Welcome to the Blue Cross Network

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

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

How to submit questions:

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

Louisiana

Welcome to the Blue Cross Network – *Professional Webinar*

Presented by Anna Granen
Senior Provider Relations Representative
Blue Cross and Blue Shield of Louisiana

March 2023

Our Networks

Network Overview

Blue Cross has comprehensive provider networks.

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

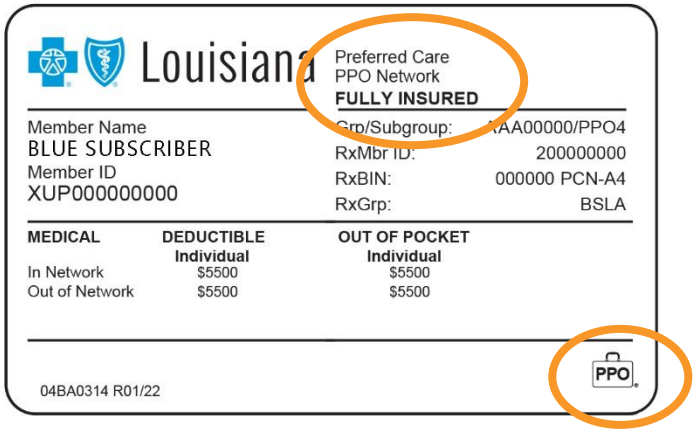
- Preferred Care PPO
- HMO Louisiana, Inc.
- Blue Connect
- Community Blue
- BlueHPN
- Precision Blue
- Signature Blue
- Blue Advantage (HMO) | Blue Advantage (PPO)
- Healthy Blue Dual Advantage (HMO D-SNP)
- Ochsner Health Network

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

Preferred Care PPO

Prefix Varies

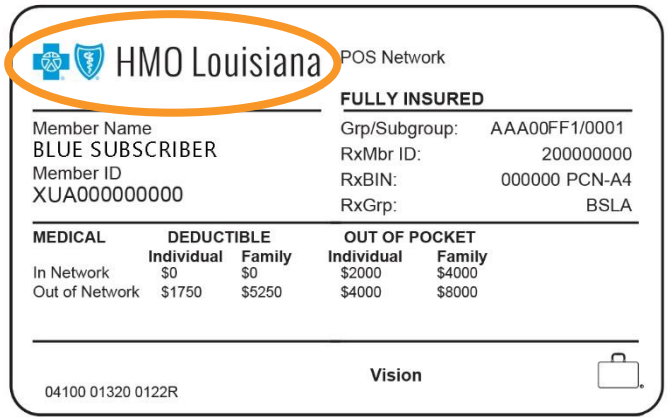
- Our Preferred Care PPO Network is available statewide.
- Members with PPO benefits receive the **highest level of benefits** when they receive services from PPO providers.
- Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network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



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

Prefix Varies

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

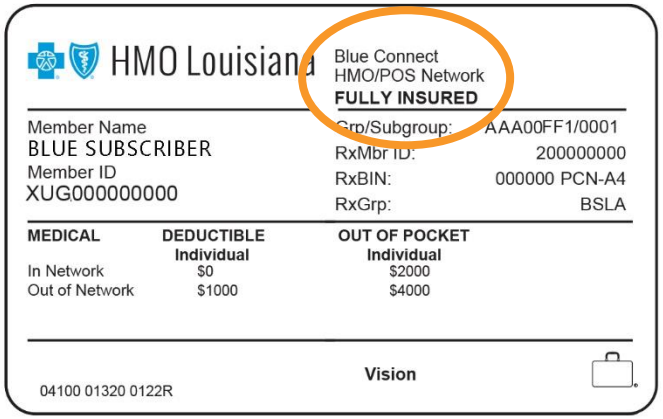


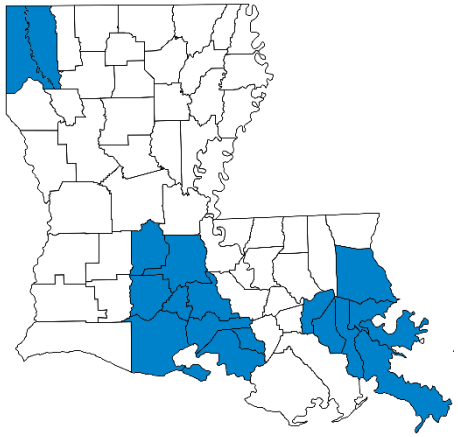
For more information, view the *HMO Louisiana Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Blue Connect

Prefixes: XUF, XUG, XUU and XUV

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





New Orleans area

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

Shreveport area

Bossier and Caddo parishes

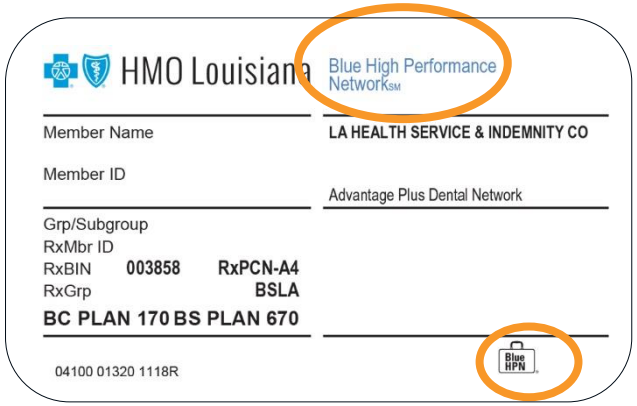
Lafayette area

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

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

BlueHPN

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



Lafayette area

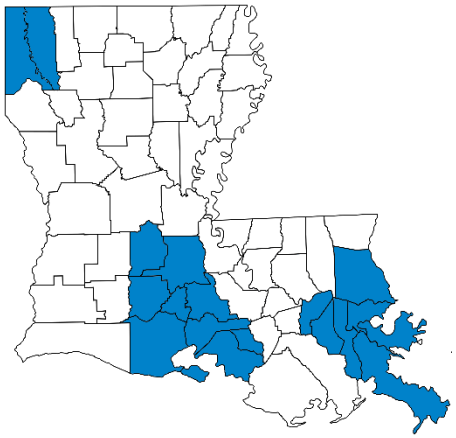
Acadia, Evangeline, Iberia, Jefferson, Lafayette, St. Landry, St. Martin and St. Mary parishes

New Orleans area

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

Shreveport area

Bossier and Caddo parishes



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

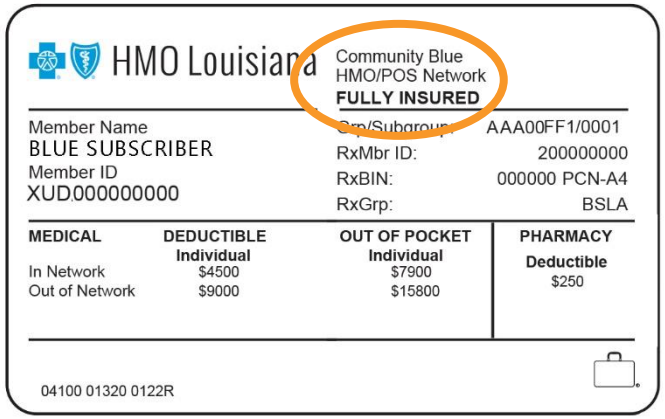
For more information, view the *BlueHPN Network Speed Guide*, available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Prefixes: XUD, XUJ and XUT

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

Baton Rouge area:

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



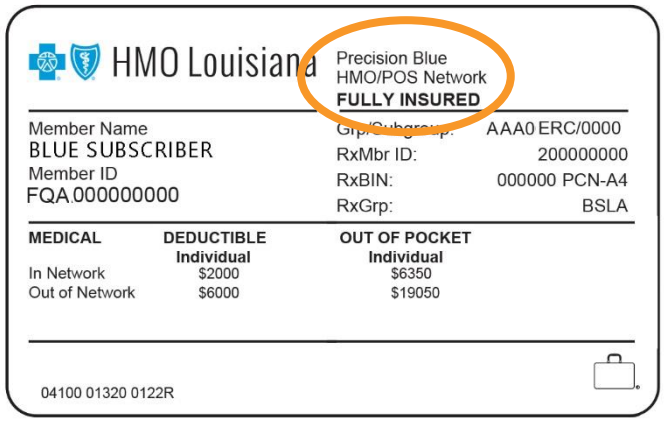
Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Community Blue Network.

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

Precision Blue

Prefixes: FQA, FQT or FQW

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

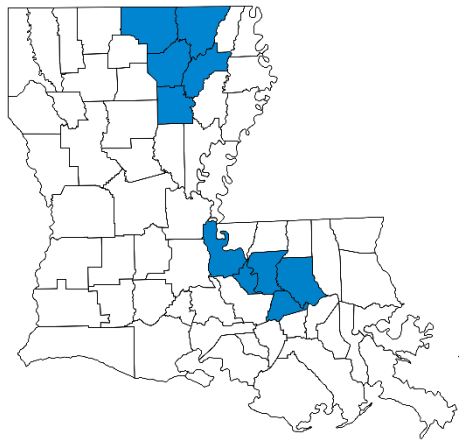


Baton Rouge area:

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

Greater Monroe/West Monroe area:

Caldwell, Morehouse, Ouachita, Richland, Union parishes

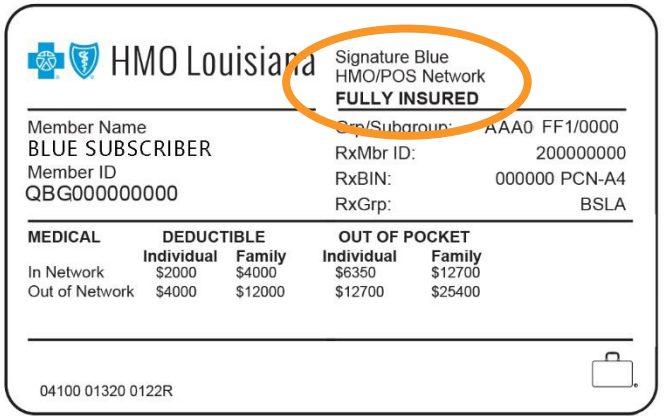


Members **may not have coverage or receive a lower level of benefits** when using a facility or provider that is not in the Precision Blue Network.

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

Prefixes: QBB, QBE, QBG and QBS

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



New Orleans area:

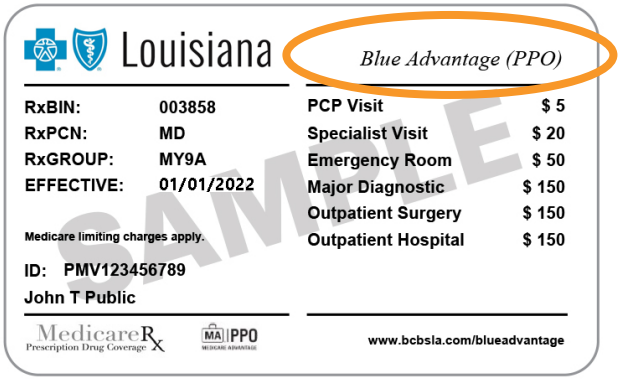
Jefferson and Orleans parishes

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

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

Prefixes: PMV and MDV

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



Prefix: PMV

Prefix: MDV

Medicare Advantage PPO Network Sharing

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

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

MA | PPO
MEDICARE ADVANTAGE

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

Healthy Blue Dual Advantage (HMO D-SNP)

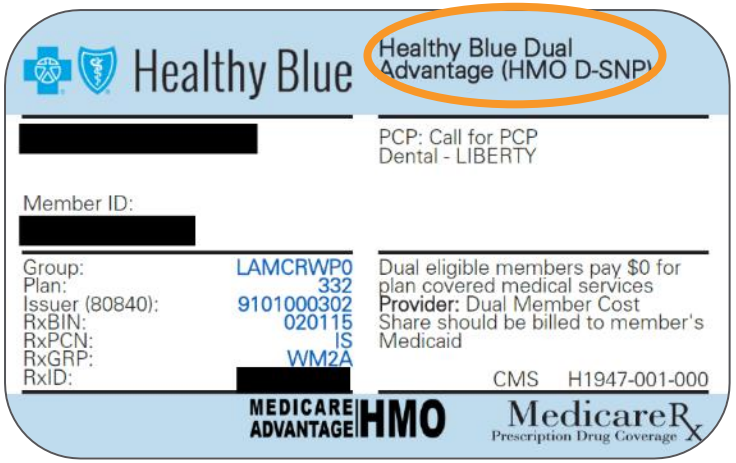
Prefix: JLA

Healthy Blue Dual Advantage (HMO D-SNP) is our Medicare/Medicaid Dual Advantage special needs product currently available to Medicare/Medicaid-eligible members.

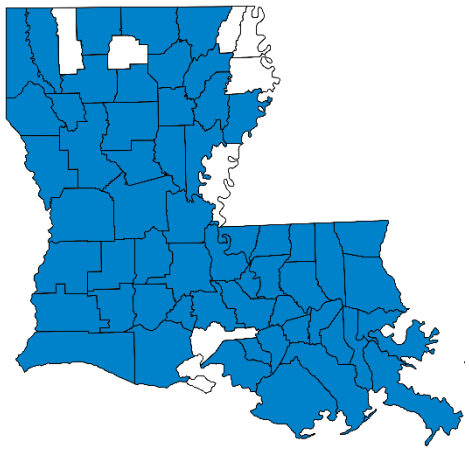
Statewide with the exception of the following parishes:

Concordia	Madison
East Carroll	Webster
Iberia	West Carroll
Lincoln	

For more information, go to **www.bcbsla.com/ilinkblue** >Other Sites >Healthy Blue.



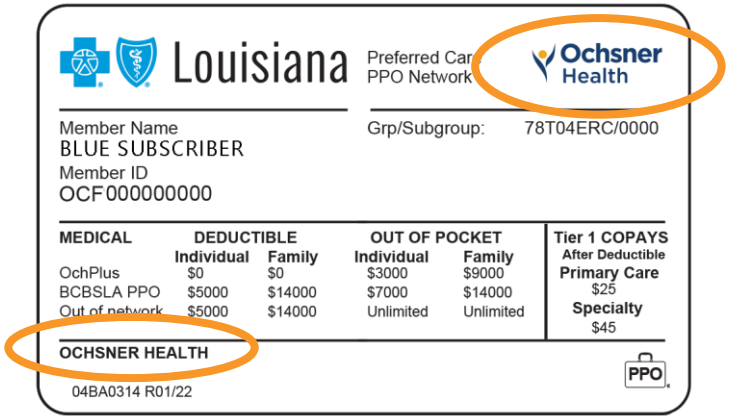
Prefix: JLA



Healthy Blue

Ochsner Health Network

Ochsner Health Network (OHN) is available statewide to eligible members. This is a select network in which BCBSLA partners with Ochsner Health Plan to manage.



Prefix: OCF

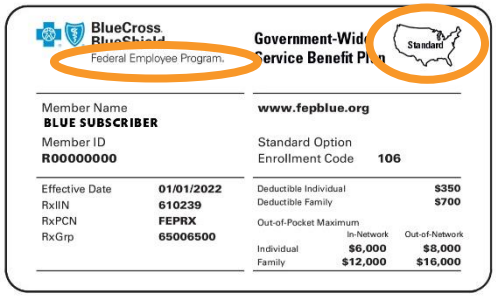
Federal Employee Program

Prefix: R (followed by 8 digits)

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

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

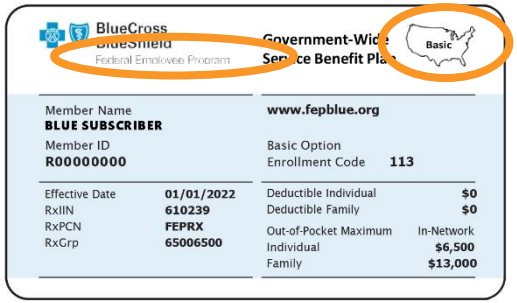
Standard



✓ In-network

✓ Out-of-network

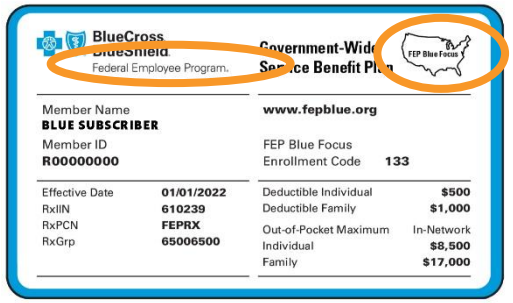
Basic



✓ In-network

X Out-of-network

FEP Blue Focus



✓ **LIMITED** in-network

X Out-of-network

Office of Group Benefits (OGB) Benefit Plans

Prefixes: OGS, LZB or LXS

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

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

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

Pelican HRA 775 (Active Employees Only)

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

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

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

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

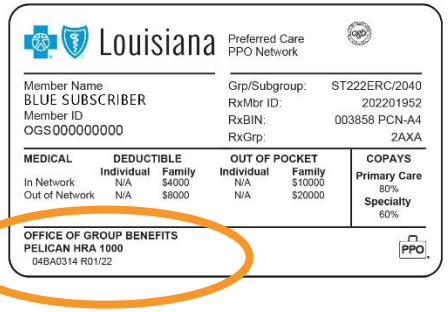
- Prefix: OGS
- HMO benefit design that uses our OGB Preferred Care PPO provider network.
- There are no benefits for services performed by out-of-network providers.

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

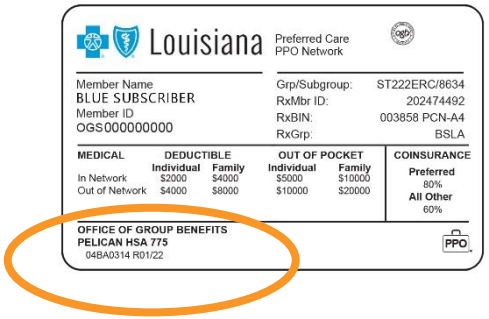
- Prefix: OGS
- PPO benefit plan
- Uses our OGB Preferred Care PPO provider network.

OGB Sample Member ID Cards

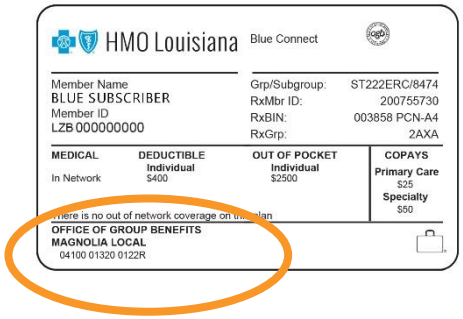
Pelican HRA 1000



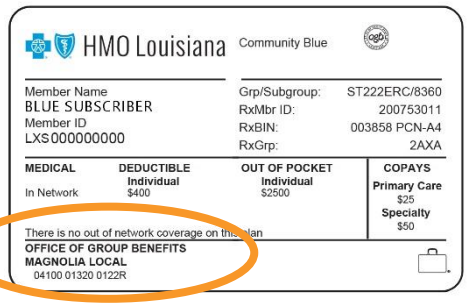
Pelican HRA 775



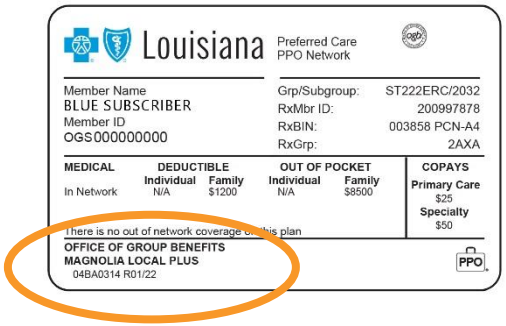
Magnolia Local Blue Connect



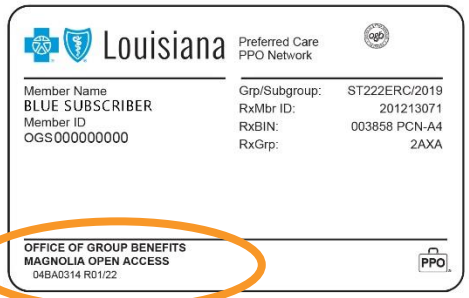
Magnolia Local Community Blue



Magnolia Local Plus



Magnolia Open Access



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

BlueCard® Program

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

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

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

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

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

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

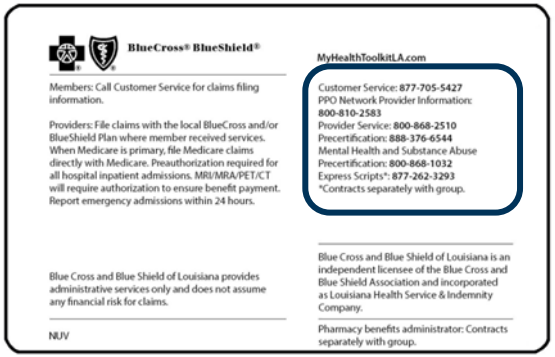
Note: BlueCard authorizations are handled through the members' home plan.

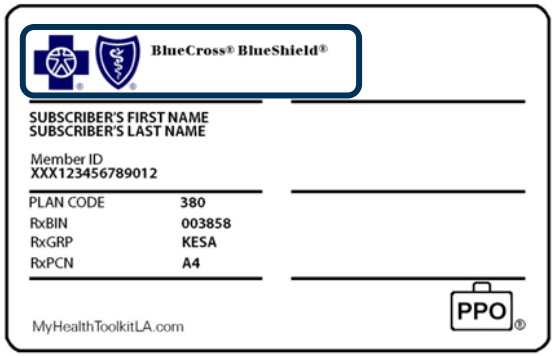
You can find additional BlueCard guidelines in the *BlueCard Program Provider Manual*, available online at **www.bcbsla.com/providers** >Resources >Manuals.

National Alliance

(South Carolina Partnership)

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

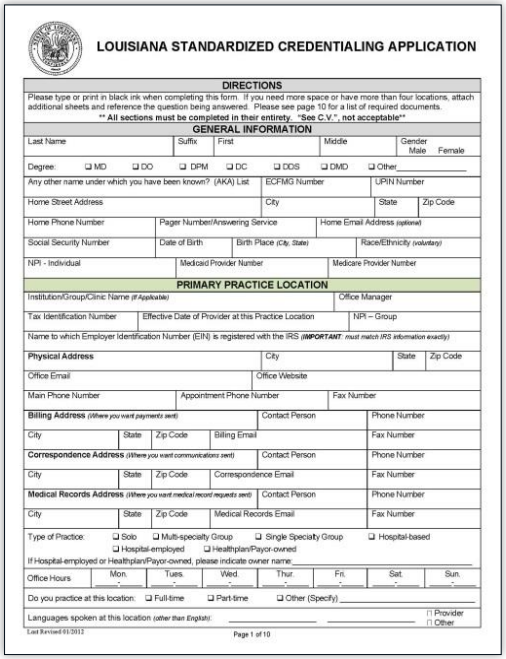




This list of prefixes is available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Recredentialing for Professional Providers

Professional Providers Recredentialing Applications



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:

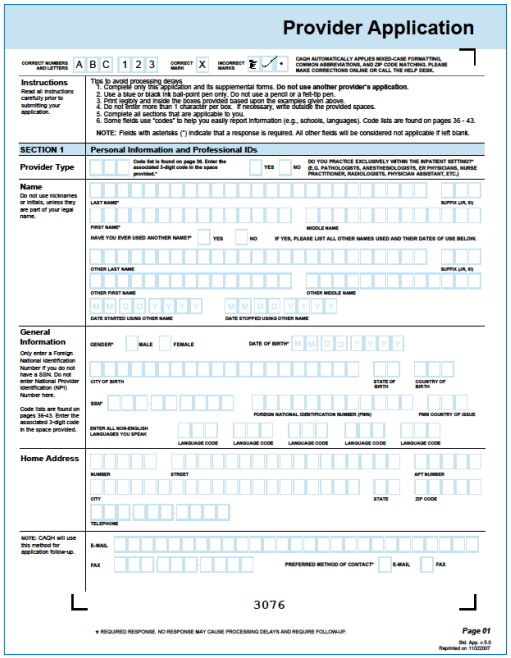
Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun.

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

Vantage accepts the LSCA, as well as the CAQH application.



Provider Application

CORRECT NUMBERS AND LETTERS A B C 1 2 3 CORRECT MARK X INCORRECT MARKS

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. Do not use another provider's application.
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not limit more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type | Code list is found on page 36. Enter the associated 2-digit code in the space provided.* | YES | NO | DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)

FIRST NAME* | MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) | DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 2-digit code in the space provided.

GENDER* MALE FEMALE | DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNN) | FNN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX | PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 01

Std. App. v.5.0 Reprinted on 11/2/2007

Find our credentialing links at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks.

Required Recredentialing Supporting Documentation for Professional Providers

The following documents must be submitted with your recredentialing application:

- Copy of state license.
- Copy of DEA registration and CDS license *(as applicable)*.
- Copy of Malpractice Liability Certificate (*copy of policy declarations page*).
- Complete the LSCA Attachment A - Location Hours.
- **Enclose a copy of the Collaborative Physician Agreement/Supervising Physician Agreement for NPs and PAs.**

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

Blue Cross Recredentialing

Use the chart below for the recredentialing process:

Form(s) to complete for professional provider recredentialing:	CAQH Application or Louisiana Standardized Credentialing Application (LSCA).
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments.
Where to submit forms:	To return the information, follow the instructions included with recredentialing application.
Who to contact:	Email **recredentialing@vhpla.com** or call (318) 807-4755.

Credentialing Update

We partner with **symplrCVO**, to assist with the primary source verification of our credentialing and recredentialing applications.

Providers in the credentialing and recredentialing process may be directly contacted by symplrCVO to verify application details and supporting documentation.

If you have additional questions, you may email our Provider Relations Department at **provider.relations@bcbsla.com**. We appreciate your understanding as we work to expedite application processing.

Credentialing Process

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

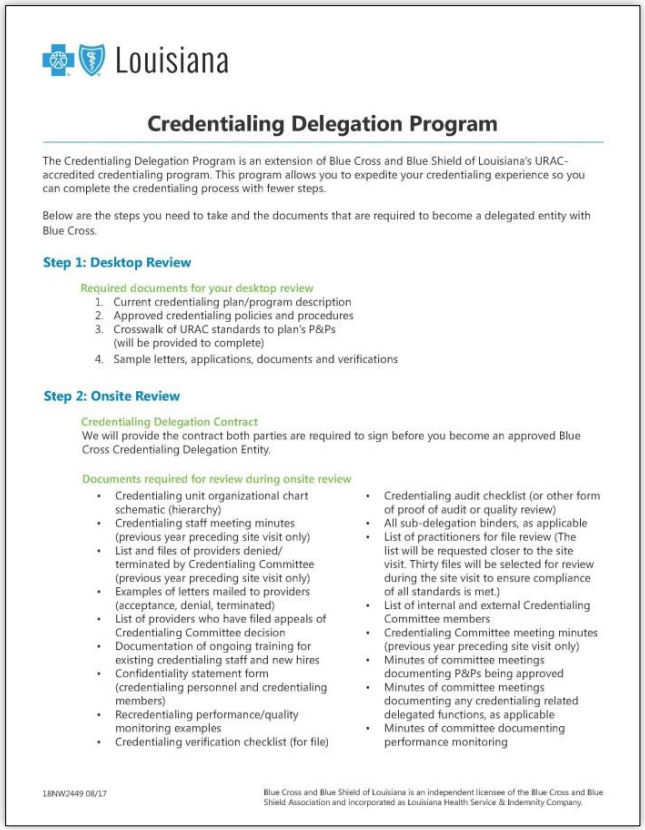
You may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **PCDMstatus@bcbsla.com**.

Credentialing Committee

The Credentialing Committee:

- Has the final authority to make decisions regarding provider participation.
- Provides guidance and suggestions for the credentialing process.
- Is made up of a diverse group of network providers from across the state with no other management role at Blue Cross.
- Includes multiple Blue Cross employees from Medical Management and Provider Credentialing & Data Management.

Credentialing Delegation Program



Louisiana

Credentialing Delegation Program

The Credentialing Delegation Program is an extension of Blue Cross and Blue Shield of Louisiana's URAC-accredited credentialing program. This program allows you to expedite your credentialing experience so you can complete the credentialing process with fewer steps.

Below are the steps you need to take and the documents that are required to become a delegated entity with Blue Cross.

Step 1: Desktop Review

Required documents for your desktop review

1. Current credentialing plan/program description
2. Approved credentialing policies and procedures
3. Crosswalk of URAC standards to plan's P&Ps (will be provided to complete)
4. Sample letters, applications, documents and verifications

Step 2: Onsite Review

Credentialing Delegation Contract

We will provide the contract both parties are required to sign before you become an approved Blue Cross Credentialing Delegation Entity.

Documents required for review during onsite review

- Credentialing unit organizational chart schematic (hierarchy)
- Credentialing staff meeting minutes (previous year preceding site visit only)
- List and files of providers denied/ terminated by Credentialing Committee (previous year preceding site visit only)
- Examples of letters mailed to providers (acceptance, denial, terminated)
- List of providers who have filed appeals of Credentialing Committee decision
- Documentation of ongoing training for existing credentialing staff and new hires
- Confidentiality statement form (credentialing personnel and credentialing members)
- Recredentialing performance/quality monitoring examples
- Credentialing verification checklist (for file)
- Credentialing audit checklist (or other form of proof of audit or quality review)
- All sub-delegation binders, as applicable
- List of practitioners for file review (The list will be requested closer to the site visit. Thirty files will be selected for review during the site visit to ensure compliance of all standards is met.)
- List of internal and external Credentialing Committee members
- Credentialing Committee meeting minutes (previous year preceding site visit only)
- Minutes of committee meetings documenting P&Ps being approved
- Minutes of committee meetings documenting any credentialing related delegated functions, as applicable
- Minutes of committee documenting performance monitoring

18NW2449 08/17

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.

- The Credentialing Delegation Program is an extension of our accredited credentialing program.
- An approved delegation entity essentially credentials its own providers and sends the information to Blue Cross to create their provider records.
- This program allows you to expedite your credentialing experience so you can complete the Blue Cross credentialing process with fewer steps.
- Available to groups with 50 or more practitioners.
- After a provider group is approved as a delegation entity, it will not be necessary to submit provider applications to be set up in the Blue Cross system.
- The *Credentialing Delegation Program* guide explains the steps network provider groups must take and the documents required to become a delegated entity.
- If you have any questions about the Credentialing Delegation Program, please email **credentialing.delegation@bcbsla.com**.

Effective Dates

For participating providers:

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

Delegation Program Providers	New Providers Not Credentialed	Providers Already Credentialed
The effective date for delegated providers is based on approval of the Credentialing Delegation spreadsheet by our Medical Director	If you are eligible for reimbursement during credentialing (joining an existing contracted group), then it is one month prior to the date of receipt of application; **OR** If you are not eligible for reimbursement during credentialing, then it is the approved date by the Credentialing Committee **AND** the execution of your network agreement.	If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is within 90 days of the calendar date, then it will be that date, but not before the group's effective date. If the requested effective date on the Provider Update Request Form (Existing Providers Joining a New Provider Group) is greater than 90 days of the calendar date, then it will be 90 days from the day the information was received, but not before the group's effective date.

Reimbursement During Credentialing

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

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

This provision does not apply for solo practitioners.

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

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

Easily complete packets & forms with DocuSign®

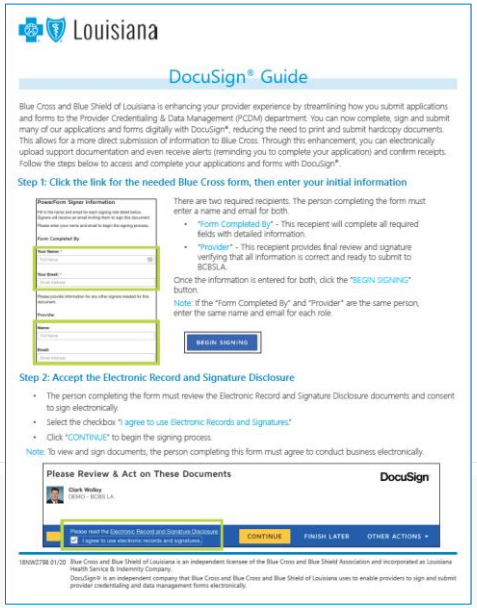
Complete, sign and submit applications and forms to the PCDM Department digitally with **DocuSign**.

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

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

What is DocuSign?

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


Louisiana

DocuSign® Guide

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

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

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

- "Form Completed By" - This 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.

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

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

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

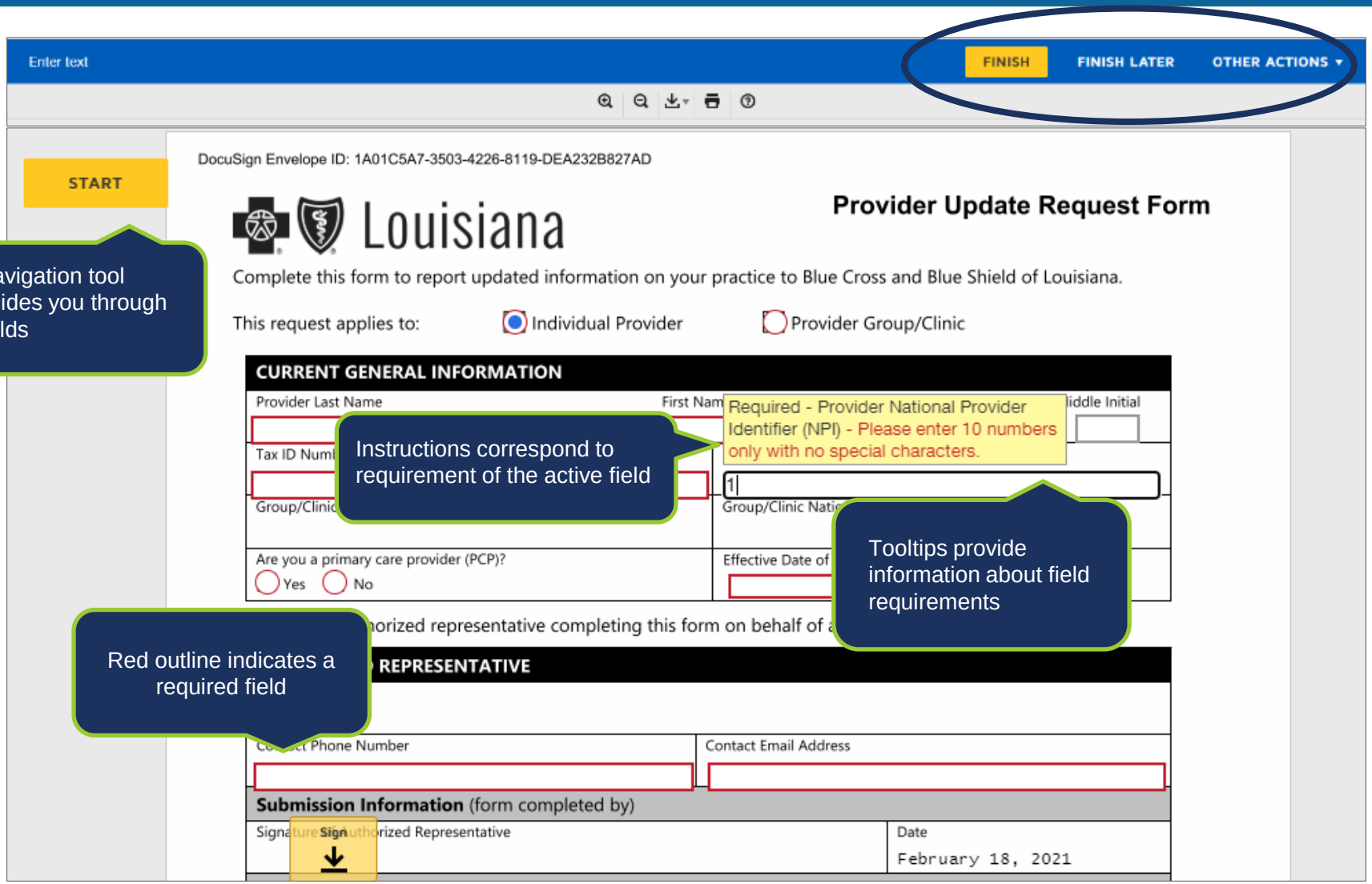
Please Review & Act on These Documents

DocuSign

CONTINUE FINISH LATER OTHER ACTIONS

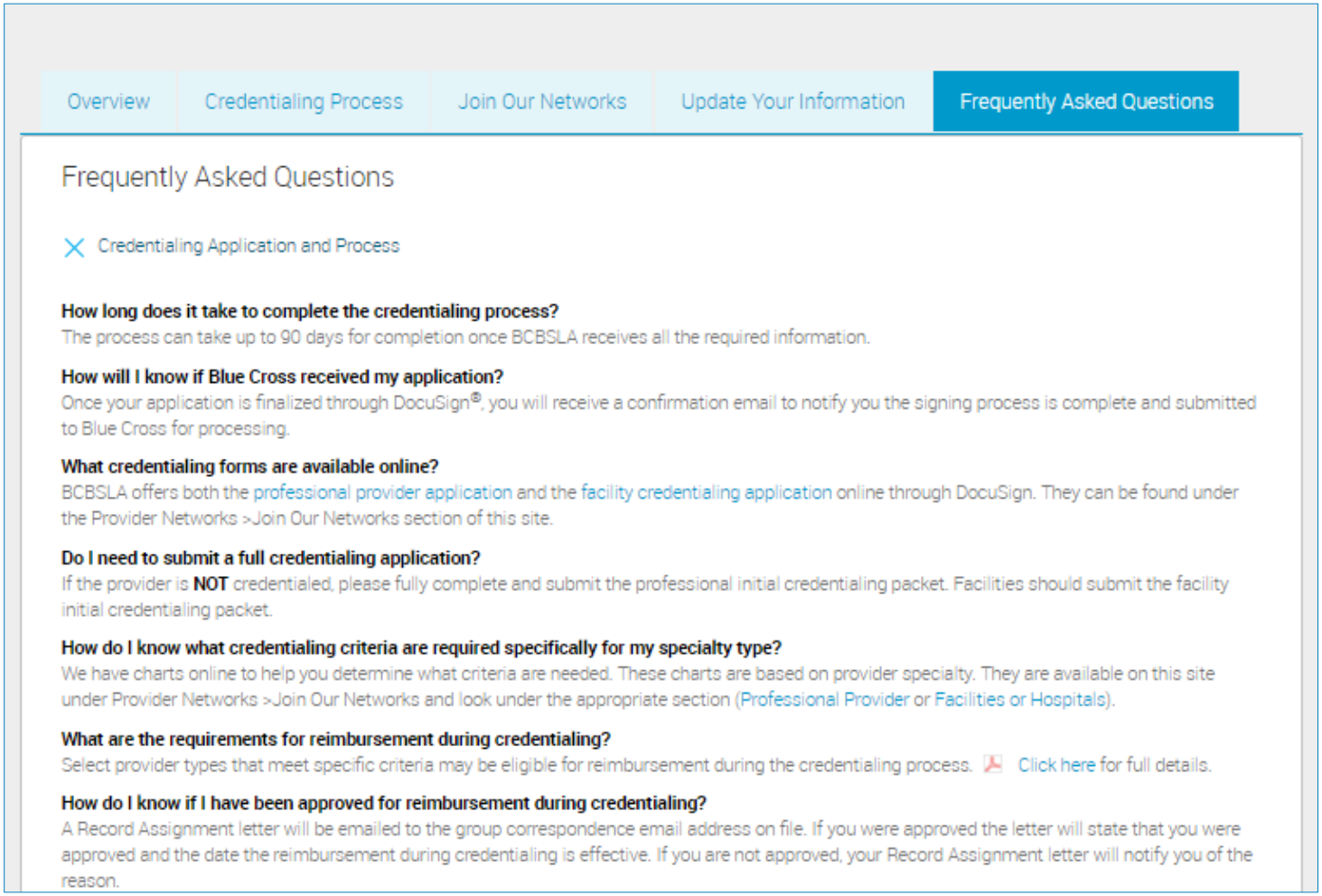
For more information, find our *DocuSign® Guide* online at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Professional Providers/Facilities and Hospitals >Join Our Networks.

Easily Complete Forms with DocuSign



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

Frequently Asked Questions

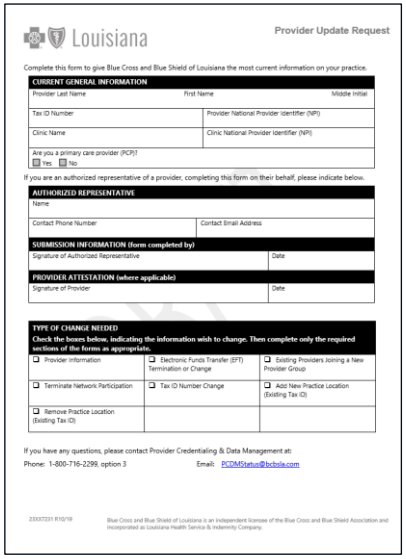


www.bcbsla.com/providers >Network Enrollment >Join Our Networks >Professional Providers/Facilities and Hospitals >Frequently Asked Questions

Data Management

How to Update Your Information

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



Louisiana

Provider Update Request

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

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

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

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

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative | Date

PROVIDER ATTESTATION (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

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

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

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

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

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

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

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

Provider Directory

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

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

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

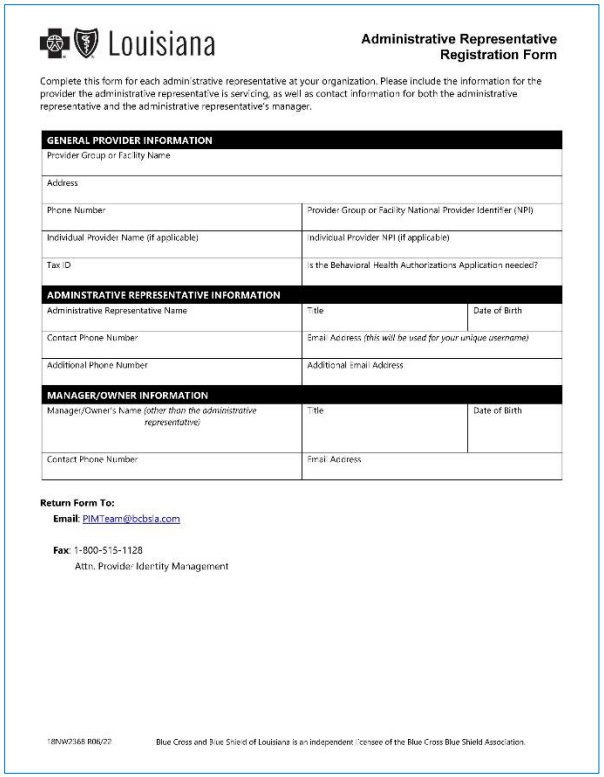
- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
  - In order to be listed in the directory, professional providers must be available to schedule patients' appointments a minimum of 8 hours per week at the location listed.

To improve the accuracy of our online provider directory, we are making changes to help create the most accurate directory for our members.

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

Administrative Representative Registration

- We require that each provider organization designate at least one administrative representative to self-manage user access to our secure online services.
- Your administrative representative is responsible for managing your secure access to the following Blue Cross online services:
  - iLinkBlue
  - BCBSLA authorizations
  - Behavioral health authorizations
  - Pre-service review for out-of-area members (BlueCard® members)
  - and more
- If you are part of a provider group or facility that already has registered an administrative representative with Blue Cross, you do not have to submit the Administrative Representative Registration Form.



Louisiana

Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION		
Provider Group or Facility Name		
Address		
Phone Number	Provider Group or Facility National Provider Identifier (NPI)	
Individual Provider Name (if apolicable)	Individual Provider NPI (if applicable)	
Tax ID	Is the Behavioral Health Authorizations Application needed?	
ADMINSTRATIVE REPRESENTATIVE INFORMATION		
Administrative Representative Name	Title	Date of Birth
Contact Phone Number	Email Address *(this will be used for your unique username)*	
Additional Phone Number	Additional Email Address	
MANAGER/OWNER INFORMATION		
Manager/Owner's Name *(other than the administrative representative)*	Title	Date of Birth
Contact Phone Number	Email Address	

Return Form To:
Email: PIMTeam@bcbsla.com

Fax: 1-800-515-1128
Attn. Provider Identity Management

18NW2368 R06/22 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

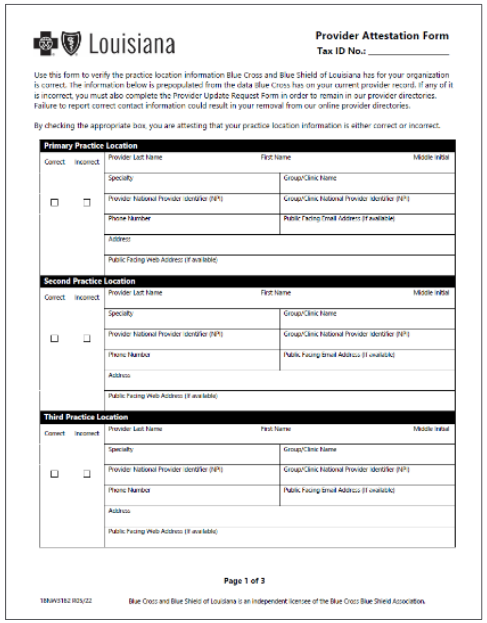
The Administrative Representative Registration packet is also available online at **www.bcbsla.com/providers** >Electronic Services >Admin Reps.

Provider Attestation Form

- Due to requirements of the federal Consolidated Appropriation Acts (CAA) 2021, our PCDM Department is sending a Provider Attestation Form every 90 days to all providers listed in our online provider directories to review their information as it appears in our directories.

- If any of your information is not correct, there will be an option within the Provider Attestation Form to complete and return our Provider Update Request Form. This allows us to update the information we publish in our directories.

- The form is emailed in a DocuSign format, prepopulated with the information we have on file. The provider must verify and attest to the accuracy of the information.



Louisiana

Provider Attestation Form

Tax ID No.: _____

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

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

Primary Practice Location

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

Second Practice Location

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

Third Practice Location

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

Page 1 of 3

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

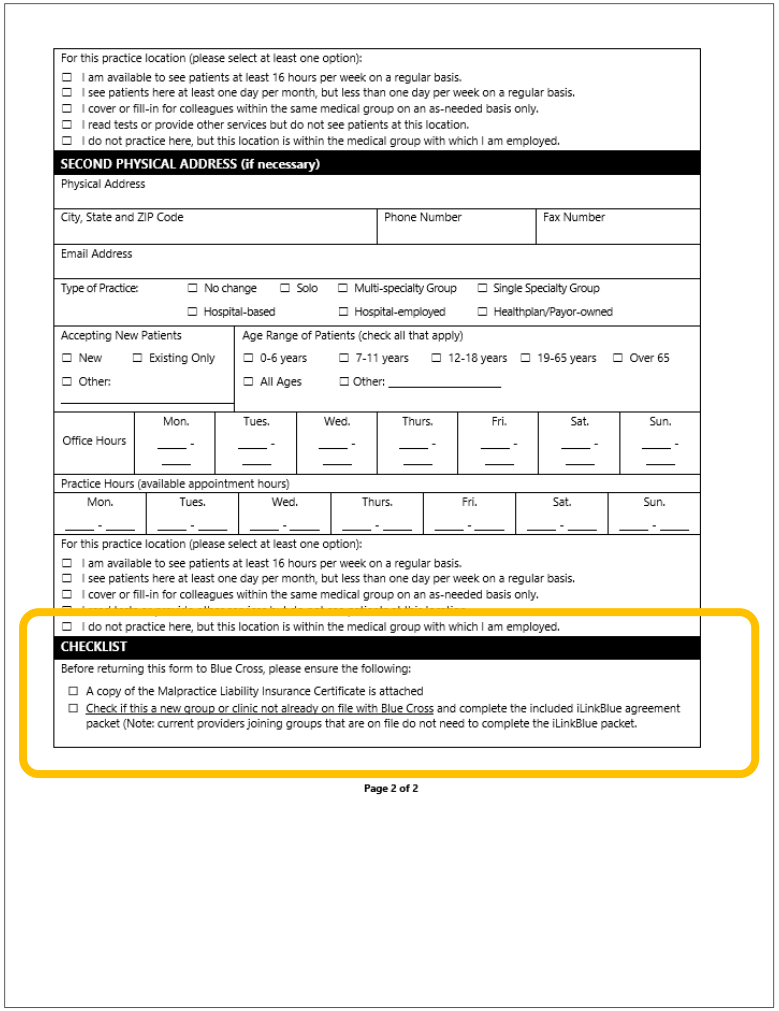
Providers who do not complete attestation of their information will be removed from our online provider directories.

Provider Update Request Form

- Indicate on the Provider Request Form they 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 Update Request Form



For this practice location (please select at least one option):
- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

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

Email Address

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Accepting New Patients: ☐ New ☐ Existing Only ☐ Other:

Age Range of Patients (check all that apply): ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

For this practice location (please select at least one option):
- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ Check if this a new group or clinic not already on file with Blue Cross and complete the included iLinkBlue agreement packet (Note: current providers joining groups that are on file do not need to complete the iLinkBlue packet.

Page 2 of 2

Complete the checklist:

- Some changes on our **Provider Update Request Form** include a checklist of **required** supporting documentation needed to complete your request.
- Be sure to complete **all** boxes on the checklist. Please ensure **all** requested items on the checklist are included or completed before submitting.
- Submissions that are missing checklist items will be returned.

Provider Credentialing & Data Management

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

Kaci Guidry, Manager, Provider Credentialing and Data Management
kaci.guidry@bcbsla.com

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

Chrisy Cavalier, Supervisor, Provider Information (PCDM Status)
chrisy.cavalier@bcbsla.com

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

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

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

Claims

Electronic Claims

Electronic Data Interchange (EDI)

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

Electronic Transaction Exchange

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

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

Electronic Payment Registers

HIPAA 835 Transaction

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

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

Hardcopy Claims

CMS-1500 (professional)

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

Mailing Addresses

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

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

For FEP Claims:

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

For BlueHPN Claims:

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

For Blue Advantage Claims:

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

For Healthy Blue Dual Advantage (D-SNP):

Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

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

Timely Filing Requirements

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

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

FEP:

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

Blue Advantage:

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

OGB:

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

Self-funded & BlueCard:

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

Healthy Blue Dual Advantage (HMO D-SNP):

- Claim must be filed within 12 months of the date of service.

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

National Drug Code (NDC) Required on Drug Claims

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

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

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

Reporting NDCs on Professional Claims

For Hardcopy Claims

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

For Electronic Claims 837P

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

For iLinkBlue Claims (Professional Only)

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

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

Reporting NDCs on Professional Claims

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

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

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

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

Closed Formulary

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

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

Submitting Action Requests

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

Common reasons to submit an Action Request

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

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

Submitting Action Requests

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

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

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

Submitting Action Requests

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

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

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

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

Helpful Reminders

Benefits of Proper Clinical Documentation

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

Provider's Role in Documenting

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

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

Coding to the Highest Level of Specificity

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

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

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

Medical Record Requests

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

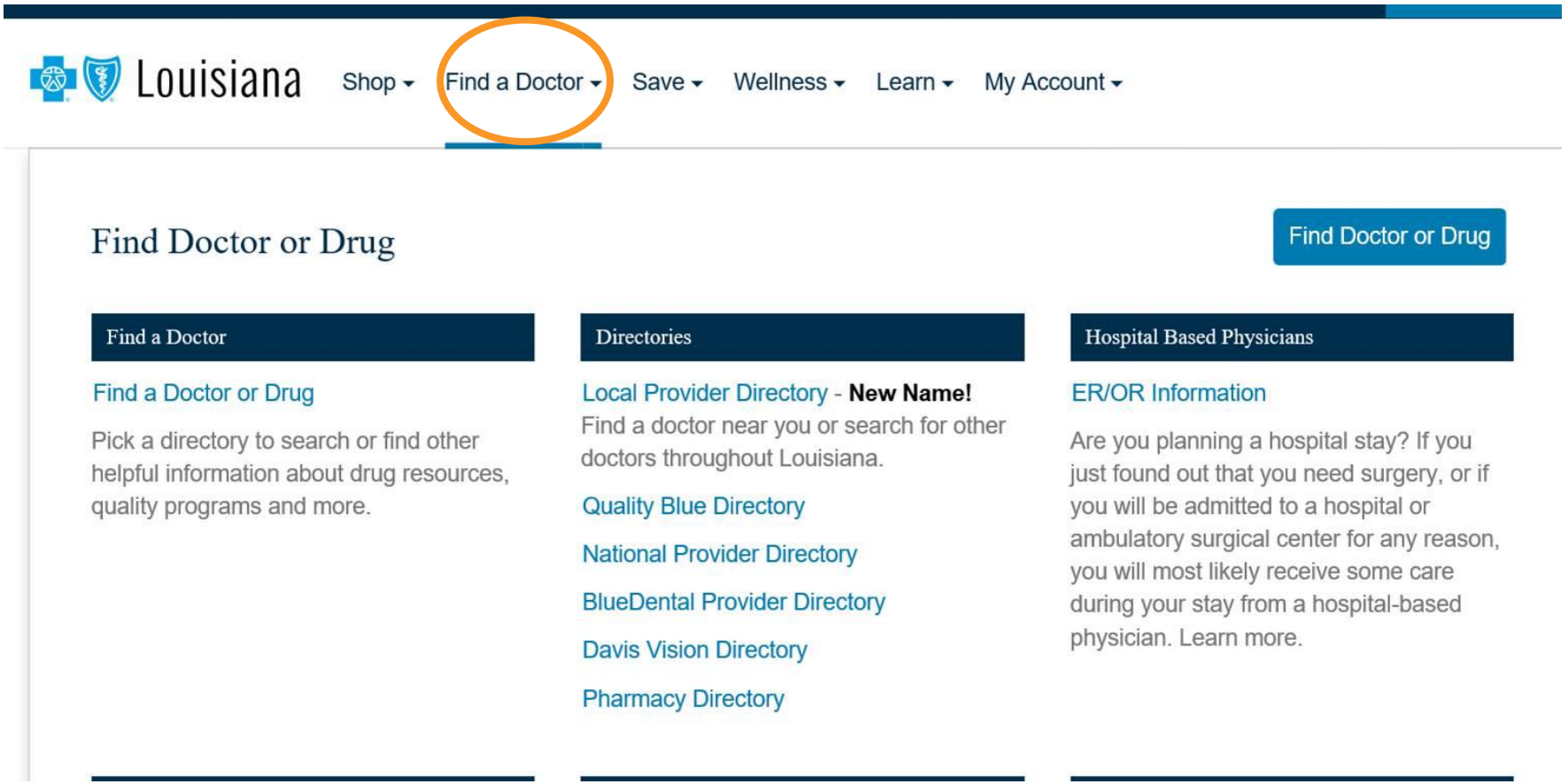
- Per your Blue Cross network agreement, **providers are not to charge a fee** for providing medical records to Blue Cross or agencies acting on our behalf.
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a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

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

- Referrals to out-of-network providers result in significantly higher cost shares (deductibles, coinsurance and copayments) for our members and is a breach of your Blue Cross provider agreement.
- **Providers who consistently refer to out-of-network providers will be audited and may be subject to a reduction in their network reimbursement.**

Finding Participating Providers

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



Laboratory Referrals

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

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

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

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

Behavioral Health Referrals

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

Lucet™

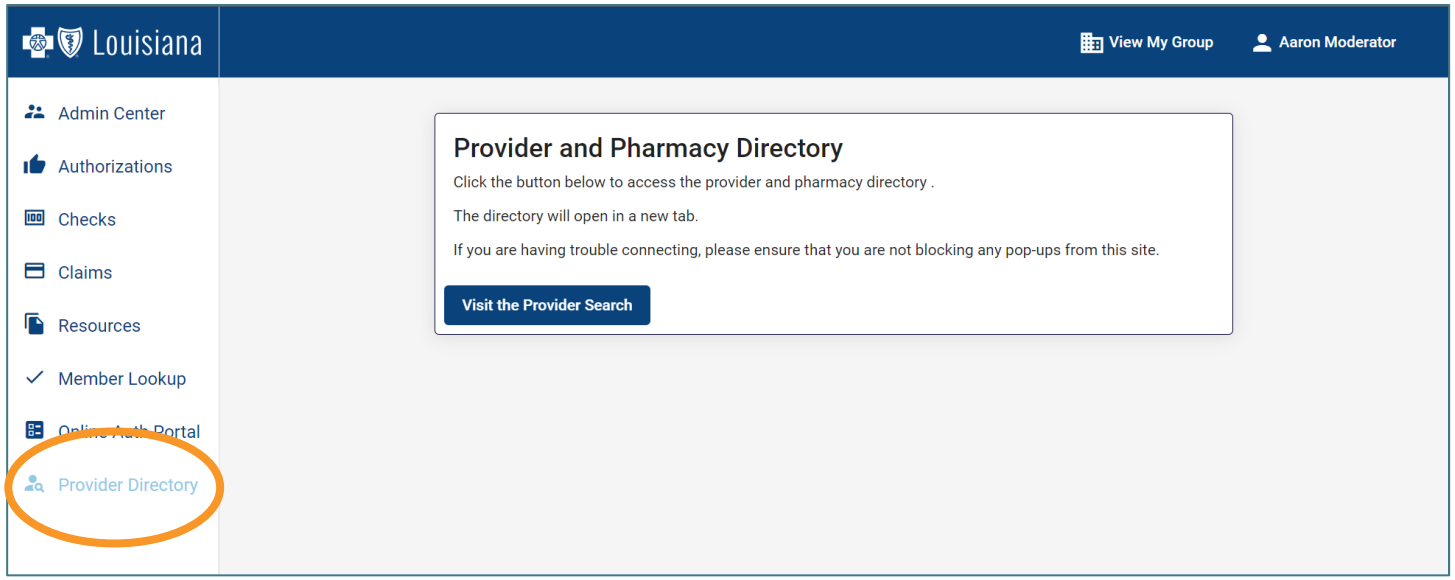
Behavioral health services that require an authorization:

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

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

Finding Blue Advantage Providers & Lab Services

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



Preferred laboratories for all specimens for the Blue Advantage network:

Clinical Pathology Labs (CPL)

Quest Diagnostics

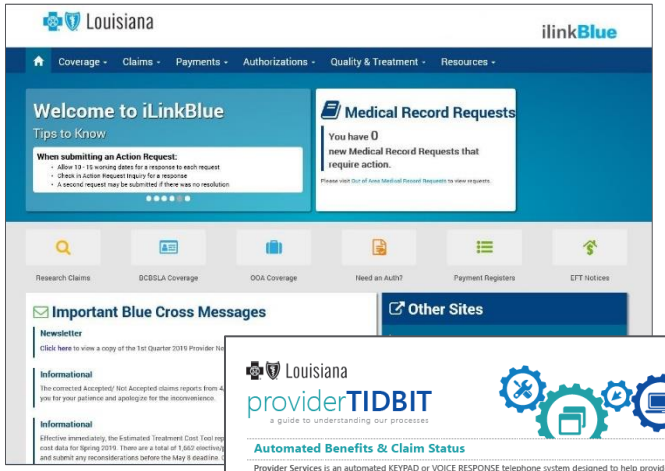
Lab Corp

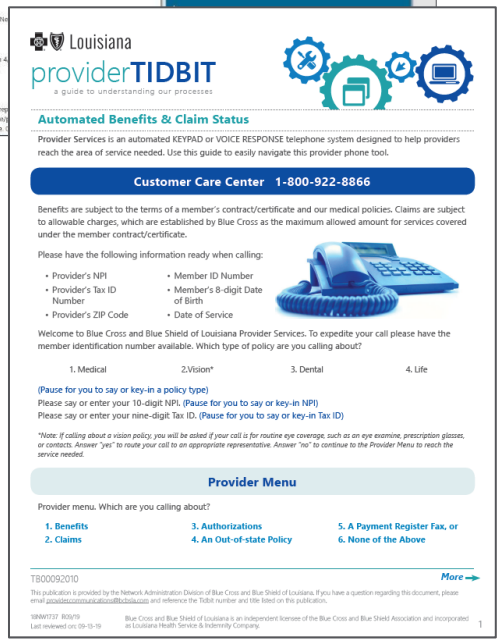
Provider Self-service

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

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

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





Self-service tools available to providers:

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

Laboratory Benefit Management Program

Laboratory Benefit Management Program

Blue Cross has partnered with Avalon Healthcare Solutions to manage our laboratory benefit management program.

Avalon provides:

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

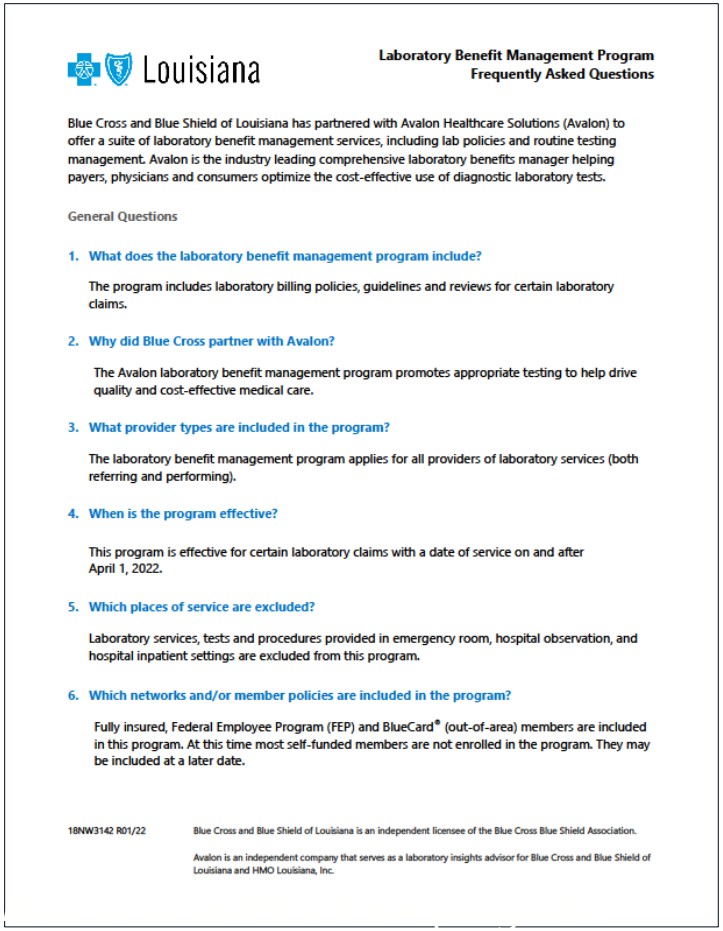
Blue Cross applies Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

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

Providers can review and research laboratory policies and guidelines online Go to **www.bcbsla.com/providers**, click on "Medical Management," then "Lab Management."

Laboratory Benefit Management Program

To receive a copy of our Laboratory Benefit Management Program Frequently Asked Questions, please email **provider.relations@bcbsla.com**.



Louisiana

Laboratory Benefit Management Program
Frequently Asked Questions

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

General Questions

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

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

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

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

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

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

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

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

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

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

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

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

18NW3142 R01/22

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

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

Authorizations

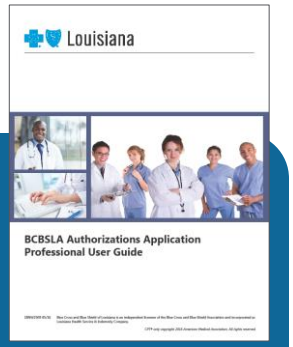
Authorization Portal Mandate

We have streamlined the process for requesting prior authorizations

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

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

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



iLinkBlue

The Administrative Representative Role

What is an Administrative Representative?

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

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

Multi-factor Authentication

All iLinkBlue users should complete several verification steps before entering iLinkBlue (**www.bcbsla.com/ilinkblue**).

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

- email
- text
- voice call
- smartphone app

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

Security Setup Application

- Delegated Access, our security setup application for administrative representatives, is available through iLinkBlue only.
  - Replaced the Sigma Security Setup Tool previously used.
  - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality.
- We migrated the data housed in the previous tool for your provider organization to the new application.

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

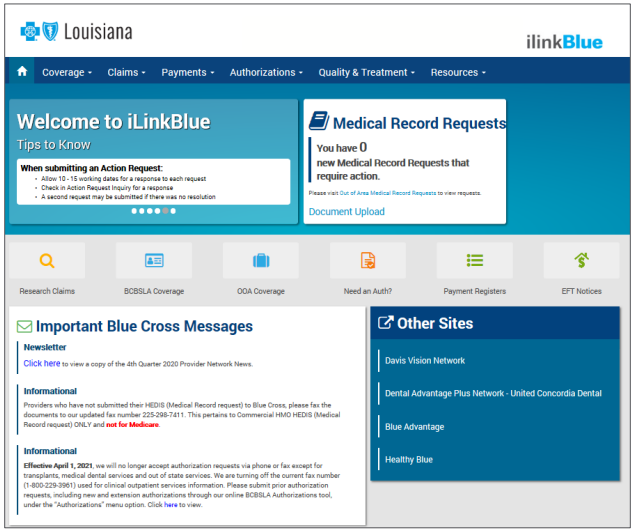
iLinkBlue

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

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

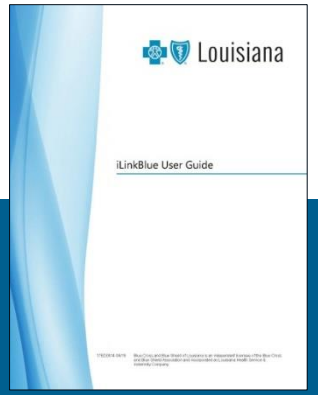
ilinkBlue

www.bcbsla.com/ilinkblue

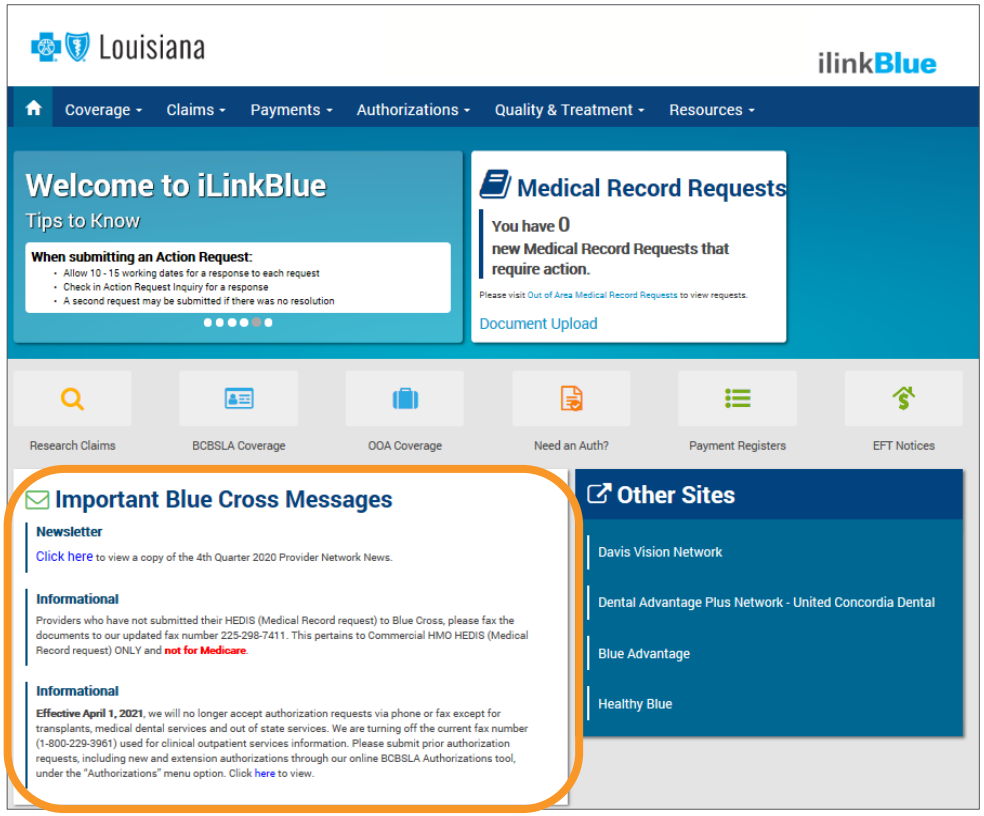


For iLinkBlue training and education, contact **provider.relations@bcbsla.com**.

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



iLinkBlue Message Board



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

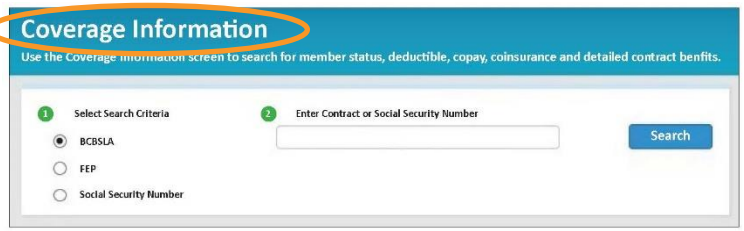
This area contains posts for:

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

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

Coverage and Eligibility in iLinkBlue

1



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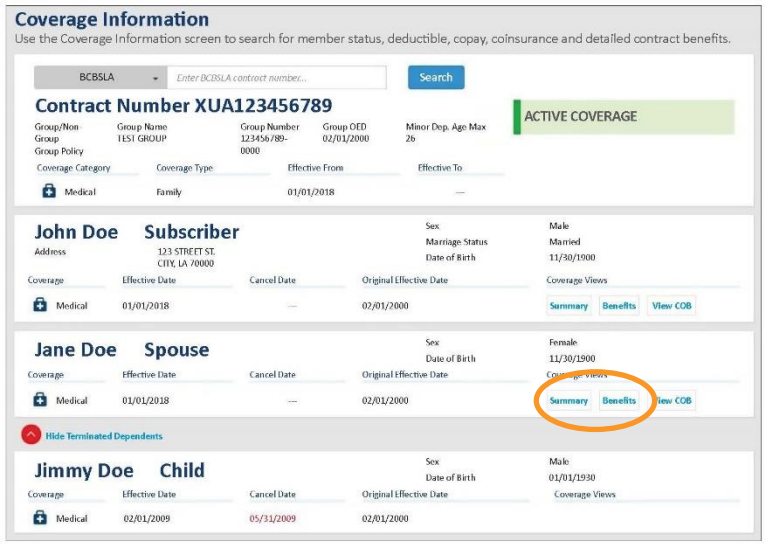

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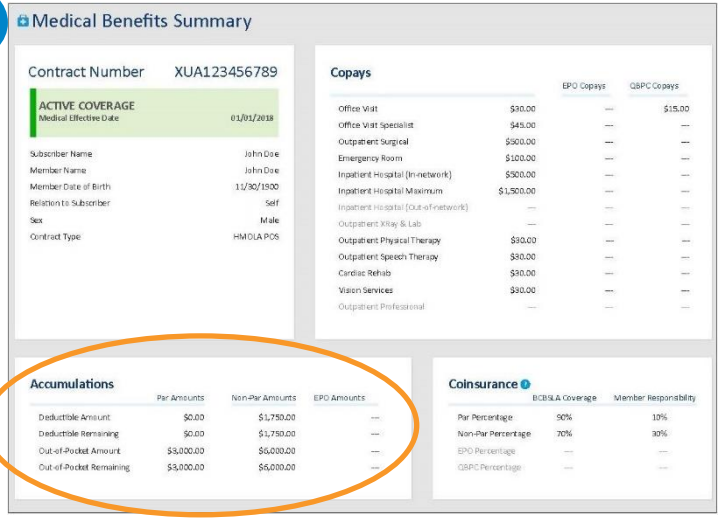


Use the “Coverage” menu option to research Blue Cross and Federal Employee Program (FEP) member eligibility, copays, deductibles and detailed contract information.

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

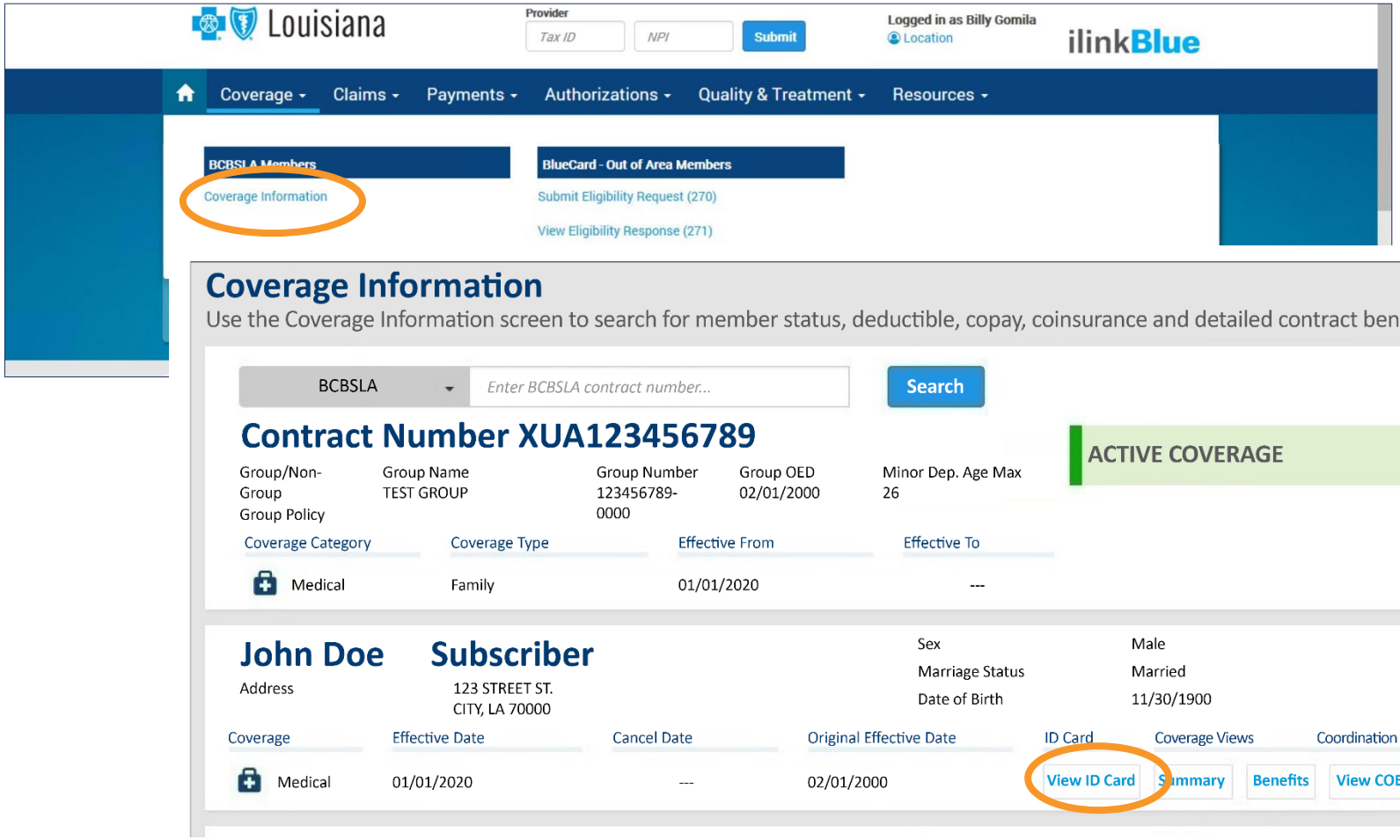
Claims Information in iLinkBlue

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

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

Digital ID Cards on iLinkBlue

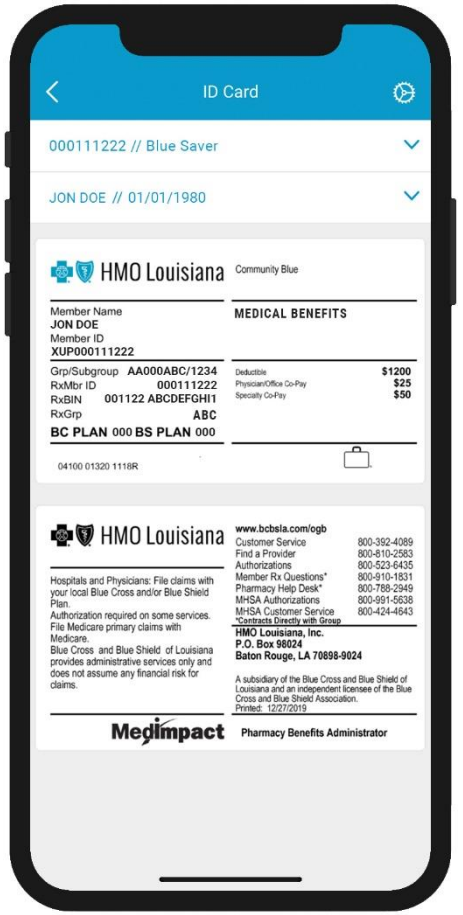
Digital ID cards are accessible through iLinkBlue as a downloadable PDF. Click the "Coverage Information" menu option, enter the member contract number in the search bar and then click “ID Card.”



Members Can Access Their Digital ID Cards

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

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



Payments Information in iLinkBlue

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

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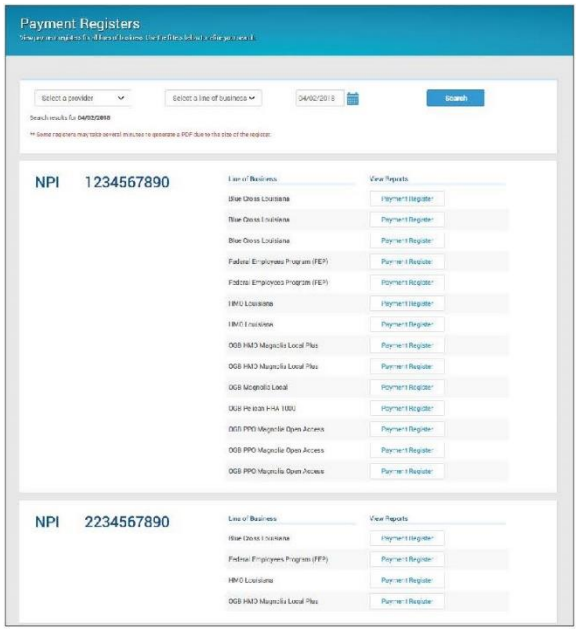
2.



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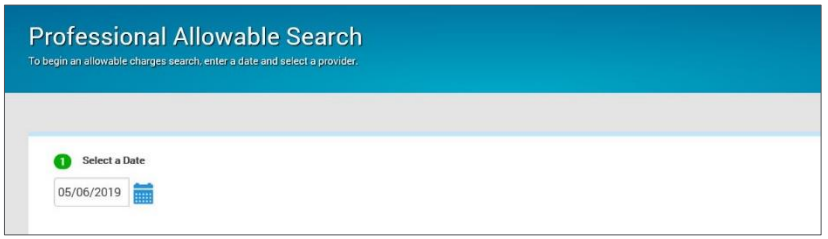
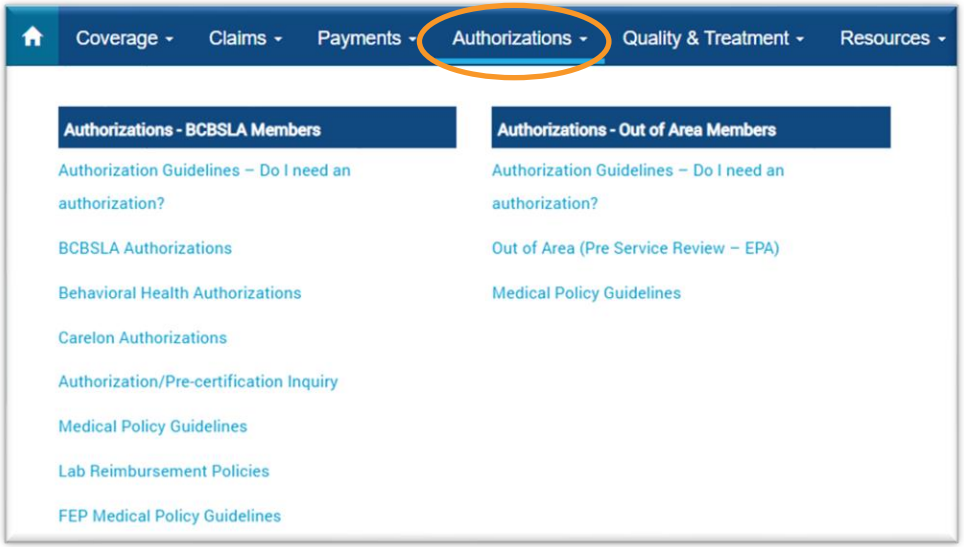


Authorization Requests Through iLinkBlue

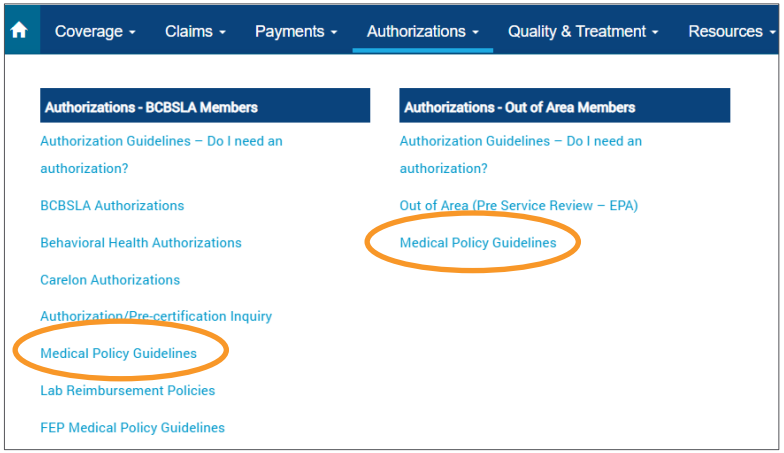


Use the "Authorizations" menu option to access online authorization applications:

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

Accessing Medical Policies in iLinkBlue

1.



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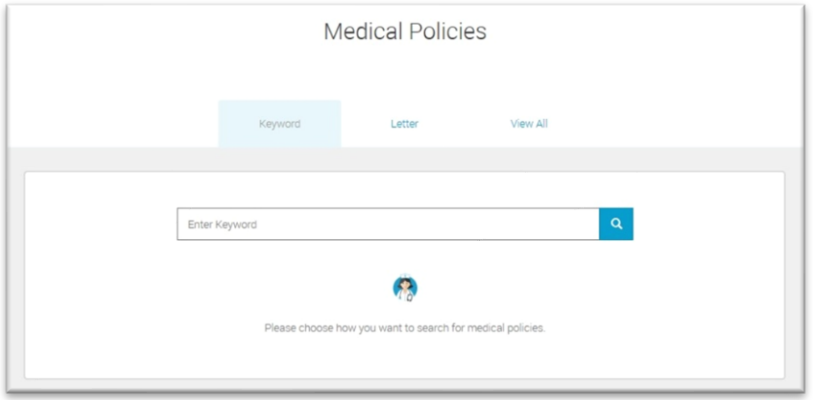
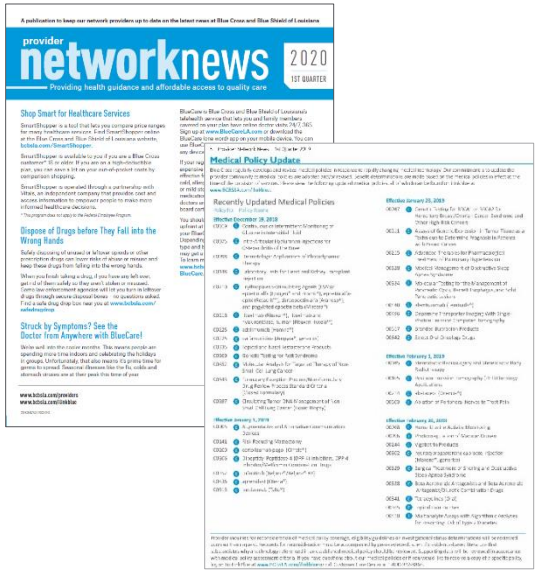


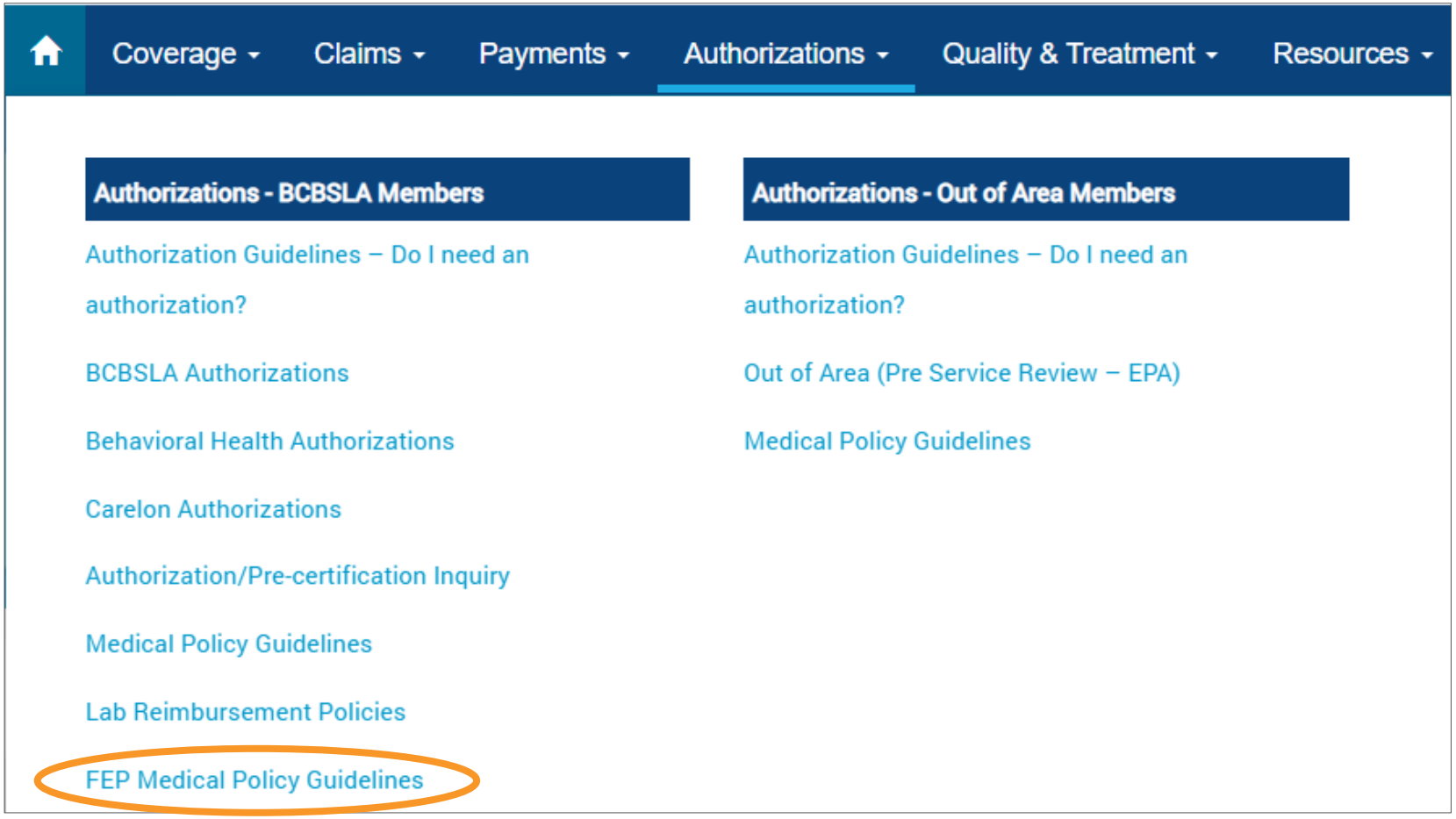
- Also use the "Authorizations" menu option to access our **Medical Policy Index**.
- Policies are listed in alpha order or you may search by policy number or procedure code.



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

FEP Medical Policy Guidelines in iLinkBlue

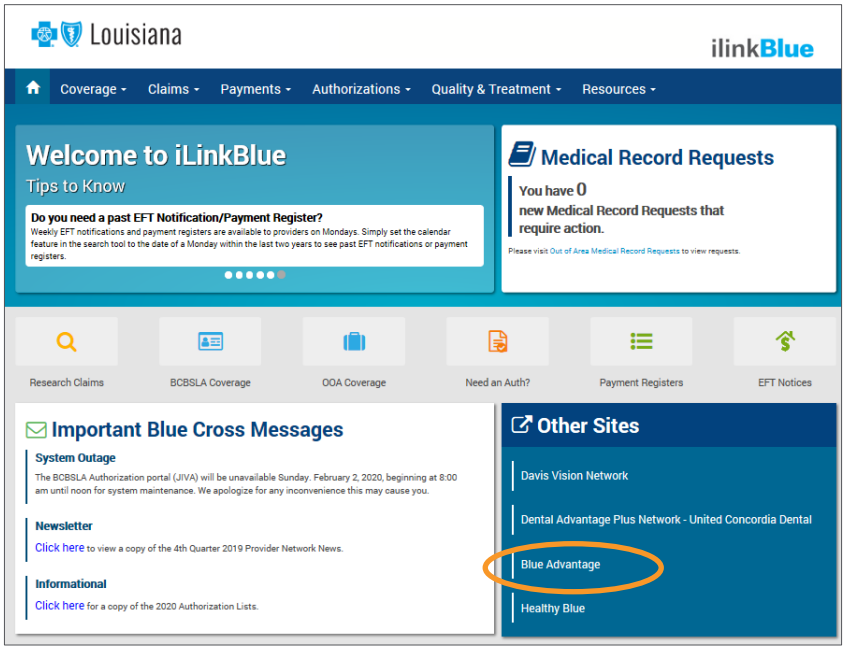
FEP Medical Policy Guidelines can now be found on iLinkBlue (**www.bcbsla.com/ilinkblue**), under Authorizations.



Blue Advantage

Accessing the Blue Advantage Provider Portal

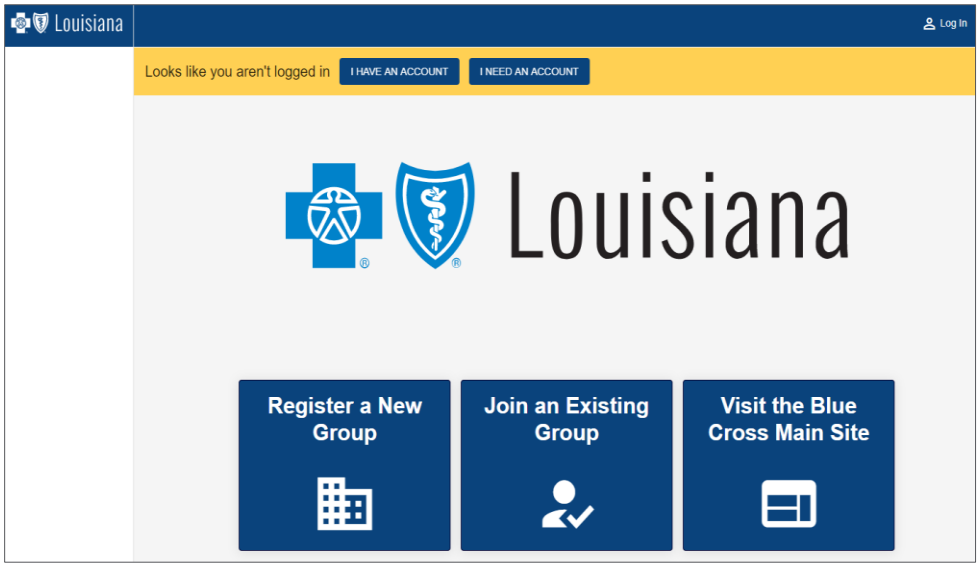
- The processes for Blue Advantage (HMO)/Blue Advantage (PPO) differ from our other provider network processes.
- There is a separate portal for these contracted providers to access needed information.
- You can access the Blue Advantage Provider Portal through iLinkBlue (**www.bcbsla.com/ilinkblue.com**),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



The Blue Advantage Provider Portal

The Blue Advantage Provider Portal offers resources such as:

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



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

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

Blue Advantage Claims

Below are the ways that providers can submit Blue Advantage claims:

Submit Blue Advantage claims to Change Healthcare (Payor ID 72107)

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

Submit Blue Advantage claims electronically to Blue Cross

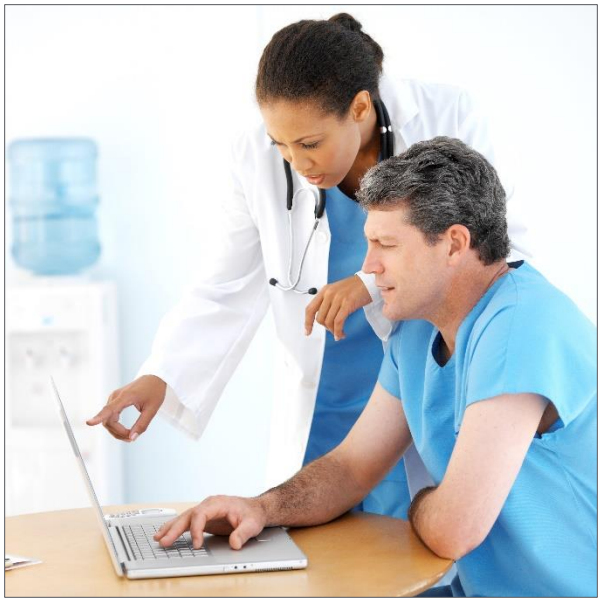
Beginning **May 28, 2023**, Blue Advantage will instead use Blue Cross and Blue Shield of Louisiana to manage electronic transactions for claims. Providers should notify their clearinghouse of the new Payer ID **77701** for claims filed on or after May 28.

Claims Editing

Claims Editing Software

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

Not Separately Reimbursable



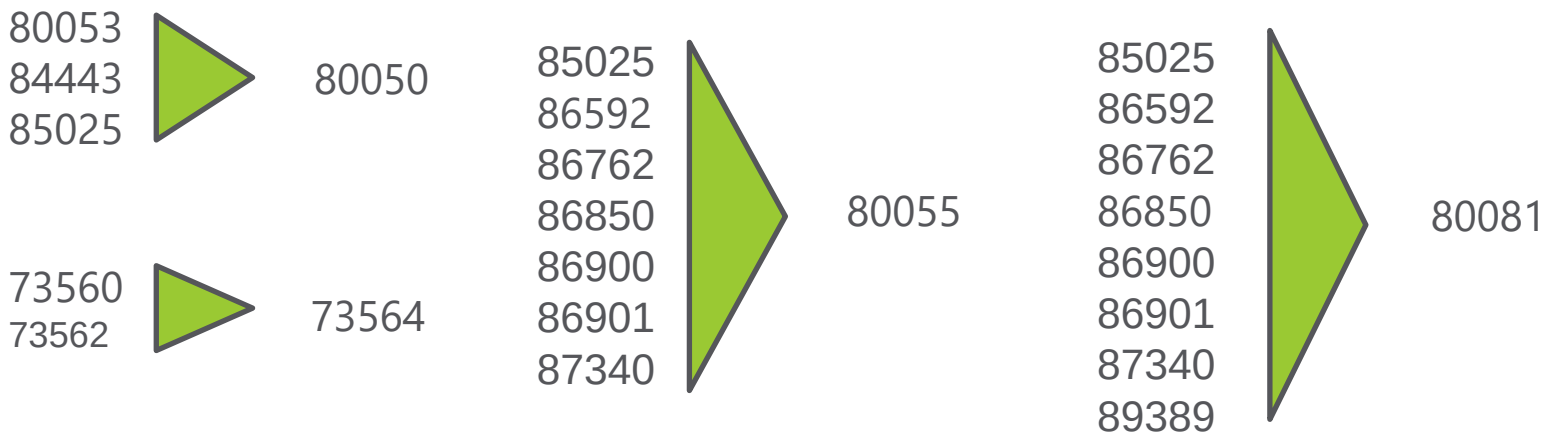
Certain codes will be denied because the services should be included with other services billed on the same day.

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

Rebundles

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

Examples:



Troubleshooting

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

Step 1

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

Step 2

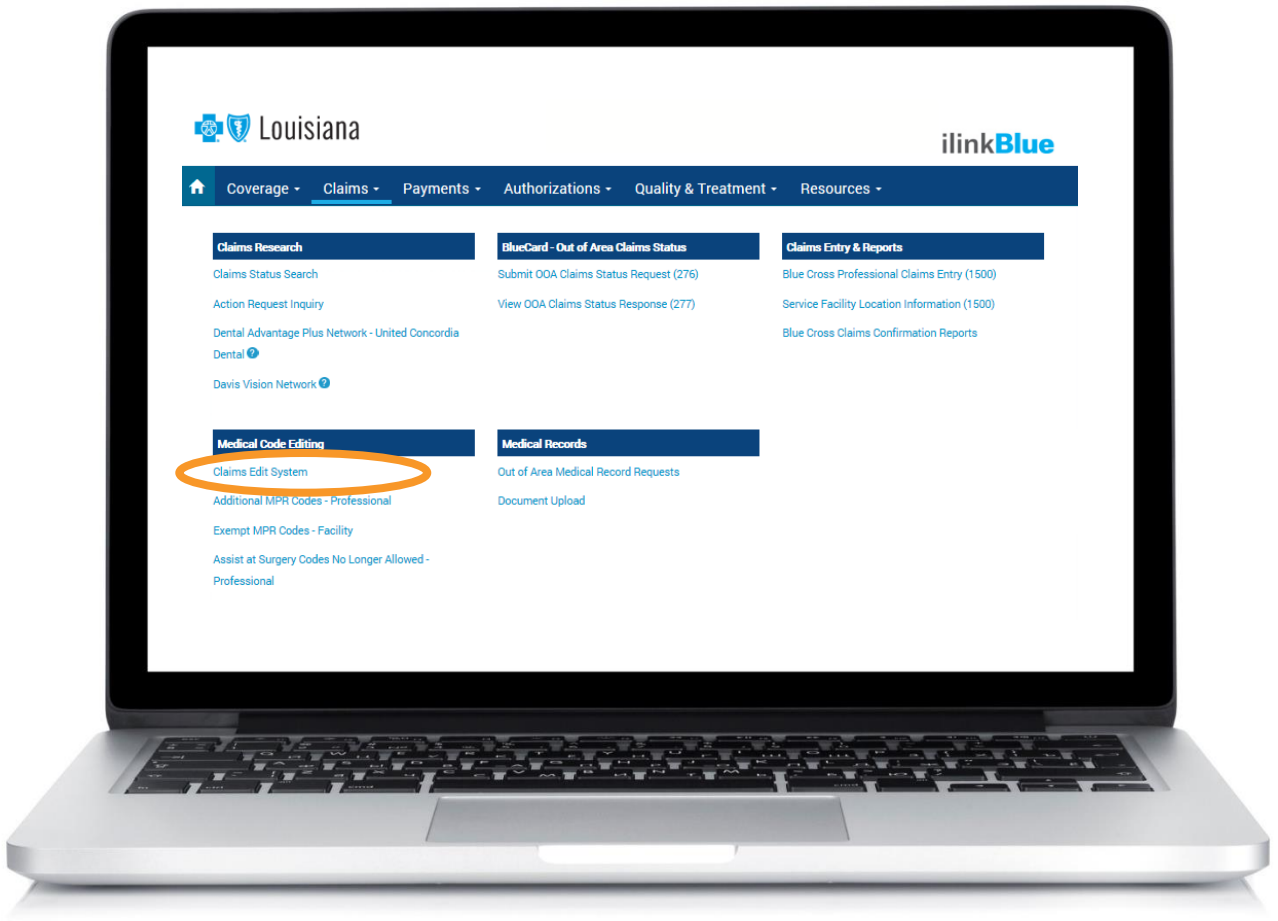
- Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code.
- This tool is located at **www.bcbsla.com/ilinkblue** >Claims >Claims Edit System.
- CES edits will appear in lower case.

Step 3

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

Claims Editing System Application

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



Claims Editing System Application

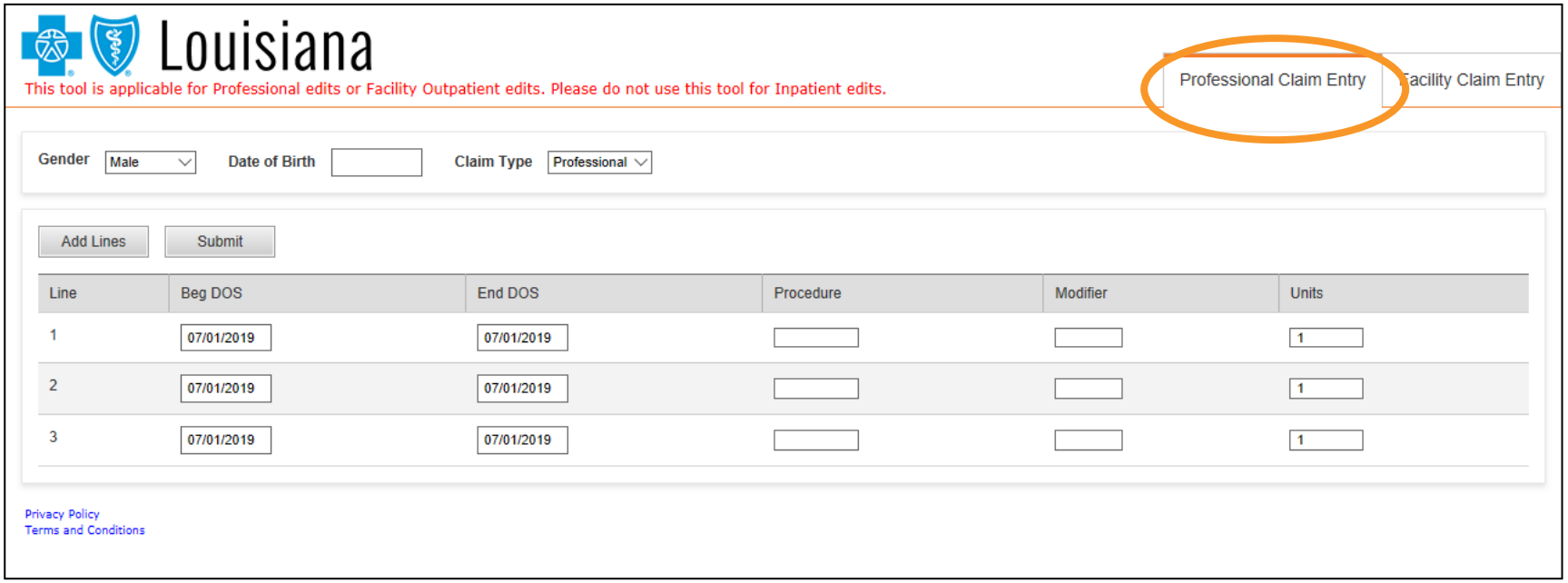
This application applies to **professional** claims and does not guarantee claims payment.

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

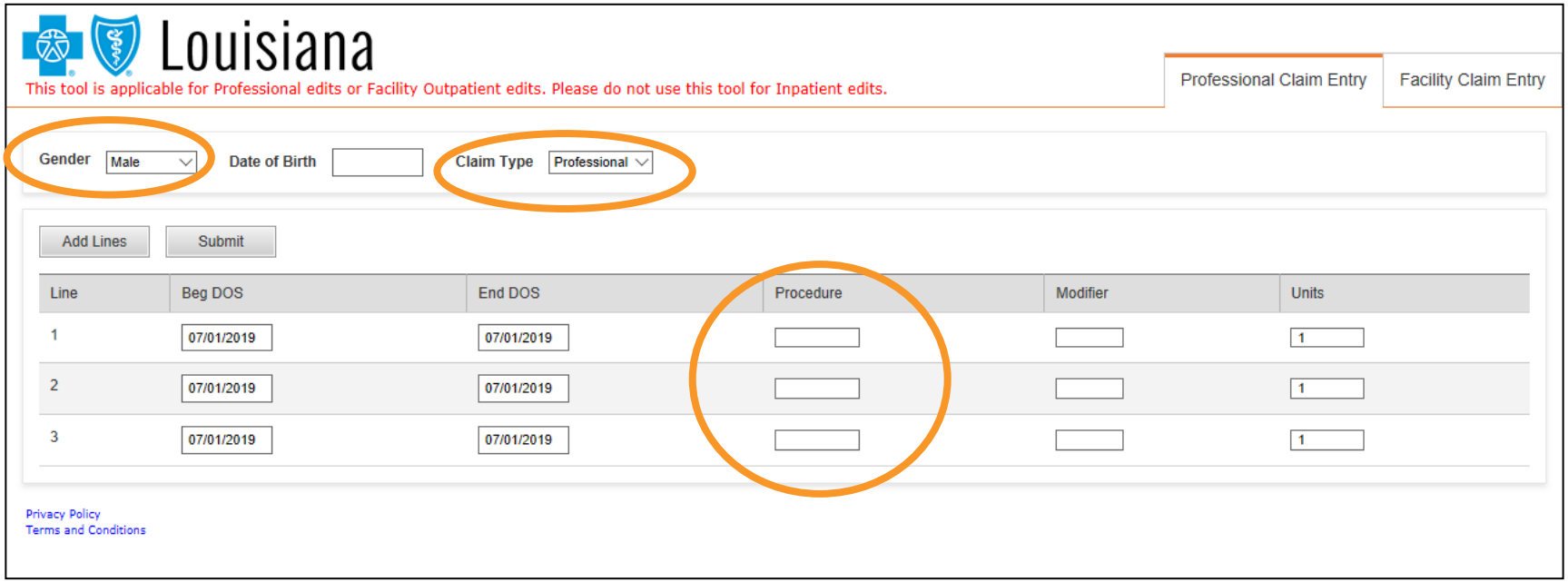
- Historical claims previously billed
- Units billed
- Global day edits for procedures
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits

Claims Editing System application

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

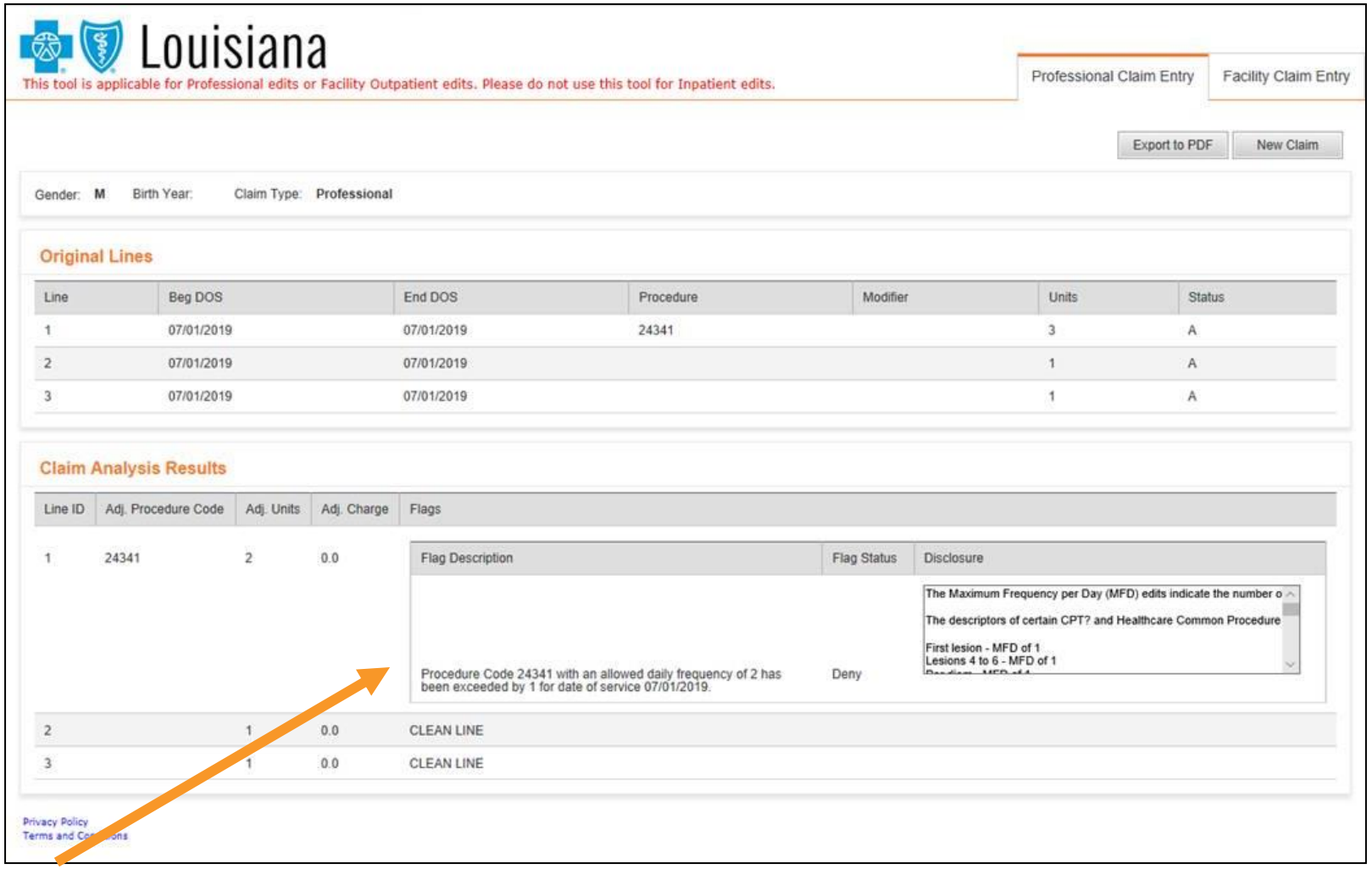


CES Application Mandatory Fields



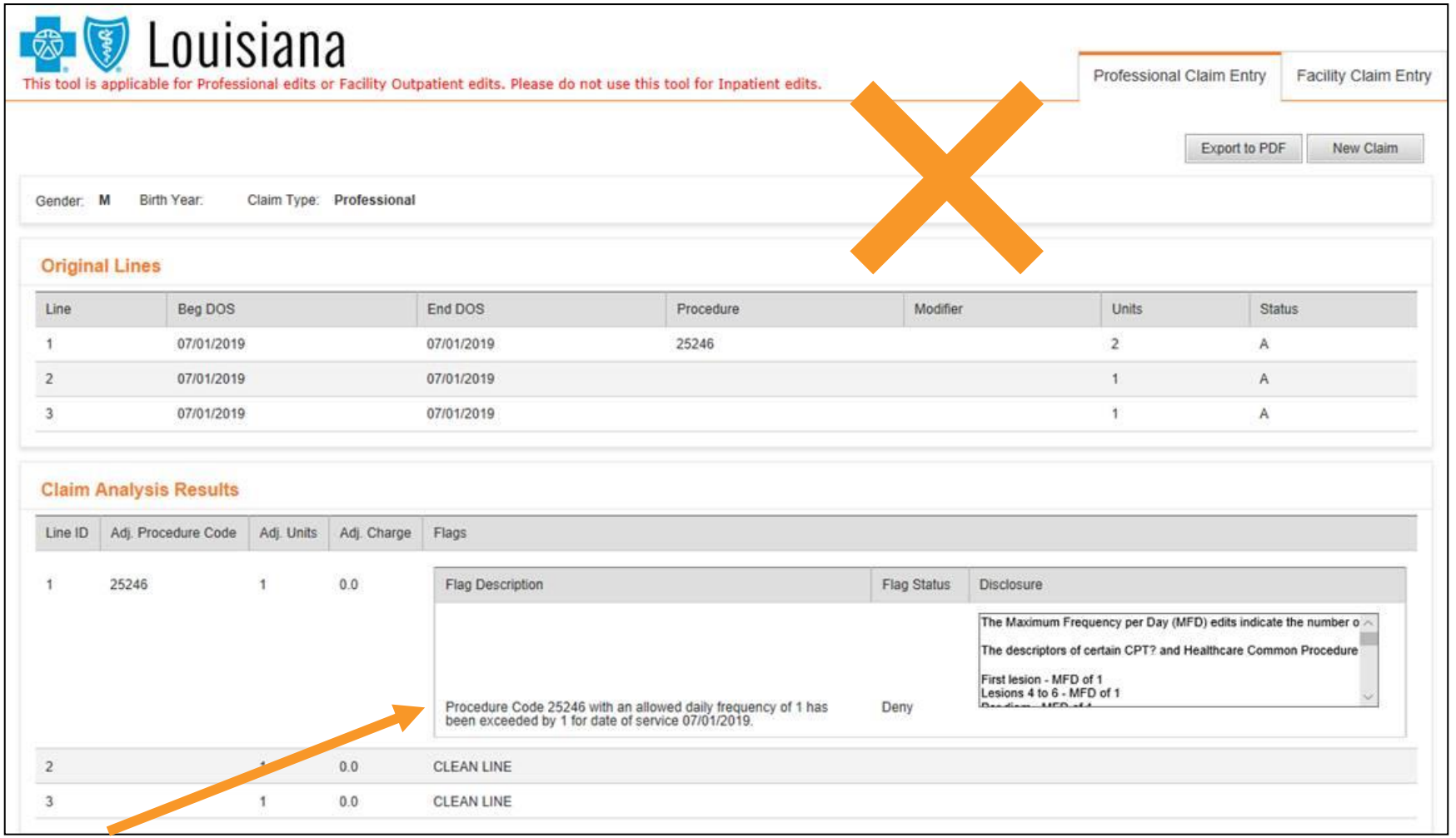
NOTE: If you do not enter the Statement From or Through dates, no edits will be returned, so the dates are necessary.

CES Application Outputs



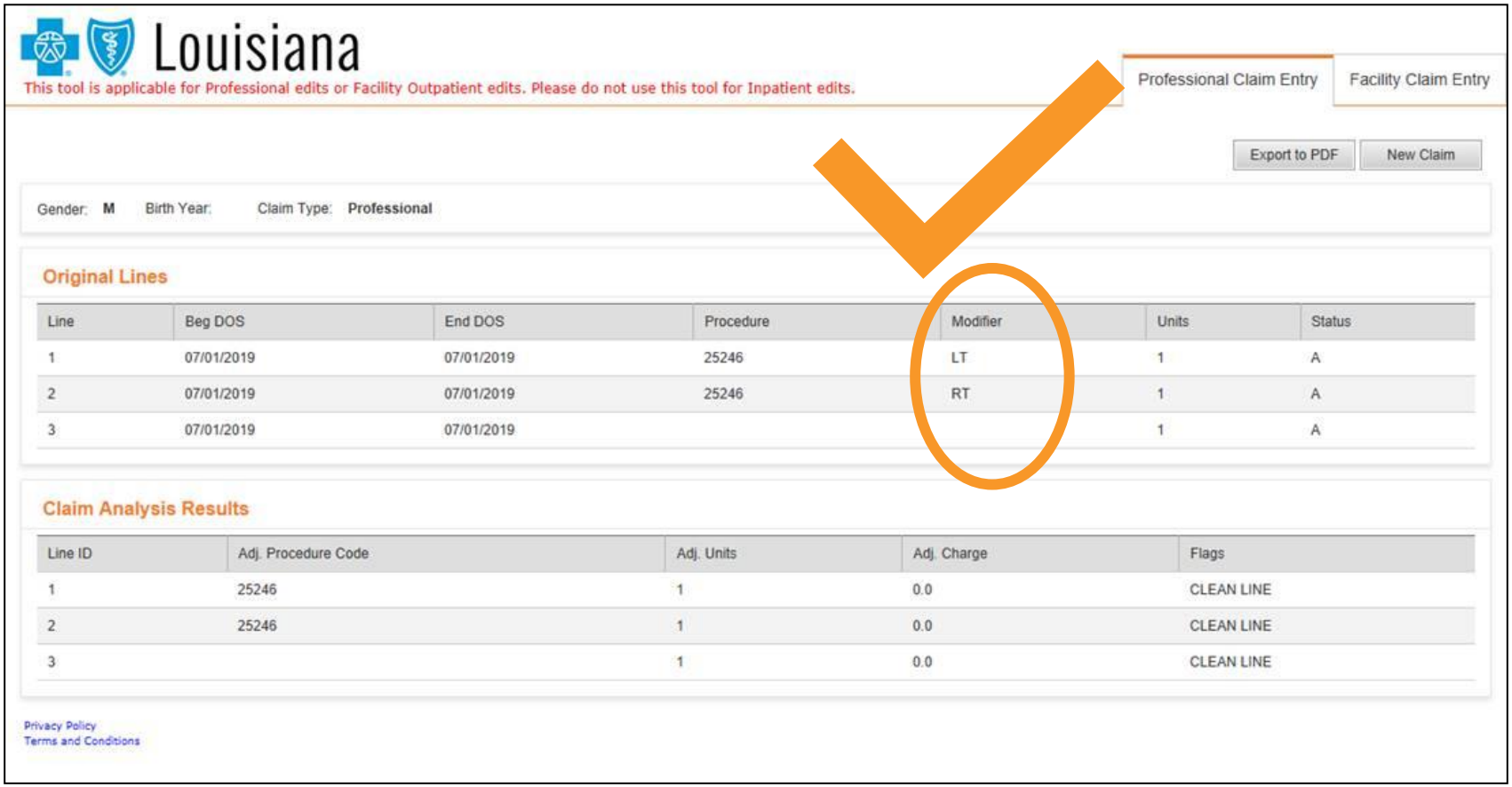
CPT Code 24341 – Repair, tendon or muscle, upper arm or elbow daily max frequency limit of 2 units. Code on one line with 3 units – 2 units will pay, 1 unit will deny.

CES Application Outputs



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

CES Application Outputs



Louisiana

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

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: M Birth Year: Claim Type: Professional

Original Lines

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

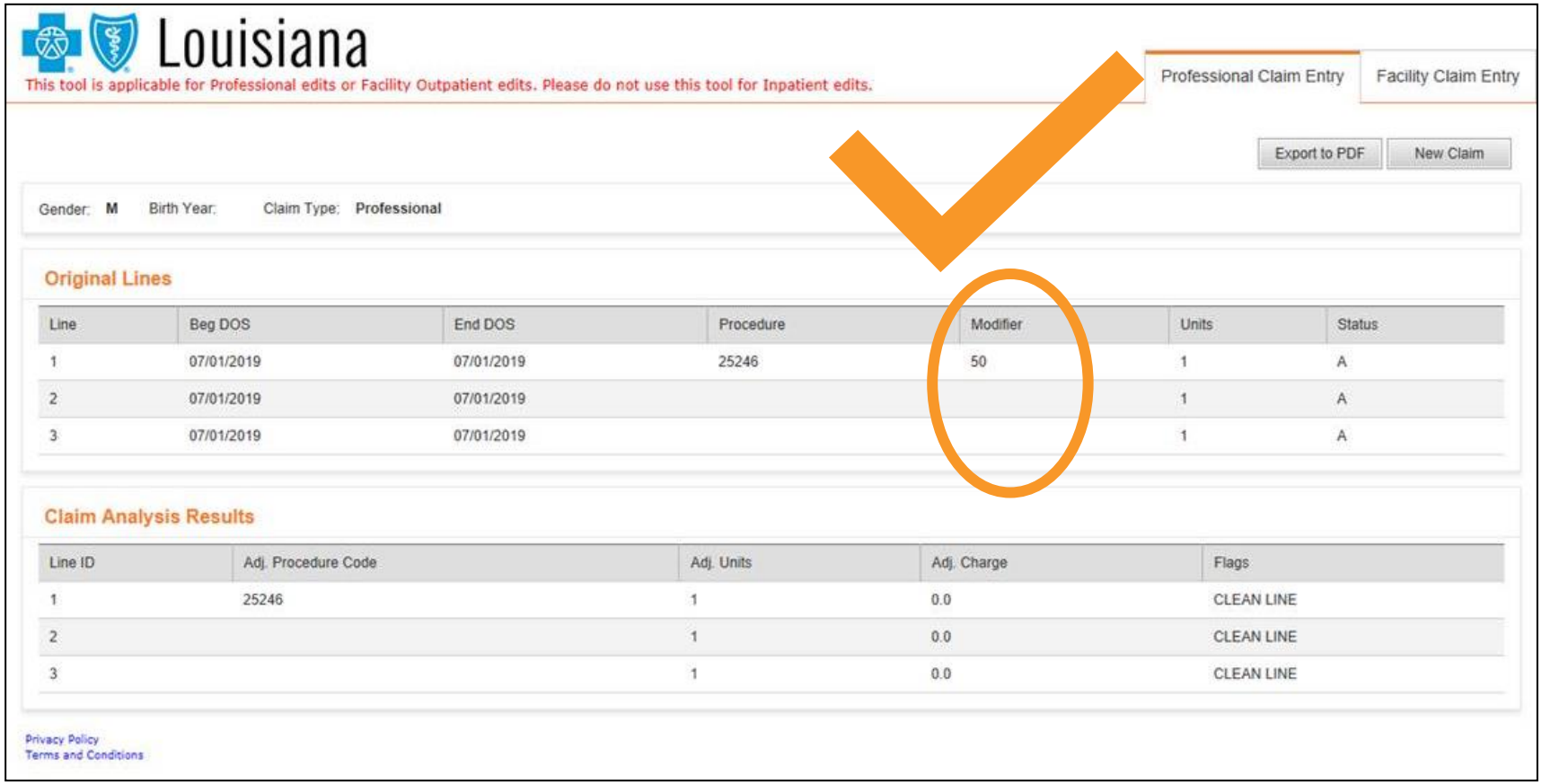
Claim Analysis Results

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

Privacy Policy
Terms and Conditions

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

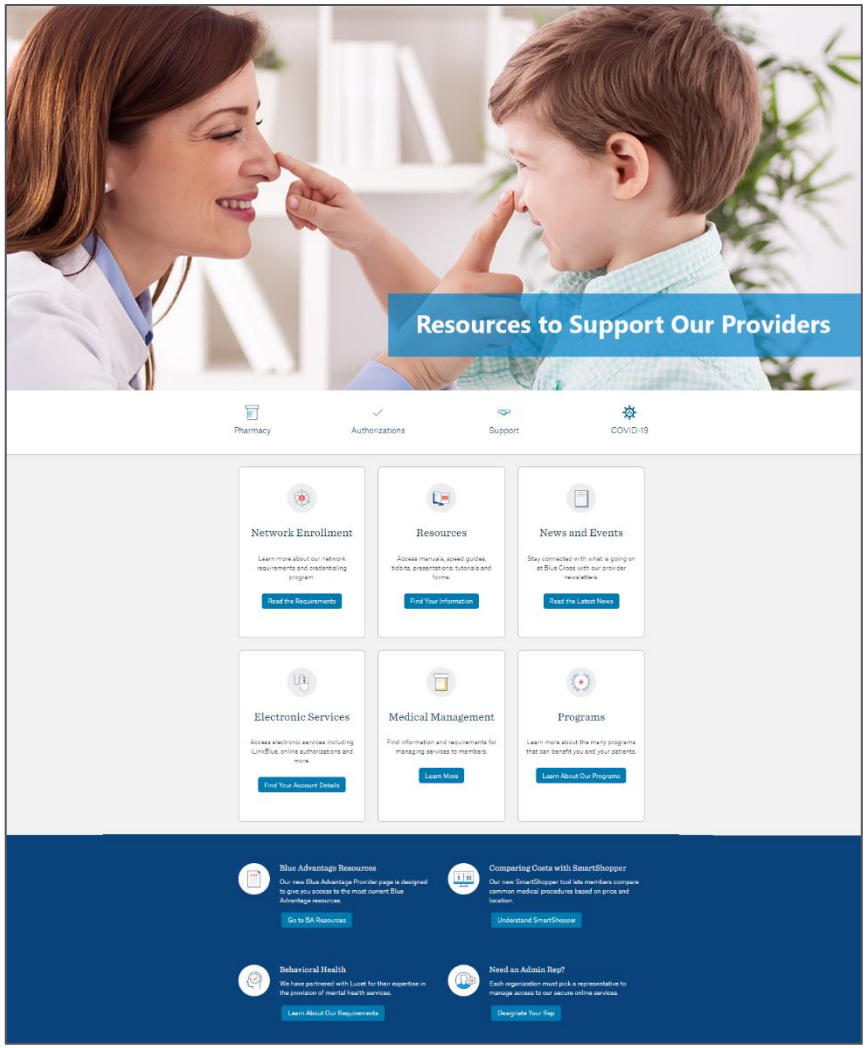
CES Application Outputs



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

Resources

The Provider Page

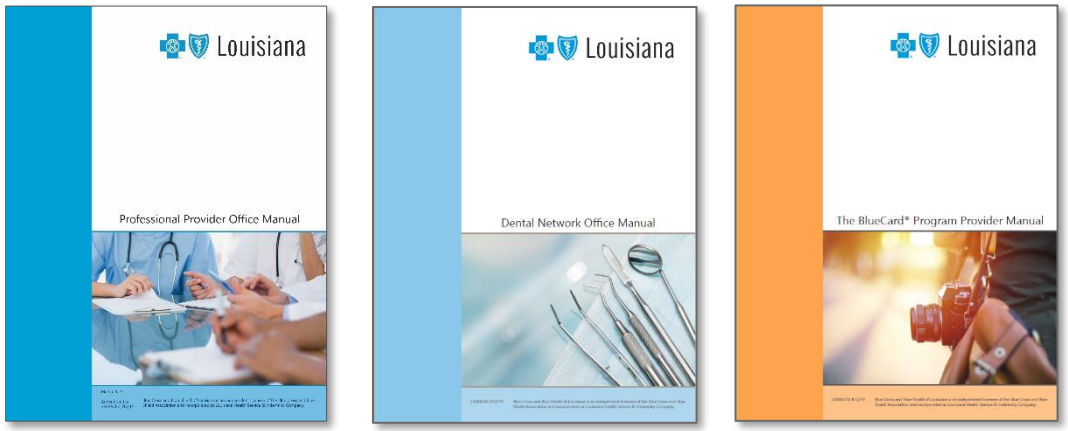


The Provider Page is home to online resources such as:

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

www.bcbsla.com/providers

Provider Manuals



www.bcbsla.com/providers >Resources >Manuals

Our manuals are an extension of your member provider agreement.

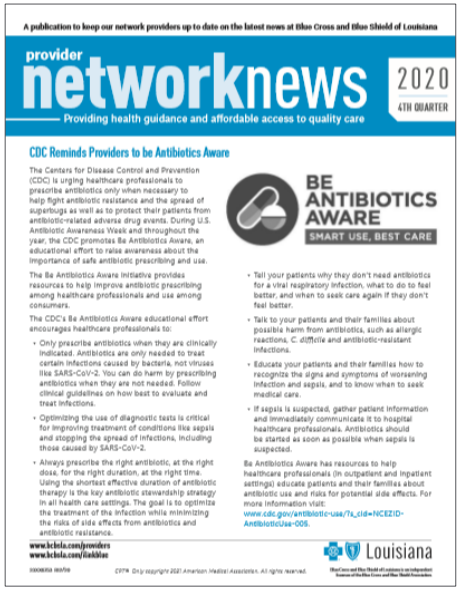
The manuals include the information you need as a participant in our networks:

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

Newsletters

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

www.bcbsla.com/providers >Newsletters


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

provider networknews 2020

Providing health guidance and affordable access to quality care

4TH QUARTER

CDC Reminds Providers to be Antibiotics Aware

The Centers for Disease Control and Prevention (CDC) is urging healthcare professionals to prescribe antibiotics only when necessary to help fight antibiotic resistance and the spread of superbugs as well as to protect their patients from antibiotic-related adverse drug events. During U.S. Antibiotic Awareness Week and throughout the year, the CDC promotes Be Antibiotics Aware, an educational effort to raise awareness about the importance of safe antibiotic prescribing and use.

The Be Antibiotics Aware initiative provides resources to help improve antibiotic prescribing among healthcare professionals and use among consumers.

The CDC's Be Antibiotics Aware educational effort encourages healthcare professionals to:

- Only prescribe antibiotics when they are clinically indicated. Antibiotics are only needed to treat certain infections caused by bacteria, not viruses like SARS-CoV-2. You can do harm by prescribing antibiotics when they are not needed. Follow clinical guidelines on how best to evaluate and treat infections.
- Optimizing the use of diagnostic tests is critical for improving treatment of conditions like sepsis and stopping the spread of infections, including those caused by SARS-CoV-2.
- Always prescribe the right antibiotic, at the right dose, for the right duration, at the right time. Using the shortest effective duration of antibiotic therapy is the key antibiotic stewardship strategy in all health care settings. The goal is to optimize the treatment of the infection while minimizing the risks of side effects from antibiotics and antibiotic resistance.

BE ANTIBIOTICS AWARE

SMART USE, BEST CARE

- Tell your patients why they don't need antibiotics for a viral respiratory infection, what to do to feel better, and when to seek care again if they don't feel better.
- Talk to your patients and their families about possible harm from antibiotics, such as allergic reactions, *C. difficile* and antibiotic-resistant infections.
- Educate your patients and their families how to recognize the signs and symptoms of worsening infection and sepsis, and to know when to seek medical care.
- If sepsis is suspected, gather patient information and immediately communicate it to hospital healthcare professionals. Antibiotics should be started as soon as possible when sepsis is suspected.

Be Antibiotics Aware has resources to help healthcare professionals (in outpatient and inpatient settings) educate patients and their families about antibiotic use and risks for potential side effects. For more information visit: www.cdc.gov/antibiotic-use/hi_cid=NCEZID-AntibioticUse-005.

www.bcbsla.com/providers
www.bcbsla.com/ilikeblue

Louisiana


A publication to keep our network providers informed on the latest Blue Advantage (HMO) | Blue Advantage (PPO) news

Blue Advantage Insight Newsletter

February 2021

In this edition:

page article

2 Help Your Patients Start the Year Off Well!
2 Primary Care Provider Selection
3 Important Authorization Reminders
3 Filing Blue Advantage Claims
4 NEW Provider Portal Features
4 Things to Remember When Using the Blue Advantage Provider Portal
5 MIPS on Blue Advantage Claims
5 Reimbursement During Credentialing
6 Be Aware of COVID-19 Vaccine Fraud
7 Do We Have Your Current Contact Information?
7 Provider Pay Disputes

Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Network News

Our quarterly newsletter for network providers.

Blue Advantage Insight

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

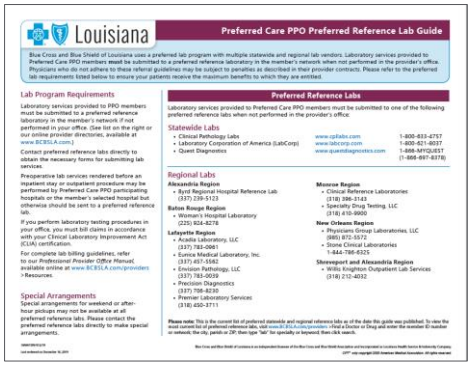
Not Getting Our Newsletters?

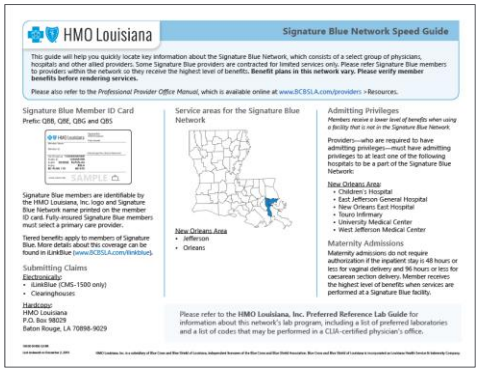
Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

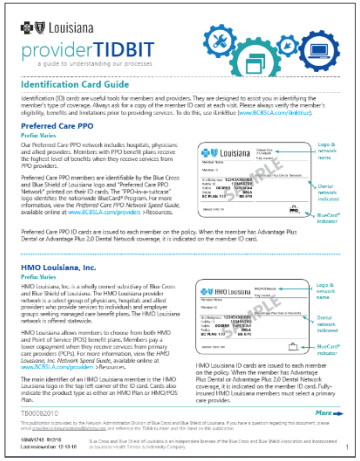
Speed Guides & Tidbits

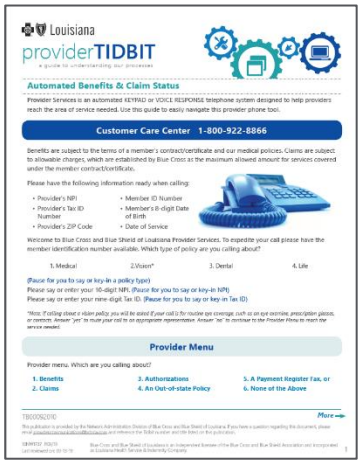
Speed Guides offer quick reference to network authorization requirements, policies and billing guidelines.

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


Louisiana
Preferred Care PPO Preferred Reference Lab Guide


HMO Louisiana
Signature Blue Network Speed Guide


Louisiana
providerTIDBIT
Identification Card Guide


Louisiana
providerTIDBIT
Automated Benefits & Claim Status
Customer Care Center 1-800-922-8866

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

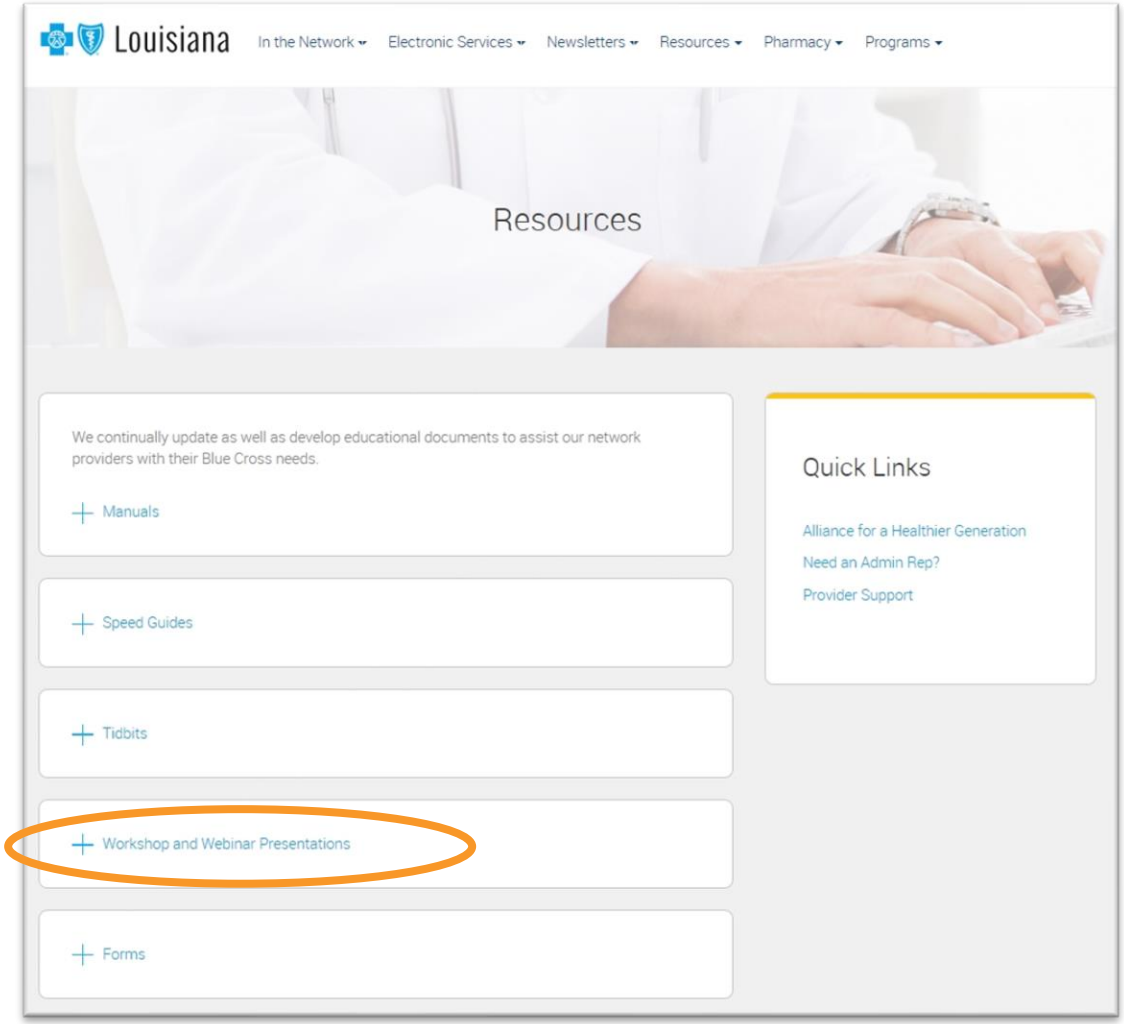
www.bcbsla.com/providers
>Resources >Tidbits

Workshops and Webinars

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

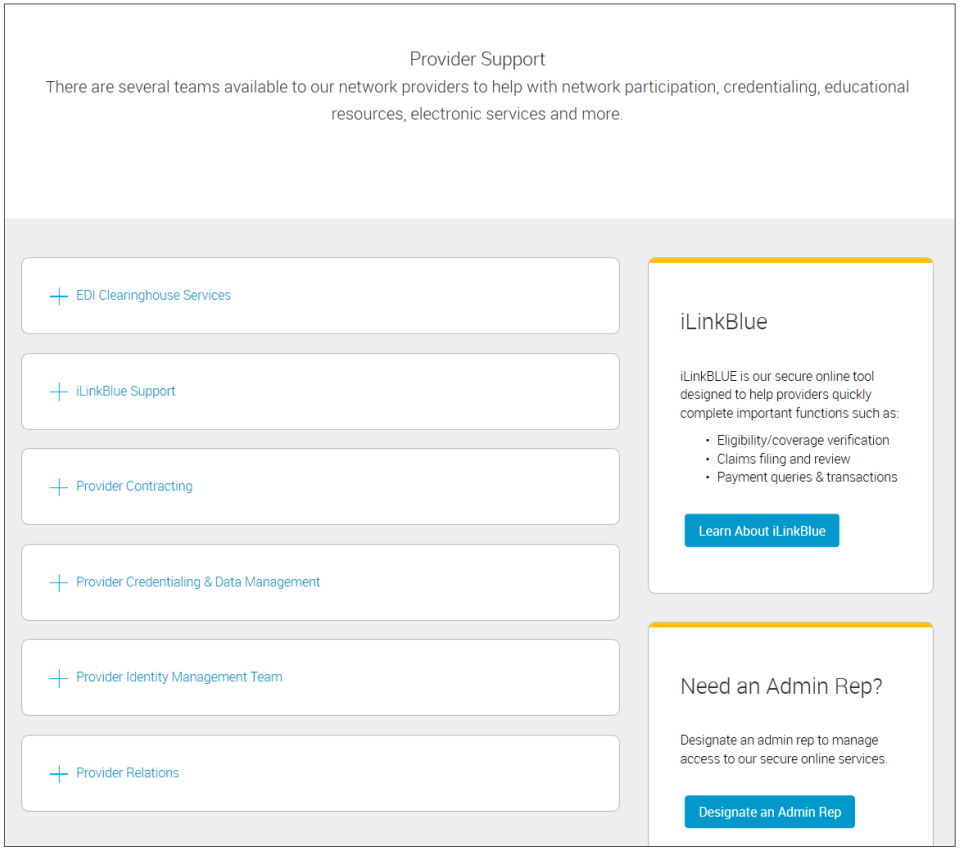
Invites to attend these events are sent to the providers' correspondence email address.

PDF copies of our workshops and webinars are available online.



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

Provider Support



We believe supporting our network providers is important.

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

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

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

Customer Care Center

Customer Care Center	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-866-508-7145**
Healthy Blue Dual Advantage (HMO) D-SNP	**1-844-209-5406**

For information NOT available on iLinkBlue

Other Provider Phone Lines

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

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

Health Services Division – 1-800-716-2299

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

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