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

3rd Quarter 2018

provider networknews

providing health guidance and affordable access to quality care

INSIDE THIS ISSUE

See Page 3 for Behavioral Health Workshop dates and locations.

Assessing Your After-hours Messaging

Most Americans do not live their lives from 9 a.m. to 5 p.m., Monday through Friday. It can be hard for them to access healthcare when a problem arises in the off hours.

Sometimes, it means an emergency room trip, which can lead to large crowds, longer waits and an inefficient use of time and resources for doctors and other healthcare staff, as well as increased costs. Per the academic journal *Health Affairs*, approximately 15 percent of emergency room visits involve acute, but not necessarily emergent, symptoms: fever, cough, headache or pain in the stomach or abdomen.

Many of these conditions could be treated by a primary care provider (PCP), although just 29 percent of U.S. primary care clinics maintain after-hours or weekend care. But, PCPs can still assist patients at these times through after-hours messaging.

Directing patients effectively in off-hours can help create a more efficient environment for all portions of our healthcare system.

It is up to all of us to help patients get the right care, in the right settings.

For tips on improving your after-hours messaging, check out our Medical Management section on Page 10!

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

Louisiana

23XX6753 R09/18

Provider Network

Tiered Benefits in iLinkBlue

We recently made changes in iLinkBlue to add clarity about the different member benefit level requirements for our select networks.

When researching member benefits for Blue Connect, Community Blue and Signature Blue members, you will notice that we have added tiers of coverage:

- Tier 1 In Network – applies for providers specifically in the member's network
- Tier 2 Out of Network Preferred – applies for providers participating with Blue Cross in a network other than the member's network
- Tier 3 Out of Network Non-Preferred – applies for providers not participating in any Blue Cross network or who are under special arrangement

Provider Amendment Coming

Network providers should be on the lookout for an amendment that will be mailed this fall. We are revising the Provider Dispute Resolution section of our provider agreements in order to clarify the dispute resolution process. The amendment is for clarification purposes, and providers will not experience a change in the handling of disputes.

Finding Preferred Labs

Blue Cross' preferred lab program includes multiple statewide and regional lab providers. For the most current list of statewide reference labs and full details on lab requirements for our products, please refer to the corresponding network speed guide. These guides are available online at www.BCBSLA.com/providers >Resources >Speed Guides.

New iLinkBlue User Guide

iLinkBlue is Blue Cross and Blue Shield of Louisiana's secure online provider resource for eligibility and coverage verification, claims filing and review, payment queries and transactions, medical policies and more.

Our new iLinkBlue User Guide is designed to offer tips and walk-throughs for accessing the most commonly used iLinkBlue functions.

iLinkBlue is your one-stop for:

- Allowable Charges
- Authorizations
- Benefits
- BlueCard® Medical Record Requests
- Claims Research
- Electronic Funds Transfer
- Eligibility
- Estimated Treatment Cost
- Grace Period Notices
- Manuals
- Medical Code Editing
- Medical Policies
- Payment Information
- And so much more.

The iLinkBlue User Guide and other manuals are available online at www.BCBSLA.com/providers >Resources >Manuals.

To get this quarterly newsletter, email provider.communications@bcbsla.com.

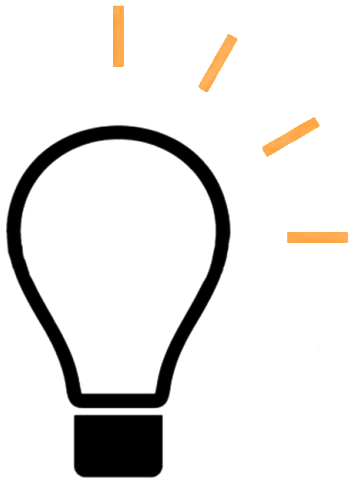
Save the Date for Our Behavioral Health Workshops

Free Behavioral Health Workshops are coming in October 2018. These are dedicated to providers and their staff who offer the following services:

- Psychiatry
- Psychology
- Licensed Professional Counseling/ Social Work
- Intensive Outpatient Programs
- Partial Hospitalization Programs
- Residential Treatment Center Services
- Applied Behavioral Analysis

October 23	Baton Rouge	9 a.m. - 12 p.m.
October 24	Shreveport	9 a.m. - 12 p.m.
October 25	Lafayette	9 a.m. - 12 p.m.
October 30	Metairie	9 a.m. - 12 p.m.

If you have not received an invitation and would like to attend, please email provider.relations@bcbsla.com.



Don't Forget! ***Opti****Net*® Assessments for Diagnostic Imaging Providers

Opti*Net*® is an AIM Specialty Health® (AIM) online registration tool that gathers information about the technical component capabilities of diagnostic imaging services.

We 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.

How Is Your Score Calculated?

Opti*Net* calculates a score for each provider. This score is based on the information self-reported through the online assessment. The site score measures basic performance indicators that are applicable for the facility as a whole, 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*

1. Log into iLinkBlue (www.BCBSLA.com/ilinkblue)
2. Click on the Authorizations menu option
3. Click on the AIM Specialty Health Authorizations link; this link takes you to the AIM ***Provider****Portal*℠
4. Click on Access Your ***Opti****Net* Registration on the left menu bar
5. Click the green Access Your ***Opti****Net* Registration button

Provider Network

AIM Shopper Program Expanded

We have partnered with AIM Specialty Health® (AIM) to deliver a shopper program that allows members to choose, based on quality and cost, the diagnostic imaging facility where their services are rendered. Today, nearly 5 million members nationwide, including BlueCard® members in Louisiana, already use this program.

Effective August 1, 2018, Blue Cross has expanded the AIM Specialty Care Shopper program to include all of our fully insured business, in addition to our Blue Cross employee group, 46210. Products such as Blue Connect, Community Blue, Signature Blue and Blue Advantage (HMO) are still excluded.

Provider Experience Survey Is Here

In October, we are conducting our Provider Experience Survey designed to help us understand your experience and satisfaction with Blue Cross. The survey covers the various interactions that you may have had with us throughout the past year.

Our goal is to identify areas for improvement and work toward making your interactions with us as efficient and easy as possible. Invitations to take the survey are being emailed in October. Your participation and feedback are valued and appreciated.

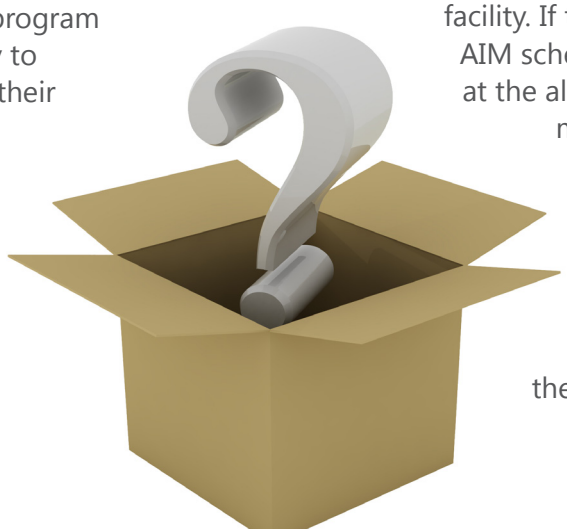
AIM Shopper FAQs:

What is the AIM Specialty Care Shopper program?

The program provides eligible members with the option to select an alternative imaging facility when diagnostic imaging services, such as MRI, MRA, CT and CTA scans, are requested. The alternative facilities deliver equal or higher quality that is more cost-effective for members.

Why was the AIM Specialty Care Shopper program developed?

To help members better manage their out-of-pocket expenses and help lower the costs of their healthcare. This program gives members an opportunity to make informed choices about their healthcare and the associated costs. They may be able to get the same quality procedure for less out-of-pocket expense at a different facility.



How does the AIM Specialty Care Shopper program work?

- The ordering provider enters an authorization in the AIM ***Provider****Portal*$_{SM}$ and selects a rendering provider.
- Once the authorization is complete, AIM determines if there are any alternative diagnostic imaging providers of high-quality and lower cost.
- AIM then notifies the member of the alternatives with the offer to switch the member to a high-quality, lower-cost facility. If the member chooses to switch, AIM schedules a new appointment at the alternate facility, updates the member authorization and reminds the member to cancel the original appointment.
- AIM emails the ordering physician and the member the new authorization information.

Billing & Coding

Incident-to Billing Policy Change

Blue Cross is updating our "Incident-to" reimbursement rules for provider types that are offered network participation. Such provider types include nurse practitioner, physician assistant, dietitian, audiologist, certified nurse anesthetist, etc.

Effective June 1, 2019, if Blue Cross offers network participation for a provider type, then that provider is required to file claims under their own provider number for services rendered. We will no longer permit services to be billed under the supervising provider. After June 1, claims may be periodically reviewed to ensure proper billing. To ensure your providers who are not currently in our networks are not impacted by this policy change, complete credentialing packets must be submitted to Blue Cross no later than March 1, 2019.

If you are one of these types of providers and currently participate in our networks, there are no additional credentialing or provider data requirements and you should bill your services please bill services directly to Blue Cross.

Only provider types that are not offered network participation will be allowed to bill and be reimbursed under the supervising provider's Blue Cross contract number.

To apply for network participation or to obtain a Blue Cross record for billing claims only, visit www.BCBSLA.com/providers, click on "Provider Networks" and then "Join Our Networks" to find the credentialing packets for Professional Providers. These packets contain all of the required forms that must be submitted to be credentialed as a network provider or to simply obtain a provider record for billing purposes.

Refer Members to In-network Preferred Reference Laboratories

As a Blue Cross network provider, you agree to refer Blue Cross members to other participating providers, unless a network provider is unavailable to fulfill the member's needs, or in emergency situations. This includes laboratory services. Out-of-network providers can balance bill our members, resulting in higher individual costs. Your *Professional Provider Office Manual* states all network providers must refer members to preferred reference lab providers when lab services are needed and not performed in the provider's office.

Pre-pay Itemized Bill Review for Acute Care Facilities

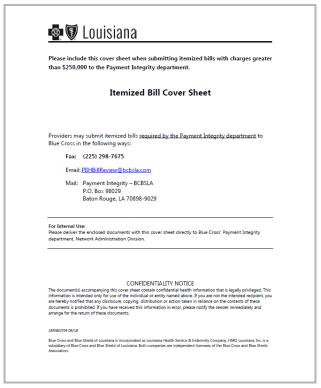
Effective November 15, 2018, Blue Cross will begin reviewing high-dollar, acute care claims. When filing an inpatient acute claim that has a billed charge of greater than $250,000, we now require an itemized bill must be submitted with our Itemized Bill Cover Sheet.

It is highly recommended that itemized bills are faxed or emailed at the same time claims are filed in order to ensure accuracy of claims reimbursement. Claims received with a billed amount of greater than $250,000 and no 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 the itemized bill does not match the charges on the claim, it will be denied for incorrect billing.

Based on our claims review, should an adjustment be required to reimbursement, we will notify you of our findings and changes. For any questions about this new claim review process for acute care facility claims over $250,000, you may contact us at PIIHBillReview@bcbsla.com.

To download a copy of the Itemized Bill Cover Sheet, visit www.BCBSLA.com/providers >Resources >Forms.


Louisiana

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

Itemized Bill Cover Sheet

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

Fax: (225) 298-7675

Email: PIIHBillReview@bcbsla.com

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

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

CONFIDENTIALITY NOTICE

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

Note: Blue Cross and its vendors reserve the right to request itemized bills when deemed necessary for claims processing and review, regardless of billed amount.

Billing & Coding

DME Supplies Included in Global Fee

In alignment with CMS' payment guidelines, Blue Cross reimburses network facilities a global rate that covers all aspects of members' care for both inpatient and outpatient stays. This global rate includes any durable medical equipment (DME), e.g. pneumatic limb compression devices, that are supplied by a subcontracted provider and used in connection with the treatment of a member during inpatient or outpatient stays. DME providers should seek reimbursement from the facility to which their supplies were delivered. Separate claim submissions to Blue Cross for DME supplies delivered to our members while they are patients in these facilities are not separately payable and should not be submitted to us for payment.

Additional information regarding reimbursement of DME supplies included in the global fee can be found in the Subcontracted Provider section of the *Member Provider Policies & Procedures Manual*, Member Provider Agreement and Allied Health Provider Agreement for Ambulatory Surgery Centers and DME suppliers.

Provider-based Billing

Blue Cross does not recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals. Under provider-based billing, the office/clinic visit is split into two bills. The facility bills a clinic charge for any facility or technical component on a UB-04 claim form and the professional services are billed separately on a CMS-1500 claim form. We do not recognize provider-based billing of office services even if the office is located on the hospital campus and/or uses the hospital tax identification number.

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service code 11. A separate facility claim on a UB-04 should not be submitted for a facility or technical fee associated with the office/clinic visit. Facilities operating provider-based clinics should submit a global bill for all services rendered in the clinic on a CMS-1500 claim form. Payment for the professional provider's services includes any technical or facility fees.

Correction Regarding SNF for FEP Members

On August 1, 2018, we mailed a letter stating that our Blue Cross and Blue Shield Federal Employee Program® (FEP) members could no longer receive services from out-of-network skilled nursing facilities (SNF). We apologize that this was a miscommunication. FEP Standard Option members can continue receiving services from out-of-network providers when the provider meets the following criteria below:

- Must be Medicare-certified as a SNF.
- Licensed in accordance with state or local law, or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such agencies or organizations).
- Admitting SNF has a transfer agreement in effect with one or more in-network hospitals.
- Is primarily engaged in providing skilled nursing care and related services for individuals who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.
- Facility is physically separate from the rest of the institution, i.e., it must represent an entire physically identifiable unit consisting of all beds within that unit, such as a separate building, floor, wing or ward. It need not be confined to a single location within the institution's physical plant.
- Must provide skilled services seven days a week, or therapy five days (minimum of two hours daily) a week with skilled nursing service for admissions solely for physical rehabilitation.
- The facility must be able to provide nursing rehabilitative, respiratory, nutritional, educational, pharmacological and behavioral health services.
- The member must have returned a signed consent agreeing to FEP case management prior to admission or transfer to SNF.

We apologize for any confusion caused by the previous communication. If you have questions about this, contact Provider Relations at provider.relations@bcbsla.com or 1-800-716-2299, option 4.

Drug Screening Assays

As stated in the *Professional Provider Office Manual*, when ordering presumptive drug screens, Blue Cross only accepts claims with CPT® drug-screen codes, and will only allow payment for one presumptive drug screen for drugs from Drug Class A and/or B (CPT codes 80305-80307), regardless of the number of services performed. To ensure you have the most up-to-date information about Blue Cross' coverage guidelines, please review our Urinary Drug Testing medical policy—number 00387. All Blue Cross medical policies are available on iLinkBlue (www.BCBSLA.com/ilinkblue) under the Authorizations section.

Blue Cross' Urinary Drug Testing medical policy 00387 also states that providers may only perform definitive drug testing under certain circumstances, including, but not limited to: an unexpected positive test; unexpected negative test results, and the need for quantitative levels to compare with established benchmarks for clinical decision making. When billing, providers should only submit claims for services they specifically rendered. Providers should not submit claims for pass-through billing, bill for patients who are not theirs or bill for services ordered/rendered by another provider who should be credentialed and self-billing.

Updated Outpatient Code Ranges

We recently completed reviews of new 2018 CPT® and HCPCS codes. As a result, we have updated the Outpatient Procedure Services and Diagnostic and Therapeutic Services code ranges. Effective October 1, 2018:

The following HCPCS code will be added to the Outpatient Procedure Services code list:

C9750

The following HCPCS codes will be added to the Diagnostic and Therapeutic Services code range list:

C9033	Q5108
C9034	Q5110

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

Remind Patients to Get Flu Shot

Each year, millions of people suffer from the flu, a highly contagious infection. It spreads easily from person to person and can be life threatening in older adults and in people of any age who have a chronic illness such as heart, kidney or lung disease.

The Centers for Disease Control (CDC) recommends that everyone six months and older get a flu shot each year. Vaccines are safe and the most effective flu prevention.

Please encourage your patients to get their annual flu shot. We will cover this shot at 100 percent when members receive their flu vaccine from a network provider or participating retail pharmacy. This means our members will pay no copayment, coinsurance or deductible for their flu shot.

Note: If providers file the flu shot with a sick or regular visit, members must still pay their copayment or deductible as applicable for the sick services.

Place of Service Billing for Lab Services

The place of service (POS) code for all clinical and anatomical laboratory services should reflect the type of facility where the patient was located when the specimen was taken, regardless of whether a global, technical or professional component of the service is being billed.

For example:

- If an independent laboratory bills for a lab sample where the sample was taken in its own laboratory, POS code "81" (reference lab) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an inpatient hospital setting, POS code "21" (inpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an outpatient hospital setting, POS code "22" (outpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in a physician office setting, POS code "11" (office) would be reported.

As a reminder, the referring physician should always be listed on claims for laboratory services.

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 June 20, 2018

00047 C Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1 or BRCA2)
00054 I Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer
00073 C Implantable Hormone Pellets
00198 C Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)
00265 C denosumab (Prolia®)
00298 I Stem Cell Therapy for Peripheral Arterial Disease
00395 C Insulins (Non-Long Acting Products)
00406 C Transcatheter Aortic Valve Implantation for Aortic Stenosis
00415 C Percutaneous Tibial Nerve Stimulation
00524 C Topical Immunomodulators (Elidel®, Protopic®, generics)
00526 C Select Inhaled Respiratory Agents
00564 C Branded Dexamethasone Packs

Effective July 1, 2018

00472 C Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors [alirocumab (Praluent®), evolocumab (Repatha™)]

Effective July 2, 2018

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

Effective July 11, 2018

00009 C Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure
00294 C ecallantide (Kalbitor®)
00318 C Topical Corticosteroids
00324 C GLP-1 Agonists for Diabetes
00385 C Sodium-Glucose Co-Transporter-2 (SGLT-2) Inhibitors and Combination Products
00601 C Select Drugs for Attention Deficit Hyperactivity Disorder (ADHD)

Effective August 1, 2018

00036 C Enhanced External Counterpulsation (EECP)
00323 C Opioid Management/Long Acting Oral Opioid Step Therapy
00443 C Myoelectric Prosthetic and Orthotic Components for the Upper Limb

Effective August 15, 2018

00012 C Botulinum Toxins
00169 C Cytochrome P450 Genotype-Guided Treatment Strategy
00245 I Genotype-Guided Warfarin Dosing
00320 C BRAF Gene Variant Testing to Select Melanoma or Glioma Patients for Targeted Therapy
00402 I Genetic Testing for Diagnosis and Management of Mental Health Conditions
00426 C Microprocessor-Controlled Prostheses for the Lower Limb
00428 C BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia
00576 C Transcatheter Pulmonary Valve Implantation

Effective September 1, 2018

00230 C Repository Corticotropin Injection (ACTH Gel, H.P. Acthar® Gel)
00328 C Medical Management of Obstructive Sleep Apnea Syndrome

Effective September 4, 2018

00145 C Artificial Intervertebral Disc: Lumbar Spine

New Medical Policies

Policy No. Policy Name

Effective July 11, 2018

00623 C Solosec™ (secnidazole)

Effective August 15, 2018

00622 I Gene Expression Profiling for Cutaneous Melanoma
00633 C burosumab (Crysvita®)

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, log on to iLinkBlue at www.BCBSLA.com/ilinkblue or call Provider Services at 1-800-922-8866.

Medical Management

MSK Utilization Management Program Expansion

On November 1, 2017, we implemented a musculoskeletal (MSK) utilization management program for spine surgery and interventional pain management. Effective September 1, 2018, we expanded the program to include joint surgery for large joint replacement and arthroscopy of the hip, knee and shoulder.

AIM Specialty Health® (AIM) is now accepting pre-service authorization reviews for MSK joint surgery services. Claims received without a preservice authorization will be denied for a post-claim review.

Until October 26, 2018, authorization requests will be approved even when medical necessity is not met. During this period, peer-to-peer discussions will be offered on cases that do not meet criteria. Then beginning October 27, 2018, MSK joint surgery services that do not meet criteria will be denied as not medically necessary, and are not billable to the member.

To initiate a request for medical necessity review for MSK joint surgery services, use the AIM ***Provider****Portal*℠, through iLinkBlue (www.BCBSLA.com/ilinkblue), under the Authorizations menu option. Or, contact AIM directly at 1-866-455-8416.

The AIM clinical guidelines for this program are available online at www.aimspecialtyhealth.com, then click the "Download Now" button.

AIM also manages authorizations for our Radiation Oncology Program.

Louisiana

STRONGER THAN

STRONGER THAN is a mind-set, a way of engaging members and providers in their journey to better health. This platform will allow us to tell our care management services story from a cohesive, user-centered experience that brings our services to their life in a meaningful way to drive positive behaviors and build powerful relationships.

More information is available online at www.BCBSLA.com/stronger.

Medical Management

Use WebPass for Utilization Submissions

We encourage providers to make use of New Directions' WebPass portal, an online tool to submit information for the utilization management process. It is available through iLinkBlue (www.BCBSLA.com/ilinkblue).

WebPass provides a way to:

- Complete preauthorization and concurrent reviews
- Submit discharge information
- Copy and paste information from other forms for easy data entry

If you are currently using WebPass, we recommend using all functions, including the discharge notification.

If you would like additional training or tips on how to use WebPass please contact prwebpass@ndbh.com. Tutorials are also available at NDBH.com.

New Directions' WebPass Portal is accessed through iLinkBlue at www.BCBSLA.com/ilinkblue >Authorizations >Behavioral Health Authorizations.

If you do not have access to iLinkBlue, please visit www.BCBSLA.com/providers >Electronic Services >iLinkBlue to sign up.

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.

Improving Your After-hours Messaging (cont. from Page 1)

Here are some tips for developing or improving your after-hours messaging as a PCP:

- Have a script! Clear, concise language is a crucial part of any provider-member relationship, and it is important to know exactly what your after-hours message is going to convey. Prepare such language in advance and review it on a regular basis.
- Tone matters: A patient calling is likely to be scared or agitated. A warm, inviting tone can help your message be absorbed better by the member. Stress that their health is your chief concern.
- Include important facts: What are your clinic's hours? Is there a doctor available through an answering service? Does it require a separate phone call? What is the approximate turnaround time on a call back?
- Mention locations of the closest Urgent Care and Emergency facilities to your practice.

And most importantly, direct the patient to seek the needed treatment. If it is an emergency, go to the hospital or call 911 if necessary. However, outlining the difference between an urgent or emergent symptom may better help the patient seek out the best care and get the most value from their health benefit plan. Chest pains, bleeding, vomiting or a severe injury may require an ER visit, but cold or flu symptoms may be treated more efficiently at an urgent care facility.

Get this newsletter emailed to you quarterly. Send an email to provider.communications@bcbsla.com. Put "newsletter" in the subject line.

Company News

Kozik Joins Blue Cross as CIO

Sue Kozik has joined Blue Cross and Blue Shield of Louisiana as senior vice president and chief information officer (CIO). As a member of the Senior Management Team, Kozik will oversee the Information Technology (IT) and Information Security departments and the Project Management Office (PMO).

Holding these key roles is a challenge that she is well prepared to meet. Kozik has more than 30 years of experience in the IT field and has led major technology and business transformation programs in healthcare, telecommunications, energy and financial services.

At Blue Cross, Kozik will lead the development and implementation of an IT strategy that will enable us to maintain our leadership position in a constantly changing and intensely competitive marketplace. She will oversee the PMO as well as IT testing and quality assurance. In addition, she will ensure that IT maintains its effective security practices that mitigate risks to our corporate systems.

Kozik comes to us from Group Health, a Seattle-based, $4 billion nonprofit integrated healthcare delivery system that recently became a part of Kaiser Permanente. There, as executive vice president and CIO, she had enterprise-wide responsibility for IT operations, applications and strategy. Prior to Group Health, Kozik held executive positions at Independence Blue Cross, Direct Energy, TIAA-CREF, Lucent Technologies, Penn Mutual Life Insurance Company and CIGNA. She has been recognized by the IT industry with many prestigious awards and was profiled in Dan Roberts and Brian Watson's 2016 book *Confessions of a Successful CIO—the Conversation Continues*.

Kozik graduated from Bates College in Lewiston, Maine, and served as a member of its board of trustees for 15 years. Since 2012, she has been a member of the board of directors at Tech Impact, a nonprofit that helps other nonprofits use technology to achieve their mission and improve outcomes. Kozik has advised a number of technology start-ups and is an active member of the Ridge Ventures CIO Group and many other advisory boards.

STAY CONNECTED

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www.BCBSLA.com/providers

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Follow us on Twitter:
@BCBSLA

Watch us on YouTube:
bluecrossla

Follow us on Instagram:
@bcbsla

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

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What's New on the Web

www.BCBSLA.com/providers

- **NEW** itemized bill cover sheet for claims greater than $250,000 available under Resources >Forms.
- **UPDATED** iLinkBlue Agreement Packet available under Resources >Forms.

Important Contact Information

Authorization
See member 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

Network Administration
1-800-716-2299, Opt. 2 Credentialing, Opt. 3 Provider File

Provider Services Call Center
1-800-922-8866

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

**Listen carefully to menu options, as they have been updated*

Updating Your Contact Information

Use the Provider Update Request Form to submit updates or corrections to your practice information. The form is available 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), our Medicare Advantage product and provider network. For Blue Advantage, we follow CMS guidelines, which are outlined in the *Blue Advantage (HMO) Provider Administration Manual*, available on the Blue Advantage Provider Portal through iLinkBlue (www.BCBSLA.com/ilinkblue).

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