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

2nd Quarter 2019

provider networknews

providing health guidance and affordable access to quality care

INSIDE THIS ISSUE

New Claims-editing Software System to Debut

On July 27, 2019, Blue Cross and Blue Shield of Louisiana will be implementing a new claims-editing software (CES) system for all providers. This new Optum system will enable us to effectively and consistently manage healthcare delivery and reimbursement by identifying potentially incorrect coding relationships on submitted claims. Notifications were sent out on this change in April.

To coincide with this change, some of our policies have been updated based on industry-recognized rules. The changes will be based on a combination of national coding edits, CPT® guidelines, specialty society guidelines, clinically-derived edits and federal regulations and policies governing healthcare claims.

It is important to understand that upon implementation of this new system, there may be changes to the way your claims are processed, which may affect your allowable charges and the way claims are priced.

CES is an editing system used to manage reimbursement, medical policy, benefit rules and industry standard coding guidelines. The system logic will be applied to claims processed on or after the implementation date for most changes. It helps ensure accurate and consistent payments in accordance with coding, billing, reimbursement and clinical policies. It will also help manage compliance with standard coding and billing practices between various types of services, such as medical, surgical, lab and radiology.

To help assist with this transition, a new code-editing tool will be available in iLinkBlue (www.BCBSLA.com/ilinkblue) that will allow you access to the new CES system logic. This new tool and related instructions will be available prior to implementation.

See Page 2 for more details.

www.BCBSLA.com/providers
www.BCBSLA.com/ilinkblue

Louisiana

23XX6753 R08/19

Billing & Coding

Examples of Changes in the New Claims-editing Software System

Below is an outline of some of the expected changes once Blue Cross and Blue Shield of Louisiana implements the new claims-editing software system. We will continue to provide more details as we get closer to implementation.

Item	Change	Claim Types Impacted	When Changes will be Applied to Claims
Assist at Surgery	Updated applicable codes as determined by clinical review; physician should bill under his/her provider number with Modifier 80, 81 or 82. Primary physician should bill Modifier AS for CRNFA or RNFA assisting at surgery. Nurse practitioner/physician assistant should bill under his/her provider number with Modifier AS.	Professional	July 27, 2019
Bundling, Incidental & Mutually Exclusive Edits	Updated list of code pair edits	Professional & Outpatient Facility	July 27, 2019
Max Frequency	Updated codes and related number of units allowed on the same date of service or a date span	Professional	July 27, 2019
		Outpatient Facility	Dates of service on and after July 27, 2019
Modifier 50	Updated codes that allows Modifier 50. When billing with Modifier 50, only one unit per line should be billed. Additional units will be reduced to 1 and approved reimbursement will be for 1 unit only per each line.*	Professional & Outpatient Facility	July 27, 2019
Modifiers	Updated rules applied for modifiers to be consistent with industry recognized rules. i.e. modifiers appropriate to use with evaluation & management (E&M) codes, modifiers appropriate to use with site-specific codes, etc.	Professional & Outpatient Facility	July 27, 2019
Multiple Procedure Reduction	Updated codes where multiple procedure reductions are applicable	Professional & Outpatient Facility	Dates of service on and after August 1, 2019
New Patient Visit	New visit codes 99201-99205 will deny if the patient has been seen by the same provider within three years from date of the initial new visit code	Professional	July 27, 2019
Not Separately Reimbursable	Certain codes will deny because these services should be included with other services billed on the same day	Professional & Outpatient Facility	July 27, 2019
Pre- and Post-op Billing	Certain codes will deny because these services should be included in global surgical package	Professional	July 27, 2019
Rebundles	Individual lines will deny when two or more codes are billed instead of one more appropriate comprehensive code. The provider will need to refile the correct, comprehensive code.	Professional & Outpatient Facility	July 27, 2019
Re-evaluations	Re-evaluations for therapy every 90 days will no longer require appeals process	Professional	July 27, 2019
835/Payment Register	Provider payment register explanation codes and associated descriptions will be different	Professional & Outpatient Facility	July 27, 2019

**When billing multiple bilateral procedures, each would be identified and billed with Modifier 50 on separate lines with a unit of 1 per each line.*

Billing & Coding

Updated Outpatient Code Ranges

We recently completed reviews of the new 2019 CPT and HCPCS codes. As a result, we have updated the Outpatient Procedure Services and Diagnostic and Therapeutic Services code ranges.

Effective April 1, 2019, the following HCPCS codes have been added to the Diagnostic and Therapeutic Services code range list:

C9040	C9042	C9044	C9046
C9041	C9043	C9045	C9141

These changes do not affect existing codes and allowables. It simply allows our system to accept these codes appropriately for claims adjudication.

Updated Drug Allowables

We updated the reimbursement schedule for drug and drug administration codes, effective for claims with dates of service on and after September 1, 2019. These allowables are available on iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Payments" section.

Professional providers can use the Professional Provider Allowable Charges Search application to access the allowable charges by entering "09/01/2019" in the "Select a Date" field. Facility providers can access these drug allowable charges under the Facility Allowables link.

Updated HCPCS and DME Allowables

The new schedule of HCPCS and DME allowable charges will be effective for claims with dates of service on and after July 1, 2019.

To find a new allowable charge, log into iLinkBlue (www.BCBSLA.com/ilinkblue), select “Payments” on the menu bar to access the Professional Provider Allowable Charges Search tool. In the “Select a date” field, enter “07/01/2019” and enter a HCPCS code in the code field.

Urgent Care Clinics to Bill Modifier SA

In a recent claim review, we noticed nurse practitioners at urgent care clinics were not billing with Modifier SA. Please remember if you are a nurse practitioner with an urgent care clinic, you must append Modifier SA when billing for all services performed.

Accurate Reporting of Polysomnography Followed by Multiple Sleep Latency Test & Maintenance of Wakefulness Testing

Per CPT guidelines, Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness Test (MWT) and polysomnography represent separate diagnostic tests that are performed at different times to access various physiological parameters of sleep. Typically, polysomnography is performed the night before the MSLT or MWT. Therefore, when reporting the testing performed, the actual date each test began is the appropriate date of service. A failure to report with different dates of service will negatively impact reimbursement.

Questions on the New Claims-editing Software System?

Blue Cross will host webinars for professional providers and facilities on July 9th and 10th:

Professional webinars:

- Tuesday, July 9, 2-3 p.m.
- Wednesday, July 10, 12-1 p.m.
- Tuesday, August 6, 10:30 a.m. -12 p.m.
- Wednesday, August 7, 9:30-11 a.m.
- Wednesday, August 7, 1:30-3 p.m.

Facility webinars:

- Tuesday, July 9, 10-11 a.m.
- Wednesday, July 10, 3-4 p.m.
- Tuesday, August 6, 1:30-3 p.m.

Invitations have been sent to network providers with an email address on file. If you need an invitation, send an email to Provider.Relations@BCBSLA.com and put "CES Webinar" in the subject line.

Billing & Coding

Tips to Know

Filing Corrected Claims Electronically

When filing corrected electronic claims, please remember 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.

For the iLinkBlue Professional 1500 form:

- In Block 19A, enter the applicable Professional Claim Adjustment/Void Indicator:

  A – Adjustment Claim V – Void Claim

- In Block 19B, enter the Internal Control Number

Please see our Corrected Claims Tidbit, available online at www.BCBSLA.com/providers >Resources >Tidbits.

More Coding Tips to Remember

As a reminder, Blue Cross does not accept Medicaid codes—such as H0014, H2022 or H0036—unless specifically required and communicated by the member's plan. The most appropriate CPT code(s) should be used to bill for these services.

Certain codes that are specific to per diem reimbursement logic, such as S9485, are not allowed to be billed by professional providers, as Blue Cross does not support this methodology unless specifically communicated by the plan.

Additionally, remember that procedures that are included in a more comprehensive code should be billed with that comprehensive code, such as 80050. Claims may be returned if not billed appropriately.

Split/Shared Billing Rules for All Places of Service

Please note that providers must meet the following requirements in order to bill a split/shared visit under the physician's provider number:

- The physician must provide a face-to-face visit with the patient
- The physician must document in a separate note at least one element of each of the following components of the evaluation & management service: history, exam and medical decision making.
  - It is not sufficient for the physician to countersign the medical record or document "seen and agree." The physician must document which aspect of the visit they personally performed for each of the components in a separate note.
- The physician must justify their involvement in the patient care by legibly signing the medical record.

NPI Required on All Lab Claims

We require a National Provider Identifier (NPI) for referring and ordering physicians on all claims. This is particularly important to remember when referring or ordering laboratory services. Providers who are self-referring must still enter their individual NPI on claims.

Laboratory claims submitted without the proper referring or ordering provider NPI may be denied. To avoid denial of these laboratory claims, please include the referring or ordering physician NPI in Block 17B of the CMS-1500 claim form or loop 2310A (if filing claims electronically).

For more information on claims filing procedures, refer to the *Professional Provider Office Manual* located at www.BCBSLA.com/providers >Resources >Manuals.

Billing & Coding

Reminder on Billing Practices

Services are to be billed by providers in accordance with our member contracts and provider agreements.

Here are some examples of billing practices not permitted under your Blue Cross provider agreement:

1 Services ordered for members not seen or treated at the hospital performing the services

Hospitals are only allowed to submit claims to Blue Cross for services rendered by the hospital while a member is being treated at that facility. This includes non-transplant related inpatient and outpatient hospital services, laboratory work and supplies. Hospitals may also submit claims for outpatient laboratory work performed by the hospital when they are ordered by a physician or other practitioner who has admitting privileges at that hospital. Hospitals cannot submit claims for services rendered by another provider, even when that other provider is a corporate affiliate of the hospital. When the hospital subcontracts services that the hospital cannot provide, the hospital must notify Blue Cross in writing of the fact in advance and follow the rules for billing for subcontracted services as explained in the *Member Provider Policy & Procedure Manual*.

2 Pass-through billing

Pass-through billing occurs when the ordering provider requests and bills for a lab service, but the lab service is not performed by the ordering provider of the Clinical Laboratory Improvement Amendments, or CLIA-certified lab owned and operated by the ordering provider. This is specifically prohibited by the *Member Provider Policy & Procedure Manual* and the provider agreement.

Our expectation is that we will receive lab claims billed from one of the following:

- The performing provider at a CLIA-certified lab, owned and operated by the ordering physician;
- The ordering provider who owns and operates a CLIA-certified lab; or
- An in-network reference lab.

3 Services ordered by physicians without hospital privileges

Hospitals should not submit claims for services ordered by physicians who do not have privileges at the hospital. Our provider agreements state that all services rendered to a Blue Cross member by a hospital must be rendered at the direction of a medical professional with staff privileges at that hospital. Facilities should only permit inpatient or outpatient hospital services when ordered by a licensed physician or other licensed health professional who has staff privileges at that hospital.

Share this newsletter with your billing department and those at your office who work with Blue Cross reimbursement.

Provider Network

Provider Availability Standards

Blue Cross is committed to providing high quality healthcare to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. Within this context and with input and approval from various network providers who serve on our Medical Quality Management Committee, we developed the following Provider Availability Standards and Acute Care Hospital Availability Standards.

TYPE	DEFINITION	ACCESS STANDARD	EXAMPLES
Emergency	Medical situations in which a member would reasonably believe his/her life to be in danger, or that permanent disability might result if the condition is not treated	Immediate access, 24 hours a day, 7 days a week	• Loss of consciousness • Seizures • Chest pain • Severe bleeding • Trauma
Urgent	Medical conditions that could result in serious injury or disability if medical attention is not received	30 hours or less	• Severe or acute pain • High fever in relation to age and condition
Routine Primary Care	Problems that could develop if untreated but do not substantially restrict a member's normal activity	5 to 14 days	• Backache • Suspicious mole
Preventive Care	Routine exams	6 weeks or less	• Routine physical • Well-baby exam • Annual Pap smear

Additional Availability Standards

- Network physicians are responsible for assuring access to services 24 hours a day, 365 days a year other than in an emergency room for non-emergent conditions. This includes arrangements to assure patient awareness and access after hours to another participating physician.
- All network providers must offer services during normal working hours, typically between 9 a.m. and 5 p.m.
- Average office waiting times should be no more than 30 minutes for patients who arrive on time for a scheduled appointment.
- The physician's office should return a patient's call within four to six hours for an urgent/acute medical question and within 24 hours for a non-urgent issue.

Acute Care Hospital Availability Standards

- Acute care hospitals are responsible for assuring access to services 24 hours a day, 365 days a year.
- All contracted hospitals must maintain emergency room or urgent care services on a 24-hour basis and must offer outpatient services during regular business hours, if applicable.

Provider Network

When to Complete the Business Associate Addendum

The iLinkBlue Agreement Packet allows providers to request access to Blue Cross' iLinkBlue website, www.BCBSLA.com/ilinkblue, in accordance with the terms of use and security policy that is available on the iLinkBlue log-in and welcome screens.

The **Business Associate Addendum**, or BAA, is included as part of the iLinkBlue Agreement Packet and;

- **Is required** to be completed only in the event you, as the provider, contract with a third-party vendor for services such as claims submission and billing, and as a result, the third-party vendor requires access privileges to iLinkBlue.
- Should **not** be completed if you do not contract with third party vendors for services.

Upon submission of the iLinkBlue Agreement Packet, please allow at least three business days to process. If an agreement is returned due to incomplete information, the processing time starts over.

The iLinkBlue Agreement Packet is available on our Provider Page, www.BCBSLA.com/providers >Resources >Forms. Submitting a correct and completed packet is the key to timely processing.

If you have any questions, you may email EDI Services at EDIServices@bcbsla.com or call 1-800-216-BLUE (2583).

Blue Cross Coverage Standards for Telemedicine

Telemedicine services are defined as the healthcare delivery, diagnosis, consultation, treatment and transfer of medical data by a network physician or nurse practitioner using interactive telecommunication technology that enables the network provider and patient at two locations, separated by distance, to interact via two-way video and audio transmissions simultaneously.

For Blue Cross purposes, providers practicing with telemedicine should use the same standard of care as if the services were rendered in person. Telemedicine encounters must be fully documented and analogous to an in-person, face-to-face encounter. Telemedicine does not include the use of audio-only telephone, fax or email, as these are not reimbursable.

In addition to establishing a physician-patient relationship, the standards state that "the practice of medicine by telemedicine, including the issuance of any prescription via electronic means shall be held to the same prevailing and usually accepted standards of medical practice as those in traditional (face-to-face) settings. An online, electronic or written mail message does not satisfy the standards of appropriate care."

To be eligible for reimbursement, the provider rendering the service must be a BCBSLA network provider and follow our guidelines for telemedicine/telehealth as noted in this article. Additionally, providers should review and adhere to any other guidelines put forth by their appropriate licensing board.

For a list of eligible coding requirements, refer to the Telehealth/Telemedicine Billing Guidelines section of the *Professional Provider Office Manual*, available online at www.BCBSLA.com/providers >Resources >Manuals.

Medical Policy Update

Blue Cross regularly develops and revises medical policies in response to rapidly changing medical technology. Our commitment is to update the provider community as medical policies are adopted and/or revised. Benefit determinations are made based on the medical policy in effect at the time of the provision of services. Please view the following updated medical policies, all of which can be found on iLinkBlue at www.BCBSLA.com/ilinkblue.

Recently Updated Medical Policies

Policy No. Policy Name

Effective March 20, 2019

00032 C Diaphragmatic Phrenic Nerve Stimulation and Diaphragm Pacing Systems

00047 C Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers

00058 I Autologous Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas

00170 C Immune Globulin Therapy

00197 I Dynamic Spinal Visualization and Vertebral Motion Analysis

00216 I Whole Body Computed Tomography Scan as a Screening Test

00345 C Noninvasive Prenatal Testing for Fetal Aneuploidies and Microdeletions Using Cell-Free Fetal DNA

00353 C Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

00368 I Melanoma Vaccines

00619 C desmopressin acetate (Noctiva™, Nocdurna®)

00634 C Therapeutic Radiopharmaceuticals in Oncology

Effective April 1, 2019

00272 I Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer

Effective April 24, 2019

00016 C Closure Devices for Patent Foramen Ovale and Atrial Septal Defects

00049 C Hematopoietic Cell Transplantation for Acute Myeloid Leukemia

00318 C Topical Corticosteroids

00342 C Topical Tretinoins and Tretinoin Combination Products

00363 C Select Ophthalmic Prostaglandins

00412 C Fetal Surgery for Prenatally Diagnosed Malformations

00458 C Amniotic Membrane and Amniotic Fluid

Effective April 24, 2019 (cont.)

00516 C buprenorphine (sublingual)

00541 C Select Anti-Epileptic Drugs

00549 C Intravitreal Corticosteroid Implants

Effective May 1, 2019

00332 C Molecular Markers in Fine Needle Aspiration of the Thyroid

Effective May 15, 2019

00295 C belimumab (Benlysta®)

00301 C Nasal Allergy Medications

00567 C dupilumab (Dupixent®)

00642 C Select Oral Oncology Drugs

Effective June 1, 2019

00084 C Magnetic Resonance Imaging for Detection and Diagnosis of Breast Cancer

00011 C Bone Growth Stimulation

00091 C Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions

00105 C Positron Emission Tomography (PET) Oncology Applications

00153 C Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA) for Coronary Artery Evaluation

00260 C Spinal Cord Stimulators

00558 C Sacroiliac Joint Fusion

Medical Policy Coverage Legend

These symbols are referenced next to medical policies listed on this page and indicate Blue Cross' coverage indications as follows:

- I Investigational
- C Eligible for coverage with medical criteria
- N Not medically necessary

Provider inquiries for reconsideration of medical policy coverage, eligibility guidelines or investigational status determinations will be reviewed upon written request. Requests for reconsideration must be accompanied by peer-reviewed, scientific evidence-based literature that substantiates why a technology referenced in an established medical policy should be reviewed. Supporting data will be reviewed in accordance with medical policy assessment criteria. If you have questions about our medical policies or if you would like to receive a copy of a specific policy, go to iLinkBlue at www.BCBSLA.com/ilinkblue to access the Medical Policy Guidelines tool under the "Authorizations" menu option.

Medical Policy Update

New Medical Policies

Policy No. Policy Name

Effective March 20, 2019

00665 C cenegermin-bkbj (Oxervate™)

Effective April 24, 2019

00667 C Xyosted™ (testosterone enanthate auto-injection)

00668 C Ryclora™ (dexchlorpheniramine oral solution)

00669 C Inveltys™ (loteprednol ophthalmic suspension)

00670 C Treatment of Hereditary Transthyretin-Mediated Amyloidosis in Adult Patients

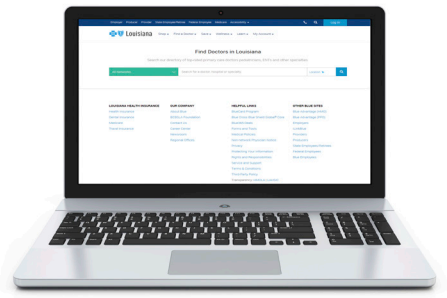
00671 C ravulizumab (Ultomiris™)

Effective May 15, 2019

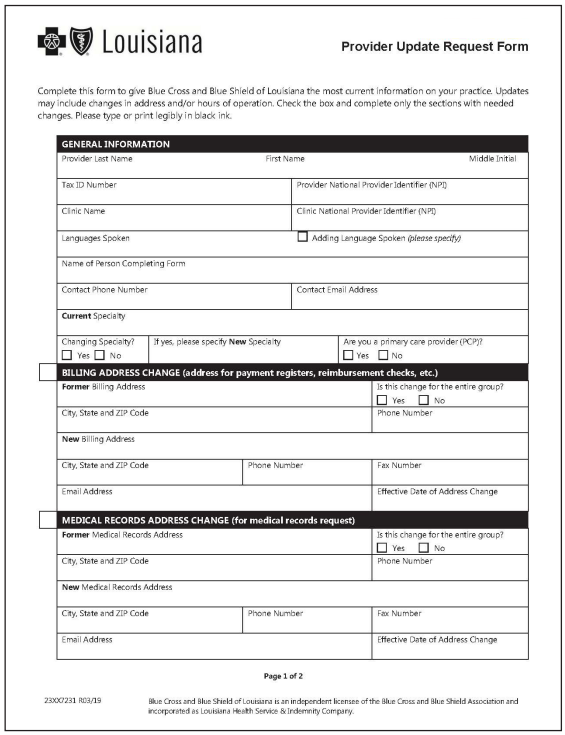
00673 I Powered Exoskeleton for Ambulation in Patients With Lower-Limb Disabilities

Electronic Services

Changes Coming to Our Provider Directory



We are making changes to our online provider directory to help create the most accurate directory for our members. The directory is available on our website at www.BCBSLA.com. Our Provider Credentialing and Data Management team will be working with you directly to help ensure your information is current and accurate.



Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Languages Spoken | ☐ Adding Language Spoken *(please specify)*

Name of Person Completing Form

Contact Phone Number | Contact Email Address

Current Specialty

Changing Specialty? ☐ Yes ☐ No | If yes, please specify **New** Specialty | Are you a primary care provider (PCP)? ☐ Yes ☐ No

☐ **BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)**

Former Billing Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Billing Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address | Effective Date of Address Change

☐ **MEDICAL RECORDS ADDRESS CHANGE (for medical records request)**

Former Medical Records Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Medical Records Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address | Effective Date of Address Change

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23X0723.1 R03/19

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

Do you need to update your contact information?

Use the Provider Update Request Form to update or correct your practice's contact information, including the correspondence email address.

It is available online at www.BCBSLA.com/providers >Resources >Forms.

Medical Management

Monitor Your Patients' Vaccination Needs

The Centers for Disease Control and Prevention (CDC) reports that there have been 1,077 cases of measles in the U.S. in 2019. Cases have been confirmed in 24 states as of May, with ongoing outbreaks in places like New York City and Los Angeles. Recent outbreaks in Washington and Chicago have been traced to common exposures at airports.

The best way to protect patients and their loved ones from a disease like the measles is through vaccination. It is important to discuss keeping vaccinations current with your patients, whether they are young children, or adults whose immunizations may not be current. Fully-insured plans cover the Measles, Mumps and Rubella (MMR) and Measles, Mumps, Rubella and Varicella (MMRV) vaccines at $0 for all non-grandfathered and grandfathered benefit plans.

Most measles cases in the U.S. result from international travel, so keep that in mind if your patients mention vacation plans. Patients should plan to be fully vaccinated at least two weeks prior to departure. However, if a trip is less than two weeks away and a patient is not protected against measles, it is recommended to get a dose of MMR vaccine.

Thank you for helping us prevent disease for our members—your patients—and the general health at large.

STAY CONNECTED

Visit BCBSLA's Provider Page:
www.BCBSLA.com/providers

Connect with us on Facebook:
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Follow us on Twitter:
@BCBSLA

Watch us on YouTube:
bluecrossla

Follow us on Instagram:
@bcbsla

Not Getting Our Newsletters Electronically?

Send an email to provider.communications@bcbsla.com. Put "newsletter" in the subject line. Include your:

- Name
- Organization name
- Contact information

Medical Management

Now is the Time to Help Patients Quit Smoking

Quitting is hard; however, providers may help Blue members through benefits available on their plan, or with free local resources.

Quality Blue: Primary care providers in our Quality Blue programs work with our health coaches to give patients the help they need to set attainable goals on the road to quitting for good.

Online Wellness Resources: After taking a simple health assessment at www.BCBSLA.com, smokers will be linked to two self-directed workshops—with four-week and 12-week options—they may take at no charge.

Other Programs and Services:

- The Smoking Cessation Trust pays for stop-smoking programs for Louisiana residents who have been smoking since before September 1, 1988 (www.smokingcessationtrust.org or 1-855-259-6346).
- The Louisiana Tobacco Quitline is a free program of counseling and support to help people quit all forms of tobacco (www.quitwithusla.org or 1-800-QUIT-NOW).
- Well-Ahead Louisiana's Community Resource Guide is a tool to search by ZIP code or parish for local help to quit smoking (www.wellaheadla.com).

Benefits related to smoking cessation are included in most Blue plans. Member benefits may be verified through iLinkBlue (www.BCBSLA.com/ilinkblue).

Patients Need Behavioral Health Treatment? Use New Directions' New Toolkit

People experiencing a mental health condition will often tell their primary care provider. As a provider, are you prepared to help them get the treatment they need? New Directions Behavioral Health has created a Primary Care Physician Toolkit to help you screen patients for things like depression, anxiety, PTSD or substance use disorder—and refer them to care management services.

Each condition-specific toolkit has screening tools, educational articles and patient resources to help you help them. You can also call their health plan's dedicated Physician Consult Line for a consultation with a New Directions psychiatrist on issues like medication management.

Visit www.ndbh.com/PCP to get started.

New Directions is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Louisiana networknews

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What's New on the Web

www.BCBSLA.com/providers

- **UPDATED** Recredentialing checklists for professionals and facilities. New checklists are available under Join Our Networks >Credentialing Process.

Important Contact Information

Authorization
See member's ID card

BlueCard® Eligibility
1-800-676-BLUE
(1-800-676-2583)

FEP
1-800-272-3029

Fraud & Abuse
1-800-392-9249
fraud@bcbsla.com

iLinkBlue & EDI
1-800-216-BLUE (1-800-216-2583)
EDIServices@bcbsla.com

PCDM
1-800-716-2299, Opt. 2 Provider Credentialing, Opt. 3 Data Management

Provider Services Call Center
1-800-922-8866

Claims Filing Address
P.O. Box 98029
Baton Rouge, LA 70898

Updating Your Contact Information

Use the Provider Update Request Form to submit updates or corrections to your practice information. The form is available online at www.BCBSLA.com/providers >Resources >Forms.

Network News

Network News is a quarterly newsletter for Blue Cross and Blue Shield of Louisiana network providers. We encourage you to share this newsletter with your staff.

The content in this newsletter is for informational purposes only. Diagnosis, treatment recommendations and the provision of medical care services for Blue Cross members are the responsibilities of healthcare professionals and facility providers.

View this newsletter online at www.BCBSLA.com/providers >Newsletters.

The content in this newsletter may not be applicable for Blue Advantage (HMO) and Blue Advantage (PPO), our Medicare Advantage products and provider networks. For Blue Advantage, we follow CMS guidelines, which are outlined in the *Blue Advantage (HMO) | Blue Advantage (PPO) Provider Administration Manual*, available on the Blue Advantage Provider Portal through iLinkBlue (www.BCBSLA.com/ilinkblue).

Get News Electronically

Your correspondence email address allows us to electronically keep you abreast of the latest Blue Cross news and some communications that are sent via email only. Email provider.communications@bcbsla.com and please include a contact name, phone number and your provider number.

Please share this newsletter with your insurance and billing staff!