LOUISIANA BLUE

Blue adVantage (HMO) and Blue adVantage (PPO)

BLUE ADVANTAGE PROVIDER ADMINISTRATIVE MANUAL



2027

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INTRODUCTION

Welcome to Blue Advantage

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

This Blue Advantage Provider Administrative Manual is intended to be used as a guide to assist providers in delivering covered services to Blue Advantage members. This manual contains policies, procedures and general reference information, including minimum standards of care, which are required of Blue Advantage providers and govern the administration of the Medicare Advantage and Prescription Drug (MA-PD) plans. The information in this manual offers general guidelines that are applicable to both Blue Advantage (HMO) and Blue Advantage (PPO) benefit plans except where noted. This manual also contains a brief summary of Louisiana Blue's Blue Advantage plans and an overview of the MA-PD. When this manual says "we," "us" or "our," it means Blue Cross and Blue Shield of Louisiana or its subsidiary, HMO Louisiana, Inc. When it says "plan" or "our plan," it means both Blue Advantage plans. Information contained in this manual that applies to only Blue Advantage (HMO) or Blue Advantage (PPO), will be noted accordingly.

This information is provided to promote an effective understanding of Louisiana Blue's Blue Advantage operations and supplements the provider participation contract. This manual is available on the **Louisiana Blue Provider Page** at www.lablue.com/providers, clicking on "Go to BA Resources," and then select "Manuals and Guides." The contact information is in the Plan Information Contact List located in the front of this manual.

Louisiana Blue may revise this manual to reflect changes in policies and procedures as necessary to comply with applicable law, rules and regulations. Network providers will be notified of any such revision(s) including effective date(s).

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Plan Information Contact List

Service	Contact Information
Blue Advantage Customer Service	For inquiries that cannot be addressed through iLinkBlue (www.lablue.com/ilinkblue), you may contact Blue Advantage Customer Support at: **phone:** 1-866-508-7145 **fax:** 1-877-528-5820 **email:** customerservice@blueadvantagela.com **mail:** Louisiana Blue Medicare Advantage P.O. Box 98004 Baton Rouge, LA 70898-9030
Blue Advantage Provider Directory	For a list of providers in Louisiana Blue's Blue Advantage network, use Blue Advantage's Provider Directory. It is available online at https://blueadvantage.lablue.com >Find a Doctor or Drug.
Authorizations (including Part B Drugs) • **Utilization Management Programs** • **Inpatient** • **Outpatient** • **Behavioral Health** • **Home Health** **1-866-508-7145 choose option 3, then option 2**	Blue Advantage requires providers to submit prior authorization requests, including new requests and extensions, through our online Louisiana Blue Authorizations application or by fax. To request prior authorization for services, providers may use Louisiana Blue's authorizations application that is available on iLinkBlue (www.lablue.com/ilinkblue) or fax completed Blue Advantage authorization request forms to our authorizations department. Exceptions include transplants, dental services covered under medical, and most out-of-state services. **Utilization Management Programs:** Utilization Management Programs use the Carelon application for our high-tech imaging, cardiology, genetic testing, musculoskeletal (MSK) and radiation therapy for oncology programs. This is the Carelon MBM Provider Portal, which is available under the "Authorizations" section of iLinkBlue (www.lablue.com/ilinkblue).

Service	Contact Information
Authorizations (continued) Note: Services and related procedure codes subject to Blue Advantage medical policies require prior authorization before services are rendered. Please refer to the *Blue Advantage Quick Reference Guide* for the complete lists of services that require prior authorization. The guide is available on the Provider page at www.lablue.com/providers >Blue Advantage Resources >Manuals and Guides.	For our Utilization Management programs: **Phone:**1-866-455-8416 **Fax by Program:** • High Tech Imaging & Cardiology: 1-800-610-0050 • Cardiology: 1-800-610-0050 • Radiation Therapy for Oncology: 1-888-222-7130 • Genetic Testing: 1-844-425-3736 • MSK (musculoskeletal): 1-844-425-3738 **Inpatient Services:** Submit completed requests electronically through iLinkBlue using the Louisiana Blue Authorizations application or download the Inpatient Authorization Request Form from our Provider page at www.lablue.com/providers >Blue Advantage Resources >Forms. Fax the completed form to the Blue Advantage Authorizations Department: **fax:** 1-877-528-5818 *(please include all supporting clinical information)* **Outpatient Services:** Submit completed requests electronically through iLinkBlue using the Louisiana Blue Authorizations application or download the Outpatient Authorization Request Form from our Provider page at www.lablue.com/providers >Blue Advantage Resources >Forms. Fax the completed form to the Blue Advantage Authorizations Department: **fax:** 1-877-528-5816 *(please include all supporting clinical information)* **Medical Drugs:** For Medical Benefit Drug Authorizations: • Targeted Medications – Care Continuum at 1- 888-278-9749 • Non-targeted Medications – Blue Advantage at 1-866-508-7145 choose option 3, then option 2

Service	Contact Information
Authorizations (continued)	**Behavioral Health Services:** Submit completed requests electronically through iLinkBlue using the Louisiana Blue Authorizations application or download the Behavioral Health Authorization Request Form from our Provider page at www.lablue.com/providers >Blue Advantage Resources >Forms. Fax the completed form to the Blue Advantage Authorizations Department: **fax:** (318) 812-6249 *(please include all supporting clinical information)* **Home Health Services:** Submit completed requests electronically through iLinkBlue using the Louisiana Blue Authorizations application or download the Home Health Authorization Request Form from our Provider page at www.lablue.com/providers >Blue Advantage Resources >Forms. Fax the completed form to the Blue Advantage Authorizations Department: **fax:** (318) 812-6265 *(please submit all supporting clinical information)*
Case Management	For assistance with case management, contact the Blue Advantage Case Management Department at: **phone:** 1-866-508-7145, option 3 **fax:** (318) 812-6250
Compliance/ Fraud, Waste and Abuse	To learn more about Blue Advantage's program, code of conduct and the provider's responsibility relative to the Compliance Program, including required training and reporting any suspected or actual violation of regulations, laws, policies or procedures. Visit the Blue Advantage website at https://blueadvantage.lablue.com >Compliance >Report Fraud, Waste & Abuse for additional information. **Compliance and Ethics Hotline:** **phone:** 1-800-973-7707 **fax:** (225) 295-2599 **email:** compliance.office@lablue.com

Service	Contact Information
	mail: Blue Advantage Compliance P.O. Box 84656 Baton Rouge, LA 70884-4656 **Fraud, Waste and Abuse Hotline:** **phone:** 1-800-392-9249 **fax:** (225) 295-2518 **email:** blueadvantageFWA@lablue.com **fraud form:** https://blueadvantage.bcbsla.com/home/reportfwa
Dental	Blue Advantage members use United Concordia (UCD) for preventive and basic dental coverage. Providers must be contracted directly with UCD to be in-network for members: **phone:** 1-866-445-5825 **mail:** (*claims* address) United Concordia P.O. Box 69441 Harrisburg, PA 17106-9420
EDI Services	Claims may be submitted electronically to Louisiana Blue directly from your office or through an approved clearinghouse. For more information about filing claims electronically and/or approved clearinghouse locations, please contact our EDI Customer Operations: **email:** EDIservices@lablue.com **phone:** 1-800-716-2299, option 3
Fitness Program	With SilverSneakers®, you get more than just a no-cost gym membership. You also get: • Access to nationwide fitness locations* • SilverSneakers LIVE online classes • 200+ On-Demand workout videos

Service	Contact Information
	• SilverSneakers GO mobile app • Community classes in neighborhood locations • Online fitness and nutrition tips *Participating locations vary. See plan details for more info. Participating locations (PL) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Inclusion of specific PLs is not guaranteed and PL participation may differ by health plan. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. SilverSneakers is an independent company that administers fitness benefits for Blue Cross and Blue Shield of Louisiana. **SilverSneakers**: **website:** SilverSneakers.com/StartHere **phone:** 1-888-423-4632 (TTY:711) **hours:** Monday-Friday 8 a.m. – 8 p.m. ET
Hearing	Blue Advantage offers special pricing on high-quality prescription hearing aids from top manufacturers through TruHearing®. Contact TruHearing via: **phone:** 1-833-723-2280 (TTY:711) **hours:** Monday-Friday 8 a.m. – 8 p.m.
iLinkBlue	Through iLinkBlue, you can research member eligibility and benefit verification, as well as claims status options, prior authorization services and more. **Registration**: Registration for iLinkBlue 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.

Service	Contact Information
	2. If you do not have access to iLinkBlue, you must register an administrative representative to manage user access. To access the administrative representative documents: ○ For the iLinkBlue packet, visit www.lablue.com/providers >Electronic Services >Learn About iLinkBlue. ○ For more on registering an administrative representative, visit www.lablue.com/providers >Designate Your Rep. For technical questions relating to registration or login access, please refer to the EDI section.
Pharmacy (for Part D Prescriptions)	Submit Part D Drug Coverage Determination and Appeal requests to Express Scripts, Inc. (ESI). **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 **website:** www.covermymeds.com www.express-path.com Blue Advantage members with Part D use the Express Scripts, Inc. pharmacy network. For a comprehensive list of participating pharmacies, use the provider/pharmacy directory at https://blueadvantage.lablue.com >Find a Doctor or Drug.
Provider Contracting	For questions on how to join the Blue Advantage provider networks: **email:** provider.contracting@lablue.com **phone:** 1-800-716-2299, option 1
Provider Credentialing & Data Management	Credentialing packets and criteria are available on our Provider page at www.lablue.com/providers >Network Enrollment >Join Our Networks. To change your address, phone number, Tax ID number, etc., please visit

Service	Contact Information
	www.lablue.com/providers, choose "Resources, then "Forms." Select a link based on the type of change you are making to access the applicable update form. For more information on our credentialing and data management process, including frequently asked questions, visit www.lablue.com/providers, choose "Network Enrollment," then "Join Our Networks," and select "Professional Providers" or "Hospitals and Facilities." For PCDM status: **email:** PCDMstatus@lablue.com **phone:** 1-800-716-2299, option 2, option 1 For recredentialing: **email:** recredentialing@lablue.com **phone:** 1-800-716-2299, option 2, option 2
Provider Disputes	Participating provider claims disputes can be submitted electronically using an online provider dispute form accessed through iLinkBlue (www.lablue.com/ilinkblue). You will have an option to open the electronic dispute form when viewing a claim on iLinkBlue. To view processed claims in iLinkBlue, go to the Claims menu option. Then select "Claims Status Search" and use the Paid/Rejected tab to search for a claim.
Provider Identity Management Team (PIM)	PIM is a dedicated team that helps establish and manage system access to our secure electronic services, including the setup process for administrative representatives. **email:** PIMteam@lablue.com **phone:** 1-800-716-2299, option 5
Provider Relations	Provider Relations representatives assist network providers with detailed and complex issues that have not been resolved through iLinkBlue or by Customer Service. **email:** provider.relations@lablue.com

Service	Contact Information
Reference Laboratories	For a list of participating laboratory providers, use Blue Advantage's Provider Directory located at https://blueadvantage.lablue.com >Find a Doctor or Drug.
Vision	Louisiana Blue directly processes vision claims for routine eye care and vision services coverage. Vision providers should use the standard claims filing process for these claims. For Non-Medicare Covered Eyewear, member allowances loaded onto the Blue Advantage Flex Card should be used for payments. Claims should not be submitted directly to Louisiana Blue.
Who Do I Contact if I Have Questions?	For claims status, member eligibility, benefit verification and care management questions that cannot be addressed through iLinkBlue, Blue Advantage network providers may contact Blue Advantage Customer Service at 1-866-508-7145.

Our Mission

To improve the health and lives of Louisianians.

Our Vision

A better state of health through preventative, easier and more affordable healthcare.

Our Goals

- Create a healthy Louisiana.
- Make healthcare affordable for members.
- Deliver the cutting-edge experience our customers expect.
- Keep our company strong.

General Information

Our Products

Blue Advantage (HMO) and Blue Advantage (PPO) offer Medicare recipients an excellent alternative to the options they currently have available with a comprehensive benefit package that covers more than original Medicare. Members have coverage available for a wide array of services, including outpatient prescription drug coverage, hospitalization, home care, and preventive care services, given that the service(s) obtained by the member are medically necessary and rendered by a participating provider.

Our plan does offer a Point of Service (POS) option for certain services. All services obtained from out-of-network providers require prior authorization (except emergency services, supplemental dental services, supplemental vision services, supplemental hearing services, urgently needed care when the network is not available and dialysis outside the plan's service area) and are subject to an out-of-network deductible and out-of-network coinsurance with a maximum for out-of-network benefit coverage.

Blue Advantage members may be responsible to pay a copayment or coinsurance for some covered services. Blue Advantage plans are available to Louisiana residents statewide.

Provider Preclusion List

To ensure patient protections and safety, the U.S. Centers for Medicare & Medicaid (CMS) will make available a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. This Preclusion List replaces the Medicare Advantage prescriber enrollment requirements. CMS makes the Preclusion List available to MA Plans and Part D sponsors and requires denial of payment for a healthcare item or service furnished by an individual or entity on the Preclusion List.

Impacted providers or prescribers should receive an email and a letter from CMS in advance of inclusion on the Preclusion List. The letter will contain the reason for preclusion, the effective date of preclusion and applicable rights to appeal.

For more information about this change, please see the Preclusion List homepage on www.CMS.gov.

Blue Advantage Member ID Cards

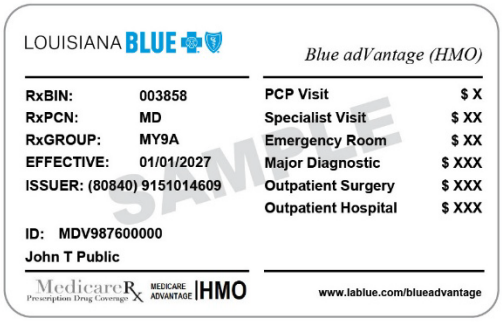
Louisiana Blue provides each Blue Advantage member with an identification (ID) card. This card contains demographic information about the covered member, as well as important coverage information such as copayment or coinsurance responsibilities and important phone numbers.

Louisiana Blue encourages Blue Advantage providers to make a copy of the member's ID card for their records. We also encourage you to confirm if the member's insurance coverage has changed and if you are their primary care provider (PCP) each time you see them. The date on the card represents their effective date with the plan, not necessarily the effective date with the PCP.

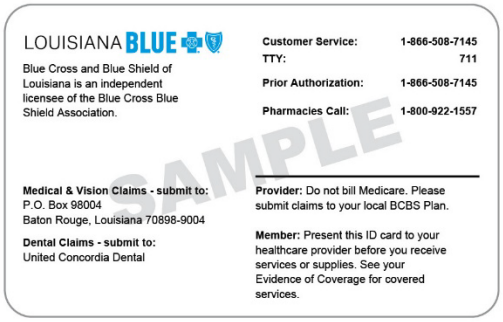
Use iLinkBlue to confirm member eligibility, current assigned PCP, maximum out-of-pocket and coordination of benefits (COB) information. It is the member's responsibility to present his or her member ID card at the time medical services are obtained. If you are not the member's assigned PCP, you can still see the member, and we will pay the claim. The member should contact Blue Advantage Customer Service to change their PCP of record, as needed.

Blue Advantage (HMO)

Blue Advantage (HMO) ID cards include the prefix of **MDV** for HMO coverage. Blue Advantage (HMO) members must use Blue Advantage network providers except for select situations such as emergency care. Below is an example of the Blue Advantage (HMO) member ID card.



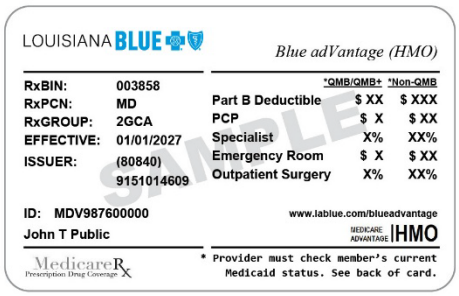
front



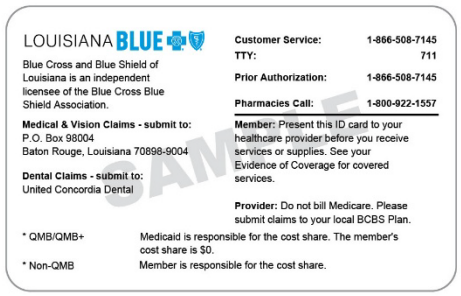
back

Blue Advantage Dual Plus (HMO-POS)

Blue Advantage Dual Plus (HMO-POS D-SNP) is a Blue Advantage (HMO) product and available to our members with a dual coverage (Medicaid and Medicare Advantage) special needs product (SNP). It includes the prefix **MDV**. It is available to Blue Advantage (HMO) members who are Qualified Medicare Beneficiary without other Medicaid (QMB), Qualified Medicare Beneficiary without other Medicaid Plus (QMB+), Specified Low-Income Medicare Beneficiary without other Medicaid Plus (SLMB+) or full benefit dual eligible (FBDE) for this plan. Blue Advantage Dual Plus includes supplemental benefits for items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the plan in addition to what Medicare covers.



front



back

Blue Advantage (PPO)

Blue Advantage (PPO) ID cards include the prefix of **NMV** for PPO coverage. Members with Blue Advantage (PPO) coverage have access to services provided by out-of-network providers; however, cost sharing may be greater when services are obtained out-of-network. Below is an example of Blue Advantage (PPO) member ID card.



front



back

Blue Advantage Member Rights and Responsibilities

Each Blue Advantage member has the right to:

- Be treated with dignity, respect and fairness at all times.
- Receive advice or assistance in a prompt, courteous and responsible manner.
- Confidentiality. All information concerning enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing. Blue Advantage members are entitled to access their medical records according to state and federal law free of charge; and with adequate notice, they have the right to review their medical records with their provider. Blue Advantage members also have the right to ask plan providers to make additions or corrections to their medical records.
- Choose a Blue Advantage-contracted primary care provider (PCP). Members are asked to establish an ongoing relationship with their PCP. Blue Advantage members have the right to change providers at any time and for any reason.
- Get appointments and services within a reasonable amount of time (see Appointment Scheduling and Waiting Time Guidelines section of this manual for more information).
- Participate fully in decisions about their healthcare and have providers explain things in a way they can understand. This includes knowing all treatment choices recommended for the condition, no matter what they cost or whether they are covered by Blue Advantage.
- Ask someone such as a family member or friend to help with decisions about healthcare. To have a guardian or legally authorized person exercise their rights on their behalf if their medical condition makes them incapable of understanding or exercising their rights.
- Make a complaint if they have concerns or problems related to coverage or care.
- Receive information about Blue Advantage, its services, its participating physicians and other healthcare providers providing care and members' rights and responsibilities.
- Discuss healthcare concerns or complaints about Blue Advantage with those responsible for their care or with Louisiana Blue representatives and to receive a response within a reasonable time period.

Cultural Competency

Cultural competency is a set of interpersonal skills that allows individuals to increase their understanding, appreciation, acceptance and respect for cultural similarities and differences, and to understand how these differences influence relationships and interactions with members. Members are entitled to dignified, appropriate and quality care, with sensitivity to cultural differences.

Network providers must ensure the following:

- Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the member's race/ethnicity and language and its influence on the member's health or illness.
- Office staff that routinely comes in contact with members has access to and participates in cultural competency training and development.
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific information. Staff will also explain race/ethnicity categories to a member so the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed, and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have printed and posted materials in English and all other prevalent non-English languages if required.

Member Orientation

Blue Advantage customer service representatives are available to assist members once they have enrolled in the plan. These representatives can provide a variety of information to the member. Members may contact Blue Advantage Customer Service with questions, regarding such topics as:

- The role of the PCP
- How to access a specialist
- Criteria for emergency room coverage
- Use of their member ID card
- Medical and prescription drug benefits

If you believe your patient is confused about their benefits or has general questions about the plan, you may call Blue Advantage Customer Service on the patient's behalf and request that a representative call the member to assist the individual. The contact information is in the Plan Information Contact List located in the front of this manual.

Network Participation

Credentialing Program Overview

Louisiana Blue fully credentials providers who apply for network participation. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC). All provider information obtained during the credentialing process is considered highly confidential.

Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers. Participation is available for **professional** providers and **facilities**.

Credentialing Packets

The credentialing packets and criteria are available on our Provider page at www.lablue.com/providers. Choose "Network Enrollment," then "Join Our Networks," then select "Professional Providers" or "Facilities and Hospitals" to find the applicable credentialing packet. All packets to create a new provider record include an application for iLinkBlue and Electronic Funds Transfer. iLinkBlue is our secure online tool for professional and facility healthcare providers.

When a request or application is received that is incomplete or missing information, a notification will be sent to the provider of the incorrect or missing information. A new request/application will need to be submitted through DocuSign®. The processing time will begin again when the new completed request or application is received.

Credentialing Program

Louisiana Blue's credentialing program includes **initial credentialing** as well as **recredentialing** every three years.

For more information on our credentialing and data management process, including frequently asked questions, visit www.lablue.com/providers, choose "Network Enrollment, then "Join Our Networks" and select "Professional Providers" or "Facilities and Hospitals."

Initial Credentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. When a fully completed credentialing packet and required supporting documentation are received, the credentialing process can take up to 90 days. Our credentialing staff verify the provider's credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to our policies and procedures and URAC standards.

Providers will remain nonparticipating in our networks until their application has been approved by the Louisiana Blue Credentialing Committee. Once approved by the credentialing committee, providers will remain nonparticipating until they sign and execute an agreement through our Contracting Department for participation. If the provider is joining a group with an existing agreement(s), they will become a participating provider.

After 90 days, providers may inquire about their credentialing status by contacting the Provider Credentialing & Data Management Department at PCDMstatus@lablue.com. If the provider's request to become credentialed is denied by the Credentialing Committee, the provider may request participation into the Plan's networks again no earlier than one year from the Credentialing Committee's final decision date.

Recredentialing

After the initialing credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. Louisiana Blue reserves the right to initiate the recredentialing process at any point during the 36-month credentialing cycle. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by our Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Credentialing Committee

Our Credentialing Committee meets to review credentialing twice per month. Based upon compliance with the criteria below, the Credentialing Committee reviews the provider's credentials to ascertain compliance. The Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's credentialing packet.

All participating providers must maintain these criteria (as applicable for provider type) on an ongoing basis:

- Unrestricted license to practice medicine in Louisiana as required by state law.
- Agreement to participate in the Blue Advantage networks.
- Professional/malpractice liability insurance that meets required amounts.
- Malpractice claims history that is not suggestive of a significant quality of care problems.
- Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours.
- Absence of patterns of behavior to suggest quality of care concerns.
- Utilization review pattern consistent with peers and congruent with needs of managed care.
- No sanctions by either the state or federal Medicaid or Medicare programs.
- No disciplinary actions.
- No convictions of a felony or instances where a provider committed acts of moral turpitude.
- No current drug or alcohol abuse.

Professional Credentialing

Professional providers requesting network participation must complete the initial professional credentialing application packet, which includes a checklist of required documents.

Louisiana Blue only accepts the Council for Affordable Quality Healthcare (CAQH) credentialing application from professional providers requesting to participate in our networks. Submit your CAQH ID using the CAQH credentialing packet found on our Provider page at www.lablue.com/providers >Network Enrollment >Join Our Network >Professional Providers >Join Our Network. All providers, regardless of network participation, must include their NPI(s) on the application.

Professional Provider CLIA Certification

Professional providers who perform laboratory testing procedures in the office are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

PCP Definition

Louisiana Blue recognizes the specialties of family practice, general practice, geriatrics, internal medicine and pediatrics as a Blue Advantage network primary care provider (PCP) when the provider practices in a full primary care capacity. Mid-level practitioners practicing in this capacity

should indicate on the credentialing packet or Individual/Group Provider Update Request Form that they are practicing as a PCP.

Reimbursement During Credentialing (for professional providers only)

Professional healthcare providers that meet certain criteria can be reimbursed for claims at network allowable charges and member benefit options during the credentialing process, with claims paid directly to the provider. Louisiana Blue 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. For example: a nurse practitioner applying for network participation must be joining a provider group that already has an executed allied health agreement on file.
- 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.

If these criteria are met, reimbursement during credentialing will be granted if applicable to the network, with an effective date up to one month prior to the receipt of a clean credentialing packet.

Practitioner Rights

Professional providers have a right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing board) to support their credentialing application. Louisiana Blue is not required to make available any references, recommendations or peer-reviewed protected information.

Facility Credentialing

Facilities requesting network participation must complete the initial facility credentialing application packet, which includes a checklist of required documents as well as the Facility Credentialing Application. Select facility types must also complete a Facility Information Form attachment:

- Facility Information Form A: Ambulance Company
- Facility Information Form B: DME Supplier or Pharmacy

- Facility Information Form C: Ambulatory Surgical Center, Birthing Center Hospital, IOP/PHP, CDU, Psychiatric, Home Health, Hospice, Skilled Nursing Facility, Long Term Acute Care or Rehabilitation Center
- Facility Information Form D: Urgent Care Clinic/Walk-in Clinic
- Facility Information Form E: Diagnostic Radiology (free-standing)
- Facility Information Form F: Retail Health Clinics
- Facility Information Form G: Laboratory
- Facility Information Form H: Outpatient Cath Lab

Facility Rights

Facilities have a right to review information obtained from outside sources (e.g., occupational or state licensing boards) to support their credentialing application. Louisiana Blue is not required to make available any references, recommendations or peer-reviewed protected information.

Facility CLIA Certification

Facilities that perform laboratory testing procedures on-site are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

Free-standing Diagnostic Imaging Facilities

Louisiana Blue requires that all freestanding diagnostic imaging facilities and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a facility performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from all Louisiana Blue networks in which they participate.

Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear cardiology

An ***Opti****Net*® score of 80% or more for each modality is required. ***Opti****Net*® is a Carelon Medical Benefits Management (Carelon) online registration tool for gathering modality-specific data on imaging providers in areas such as facility qualifications, technologist and physician qualifications,

accreditation and equipment.

This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

Louisiana Blue reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Louisiana Blue within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Louisiana Blue's credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging facility no longer performs a modality that requires accreditation or performs another modality that does not require accreditation.

This credentialing policy applies for freestanding (not hospital-based) diagnostic imaging facilities only.

Medical Staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Certified Registered Nurse First Assistant (CRNFA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), Physician Assistant (PA) or Psychologist can be set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital reimbursement and will not be set up independently under the hospital agreement.

Subcontracted Providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to: EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, initial hearing screens for newborns, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all facility services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Louisiana Blue or the member for such services.

For those instances when Member Providers may need to send a member to another facility when the member is inpatient, the Member Provider should bill Louisiana Blue for that service. The other facility should not bill Louisiana Blue for the services rendered.

For example, a member, who is an inpatient at ABC Hospital, needs hyperbaric oxygen therapy, but ABC Hospital does not have the necessary equipment. Therefore, ABC Hospital sends the member to XYZ Hospital. Once the procedure is completed, the member returns to ABC Hospital. In this case, ABC Hospital should bill Louisiana Blue for the hyperbaric oxygen therapy and reimburse XYZ Hospital accordingly. XYZ Hospital should not bill Louisiana Blue or the member.

At least annually, Member Providers should furnish Louisiana Blue with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement.

Note: Louisiana Blue will not pay for initial hearing screens done on newborns when performed after discharge from the facility of birth. Initial hearing screens are inclusive of the hospital stay.

Statute: R.S. 46:2264(A) The Office of Public Health in the Louisiana Department of Health shall establish, in consultation with the advice of the Louisiana Commission for the Deaf and the advisory council created in R.S. 46:2265, a program for the early identification and follow-up of infants at risk, hearing impaired infants, and infants at risk of developing a progressive hearing impairment.

Source: Senate Bill No. 436.

Telehealth Providers

Louisiana Blue's provider record policy includes additional guidance for the provision of telehealth services to our members.

Qualifications

An individual provider must meet the following criteria to obtain a Louisiana Blue provider record as a telehealth provider.

1. Telehealth-only provider located within the state of Louisiana who is not considered a behavioral health provider:
    - Must be individually located within the state of Louisiana.
    - Must be affiliated with an approved physical practice or clinic location within the state of Louisiana.
    - Must meet Louisiana Blue's credentialing and contracting requirements.
2. Telehealth-only provider located within the state of Louisiana who is considered a behavioral health provider:

- Must be individually located within the state of Louisiana.
- Must meet Louisiana Blue's credentialing and contracting requirements.

3. Telehealth-only provider located outside the state of Louisiana with an in-state practice affiliation:
    - Must be licensed to practice within the state of Louisiana and have a telehealth permit when applicable.
    - Must be affiliated with a practice or group with an approved physical practice or clinic location within the state of Louisiana.
    - Must meet Louisiana Blue's credentialing and contracting requirements.
4. Telehealth-only provider located outside the state of Louisiana with no in-state affiliation:
    - Must contact the Blue Cross and Blue Shield Plan local to the practitioner to contract, credential and file claims.

Virtual Office or Shared Spaces for Practitioner Location

What is considered a virtual office or shared space?

- A virtual office is a service-based business solution that may provide such services as a professional, physical mailing address, mail handling or communication services without requiring a long-term traditional office lease. It allows a credible presence while working from anywhere but the office location without the individual being required to be physically present at the location.
- Generally, it has a monthly fee to use the space that is a lower rate vs. paying to lease a physical location to treat in person.
- It will sometimes offer the ability to purchase hours to physically use space within the location.
- The owner of the space generally identifies it as a "virtual office."

Louisiana Blue does not support the use of virtual offices or shared spaces for any type of provider. The provider must apply to their local Blue Cross and Blue Shield Plan within the state of their residence to be credentialed, contracted and to file all claims.

The purchase of hours to treat in person at the office space is not recognized, as this does not guarantee the provider will be treating at the office on a regularly scheduled basis.

All requests that include a virtual office or shared space will be rejected upon receipt.

Continuous Monitoring

The Health Plan conducts ongoing monitoring of participating providers. Providers are continuously screened against the Office of Inspector General (OIG), Office of Foreign Assets Control (OFAC) and System for Award Management (SAM) exclusion databases. Providers identified on any of these lists are subject to denial or termination from the network.

State licenses and certifications are monitored on an ongoing basis. Practitioners who fail to renew a required license or certification before its expiration date will be immediately suspended from the network. Reinstatement may occur if the license/certification is renewed within 30 days of the lapse. Services rendered during periods of lapsed licensure or certification are not eligible for reimbursement.

The Health Plan also monitors the National Practitioner Data Bank (NPDB) during credentialing and continuously thereafter. Adverse actions identified through NPDB monitoring may be referred to the Credentialing Committee for review. Providers denied participation based on committee review will receive written notification of the decision.

Terminations

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Voluntary Termination

While we make reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in our networks. **Providers must do so by providing at least 90 days advance written notice** in accordance with the terms of the provider's network agreement.

Upon receiving a contract termination notice for a PCP or a specialist, we will close the PCP's panel to new members and notify affected members of the forthcoming contract termination. We will provide assistance, as needed, to transition care to another participating PCP or specialist. The resigning provider is responsible for the continued care of Blue Advantage patients during the 90-day notification period.

To request network termination, use the Request for Termination Form. The form is available online at www.lablue.com/providers >Resources >Forms. This form can be completed, signed and submitted digitally with DocuSign®. We will advise you if additional information is necessary to

process your request.

Involuntary Termination

Louisiana Blue may terminate the participation of an individual provider or a facility for cause. Louisiana Blue gives notice in accordance with the terms of the Participation Agreement.

Louisiana Blue reserves the right to terminate an individual provider's or a facility's network participation due to lack of claims activity over a given 24-month period by providing written or electronic notice to the provider at the appropriate correspondence address or email address, as provided in the applicable Participation Agreement, or as otherwise provided to Plan for correspondence purposes. The termination shall be effective upon the date written or electronic notice is sent by Louisiana Blue unless otherwise stated in the notice.

Provider Termination Disputes

Any provider's participation that is terminated from a Louisiana Blue network for failure to adhere to applicable credentialing requirements will receive direct correspondence detailing the process by which an appeal to the determination may be submitted to Louisiana Blue.

Concierge Medicine

The provider will notify affected Blue Advantage members 30 days in advance of transitioning to a concierge medicine provider. Additionally, the provider must apprise the member of the potential financial impact to the provider if services are continued as a concierge provider. Should you change your practice to concierge medicine, you must submit notice of this change. This change does not affect your participation in our provider networks.

Credentialing Criteria Changes

Status Changes

A provider is required to report changes in their credentialing criteria to Louisiana Blue within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

Examples of status changes providers are required to report include, but are not limited to:

- Change in hospital admitting privileges
- Suspension/revocation of any license
- Change in Collaborative/Supervising Physician Agreement

iLinkBlue and Electronic Funds Transfer

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The iLinkBlue Enrollment Request Form and Electronic Funds Transfer Form are included in our credentialing packets. These documents are required to become a participating provider.

Digitally Submitting Credentialing & Demographic Forms

Providers can complete, sign and submit many of our packets and forms digitally with DocuSign®. This replaces the need to print and submit hardcopy documents to Louisiana Blue. Through this enhancement, providers can electronically upload support documentation and even receive alerts (reminding them to complete packets) and confirm receipt.

The documents below are available in DocuSign format only.

- CAQH Professional Credentialing Packets (includes Attachment A - Location Hours)
- Facility Credentialing Packet (includes all Facility Information Forms)
- iLinkBlue Enrollment Request Form
- Electronic Funds Transfer (EFT) Enrollment Form
- Individual/Group Provider Update Request Form
- Facility Update Request Form
- Professional Tax Identification Number (TIN) Change Form
- Facility Tax Identification Number (TIN) Change Form
- Add Practice/Link to Group or Clinic Request Form
- Add Facility Location Form
- National Provider Identifier (NPI) Change Form
- Request for Termination Form
- Electronic Transactions Transfer (EFT) Change/Termination Form

- Electronic Remittance Advice (ERA) Enrollment Form
- Business Associate Profifile (BAP) Form

Note: When submitting DocuSign documents, please do not also separately email them. Double submissions (submitting through DocuSign and sending an email of the completed form) could delay the processing time for your request.

If you have any questions on submitting DocuSign forms to our PCDM Department, you may email PCDMstatus@lablue.com.

We will advise the provider if additional information is necessary to process your request.

Facility Name and Tax Identification Changes

If a facility has undergone a change of ownership, or any update that has resulted in a name or Tax Identification Number (TIN) change, then you need to submit the appropriate form and packet as indicated below.

To ensure the update is processed correctly, the forms must be submitted in the appropriate order, as this request requires the creation of a new provider record. In addition, the facility must complete the initial credentialing process so that all required documentation can be collected, reviewed and processed accordingly.

Submit TIN changes in the following order:

- Facility Tax Identification Number (TIN) Change Form
- Facility Credentialing Packet (fill out with new TIN)

Submit name changes in the following order:

- Facility Update Request Form
- Facility Credentialing Packet (fill out with new name)

National Provider Identifiers

All covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. Claims processing

cannot be guaranteed unless you notify Louisiana Blue of your NPI(s) prior to filing claims using your NPI(s).

Notifying Louisiana Blue of Your NPI

If your NPI changes, please notify Louisiana Blue as soon as possible. To do so, you may use the National Provider Identifier (NPI) Change Form located in the "Resources" section of the Provider page.

Filing Claims with NPIs

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Louisiana Blue of your NPI, by using one of the methods above, prior to filing claims. See the first part of this section for more details on how to submit claims to Louisiana Blue.

For more information, including who should apply for an NPI and how to obtain your NPI, visit our website or the CMS website. If you have any questions about the NPI relating to your Louisiana Blue participation, please contact Provider Credentialing & Data Management.

Provider Directories

As a network provider, you may only participate in our networks and be listed in the provider directory as the primary specialty you identified on your credentialing packet. As a participating provider, your name is included in the product-specific provider directories featured on our website. Participating providers are listed in the directories by parish in alphabetical order under their specialty(ies).

Thousands of healthcare professionals and facilities across the state are in Louisiana Blue's networks. You can find the one you need quickly with our easily searchable directories online. Listings are updated daily, excluding holidays. We make every effort to ensure the information in our provider directories is current and accurate.

You must notify the Provider Credentialing & Data Management Department if you have any changes within your practice. To do so, visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form. The forms are available in DocuSign® format, which allows you to complete, sign and digitally submit them directly to our Provider Credentialing & Data Management Department.

We will advise you if additional information is necessary to process your request.

Provider Directory Information

A part of our commitment to serving our members is to provide them with current comprehensive information about our network providers. Provider directory information includes demographic information such as education and training, languages spoken and whether a physician's office is accepting new patients. Other information like providers' specialties, board certifications, hospitals where they admit and certain accreditation information is also available.

Provider Directory Verification

Under the Consolidated Appropriations Act (CAA) 2021, providers are required to verify their demographic information in our online provider directories every 90 days. This ensures that the information published is accurate for member/patient use.

Professional Provider Verification

Louisiana Blue verifies professional provider information through CAQH. Practitioners can attest to their directory data and confirm practice locations in the CAQH Provider Data Portal. Every 90 days, CAQH will send a reminder asking you to attest your location information is up to date.

Should a provider fail to verify their information, they will be removed from our online provider directories. Network participation will not be affected, but a person searching our provider directories will not have access to your information.

Note: All updates to provider records, whether for an individual practitioner or a group/clinic, must be submitted to Louisiana Blue through our DocuSign forms. The required forms are available online at www.lablue.com/providers >Resources >Forms.

This requirement applies to all record changes, including, but not limited to:

- Linking to a new clinic/group
- Addition or removal of practice locations
- Updates to mailing addresses or contact information
- Name changes for a practice
- Changes to banking information for a group/clinic record
- Termination of practitioner from Tax Identification Number

Submitting updates through DocuSign helps ensure that information is processed accurately and maintained in accordance with Louisiana Blue's provider record requirements.

If you are practicing at a new location, have a change to an existing location or are no longer at a location, you should make those updates in the CAQH portal in order to ensure our system data is in agreement with CAQH.

Facility Verification

Louisiana Blue sends facilities a prepopulated Facility Provider Attestations Form via Docusign to verify directory information. An authorized representative for the facility must attest that the information is correct/incorrect. If any of the data on the form is incorrect, the representative must complete the Facility Provider Attestation Appendix Form to report updated information.

Should a facility fail to verify their information, they will be removed from our online provider directories. Network participation will not be affected, but a person searching our provider directories will not have access to your information.

Please ensure your facility correspondence email address is kept current in order to receive attestation-related emails from Louisiana Blue. To update your correspondence email address, complete the Correspondence Address Change section of the Facility Update Request form. Access this form at www.lablue.com/providers, click "Resources," then "Forms" and choose "I need to update my FACILITY demographic information."

Provider Directory Locations Policy

Louisiana Blue limits the published practice locations of professional providers in our online provider directories as follows:

- Professional providers must be available to schedule patient appointments at a minimum of 8 hours per week at the location listed.
- A member must also be able to call and schedule a patient appointment at the location listed in the directory.
- A maximum of five locations per Tax ID, per professional provider will be displayed.

Each professional provider must report patient appointment availability for each location reported to Louisiana Blue. This information should be reported for new providers via the credentialing packet on Attachment A – Location Hours. Existing network providers must report this information on the recredentialing packet during the recredentialing process.

Additionally, professional providers are asked to report this information on the indicated form when making the following changes:

- Updating your physical address (Individual/Group Provider Update Request Form)

- Joining a new provider group or clinic (Add Practice/Link to Group or Clinic Request Form)
- Changing your Tax ID number (Tax Identification Number TIN Change Form)
- Adding a new practice location (Add Practice/Link to Group or Clinic Request Form)

Provider Roles and Responsibilities

Non-discrimination Agreement

PROVIDER agrees: (1) not to deny, limit, condition, differentiate or discriminate in its provision of services to MA members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, health status (which includes, but is not limited to, medical condition, including mental as well as physical illness, claims experience, receipt of healthcare, payor identity, medical history, genetic information, and evidence of insurability, including conditions arising out of acts of domestic violence), disability, source of payment, enrollees' complaint or grievance in connection with any evidence or certificate of coverage, age, or whether or not an MA member has executed an advanced directive; and (2) to render services to enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to non-plan patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient. Without limiting the generality of the foregoing, PHYSICIAN expressly agrees to comply with Title VI of the Civil Rights Act of 1964 and 45 C.F.R. 84; the Age Discrimination Act of 1975 and 45 C.F.R. 91; the Americans with Disabilities Act, and its amendments; the Rehabilitation Act of 1973; other laws applicable to recipients of federal funds; and all other applicable federal and state laws, rules and regulations. Without limiting the generality of the foregoing, PHYSICIAN shall make its services available to MA members on the same basis and time limits as those made available to patients who are not members of a plan (42 C.F.R. § 422.110).

Compliance Responsibilities for Blue Advantage Providers

As a Medicare Advantage Organization (MAO) with an established contract with CMS, Louisiana Blue is required to communicate its compliance program requirements to providers and ensure compliance with these requirements. Providers contracted with Louisiana Blue to provide medical or administrative services to Blue Advantage members are required to comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions and with all other applicable federal, state and local laws, rules and regulations; to cooperate with Louisiana Blue in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all healthcare professionals employed or under contract to render health services to Blue Advantage members, including covering physicians, comply with these provisions.

Louisiana Blue requires written attestation of such compliance through its provider contracting process as well as through its contracted entity compliance training and education program. We

may send written notification to providers and other contracted entities with a description of the compliance training and education requirements and a request to attest that our Code of Conduct, selected policies and procedures and other compliance-related documents (or their equivalents) are read, followed and distributed to any individuals employed or contracted by the entity to provide medical or administrative services to Blue Advantage members. Upon request, your attestation of compliance must be completed within 60 days of notification.

Sanctions under Federal Health Programs and State Law

Network providers must ensure that no management, staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal/state government healthcare programs are employed or subcontracted by the network provider.

As more fully stated in your contract, Blue Advantage network providers must disclose to Louisiana Blue whether the provider or any staff member or subcontractor has had any prior violation, fine, suspension, termination or other administrative action taken against them under Medicare or Medicaid laws; under any federal or state laws and regulations regarding the provision of medical services, by any insurer. Blue Advantage network providers must notify Louisiana Blue immediately if any such sanction is imposed on the provider, a staff member or subcontractor.

Responsibility to Check for Exclusions

Medicare payment may not be made for items or services furnished or prescribed by a provider or entity that has been excluded by the U.S. Department of Health and Human Services Office of Inspector General (OIG) or General Services Administration (GSA). Providers have compliance responsibility for routinely verifying that no employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage members are excluded by the OIG/GSA and should immediately communicate any such exclusion to Louisiana Blue's Compliance Department.

Reporting Compliance Concerns

Actual or suspected Medicare program noncompliance, potential fraud, waste and abuse or any compliance concerns or violations relating to the Blue Advantage plan or its members must be reported. Providers must ensure that employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage members are aware of our expectations of reporting and its policy of non-intimidation and non-retaliation for good-faith reporting of compliance concerns and participation in the compliance program. Information about how to report

compliance concerns can be found in the Plan Information Contact List section of this manual and should be publicized or otherwise made available throughout your facilities.

Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or email. Providers and facilities are required to report the misrouted PHI to Louisiana Blue's Privacy Office at (225) 298-1652 or privacy.office@lablue.com, and destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI.

Professional Manner

Providers must offer services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

Provider and Member Communications

Providers must offer appropriate and adequate medical care to all Blue Advantage members. No action of Louisiana Blue or any entity on their behalf in any way relieves or lessens the provider's responsibility and duty to provide appropriate and adequate medical care to all members under the provider's care. Louisiana Blue agrees that, regardless of the coverage limitations, the provider may freely communicate with members regarding available treatment options and nothing in this provider manual shall be construed to limit or prohibit open clinical dialogue between the provider and the member.

Preventive Health Guidelines

Preventive healthcare is a pinnacle component of our health plan and we endorse the guidelines that are outlined by the U.S. Preventive Services Task Force. This task force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. Practitioners must use their own judgment in the care of individual patients. To ensure the most up-to-date guidance, please refer to the U.S. Preventive Services website or go to www.uspreventiveservicestaskforce.org/Page/Name/recommendations.

Guidelines for Providers When Discussing Blue Advantage

Healthcare providers and their staff must remain neutral parties when discussing Medicare coverage options with their patients.

Healthcare providers and their staff **must not**:

- Offer Medicare Advantage and/or Part D sales/appointment forms to Medicare beneficiaries.
- Accept enrollment applications for Medicare Advantage plans and/or Medicare Part D plans.
- Make phone calls to direct, urge or attempt to persuade Medicare beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mail marketing materials to Medicare beneficiaries on behalf of Medicare plan sponsors.
- Offer anything of value to induce Medicare plan enrollees to select them as their healthcare provider.
- Offer inducements to persuade Medicare beneficiaries to enroll in a particular Medicare Advantage/Part D plan or organization.
- Perform health screenings in direct or indirect connection with the sharing of information about Medicare coverage options.
- Accept compensation directly or indirectly from a Medicare Advantage and/or Medicare Part D plan for beneficiary enrollment activities.
- Conduct or facilitate sales activities in patient service areas (i.e., exam rooms, waiting rooms).

Healthcare providers and their staff **are permitted** to:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from www.medicare.gov) including in areas where care is delivered.
- Provide the names of all plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS).
- Refer patients to plan marketing materials available in common areas.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered.
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, Plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS's website at www.medicare.gov, or 1-800-MEDICARE.

The Role of the Primary Care Provider (PCP)

The PCP designation generally includes the provider specialties of family practice, general practice, geriatrics, internal medicine and pediatrics. These provider types must meet state requirements and be trained to give basic medical care. The PCP is to function within his/her scope of licensure or certification, has admitting privileges at a hospital and agrees to provide primary healthcare services to members 24 hours a day, seven days a week.

The PCP serves as the member's initial and most important contact for receiving medically necessary covered services. The PCP provides or coordinates care for each member. This includes:

- Maintaining continuity of care for all members by serving as PCP.
- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary healthcare services to members.
- Maintaining a current medical record for each member, including documentation of all medical services (PCP and specialty) provided to the member.
- Providing periodic physical examinations.
- Providing routine injections and immunizations.
- Providing or arranging 24 hours a day, seven days a week access to medical care.
- Assisting members to obtain needed specialty care and other medically necessary services.
- Arranging and/or providing necessary inpatient medical care at participating hospitals.
- Providing health education and information.
- Discussing Advance Medical "Directives" with all members as appropriate, and documenting in medical records (in a prominent place) if a member has executed a directive. In Louisiana, the directive may be referred to as a "declaration."
- Maintaining records of periodic preventive services and providing appropriate timely reminders to members when services are due.

All member education materials encourage members to seek their PCP's advice before accessing medical care from any other source, except for emergency services.

PCP Patient Access

Louisiana Blue encourages all new Blue Advantage members to become established with their PCPs and not wait until they are sick or experience health problems. We understand that medical issues can arise prior to the member becoming established with the practice and those problems need to be addressed by the PCP's office until the initial appointment can be completed. It may be warranted to prepare front office personnel to ask appropriate questions of the member when they call, in order to triage and resolve the medical need(s) of the member.

Selecting a PCP

Blue Advantage members select a PCP at the time of enrollment. The member's PCP will be responsible for providing, coordinating and arranging all medically necessary services for the member. In rare cases, if the member has not identified a PCP and we cannot verify his/her choice, a PCP may be assigned.

A PCP serves as the member's total care coordinator for non-emergent care. PCPs are available to members 24 hours a day, seven days a week through regular scheduling or on-call coverage. There will always be a provider on call to help them.

Changing a PCP

It is important that members have a good relationship with their PCP, as they provide most of their care. Members can change their PCP to another Blue Advantage contracted PCP at any time for any reason. Members can do so by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual. The change will be effective the first day of the month following receipt of the member's request.

In rare situations, a member may be retroactively assigned to a PCP. For example, the member's PCP may have terminated the contract without notification because of illness or death.

We will assist the member in finding a new PCP as quickly as possible to promote continuity of healthcare and coverage, but there may be a slight time lapse that causes the assignment to have a retroactive effective date.

It is important to have office procedures in place for confirming member eligibility online on iLinkBlue and to confirm that you are the PCP of record prior to a member's appointment. For more information on iLinkBlue, see the Online Services section of this manual.

Appointment Scheduling and Waiting Time Guidelines

All Blue Advantage network providers must use 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 to the provider office from the member	Same day; no later than next business day

- Routine care without symptoms includes physical exams and well-woman exams.
- Non-routine care with symptoms includes rashes, coughs and other non-life-threatening conditions.
- Urgent care is defined as medical conditions that could result in serious injury or disability if medical attention is not received.
- Emergency is defined as medical situations in which a member would reasonably believe his/her life to be in danger or that permanent disability might result in the condition if not treated.

Practitioners should make every effort to see the patient within an average of one hour from the patient's scheduled appointment time. This includes time spent both in the lobby and the examination room.

Members who are late for their scheduled appointments may not be able to be seen within the hour.

Providers and suppliers are allowed to charge Medicare beneficiaries for missed appointments. Medicare itself does not pay for missed appointments, so such charges should not be billed to Louisiana Blue.

Capitation: Reporting Patient Encounters

Your agreement with Louisiana Blue as a Blue Advantage provider indicates, and CMS requires, that all patient encounters must be submitted via a claim, regardless of your reimbursement methodology. While the claims will appear on your weekly remittance notice once processed, payment for non-carve out services will be issued on a monthly basis separate from the remittance notice.

Send Members to Network Providers

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.

Referring patients to out-of-network providers may result in significant costs to the member. Referring Blue Advantage members to network providers allows them to receive the maximum amount of their benefits. Providers who repeatedly refer members to nonparticipating providers could be subject an overall reimbursement rate reduction.

Plan Directed Care (PDC)

PDC occurs when an in-network provider refers a Blue Advantage member to an out-of-network provider. Under CMS guidelines, contracted providers are responsible for ensuring that referred services are covered by Medicare and the member's Blue Advantage plan, including applicable medical necessity, plan directed care, organizational determination and prior authorization requirements.

It is the responsibility of the referring provider to verify the network participation status of the rendering provider and to obtain all required prior authorizations, referrals, and plan determinations and approvals before services are rendered. When referring a member to an out-of-network provider, the referring provider is responsible for ensuring the rendering provider is aware the services are being provided as plan-directed care and is subject to applicable Blue Advantage coverage, determination, and authorization requirements.

Failure to comply with Louisiana Blue's Plan Directed Care requirements, including required prior authorization and/or organizational determinations, will result in denial of reimbursement and assignment of financial liability to the in-network/referring provider. Claims paid without appropriate approvals as described above remain subject to post-payment review and recovery. Consistent with CMS requirements, members will not be held financially responsible for covered services received as a result of an authorized or plan-directed referral when provider obligations under these requirements are not met.

Provider-patient Relationship

A valid provider-patient relationship is established between a member and a provider, including, without limitation, a physician, an allied health provider, or other provider type, as defined by plan, when the member and the provider engage in a healthcare encounter that includes a fully documented clinical assessment (in-person or telemedicine) of the member (patient). For physicians, physician assistants and nurse practitioners, this initial documentation must include, at a minimum, pertinent history, pertinent examination and medical decision making (MDM). MDM may include making a specific diagnosis(es), providing a clinical recommendation(s) and/or medical plan of care, and providing other specific services such as order(s) for ancillary services (e.g., imaging and labs), diagnostic or therapeutic tests, issuance of a prescription(s), and/or the delivery of healthcare item(s) (i.e., any substance, product, device, equipment, supplies, or other tangible good or article) when medically necessary and meets the standard of care. For all others, the documentation must conform to the accepted standards of that provider type.

Coverage is not available for care provided to members outside of an established provider-patient relationship as defined by the plan. The stipulation of a required provider-patient relationship does not apply to healthcare services provided in urgent care centers, emergency room departments, imaging services, pathology/laboratory services, and/or services provided while the member(patient) is in a facility.

Covering Physician Policy

PCPs with a capitation arrangement will be responsible for paying a covering physician for services that are rendered on their behalf so the covering physician will get paid fee for service.

If you are not a capitated PCP, then your covering physician will be able to submit a claim to Louisiana Blue for payment. We stress that your physician be a contracted Louisiana Blue - Blue Advantage provider.

The Role of Specialists

Specialty care providers (specialists) deliver services beyond the scope of primary care to members. For members who have a PCP, the specialist is encouraged to coordinate care through the member's PCP.

It is important for the specialist to communicate regularly with the PCP regarding any specialty treatment.

Specialists are encouraged to report the results of their services to the member's PCP. The specialist should copy all test results in a written report to the PCP.

Telemedicine

Provider healthcare encounters provided utilizing telemedicine shall (i) verify the identity of the individual requesting treatment with the appropriate contact and identifying information (ii). Obtain oral or written consent from the member (patient or guardian) if state law requires the consent of a parent or guardian (iii) conduct an appropriate examination that meets the same standards of care as an in-person visit. (iv) create and maintain member (patient) records in accordance with the same standards of care as in an in-person visit.

A Telemedicine health encounter is held to the same prevailing and usually accepted standards of medical practice as those services provided in a traditional (face-to-face) setting (as defined in Part XLV67 Louisiana Administrative Code July 2021 §7503).

The encounter satisfies the elements of the provider-patient relationship as defined by the plan. Provider-patient relationship: A valid provider-patient relationship is established between a member and a provider, including, without limitation, a physician, an allied health provider or other provider type, as defined by plan, when the member and the provider engage in a healthcare encounter that includes a fully documented clinical assessment (in-person or telemedicine) of the member (patient). For physicians, physician assistants and nurse practitioners, this initial documentation must include, at a minimum, pertinent history, pertinent examination and medical decision making (MDM). MDM may include making a specific diagnosis(es), providing a clinical recommendation(s) and/or medical plan of care, and providing other specific services such as order(s) for ancillary services (e.g., imaging and labs), diagnostic or therapeutic tests, issuance of a prescription(s), and/or the delivery of healthcare item(s) (i.e., any substance, product, device, equipment, supplies or other tangible good or article) when medically necessary and meets the standard of care. For all others, the documentation must conform to the accepted standards of that provider type. The stipulation of a required provider-patient relationship does not apply to healthcare services provided in urgent care centers, emergency room departments, imaging services, pathology/laboratory services and/or services provided while the member (patient) is in a facility.

Online Services

Accessing iLinkBlue

iLinkBlue allows Blue Advantage network providers and nonparticipating providers access to information that assists in improving patient care and office efficiency. Providers in our Blue Advantage network must access and manage eligibility, benefits, claims and more electronically, through iLinkBlue.

iLinkBlue Features:

- Provider Quick Reference Guide (lists services that require an authorization)
- Provider/Pharmacy Directory
- Drug Formulary Search
- Member Eligibility
- Claim Inquiries
- Authorization Inquiries

For instructions on how to use these features, please see our *iLinkBlue User Guide*. It is available on the Provider page at www.lablue.com/providers >Resources >Manuals.

Secure Access to iLinkBlue:

iLinkBlue is available at no cost for healthcare providers. To gain access, your organization must:

1. Complete the iLinkBlue Provider Enrollment Request Form packet available online at www.lablue.com/providers >Electronic Services >iLinkBlue.
2. Designate at least one Administrative Representative using the registration forms included with the iLinkBlue Provider Enrollment Form packet.
3. Organizations that are not currently enrolled in electronic funds transfer (EFT) payments should also complete an EFT Enrollment Form. Submit the form to the Louisiana Blue Provider Credentialing & Data Management Department. That form is available at www.lablue.com/providers >Resources >Forms.

Verifying Member Eligibility

Providers can securely access current member eligibility online through iLinkBlue.

In addition to eligibility, iLinkBlue includes information such as:

1. Up-to-date member maximum out-of-pocket (MOOP)
2. The member's current PCP
3. Coordination of benefits (COB) information

Members have access to their eligibility through the Blue Advantage Member Portal.

Online Claim Inquiry

Louisiana Blue encourages all network providers to use iLinkBlue for standard claims status checks. This allows Blue Advantage Customer Service advisers to be available for more complex issues that cannot be handled via an automated process.

Once a claim has been processed, it can be viewed through iLinkBlue. To view processed claims in iLinkBlue, go to the Claims menu option. Then select "Claims Status Search" and use the Paid/Rejected tab to search for a claim.

You can inquire about a claim using any of the following methods:

1. Member ID
2. NPI
3. Date Range

For each listed claim, the screen displays the claim number, date(s) of service, provider, patient name, claim status, date of the claim status and payment amount. A detailed summary is provided for all finalized claims. Please note that if the status of the claim is "Pending" you will not be able to review in detail. The summary detail screen provides a brief summary, a payment detail and a summary of each line item.

General Operation Guidelines

Advance Directives

Members have the right of self-determination. An Advance Directive enables an individual to outline, in advance of a serious illness, what kind of treatment the person wants or does not want, should they become unable to decide or speak for themselves.

Because this is an important matter, members are advised to talk to family, close friends and their physicians before completing an Advance Directive.

The two most common forms of Advance Directives are a Healthcare Directive (Living Will) and Durable Power of Attorney for Healthcare.

A Healthcare Directive is a document that allows individuals to state in advance their wishes regarding the use of life-prolonging procedures. It may be relied upon if individuals become unable to communicate their decisions. It is sometimes called a "Living Will." In most states, adults may complete and sign a pre-printed form or draw up their own forms.

A Durable Power of Attorney for Healthcare is a signed, dated and notarized legal document that allows individuals to appoint someone to make healthcare decisions for them if they are not able to do so. These decisions may include instructions about any treatment they desire or those they wish to avoid, including decisions to withhold or withdraw life-prolonging procedures.

Blue Advantage network participating providers are encouraged to ask their patients if they have an Advance Directive and are advised to place a signed, notarized copy of any Advance Directives in patients' medical records.

Individuals may change their minds or cancel either document at any time in accordance with state laws. Any change or cancellation should be written, signed and dated in accordance with the applicable state law and copies given to their healthcare providers.

If an individual wishes to cancel an Advance Directive while in the hospital, the individual should notify the treating physician, PCP, family members and others who may need to know.

In Louisiana, you can find further information, including advance directive forms, on the Office of the Attorney General State of Louisiana website at www.ag.state.la.us/.

Making Changes in Healthcare Coverage

Medicare restricts the number of times beneficiaries can voluntarily change their membership in a health plan. When a beneficiary is new to Medicare, the individual is given an Initial Coverage Election Period (ICEP) of seven months that allows the beneficiary to enroll in a Medicare Advantage plan. After the ICEP there is one primary time, the Annual Enrollment Period (AEP), when all Medicare beneficiaries may choose to make a change to the way they receive Medicare coverage. The AEP, which takes place Oct. 15-Dec. 7 each year, is the time when all beneficiaries should review healthcare and drug coverage options for the upcoming year and are able to make changes that will be effective Jan. 1 of the following year.

The Medicare Advantage Open Enrollment Period (MA OEP) is the time when anyone enrolled in a Medicare Advantage plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare prescription drug plan).

Individuals may also qualify for what is called a Special Election Period (SEP). An SEP is a special timeframe outside the normal AEP when an individual may make a change to membership in a health plan, such as enroll in a new plan or request to disenroll from an existing plan. Examples of circumstances that warrant an SEP include but are not limited to the following: individuals who qualify for Medicaid benefits, individuals who get extra help (low income subsidy) and individuals who move out of the service area. Natural disasters such as hurricanes can also qualify Medicare beneficiaries for an SEP.

For more information on when changes can be made, see the enrollment table on the next page. Please note that this is not an all-inclusive list of available SEPs.

Effective dates are as follows:

Election Period	Effective Date of Coverage	Do MA organizations have to accept enrollment requests this election period?
Initial Coverage Election Period and Initial Enrollment Period for Part D	• First day of the month of entitlement to Medicare Part A and Part B **or** • First of the month following the month the enrollment request was made if after entitlement has occurred	Yes – unless capacity limit applies (see §30.9 for capacity limit information). IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request	No – the MA organization can choose to be "open" or "closed" for enrollments during this period.
Annual Election Period	Jan. 1 of the following year	Yes – unless capacity limit applies
Special Election Period	First day of the month after the month the MA organization receives an enrollment request, unless otherwise noted	Yes – unless capacity limit applies
Medicare Advantage Open Enrollment Period (MA OEP)	Annually from Jan. 1 to March 31	No – only applies to beneficiaries who made an election during the preceding AEP. Only one election is allowed during OEP.

Medical Records

Louisiana Blue has adopted guidelines for the maintenance of medical records within participating provider offices that support consistent and complete documentation of each member's medical history and treatment. Appropriate documentation is an essential component of quality care. Medical record guidelines and review procedures have been developed to comply with state, CMS and other nationally recognized standards. At a minimum, **medical records must be retained for 10 years**.

The Blue Advantage Quality Management Committee has established the following minimum set of guidelines for a complete patient record. We may, from time to time, review a sampling of the provider's medical records to determine compliance with these guidelines. Whenever possible, we will give the practice reasonable notice of medical record review.

Each medical record will be reviewed in relation to the following criteria:

- Medical record is organized and does not contain loose papers.
- All sheets contain the patient's name, date of service and another unique patient identifier (DOB, MRN, etc.).
- Written entries are complete and legible.
- Only standard medical abbreviations are used.
- Each entry is dated and signed or initialed by the person making the entry. The reviewer must be able to identify the name and professional title of the person who made the entry.
- All charts must contain the following information:
  - Patient's identification information/demographics.
  - List of allergies or a statement that the patient has reported no allergies.
  - Problem list with dates of onset and resolution, including names of consulted providers, as applicable.
  - Medication list, including diagnosis treated, and dates initially prescribed and discontinued, as applicable.
  - Past medical history.
  - Past surgical history or prevention check list, including age-appropriate immunizations, bone mass measurements and screenings for colorectal exams, mammograms, Pap smears/pelvic exams, prostate cancer exams and cardiovascular screening blood tests.
  - Durable Power of Attorney for Healthcare and Healthcare Directive, or a statement that these documents were discussed with the patient.
- Office visits document the following information:
  - Reason for the visit: chief complaint, as applicable.
  - Pertinent biometrics and vital signs.
  - History and physical examination pertinent to the reason for the visit.

- Assessment of the patient's health problem(s), including any medical history related to this episode of care that is not previously documented.
- Plan of treatment, including testing, referrals, therapies and health education to be provided.
- Results of lab work, radiology services, etc. including change in the Plan of Treatment based on results of testing.

- All associated medical records, including specialist and/or ancillary reports, are signed and dated with any abnormalities addressed.
- Cloned or Template Generated Documentation – Medical records documentation must be specific to the patient's situation at the time of the service. Each patient will have a unique set of problems, symptoms and treatment, so the expectation is that documentation would not look exactly the same across patients. The expectation would also be that medical records entries for a patient would not be worded exactly alike or similar to previous entries. Please be cautious when using templates to generate the medical record to ensure that what is documented in the medical record actually occurred for that patient on the indicated date of service.

Medical Record Review

Providers are expected to achieve an 80% score, at a minimum, on the medical record reviews. Medical records of providers scoring below this threshold will be re-audited in 180 days to ensure the documentation meets expected standards. Results of medical record reviews become part of the provider's profile. Deficiencies in medical record documentation are addressed through the Quality Management corrective action plan process and in collaboration with the physician.

Occasionally, Louisiana Blue may request medical record documentation to investigate a member grievance or appeal. In this event, the practitioner should respond within the timeframe stated in the request or within 10 calendar days of the date of the request.

Coding Support

All reported diagnoses must be supported by medical record documentation. A diagnosis can only be coded when it is explicitly spelled out in the medical record. Diagnoses must be clear enough to be abstracted by a competent professional coder. A list of diagnoses or complaints without indication of treatment, or assessment of current disease, specific signs, symptoms or status is inadequate and cannot be used for coding purposes. The record must contain evidence of evaluation and be linked to each diagnosis listed.

Coding Audits

Coding audits are conducted by certified coders, physicians or clinically qualified individuals. Determination of the type of audit to be conducted is based on reported trends or risk areas, or issues identified upon review of claims, reports or specific diagnoses.

The coding department discusses audit results and provides details of specific coding/documentation concerns to the provider or the provider's group administration. In the event audit results are unfavorable, additional monitoring and a possible corrective action plan may be implemented, contingent upon the severity of the issue(s) identified.

Laboratory Tests

Blue Advantage network providers have the following options for lab work:

- Perform lab work in the office in accordance with the level of Clinical Laboratory Improvement Amendments (CLIA) certification.
- Draw labs in the office and send specimens to one of our participating lab facilities identified in our Provider/Pharmacy Directory.
- Send Blue Advantage members to a Blue Advantage network reference laboratory, which are listed in the Plan Information Contact List located in the front of this manual.

Physician Signature Guidelines

CMS guidelines mandate the presence of signatures specifically for all medical review purposes. Records pertaining to any procedures billed to Medicare Part B are potentially subject to review by not only Louisiana Blue but also other CMS contractors. CMS allows the use of handwritten or electronic signatures.

Electronic signatures must be date and time stamped. Please note that the individual performing the service must be the provider who signs the documentation.

See next page for more information on signature guidelines.

Please adhere to the following guidelines to ensure that signature requirements are met:

Description	Signature Requirements	
	Met	Not Met
1. Legible full signature	X	
2. Legible first initial and last name	X	
3. Illegible signature over a typed or printed name Example:  John Whigg, MD	X	
4. Illegible signature where letterhead, addressograph or other information on page indicates identity of signature Example: an illegible signature appears on a medical record. The letterhead lists three provider names. One of the names is circled.	X	
5. Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a. A signature log or b. An attestation statement	X	
6. Illegible signature NOT over a typed/printed name and NOT on letterhead, and the documentation is unaccompanied by: a. A signature log or b. An attestation statement Example: 		X
7. Initials over a typed or printed name	X	
8. Initials NOT over a typed/printed name but accompanied by: a. A signature log or b. An attestation statement	X	
9. Initials NOT over a typed/printed name unaccompanied by: a. A signature log or b. An attestation statement		X
10. Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11. Unsigned typed note without provider's typed/printed name		X
12. "Signature on file"		X

Electronic Signatures

The following are examples of acceptable electronic signatures:

- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed before import by" with provider's name
- "Signed: John Smith MD"
- "Digitized signature:" Handwritten and scanned into computer
- "This is an electronically viewed report by John Smith MD"
- "Authenticated by John Smith MD"
- "Authorized by John Smith MD"
- "Digital Signature: John Smith MD"
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically Approved by" with provider's name
- "Signature Derived from Controlled Access Password"

The following are examples of unacceptable electronic signatures:

- Dictated but not read
- Signed but not read
- Auto-authentication
- Generated by

Record Corrections

Any correction, addition or change in any member's medical record made more than 48 hours after the final entry is entered in the record and signed by the provider, shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition or change shall be included as well as the reason for the correction, addition or change.

Confidentiality of Medical Records

Medical records of members are confidential documents and must be treated as such to comply with state and federal laws and regulations. Providers must maintain the confidentiality of all information contained in a member's medical record and only release such records or information: a) in accordance with the provisions in the signed Provider Agreement, b) subject to applicable laws, regulations or orders of any court of law, c) as necessary, to other providers treating a member or d) with the written consent of the member.

Availability and Transfer of Medical Records

When members change PCPs, they may request a transfer of medical records or copies of medical records. These records must be forwarded to the member or to the new provider within 10 business days from receipt of the request.

Participating physicians and other providers, including facilities, are required to comply with Louisiana Blue's Quality Improvement and Utilization Management activities. In many instances, this is accomplished by making medical records available to the health plan or its authorized agent. In addition, authorized representatives from CMS are allowed access to patient records of Blue Advantage members for specific purposes.

To facilitate this process, all members sign a release of medical information as part of their enrollment process. This release is in effect for the duration of their status as a Blue Advantage member:

> *I authorize any health professional or organization to provide to Louisiana Blue or any of its affiliates, information related to medical history, care, treatment or consultation provided to me for the purpose of administering or coordinating the Medicare program.*

This release authorizes Louisiana Blue access to Blue Advantage members' medical records and to make copies as necessary. Louisiana Blue will request, access and, if applicable, copy only the section or sections of the medical record that is necessary to make a coverage determination, pay

claims and carry out other health plan benefit administration and quality management activities.

Transfer of Information Between Providers

Louisiana Blue will educate Blue Advantage network providers and their office staff on the following to promote continuity of care for Blue Advantage members:

- Primary Care Providers: When a PCP refers a patient to a specialist, the PCP should forward relevant notes, X-rays, reports or other medical records to the specialist prior to the patient's scheduled appointment.

- Specialists: Specialists should report preliminary diagnosis and treatment plans to the patient's PCP within two weeks from the date of the first office visit. The specialist should provide the PCP with a detailed patient summary report within two weeks after the completion of the evaluation or treatment and within two weeks of each subsequent encounter.

- Confidentiality: Participating providers should ensure that medical record information transfers are performed in a confidential, timely and accurate manner that is consistent with applicable state and federal laws.

Fraud, Waste and Abuse

Louisiana Blue 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.

Work Related Issues

Employment Requests – the plan will not cover tests needed for purposes of employment only (with no medical necessity). The requesting provider will need to submit the pre-service request to the plan for approval/denial rights to be given to the member.

Workers' Compensation Claims

If you believe that a Blue Advantage patient requires treatment for a work-related illness or injury, ensure he/she has contacted the employer to report the condition in accordance with the State Workers' Compensation Law. Claims for your treatment of this patient's work-related illness or injury should be billed to the employer or the employer's Workers' Compensation insurer. Louisiana Blue's Blue Advantage *Evidence of Coverage* specifically excludes work-related illnesses and injuries.

If the patient's employer or the employer's Workers' Compensation insurer denies reimbursement for your services, you should advise the patient of that fact. The patient may elect to be treated by a provider who the employer or its insurer designates to treat such work-related conditions or to pay for your services on a fee-for-service basis and then seek reimbursement from the employer or insurer. In any case, it is important to follow Louisiana Blue's authorization procedures so that if the employee successfully contests the issue, you will be reimbursed.

Subrogation

In situations involving settlements to beneficiaries paid by liability insurance, no-fault insurance and uninsured or underinsured motorist insurance that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance Section 1862 (b) of the Social Security Act grants Medicare a priority right of recovery will be done. Section 1862 (b) also gives the Medicare program the right of subrogation for any amounts payable to the program under the act.

Therefore, Louisiana Blue, operating a Medicare Advantage contract, has the same right of recovery. Louisiana Blue's right to recover its benefits takes precedence over the claims of any other party, including Medicaid.

Claims that contain potential third-party liability (TPL) will be paid by Louisiana Blue on a conditional basis, which permits us to recoup any payments if/when a settlement is reached.

Readmissions

Readmissions to the same or affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed, as the original payment is full reimbursement for treatment of the original condition and any complications.

Effective Aug. 1, 2024, we audit readmissions to the same or affiliated facility for the same condition, similar condition, or a complication of the original condition within 30 days of discharge. This applies when the patient is discharged from the first admission to home or home health.

Providers cannot bill members for services recouped as a result of this policy.

Louisiana Blue uses HEDIS® Plan All-Cause Readmissions algorithm to flag readmissions for exclusion from the readmissions policy. Most conditions excluded from the HEDIS All-Cause Readmissions measure are also excluded from this policy.

Cases will be excluded from the policy if the admission is related to:

- Chemotherapy*
- Non-acute facility
- Children under 18 years of age
- Organ transplant*
- Medicaid
- Potentially planned procedures*
- Medicare critical access hospitals
- Rehabilitation*
- Sickle cell disease
- Leaving against medical advice on the original admission

**HEDIS Plan All-Cause Readmissions algorithm is applied to these cases to identify an admission for exclusion from the policy.*

Sepsis

Louisiana Blue conducts clinical validation to ensure the accuracy of diagnosis and procedure codes and diagnosis-related group (DRG) assignment for all inpatient DRG claims. Our reviewers (including our vendors) use evidence-based clinical guidelines from nationally recognized sources (current and widely accepted Sepsis-3 criteria) to clinically evaluate medical records. DRG validation of clinical records allows us to confirm that clinical evidence supports the codes billed on a claim and reflects the clinical scenario for Sepsis 3. Louisiana Blue requires all claims for payment to include diagnoses that can be clinically validated in the medical record documentation. The Sepsis-3 definitions, published in 2016, are the global standard for diagnosing sepsis. They define sepsis as life-threatening organ dysfunction caused by a dysregulated host response to infection, using the Sequential Organ Failure Assessment (SOFA) score to quantify organ dysfunction.

Inpatient Unbundling Policy

Louisiana Blue's Blue Advantage Inpatient Unbundling Policy generally aligns with, and is similar to, the CMS policy on routine services and supplies that should be bundled in the room and board charges.

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

Please see below for the Inpatient Unbundling Policy. *See also* the CMS *Provider Reimbursement Manual*, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6.

Description

The purpose of the Inpatient Unbundling Policy is to document a payment policy for covered medical and surgical services and supplies. Healthcare providers (facilities, physicians and other healthcare professionals) are expected to exercise independent medical judgment in providing care to patients. The Inpatient Unbundling Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes for HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, National Uniform Billing Committee (NUBC), CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Reimbursement Information

A claim review conducted on an itemized bill statement involves an examination of that statement and may involve reviewing the associated medical records for unbundling of charges and/or inappropriate charges.

CMS *Provider Reimbursement Manual*, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6, defines "routine services" as those services included by the provider in a daily service charge–sometimes referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine service and (2) special care units (SCU), including coronary units (CCU) and intensive care units (ICU). Included in routine services are the regular room, dietary services, nursing services, minor medical and surgical supplies, medical social services, psychiatric social services and the use of certain equipment and facilities for which a separate charge is not applicable.

Equipment commonly available to patients in a particular setting or ordinarily furnished to patients during the course of a procedure, even though the equipment is rented by the hospital, is considered routine and not billed separately. Special care units must be equipped or have available for immediate use, life-saving equipment necessary to treat critically ill patients. The equipment necessary to treat critically ill patients may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

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

The following illustrative tables include, but are not exclusive lists of, those kinds of facility general and administrative costs and charges, including routine disposable and reusable equipment, supplies and items, which a facility may not separately bill for reimbursement.

Personnel and additional staff	Oxygen transport fees
Non-specific hospital nursing teams. Specific nursing teams performing services related to wound care, advanced IV access lines, ostomy care, etc. may be allowed.	Pharmacy fees of any kind, including "mixing fees," phone calls, pharmacy drug consults and any pharmacy related charges outside the cost of the medication.
Call back time for physicians or staff.	Stand by charges for physicians or staff.
Hospital emergency code alerts, rapid alert teams, code teams, etc.	Stat charges.
Any administration fees performed by hospital nurses, i.e., TPN, blood transfusion, medication, chemotherapy, IV fluid administration, etc.	Technician time of any kind, i.e., respiratory, X-ray, lab, nursing, etc.
Isolation care and/or Universal Precautions.	Maintenance of hospital equipment.
Any form of incremental nursing care.	Assistance by hospital staff for any bedside procedures performed by physicians or other qualified healthcare personnel regardless of patient location.
Management and/or participation in cardiac arrest event and/or performance of CPR (cardiopulmonary resuscitation) by hospital staff.	Insertion, discontinuation and/or maintenance of IVs, PICC lines, nasogastric tubes, foley catheters, etc. performed by hospital nurses.
Respiratory services performed by hospital nurses, i.e., incentive spirometry, nebulizer treatments, suctioning, trach care, etc.	Monitoring and maintenance of peripheral or central IV lines and sites, including site care, dressing changes and flushes.
Patient monitoring of any kind.	Patient transportation fees.
Set up and take down of any equipment.	Patient and family Education and Counseling, including diabetic education, smoking cessation, lactation, CPR.
Oximetry	Any charge for the performance of a bedside procedure.

Routine services and supplies are included by the provider in the general cost of the room where services are being rendered or the reimbursement for the associated surgery or other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies and services that are not separately billable. This is not an all-inclusive list:

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over the counter are not separately billable, including medications available over the counter without a prescription. This shall include, but is not limited to, medications such as acetaminophen, ibuprofen, guaifenesin, ascorbic acid, famotidine, probiotics, zinc sulfate, melatonin, senna/docusate and multivitamins.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment, such as pulse oximeter, blood pressure cuffs, bedside table, etc., that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

1. Routine Supplies

The hospital basic room and critical care area room (cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recover and trauma) daily charge shall include all personal care, supply items and equipment, and are not separately billable. These include, but are not limited to:

- Admission, hygiene and/or comfort kits soap
- Alcohol swabs
- Band-aids
- Basin
- Bedpan, regular or fracture pan
- Blood tubes
- Drapes
- Dressings
- Emesis basin
- Heat light or heating pad
- Ice packs
- Irrigation solutions
- Items used to obtain a specimen or complete a diagnostic or therapeutic procedure
- IV arm boards
- Kits, trays or packs, including angio kits, cath lab kits, dressing change or line insertion kit
- Lotion
- Lubricant jelly
- Meal trays
- Mid-stream urine kits
- Mouth care kits
- Mouthwash
- Needles
- Oral swabs
- Oxygen masks
- Pillows
- Preparation kits
- PPE used by patients or staff
- Razors
- Restraints
- Reusable sheets, blankets, pillowcases, drawsheets, underpads, washcloths and towels
- Saline solutions
- Sharps containers
- Socks/slippers
- Specipan
- Staplers and reloads
- Sutures
- Syringes
- Tape
- Tubes
- Thermometers

2. Medical Equipment

The hospital basic room and critical care area room (cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recover and trauma) daily charge shall include, but is not limited to, all of the following services, personal care and supply items and equipment, and are not separately billable:

- Ambu bag
- Aqua pad motor
- Arterial pressure monitors (inclusive of critical care room charge only)
- Auto syringe pump
- Automatic thermometers and blood pressure machines
- Bed scales
- Bedside commodes
- Blades
- Blood pressure cuffs
- Blood storage
- Blood tubes
- Blood warmers
- Cardiac monitors
- Catheters (exception of catheters for heart cath and drug eluting or coronary stents)
- Cannisters or containers/bags of any kind
- CO2 monitors
- Connectors and stopcocks
- Crash cart
- Defibrillator and paddles
- Digital recording equipment/printouts or photography
- Dressing/gauze/bandages
- Emerson pumps
- Fans
- Feeding pumps
- Flow meters
- Footboard
- Glucometers
- Guest beds
- Heating or cooling pumps
- Hemodynamic monitors (inclusive of critical care room charge only)
- Hemostats
- Humidifiers
- Infant warmer
- IV pumps; single and multiple line; tubing
- Kits, trays or packs (including angio kits, cath lab kits, dressing change or line insertion kit)
- Nebulizers
- Overhead frames
- Over-bed tables
- Oximeters/oxisensors – single use or continuous
- Patient room furniture; manual, electric, semi-electric beds
- PCA pump
- Penlight or other flashlight
- Pill pulverizer
- Pressure bags or pressure infusion equipment
- Radiant warmer
- Sealants/skin adhesives
- Sitz baths
- Staplers and reloads
- Stethoscopes
- Sutures
- Telephone
- Televisions
- Traction equipment
- Transport isolette
- Tubes and lines
- Wall suction, continuous or intermittent
- Wound care supplies and wound vacs

3. Routine Services Included in Facility Basic Charges

The hospital basic room and critical care area room (cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recover and trauma) daily charge shall include, but is not limited to, all of the following services, personal care and supply items and equipment, and are not separately billable:

- Administration of blood or any blood product by nursing staff (does not include tubing, blood bank preparation, etc.)
- Administration or application of any medicine, chemotherapy and/or intravenous fluids
- Assisting patient onto bedpan, bedside commode or into bathroom
- Assisting physician or other licensed personnel in performing any type of procedure in the patient's room, treatment room, surgical suite, endoscopy suite, cardiac catheterization lab or X-ray
- Bathing of patients
- Blood storage
- Body preparation of deceased patients
- Cardiopulmonary resuscitation
- Changing of dressing, bandages and/or ostomy appliances
- Changing of linens and patient gowns
- Chest tube maintenance, dressing change, discontinuation
- Enemas
- Enterostomal services
- Feeding of patients
- Incontinent care
- Insert, discontinue and/or maintain nasogastric tubes
- Insertion and maintenance of peripheral or central intravenous lines and/or arterial lines and sites – to include site care, dressing changes and flushes
- Intubation
- Lab specimen collection
- Lidocaine or xylocaine
- Maintenance and flushing of J-tubes, PEG tubes and feeding tubes of any kind
- Management or participation in cardiopulmonary arrest event. Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry.
- Medical record documentation
- Monitoring of cardiac monitors, CVP (central venous pressure) lines, Swan-Ganz lines/pressure readings, arterial lines/readings, pulse oximeters, cardiac output, pulmonary arterial pressure
- Nerve block anesthesia
- Neurological status checks
- Nursing care
- Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry
- Obtaining of: finger-stick blood sugar, blood samples from either venous sticks or any type of central line catheter or PICC (peripherally inserted central catheter) line, urine specimens, stool specimens or any body fluid specimen
- Oral care
- Oxygen and oxygen maintenance
- Patient and family education and counseling
- Physician critical care
- Preoperative care
- Set up and/or take-down of: IV pumps, suctions, flow meters, heating or cooling pumps, over-bed frames, oxygen, feeding pumps, TPN, traction equipment, monitoring equipment
- Shampoo hair
- Start and/or discontinue intravenous lines
- Suctioning or lavaging of patients
- Tracheostomy care and changing of cannulas
- Transporting, ambulating, range of motion, transfers to and from bed or chair
- Turning and weighing patients
- Urinary catheterization

4. Critical Care Units

In addition to the above listed services, personal and supply items, and equipment, if post-operative surgical or procedural recovery services are performed in any critical care room setting (other than the post-anesthesia recovery room), the critical care daily room charge will cover recovery service charges and intensive care nursing.

5. Surgical Rooms and Services

The hospital surgical room (surgical suites (major and minor), treatment rooms, endoscopy labs, cardiac cath labs, X-ray, pulmonary and cardiology procedural rooms) charge shall include nursing personnel services, supplies and equipment (as included in the basic or critical care daily room charges). In addition, the following services and equipment, which are provided for illustrative purposes and do not constitute an all-inclusive list, will be included in the surgical rooms and service charges, and are not separately billable:

- Air conditioning and filtration
- All reusable instruments charged separately
- All services rendered by RNs, LPNs, scrub technicians, surgical assistants, orderlies and aides
- Anesthesia equipment and monitors
- Any automated blood pressure equipment
- Any surgical kit, tray or pack (including angio kits, cath lab kits, dressing change or line insertion kit)
- Blades
- Blood storage
- Cannisters or containers/bags of any kind
- Cardiac monitors
- Cardiopulmonary bypass equipment
- CO2 monitors
- Crash carts
- Digital recording equipment and printouts
- Dinamap
- Dressings/gauze of any kind
- Fracture tables
- Grounding pads
- Hemochron
- Hemoconcentrator
- Hemostats
- Laparoscopes, bronchoscopes, endoscopes and accessories
- Lights, light handles, light cord, fiber optic microscopes
- Midas Rex
- Monopolar and bipolar electrosurgical/bovie or cautery equipment
- Obtaining laboratory specimens
- Power equipment
- Room heating and monitoring equipment
- Room set up of equipment and supplies
- Saline slush machine
- Sealants/skin adhesives
- Solution warmer
- Staplers and reloads
- Surgeons' loupes or other visual assisting devices
- Sutures
- Transport monitor
- Tubes/lines
- Video camera and tape
- Wall suction equipment
- Wound supplies
- X-ray film

6. Telemetry

In any basic care room billed at higher than the provider's posted base room rate, or any room identified as a post-critical care, progressive care, intermediate care or step-down care, wherein the patient is monitored by telemetry, telemetry will be considered included in the higher room rate. Charges for medically necessary mobile telemetry units will be allowed unless services are rendered in one of the settings described in the preceding sentence. Examples of basic care rooms are labor and delivery, newborn nursery (levels I and II), pediatric, medical, surgical, rehabilitative, oncology, orthopedic, neurological and urological.

7. Respiratory Therapy

Respiratory treatment charges include the machine, circuits, respiratory technician time, water, ambu bag and any vent disposable supplies. A ventilator or bipap/CPAP hourly/daily charge includes the following respiratory technician services: manual ventilation charges during any in hospital transport; intubation and/or extubation charges and related supplies; respiratory assessment; endotracheal tube care, etc.

An oxygen or vapotherm hourly/daily charge is not reimbursed separately from a ventilator hourly/daily charge. When more than one level of respiratory/ventilation support occurs on the same date of service within the same 24-hour period of time, only the highest level of respiratory support will be allowed.

Any education, observation and evaluation of patient use of respiratory equipment will be limited to one charge per stay. Chest wall manipulation, postural drainage, and/or chest physiotherapy are not separately billable. For individual respiratory treatment/inhalers administered multiple times per day, these will be limited to one charge allowed per day.

8. Inpatient Hospital Claim/Billed Charges for Revenue Code 278 Other Implants

Billed charges for revenue code 278 may require a vendor's invoice to support supplies used that correspond to the services rendered unless otherwise agreed upon.

These units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue code 278 will be denied unless otherwise agreed upon.

If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue code 278 will be denied unless otherwise agreed upon.

Louisiana Blue reserves the right to ask for invoices for any item billed.

References

CMS *Provider Reimbursement Manual*, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6.

www.medicalbillingandcoding.org/health-insurance-guide/understanding-medical-bills/

https://aspe.hhs.gov/reports/frequently-asked-questions-about-code-set-standards-adopted-under-hipaa

Medical Management

Overview

Necessary prior authorizations must be obtained for hospital admissions, outpatient services and/or specified diagnostic testing procedures. Refer to the Provider Quick Reference Guide for a listing of procedures requiring prior authorization.

Louisiana Blue affirms:

- Utilization management decisions are based only on appropriateness of care and service and existence of coverage.
- Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or care.
- Financial incentives for utilization management decision makers do not encourage decision that may result in underutilization.
- Incentives are not used to encourage barriers to care and service.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Provider Quick Reference Guide

To determine services that require prior authorization or notification, please refer to the Provider Quick Reference Guide, available on the Blue Advantage Resources page at www.lablue.com/providers, click on "Go to BA Resources," then "Manuals and Guides." (www.lablue.com/ilinkblue). These lists are updated periodically, as applicable.

Medical Criteria

The Medical Management Department is responsible for administering authorizations, medical necessity determinations and monitoring the appropriateness and efficiency of services rendered. Certain services require an authorization to confirm that the member's PCP and Louisiana Blue has approved the member's specialty care services.

Resources utilized for benefit and medical necessity determinations include:

- Member's Evidence of Coverage (EOC) and Summary of Benefits
- Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare Managed Care Manuals

- Medicare Advantage criteria documents including medical policy and authorization guidelines
- Louisiana Blue medical directors or other appropriate practitioners with professional or clinical expertise
- Standardized Criteria (e.g., InterQual, DSM-5, ASAM, etc.)

For more information, please contact the Blue Advantage Medical Management Department. In addition, Blue Advantage Medical Policy is developed, approved and updated periodically with involvement from actively practicing Blue Advantage Providers and other healthcare professionals as needed. All criteria, including behavioral health, are reviewed and approved by the Utilization Review Committee annually and as needed in the interim. At least annually, the entire collection of policies is evaluated by the Utilization Review Committee for continued relevance and effectiveness.

Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they relate to the member's clinical circumstances.

The criteria used in the determination of medical appropriateness of services are clearly documented. The criteria are available upon request to all participating providers, to members and the public. The materials provided are guidelines Louisiana Blue uses to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and benefits covered under individual provider contracts and/or member benefit plans.

Incentives and/or bonuses are not used to influence clinical or utilization review decisions made by physicians or staff. Medical Management decisions are based only on appropriateness of care and service, application of appropriate criteria and existence of coverage. Practitioners or other individuals conducting utilization review are not specifically rewarded or given financial incentives for issuing denials of coverage or making determinations resulting in under-utilization of healthcare. Employees and all decision-making practitioners and providers who attend the Utilization Review Committee meetings sign a statement to this effect. Louisiana Blue may develop recommendations or clinical guidelines for the treatment of specific diagnoses or the utilization of specific drugs. These guidelines will be communicated to participating providers through iLinkBlue, direct emails or other communications.

If you would like to propose a topic to be considered for discussion by Louisiana Blue's Utilization

Review Committee, please contact the Medical Management Department or a Louisiana Blue medical director.

Prior authorization or any other determination of medical necessity does not guarantee eligibility for payment. Eligibility of members for payment to providers shall be based upon the member's actual eligibility under the applicable benefit plan at the time covered services are rendered and shall be subject to the rescission policy of Louisiana Blue.

New Technologies

Louisiana Blue advocates the provider's freedom to communicate with patients regarding available treatment options, including medication alternatives, regardless of benefit coverage.

Louisiana Blue also has a process for accepting requests from providers to consider new and emerging technologies and criteria. Such requests should be submitted with a letter outlining the medical necessity of the procedure or criteria and any medical documentation on the subject. Louisiana Blue will determine if the new treatment or procedure is a covered benefit.

Please note that new and emerging technology must be a covered benefit under traditional Medicare before it can be approved for Blue Advantage members.

Organization Determinations

Patient-specific information is needed by Louisiana Blue to determine the medical necessity and member's benefit for a requested procedure. This information includes:

- ICD-10 diagnosis and procedure codes, as applicable
- Prior procedures/testing/treatments that have been tried and failed (include supporting documentation, photos, if applicable)
- Plan of treatment
- Requested service description (include CPT® and HCPCS codes)
- Expected outcome
- Location services are to be provided
- Requesting provider information

If the request is for Blue Advantage (HMO) out-of-network services, also include:

- The reason the member needs to go out-of-network.
- The name of network providers who have been consulted.
- The medical records from the requesting physician and consulting physicians.

Please send all requests for benefit determinations to Blue Advantage Medical Management, at the address or fax noted in the Plan Information Contact List in the front of this manual or call the Medical Management Department to make a request.

For information regarding members' benefits and coverage, providers can find this in iLinkBlue by clicking on "Coverage," selecting "Coverage Information," then entering the member's contract number or Social Security Number to access the Coverage Information screen. Next, click "Summary" to view the member's cost share information or click "Benefits" to view their coverage details.

Prior Authorizations and Notifications

Prior authorization is the process of collecting information in advance of authorizing the non-emergency use of facilities, diagnostic testing and other services before care is provided.

Note: See Carelon Utilization Management Programs section of this manual for services that require Carelon Medical Benefits Management review.

To request a prior authorization of items or services, providers may use iLinkBlue to electronically submit authorizations for select services. Providers can also fax authorization request by downloading authorization forms from our Provider page at www.lablue.com/providers >Blue Advantage Resources >Forms. If a call is needed to the Blue Advantage Medical Management Department, contact information can be found in the Plan Information Contact List located in the front of this manual. The phones are forwarded to a secure voice mail system during non-business hours. Calls received after hours or on the weekend are returned on the next business day. The fax is available 24 hours a day, seven days a week. Please allow up to 7 days for a standard decision and 72 hours for an expedited decision to be rendered.

The prior authorization process permits advanced eligibility verification, determination of coverage and communication with the requesting provider or member. Prior authorization also allows Blue Advantage providers to identify members for pre-service discharge planning and case management. Prior authorizations will define the amount type to be authorized and/or an acceptable length of stay.

Prior authorizations are accepted by telephone, fax, or the online authorization portal for certain service types, with a review conducted by a representative of the Medical Management Department, medical director or board-certified specialist. In each case, the review ensures that coverage for the services are included in the individual's benefit plan, that services are provided at the most appropriate level of care and site, and that the services are medically necessary. Only the medical director may determine a denial of services based on medical necessity. Providers may request

criteria used to make a medical necessity determination by calling the Blue Advantage Medical Management Department.

Outpatient Services Requiring Prior Authorization

Providers must contact Blue Advantage Medical Management at least 7 days prior to the services or procedure being provided. If a previously authorized elective service is canceled, Blue Advantage Medical Management must be notified of that cancellation and the rescheduled date, if applicable. A list of outpatient services requiring authorization are included in the Provider Quick Reference Guide.

A new authorization may be required if the authorized health service requested has not been delivered within the time frame specified in the authorization.

Louisiana Blue's decision regarding an authorization is an organization determination. Louisiana Blue's decision is never intended to limit, restrict or interfere with the provider's medical judgment. In all cases, decisions regarding treatment continuation or termination, treatment alternatives or the provision of medical services are between provider and patient.

Notification is the act of providing notice or alerting Louisiana Blue of a particular service provided to a Blue Advantage member. The notification process permits eligibility verification, communication with the PCP and/or member, identifies members for concurrent review, pre-service discharge planning and case management. The Blue Advantage Medical Management Department will accept verbal notification from the scheduling specialist, the facility or the PCP.

Other Outpatient Services that Require Authorization

Home Health Services: When it is medically appropriate and a member is confined to his/her home, home health care may be an appropriate alternative.

Initial authorizations and subsequent requests for home health services may be obtained from the Home Health Case Management Department. Please submit the request electronically through iLinkBlue using the Louisiana Blue Authorizations application or fax the request with progress notes and the current plan of care to the number referenced in the Plan Information Contact List at the beginning of this manual. To check the status of a request that has been submitted, you may contact the Blue Advantage Home Health Case Management Department.

Louisiana Blue requires one Notice of Admission (NOA) for any series of Home Health periods of care beginning with admission to home care and ending with discharge. Home Health Agencies (HHAs) shall not submit an NOA for subsequent 30-day periods of care with the exception of the one-time NOA submission for beneficiaries receiving HH services in 2025 and continuing services in 2026.

Durable Medical Equipment (DME): Blue Advantage members are eligible to receive medically necessary durable medical equipment and supplies. Please refer to the "Provider Quick Reference Guide" for authorization requirements.

DME Providers must submit the request to the Blue Advantage Medical Management Department for authorization for rental or purchase of DME items. Blue Advantage will issue a decision as expeditiously as the member's health condition requires in order to minimize any disruption in the provision of healthcare. These requests would be submitted through the Medical Management Outpatient Services fax, electronically through iLinkBlue using the Louisiana Blue Authorizations application or phone number as referenced in the Plan Information Contact List at the beginning of this manual.

Inpatient Admissions

Initial and concurrent review encompasses those aspects of patient care management that take place during the provision of services at an inpatient level of care. All reviews are conducted electronically, by phone or via fax utilizing medical necessity review criteria and Medicare guidelines. Contact information, including fax and phone numbers, are identified in the Provider Quick Reference Guide, as well as in the Plan Information Contact List at the beginning of this manual. Requests for urgent concurrent cases will be completed and the facility notified within 72 hours of receipt, as long as all required information is submitted with the request.

The concurrent review process includes the following activities:

- Collection of necessary information from providers and facilities concerning the care provided to members.
- Assessment of the clinical condition and ongoing medical services and treatments to determine benefit coverage and medical necessity.
- Identification of continuing care needs to facilitate discharge to the appropriate setting.
- Discharge planning and coordination.

To facilitate initial and concurrent review and discharge planning, facilities are required to perform the following activities:

- Provide clinical information to Blue Advantage Medical Management upon one business day of admission to obtain an initial authorization.
- Provide updated clinical information as requested by plan staff within one business day of request to obtain authorization for days beyond the initial length-of-stay authorization.
- Provide anticipated discharge dates to Blue Advantage Medical Management to issue final length-of-stay authorization for claims payment and ensure effective and appropriate coordination of after-care services.

Prior Authorization of Elective Inpatient/Hospital Services

Providers are required to obtain prior authorization for all elective inpatient/hospital admissions from the Blue Advantage Medical Management Department. Prior authorization is mandatory for elective inpatient hospital cases to qualify for payment.

Louisiana Blue may accept the hospital's or the attending physician's request for prior authorization of elective hospital admissions. However, neither party should assume that the other has obtained prior authorization.

Note: Carelon reviews select inpatient services such as spine surgery, total hip replacements and total knee replacements. See the Carelon Utilization Management Programs section of this manual.

Inpatient Rehabilitation Admissions

If a member requires an inpatient rehabilitation admission to a rehabilitation hospital, the rehabilitation hospital must contact Blue Advantage Medical Management prior to admission. The admission will be reviewed utilizing national and local coverage decision guidelines, InterQual Level of Care Criteria® and/or applicable medical policy as well as the Medicare Benefit Policy Manual Chapter 1-Inpatient Rehabilitation Facility (IRF), which can be accessed on the CMS website for reference. All denials are reviewed by a medical director.

Inpatient Skilled Nursing Facility

An admission to a skilled nursing facility will be reviewed by the Blue Advantage Medical Management Department for medical necessity of the admission. These admissions and continued stays will be reviewed for the need for skilled nursing care or rehabilitation services that can only be provided on an inpatient basis in a skilled nursing facility under the supervision of professional or technical personnel. These will be reviewed utilizing InterQual Level of Care Criteria® and/or medical policy as appropriate as well as the Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (Skilled Nursing Facility) Level of Care, which can be accessed on the CMS website for reference. All denials are reviewed by a Louisiana Blue medical director.

Notice of Discharge from an Inpatient Facility, Home Health or Comprehensive Outpatient Rehabilitation Facility (CORF)

The Important Message from Medicare (IM) is an existing statutorily required notice designed to inform Medicare beneficiaries that their covered hospital care, home health or comprehensive outpatient rehabilitation is ending. The physician who is responsible for the member's inpatient hospital care must make the decision that discharge is appropriate. The IM must be given to the member within two days of discharge.

The Notice of Medicare Non-Coverage (NOMNC) is issued to Blue Advantage members notifying them that their skilled services, home health care or CORF services are ending. Per CMS guidelines, the NOMNC must be given to the member and/or their identified representative a minimum of two days prior to discharge even if they agree the service should end. A signed NOMNC must be faxed to Blue Advantage Medical Management.

This form is located on the Blue Advantage Provider Portal and sample document is included at the end of this manual. The member's appeal rights are included in both the IM and NOMNC forms.

Medicare Outpatient Observation Notice (MOON)

CMS requires all hospitals to notify Medicare enrollees, including MA members, of their status as an outpatient receiving observation services. The Medicare Outpatient Observation Notice (MOON) is a standardized notice developed to inform members that they are not an inpatient of the hospital or critical access hospital (CAH) and the implications of outpatient observation status with regard to cost-sharing and eligibility for skilled nursing facility (SNF) coverage.

Hospitals and Critical Access Hospitals (CAH) are required to furnish the MOON to Medicare beneficiaries when a member is in observation setting for 24 hours or more, if the member has not already received the form prior to being admitted for observation.

The notice must be provided no later than 36 hours after emergency department or observation services are initiated or, sooner, if the member is transferred, discharged or admitted.

Services with an applicable medical policy rendered during an observation stay require Prior Authorization.

Note:

- Observation stays do not require prior authorization. However, Louisiana Blue will review services provided during an observation stay against applicable medical policies prior to claims payment. Applicable Prior Authorization penalties and rules will apply.

- Providers are required to request a prior authorization review of medical policy services that will be performed during an observation stay prior to the service(s) being rendered.
- Carelon Medical Benefits Management (Carelon) reviews a subset of Blue Advantage medical policies, but not in the observation setting. If Carelon reviews and denies a service related to medical policy in a setting other than observation, Louisiana Blue will not reimburse the same service even though performed in the observation setting. If your original plan of care includes services with applicable medical policy and criteria that are now planned for the observation setting, contact Louisiana Blue directly.
- If you would like to review specific medical policy coverage guidelines, access our medical policy index on the Provider page (www.lablue.com/providers) under "Blue Advantage Resources," then "New/Revised Medicare Advantage Medical Policies." Policies are listed in alpha order or you may search by keyword, procedure code, policy name or policy number.

Carelon Utilization Management Programs

Louisiana Blue has several utilization management programs that are administered by Carelon Medical Benefits Management (Carelon), an independent company that serves as an authorization manager for Louisiana Blue, HMO Louisiana and Blue Advantage members. For these programs, prior authorization requests should be made directly to Carelon using its MBM Provider Portal, which is available under the "Authorizations" section of iLinkBlue.

Ordering physicians (whether a primary care provider or specialist) are required to provide Carelon with basic clinical information and patient demographics to obtain the authorization. PCPs are not expected to obtain the authorization if a specialist orders the service. Hospitals and freestanding facilities may check the status of an authorization request through the Carelon MBM Provider Portal accessed on iLinkBlue. They may also obtain authorization if they have all relevant information required for the authorization process.

Carelon clinical appropriateness guidelines are available online at www.guidelines.carelonmedicalbenefitsmanagement.com. If a request for authorization is denied, Carelon notifies the ordering physician of the denial and the process for appeals. Reconsideration of a denied authorization should be submitted directly to Louisiana Blue using the process outlined in the Adverse Initial Organizational Determination Process section of this manual. Please allow ample time in scheduling services to ensure the authorization process is completed and approved before the patient receives services. Services that do not meet criteria will be denied and are not billable to the member.

Reminders for navigating Carelon's review process:

- If you file a claim for a service that requires prior authorization, but prior authorization was not completed contact Louisiana Blue customer service for next steps.
- Provide medical records to Carelon during the review process. If you send medical records to Louisiana Blue, we will not forward them to Carelon. We will send them back to you and advise you to contact Carelon. This is because Louisiana Blue does not perform these reviews.
- You can initiate these reviews through the Carelon MBM Provider Portal, accessed on iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" tab, or by contacting Carelon at 1-866-455-8416.

Behavioral Health Authorization Information

Inpatient, Partial Hospitalization and Intensive Outpatient Program

Providers are required to obtain authorization for inpatient behavioral health hospitalization, substance abuse detoxification, partial hospitalization and intensive outpatient treatment to receive payment for services. Due to the typically urgent nature of inpatient psychiatric and substance abuse detoxification admissions, a request for authorization must be submitted within 24 hours of admission when preauthorization is not possible. Preauthorization must be obtained for all non-urgent elective services such as partial hospitalization or intensive outpatient treatment. All requests for authorization must be submitted using the "Request for Authorization of Behavioral Health Services." This document provides detailed information concerning information required for authorization as well as contact information for Blue Advantage Behavioral Health Utilization Management. A sample form is included at the end of this manual and is also located in iLinkBlue.

Behavioral Health Medical Management staff will utilize InterQual Level of Care Criteria® when conducting medical necessity reviews for initial authorization and concurrent review. All cases that do not meet medical necessity criteria per InterQual criteria or other approved clinical practice guidelines are referred to a medical director for secondary review. All denial decisions are issued by a medical director following secondary review.

Other Behavioral Health Services

Utilization reviews for behavioral health and substance abuse are conducted through preauthorization reviews, concurrent reviews, and/or retrospective reviews. At Louisiana Blue's discretion, services may be approved retroactively for up to 30 days.

Components of the Behavioral Health Medical Management program will include:

- The management of the member's care (where and when appropriate) according to the identified medically necessary need and clinical criteria. These efforts supplement any services provided by the member's healthcare provider.
- Ensuring the provision of services based on access time frames as determined by regulatory authorities and community standards.
- Ongoing collaboration and cooperation (where and when appropriate) among the various entities and agencies involved in the member's care.
- Ensuring the provision of treatment services according to best practices and methodologies.
- Referring members to appropriate Louisiana Blue Care Management Programs. A description of the Blue Advantage Care Management Programs is included in this manual.

Louisiana Blue provides additional support and guidance through the Blue Advantage Behavioral Health Service Authorization Guidelines, which are available on iLinkBlue (www.lablue.com/ilinkblue). This document provides additional information to providers regarding expectations for quality of care and clinical documentation required before obtaining authorization for services.

Network and Out-of-Network Providers

Louisiana Blue strives to provide a comprehensive network of providers to meet our members' healthcare needs. Participating providers help ensure the affordability and success of their patients' healthcare by referring them to participating network providers. In rare instances, a patient may have a medical need for a non-emergent service that cannot be met by a network provider. If the contracted providers are unable to refer to a network provider, prior authorization from the Medical Management Department will be required before the patient can be referred to a nonparticipating provider, for members enrolled in the Blue Advantage (HMO) plan.

Blue Advantage (PPO) plan members do not require prior authorization to obtain services out-of-network. If a contracted provider wishes to refer to an out-of-network (OON) provider, the referring contracted provider must contact the Blue Advantage Medical Management Department at the number in the front of this manual. Medical Management will perform the following activities:

- Confirm the provider is OON.
- If OON, search the provider/pharmacy directory to determine if there is an in-network specialist of the same type as being requested within the member's service area. If there is not, the OON request may be approved by Plan at its sole discretion.

- If there is an in-network specialist, Medical Management requests the referring contracted provider's office to withdraw the request for the OON specialist and redirect to an in-network specialist.
- If the referring contracted provider does not want to redirect, they are asked to send in clinical information to Medical Management to support the need for the OON specialist.

The Gold Card Program

Louisiana Blue implemented a Gold Card Program for certain services that require authorization. This program is designed to help lessen the administrative burdens for providers meeting the established criteria.

The Gold Card Program applies to high-tech imaging services. Participating providers who meet the below program criteria receive the following benefits.

Provider Type	Participation Criteria	Gold Card Program Benefit
Professional Providers	• Has a volume of at least 50 high-tech imaging service requests per year. • Maintains an authorization approval rating of 95-99%.	Always receives an approval for the following high-tech imaging authorization requests: • Computerized Tomography (CT) Scans • Magnetic Resonance Imaging (MRI) • Magnetic Resonance Angiography (MRA) • Nuclear Cardiology Procedures • Positron-emission Tomography (PET) Scans

Professional providers participating in the high-tech imaging Gold Card Program must continue to submit authorization requests to allow for claim payments. Louisiana Blue also needs this information for audit purposes to evaluate continuation in the program annually. Submit high-tech imaging requests through the Carelon Authorizations application available through iLinkBlue (www.lablue.com/ilinkblue). Services authorized by Louisiana Blue rather than Carelon should be submitted through the Louisiana Blue Authorizations application in iLinkBlue. Louisiana Blue will always approve the authorization for the high-tech imaging service.

If your case is selected for audit, you will see a message at the top of the Carelon page directing you to upload additional documentation that supports the medical necessity of the request. If you do

not submit the requested additional documentation for the audit case, we will consider the case "audit criteria not met." Failure to participate or to pass the audit will result in loss of future Gold Card status.

Note: Providers must request at least 50 cases during the Gold Card period to continue participation.

Transition of Services criteria:

- With the exception of transplant services, the services requested are not available from contracted providers within the member's service area.
- Dialysis, until the member can be transitioned to a participating provider or up to a period of 60 days from the effective date for new members or from the time the member's provider terminated from the network. Newly-diagnosed or relapsed cancer in the midst of a course of treatment (radiation or chemotherapy).
- Members who are a recipient of an organ or bone marrow transplant and are within a year post-transplant.
- Current hospital confinement.
- A terminal illness, for the length of the terminal illness.
- Performance of a scheduled surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment and is scheduled to occur within 30 days of the provider's contract termination date or the effective date of coverage for a new member.
- A pregnancy in the second or third trimester on the member's effective date and the immediate post-partum period.

Non-emergent, out-of-network services will not qualify for coverage unless authorized prior to services being rendered by Blue Advantage's Medical Management Department.

Initial Organizational Determination (IOD)

Whenever a Blue Advantage member contacts Louisiana Blue to request a service, the request indicates that the member believes that Louisiana Blue should provide or pay for the service. Thus, the request constitutes a request for a determination and Louisiana Blue's response to the request constitutes an organization determination. However, if a provider declines to give a service that a member has requested or offers alternative services, this is not an organization determination (the provider is making a treatment decision). In this situation, the member must contact Louisiana Blue to request an organization determination for the service in question or the provider may request the organization determination on the member's behalf.

When there is a disagreement with a provider's decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an organizational determination from Louisiana Blue regarding the services or treatment being requested. Louisiana Blue is required to make an independent decision in these matters and will request medical records in order to make that decision. All parties will be notified in writing of the plan's decision.

Adverse Initial Organizational Determination Process

An adverse determination is a decision by the plan or its designee that an admission, availability of care, continued stay or other healthcare service has been reviewed and, based upon the information provided, does not meet the plan's requirements for coverage. These requirements include medical appropriateness and necessity, appropriate healthcare setting/level of care or quality and effectiveness of care. As a result of not meeting these requirements, the coverage for the requested service is subsequently denied or reduced. Louisiana Blue provides an appeal process for members in the event of an adverse determination.

For adverse decisions on pre-service requests, Louisiana Blue offers a peer-to-peer discussion to the requesting provider. This discussion is not an appeal, and the member or member's representative can appeal the adverse decision by following the directions on the accompanying denial notice.

Adverse determinations of requested services made in the course of the review process are communicated verbally or via fax to the requestor within one business day from when the determination is made. This communication is confirmed in writing via the Integrated Denial Notice (IDN) within three days of the oral communication. A copy of the Integrated Denial Notice is included in the "Forms" section of this manual. This notification is sent to the patient or responsible party, the physician and facility (if applicable). The reason(s) for the adverse determination of requested services, available alternatives and the appeal rights and procedures are included in the notices of denial. Blue Advantage members must receive this determination within 14 days of service request, unless an expedited determination is necessary. Other levels of the member's appeal process are addressed in Louisiana Blue's Evidence of Coverage.

Expedited Member Appeals

Expedited appeals for requested services pertain to those services in which the standard appeal time period (30 days) could seriously jeopardize the member's life, physical or mental health or the member's ability to regain the maximum function. Louisiana Blue must resolve an expedited review within 72 hours or as expeditiously as the member's physical or mental health requires. An expedited appeal can be made by the member or provider on behalf of the member.

Clinical Trials

There are certain requirements for Medicare coverage of clinical trials. Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage (MA) plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials.

If you have a patient that you intend to refer for a clinical trial, please notify Blue Advantage's Medical Management Department prior to enrolling the member in the clinical trial or providing service related to the clinical trial.

Policy Statement for Medicare Advantage Plans

Louisiana Blue follows the U.S. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) and coverage guidelines for clinical trials. Original Medicare (also referred to as Medicare "fee for service") covers most of the routine costs for Medicare Advantage plan members participating in qualified Medicare clinical trials. Qualified Medicare clinical trials are found at www.clinicaltrials.gov.

Clinical Trials that qualify for coverage under the Clinical Trials Policy (CTP)

Louisiana Blue is responsible for the difference in the member cost sharing for original Medicare and the member's Blue Advantage plan cost sharing. If the Blue Advantage plan cost share is higher than original Medicare, then Louisiana Blue will not make a payment. Claims should first be submitted with the Medicare contractor that processes fee-for-service claims and then submit the claim to Louisiana Blue with the Medicare Explanation of Member Benefits.

Investigational Device Exemption (IDE) Studies

Category A IDE studies – Louisiana Blue reimburses coverage of routine services only related to Category A IDE studies.

Category B IDE studies – Louisiana Blue covers devices and services related to Category B IDE studies, unless the Category B device is paid for by the trial sponsor. Category B investigational devices must be used in the context of an FDA-approved trial. Approved IDE studies are posted on www.cms.gov/medicare/coverage/evidence.

Clinical Trials approved under Coverage with Evidence Development (CED)

For National Coverage Determinations (NCD's) requiring CED, Louisiana Blue will reimburse items and services in CMS-approved CDE studies unless CMS determines that the significant cost threshold is exceeded for that item or service. Approved CED studies are found at www.cms.gov/medicare/coverage/evidence.

Where to submit claims

Type of clinical trial	Where to submit claim
IDE (category A and category B)	MA plan
Clinical trials that qualify for coverage under a CED	MA plan unless CMS determines that the significant cost threshold is exceeded
Clinical trials that qualify for coverage under the clinical trial policy	Original Medicare

Billing Requirements

It is **mandatory** to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED. Electronic claim 837I, the 8-digit clinical trial number should be in Loop 2300 REF02 (REF01=P4). Electronic claim 837P, the 8-digit clinical trial number should be in Loop 2300, REF02, REF01=P4 (do not use 'CT' prefix on the electronic claim). Paper UB claims, the 8-digit clinical trial number should be in Field Locators 39-41 (use 'D4'). Paper CMS-1500 form, the 8-digit clinical trial number should be in Field 19 (preceded by 'CT'). **Important: All claims submitted without an 8-digit clinical trial number shall be returned as unprocessable.**

In addition to the 8-digit clinical trial number, institutional and practitioner paper and electronic claims shall include:

- Condition code 30
- ICD-10 diagnosis code Z00.6 (in either the primary/secondary positions)
- HCPCS modifier Q0 or Q1 as appropriate (outpatient claims only)

Modifier definitions		
Q0	-	**Investigational clinical service provided in a clinical research study that is in an approved clinical research study.**
Q1	-	**Routine clinical service provided in a clinical research study that is in an approved clinical research study.**

The billing provider must include in the beneficiary's medical record the following information: trial name, sponsor and sponsor-assigned protocol number. This information does not need to be submitted with the claim but must be provided if requested for medical review.

References

42 USC CHAPTER 6A, SUBCHAPTER XXV, Part A, Subpart I: General Reform

CMS IOM Publication 100-04 Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, Section 68 - Investigational Device Exemption (IDE) Studies

Clinical Trials - Billing and Coding of Routine Costs

Medicare Coverage Document - Coverage with Evidence Development ced-guidance2024pdf.pdf

Coverage with Evidence Development | CMS

Emergency Care

Louisiana Blue advises members to go to the nearest hospital emergency room if they believe their health is in serious danger. A medical emergency may include severe pain, a serious injury or illness or a medical condition that is rapidly getting worse.

The Blue Advantage Medical Management Department MUST be notified of a hospital admission within 24 hours or by the end of the next business day. If an admission through the emergency room is made by a provider other than the PCP, the PCP should be notified within 24 hours or the next business day following the admission.

Ambulance service for transportation to the hospital is a covered benefit for members in emergencies only. In such an emergency, 911 or another local emergency number should be called.

Out-of-area Care/Urgent Authorizations

Urgent care refers to care delivered when members need medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for members to get medical care from their PCPs or other plan providers. Members (or their authorized representatives) are instructed to contact their PCPs as soon as possible. When urgent care is needed in the service area, members should contact their PCP to direct their care. Notification is required for all urgent out-of-area hospital admissions. You or your patient (or your patient's representative) may satisfy this obligation by contacting a representative of the Medical Management Department.

Nonparticipating Hospitalization

Whenever Louisiana Blue is advised that a Blue Advantage member has been hospitalized on an emergency basis in a nonparticipating facility, we will notify the member's PCP. If the member calls the PCP, then the PCP is required to notify Louisiana Blue within one business day. The patient may be transferred to a Blue Advantage network participating facility when the patient's condition has stabilized. These services require authorization by the Medical Management Department.

Dialysis Patients

For those providers who initiate dialysis for ESRD patients, CMS requires dialysis providers to enter the CMS-2728 Form into the CMS established and governed system, CROWNWeb. Once the information is entered into the system, the provider should print out the form, sign it, have the member sign it and mail it to the Social Security Administration. The website for CROWNWeb is https://mycrownweb.org.

Institutionalized Patients

When a member is in need of long-term custodial care, the member and family can choose any facility within our service area to reside. Please note that the member is going to that facility in a private pay capacity, as neither Louisiana Blue's Blue Advantage plans nor Original Medicare cover the cost of custodial care. Louisiana Blue needs to be informed of this action either by the member, family member or the PCP. The individual can remain a member of his/her Blue Advantage plan; however, the member must continue to abide by plan rules for any care required while living in the facility. For example, non-custodial care must be directed by a network PCP. Blue Advantage network providers must be utilized to receive most covered services.

The PCP has various options to manage a custodial patient, which include:

1. If practical, the patient can continue to be seen in the PCP's office.

2. The PCP can continue to see and treat the patient in the facility.
3. The medical director of the facility may oversee the patient's care on behalf of the PCP. Good communication needs to be established between the PCP and the medical director for the continuation of coordinated care.

Blue Advantage Complex Case Management Program

Purpose

The Blue Advantage Complex Case Management (CCM) Program is designed to help members with complex diseases to regain optimum health or improved functional capacity. Conditions and complex diseases that often benefit from the CCM Program include:

- Hypertension
- Congestive Heart Failure (CHF)
- Atrial Fibrillation
- Coronary Artery Disease
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)

These conditions result in increased acute inpatient hospitalizations and emergency department utilization which drive healthcare costs, making them complex conditions to manage. The program provides coordination of care and ensures applicable resources are delivered in the most cost-efficient setting for members who require extensive or ongoing services. Developed in accordance with the Case Management Society of America's (CMSA) Standards of Practice and evidenced based clinical practice guidelines, CCM services include a comprehensive assessment of the member's health status; determination of available benefits and resources; development and implementation of a care management plan with performance goals, ongoing monitoring and follow-up. Services are provided telephonically and through written educational communication, with an overall goal of improving the member's ability to self-manage his/her condition through increasing care coordination and interaction with the member's primary care provider (PCP) and reducing unnecessary acute inpatient admissions and emergency department utilization.

Goals and Objectives

Objectives of the Blue Advantage CCM Program include:

1. To identify and provide care coordination to members with complex diseases and/or conditions who might benefit from care management services.
2. To facilitate processes to actively assist members and providers with the management of those diseases and to promote self-management of these health conditions.
3. To facilitate access to medical services, preventive health services, behavioral health services

and social services, in addition to other resources.

4. To encourage involvement of members and caregivers in the care process.
5. To ensure appropriate utilization of services and benefits.
6. To promote effective and ongoing health education and disease prevention activities.
7. To assist the member to regain optimum health or improved functional capability.
8. To ensure case management activities take into consideration the patients' health status, history, medications, condition-specific issues, activities of daily living, cognitive and mental health status, life-planning activities, and cultural and physical preferences and limitations.
9. To assist in the identification of barriers and how to overcome them, progress assessment, prioritization of goals, follow-up and communication of self-management plans, as well as involvement of caregivers and referrals to resources.

Provider Referrals

Louisiana Blue values the role that our providers hold in the coordination of care for our members. We encourage referrals directly from providers when they identify a member/patient who might benefit from a more structured program such as the Blue Advantage Complex Case Management Program. For referrals, please contact:

Blue Advantage Case Management Department
Phone: 1-866-508-7145, option 3
Fax: (318) 812-6250

Pharmacy Management

Pharmacy Network

Louisiana Blue provides coverage for prescription medications, and Blue Advantage members may have their prescriptions filled through a wide network of pharmacies, including mail order. Please refer your Blue Advantage patients to their provider/pharmacy directory for a comprehensive list of participating pharmacies. To view the provider/pharmacy directory, go to https://blueadvantage.lablue.com >Find a Doctor or Drug.

Our pharmacy network includes pharmacies that offer preferred cost-sharing. Members who fill their prescriptions at a preferred pharmacy (including mail-order) may pay less for their medications. Preferred pharmacies will be identified in the provider/pharmacy directory.

Medicare Part D Formulary

Louisiana Blue utilizes a formulary (list of covered drugs) for Medicare Part D coverage. For a specific list of covered drugs for Blue Advantage plan members, please refer to the Blue Advantage formulary, which is available in print and also on our website. The formulary is updated each month and posted to https://blueadvantage.lablue.com.

The Medicare Modernization Act of 1996 specifically prohibits certain medications from being covered under Medicare Part D; therefore, the following types of drugs are specifically excluded from coverage for Blue Advantage members:

- Drugs used for anorexia, weight loss or weight gain (except when used to treat AIDS wasting and cachexia due to a chronic disease)
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription (over-the-counter) drugs
- Agents when used for the treatment of sexual or erectile dysfunction (ED)

Louisiana Blue has made arrangements with its pharmacy benefit manager, Express Scripts, Inc., to perform certain Part D functions such as Coverage Determinations and Appeals. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in

the published formulary for Blue Advantage plan members. For information on how to submit a coverage determination or formulary exception request, please refer to the section below called **Part D and Part B Drugs Requiring Prior Authorization**.

Medicare Part D Benefit

Drug Category (Tier)
Tier 1 – Preferred Generics
Tier 2 – Generics
Tier 3 – Preferred Brand*
Tier 4 – Non-preferred Drug
Tier 5 – Specialty

The Blue Advantage Part D formulary is organized into five drug tiers. Members pay a copayment for drugs in Tiers 1 through 4, and a coinsurance for drugs in Tier 5. In general, the lower the drug tier, the lower the member's cost share.

There are three coverage phases under the Medicare Part D benefit: 1) Annual Deductible; 2) Initial Coverage and 3) Catastrophic Coverage Phase. During the 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 Louisiana Blue pays the remainder. The member remains in the ICP until the member's out-of-pocket costs reach $2,400. Once members reach the $2,400 Part D MOOP, they move to the Catastrophic Phase and the plan pays the full cost of the member's Part D covered drugs.

**Some generics are included on this tier.*

3-Month Supply: Member Cost-Savings and Improved Adherence Drugs

When treating chronic conditions, patients that receive prescriptions for an extended (3-month) supply often have better medication adherence. Studies demonstrate increased medication adherence leads to better outcomes and lower total cost of care. To assist with this, we allow most medications to be filled as a 3-month supply at retail pharmacies and via mail-order. For additional cost-savings, patients can get a 3-month supply of Tier 1 drugs for a $0 copay when filled at a preferred retail pharmacy or by mail. We encourage you to write for a 3-month supply—pharmacies may not be able to convert a traditional 1-month prescription. More information about 3-month supplies and mail-order can be found on the Pharmacy page of the member portal.

Medicare-covered Drugs (also called Medicare Part B Drugs)

Drugs covered under original Medicare are also covered for Blue Advantage members. This includes substances that are naturally present in the body, such as blood clotting factors. There is no benefit limit on these drugs, and their cost does not count toward the member's outpatient prescription drug benefit. There is no formulary for Part B covered drugs, but certain Part B drugs require prior

authorization from Louisiana Blue. For more information, please see "Part D and Part B Drugs Requiring Prior Authorization" below. For more information on Part B drugs requiring prior authorization and when prior authorization may be required, please see the Blue Advantage Provider Quick Reference Guide.

The following drugs are Medicare-covered drugs:

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services.
- Drugs used with durable medical equipment (such as nebulizers) that were authorized by Louisiana Blue.
- Clotting factors self-administered by a member that has hemophilia.
- Immunosuppressive drugs, if the member had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and the member cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs, once only available in an injectable form, that were covered by Medicare.
- Certain oral anti-nausea drugs used as a full replacement for intravenous treatment and administered within 48 hours of cancer treatment.
- Insulin when administered via insulin pump.
- Erythropoietin if the member has end-stage renal disease, receives home/outpatient dialysis and needs this drug to treat anemia.
- Select immunizations, including flu and pneumonia, and Hepatitis B for individuals at high or intermediate risk.

Part D and Part B Drugs Requiring Prior Authorization

Requests for coverage of drugs are routed differently depending on who is furnishing and billing for the drug (pharmacy vs. medical). Please review the information and educate office staff as needed to ensure that coverage requests are submitted through the proper channels. This helps prevent situations where a drug was authorized through one channel but billed through another channel and subsequently denied for no authorization in place. The coverage criteria for Part D drugs that require prior authorization can be found at https://blueadvantage.lablue.com >Find a Doctor or

Drug >Pharmacy Directory >View the Formulary & Utilization Management.

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 but we may need additional information to determine if the drug should be paid under Part B or Part D.

Part D Drugs Furnished and Billed Through Pharmacy
Part D Prescription Drug Coverage Form

You have several methods to choose from when requesting a coverage determination for your Blue Advantage patient. You can reach us by phone, fax, mail or online. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in Louisiana Blue's published Blue Advantage formulary. These are all examples of coverage determinations. To request a coverage determination for a Part D drug, contact Express Scripts, Inc. The contact information is in the Plan Information Contact List located in the front of this manual. You can also complete the Part D Prescription Drug Coverage Determination Request Form and return it to the contact information listed in the Plan Information Contact List located in the front of this manual. The form is available for download from iLinkBlue under the Forms link or you can call the plan and request that we fax the form to your office. You can also access an electronic version of the form from iLinkBlue.

To submit an electronic request for a review determination for a Part D drug, online tools are available to provide real-time responses. There are three options for prescribers based on their practice preferences. The first two options are web-based portals; see the URL links below. Prescribers will simply need internet access to be able to submit requests electronically. You must first register as a user on each portal. Once registered with your selected vendor, covermymeds or expressPAth, you will see the step-by-step process for submitting coverage determination requests. The required information you enter when submitting an electronic request is identical to what you would need to provide via phone or fax.

www.covermymeds.com

www.express-path.com

Electronic Prior Authorization (ePA) is available within the practice EMR software today (if ePA capabilities are not available in your practice software, you may request the capability from your software vendor). In this application, the prescriber can be alerted that a prior authorization is required when submitting an electronic prescription. The prescriber is able to initiate a coverage

determination request from within the practice software and does not need to move to one of the web-based portals mentioned above.

Some drugs require a coverage determination for the purpose of determining whether they should be covered under Part D or Part B for the specific situation, based on Medicare rules. You may be asked to provide information regarding diagnosis or other pertinent information in order to facilitate the determination.

To access the Part D Prescription Drug Coverage Determination Form, please refer to iLinkBlue.

Part B Drugs Furnished and Billed Through Medical
Part B Drug Prior Authorization Request Form

Certain Part B drugs billed through the medical benefit require prior authorization, this includes targeted Part B drugs that are subject to Blue Advantage medical policy criteria as well as those subject to Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Prior authorization requests for most targeted Part B drugs may be made by calling Care Continuum (CCUM). The contact information for CCUM is under the "Authorizations" section of the Plan Information Contact List located in the front of this manual. Requests may also be made by completing the Outpatient Authorization Request Form or found on iLinkBlue. Completed forms should be faxed or mailed to Blue Advantage Medical Management at the fax number/address located at the top of the form.

Timeframes for Prior Authorization Requests

Review for Part B drugs billed through medical that have a prior authorization will now share the same timeframes for determination as required for Part D drugs – 72 hours for standard requests or 24 hours for an expedited review.

Expedited prior authorization requests should be reserved for cases when you are able to attest that the patient's health or life could be in jeopardy if the standard timeframe is applied. Please note that for expedited requests for Part D drugs, the plan must make the determination and notify the member within 24 hours. If expedited requests are submitted late on a Friday or the day before a holiday, the plan has limited time to contact you for information, and you have limited time to respond before your office closes and the 24-hour expedited timeframe expires. We will make every effort to contact the office, but by requesting the standard timeframe (72 hours) whenever medically appropriate, you give yourself and the plan sufficient time to obtain information needed to make the determination. CMS recently clarified the expectation that plans reach out to the on-

call physician for expedited Part D coverage requests on weekends or holidays, so the plan will make such outreaches. Please discuss this with your office staff who complete and fax the forms.

With all requests, particularly expedited requests, please make every effort to provide as much information as possible in order for the plan to make the determination. It is helpful to review the prior authorization criteria on iLinkBlue and submit all of the required information with the request. For some Part B drugs billed through medical, there are drug-specific prior authorization request forms which can be found on iLinkBlue and will show you the specific information we need for that drug. Finally, if the plan reaches out to your office to request additional information, please respond promptly.

Opioid Utilization Review and Controls

CMS mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications; specifically to address opioid overutilization among its Part D enrollees. CMS recognizes "overutilization" as filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically-accepted norms of dosing. In an effort to prevent and combat opioid overuse, we have placed limits on prescription opioids. We now limit initial opioid prescriptions to a seven-day supply and limit all opioid prescriptions to 200 morphine milligram equivalents (MME) per day unless prior authorization is obtained. CMS also expanded the Overutilization Monitoring System (OMS) and now allows Louisiana Blue to "lock-in" patients we identify as a high-risk opioid user to a single provider or pharmacy. There are specific requirements that we must follow if this were to be implemented for one of your patients and we would work with you before those actions are taken. These controls were put in place, per CMS guidance, to aid national efforts in tackling opioid abuse and misuse.

If your office is contacted by Louisiana Blue regarding a member identified through the Opioid Overutilization Monitoring Program, please respond promptly to facilitate the case management process.

Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

CMS requires that Part D sponsors place beneficiary-level prior authorization requirements on four categories of drugs for patients enrolled in hospice, to prevent hospice-related drugs from paying under Part D. These categories include analgesics, antiemetics, laxatives and anxiolytics. For members enrolled in hospice, these drugs will not pay under Part D, unless the hospice provider attests that the drug is unrelated to the terminal illness and related conditions. If the drug is deemed to be unrelated to the terminal illness and related conditions, an authorization will be placed into the pharmacy claims system to allow the drug to pay under Part D. Otherwise members will be directed to obtain the medicine from the hospice provider.

Payment for Drugs for Beneficiaries with ESRD

CMS requires that Part D sponsors use point-of-sale edits to prevent ESRD-related drugs from paying under Part D. If a member has an ESRD flag, drugs that are considered by CMS to be always related to ESRD will not pay under Part D. Members will be directed to obtain the medicine from their dialysis facility.

Medication Therapy Management Program (MTMP)

The Blue Advantage MTMP is a patient-centric program aimed at improving medication use and adherence, reducing the risk of adverse events and helping patients who have difficulty paying for medicines find lower-cost therapeutically appropriate medications or resources to help pay for medications. Certain members who have chronic diseases, take multiple medications and have high cost for medicines are enrolled in the program. We provide telephonic comprehensive medication reviews (CMR) as well as targeted medication reviews (TMR) to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians and does not interfere with the doctor-patient relationship. We have found that our members are very appreciative of the program.

Claims and Billing Guidelines

Fiscal Intermediary Letter Requirement

As a Medicare Advantage plan, our Blue Advantage network follows CMS billing guidelines. To ensure accurate claim processing, Louisiana Blue must have a copy of your fiscal intermediary letter on file for the following provider types:

- Critical Access Hospitals (CAH)
- Rural Health Clinics (RHC)

If the fiscal intermediary letter is not received, Louisiana Blue cannot correctly calculate the payment owed to the provider. Blue Advantage providers, paid on a reasonable cost basis, should include the member ID number and date of service on the fiscal intermediary letter. Claims will be denied if the fiscal intermediary letter is not received by Louisiana Blue.

Please email your fiscal intermediary letter to provider.contracting@lablue.com.

Medicare Advantage PPO Network Sharing

All Blue Medicare Advantage PPO plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO plan as long as the member sees a contracted MA PPO provider. In Louisiana, we share our Blue Advantage (PPO) network with MA PPO members from other states.

- If you are a contracted Blue Advantage (PPO) provider, you should provide the same access to care for Blue MA PPO members as you do for Blue Advantage (PPO) members. Services for Blue MA PPO members will be reimbursed in accordance with your Blue Advantage (PPO) allowable charges. The Blue MA PPO member's in-network benefits will apply.

  If your practice is closed to new Blue Advantage (PPO) members, 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 as to Blue Advantage (PPO) members.
- If you are not a participating Blue Advantage (PPO) provider 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.

Blue MA PPO members are recognizable by the "MA" suitcase on the member ID card. Blue MA PPO members have been asked not to show their standard Medicare ID card when receiving services. Instead, Blue MA PPO members should provide their Blue Cross/Blue Shield member ID card.



For these members with benefits through another Blue Plan, use iLinkBlue (www.lablue.com/ilinkblue) to verify eligibility and benefits or call the number on the member ID card. Claims for services rendered in Louisiana should be filed directly to Louisiana Blue. Do not bill Medicare directly for any services rendered to a Blue MA PPO member.

Claims and Encounter Data Submission

Claims and encounter data (for capitated and non-capitated providers) must be submitted using standard Medicare guidelines. Louisiana Blue accepts CMS-1500 or UB-04 claim forms and electronically submitted claims.

Contracted providers should seek electronic claims solutions as indicated in their Blue Advantage contract. Providers who bill on paper should follow standard CMS claims submission requirements including submission of the Blue Advantage Member ID with leading zeros and NPI in the appropriate claim form field.

The provider is responsible for ensuring accurate and complete data for submission. The provider is also responsible for any request made on his or her behalf by the staff personnel. Claims are not accepted via fax. When filing claims for secondary coverage, please be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied. Louisiana Blue is able to accept COB (coordination of benefits) claims filed electronically, as long as the applicable fields are completed.

Louisiana Blue processes all clean claims within the 30-day CMS required standards. Status checks/claims inquiries can be performed via iLinkBlue our Provider Portal. Since Louisiana Blue permits submission of the claims for up to 12 months from the date of service, unless indicated otherwise in your specific provider agreement, it is not necessary to establish a short auto claims submission refiling cycle.

Not all claims for Blue Advantage members are filed directly to the Louisiana Blue - Blue Advantage plan administration office. Preventive and routine dental services are filed to United Concordia. Contact information is in the Plan Information Contact List in the front of this manual.

Second Opinions

Blue Advantage members have the right to receive a second opinion should they desire to do so. If the second opinion fails to confirm the primary recommendation for a treatment plan, or if the member so desires, a third opinion, provided by a third provider can be sought. If there is no qualified provider to perform the second or third opinion consultation within the Blue Advantage provider network, the PCP will need to contact the Medical Management Department for assistance and approval to go outside the network for the consultation.

Electronic Claims

Electronic claims require the same information as paper. However, electronic submission of claims dramatically improves the exchange of information and the acceptance rate of claims, while reducing opportunities for error. This process also decreases the turnaround time for claims payment. These factors combine to reduce a provider's overall administrative costs. Louisiana Blue accepts claims submissions electronically through Blue Advantage:

- Blue Advantage claims with dates of before Jan. 1, 2026 should be filed using Payer ID 72107.
- Blue Advantage claims with dates of service on or after Jan. 1, 2026 should be filed using Payer ID 53120.

For every batch of claims filed electronically, the provider should receive a report that the clearinghouse accepted the batch.

If your EDI submissions are being rejected, and you are not receiving clear direction as to the cause, contact Blue Advantage Customer Service. Explain that you are experiencing an ongoing EDI submission issue, and you will be directed to the appropriate staff to help work on a resolution.

Electronic Claims Submission

Electronic 837 claim transmissions can be submitted to Louisiana Blue using a secure connection setup of MFT.LHEC.NET or AST.LABLUE.COM. Please refer to the 837 Companion Guides for additional information. Companion Guides are available at www.lablue.com/providers >Electronic Services >Companion Guides.

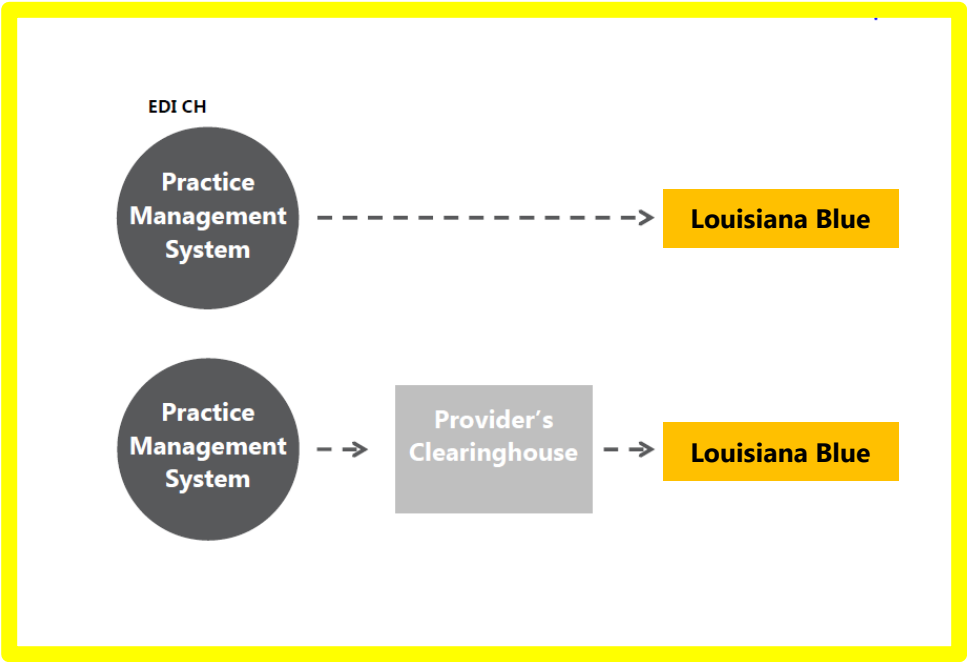
Blue Advantage member claim submissions for dates of service prior to Jan. 1, 2026:
If the member identification number includes PMV or MDV prefix **and the date of service is on or before Dec. 31, 2025**:

- The claim must be batched in a distinct batch with a file name that begins with **BAM** in the first three positions of the batch file name. This identifies the claim as a Blue Advantage claim.
- These special batches require specialized routing for adjudication.
- Failure to adhere to this guideline could result in incorrect routing and the denial of your claim.

Blue Advantage claim submissions for dates of service on and after Jan. 1, 2026:
If the member identification number includes a prefix of PMV, MDV or NMV **and the date of service is on or after Jan. 1, 2026, the claim can be filed with other commercial claims. There is no need for special batching.**

All claims submitted are validated against a comprehensive set of Louisiana Blue business rules. The Accepted/Not Accepted Report is provided to reflect all claims that passed HIPAA validation (failures are provided on the BCCLREDI report) and were subjected to our Louisiana Blue business rules. Claims that pass the Louisiana Blue business rules are listed on the Accepted Report and claims that fail the Louisiana Blue business rules, appear on the Not Accepted Report.

All electronic claims (professional and facility) must be received via Louisiana Blue. We are unable to receive claims filed directly from any other source.



Louisiana Blue does offer Electronic Remittance Advice availability. Please see specific details under the **Electronic Payment and Remittance Notice** section of this manual.

Proper Submission of Provider IDs and Incident-to Billing

For Provider Types Eligible for Network Participation

Louisiana Blue 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.

If you are one of these provider types, you should bill your services directly to Louisiana Blue. Claims will periodically be reviewed to ensure billing by the appropriate provider type.

Where services are filed under a facility NPI (i.e., an urgent care facility), all claims lines for services rendered by nurse practitioners, physician assistants, etc. must be appended with the Modifier SA so that the slightly reduced fee schedule can be applied appropriately.

For Provider Types Not Eligible for Network Participation

For provider types that are not eligible for network participation, Louisiana Blue follows CMS incident-to guidelines for processing incident-to claims.

"Incident-to" means that services performed must be furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services billed directly (not part of the physician's personal professional services) are not "incident-to."

General requirements for services to be considered incident-to are as follows:

- The service provided must be reasonable and medically necessary, must be within practitioner's scope of practice as defined in state law where they are licensed to practice, and performed in collaboration with a physician.
- The practitioner must be an employee or independent contractor to the physician, physician's group or physician's employer.
- Supervising physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.
- An office/clinic must have identifiable boundaries when part of another facility and services must be furnished within the identifiable boundary; where this office is one room, the physician must be in it to supervise.
- Physician has performed initial service and subsequent services of a frequency that reflect his/her active participation in and management of the course of treatment.
- The professional identity of the staff furnishing the service must be documented and legible.

Note: a counter signature alone is not sufficient to show that the incident-to requirements have been met.

Provider IDs via paper claims:

CMS-1500

Block 25: the Tax ID must be indicated

Block 31: the rendering provider's name must be indicated

Block 24J: the rendering provider's NPI must be indicated

Block 32: the location where the services were provided

Block 32A: the NPI of the location where the services were provided

Block 33: billing provider name such as the group practice, company name, etc.

Block 33A: billing provider's NPI

UB-04

Block 1: provider name, address and telephone number

Block 2: pay to name, address and telephone number Box 5 the Tax ID

Block 56: NPI

Explanation of Benefits

Louisiana Blue issues two types of explanation of benefits (EOB) to members:

1. A medical EOB is generated monthly and reflects all claims processed the prior month with the exception of services which are rejected back to the provider of service. Rejected claims are claims which require additional or corrected information in order to consider the service for benefits. (An example of rejects are claims that require a corrected procedure code or a primary carrier's EOB).
2. A Part D prescription drug EOB is generated monthly and reflects both the prior month's Part D claims activity as well as the member's year-to-date total drug spend and true out-of-pocket costs, which determines the Part D benefit phase the member is currently in.

Members can also obtain real-time information online via our website once they establish a secure login and password. EOBs are only issued if the member has had claims activity the prior month.

Coordination of Benefits (COB)

When Louisiana Blue is the primary carrier, we will compensate participating providers in accordance with the terms of their Blue Advantage agreements. If the payment does not cover all incurred charges, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from members other than copayments and coinsurance.

When Louisiana Blue is the secondary carrier, the provider should first seek payment from the member's primary carrier. For Louisiana Blue to pay the Blue Advantage member's copayment or coinsurance, up to the amount we would have paid had we been the primary carrier, the provider must send us a copy of the explanation of benefits from the primary carrier.

Louisiana Blue receives COB information based on CMS records. Claims are adjudicated based on this information. Members are asked to validate the information and notify us immediately if incorrect. Louisiana Blue will work with the proper CMS party to have the file updated, but until that is completed, we may continue paying claims as secondary. If you are aware of an issue with the member's records, do not balance bill the member until the issue is resolved. Members eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Physician will be informed of Medicare and Medicaid benefits and rules for members eligible for Medicare and Medicaid. Physician may not impose cost-sharing that exceeds the amount of the cost share that would be permitted with respect to the individual under Title XIX of the Social Security Act if the individual were not enrolled in such a plan. Physician must (a) accept Blue Advantage payment as payment in full or (b) bill the appropriate state source (42 C.F.R. § 422.504(g)(1)(iii)).

Whether Louisiana Blue is the primary or secondary payor, all requirements for prior authorization must be met prior to the delivery of a service or item.

Subsequent Claim Submissions

Timely Filing Requirements

- Both contracted and non-contracted providers have 12 months from the date of service to file an initial claim unless the individual provider agreement states otherwise.
- Both contracted and non-contracted providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim, this again can vary depending upon individual agreement language.
- Providers should follow the CMS filing guidelines for corrected claims. Refer to the corrected claim information further in this section.

- A non-contracted provider has 60 days from the date the claim was processed (remit date) to appeal a claim determination.

Louisiana Blue permits claims submission up to 12 months from the date of service. In exchange, Louisiana Blue's Blue Advantage plan policy requires providers resubmit any standard billing denials, (i.e., wrong or incomplete member ID, invalid procedure code modifier combination, etc.) as a new claim either on paper or electronically, whichever applies to your regular billing method. This is the most expeditious way to receive payment. The resubmitted claim will not be denied as a duplicate claim, as long as no payment was issued on the service line in question. If the claim was denied for no referral or prior authorization, the provider needs to confirm via the portal or by calling Medical Management that an authorization is on file prior to resubmitting the claim.

If a provider is disputing a timely filing denial of a claim, and the claim is filed, the provider must submit supporting documentation from the provider's practice management system. This must include the applicable field descriptions since the documentation is specific to your system OR a UB-04, CMS-1500 with the original date billed AND documentation to support the claim being submitted within 12 months from the date of service, AND follow-up done at a minimum of every 60 days. If there is no documentation supporting the follow-up activity, (i.e., filed second submission MM/DD/YYYY or contacted plan and spoke with_____, on MM/DD/YYYY), the timely filing denial will stand. We must have the documentation for CMS audits.

Claim Resubmission

A claim is processed by Louisiana Blue and the provider resubmits the claim generally due to a denial that occurs on either a claim line or the entire claim (i.e., no referral on file). If an amount was paid on the claim line in question, the provider should not use the claim resubmission process. See additional options below. However, if no payment was issued on the claim line in question, the claim can be resubmitted on paper or electronically, not faxed, unless an approved exception is made due to special circumstances. No provider explanation is necessary on the resubmitted claim. The claim will be treated as an initial claim for processing purposes.

Corrected Claim

A corrected claim, per the standard contract language, is a claim in which the provider needs to add, remove or change a previously paid claim line. This must be within the time frames outlined in the individual provider contract but is often a very short span of time 90 days from the original claim submission unless provider contract states otherwise. Examples of removing or adding a previously paid claim line would be: Remove charges billed for a service that was ultimately not provided or add charges for a service that was provided and not billed. Examples of changing a previously paid

claim line include changing incorrect dates or service or correcting an incorrect procedure code. All requests must be submitted as corrected claims. All corrected claims must be clearly indicated as a correction as follows:

CMS-1500 Claim Form (professional):

- EDI/1500/Professional claim forms submitted as "Corrected Claims" can be submitted electronically.
- In Loop 2300 ~ CLM05-03 must contain a "7," REF01 must contain an "F8," and REF02 must contain the Original Reference Claim Number.
- CMS-1500 paper claim forms submitted as "corrected claims" can also be submitted on paper. The paper 1500 claim must indicate a frequency of 7 in Block 22 (Resubmission Code) and the Original Reference Claim Number in Block 22 (Original Ref. No.).
- The claim form should reflect a clear indication as to what has been changed. All previous unchanged line items must be submitted on the corrected claim along with the line items that are being corrected.

UB-04 Claims Form (facility):

- EDI/UB/Facility claim forms submitted as "Corrected Claims" can be submitted electronically.
- The Type of Bill (TOB) must indicate a frequency 7 and the claim submitted must indicate in Loop 2300 REF01 an "F8" and REF02 must contain the Original Reference Claim Number.
- UB-04 paper claim forms submitted as "corrected claims" can also be submitted on paper.
- The paper claim must indicate a Frequency of 7 in Block 4, the Original Reference Claim Number in Block 64 and a reason for the correction in Block 80.

Re-openings

This is generally used by the plan if they discover an issue and proactively reprocess claims based on that finding. For example, we find we have incorrectly denied a certain type of claim for a particular provider and run an extract to identify past denied claims and adjust them in an effort to send out the correct payment.

If a denial occurred as the result of a **Louisiana Blue error**, the provider is permitted to contact Customer Service and if possible, the necessary action to correct the situation will occur without additional action from the provider.

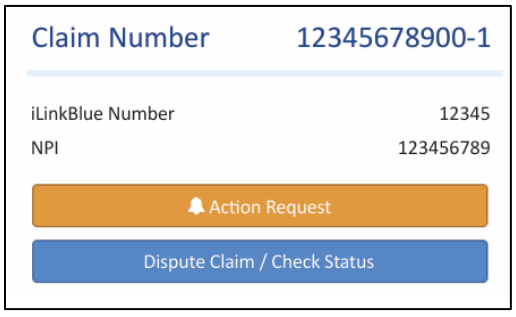
Contracted Provider Disputes

Louisiana Blue recognizes there may be times when participating providers disagree with the way a claim was adjudicated. If your claim issue is one of the below reasons, then a claims dispute may be needed. This is different than an appeal or grievance. Disputes are defined as written requests from our contracted Blue Advantage providers disputing a processed claim and may include one of the following reasons:

- Reimbursement concerns:
  - Allowable disputes (must include breakdown of expected amount, allowable charge, etc.) Note: Make sure the fee schedule being used to calculate the allowable is current or was current for the date of service in question.
- Authorization issues:
  - If an authorization was obtained prior to a service, **do not** submit a provider dispute. For questions/inquiries, send an action request or contact the Customer Care Center.
- Timely filing denials (must attach supporting documentation)
- Refund disputes

Louisiana Blue encourages contracted providers to contact our Blue Advantage Customer Service to discuss questions or concerns regarding Blue Advantage's processing of a claim. If Louisiana Blue is not able to successfully resolve a contracted provider's concerns over the phone, you may submit a claims dispute through iLinkBlue (www.lablue.com/ilinkblue). You will have an option to open the electronic dispute when viewing a claim on iLinkBlue. To view processed claims in iLinkBlue, go to the Claims menu option. Then select "Claims Status Search" and use the Paid/Rejected tab to search for a claim.

Providers can access an electronic dispute form when viewing a claim on iLinkBlue. To view processed claims in iLinkBlue, go to the Claims menu option. Select "Claims Status Search" and use the Paid/Rejected tab to search for a claim. Click on a claim number to open the Claim Detail summary page for that processed claim. Click the "Dispute Claim/Check Status" button. This will bring you to the Epic homepage. See the next page for additional instructions.



How to Access the Dispute Claim Form
1. On the Epic homepage, click on “View In basket” or “In basket.” 2. On the In Basket page, click on the “New Msg” dropdown. 3. Select “Provider Claims Dispute Request.” 4. Complete the electronic dispute form. Required fields are indicated by a red stop sign. Add any supporting documents as attachments. Note: Please do not also complete a hardcopy version of the form and submit it as an attachment. 5. Click the “Submit” button when finished.
How to Check Status/Ensure Your Dispute Was Received
1. On the Epic homepage, click on “View In basket” or “In basket.” 2. On the In Basket page, click on the “Customer Service Reply” folder. 3. The screen will display an email-style listing of dispute notifications by patient name. Find the patient and the date you submitted the dispute. Click on the patient’s name. Note: You may need to refresh the screen to see a newly entered dispute. 4. The lower half of the screen will display different panes of information. • Under RE: Reimbursement, you will see the Provider Dispute Acknowledgement of your dispute. This is your confirmation Louisiana Blue received your dispute. • Under CRM#, you will see the “Unresolved” status while we are reviewing your case. The status will change to “Resolved” once a determination is made and you can expect to receive a written response by mail. • Under Resolution, you will see whether the dispute was “Overturned” or “Upheld” once we render a determination.

Member Appeals

A claim appeal can be filed by either a member or a non-contracted provider. Appeals must be filed within 65 days from the date of the initial organizational determination (for example, an EOB is issued or provider remit, whichever is applicable). Appeals must be submitted in writing and do not apply to contracted providers unless it involves a pre-service request. Any non-contracted provider appeals must include a CMS waiver of liability (WOL) form, which states the provider will not bill the member regardless of the outcome of the appeal. The WOL form is sent to the provider upon receipt of any non-contracted appeal requests and is also available on our website.

mail: Louisiana Blue Medicare Advantage
P.O. Box 98004
Baton Rouge, LA 70898-9004
fax: 1-877-553-6153

Electronic Payment and Remittance Notice

Louisiana Blue is able to generate an electronic fund transfer (EFT) for payment of services and an electronic remittance advice (ERA) through Louisiana Blue.

Electronic Funds Transfer (EFT) is a provider service where your payments are directly deposited into your checking account. EFT is a free service to providers. Providers have access to EFT notifications and payment registers (that can be printed). EFT information and payment registers are available for Blue Advantage providers in iLinkBlue.

To receive electronic payments for your Blue Advantage claims, please enroll for EFT with Louisiana Blue. The EFT Enrollment Form is available in DocuSign® format at www.lablue.com/providers >Electronic Services >Electronic Funds >Quick Links.

Electronic Remittance Advice (ERA) is available for providers who submit their claims electronically. The provider's software system can be programmed so the ERA is uploaded into an automated posting system. The ERA is available on Monday mornings. For more information, please contact our EDI Services (contact information is in front of manual).

To receive ERAs for your Blue Advantage claims, please enroll with Louisiana Blue. You must complete the ERA Enrollment Form; available at www.lablue.com/providers >Electronic Services >Clearinghouse Services >Quick Links.

Member Copayments and Coinsurance

- Copayment – It is the provider's responsibility to collect applicable copayment from members at the time of service.
- Coinsurance – Blue Advantage members have the responsibility of coinsurance rather than a copayment for some services. If you provide a service to a member that has a member coinsurance, it is your responsibility to bill the member for the coinsurance amount after Louisiana Blue makes payment on the claim. The remittance advice will indicate the member's liability to be billed by your office. If you know the coinsurance amount you are permitted to collect at the time of the service.

Balance Billing

The term "balance billing" refers to billing a member above an approved amount for a payable service or billing a member for a service Louisiana Blue denied. Please note that Blue Advantage members cannot be "balance billed" in most cases, whether you are a Blue Advantage network provider or not. Blue Advantage members are protected under Medicare balance billing guidelines. The Blue Advantage member is held harmless for payment beyond the Blue Advantage plan cost share (copayment or coinsurance). The member's EOB (your share) and the provider's remit notice (member responsibility) indicates whether an amount is owed by the member and that is what the provider should follow when billing the member.

If Louisiana Blue denies a claim for administrative reasons (invalid procedure code billed, services are not separately payable, timely filing denials, etc.), the claim should be corrected, if applicable, and rebilled for payment consideration. The member should not be billed. Please refer to our claims timely filing policy found previously in this section.

Advance Beneficiary Notice of Non-coverage (ABN)

ABNs are not applicable to Blue Advantage members (or any Medicare Advantage plans). Contracted providers must do the following to hold members financially liable for non-covered services not clearly excluded in the member's EOC (Evidence of Coverage):

- Request a pre-service organization determination from Louisiana Blue if they know or have reason to know that a service may not be covered by Medicare.
- If Louisiana Blue denies the coverage request, it will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.
- After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN,

should the member desire to receive them.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform an RADV audit in order to validate the Medicare Advantage members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a RADV audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

General Billing/Reimbursement Guidelines Multiple Surgeries

Following are the payment guidelines for a facility for multiple surgical procedures performed at the same operative session, unless your specific agreement states otherwise:

Facilities

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable
- Third through Fifth Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable

Following are the payment guidelines for physician/practitioner for multiple surgical procedures performed at the same operative session, unless your agreement states otherwise:

Physician/Practitioner

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable
- Third through Fifth Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable

Louisiana Blue follows Medicare pricing for endoscopy procedures by reducing a multiple, same family, endoscopy claim by the base scope allowable and applying the applicable multiple surgery reductions to different family endoscopy claims.

General Billing/Reimbursement Guidelines for Special Pathology Stains

Requirements for special pathology stains and immune stains:

Claims for special pathology stains (e.g., CPT codes 88312, 88313, 88314, 88319) and immune stains (e.g., CPT codes 88341, 88342, 88344, 88346) are not eligible for reimbursement without documentation in the medical record from a pathologist. The pathologist's record must document the recommendation or order for the stain and attest to its medical necessity based on microscopic examination of the initial pathology specimen. Special-stain and immune-stain services that do not include this documentation are not eligible for reimbursement.

Requirements for submitting claims for the technical component (TC) of a laboratory service:

In order for claims for the technical component of a laboratory service (e.g., pathology stain procedures) to be eligible for reimbursement, a corresponding claim must be received by Louisiana Blue from a Blue Advantage network provider for the professional services of the same laboratory service.

Drug Screening Assays

Louisiana Blue requires that claims be filed using CPT codes 80305-80377 rather than the temporary Medicare HCPCS codes G0480-G0483. Claims filed with HCPCS codes G0480-G0483 will be denied and must be refiled with current CPT codes.

Presumptive drug screening: CPT codes 80305-80307:

Louisiana Blue will only allow payment for one presumptive drug screen for drugs from Drug Class A and/or B (CPT codes 80305-80307) regardless of the number of services performed.

Definitive Drug Testing

Definitive drug testing codes will be subject to a multiple-service reduction as follows *(for the same patient for the same encounter*):

- First or initial lab will be considered for 100% of the allowable charge
- Second lab will be considered for 100% of the allowable charge
- Third lab will be considered for 50% of the allowable charge
- Fourth lab will be considered for 25% of the allowable charge
- Fifth lab and any additional labs will be considered for 5% of the allowable charge
- Multiple services for urine validity will be bundled

Note: Providers will not be separately reimbursed for validity testing, such as urinary pH, specific gravity, nitrates, oxidants or urine specimens used for drug testing.

Split/Shared E&M Services

A split/shared evaluation and management (E&M) service is an encounter with a patient where a physician and a non-physician practitioner (e.g., NP, PA, CNM) each personally perform a portion of an E&M visit face-to-face with the same patient on the same date of service. Providers must meet the following requirements in order to bill a split/shared E&M visit under the physician's provider number:

The physician must provide a face-to-face visit with the patient. The physician must document in a separate note the E&M work that they personally performed. It is not sufficient for the physician to countersign the medical record or document "seen and agree." The physician must document the work that they personally performed during the visit.

If time is used to select the E&M code for a split/shared visit, the time spent by the physician and other qualified healthcare provider is summed to determine the total visit time. Also, as outlined in the CPT 2021 Professional Edition, "Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient care, only the time of one individual should be counted)."

The physician must justify their involvement in the patient care by legibly signing the medical record.

In addition, the following requirements apply to split/shared E&M services:

- Services must be rendered by the attending physician and specified non-physician practitioners: nurse practitioners, physician assistants and certified nurse-midwives.
- The attending physician and the non-physician practitioner must be part of the same group practice, either through direct employment or a contractual arrangement, which links the two individuals.

Note: Only one provider should bill for the E&M service.

Office Setting

Louisiana Blue follows AMA guidelines regarding the definition of "office" setting; however, Louisiana Blue also defines "office" setting as:

- Any office space within a hospital or facility which is separately identifiable as a provider's private practice.
- Any office space at a hospital or facility's off-campus or freestanding location which is separately identifiable as a provider's private practice.

- Any services performed in a provider's rented office space within a hospital or facility regardless of who owns the equipment (e.g., radiology, etc.)
- Any other service location that Louisiana Blue reasonably determines operates as, presents as, or has comparable characteristics to the examples of locations that constitute an "office" under this section, regardless of whether such location technically functions as a private practice.

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service 11. Place of service 19 should not be used for any services.

Louisiana Blue does not recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals. For more information, please refer to the Provider Based Billing section of this manual.

Provider-Based Billing

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

We do not recognize provider-based billing of office services even if the office is located on the hospital campus and/or uses the hospital Tax ID number (TIN).

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service "11." A separate facility claim on a UB-04 should not be submitted for a facility or technical fee associated with the office/clinic visit.

Facilities operating provider-based clinics should submit a global bill for all services rendered in the clinic on a CMS-1500 claim form. Payment for the professional provider's services includes any technical or facility fees.

Prohibition Against Services Rendered By/To Family Members

Benefits are excluded for services, surgery, supplies, treatment, or expenses rendered, prescribed, or otherwise provided by a Provider who is the Member, the Member's spouse, child, stepchild, parent, stepparent or grandparent; or who regularly resides in the in the member/provider's household.

Assistant Surgeons

Following are the payment guidelines for assistant surgeons (assuming that an assistant surgeon is warranted based upon the surgery performed):

- Physician – 16% of total amount paid to the surgeon minus copayments and deductibles, as

applicable

- Physician Assistant, nurse practitioner and clinical nurse specialist – reimbursement is limited to 85% of what a physician is paid under the Medicare Physician Fee Schedule
- Multiple surgery restrictions apply

Not Otherwise Classified (NOC) Part B Drugs

In order for Louisiana Blue to correctly reimburse NOC drugs and biologicals, providers must indicate the following in the 2400/SV101-7 data elements or Block 19 of the CMS-1500 form:

- The name of the drug
- The total dosage (plus strength of dosage, if appropriate)
- The method of administration
- The National Drug Code (NDC) of the drug administered

List one unit of service in the 2400/SV1-04 data element or in Block 24G of the CMS-1500 form. Do not quantity-bill NOC drugs and biologicals, even if multiple units are provided. Louisiana Blue determines the proper payment of NOC drugs and biologicals by the narrative information and the NDC, not the number of units billed.

Adjusted Claims, Additional Payments, Overpayments & Voluntary Refunds

Upon discovery of an incorrectly processed claim, Louisiana Blue will perform an adjustment. Adjusted claims can be identified on the Provider Remittance Notice as ending in A1, A2, A3, etc. For example, claim ID 20246000001 would be 20246000001A1. Facility claims often reflect several "adjustments" due to interim bills.

Louisiana Blue's claims processing system will compare the adjusted claim payment amount to the prior payment to determine whether the adjustment will result in an additional payment or overpayment. If the claim is adjusted several times, it will not consider the action of all prior adjustments, only a single prior one. So, an A2 adjustment will not consider what was paid on the 00, only what occurred under the A1 claim. As a result, if an 01 adjustment is created in error, causing an overpayment, you may be required to issue the refund, in order for us to perform a A2 adjustment and issue an additional payment. For your 1099, (tax purposes) our records reflect the correct payment amount on that particular account.

If the adjustment results in an additional payment, this will appear on the weekly provider remit. Louisiana Blue issues additional payments within 30 days of discovery. If the adjustment results in an overpayment, Louisiana Blue will recoup the funds on the next scheduled check run, and this will

appear on your Provider Remittance Notice.

If you discover an overpayment via posting your Blue Advantage provider payments, you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund. Louisiana Blue has created a Voluntary Refund Form (see copy in the Forms section of this manual) to ensure all information necessary to process the refund is provided. Your cooperation with timely refunds for overpayments is appreciated.

If the claim is adjusted, the last two digits will no longer end in 00. Depending on the amount of times it is adjusted, it will increment accordingly, (i.e., A1, A2 etc.).



Claim #: 22019100270A1 Provider:SPECIALISTS HOSPITAL SHREVEPORT Account #: [redacted]

Patient: [redacted] Group: STANDARD AFFINITY PLAN Member ID #: [redacted]

Date(s) of Service	Procedure	Units	Total Billed	Not Allowed	Eligible Charges	Not Covered	Co-pay	Patient Deductible	Coinsurance	Discount/ Interest	Explanation Code(s)	Payment Amount
07/01/20-07/01/20	DRUGS, GENERAL 0250	11	$134.31	$134.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	CR;A	$0.00
07/01/20-07/01/20	INJECTION CEFAZOLIN SODIUM 500 J0690	5	$60.30	$60.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	CR;A	$0.00
07/01/20-07/01/20	INJECTION HYDROMORPHONE	1	$5.70	$5.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	CR;A	$0.00

Quality Improvement Services

Purpose of the Quality Management Program

The Quality Management (QM) Program is a coordinated, multidisciplinary approach designed to objectively and systematically monitor and evaluate the quality and appropriateness of care delivery and to identify opportunities to improve care within the organization.

The primary purpose of the QM Program is to promote excellence in care through continuous objective assessment of important aspects of care/service, the resolution of identified problems and the implementation of process improvements. This program will encompass quality management activities that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have beneficial effect on health outcome and patient satisfaction.

Louisiana Blue's QM Committee is an interdisciplinary committee that is responsible for the oversight of the QM Program. The mission of the QM Committee is to ensure that members receive quality healthcare and services. The QM Committee meets every quarter and may meet more frequently, if deemed necessary.

Quality Improvement Program

All Blue Advantage providers are required to participate in the Blue Advantage Quality Improvement (QI) Program. The Blue Advantage QI Program is central to achieving our mission of improving the health and quality of life of our members. The goal of the QI Program is to link together the knowledge, structure, and processes throughout Louisiana Blue, as well as to assess and improve the quality of care and service for members. Louisiana Blue utilizes quality improvement tools to assess and improve key processes and outcomes throughout the organization.

The objectives of the Blue Advantage QI Program are:

- To continually monitor key clinical and service indicators.
- To analyze aggregate data on specific occurrences.
- To manage disease and health programs.
- To conduct outreach and health education activities.

- To develop programs for populations with special needs.
- To conduct intervention studies in clinical and service areas that were selected based on review of data.
- To perform appropriate oversight of delegated activities.
- To conduct member and provider satisfaction surveys.
- To coordinate activities related to structure and process with cross-functional areas to improve care and service.
- To foster an environment that helps providers improve the safety of their practices.
- To conduct oversight of risk management.
- To evaluate the effectiveness of the QI program.

Quality Review of Key Clinical and Service Indicators

One of Louisiana Blue's Blue Advantage QI Program objectives is to perform a quality review of key clinical and service indicators to assess and improve member and provider satisfaction. These clinical and service indicators include review of:

- Hospital medical records
- Provider office medical records
- Inpatient utilization data
- Ambulatory care utilization data
- Diagnostic utilization
- Outcome studies analysis
- HEDIS data
- Quality Indicator studies
- Clinical guideline performance studies
- Claims data
- Member satisfaction surveys
- Provider satisfaction surveys
- Member complaints, grievances, and appeals
- Preventive medicine monitors
- Health risk assessment and screening monitors
- Member disenrollment data
- Peer case reviews
- Medicare studies
- Focused reviews
- Pharmacy utilization data

Blue Advantage providers are expected to participate in quality improvement committees, special ad hoc work groups, and medical records review activities to improve the health and quality of life for our members.

The medical records of Blue Advantage members must be made available to Louisiana Blue for support of any of the above activities upon request.

Other Medicare Advantage Services

These services may not directly involve or impact our Blue Advantage products. The content in this section is for informational purposes only.

Medicare Dual Eligible Special Needs Plans

Dual Eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and may offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs are open to beneficiaries in all Medicaid eligibility categories including: Qualified Medicare Beneficiary without other Medicaid (QMB only), QMB+, Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only), SLMB+, Qualifying Individual (QI), other full benefit dual eligible (FBDE) and Qualified Disabled and Working Individual (QDWI).

To be eligible for Blue Advantage Dual Plus (HMO-POS D-SNP), members must be enrolled in the Louisiana State Medicaid program and be classified as QMB, QMB+, SLMB+ or FBDE. If an enrolled member has a change in Medicaid status and no longer has eligible status, the member's cost share will revert to Original Medicare.

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare Zero-Cost-sharing D-SNPs
- Medicare non-Zero-Cost-sharing D-SNPs

All health plans that offer a **Dual Plus** benefit plan are required by CMS to create a Model of Care (MOC). The **Dual Plus MOC** is a guideline for delivering care management and services to members that have the Dual Plus plan. It offers a detailed description of:

- Characteristics of **Dual Plus** members
- Provider Networking/Adequacy
- Care Coordination through:
  - Case Management
  - Health Risk Assessments

  - Individualized Care Plans
  - Interdisciplinary Care Team
- Quality Measurement and Performance Improvement

Blue Advantage's D-SNP MOC can be found on iLinkBlue (www.lablue.com/ilinkblue).

Samples of Forms

Provider Update Forms

The following update forms should be used to notify Louisiana Blue of changes or additions to provider demographic information, including what is displayed in our provider directories. To find our update forms, visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form.

Professional Update Forms

- Individual/Group Provider Update Request Form
- Professional Tax Identification Number (TIN) Change Form
- Add Practice/Link to Group or Clinic Request Form
- National Provider Identifier (NPI) Change Form
- Request for Termination Form
- Electronic Transactions Transfer (EFT) Change/Termination Form

Facility Update Forms

- Facility Update Request Form
- Facility Tax Identification Number (TIN) Change Form
- Add Facility Location Form
- National Provider Identifier (NPI) Change Form
- Request for Termination Form
- Electronic Transactions Transfer (EFT) Change/ Termination Form

Complete, sign and submit the update forms digitally with DocuSign®. It is not necessary to print and submit via hardcopy. These forms are accepted through DocuSign only.

Know Which Provider Update Forms Apply to You

Professional Provider Types

Louisiana Blue classifies the following provider types as professionals. If you are one of these provider types, use the forms identified under Professional Update Forms to change your information.

- Applied Behavioral Analysts
- Acupuncturists
- Audiologist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse First Assistant
- Clinical Nurse Specialist
- Doctor of Chiropractic
- Doctor of Osteopathic
- Doctor of Medicine
- Doctor of Podiatric Medicine
- Doctor of Dental Surgery
- Doctor of Medicine in Dentistry
- Hearing Aid Dealer
- Licensed Addiction Counselor
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Louisiana Registered Doula
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physician Assistant
- Psychologist
- Physical Therapist
- Registered Dietitian and Nutritionist
- Registered Nurse First Assistant
- Speech-Language Pathologist and Audiologist

Facility Provider Types

Louisiana Blue classifies the following providers as facilities. If you are one of these provider types, use the forms identified under Facility Update Forms to change your information.

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

Special Exceptions

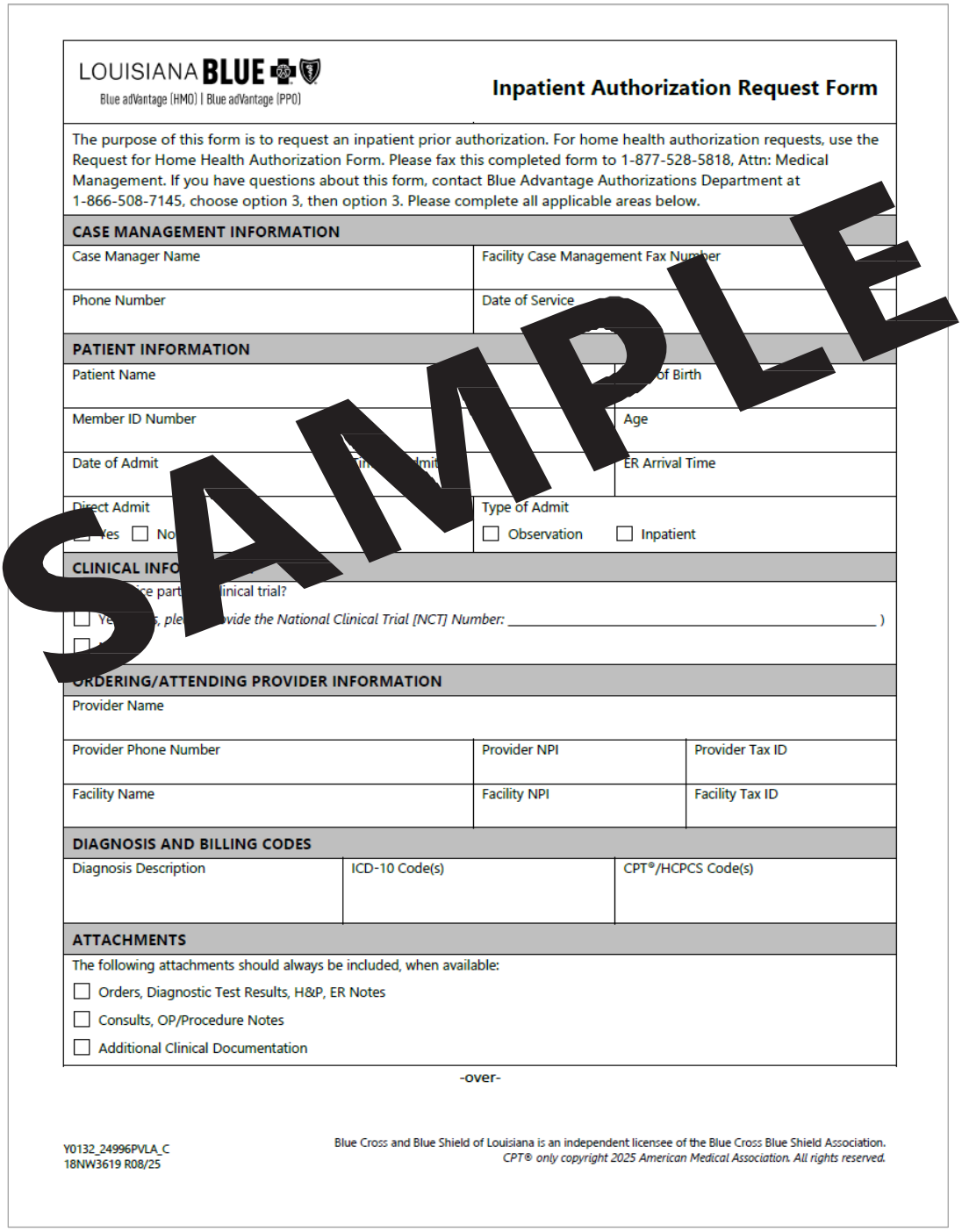
Most clinics and group practices consider themselves facilities, but Louisiana Blue treats them as professional providers. Submitting facility forms will not update information for their physicians, nurse practitioners, physician assistants or other clinicians. Please use the Louisiana Blue professional forms to make updates.

Emergency room professional groups are an exception to this rule. Louisiana Blue treats emergency room professional groups as facilities. Please use the Louisiana Blue facility forms to update the provider record of an emergency room professional group.

Many rural health clinics and Federally Qualified Health Centers also view themselves as facilities. Louisiana Blue treats these entities as professional providers. These organizations should complete the Louisiana Blue professional provider update forms.

Inpatient Authorization Request Form

This form is available online at www.lablue.com/providers >Blue Advantage Resources >Forms.



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Inpatient Authorization Request Form

The purpose of this form is to request an inpatient prior authorization. For home health authorization requests, use the Request for Home Health Authorization Form. Please fax this completed form to 1-877-528-5818, Attn: Medical Management. If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

CASE MANAGEMENT INFORMATION

Case Manager Name	Facility Case Management Fax Number
Phone Number	Date of Service

PATIENT INFORMATION

Patient Name	of Birth
Member ID Number	Age
Date of Admit	ER Arrival Time
Direct Admit ☐ Yes ☐ No	Type of Admit ☐ Observation ☐ Inpatient

CLINICAL INFO

ce part linical trial?

☐ Ye , ple vide the National Clinical Trial [NCT] Number: _____)

☐

ORDERING/ATTENDING PROVIDER INFORMATION

Provider Name		
Provider Phone Number	Provider NPI	Provider Tax ID
Facility Name	Facility NPI	Facility Tax ID

DIAGNOSIS AND BILLING CODES

Diagnosis Description	ICD-10 Code(s)	CPT®/HCPCS Code(s)

ATTACHMENTS

The following attachments should always be included, when available:

☐ Orders, Diagnostic Test Results, H&P, ER Notes

☐ Consults, OP/Procedure Notes

☐ Additional Clinical Documentation

-over-

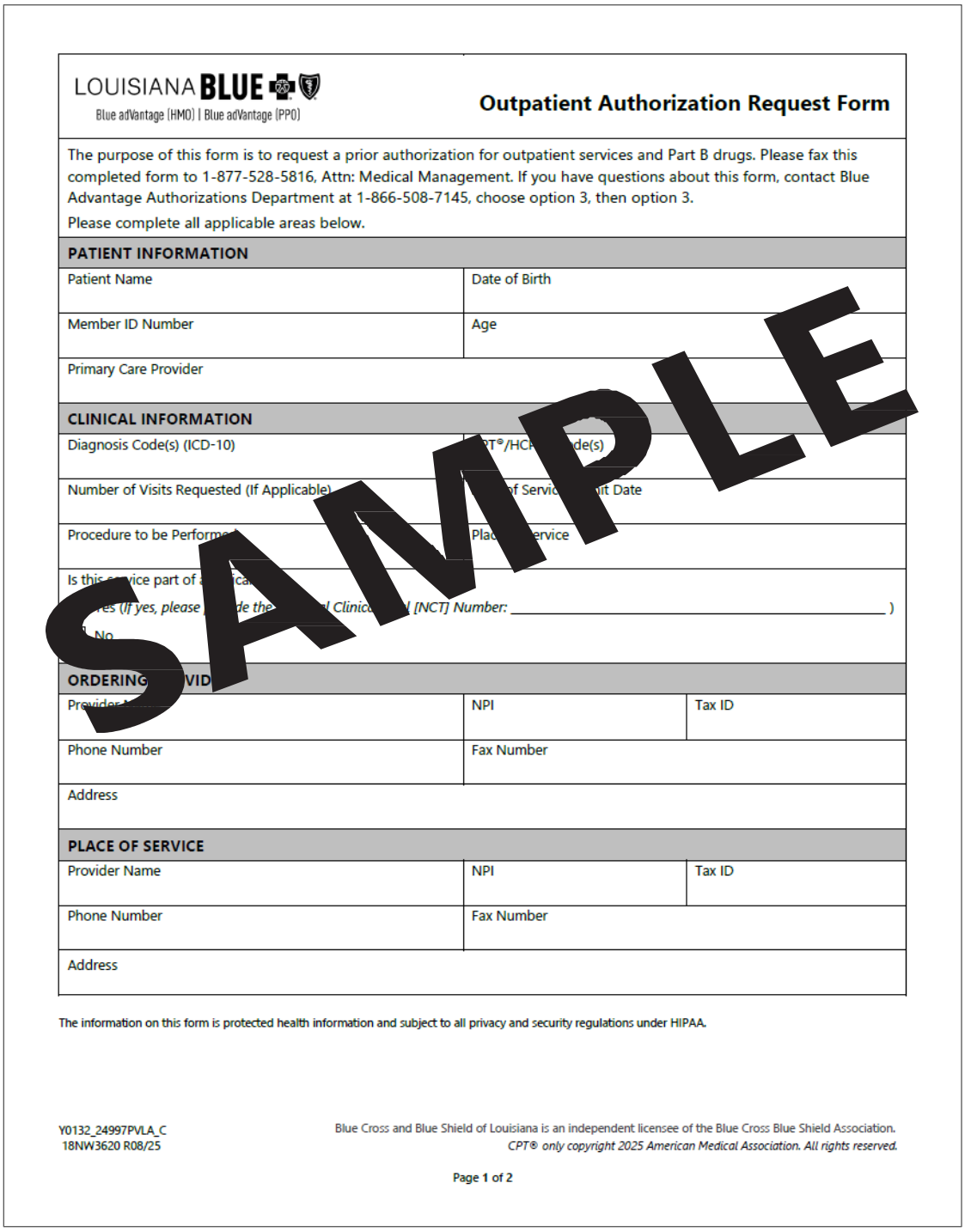
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SAMPLE

Outpatient Authorization Request Form

This form is available online at www.lablue.com/providers >Blue Advantage Resources >Forms.



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Outpatient Authorization Request Form

The purpose of this form is to request a prior authorization for outpatient services and Part B drugs. Please fax this completed form to 1-877-528-5816, Attn: Medical Management. If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3.

Please complete all applicable areas below.

PATIENT INFORMATION

Patient Name	Date of Birth
Member ID Number	Age
Primary Care Provider	

CLINICAL INFORMATION

Diagnosis Code(s) (ICD-10)	CPT®/HCPCS Code(s)
Number of Visits Requested (If Applicable)	Date of Service / Visit Date
Procedure to be Performed	Place of Service
Is this service part of a clinical trial?	
Yes (If yes, please provide the National Clinical Trial [NCT] Number: _____)	
No	

ORDERING PROVIDER

Provider Name	NPI	Tax ID
Phone Number	Fax Number	
Address		

PLACE OF SERVICE

Provider Name	NPI	Tax ID
Phone Number	Fax Number	
Address		

The information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

SAMPLE

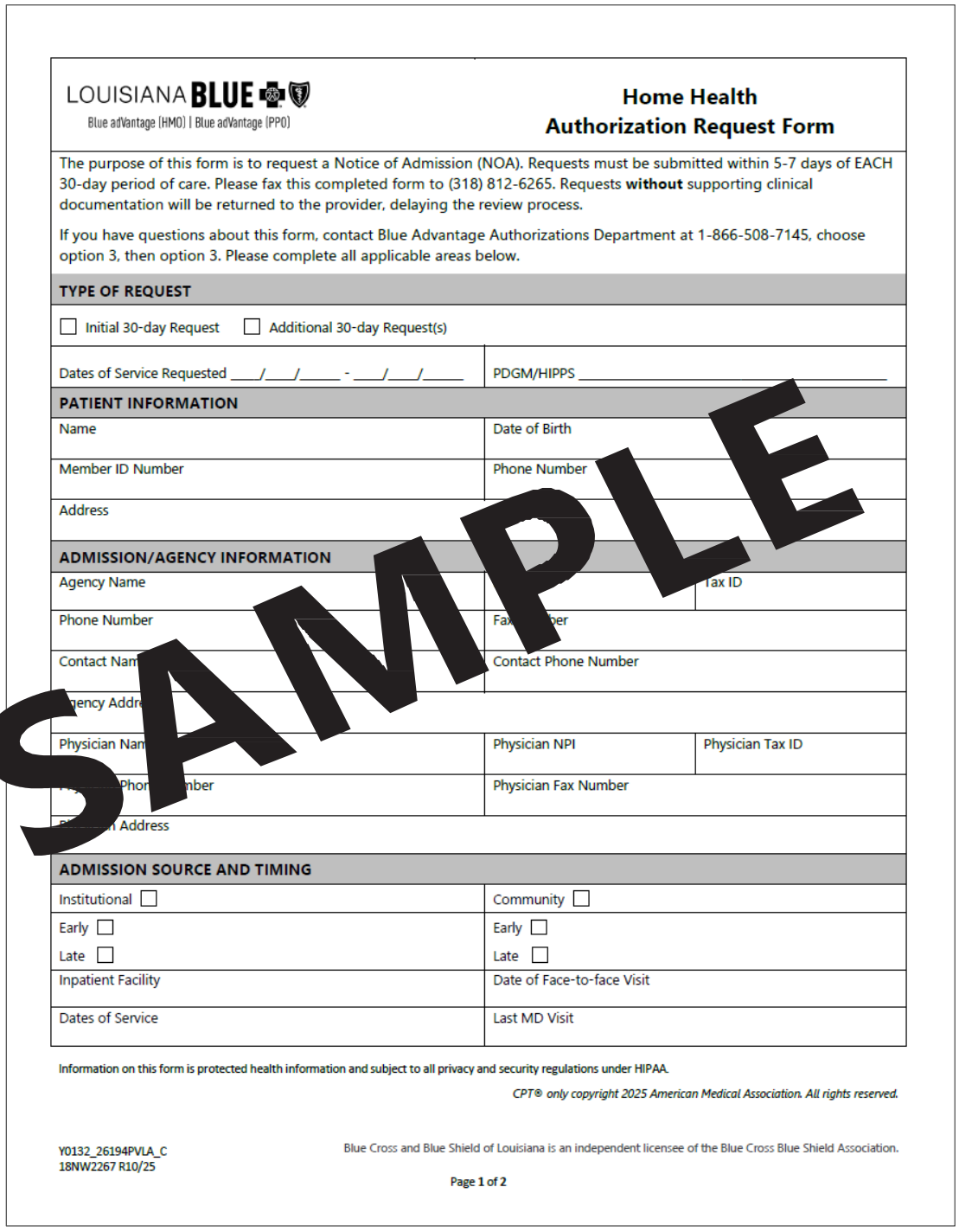
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18NW3620 R08/25

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Page 1 of 2

Home Health Authorization Request Form

This form is available online at www.lablue.com/providers >Blue Advantage Resources >Forms.



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Home Health Authorization Request Form

The purpose of this form is to request a Notice of Admission (NOA). Requests must be submitted within 5-7 days of EACH 30-day period of care. Please fax this completed form to (318) 812-6265. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

TYPE OF REQUEST

☐ Initial 30-day Request ☐ Additional 30-day Request(s)

Dates of Service Requested ____/____/_____ - ____/____/_____	PDGM/HIPPS _____

PATIENT INFORMATION

Name	Date of Birth	
Member ID Number	Phone Number	
Address		

ADMISSION/AGENCY INFORMATION

Agency Name		Tax ID
Phone Number	Fax Number	
Contact Name	Contact Phone Number	
Agency Address		
Physician Name	Physician NPI	Physician Tax ID
Physician Phone Number	Physician Fax Number	
Physician Address		

ADMISSION SOURCE AND TIMING

Institutional ☐	Community ☐
Early ☐	Early ☐
Late ☐	Late ☐
Inpatient Facility	Date of Face-to-face Visit
Dates of Service	Last MD Visit

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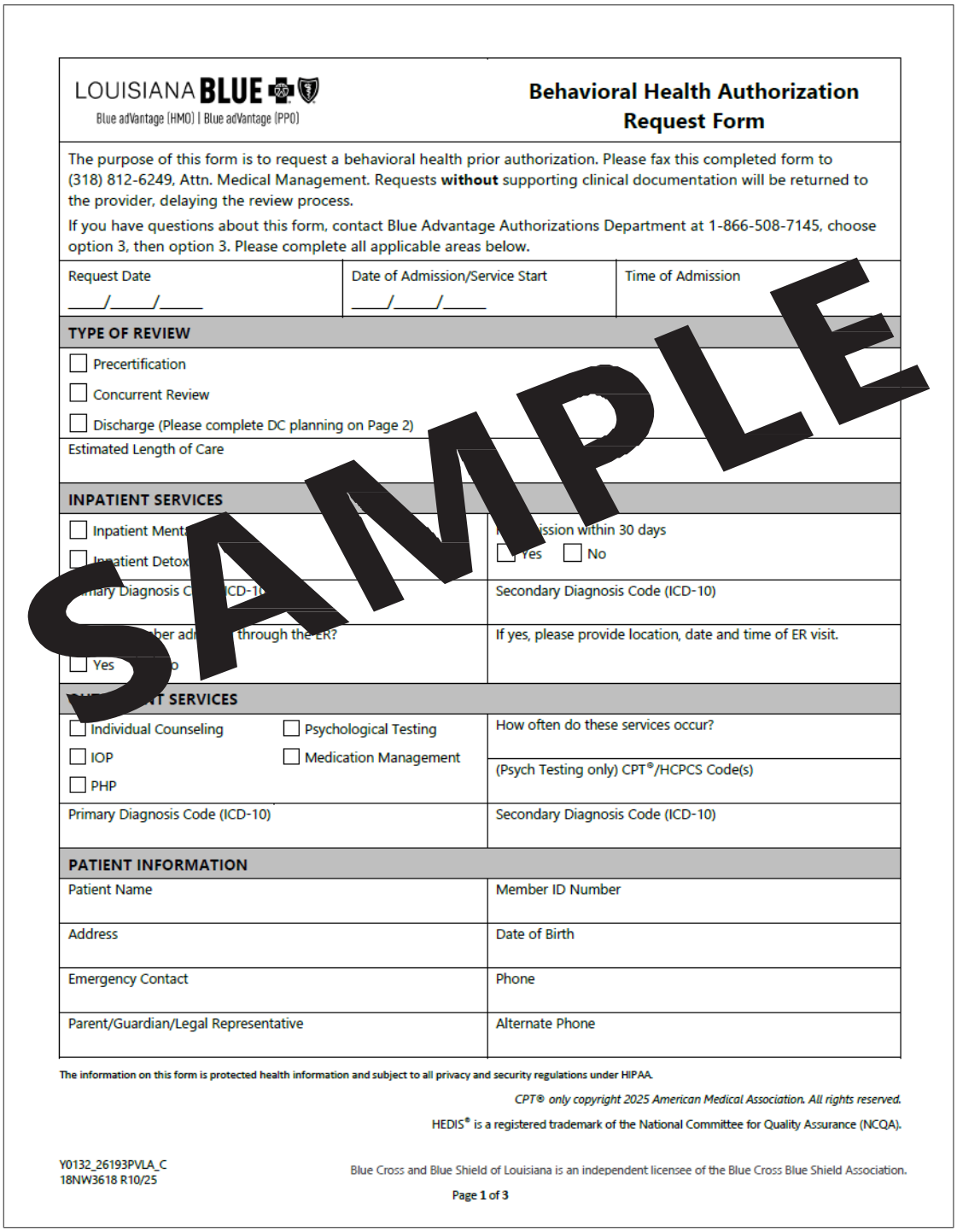
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Page 1 of 2

SAMPLE

Behavioral Health Authorization Request Form

This form is available online at www.lablue.com/providers >Blue Advantage Resources >Forms.



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Behavioral Health Authorization Request Form

The purpose of this form is to request a behavioral health prior authorization. Please fax this completed form to (318) 812-6249, Attn. Medical Management. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

Request Date	Date of Admission/Service Start	Time of Admission
____/____/____	____/____/____	

TYPE OF REVIEW

- ☐ Precertification
- ☐ Concurrent Review
- ☐ Discharge (Please complete DC planning on Page 2)

Estimated Length of Care

INPATIENT SERVICES

☐ Inpatient Ment…	…ission within 30 days ☐ Yes ☐ No
☐ Inpatient Detox	
…mary Diagnosis C… ICD-10	Secondary Diagnosis Code (ICD-10)
…ber ad… through the ER? ☐ Yes …o	If yes, please provide location, date and time of ER visit.

…T SERVICES

☐ Individual Counseling ☐ Psychological Testing ☐ IOP ☐ Medication Management ☐ PHP	How often do these services occur?
	(Psych Testing only) CPT®/HCPCS Code(s)
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)

PATIENT INFORMATION

Patient Name	Member ID Number
Address	Date of Birth
Emergency Contact	Phone
Parent/Guardian/Legal Representative	Alternate Phone

SAMPLE

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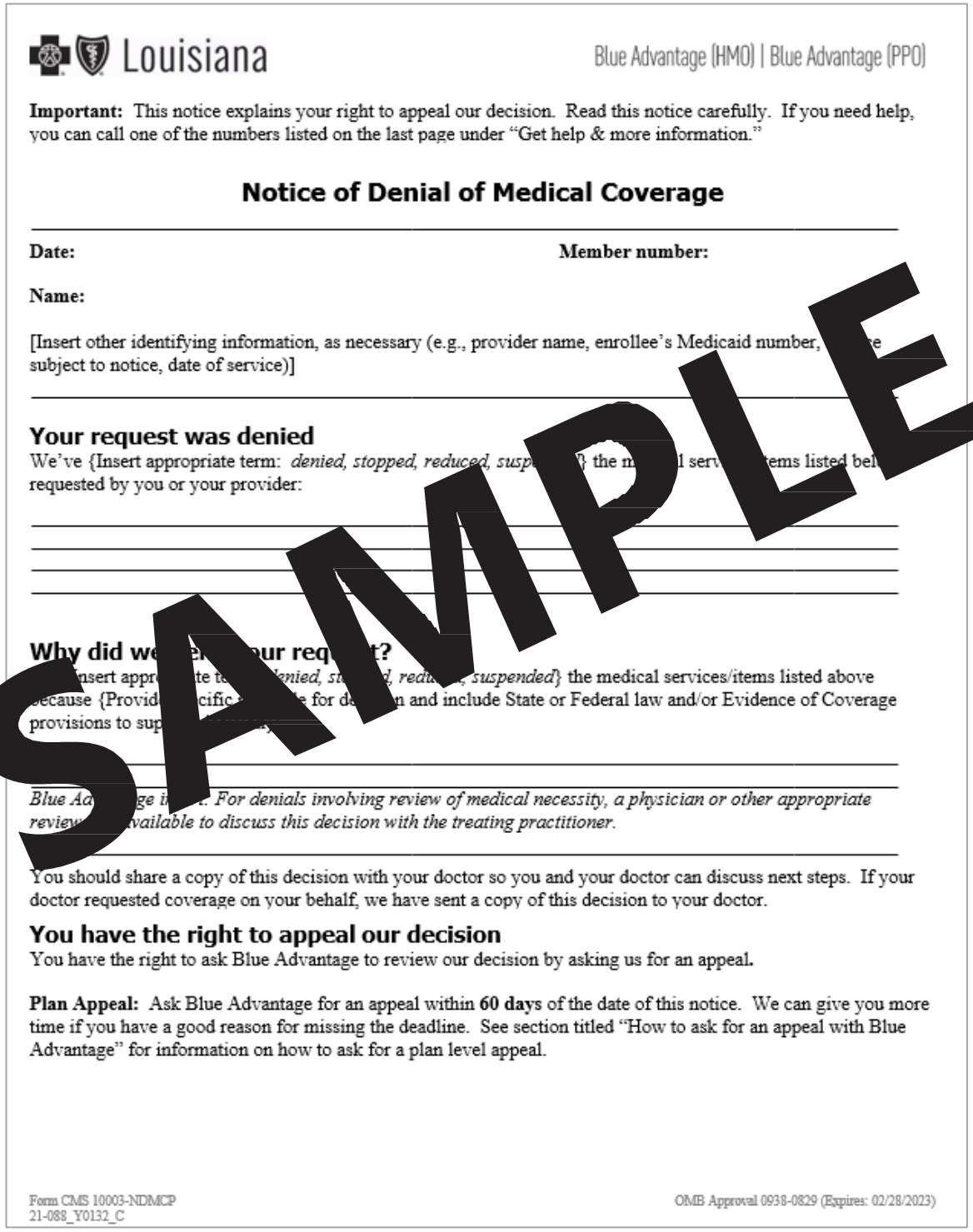
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18NW3618 R10/25

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Page 1 of 3

Integrated Denial Notice



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage

Date: **Member number:**

Name:

[Insert other identifying information, as necessary (e.g., provider name, enrollee's Medicaid number, [illegible] subject to notice, date of service)]

Your request was denied

We've {Insert appropriate term: *denied, stopped, reduced, suspended*} the medical services/items listed below requested by you or your provider:

Why did we [illegible] your request?

{Insert appropriate term: *denied, stopped, reduced, suspended*} the medical services/items listed above because {Provide specific reason for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}

Blue Advantage is not. For denials involving review of medical necessity, a physician or other appropriate reviewer is available to discuss this decision with the treating practitioner.

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask Blue Advantage to review our decision by asking us for an appeal.

Plan Appeal: Ask Blue Advantage for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Blue Advantage" for information on how to ask for a plan level appeal.

Form CMS 10003-NDMCP
21-088_Y0132_C

OMB Approval 0938-0829 (Expires: 02/28/2023)

SAMPLE

[Provider Information]
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent me[illegible]view ([illegible]al) of the decision to end Medicare coverage of these se[illegible]rvice[illegible] continue during the appeal.
- If you choose to appeal, the indepe[illegible]eviewe[illegible] your op[illegible] reviewer also will look at your medi[illegible]ds and [illegible] relevant inf[illegible]tion. You do not have to p[illegible] anythin[illegible]g, but [illegible]ave the right to do so if you wish.
- If you ch[illegible]se to appea[illegible] the [illegible]nt revi[illegible]er will each receive a copy [illegible]detailed exp[illegible]ti[illegible]hy [illegible]coverage for services should not conti[illegible] will receiv[illegible]s de[illegible]notice only after you request an appeal.

If you [illegible]ose[illegible]peal, a[illegible]e independent reviewer agrees services should no longe[illegible] co[illegible]r the [illegible]ective date indicated above;
  - N[illegible]edic[illegible]r your plan will pay for these services after that date.

[illegible]you [illegible] services no later than the effective date indicated above, you will avoid [illegible]anc[illegible]ability.

[illegible]o Ask For an Immediate Appeal

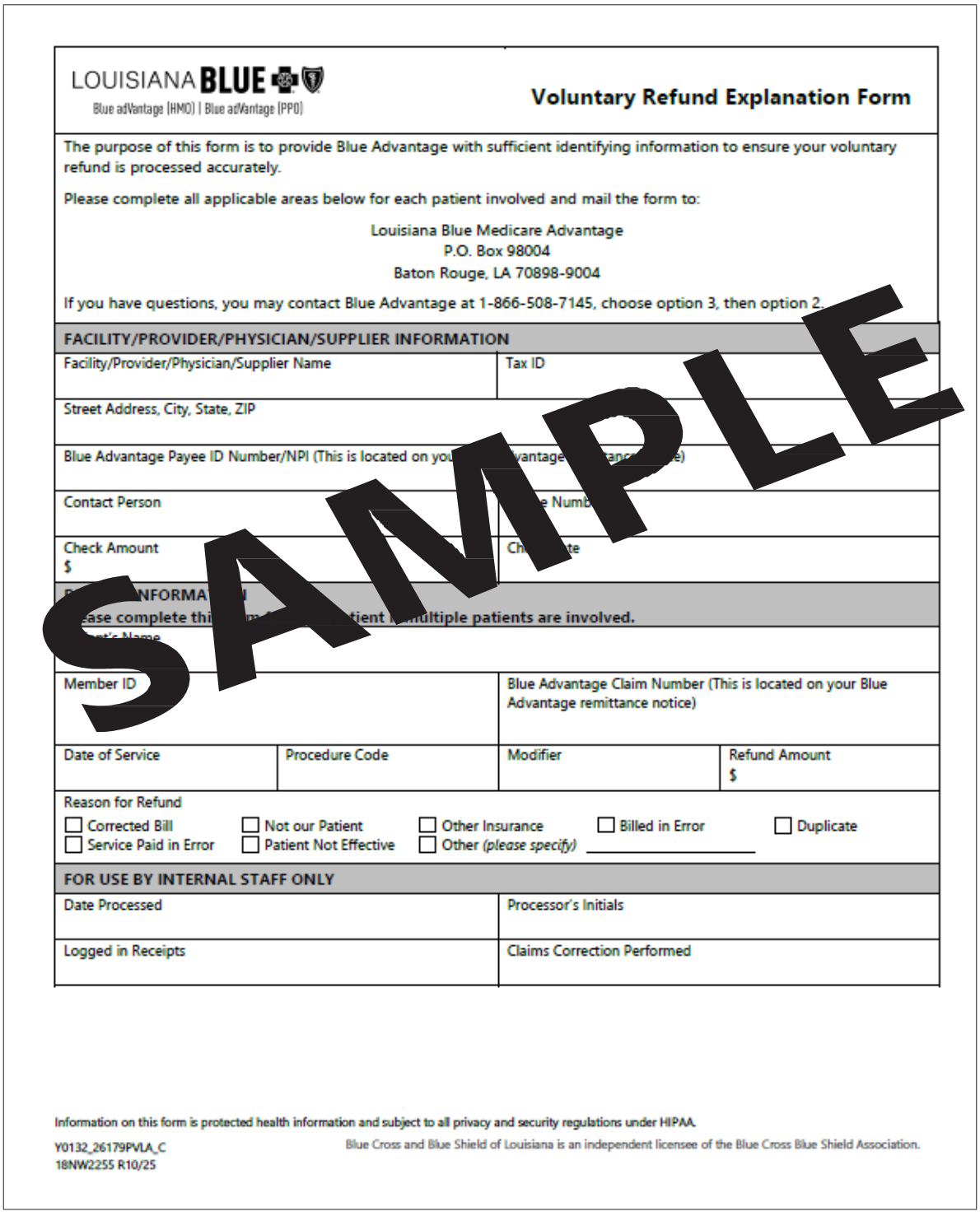
- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO, 1(888) 315-0636 to appeal, or if you have questions.

See page 2 of this notice for more information.

SAMPLE

Voluntary Refund Explanation Form

This form is available online at www.lablue.com/providers >Blue Advantage Resources >Forms.



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Voluntary Refund Explanation Form

The purpose of this form is to provide Blue Advantage with sufficient identifying information to ensure your voluntary refund is processed accurately.

Please complete all applicable areas below for each patient involved and mail the form to:

Louisiana Blue Medicare Advantage
P.O. Box 98004
Baton Rouge, LA 70898-9004

If you have questions, you may contact Blue Advantage at 1-866-508-7145, choose option 3, then option 2.

FACILITY/PROVIDER/PHYSICIAN/SUPPLIER INFORMATION

Facility/Provider/Physician/Supplier Name	Tax ID
Street Address, City, State, ZIP	
Blue Advantage Payee ID Number/NPI (This is located on you	vantage
Contact Person	e Numb
Check Amount $	Ch te

NFORMA

ease complete thi tient multiple patients are involved.

Member ID	Blue Advantage Claim Number (This is located on your Blue Advantage remittance notice)

Date of Service	Procedure Code	Modifier	Refund Amount $

Reason for Refund

☐ Corrected Bill ☐ Not our Patient ☐ Other Insurance ☐ Billed in Error ☐ Duplicate
☐ Service Paid in Error ☐ Patient Not Effective ☐ Other *(please specify)* _____

FOR USE BY INTERNAL STAFF ONLY

Date Processed	Processor's Initials
Logged in Receipts	Claims Correction Performed

SAMPLE

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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Summary of Changes

Below is a summary of changes to the *Blue Advantage Provider Administrative Manual*. Minor revisions not detailed in this summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document. General style changes are not noted in this Summary of Changes.

January 2027

Plan Information Contact List

iLinkBlue

- Renamed this section iLinkBlue and removed references to the retired Blue Advantage Provider Portal

Provider Credentialing & Data Management

- Updated contact information and website navigation

General Information

Blue Advantage Member ID Cards

- Updated images of ID cards

Network Participation

Credentialing Program

- Updated website navigation

Initial Credentialing

- Added information about credentialing requests after a denial

Professional Provider CLIA Certification

- Renamed this section to distinguish from Facility CLIA Certification

Practitioner Rights

- Added new section

Facility Rights

- Added new section

Facility CLIA Certification

- Added new section

Subcontracted Providers

- Replaced hospital references with facilities

Telehealth

- Added new section

Continuous Monitoring

- Added new section

Involuntary Terminations

- Replaced hospital references with facilities

Provider Termination Disputes

- Added new section

iLinkBlue and Electronic Funds Transfer

- Added new section

Digitally Submitting Credentialing & Demographic Forms

- Updated names of forms

Facility Names and Tax Identification Changes

- Added new section

National Provider Identifiers

- Added new section

Notifying Louisiana Blue of Your NPI

- Added new section

Filing Claims with NPIs

- Added new section

Provider Directory Verification

- Updated section to create subsections distinguishing professional provider and facility directory verification

Provider Directory Locations Policy

- Updated maximum number of locations per Tax ID
- Updated names of forms

Provider Roles and Responsibilities

Plan Directed Care (PDC)

- Updated to include information on PDC requirements and claim denials

General Operation Guidelines

Sepsis

- Added new section

Pharmacy Management

Medicare Part D Benefit

- Updated member out of pocket cost to $2,400

Part B Drugs Prior Authorization Request Form

- Added information on Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria

Claims and Billing Guidelines

Electronic Claims

- Updated electronic claims submission Payer ID to distinguish between claims with dates of service before and after 01/01/2026
- Updated MFT URL

Split/Share E&M Services

- Added new section

Office Setting

- Added new section

Provider-Based Billing

- Added new section

Prohibition Against Services Rendered By/To Family Member

- Added new section

Contracted Provider Disputes

- Added information on accessing the Dispute Claim Form and checking dispute status

Member Appeals

- Updated member appeals deadline

Sample of Forms

- Added information on provider update forms and knowing which forms apply to professional providers and facilities

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