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 only.
- Please limit your questions to information presented in today's webinar.

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.

New to Blue Advantage

April 2025

Blue adVantage (HMO) | Blue adVantage (PPO)

LOUISIANA BLUE

Y0132_25684PVLA_C

Welcome to the Blue Advantage Network!

- Thank you for participating in our Blue Advantage (HMO) and Blue Advantage (PPO) provider networks.
- As a participating provider, you play an important role in the delivery of healthcare services to Blue Advantage plan members.
- You have our commitment to work collaboratively with you to provide members access to excellent care and coverage.

Our Mission

To improve the health and lives of Louisianians.

Our Core Strategies

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

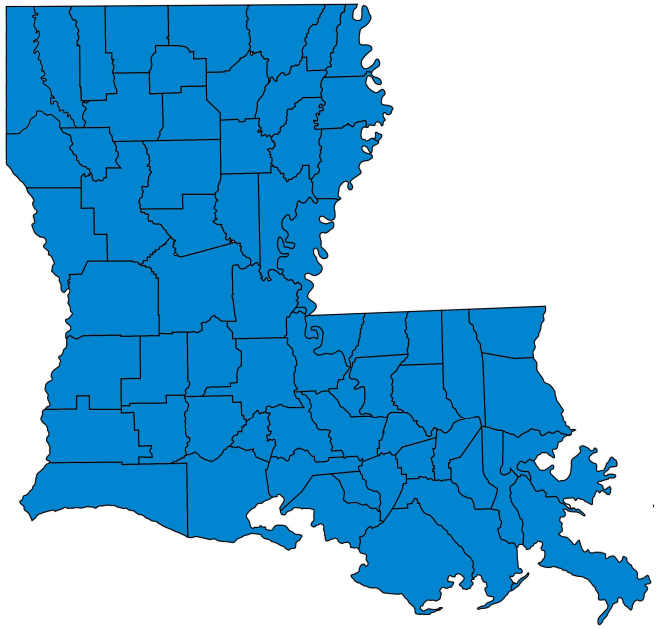
Agenda

As a Blue Advantage provider, we want to make sure you have the tools and resources you need when doing business with Blue Advantage. Today we will discuss:

- Credentialing and Recredentialing
- Identifying Your Patients
- Coding
- Authorizations
- Pharmacy
- Claims and Billing
- Other Services
- Resources

Welcome to the Blue Advantage Network

Blue Advantage is our Medicare Advantage product currently available to Medicare-eligible persons statewide.



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Blue adVantage (HMO) | Blue adVantage (PPO)

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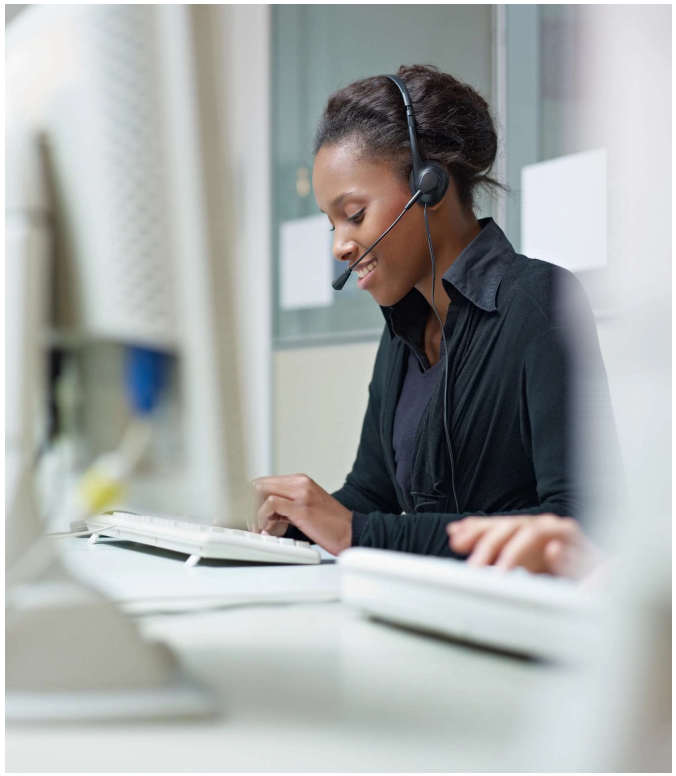
Credentialing and Recredentialing

Blue Advantage Credentialing



Credentialing is required for network participation. We partner with **symplrCVO** to conduct credentialing verification processes for our Blue Advantage networks.

Any Medicare eligible provider who intends to see Medicare beneficiaries is required by the Centers for Medicare and Medicaid Services (CMS) to apply for a Provider Transaction Access Number (PTAN). Providers wishing to participate in Blue Advantage must submit the PTAN when submitting an application.

Reimbursement During Credentialing

Professional healthcare providers that meet certain criteria can be reimbursed at network allowable charges and member benefit options during the credentialing process, with claims paid directly to the provider. Blue Advantage sets up qualifying providers for this reimbursement when they meet the following criteria:

- Provider is not a solo practitioner.
- Provider must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Advantage for the same provider type.
- Nurse practitioners (NPs) must submit a copy of the collaborating agreement with physician. Collaborating physician must participate in the same networks as the NP.
- Physician assistants (PAs) must submit a copy of intent to practice agreement with physician that participates in the same networks as PA.

Note: If reimbursement during credentialing criteria is met, reimbursement during credentialing is backdated up to one month prior to the date of application receipt.

Recredentialing

- Providers are recredentialed every 36 months.
- Blue Advantage will reach out to providers with information about the recredentialing process prior to the due date.
- We use the corresponding email on file to begin the process.

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Identifying Your Patients

Medicare Advantage Members from Other Blue Plans

- Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage, generally referred to as “traditional Medicare.”
- All Medicare Advantage Blue Plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services.
- Medicare Advantage organizations may also offer a Special Needs Plan (SNP).
- MA Blue Plans may allow in- and out-of-network benefits, depending on the type of product selected.
- **Out-of-network services require prior authorization**.

To verify eligibility and/or benefits for MA members from other Blue Plans, call BlueCard Eligibility, or submit an inquiry through **iLinkBlue**.

Louisiana Blue offers two MA products statewide

- Blue Advantage (HMO)
- Blue Advantage (PPO)

Benefit and eligibility for these products are handled through the Blue Advantage Provider Portal (**www.lablue.com/ilinkblue** >Blue Advantage). This tool is not used for BlueCard MA members.

Member ID Cards

Blue Advantage provides each member with an ID card containing the following:

- Name of the covered member
- Copayment or coinsurance responsibilities
- Important phone numbers

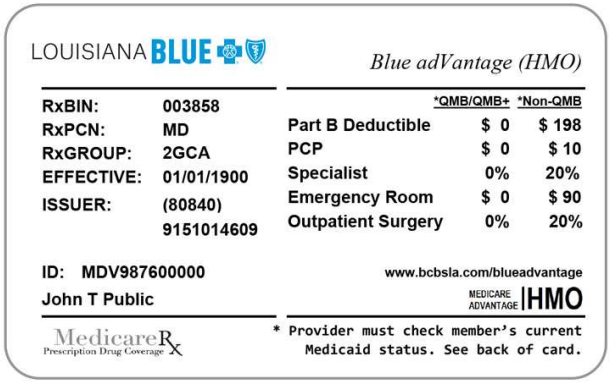
The member ID card is used for all types of coverage such as Medicare Part A, Part B and Part D (pharmacy).

PMV prefix

MDV prefix

D-SNP Member ID Cards

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



MDV prefix

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 in-network 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 Louisiana Blue 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.

Blue Advantage Customer Service

For inquiries that cannot be addressed through the Blue Advantage Provider Portal, providers may contact customer service at:

1-866-508-7145

Customer Services prompts have been updated, please listen carefully to the new options when calling in. Blue Advantage Customer Service is available 8 a.m. to 8 p.m., 7 days a week from October to March and 8 a.m. to 8 p.m., Monday – Friday from April to September.

1-877-528-5820

customerservice@blueadvantagela.com

Blue Advantage
130 DeSiard St, Ste 322
Monroe, LA 71201

Providers may also contact customer service on the patient's behalf and request a representative call the member to assist with their questions.

Primary Care Provider (PCP) Roles

The PCP should be involved in the overall care of the member.

- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff.
- Develop and grow the provider-member relationship while being proactive and cost effective.
- Responsible for coordinating members' medically necessary services.
- When a member changes PCP, upon request, the prior PCP has 10 business days to submit records to the new PCP.

Blue Advantage does not require a referral from the PCP for the member to obtain services from a specialist or another primary care provider.

Primary Care Provider (PCP) Roles

- Send members to network providers.
  - Referring patients to out-of-network providers may result in significant costs to the member. To help your Blue Advantage patients find specialists in their network, direct them to the Blue Advantage member website at https://blueadvantage.lablue.com >Find a Doctor.
- Plan Directed Care (PDC)
  - Louisiana Blue follows CMS guidelines related to PDC.
- Provider-patient Relationships
  - Valid provider-patient relationships are established between members and providers, including, without limitation, physicians, allied health providers, or other provider type, as defined by Plan, when the members and the providers engage in a healthcare encounter that includes a fully documented clinical assessment (in-person or telemedicine) of the member (patient).

Provider-Patient Relationships

Maintaining good provider-patient relationships are important, particularly when a patient receives a survey from CMS asking about their experience with their personal provider.

Think about how your patients would respond to questions like these:

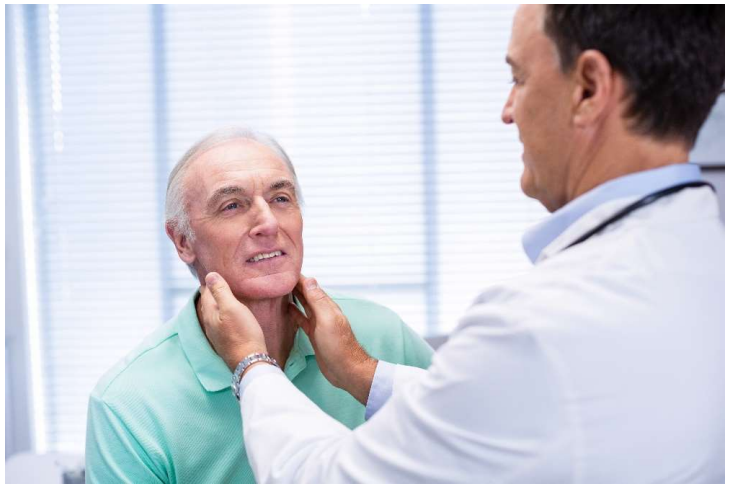
- Did your personal provider make things easy to understand?
- Did your personal provider listen carefully to your concerns and show respect for them?
- Did your personal provider spend enough time with you?
- Did your personal provider talk to you about your prescription drugs?

RHC Reporting Requirement – Modifier CG

- Rural health clinics (RHCs) shall report Modifier CG (policy criteria applied) on RHC claims and claim adjustments. Providers should report Modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services subject to coinsurance and deductible. If only preventative services are furnished during the visit, report Modifier CG with the preventive service HCPCS code that represents the primary reason for the medically necessary face-to-face visit.
- Medical and preventative services HCPCS codes are billed with revenue code **052X**
- Mental health services HCPCS codes are billed with revenue code **0900**
- Claims submitted without Modifier CG will process incorrectly and the provider will need to adjust the claim
- For a copy of the below resources, please email **provider.relations@lablue.com**
- Rural Health Clinics Reporting Requirements Frequently Asked Questions
- MLN Matters Article MM9269 – Required Billing Updates for Rural Health Clinics
- Rural Health Clinic Qualifying Visit List (RHC QVL)

Importance of Annual Wellness Visits

- Provides the ability to effectively assess your patients' chronic conditions, as well as close care and coding gaps for Blue Advantage patients.
- Covered at 100%, **once every calendar year**, for Blue Advantage patients.



Quality

- Assess and capture outstanding Star Rating Care Gaps for value-based contract performance and better patient outcomes.

Risk Adjustment

- Greater appointment time allotment for comprehensive assessment and care planning for chronic conditions.

Blue Advantage Quality Program

All PCPs participating in our Blue Advantage network(s) are eligible to receive performance incentive payments based on closing gaps in care for CMS HEDIS® measures.

Pay for Performance Medicare Advantage Star Rating Incentive (P4P MA SI) is available to all PCPs participating in Blue Advantage networks.

- Information is then used to help build STAR rating incentive.
  - 4 Star: $50 PMPY
  - 5 Star: $100 PMPY
  - Payments are Risk Adjusted

QB – Condition Assessment Program

- AWV Completion – Payment of $60 per completed AWV, available to all network PCPs

- Two options for Condition Assessment:
  - Condition Assessment via Epic – Payment of $40 per condition assessed
  - Condition Assessment via Stellar Health – Payment of $40 per condition assessed
    - Minimum attribution requirements apply to enrollment in Stellar Health

QB – Condition Assessment Program

- Providers who do not participate in condition assessment with Epic or Stellar **and** have 10+ members are eligible for an escalating Annual Incentive for reaching thresholds of AWV completion.

- Panel AWV Completion Rate:
  - Over 50% - $5 PMPY
  - Over 60% - $15 PMPY
  - Over 80% - $20 PMPY
  - Over 90% - $25 PMPY

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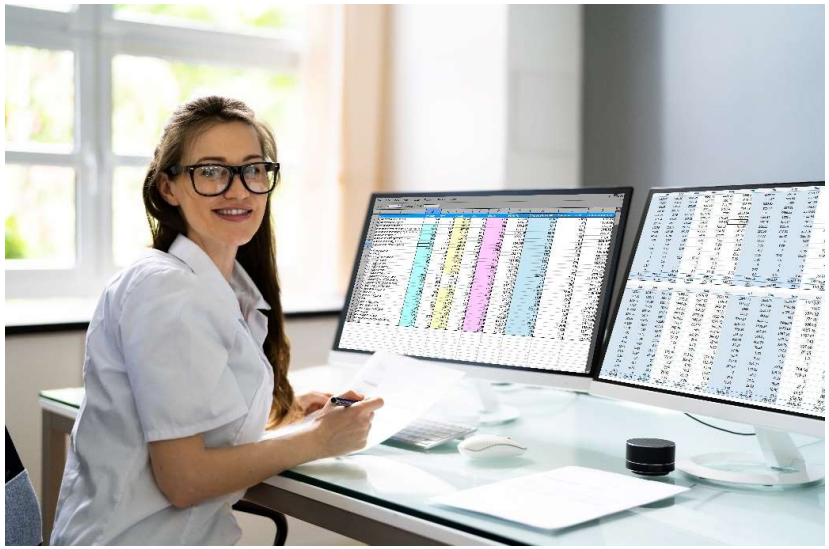
Coding

Importance of Complete and Accurate Clinical Documentation and ICD-10 Coding

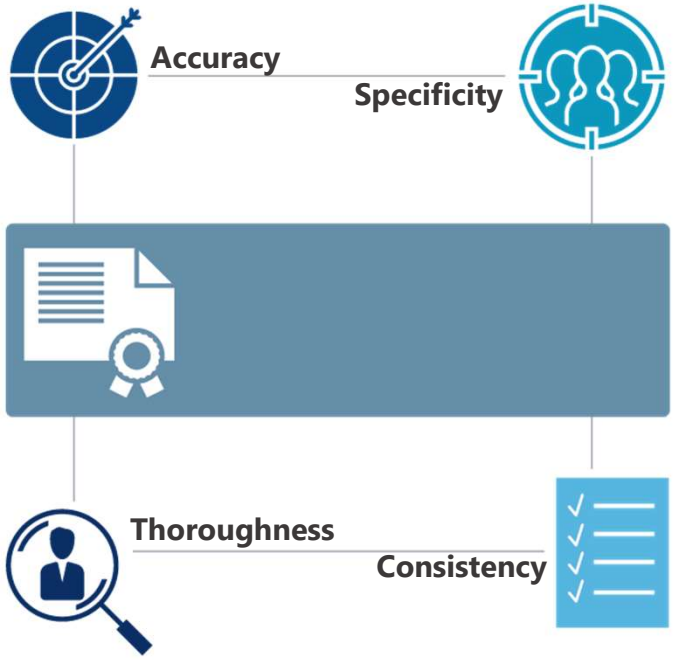


- Providers that treat sicker populations have higher average cost and utilization per patient. Risk-adjusted reporting can accurately reflect these sicker patients.
- The Centers for Medicare and Medicaid Services (CMS) sets risk scores for a calendar year based on diagnoses from the previous calendar year.
- All existing diagnoses must be submitted every calendar year for risk scores to be accurate.
- Member attribution is done by wellness exams.

Complete and Accurate Clinical Documentation and ICD-10 Coding

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease).
- Treatment and reason for level of care needs to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.



Advantage of Assigning CPT II Codes

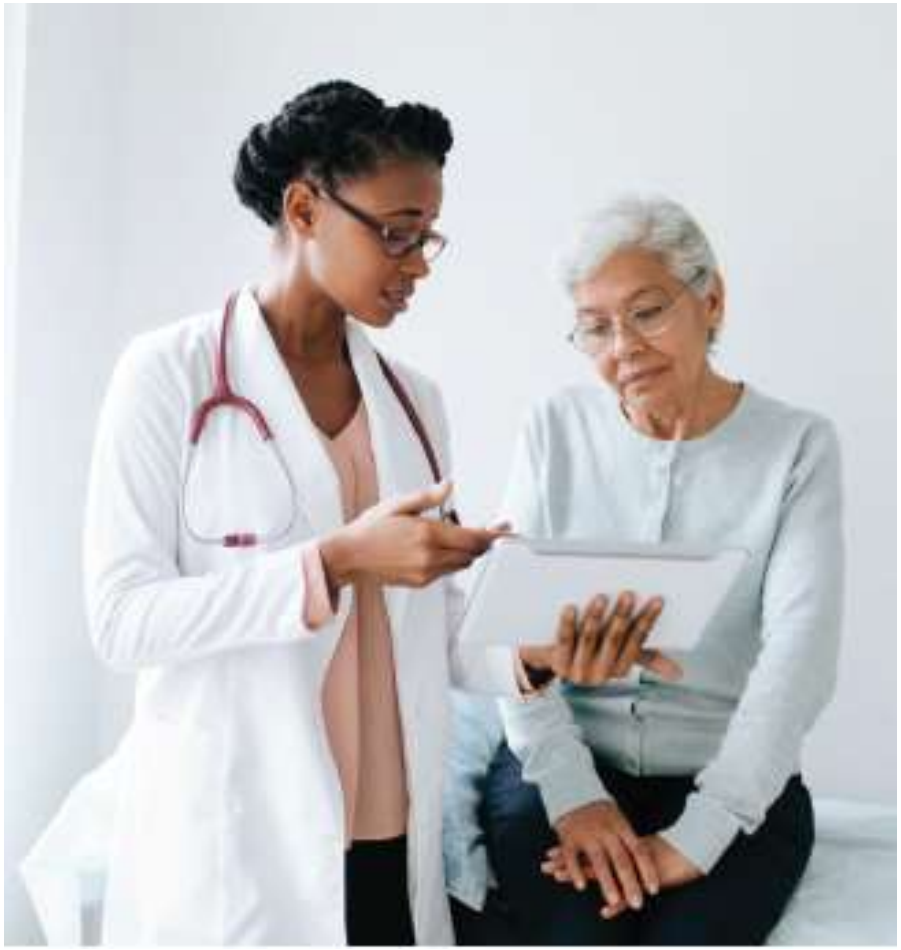
Why use CPT II Codes?

CPT II codes describe clinical components that may be typically included in evaluation and management services or other clinical services and do not have a relative value associated with them. These codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

- Lessens the administrative burden of chart review for quality programs such as:
  - Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures
  - Blue Advantage HHC gaps
  - RADV gap
- Enables organizations to monitor internal performance for key measures throughout the year, rather than once per year as measured by health plans and pay for performance
- Identifies opportunities for improvement so interventions can be implemented to improve performance during the service year

Coding Annual Exams

- OB/GYN providers seeing females should use codes 99381-99397.
    - Select the appropriate age and encounter type (new patient/subsequent).
- Other provider types should use G0438/G0439.



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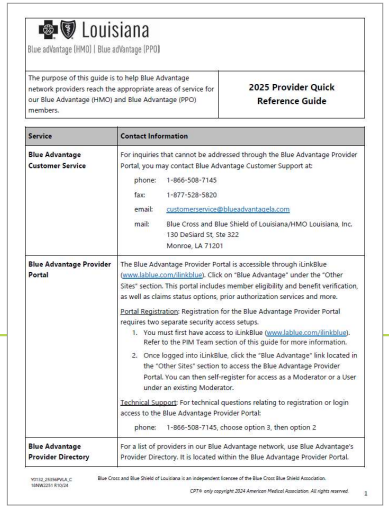
Authorizations

Hospital Authorizations

Hospital Admissions:

- Providers can report inpatient admissions to the Medical Management Team by:
  - Phone: 1-866-508-7145

    Phones are forwarded to a secure voicemail system during non-business hours.
  - Fax: 1-877-528-5818 *(available 24 hours a day)*
- Confirmed by Blue Advantage Medical Management staff with a reference number *(a reference number does not guarantee payment).*



Louisiana
Blue advantage (HMO) | Blue advantage (PPO)

The purpose of this guide is to help Blue Advantage network providers reach the appropriate areas of service for our Blue Advantage (HMO) and Blue Advantage (PPO) members.

2025 Provider Quick Reference Guide

Service	Contact Information
Blue Advantage Customer Service	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at: phone: 1-866-508-7145 fax: 1-877-528-5820 email: customerservice@blueadvantagela.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. 130 DeSiard St, Ste 322 Monroe, LA 71201
Blue Advantage Provider Portal	The Blue Advantage Provider Portal is accessible through iLinkBlue (www.lablue.com/ilinkblue). Click on "Blue Advantage" under the "Other Sites" section. This portal includes member eligibility and benefit verification, as well as claims status options, prior authorization services and more. Portal Registration: Registration for the Blue Advantage Provider Portal requires two separate security access setups. 1. You must first have access to iLinkBlue (www.lablue.com/ilinkblue). Refer to the PIM Team section of this guide for more information. 2. Once logged into iLinkBlue, click the "Blue Advantage" link located in the "Other Sites" section to access the Blue Advantage Provider Portal. You can then self-register for access as a Moderator or a User under an existing Moderator. Technical Support: For technical questions relating to registration or login access to the Blue Advantage Provider Portal: phone: 1-866-508-7145, choose option 3, then option 2.
Blue Advantage Provider Directory	For a list of providers in our Blue Advantage network, use Blue Advantage's Provider Directory. It is located within the Blue Advantage Provider Portal.

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

Services requiring authorization are listed in the *Provider Quick Reference Guide* that is available on the Blue Advantage Resources page and the Blue Advantage Provider Portal.

Hospital Authorizations

Inpatient Admission:

Plan requires notification within one business day of inpatient (IP) admission.

Observation:

Plan requires notification within one business day of observation (OBS) admission.

Notification is required within one business day of **discharge**.

Once the member is discharged, the visit and discharge summary must be faxed to Blue Advantage Medical Management.

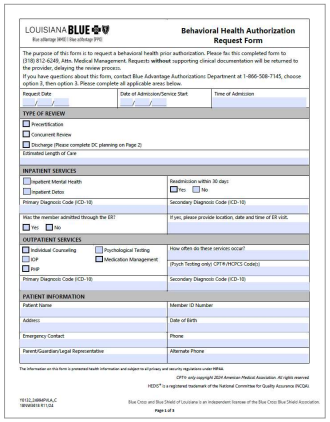
The plan reviews and makes determinations for IP/OBS, SNFs, Acute Rehabs, LTACs, HHCs, LOSs, LOCs and discharge planning.

Medical Necessity Criteria:

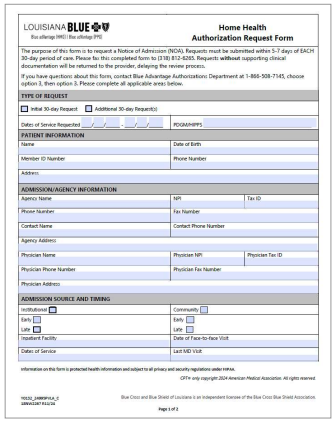
- Standardized criteria (e.g., InterQual®, DSM-5, ASAM, etc.)
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)

Prior Authorizations Forms

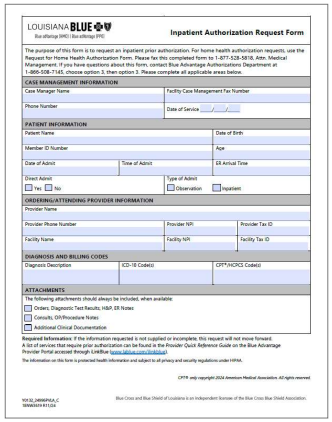
Providers may submit prior authorization requests by using one of the following authorization forms:



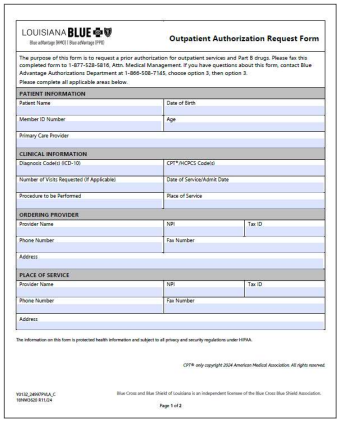
Behavioral Health Authorization Request Form



Home Health Authorization Request Form



Inpatient Authorization Request Form



Outpatient Authorization Request Form

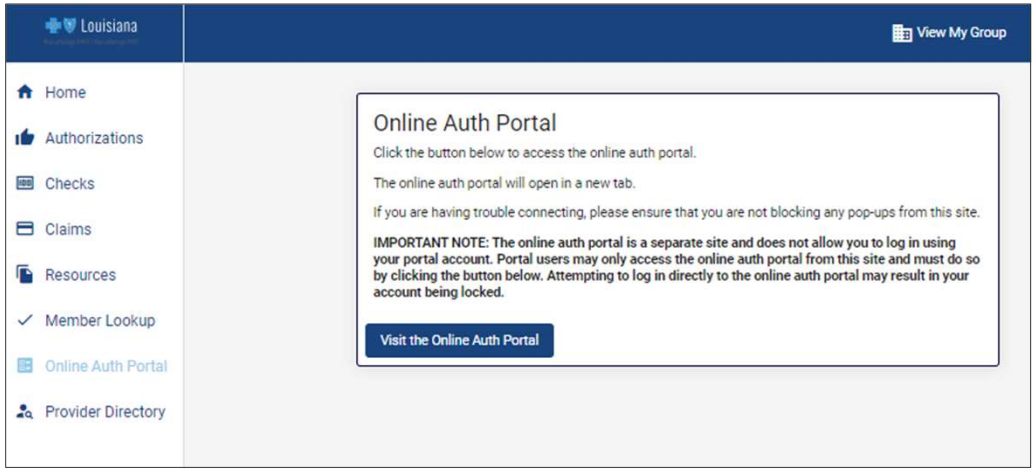
Download authorization forms by going to www.lablue.com/ilinkblue, then clicking on “Blue Advantage” under the “Other Sites” section. Click “Resources” then “Forms.”

The 2025 *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Resources page, www.lablue.com/providers, then click on “ Go to BA Resources” under the “Manuals and Guides” section.

Online Prior Authorizations Portal

Providers can use the "Online Auth Portal" to request a prior authorization for the following services:

- OPMD – a procedure performed in the office setting
- OPFAC – a procedure performed in an outpatient facility setting
- ASU – a procedure performed in an ambulatory surgical setting
- POC – authorization for post op care for surgeries with 90-day global periods
- BH – outpatient behavioral health services



Pharmacy Authorizations

To request a coverage determination for a Part D drug, contact Express Scripts, Inc. using one of the following methods:

Phone:	1-800-935-6103/TTY:711
Fax:	1-877-251-5896
Mail:	ESI – Attn: Medicare Reviews
	P.O. Box 66571
	St. Louis, MO 63166-6571
Online:	www.covermymeds.com
	www.express-path.com

For a comprehensive list of participating pharmacies, use the provider/pharmacy directory at www.lablue.com/ilinkblue >Blue Advantage (under Other Sites) >Provider Directory.

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Pharmacy

The Basics: Outpatient Drug Coverage

Part D drugs

- Prescription drugs filled at a retail pharmacy or by mail.
- Vaccines not covered under Part B.
- This amount applies to the **True Out-Of-Pocket (TrOOP)**.
- Member cost share depends on the drug's assigned tier.*
- Some generics are included in the Part B Tier 3 – Preferred Brand Drugs.

Part B drugs

- Drugs received at a doctor's office or outpatient hospital setting (infusion center).
- Vaccines such as COVID-19, influenza, pneumonia, hepatitis B (with certain risk factors).
- Immunosuppressive drugs following a Medicare-covered transplant.
- Drugs taken at home for certain conditions such as kidney disease, blood clotting disorders.
- Drugs that require a medical device or pump to administer (e.g., albuterol from a nebulizer).
- Members may have a 20% Part B coinsurance.
- This amount applies to the **Max Out-Of-Pocket (MOOP)**.

**D-SNP Plan does not include drug tiering.*

The Basics: Outpatient Drug Coverage

Part D drugs and Part B drugs

Drugs on the formulary that could process under Part D or Part B at a pharmacy are labeled with abbreviation “B/D PA.” These drugs are covered through the pharmacy benefit. However, we may need additional information to determine if the drug should be paid under Part D or Part B.

Medicare Part D Benefits

- Medicare has three coverage phases under the Part D benefit:
  - Annual Deductible
  - Initial Coverage
  - Catastrophic Coverage Phase

- During the Initial Coverage Phase (ICP), a member pays part of the cost of a covered Part D drug, such as a deductible, if applicable, and a copayment or coinsurance and Blue Advantage pays the remainder. The member remains in the ICP until the member's out-of-pocket costs reach $2,000.
- Once members reach the $2,000 Part D member out-of-pocket (MOOP), they move into the Catastrophic Phase and the plan pays the full cost of the member's Part D covered drugs.

Part D Exclusions: Examples

Vitamins and supplements

- Vitamin D supplements (alone and combination)
- Vitamin B and Cyanocobalamin supplements (oral and injection)
- Calcium citrate/calcium carbonate (alone and combination)
- Magnesium oxide/Mag oxide/Magnesium citrate
- Ferrous sulfate/Ferrous fumarate
- Folic acid

Drugs for symptomatic relief of cough and colds

- Tessalon Perles®
- Cough syrups (e.g., codeine/promethazine/guaifenesin)

Nonprescription/OTC drugs

- Acetaminophen
- Gas-X® (simethicone)

Drugs used for weight loss or weight gain (some exceptions)

- Adipex-P® (phentermine)
- Megace® (megestrol)
- Wegovy® (semaglutide)

Drugs used for cosmetic purposes, hair growth, hair removal

- Retin-A® (tretinoin)
- Vaniqa®

Drugs to treat sexual dysfunction

- Levitra®
- Viagra®
- Addyi®

Preferred Value Pharmacy Network

- The retail Preferred Value Pharmacy Network is anchored by Walgreens; however, it also includes other chains and many independent pharmacies.
- Members may use standard network pharmacies but will pay higher copayments on drugs in Tiers 1–3 compared to a preferred pharmacy.

Louisiana chain pharmacies include:

Walgreens, Sam's Club, Walmart

Many independent pharmacies also participate

Preferred Value Pharmacy Network

- **Benefits of Preferred Network**
- **Cost-savings for member**
  - Members will pay less for drugs in Tiers 1–3
  - Copays are now the same at both preferred retail and mail order pharmacies
  - Free standard shipping is included with Express Scripts mail order
- **Enhanced programs to improve adherence**
  - Write for three-month supply of maintenance medications
  - Improve engagement with patient and physician outreach
- **Connect members to pharmacies that support Clinical Star measures**

Express Scripts Mail-order Pharmacy

Two Steps to set up home delivery:

1) Prescribe a three-month supply directly to Express Scripts Mail Order Pharmacy.
   - Prescription can be sent electronically from the EMR or called in to Express Scripts Pharmacy.
2) Member can contact Express Scripts directly to have prescription transferred.
   - Call: 1-800-282-2881 (24 hours a day, 7 days a week)
     TTY users: 1-800-759-1089
   - Go online: www.express-scripts.com

To Be Safe:

- New prescriptions and refills should allow 10-14 days for processing and shipping.
- When first switching from retail to mail-order, we recommend members have a 30-day supply of medication on hand to allow processing time.

Benefits of Home Delivery

- **No-cost Shipping**
  - Standard shipping right to the member's door at no extra cost.
- **Refill Reminders**
  - Refill reminders make it less likely to miss a dose.
- **Avoid Interactions**
  - Safety reviews to find possible interactions with other drugs.
- **Pharmacists Available**
  - Access to a pharmacist 24/7 from the privacy of member's home.

In order to improve medication adherence, we ask that maintenance medications are written for a 3-month supply to ensure that patients continue to take as directed. Express Scripts Pharmacy® also has autofill options to help avoid forgetting refills.

Diabetic Testing Supplies

How members may get FREE meters and strips:

- **Go to a Blue Advantage network pharmacy.**
  - Members can take their prescription for a covered meter to a Blue Advantage network pharmacy.
  - All the covered meters are available through network pharmacies.

Members can find information on the following products online at www.lablue.com/blueadvantage:

- Abbott
- LifeScan
- Arkray

Pharmacist Outreach Initiatives

- **Therapeutic Opportunities**
- **Provider Outreach**
  - Star Report Cards containing gaps in care opportunities are distributed by the Blue Advantage provider team.
  - Value Program Pharmacists are assigned organizations and assist them with improving their pharmacy quality measures and identify ways to reduce pharmacy costs, when clinically appropriate.
    - Meet with organizations at an agreed upon cadence to discuss pharmacy opportunities and review reports.
    - Provide pharmacy reports at an agreed upon cadence to appropriate personnel for each organization (i.e., weekly, monthly, quarterly).
    - Provide educational pieces on pharmacy quality measures.
- **Member Outreach**
  - Pharmacists reach out to members eligible for Medication Therapy Management (MTM), members falling into pharmacy star measures, such as Medication Adherence, and members meeting specific criteria with certain chronic disease states (i.e., COPD and diabetes).

Pharmacist Outreach Initiatives

Medication Therapy Management (MTM) Program

Targets members who meet the following criteria:

- 3+ chronic conditions
- 8+ select maintenance medications
- Spent $405 in the previous 3 months on Part D covered medications.

Members will be invited to schedule a Comprehensive Medication Review (CMR) with an MTM-certified pharmacist which includes:

- Review of the member's entire medication profile (including prescriptions, OTCs, herbal supplements and samples).
- Discuss purpose and directions for the use of each medication with documentation being provided to the member after completion of the call.
- Answer any additional questions or concerns.

After the completion of a CMR, you and the member will receive a detailed report.

The pharmacist performing the CMR may contact you directly in the event a significant drug therapy problem is identified.

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Claims and Billing

Billing Requirements

Providers should bill according to Medicare guidelines.

CMS guidelines are followed for all claims, both electronic and paper:

- Faxed claims are not accepted.

Timely Filing

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

Refer to www.cms.hhs.gov for specific details.

Proper Submission of Provider IDs and Incident-to Billing

Blue Advantage has “Incident-to” reimbursement rules for provider types that are eligible to participate in our networks as follows:

1. If network participation is available for a provider type, then that provider type is required to file claims under their own provider number. Services should not be billed under a supervising provider.
2. Only providers covered by our subscriber contracts and not offered network participation are eligible to bill incident-to services and be reimbursed under a supervising provider’s Blue Advantage contract number. Providers who are considered in training (e.g., residents, post-doctoral and other students, and providers with provisional licensure) are not eligible to bill incident-to services.

Under this policy, provider types that are required to file claims under their own provider number include (but may not be limited to) nurse practitioner, physician assistant, dietitian, audiologist, certified nurse anesthetist and behavior analyst. These provider types are eligible to participate in our networks.

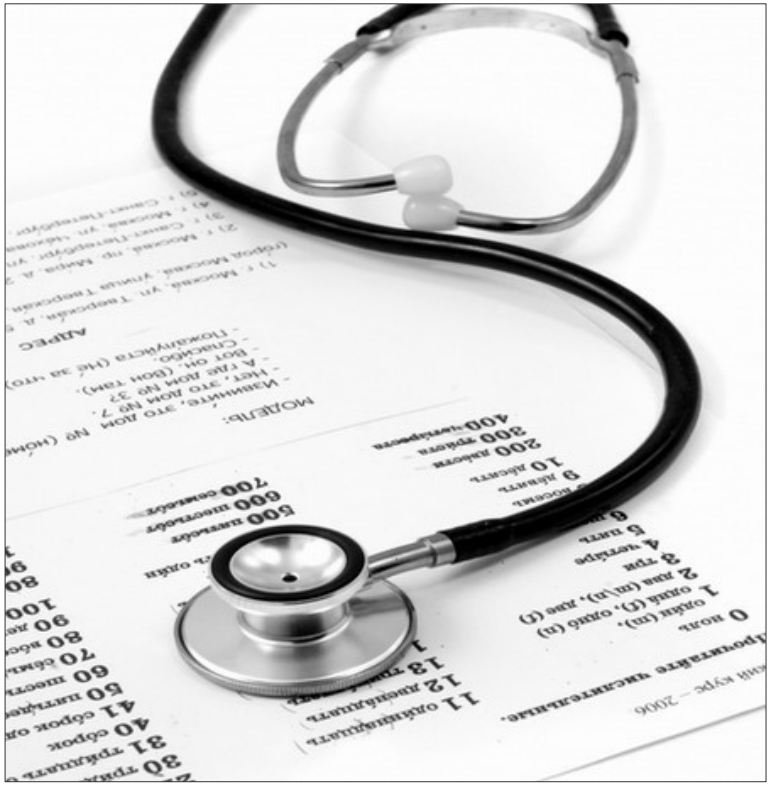
Claims Submission

For claims that are not sent electronically, please mail all paper claims to:

Blue Advantage
130 DeSiard St, Ste 322
Monroe, LA 71201

Blue Advantage Medical Record Reviews

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



ABNs Not Used for Blue Advantage

CMS does not allow use of Advanced Beneficiary Notices (ABNs) for MA plans.

To hold members financially liable for non-covered services not clearly excluded in the member's Evidence of Coverage (EOC), contracted providers must do the following:

- If contracted provider knows or has reason to know that a service may not be covered, request a prior authorization from Blue Advantage.
- If the coverage request is denied, an Integrated Denial Notice (IDN) will be issued to the member and requesting provider.
- If the member desires to receive the denied services **after** the IDN has been issued, the provider may collect from the member for the specific services outlined in the IDN after services are rendered.

Corrected Claims

EDI/1500/Professional claims can be submitted electronically as “Corrected Claims”

- Loop 2300 ~ CLM05-03 must contain a “7,” REF01 must contain an “F8” and REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

1500 paper claim forms can be submitted as “corrected claims”

- The paper 1500 claim submitted must indicate a frequency of 7 in Block 22 (Resubmission Code Box) and the original reference claim number in Block 22 (Original Ref. No. Box).

The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.

EDI/UB-04/Facility corrected claims can be submitted electronically as “Corrected Claims”

- The type of bill must indicate a frequency of 7.
- “F8” must indicate in Loop 2300 REF01.
- REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

UB-04 corrected claims can also be submitted on paper as “corrected claims”

- The paper UB-04 corrected claim submitted must indicate a frequency of 7 in Block 4.
- The original reference claim number in Block 64.
- Reason for the correction in Block 80.
- The corrected claim will be denied as a duplicate if the original claim number is not included.

Resolving Claims Issues

Contact Blue Advantage Customer Service at **1-866-508-7145:**

- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 working days for first request.
- Check the Blue Advantage Provider Portal for a claims resolution.
- Request a second review for correct processing.
- Allow 10-15 working days for second request.

When to Contact Provider Relations for Claims Help:

If unresolved after second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations.

provider.relations@lablue.com

It is required to document the customer service representative's name and date for each call.

Claims

Resubmission

- No payment was issued on the claim line in question.
- The incorrect or missing information on the original claim resulted in the claim denial. This would be corrected/added and resubmitted (i.e., invalid procedure code modifier combination).
- The claim can be resubmitted on paper or electronically, **not faxed**.
- The claim will be treated as an initial claim for processing purposes with no provider explanation necessary.

Please note that if the status of the claim is **Pending**, you will not be able to review in detail.

Corrected

- A **previously paid claim** in which the provider needs to add, remove or change a previously paid claim line.
- Providers must submit a corrected claim if all lines of the claim were previously paid, and they are wanting to add or remove a claim line or change something on a claim line. Example: date of service, procedure code, etc.
  - Examples:
    - Adding or removing a previously paid claim line where charges were billed for a service that was not rendered, or provider did not bill for a service that was rendered.
    - Changing a previously paid claim line where an incorrect date of service or an incorrect procedure code was billed.
- The corrected claim will be denied as a duplicate if the original claim number is not included.

Provider Pay Disputes

When a participating provider disagrees with the amount that has been paid on a claim or line item:

- Disputes over the payment amount must be filed within the timeframe specified in your contract, which is based on the date the claim was processed.
- The dispute notice should be submitted in writing and include the basis for the dispute and documents supporting your position.
- Regardless of the existence or outcome of the dispute, participating providers are not allowed to seek additional compensation from members other than copayments, coinsurance and payment for non-covered services.

Once a decision has been made:

- Blue Advantage will communicate the decision in writing if it is determined the correct amount was previously paid.
- If payment is corrected, it will appear on a remittance advice to the requesting provider.
- If you still disagree with Blue Advantage's decision, you have opportunities for additional levels of administrative review. Please follow the instructions in your contract.

Provider Pay Dispute Address:

Blue Advantage
Attn: Payment Disputes
130 DeSiard St, Ste 322
Monroe, LA 71201

Member Appeals

When a member disagrees with a denial of services, an appeal:

1. Must be filed within **60 days** from the date of the original determination (e.g., EOB or provider remit is issued, whichever is applicable).

2. Must be submitted in writing and **does not apply to participating providers unless it involves a pre-service request**.

3. Claim appeals can be filed by either a member or a non-contracted provider.

4. Pre-service appeals can be filed by both participating and non-participating providers, the member or the member's authorized representative, and can be submitted in writing or requested by calling Blue Advantage Customer Service at 1-866-504-7145.

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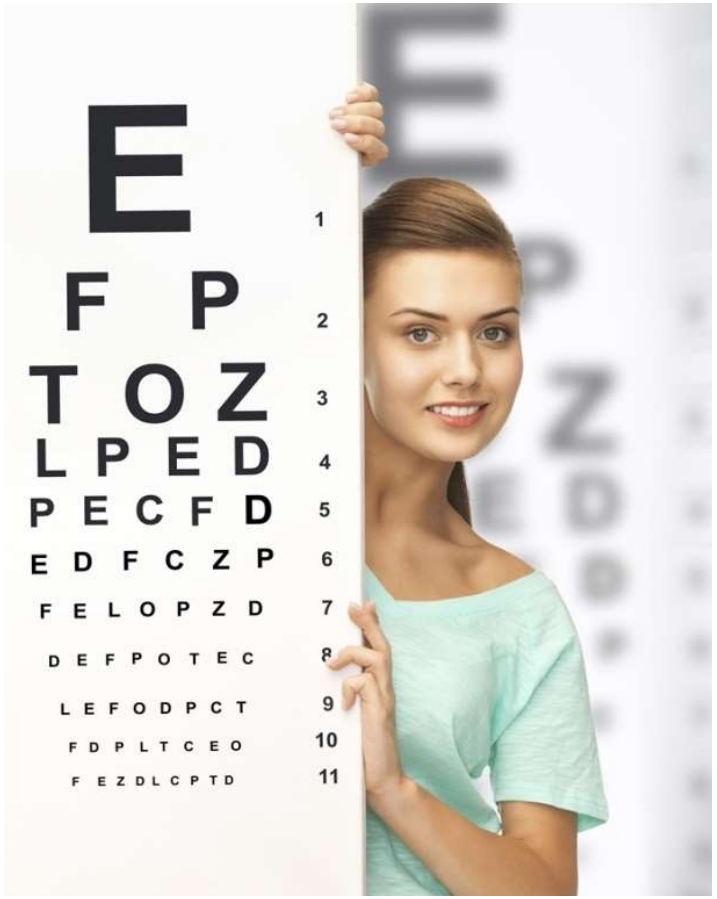
Other Services

Refractions

- Refractions are not covered unless performed by a contracted Blue Advantage ophthalmologist or optometrist.
- As a CMS requirement, contracted providers are not permitted to render non-covered services and hold the member responsible.
- For network vision providers, please search the Blue Advantage provider directory or call 1-866-508-7145.



The provider directory can be accessed through iLinkBlue (www.lablue.com/ilinkblue) >Blue Advantage under “Other Sites.” Once logged into the Blue Advantage Provider Portal, click on Provider Directory, then select “Visit the Provider Search.”

Other Services

- **Express Scripts**

  administers pharmacy benefit management

  phone: 1-800-935-6103/TTY:711

- **Liberty Dental**

  administers preventative and comprehensive dental services

  phone: 1-866-609-0424

See the "Plan Information Contact List" section of the *Blue Advantage Provider Administrative Manual* for more information about these services.

Outpatient Lab Tests

Blue Advantage network providers can:

- Perform lab work in the office if they are Clinical Laboratory Improvement Amendments (CLIA) certified.
- Draw specimens and send to one of our participating lab facilities identified in our Provider/Pharmacy Directory.

Blue Advantage Preferred Labs:

- Clinical Pathology Laboratories (CPL)
  www.cpllabs.com
- Laboratory Corporation of America (LabCorp)
  www.labcorp.com
- Quest Diagnostics
  www.questdiagnostics.com

Blue Advantage Flex Card

- Personal prepaid debit card with allowances that can only be used for approved products for Blue Advantage members.
- Card allowances are not transferable.
- Card allowances do not roll over.
- If purchases exceed the allowance amount of the Flex Card, the member is responsible for paying the difference.
- Card allowances will vary by plan and include:
  - Annual allowance for prescription hearing aids
  - Annual allowance for eyewear like eyeglasses and contact lenses
  - Quarterly allowance for over-the-counter supplies available for purchase at major retailers or online
  - D-SNP has a monthly allowance for over-the-counter health-related products and healthy foods

To set up, replace or ask questions about your Flex Card, please call us at 1-833-952-2772, Monday – Friday, 7 a.m. to 7 p.m.

Healthy Rewards Program for Your Patients

Help your patients earn Healthy Rewards to congratulate them for taking steps on a journey to better health!

- Blue Advantage's Healthy Rewards program is an easy way for members to earn extra money on your Flex Card – just by completing a few preventive services such as your Annual Wellness Visit, or flu shot.
- The Healthy Rewards program is simple. Blue Advantage members who enroll in our program will receive educational information, tools and reminders to help them make the most of their preventive benefits.
- Members must enroll in the program each plan year in order to participate. All eligible health actions must be completed by 12/31 to receive funds for that plan year.

- Annual Wellness Visit - $50
- Breast Cancer Screening (Mammogram) - $50
- Colorectal Cancer Screening (Colonoscopy or Flexible Sigmoidoscopy) - $50
- Annual Flu Vaccine - $10
- Retinal Eye Exam - $25
- Health Risk Assessment - $25

How Your Patients Receive Healthy Rewards

Opt In to Receive Rewards

The members must log in to their Blue Advantage Member Portal account (bcbslamemberportal.com) and click the Healthy Rewards tab to opt in to the Healthy Rewards program. They can also call our Healthy Rewards servicing team at 1-833-952-2775 to opt in over the phone.

How to Earn Rewards

After completing one of the health actions listed above, the provider will submit a claim to Blue Advantage for processing. The claim must be coded appropriately, processed and paid by Blue Advantage prior to the member earning their reward. There is no out-of-pocket cost to members for in-network preventive services.

How to Use Rewards

The Blue Advantage Flex Card will be loaded with the funds they have earned each week for claims paid by Blue Advantage in the prior week. The Healthy Rewards funds are deposited into their Flex Card’s Reimbursements and Incentives purse.

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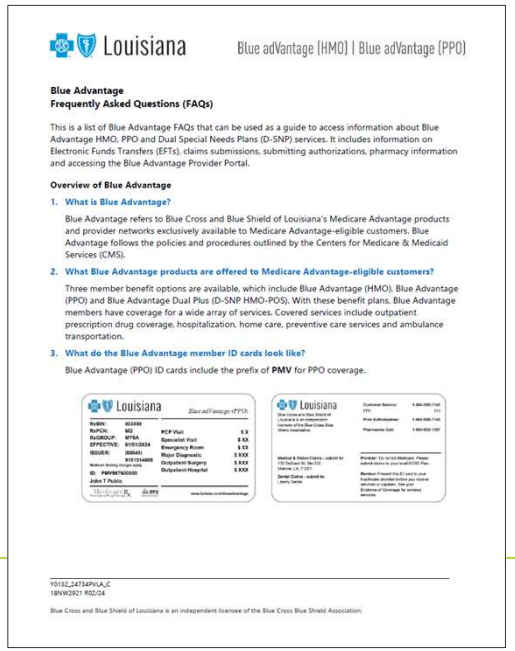
Resources

Updated Blue Advantage FAQs

We recently updated the Blue Advantage FAQs with information on topics including:

- Blue Advantage Provider Portal
- Authorizations
- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
- Claims Submission
- Pharmacy
- Care Management



Louisiana Blue adVantage (HMO) | Blue adVantage (PPO)

Blue Advantage
Frequently Asked Questions (FAQs)

This is a list of Blue Advantage FAQs that can be used as a guide to access information about Blue Advantage HMO, PPO and Dual Special Needs Plans (D-SNP) services. It includes information on Electronic Funds Transfers (EFTs), claims submissions, submitting authorizations, pharmacy information and accessing the Blue Advantage Provider Portal.

Overview of Blue Advantage

1. **What is Blue Advantage?**

   Blue Advantage refers to Blue Cross and Blue Shield of Louisiana's Medicare Advantage products and provider networks exclusively available to Medicare Advantage-eligible customers. Blue Advantage follows the policies and procedures outlined by the Centers for Medicare & Medicaid Services (CMS).

2. **What Blue Advantage products are offered to Medicare Advantage-eligible customers?**

   Three member benefit options are available, which include Blue Advantage (HMO), Blue Advantage (PPO) and Blue Advantage Dual Plus (D-SNP HMO-POS). With these benefit plans, Blue Advantage members have coverage for a wide array of services. Covered services include outpatient prescription drug coverage, hospitalization, home care, preventive care services and ambulance transportation.

3. **What do the Blue Advantage member ID cards look like?**

   Blue Advantage (PPO) ID cards include the prefix of **PMV** for PPO coverage.

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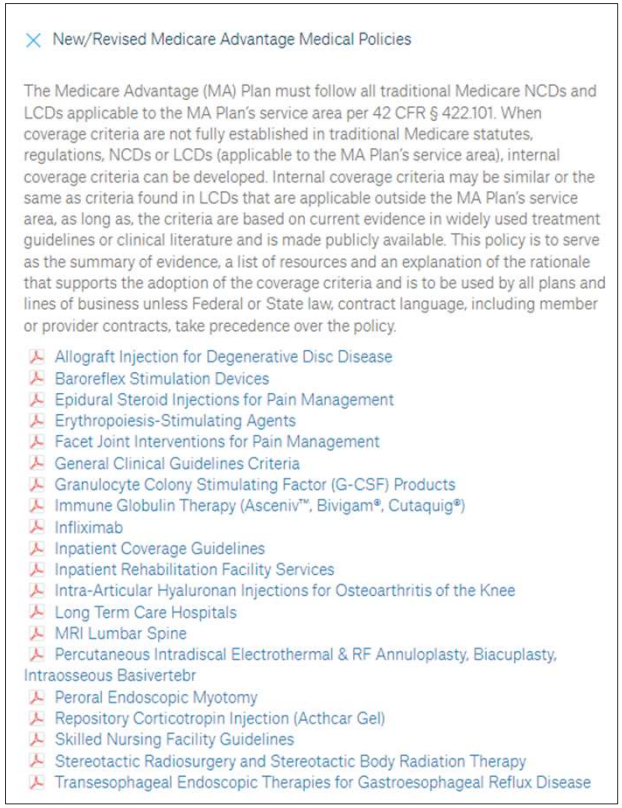
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

The FAQs are also available in two locations:

- The Blue Advantage Provider Portal www.lablue.com/ilinkblue, under Other Sites click “Blue adVantage.”
- The Louisiana Blue Provider page www.lablue.com/providers >Blue Advantage Resources >Manuals and Guides.

Blue Advantage Medical Policies



New/Revised Medicare Advantage Medical Policies

The Medicare Advantage (MA) Plan must follow all traditional Medicare NCDs and LCDs applicable to the MA Plan's service area per 42 CFR § 422.101. When coverage criteria are not fully established in traditional Medicare statutes, regulations, NCDs or LCDs (applicable to the MA Plan's service area), internal coverage criteria can be developed. Internal coverage criteria may be similar or the same as criteria found in LCDs that are applicable outside the MA Plan's service area, as long as, the criteria are based on current evidence in widely used treatment guidelines or clinical literature and is made publicly available. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of the coverage criteria and is to be used by all plans and lines of business unless Federal or State law, contract language, including member or provider contracts, take precedence over the policy.

- Allograft Injection for Degenerative Disc Disease
- Baroreflex Stimulation Devices
- Epidural Steroid Injections for Pain Management
- Erythropoiesis-Stimulating Agents
- Facet Joint Interventions for Pain Management
- General Clinical Guidelines Criteria
- Granulocyte Colony Stimulating Factor (G-CSF) Products
- Immune Globulin Therapy (Asceniv™, Bivigam®, Cutaquig®)
- Infliximab
- Inpatient Coverage Guidelines
- Inpatient Rehabilitation Facility Services
- Intra-Articular Hyaluronan Injections for Osteoarthritis of the Knee
- Long Term Care Hospitals
- MRI Lumbar Spine
- Percutaneous Intradiscal Electrothermal & RF Annuloplasty, Biacuplasty, Intraosseous Basivertebr
- Peroral Endoscopic Myotomy
- Repository Corticotropin Injection (Acthcar Gel)
- Skilled Nursing Facility Guidelines
- Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy
- Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease

Medical policies for Blue Advantage members are now available on our Blue Advantage Resources page online at www.lablue.com/providers >Blue Advantage Resources >New/Revised Medicare Advantage Medical Policies.

Compliance Reminders

As a Blue Advantage provider, you are required to:

- Follow the provider guidelines in your provider manual when discussing Medicare Advantage.
- Routinely check for exclusions by the OIG/GSA (Office of Inspector General/General Services Administration).
- Report any actual or suspected compliance concerns.
- Notify us of any practice information changes.
- Verify that provider training has been completed in:
  - General compliance
  - Fraud, waste and abuse

CMS offers more information on compliance that you can access through the Blue Advantage Provider Portal. Under the “Forms & Resources” section, click on “Compliance Program,” under “Helpful Links” then “CMS Medicare Compliance and Fraud, Waste and Abuse Training.”

Blue Advantage Provider Portal

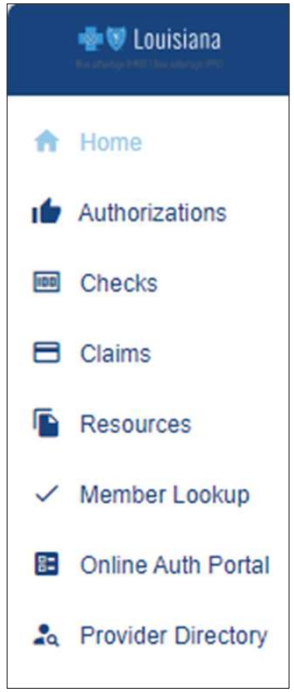
- Claims Inquiry
- Member Eligibility
- Provider Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more

The Blue Advantage Provider Portal is available through iLinkBlue (www.lablue.com/ilinkblue) >Blue Advantage under “Other Sites.”

Accessing the Blue Advantage Provider Portal

Provider Portal Login

Once registration is complete, providers will be able to login and access all **available** portal features.



Provider Portal Features

To access the Blue Advantage Provider Portal, visit www.lablue.com/ilinkblue, then click on “Blue Advantage” under the “Other Sites” section and select the option to log in.

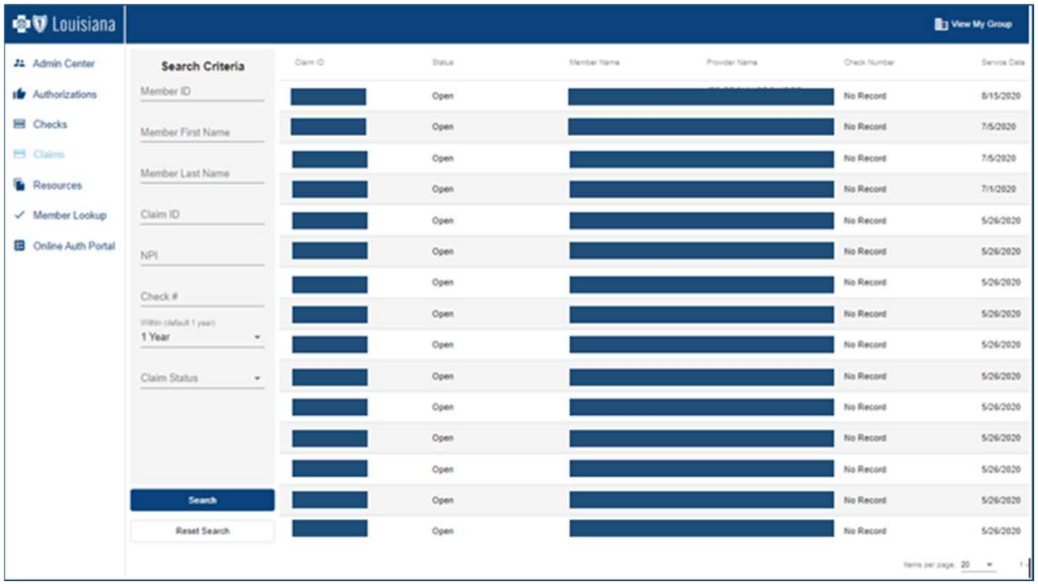
Checking Claim Status

Use the Claim Inquiry tool (available on the Blue Advantage Provider Portal) for standard claims status checks.

- There are multiple ways to inquire about a claim listed in the *Blue Advantage Provider Administrative Manual*.

For each claim listed, the portal screen will display:

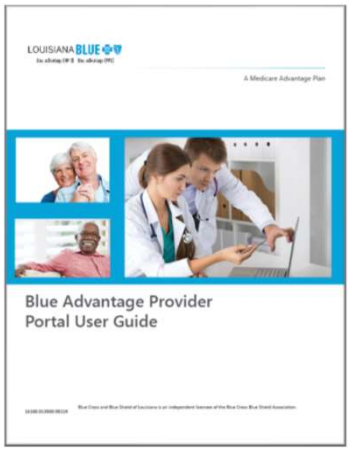
- Claim number
- Date(s) of service
- Provider name
- Member name
- Claim status
- Date of claim status
- Payment amount



If the status of the claim is "**In Process**," you will not be able to review the summary.

Blue Advantage Manuals and Guides

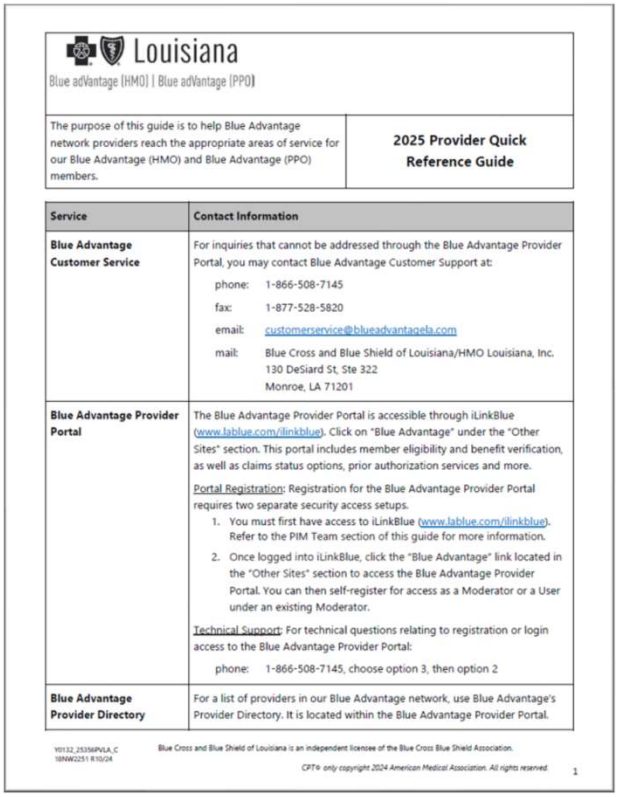
- Policies
- Procedures
- Reference information required of our Blue Advantage network providers



- How to access and register for the portal
- Overview of portal features
- Troubleshooting

Available on both the Blue Advantage resource page and Provider Portal. To access the Blue Advantage Provider Portal, visit www.lablue.com/ilinkblue, then click on “Blue Advantage” under the “Other Sites” section and select the option to log in.

Blue Advantage Manuals and Guides



Louisiana
Blue adVantage (HMO) | Blue adVantage (PPO)

The purpose of this guide is to help Blue Advantage network providers reach the appropriate areas of service for our Blue Advantage (HMO) and Blue Advantage (PPO) members.

2025 Provider Quick Reference Guide

Service	Contact Information
Blue Advantage Customer Service	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at: phone: 1-866-508-7145 fax: 1-877-528-5820 email: customerservice@blueadvantagela.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. 130 DeSiard St, Ste 322 Monroe, LA 71201
Blue Advantage Provider Portal	The Blue Advantage Provider Portal is accessible through iLinkBlue (www.lablue.com/ilinkblue). Click on "Blue Advantage" under the "Other Sites" section. This portal includes member eligibility and benefit verification, as well as claims status options, prior authorization services and more. Portal Registration: Registration for the Blue Advantage Provider Portal requires two separate security access setups. 1. You must first have access to iLinkBlue (www.lablue.com/ilinkblue). Refer to the PIM Team section of this guide for more information. 2. Once logged into iLinkBlue, click the "Blue Advantage" link located in the "Other Sites" section to access the Blue Advantage Provider Portal. You can then self-register for access as a Moderator or a User under an existing Moderator. Technical Support: For technical questions relating to registration or login access to the Blue Advantage Provider Portal: phone: 1-866-508-7145, choose option 3, then option 2
Blue Advantage Provider Directory	For a list of providers in our Blue Advantage network, use Blue Advantage's Provider Directory. It is located within the Blue Advantage Provider Portal.

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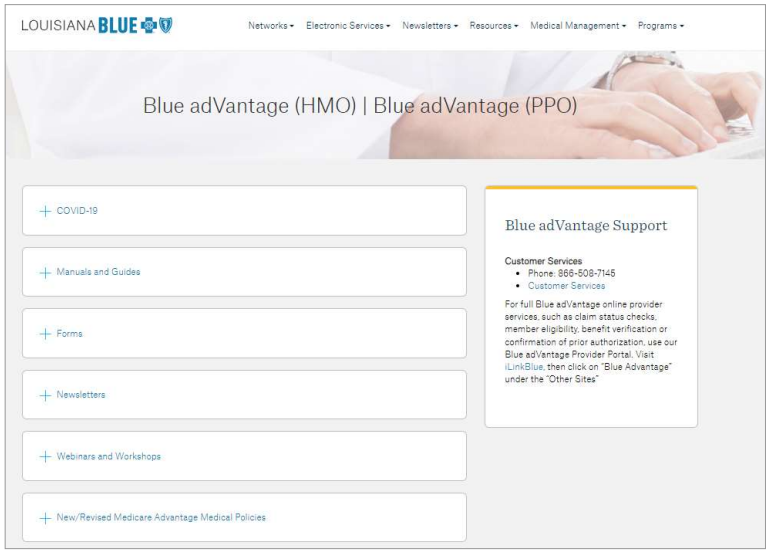
- Key information about the Blue Advantage Networks
- Services requiring authorization, including Part B drugs
- Information on our Blue Advantage electronic tools
- Blue Advantage Department phone numbers and/or email addresses

Available on both the Blue Advantage resource page and Provider Portal**.** To access the Blue Advantage Provider Portal, visit www.lablue.com/ilinkblue, then click on “Blue Advantage” under the “Other Sites” section and select the option to log in.

Blue Advantage Resources Page



Resources that can be found on this page:

- Manual
- Authorization guide
- Forms
- Newsletters
- Webinars/workshops

Designed to give providers access to the most current Blue Advantage resources www.lablue.com/providers >Blue Advantage Resources.

Provider Relations

Jami Zachary Director

Paden Mouton Provider Relations Manager

Mary Reising Provider Relations Health System Representative

Brittney Brooks
Acadia, Allen, Cameron, Evangeline, Iberia, Jefferson Davis, St. Charles, St. Mary, St. John the Baptist, St. Landry, Vermillion

Marie Davis Senior Provider Relations Representative
Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll

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

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

Melonie Martin
Ascension, East Baton Rouge, West Baton Rouge

Lisa Roth
Online Portal Training

Amber Strahan
Assumption, Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn

Mary Catherine Vial
Calcasieu, Lafayette

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

Provider Contracting

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

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

Jordan Black, Sr. Provider Network Development Representative – jordan.black@lablue.com
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@lablue.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension and Iberville parishes

Cora LeBlanc, Sr. Provider Network Development Representative – cora.leblanc@lablue.com
Assumption, St. John The Baptist, Terrebonne, St. Mary, Lafourche, St. Charles, St. James, St. Tammany, Tangipahoa and Washington parishes

Dayna Roy, Sr. Provider Network Development Representative – dayna.roy@lablue.com
Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Grant, Jefferson Davis, Rapides and Vernon parishes

Lauren Viola, Provider Network Development Representative – lauren.viola@lablue.com
Jackson, Lincoln, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula and Lasalle parishes

Kim Jones, Provider Network Development Representative – kim.jones@lablue.com
Caddo, Bossier, Webster, Claiborne, Desoto, Red River, Bienville, Sabine, Natchitoches and Winn parishes

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

Doreen Prejean **Mary Landry** **Karen Armstrong**

Provider Credentialing & Data Management

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

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

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

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

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Questions?

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Addendum

Provider Appeals

Standard	Expedited
Determination and member notification provided within 14 days of receipt (non-emergent/urgent care).	Determination and member notification provided within 72 hours of receipt (emergent/urgent care).
Favorable – member and provider notified verbally or in writing within 14 days of request.	Favorable – member and provider notified verbally or in writing within 72 hours of request.
Partially Favorable or Denied – member and provider notified verbally or in writing within 14 days of receipt.	Partially Favorable or Denied – member and provider notified verbally or in writing within 72 hours of receipt.
Integrated Denial Notice (IDN) mailed to member within three days of oral communication.	Integrated Denial Notice (IDN) mailed to member within three days of oral communication.

Contracted providers can submit an appeal only when it involves a pre-service request, and the member sent written Notice of Right to an Expedited Appeal.

Helpful Hints for Accessing the Blue Advantage Provider Portal

- For additional details on how to register for the Blue Advantage Provider Portal, download the *Blue Advantage Portal User Guide*. Go to www.lablue.com/ilinkblue then click “Blue Advantage” under the “Other Sites” section.
- We recommend using Google Chrome to access the Blue Advantage Provider Portal.
- The new portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.
- For additional information, please see the “Troubleshooting” section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

Billing Reminders

- Blue Advantage Ambulatory Surgical Center (ASC) claims must be submitted on a CMS-1500. The ASC's NPI should be listed as the rendering provider as well.
- When a member is seen by a hospital-based provider:
  - Providers must include POS 19 **or** 22 when services are rendered in hospital-based clinic.
    - *Note: site of service reduction will be applied to the professional fee.*
  - Facilities must bill these services under revenue code 510 **or** 761.
  - Member's cost share will apply to the professional charge only.
- When billing diagnostic services on the same day as an office visit, providers should bill **both** services on the same claim form.
- When billing anesthesia services, providers must include the appropriate modifiers in accordance with CMS guidelines.
- All nurse practitioners, physician assistants and other physician extenders must be identified on the claim **with their own NPI**.

Refer to www.cms.hhs.gov for specific details.

EFTs and ERAs for Blue Advantage Claims

Louisiana Blue processes electronic funds transfer (EFT) and electronic remittance advice (ERA) 835. Therefore, all Blue Advantage claims payments will be made through Louisiana Blue.

For questions about EFT and ERA, please contact our EDI Department at EDIservices@lablue.com or by phone at 1-800-716-2299, option 3.

Blue Cross Processing Electronic Transactions for Blue Advantage

HIPAA 837 and 27x electronic transactions for Blue Advantage are managed by Louisiana Blue.

New Hostname	Use the Blue Cross SFTP application (MessageWay) server hostname mft.lhec.net for batch submissions.
New Batch File Naming Requirements	Submit all batch files with the first three positions of the file name as “BAM” for Blue Advantage. Not including these three-letters at the beginning of the file name will result in the claims routed incorrectly and rejected.
Payor ID	72107
Real Time rules for 2100A Loop	Real Time requests must be submitted to the following URL: www.bcbsla.com/realtimesubmission/realtimesubmission.aspx. Trading partners must submit the 27x real-time transactions using the following rules for the 2100A loop in the 270/276 request: • NM101 = PR • NM103 = BAM • NM108 = PI • NM109 = 72107
ISA06-Interchange Sender ID/Trading Partner ID	ISA06 is the Trading Partner number assigned by Louisiana Blue. ISA06 field is a fixed length requiring 15 positions and must be left justified. ISA06 must be identical to GS02.
ISA08-Interchange Receiver ID/BCBSLA	ISA08 must be BCBSLA001. The field is fixed length requiring 15 positions and must be left justified.

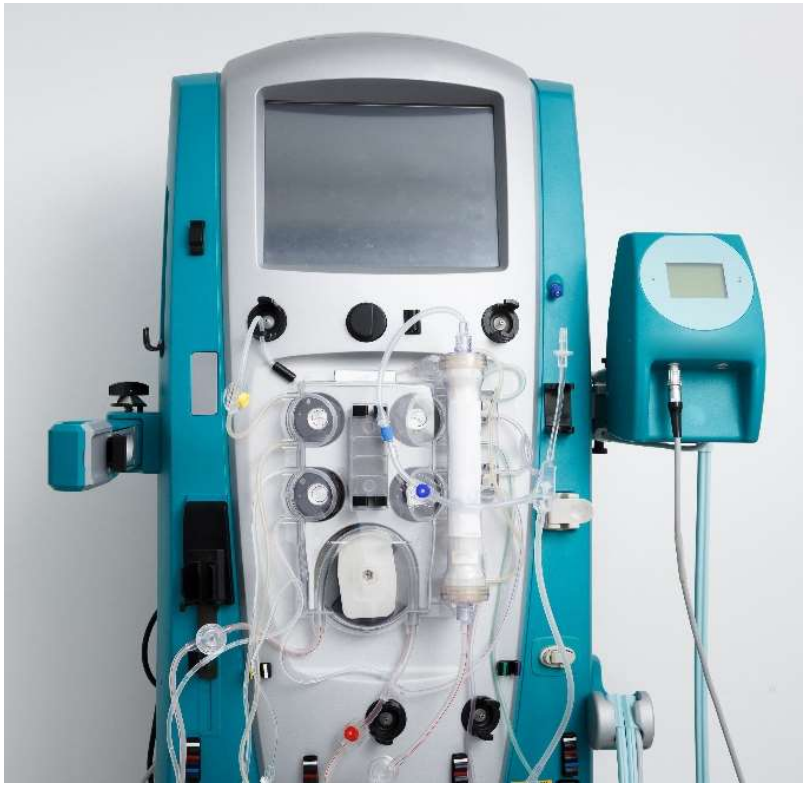
Fraud, Waste and Abuse

- Blue Advantage defines fraud, waste and abuse as follows:
- Fraud is the knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.
- Waste is the overuse of services that, directly or indirectly, results in unnecessary costs.
- Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss to the plan. Abuse usually does not involve a willful intent to deceive.
- Providers can review Blue Advantage's program, code of conduct and the provider's responsibility relative to the Compliance Program by visiting the Blue Advantage Provider Portal (www.lablue.com/providers >Blue Advantage Resources). Look under the Resources >Compliance section.

For more on these issues, please see the Compliance/Fraud, Waste and Abuse "Plan Contact Information" section in the *Blue Advantage Provider Administrative Manual*.

Dialysis Patients

- Dialysis providers initiating hemodialysis for ESRD patients must enter the CMS-2728 form into the CMS system, CROWNWeb.
- Once entered into the system, the provider must print the form, sign it, then have the member sign and mail it to the Social Security Administration office.



The CROWNWeb is located at https://mycrownweb.org.

Appointment Scheduling & Waiting Time Guidelines for PCPs

Blue Advantage network PCPs should make their best effort to adhere to the following standards for appointment scheduling and waiting time.

PCP-New Patient	Within 30 days of the patient's effective date on the PCP's panel – to be initiated by the PCP's office.
Routine Care without symptoms	Within 30 days.
Non-routine Care with symptoms	Within five business days or one week.
Urgent Care	Within 24 hours.
Emergency	Must be available immediately 24 hours per day, seven days per week via direct access or coverage arrangements.
OB/GYN	First and second trimester within one week. Third trimester within three days. OB emergency care must be available 24 hours per day, seven days per week.
Phone calls into the provider office from the member	Same day; no later than next business day.

Medical Record Retention and Requests

Specific documentation requirements can be found in the *Blue Advantage Provider Administrative Manual* in the "Medical Records" section.

The guidelines for the maintenance of medical records state they must be:

- Retained for a minimum of 10 years.
- Contain consistent and complete documentation of each member's medical history and treatment.

Medical record request:

- Should be responded to within 10 days of the request.

  When members change their PCP and request a transfer of their medical records, the provider has 10 business days of the request to forward the records.

Note: Providers are contractually responsible for sending medical records without charge.

Case Management Services

Case management programs seek to maximize the quality of care, member satisfaction and efficiency of services through effective engagement with members and their providers.

How we do it:

- Education and support of members and family/caregivers, including self-management
- Coordination of care
- Medication adherence
- Fall prevention and safety
- Access to community resources
- Advance care planning
- Telephonic outreach

For a list of conditions and complex diseases that often benefit from the case management program, see the *Blue Advantage Provider Administration Manual*, available on the Blue Advantage Provider Portal, (www.lablue.com/ilinkblue) >Blue Advantage (under “Other Sites”).

Subrogation

- Blue Advantage subrogates with other liability carrier to recoup CMS funds.
- Conditional payments are made, which allows recoupment when a settlement is reached.
- Blue Advantage allowable charges apply.
- Claims that contain potential third-party liability (TPL) will be paid by Blue Advantage on a conditional basis, which permits us to recoup any payments if/when a settlement is reached.