.
OGB	• Claim must be filed within 12 months of the date of service. • Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim.
Self-funded & BlueCard	Timely filing standards may vary. Always verify the member's benefits, including timely filing standards, through iLinkBlue.

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

Ordering/Referring Policy

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

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

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

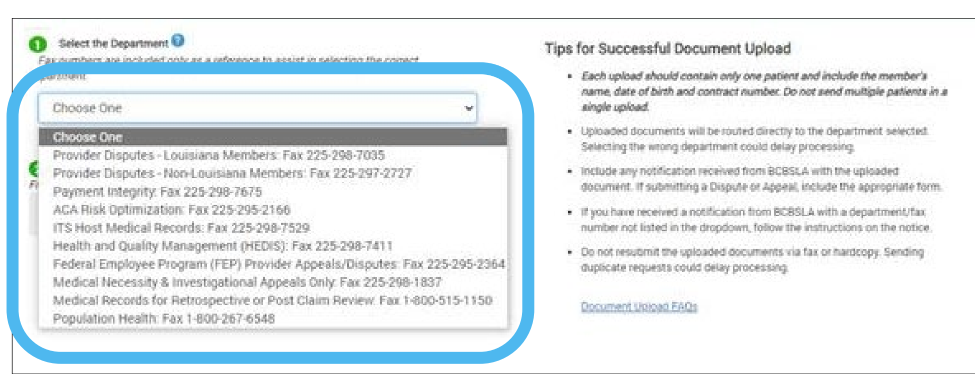
Please enter the ordering/referring provider's information for paper and electronic claims as indicated below:

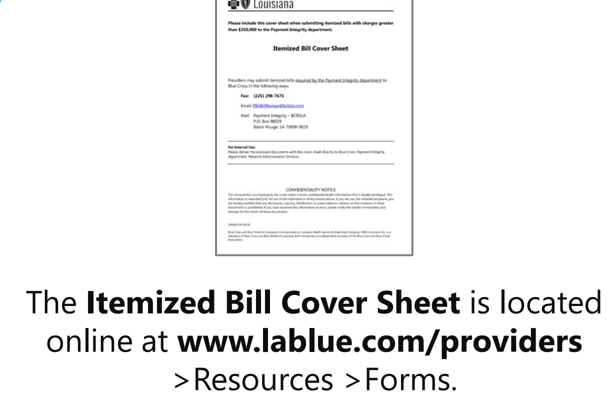
Paper Claims	• CMS-1500 Health Insurance Claim Form: Block 17B
Electronic 837P, Professional Claims	• Referring Provider - Claim Level: 2310A loop, NM1 Segment • Referring Provider - Line Level: 2420F loop, NM1 Segment • Ordering Provider - Line Level: 2420E loop, NM1 Segment

Pre-pay Itemized Bill Review

$100,000 minimum, please follow these guidelines:

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





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

Inpatient Unbundling Policy

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

Louisiana Blue has expanded this policy effective August 1, 2024. This policy expansion includes more items that will now be considered routine supplies and services under our Inpatient Unbundling Policy. Some of these items include, but are not limited to kits, trays, packs, sutures, staplers, wound vacs, blades, connectors, hemostats, sealants, skin adhesives, lidocaine, nerve blocks, blood storage, tubes, lines and catheters.

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

Louisiana Blue will not separately reimburse for over-the-counter medications that are part of inpatient acute-care claims.

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

Louisiana
2024
Member Provider Policy & Procedure Manual

Routine Services

Louisiana Blue has expanded this policy on **August 1, 2024**, to include more items that will now be considered routine supplies and services under our Inpatient Unbundling Policy. For more information, see the Inpatient Unbundling Policy section (5.14) of the *Member Provider Policy & Procedure Manual.*

Routine services as those services included by the provider in a daily service charge–sometimes referred to as the "room and board" charge.

Routine supplies are included in general cost of the room where services are rendered. These items are considered floor stock and are generally available to all patients receiving services. As routine supplies, they cannot be billed separately. Examples include drapes, saline solutions and reusable items.

The following are examples of facility general and administrative costs and charges, including routine disposable and reusable equipment, supplies and items, which a facility may not separately bill for reimbursement.

- Oxygen transport fees
- Oximetry
- Personnel and additional staff
- Patient transportation fees
- Patient monitoring of any kind
- Maintenance of hospital equipment
- Any charge for the performance of a bedside procedure
- Call back time for physicians or staff
- Hospital emergency code alerts, rapid alert teams, code teams, etc.
- Supplemental feedings or nutrition such as Ensure, Isocal, including tube feeding, etc.
- Any nursing care service within the scope of normal nursing practice, i.e., admission, assessment, discharge, etc.

Inpatient Unbundling Reports

Louisiana Blue reviews inpatient acute care claims for billing accuracy based on the inpatient unbundling policy. In the past, when an inpatient acute care claim was unbundled, facilities had to request a report for how the claim was reprocessed.

Facilities can now use iLinkBlue (**www.lablue.com/ilinkblue**) to review automatically generated reports on how inpatient claims were unbundled.

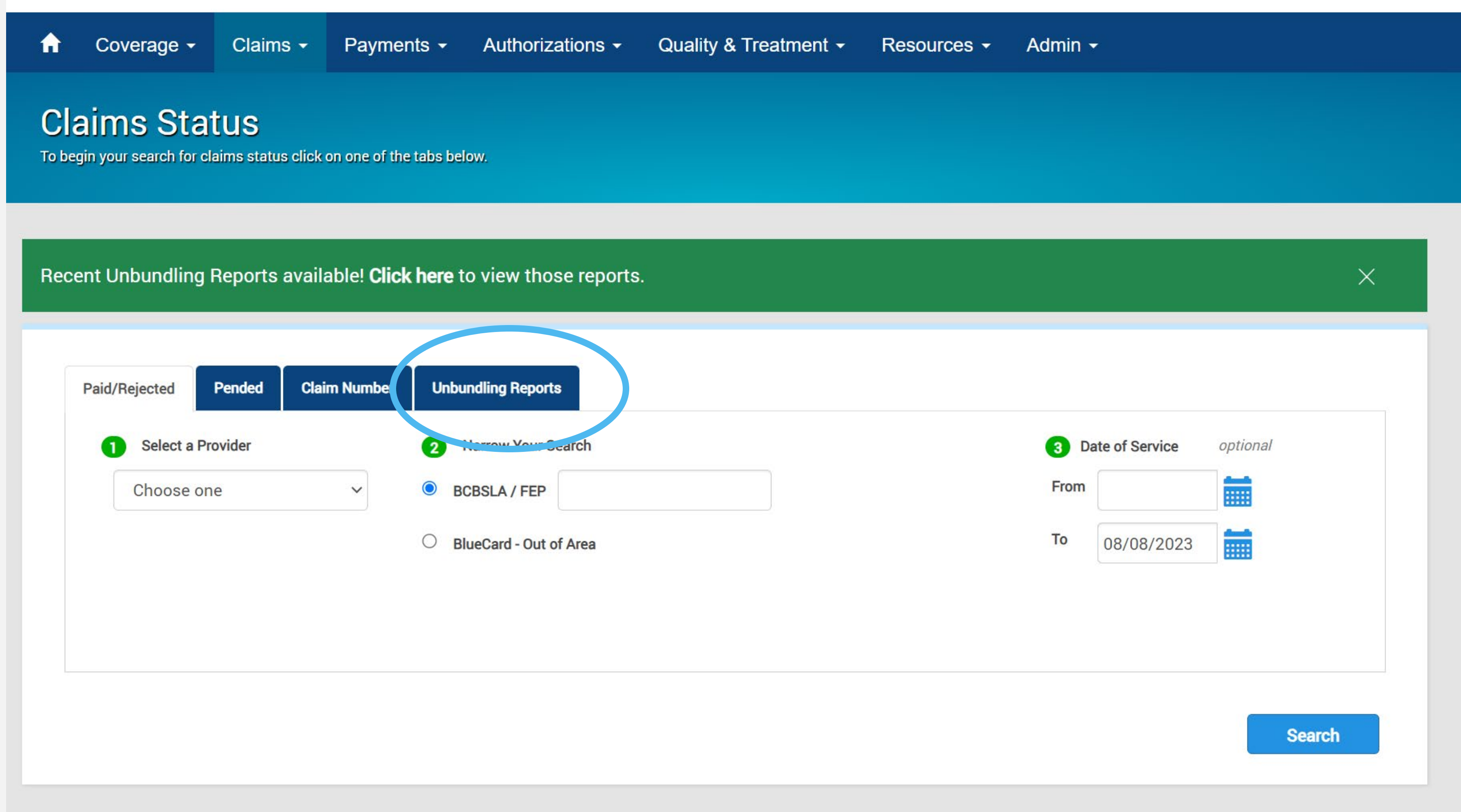
- If you have no reports, it simply means you have no unbundled claims.
- Reports will be retained within iLinkBlue for 16 months from the date of generation.

Unbundling Reports will apply to the following:

- Prepay claims
- Acute Care Facilities
- Charges greater than $100,000

Viewing Inpatient Unbundling Reports

www.lablue.com/ilinkblue



Inpatient Unbundling Policy FAQs

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

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Louisiana

Inpatient Unbundling Policy Frequently Asked Questions

What claims will the inpatient unbundling policy apply to?

This policy applies to all inpatient acute care claims.

Why is Blue Cross implementing the inpatient unbundling policy?

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

When does the inpatient unbundling policy take effect?

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

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

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

How will the claim review process work?

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

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

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

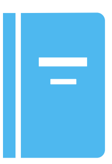
What happens if the itemized bill is not sent to Blue Cross in a timely fashion?

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

18NW2930 09/20 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 1

Readmissions Policy

- **Effective August 1, 2024**, Louisiana Blue began auditing readmissions to the same or affiliated facility for the same condition, similar condition, or a complication of the original condition within 30 days of discharge when the patient is discharged from the first admission to home or home health.
    - Louisiana Blue began excluding admissions related to Sickle Cell Disease from our Readmissions Policy. For a list of other exclusions, please see the Inpatient section (5.13) of the *Member Provider Policy & Procedure Manual*.
- Readmissions to the same or an affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed.
- The first admission payment will encompass full reimbursement for treatment of the condition and/or any related complications.
- Providers cannot bill members for service recouped as a result of this policy.
- EXCD codes related to our provider integrity audits will appear on the payment register for the Louisiana Blue (excludes FEP and BlueCard claims) members only. Readmissions will be identified by the code **"VT8."**



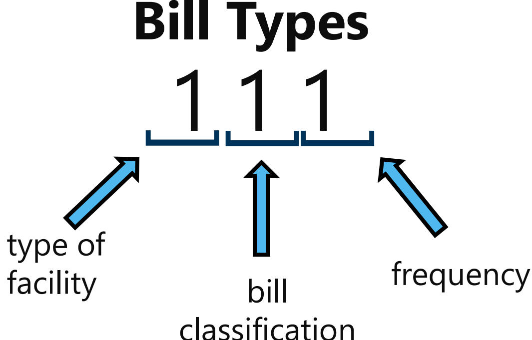
To view the full Louisiana Blue readmissions policy, refer to *our Member Provider Procedure & Policies Manual*, available in iLinkBlue (**www.lablue.com/ilinkblue**) under the "Resources" menu option.

Facility Billing Guidelines

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

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

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



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

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

Coordination of Benefits

If Louisiana Blue or HMO Louisiana is not the primary insurer of a member, providers must submit an explanation of benefits from the primary carrier when filing a claim.

Scenarios in which claims may pend or deny due to coordination of benefits still exist and include (but not limited to):

- A member with Medicare, plus a group policy through Louisiana Blue.
- A child with coverage from different parents' group plans.

In these cases, claims will deny if we do not receive an explanation of benefits. Always verify member benefits before rendering services. You may find information about a member's network on their ID card.

This does not include Federal Employee Program (FEP) members or BlueCard® claims.

Updated Drug Allowables

- As part of our routine biannual drug and drug administration code pricing review, we are updating the reimbursement schedule for drug codes, effective for claims with dates of service on and after **September 1, 2024**.
- Facility providers can research allowable charges in iLinkBlue (**www.lablue.com/ilinkblue**). The application is available under the "Payments" section.
- By "Select a date," enter "09-01-2024" to access the allowable charges that will go into effect September 1, 2024.

If you have any questions, please contact your Provider Contracting Representative or email **provider.contracting@bcbsla.com**.

Revenue 250

For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) that line will not be reimbursed. This only applies to claims where Louisiana Blue is the primary payor.

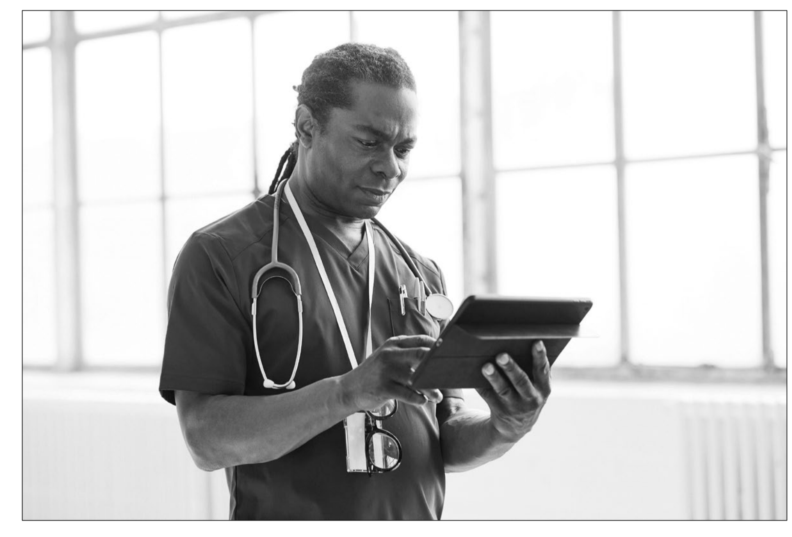
For Hardcopy Claims

- On the CMS-1500 claim form, report the NDC in the shaded area of Block 24A. We follow 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., N499999999999. The drug quantity and measurement/qualifier should be included.
- On the UB-04 claim form, report the NDC and the quantity in Block 43 (description field). We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N499999999999. The drug quantity and measurement/qualifier should be included.

Outpatient Code Change Reminder

Each quarter, Louisiana Blue, including HMO Louisiana, Inc., reviews new CPT® and HCPCS codes to determine needed updates to the Diagnostic and Therapeutic Services and Outpatient Procedure Services code ranges.

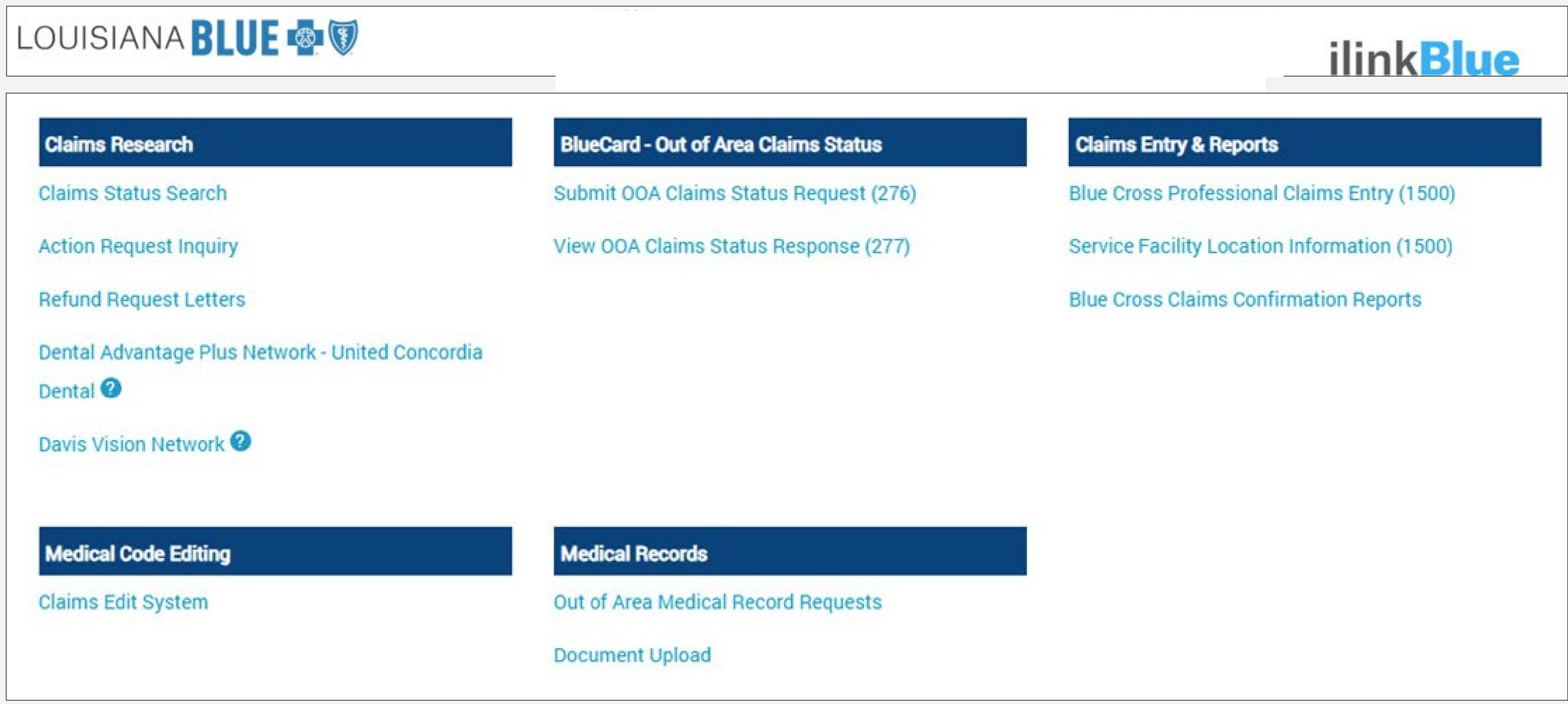
A complete list of procedure code ranges can be found in section 5.20 Outpatient of the *Member Provider Policy & Procedure Manual* found online at **www.lablue.com/ilinkblue** >Resources >Manuals.



ILINKBLUE SELF SERVICE

Finding Your Claims in iLinkBlue

Use iLinkBlue (**www.lablue.com/ilinkblue**) to research received, pended and paid claims.

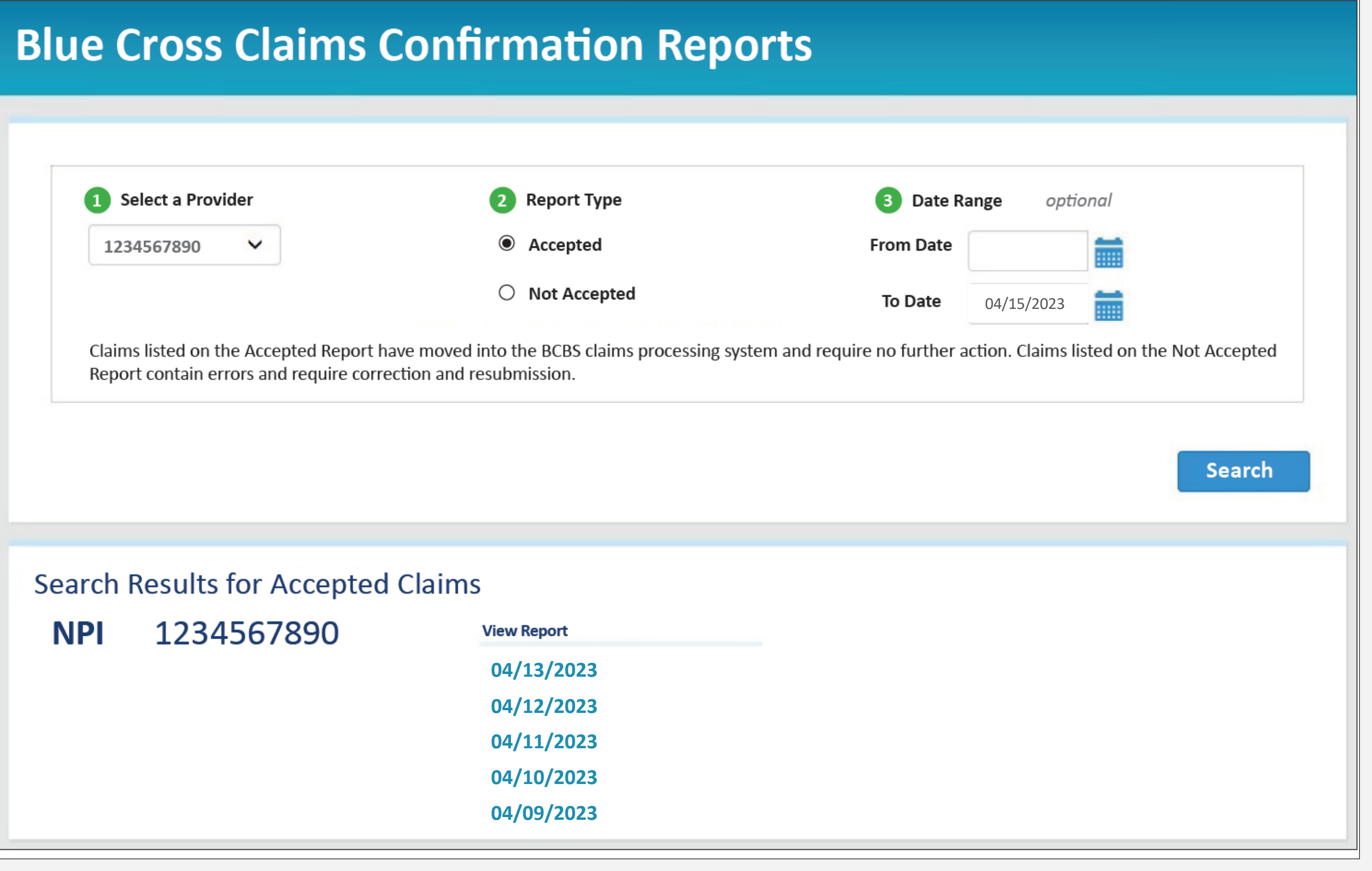


Claims Confirmation Reports in iLinkBlue

- These reports include detailed claim information on transactions that were accepted or not accepted by Louisiana Blue for processing.
- You may access these reports from the iLinkBlue menu by choosing "Claims," then "Blue Cross Claims Confirmation Reports."
- Reports are available up to 120 days.
- The reports include claims submitted through iLinkBlue, as well as, through a clearinghouse or billing agency.

Blue Cross Claims Confirmation Reports

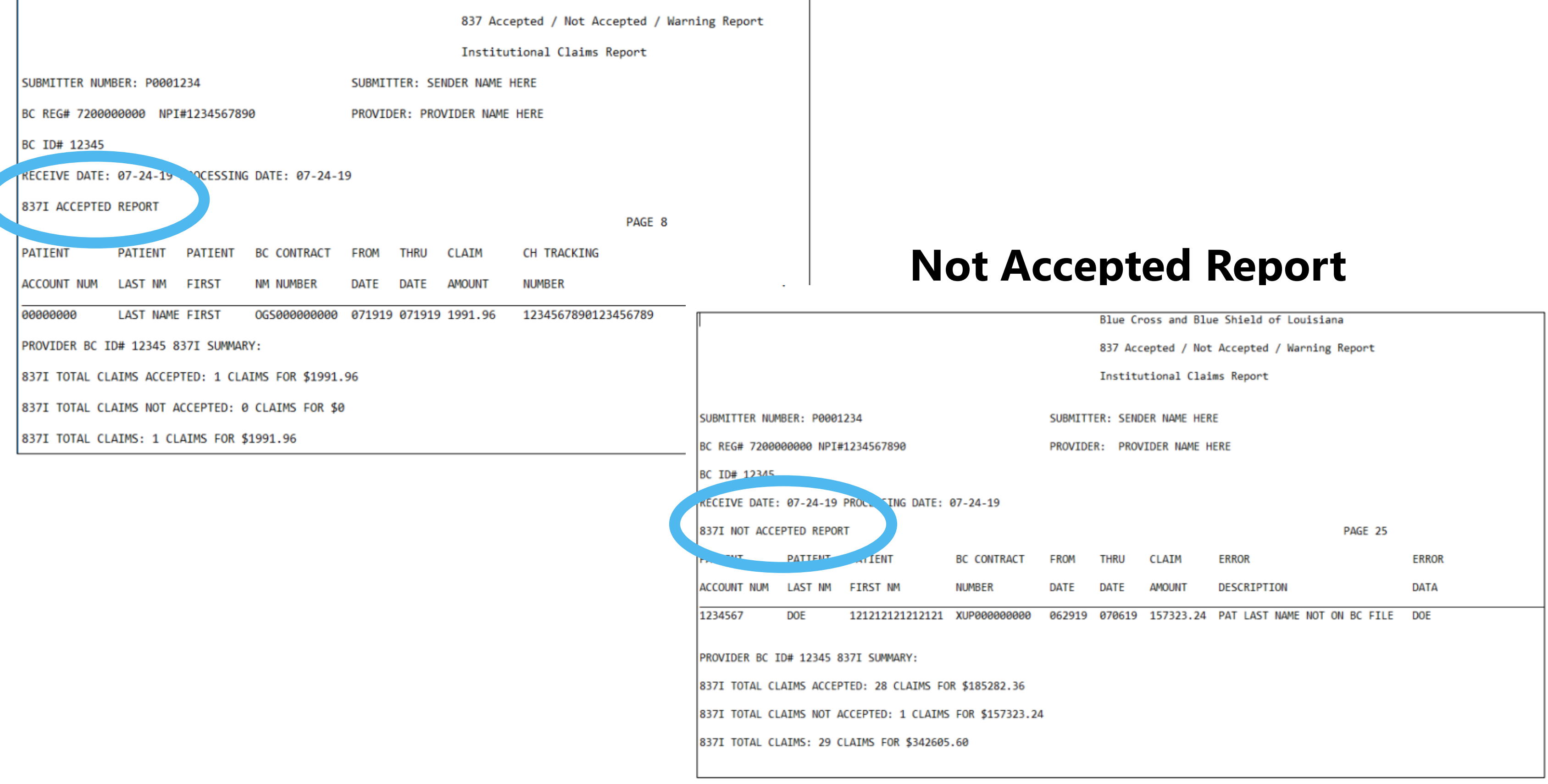
Confirmation reports can be found under at **www.lablue.com/ilinkblue** >Claims >Claims Entry and Reports >Blue Cross Claims Confirmation Reports.



Blue Cross Claims Confirmation Reports

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

Accepted Report



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

SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME HERE
BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE
BC ID# 12345
RECEIVE DATE: 07-24-19 PROCESSING DATE: 07-24-19
837I ACCEPTED REPORT
PAGE 8

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST	BC CONTRACT NM NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	CH TRACKING NUMBER
00000000	LAST NAME	FIRST	OGS000000000	071919	071919	1991.96	1234567890123456789

PROVIDER BC ID# 12345 837I SUMMARY:
837I TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $1991.96
837I TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0
837I TOTAL CLAIMS: 1 CLAIMS FOR $1991.96

Not Accepted Report

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

SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME HERE
BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE
BC ID# 12345
RECEIVE DATE: 07-24-19 PROCESSING DATE: 07-24-19
837I NOT ACCEPTED REPORT
PAGE 25

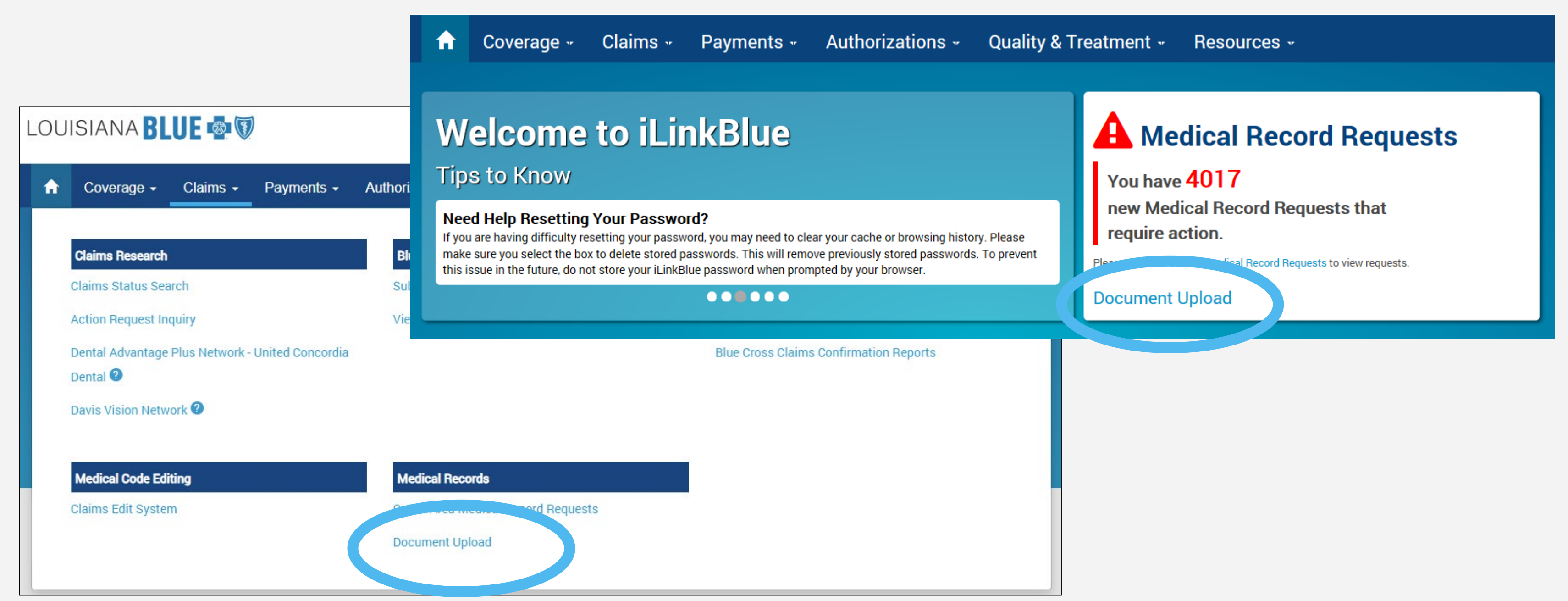
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
1234567	DOE	121212121212121	XUP000000000	062919	070619	157323.24	PAT LAST NAME NOT ON BC FILE	DOE

PROVIDER BC ID# 12345 837I SUMMARY:
837I TOTAL CLAIMS ACCEPTED: 28 CLAIMS FOR $185282.36
837I TOTAL CLAIMS NOT ACCEPTED: 1 CLAIMS FOR $157323.24
837I TOTAL CLAIMS: 29 CLAIMS FOR $342605.60

Document Upload Feature

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

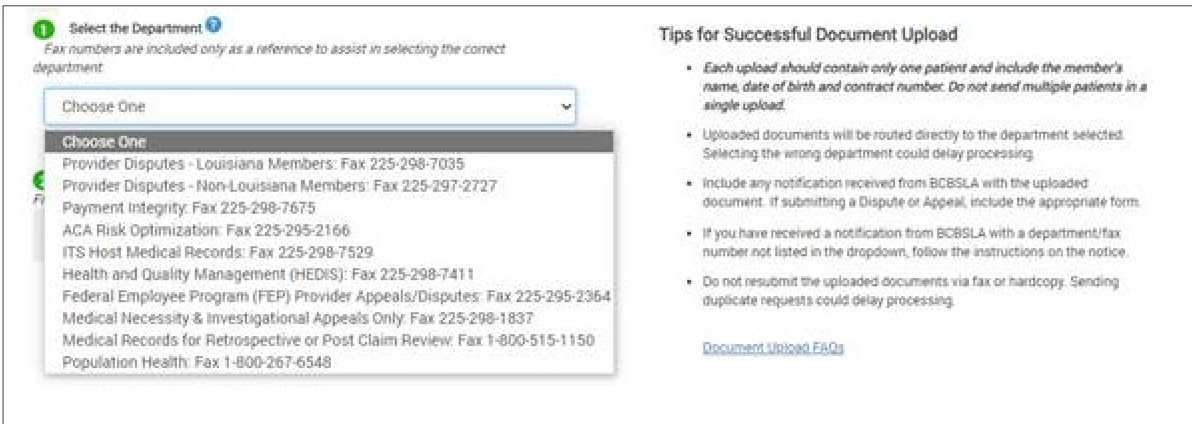
The new feature is quick, secure and available at any time through iLinkBlue.



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

Document Upload Feature

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



Louisiana Blue accepts document uploads for:

- Provider Disputes (Louisiana)
- Provider Disputes (non-Louisiana)
- Payment Integrity
- ACA Risk Optimization
- ITS Host Medical Records
- Health and Quality Management (HEDIS®)
- Federal Employee Program (FEP) Appeals
- Medical Necessity & Investigational Appeals Only
- Medical Records for Retrospective or Post Claim Review
- Population Health

Document Upload Feature FAQs

What should be included in the uploaded document?

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

What file types are allowed in the upload process?

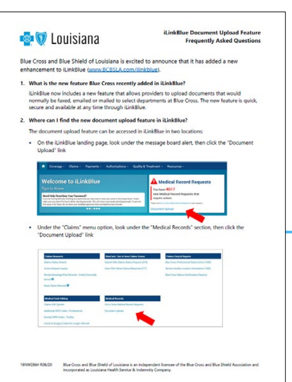
- DOC, DOCX, PDF, TIF, TXT

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

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

Is there a file size limitation?

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



Louisiana

iLinkBlue Document Upload Feature
Frequently Asked Questions

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

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

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

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

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

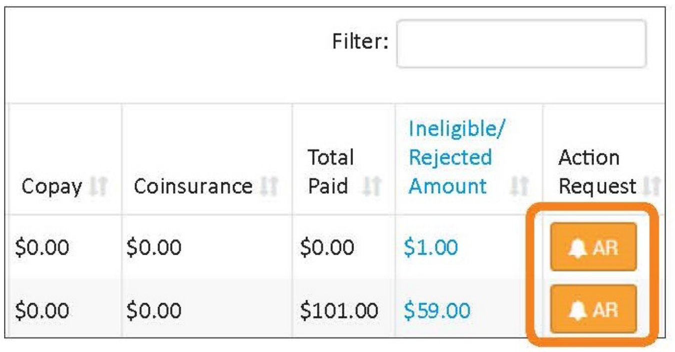
   - On the iLinkBlue landing page, look under the message board alert, then click the "Document Upload" link

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

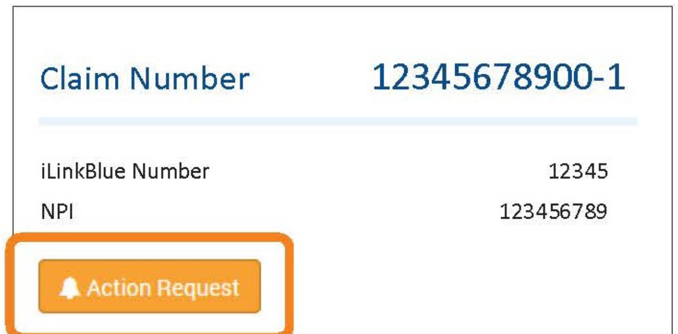
18NW2864 R08/20 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

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

Submitting Action Requests



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



- 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
- You only have to do one action request per claim; not one action request per line item of the claim.

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 at **1-800-922-8866**) and have allowed 10-15 business days after second request, or
- It is a system issue affecting multiple claims.

Refund Request Letters

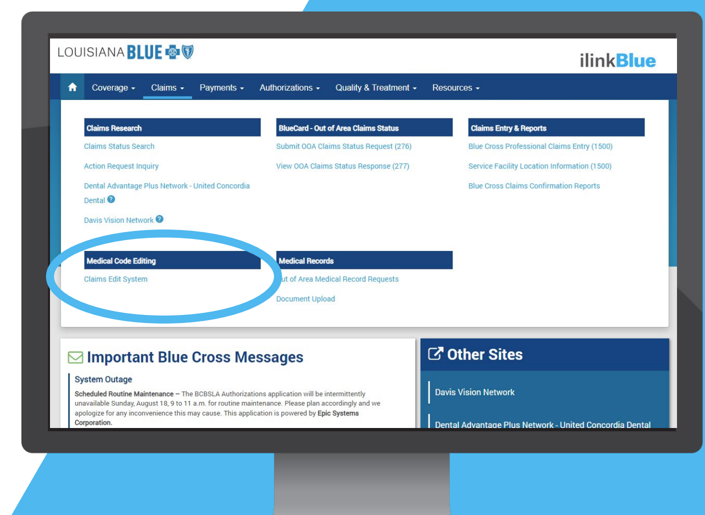
Refund Request Letters can now be accessed in iLinkBlue (**www.lablue.com/ilinkblue**).

- These letters can be accessed be accessed on the "Claims" menu under "Refund Request Letters."
- They will be available for 24 months from their issue date.
- These letters can be downloaded as a PDF and/or printed.

Claims Editing System (CES) Application

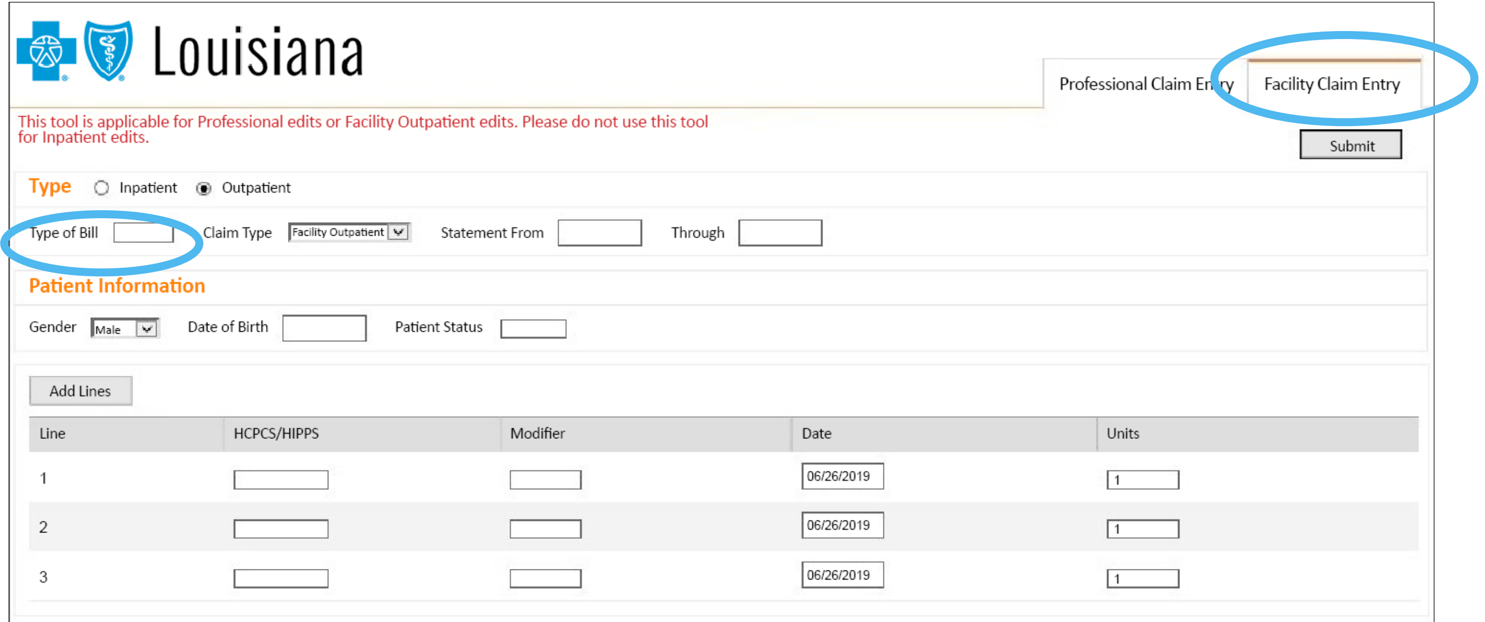
We have an application in iLinkBlue for providers to calculate claim-edit outcomes.

www.lablue.com/ilinkblue



CES Application

The **Facility Claim Entry** screen is for entering codes for hospital outpatient and ambulatory surgery center (ASC) claims. **Do not use for inpatient claim edits.**



Required Fields:

- Type – select outpatient
- Type of Bill – enter an appropriate 3-digit type of bill
- Claim Type – select Facility Outpatient
- Statement From/Through – date range of the procedure
- Gender – this field defaults to Male
- Date of Birth
- Patient Status – enter appropriate 2-digit patient status
- HCPCS/HIPPS – enter the valid CPT/HCPCS code
- Modifier – appropriate modifier for this CPT code
- Units – enter the number of units, this field defaults to a value of one

MEDICAL RECORDS

Medical Record Requests

Medical Request Reminders:

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

RADV Audits

Each year, Louisiana Blue contacts providers to request medical records for reviewing:

- Patient health risks
- Preventive service needs
- Thorough medical evaluations

This review is conducted in accordance with U.S. Department of Health and Human Services Risk Adjustment Data Validation (HHS-RADV) guidelines for applicable health benefit plans.

Reviewing medical records is a key component of the risk adjustment data validation audit process and enables us to identify conditions in the progress notes that were:

- Not included on the claim at the time of the visit; and/or
- Not coded to the highest degree of specificity at the time of the visit

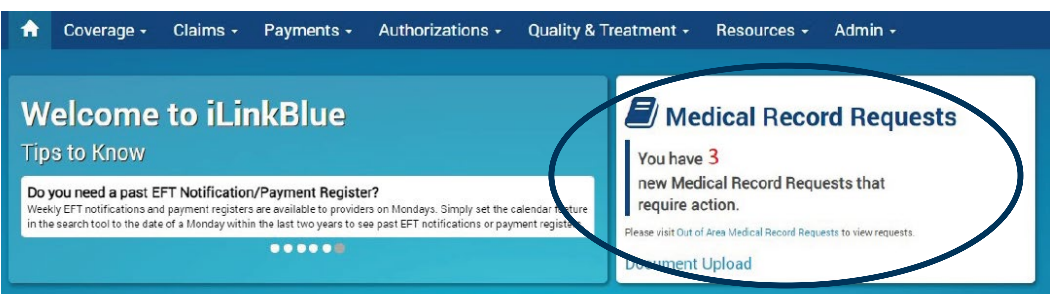
RADV Audits

- Providers can submit records by email, fax or mail; or through an onsite visit within five to ten business days of receipt of notification. The notification will include contact information.
- Several providers have provided direct access to their records using electronic medical records (EMR) systems. Our team will review the records that are accessible through those EMRs.
- Only records that are unable to be found in the EMR, and from locations we do not have EMR access, will be requested.
- If you have questions about risk adjustment chart reviews or would like to lighten the burden on your office by providing EMR access to our team, please contact Taylor Lawrence by phone at (225) 298-1576 or email **taylor.lawrence2@lablue.com**.

BlueCard Medical Record Request

- Providers no longer receive hardcopy letters for BlueCard medical record requests. Instead, Louisiana Blue will only alert providers through iLinkBlue.

- This change does not affect non-BlueCard medical record requests. Louisiana Blue will continue to send hardcopy requests for non-BlueCard members.



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

Louisiana

providerTIDBIT

a guide to understanding our processes

Medical Record Guidelines for BlueCard®

1. Always direct medical records submissions to Blue Cross and Blue Shield of Louisiana when requested. You will be alerted of BlueCard medical record requests through our secure online tool iLinkBlue (www.BCBSLA.com/ilinkblue). These alerts will be visible on the iLinkBlue home page.

2. If a claim denies for one of the following reasons: "lack of information received," "additional information needed" or "waiting on requested information," wait until you receive a medical records request in iLinkBlue before submitting records.

   For these types of denials, providers should wait 10 business days to allow us time to send a request for medical records. If you do not receive a request after 10 business days, contact customer service to verify the exact information needed.

3. Send medical records to us within 10 business days after receiving an alert.

4. Include a printed copy of the iLinkBlue medical record alert as the cover or first page of your submission.

Do NOT submit BlueCard Medical Records:
- unless you receive a request from Blue Cross and Blue Shield of Louisiana
- with a copy of the original claim as an attachment
- without the request for medical records notification from iLinkBlue attached
- by certified mail

Once confirmed that we received your records, please allow 30 days for Blue Cross and Blue Shield of Louisiana and/or the member's Blue Plan to complete the review process. If you receive no response after 30 days, please follow up with us by calling the Customer Care Center at 1-800-922-8866.

More →

TB00022019

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 of this publication.

18NW1737 R02/21
Last reviewed on: 02-25-21

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.

1

Blue Advantage Medical Record Requests

- Blue Advantage is currently partnered with **Cognisight** to assist us in conducting medical record reviews.
- As a provider in our Blue Advantage network, you are not to charge a fee for providing medical records to Blue Advantage or vendors acting on our behalf.
- Additionally, the patient's Blue Advantage member contract allows for the release of information to Blue Advantage or its designee.
- In accordance with all applicable state and federal laws and HIPAA, any information shared with our vendors will be kept in the strictest of confidence.

Electronic Medical Records (EMRs)

- Granting Louisiana Blue access to your EMR can save you time!
- With your permission and agreement on file, Louisiana Blue can access your HEDIS, RADV and other **non-claims records** without having to request them from you, saving you time and effort.
- Simply send your EMR agreement to our Provider Relations Department at **provider.relations@bcbsla.com**.

HEDIS®

What is HEDIS?

Healthcare Effectiveness Data and Information Set

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

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

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

Purpose of HEDIS Results

Health plans use HEDIS performance results to:

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

HEDIS Data Collection Methods

Administrative Method - Obtained from our claims database and supplemental data.

Hybrid Method - Obtained from our claims database and medical record reviews.

Survey Method - Obtained from member surveys.

Tips for Improving Quality of Care HEDIS

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

If you have questions related to HEDIS measures or medical record collections, please contact the Health and Quality Department at **HEDISteam@bcbsla.com**.

HEDIS® Medical Record Requests

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

SUPPORTING YOUR NEEDS

Call Centers

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

For information NOT available on iLinkBlue

Other Provider Phone Lines

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

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

Health Services Division – 1-800-716-2299
- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing and provider record information
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding security access to online services

Provider Relations

Jami Zachary **Director**

Paden Mouton **Provider Relations Manager**

Mary Reising **Health System Representative**

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

Brittany Fields
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Lisa Roth
Online Portal Training

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

Yolanda Trahan, **Sr Provider Relations Representative**
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

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

Provider Contracting

Jason Heck, Director – jason.heck@lablue.com

Diana Bercaw, Lead Provider Network Development Representative – **diana.bercaw@lablue.com**
Jefferson, Orleans, Plaquemines and St. Bernard parishes

Jordan Black, Sr. Provider Network Development Representative – **jordan.black@lablue.com**
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Sue Condon, Lead Network Development & Contracting Representative – **sue.condon@lablue.com**
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Kim Jones, Provider Network Development Representative – **kim.jones@lablue.com**
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Cora LeBlanc, Sr. Provider Network Development Representative – **cora.leblanc@lablue.com**
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Dayna Roy, Sr. Provider Network Development Representative – **dayna.roy@lablue.com**
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Lauren Viola, Provider Network Development Representative – **lauren.viola@lablue.com**
Jackson, Lincoln, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula and Lasalle parishes

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

Weekly Digest

The Weekly Digest is a consolidated communication that is emailed every Thursday to the correspondence email on file, as well as iLinkBlue users and administration representatives.

It includes:

- General announcements
- Billing guidelines
- Medical policy updates
- Quick tips
- Webinar/workshop event information and registration

PROVIDER NOTICES

Lab Reimbursement Policy Update

Audience: All professional and facility providers should read this message.

Part of the Blue Cross and Blue Shield of Louisiana Laboratory Benefit Management Program requires routine reviews, updates and implementations of laboratory reimbursement policies as needed. As a result of our most recent review, we revised the below lab reimbursement policy, effective November 15, 2024.

Provider Letter
Revised Policy No. G2022: Biomarker Testing for Autoimmune Rheumatic Disease

UPCOMING EVENTS

Register Today!

Louisiana Blue offers training events for our providers that focus on Louisiana Blue processes, programs and resources. Please pre-register for the event(s) you wish to attend. Once registered, you will receive an email with information and instructions on how to join the webinar.

Risk Adjustment 101 Webinar

Date: August 20, 2024
Time: 12 - 1 p.m.

Register

The Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) use Risk Adjustment to ensure health plans are able to appropriately provide benefits and access to care for enrollees. Proper documentation of conditions, and thus coding accuracy, play a crucial role in the risk adjustment process. We will discuss documentation best practices, miscoded conditions that we see in our audits, as well as conditions typically seen in the Office of Inspector General's (OIG's) audits.

Who should attend?
Your organization's medical and coding staff.

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

Future Educational Opportunities

BlueCard

- October 9

New to Louisiana Blue

- October 22

PCDM

- November 6

iLinkBlue Training

- November 14

Invitations for webinars are included in our Weekly Digest emails that are sent on Thursdays.

Provider Engagement Survey

Your feedback is important!

THANK YOU to everyone who took our 2023 survey. We would ❤ for you to complete our 2024 survey. Participants could win 1 of 26 gift cards with top prize of $500.

The survey ends on:

If you have not received a survey link, send us an email to **provider.communications@bcbsla.com** and put "Provider Engagement Survey" in the subject line.

QUESTIONS?

Appendix

PROVIDER SUPPORT

Provider Credentialing & Data Management

Sam Measels
Director, Provider
Credentialing and Information
sam.measels@lablue.com

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

Kaci Guidry
Manager, Provider Data
Management & PCDM Status
kaci.guidry@lablue.com

Kristin Ross
Manager, Provider Contract
Administration
kristin.ross@lablue.com

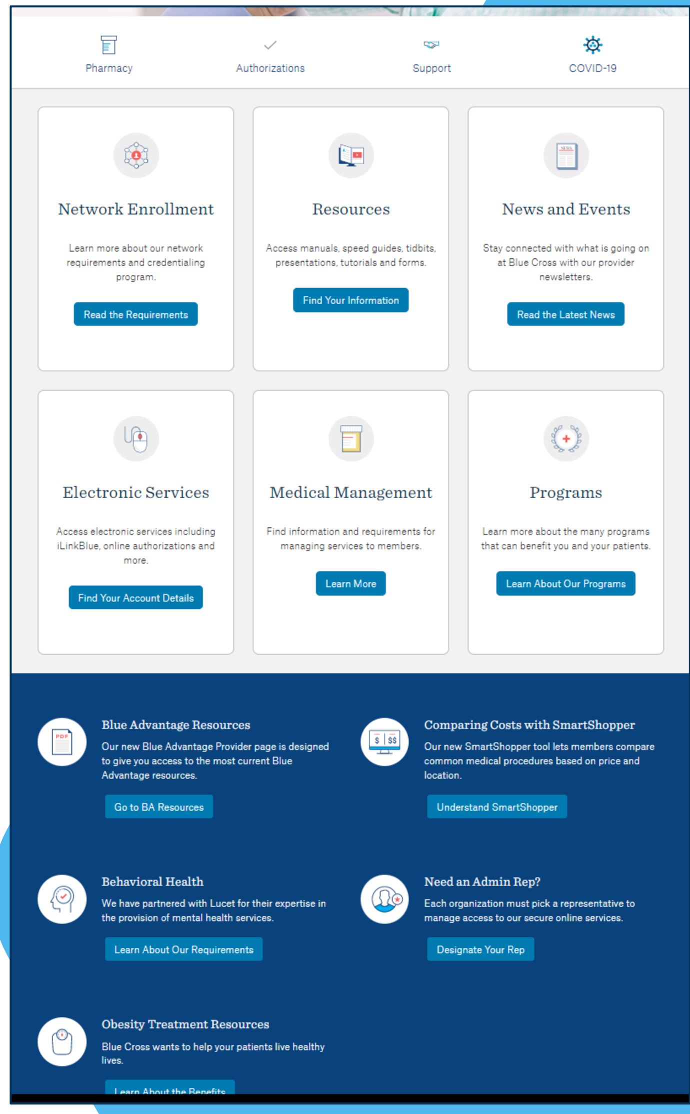
1-800-716-2299 | option 2 – provider record information
PCDMstatus@bcbsla.com

Provider Page

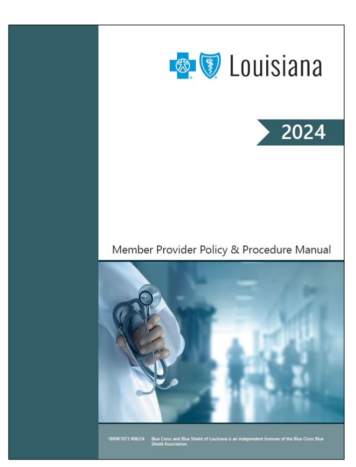
www.lablue.com/providers

The Provider page is home to online resources such as:

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



Manuals & Newsletters



Our provider **manuals** are extensions of your network agreement(s). The manuals are designed to provide the information you need as a participant in our network. Member Provider and Procedure manual is accessible through iLinkBlue only.

www.lablue.com/iLinkBlue >Resources >Manuals

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

provider networknews 2024 2ND QUARTER

Providing health guidance and affordable access to quality care

Blue Cross Has Self-service Tools for You!

Blue Cross and Blue Shield of Louisiana has several self-service tools to help providers seeking information.

Our self-service tools include:

- iLinkBlue (www.bcbsla.com/ilinkblue)
- the Interactive Voice Recognition (IVR) System (1-800-922-8866)
- HIPAA Transactions

Our secure online tool, **iLinkBlue**, can keep you up-to-date with information such as allowable charges, member eligibility and benefits, and medical policies.

iLinkBlue has a document upload feature that allows you to submit documents that you would otherwise fax, email or mail to Blue Cross departments. You can even submit authorization requests, action requests for claims questions and check on the status of a claim through iLinkBlue.

Our iLinkBlue User Guide has step-by-step instructions for navigating the tool, as well as important information on how to sign up. It is available online at www.bcbsla.com/providers >Resources >Manuals.

Call our **IVR System** for automated benefits and claims status inquiries. IVR has both keypad and voice response options for navigation.

More information and tips for navigating the IVR System are in our Automated Benefits & Claim Status (IVR Navigation Guide) provider tidbit. It is available online at www.bcbsla.com/providers >Resources >Tidbits.

You may also submit electronic inquiries to Blue Cross via **HIPAA Transactions**. These electronic transactions can help you find member eligibility and benefits or check the claims status of a patient.

Detailed companion guides for these transactions are available online at www.bcbsla.com/providers >Electronic Services >Companion Guides.

Also, we have a Provider Self-service Quick Reference Guide, available at www.bcbsla.com/providers >Resources >Speed Guides.

www.bcbsla.com/providers
www.bcbsla.com/ilinkblue

Louisiana

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

www.lablue.com/providers >Newsletters

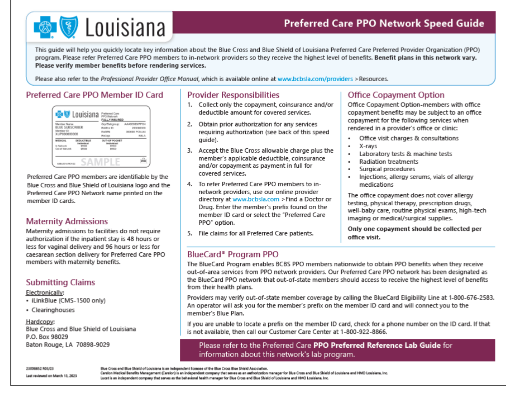
Not Getting Our Newsletters?

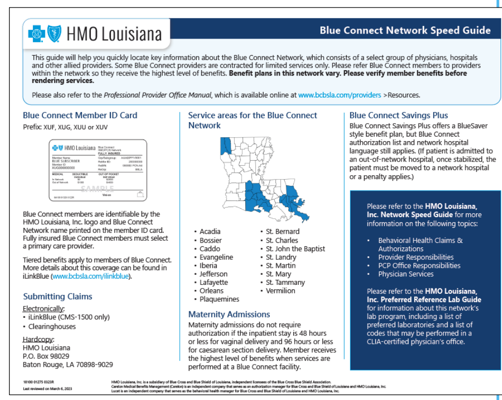
Send an email to **provider.communications@bcbsla.com**. Put “newsletter” in the subject line. Please include your name, organization name and contact information.

Speed Guides & Tidbits

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

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





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

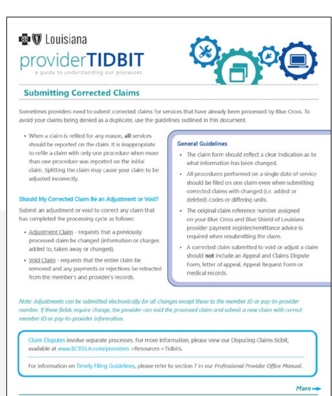
www.lablue.com/providers
>Resources >Tidbits

BILLING HIGHLIGHTS

Submitting a Corrected Claim

- When a claim is refiled for any reason, all services should be reported on the claim.
- Adjustment Claim – requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim – requests that the entire claim be removed, and any payments or rejections be retracted from the member's and provider's records.
- **Corrected claims submitted in the 837 format should include the following:**
- In Loop 2300 Segment CLM05-03, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Loop 2300 in the REF segment, use "F8" as the qualifier and enter the original claim reference number.
- **Corrected claims submitted on a UB-04:**
- In Block 4, Type of Bill, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Block 64, Document Control Number, enter the original claim reference number.

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



Louisiana

providerTIDBIT

a guide to understanding our processes

Submitting Corrected Claims

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

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

Should My Corrected Claim Be an Adjustment or Void?

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

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

General Guidelines

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

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

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

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

More →

Authorizations Highlights

OGB Authorizations

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

OGB PLAN SERVICES REQUIRING AUTHORIZATION

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

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

INPATIENT

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

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

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

STOP

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

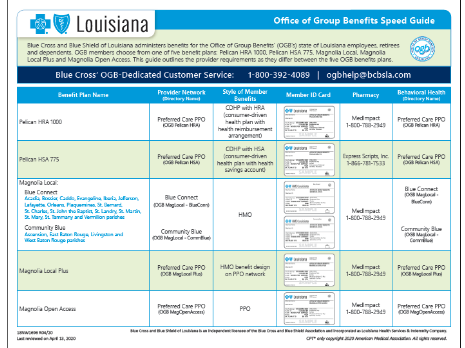
OUTPATIENT

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

Louisiana | Blue Cross and Blue Shield of Louisiana Member Provider Policy & Procedure Manual | 4-10 December 2018

The list of OGB authorization requirements can be found in our *Member Provider Policy & Procedure Manual* available on iLinkBlue at **www.lablue.com/ilinkblue**, click on "Resources," then "Manuals."

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



Louisiana

Office of Group Benefits Speed Guide

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

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

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

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Last reviewed on April 13, 2020

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

OptiNet® Highlights

OptiNet Registration in iLinkBlue

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

Why Is Your Score So Important?

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

OptiNet Registration in iLinkBlue

How Is Your Score Calculated?

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

How to Access *Opti*Net®?

- Log into iLinkBlue (**www.lablue.com/ilinkblue**).
- Click on the "Authorizations" menu option, then click on the "Carelon Specialty Health Authorizations" link; this link takes you to the Carelon MBM Provider Portal.
- Click on "Access Your ***Opti****Net*® Registration" on the left menu bar.
- Click the green "Access Your ***Opti****Net*® Registration" button.

HEDIS Highlights

Administrative Method

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

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

Administrative Method: Supplemental Data

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

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

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

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

Hybrid Method

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