

HMO Louisiana, Inc. Provider Manual

*A supplement to your Blue Cross and Blue Shield of Louisiana
Provider Office Manual*



A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.

Please note: HMOLA providers should follow the guidelines set forth in this manual. Differences and additional guidelines can be found in the Professional Provider Office Manual. View a copy online at www.bcbsla.com, Provider, Manuals & Speed Guides.

HMOLA Network: An Overview

HMO Louisiana, Inc. (HMOLA) is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. Since 1996, HMOLA has worked to develop business relationships with doctors, hospitals and other healthcare providers throughout Louisiana. The HMOLA provider network is a select group of physicians, hospitals and allied providers who provide services to individuals and employer groups seeking managed care benefits. The HMOLA network is offered in the Baton Rouge, New Orleans and Shreveport service areas only.

HMOLA members pay a lower copayment when they receive services from primary care physicians (PCPs) and receive the highest level of benefits when they receive care from in-network providers.

HMOLA offers two managed care benefit plans:

Health Maintenance Organization (HMO)

This benefit design is similar to the POS benefit design in that members with either a POS or HMO benefit plan access the same network of providers and have the same type of benefits, except there is no out-of-network option with the HMO benefit.

- Uses HMOLA providers
- Member is responsible for any applicable coinsurance, deductible and/or copayment
- Member receives high-level benefits for in-network providers with authorization (if necessary)
- Member has **no benefits** for out-of-network providers (without Plan approval)

Point of Service (POS)

Allows members to choose each time they need care—at the point of service—whether to use a network provider or go out-of-network and receive reduced benefits. Members with a POS benefit plan receive the highest level of benefits when using network providers with the proper authorization (when services require plan approval) and a lower level of benefits when receiving care that is not authorized or from providers who are not in the HMOLA network.

- Uses HMOLA providers
- Member is responsible for any applicable coinsurance, deductible and/or copayment
- Member receives high-level benefits for in-network providers with authorization (if necessary)
- Member receives **low-level benefits** for out-of-network providers (without Plan approval)

Nonparticipating (or Out-of-Network) Providers

HMOLA members have no benefits for services provided by nonparticipating or out-of-network providers without obtaining prior approval. After an authorization is obtained for medically necessary services to a nonparticipating provider, please note the following regarding reimbursement:

- The allowable charge is the lesser of the provider's billed charge, or an amount negotiated with the provider as payment in full, for the member's covered services.
- This amount is the nonparticipating provider's allowable charge and it is used to determine the amount paid for the member's covered services.

An HMOLA member does not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility. In this case, the allowable charge is the lesser of the provider's billed charge, or an amount negotiated with the provider as payment in full, for the member's covered services. This amount is the nonparticipating provider's allowable charge and it is used to determine the amount that will be paid for the member's covered services.

Identifying HMOLA Members



When HMOLA members arrive at your office, be sure to ask them for their current HMOLA ID card. The main identifier for HMOLA members is the HMO Louisiana, Inc. logo in the top left corner of the card. Cards also indicate the product type as either the HMO Plan or Point of Service (POS) Plan. HMOLA members carry an ID card similar to the one shown here. HMO members are issued ID cards with the same ID number for each covered member.



Direct Access

Direct Access is an innovative approach to managed care that was implemented by Blue Cross and HMOLA. Members may choose to receive care from a primary care physician (PCP) or go directly to a network specialist for office visits without receiving a referral. Members with Direct Access have “Direct Access” printed on their ID cards.

How does Direct Access affect the member’s benefits?

Copayments for members with Direct Access are different depending on whether or not the services are rendered by a network PCP or by a network specialist. The applicable copayment for each provider type is listed on the member’s ID card.

Who Is Eligible for the PCP Copayment

The following specialties are considered PCPs by HMOLA:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Please note that the following provider types should also collect the PCP copayment:

- Chiropractors
- Federally Qualified Rural Health Clinics
- Occupational Therapists
- Physical Therapists
- speech Therapists



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Submitting claims for HMOLA Members

Providers file claims for services related to inpatient, outpatient and professional services. To ensure prompt and accurate payment, it is important that you provide all patient information on the required claim form including appropriate HCPCS, CPT® codes and ICD-9-CM diagnosis and procedure codes. Also, remember to include your HMOLA assigned five-position or ten-position provider number. All completed claim forms should be forwarded to the following address for processing:

HMO Louisiana, Inc.
P.O. Box 98024
Baton Rouge, LA 70898-9024

Electronic Submission of Claims

By filing your claims electronically, you will have less paperwork and your claims will be paid faster, often within 7 to 14 days. If you are interested in submitting electronic claims to HMOLA, you may choose from the following options. Get more information by calling the phone numbers listed for each below:

- Clearinghouse Submissions 225.291.4334
- System-to-System Electronic Transactions 225.291.4334
- ACTS 2000 225.293.LINK (5465)
- iLinkBLUE *Provider Suite* 800.216.BLUE (2583) or 225.293.LINK (5465)

What is the timely filing limit for claim submissions?

All claims for HMOLA members must be filed within 15 months of the date of service. Claims received after 15 months will be denied, and the member and HMOLA should be held harmless for these amounts.

Services That Require Authorization

The following services and/or procedures require authorization prior to the service being performed. Authorization requirements may vary slightly by the member's health benefit plan. To obtain authorization, please call Provider Services at 800.922.8866, option 2.

- Applied Behavior Analysis
- Bone Growth Stimulator
- CT Scans**
- Dialysis
- DME – Plan approval is required for DME that exceeds \$300
- Drugs Requiring Authorization – Complete list of drugs that require authorization available online at:
• www.bcbsla.com/pharmacy; Drugs Requiring Prior Authorization
- Electric & Custom Wheelchairs
- Home Health and Private Duty Nursing
- Hospice
- Hyperbarics
- Implantable Medical Devices over \$2000.00 including, but not limited to, defibrillators and insulin pumps
- Infusion Therapy – home and facility administration (exception: physician's office, unless associated with a specialty pharmacy drug).
- Inpatient Hospital Services (except routine maternity stays)*

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- Low Protein Food Products
- Mental/Alcohol/Drug Abuse Treatment
- MRI/MRA**
- Nuclear Cardiology**
- Oral Surgery
- Orthotics/Prosthetics
- Outpatient Services (except X-ray, lab, and physical, occupational and speech therapy) – when performed in an outpatient setting (hospital/ambulatory facility).
- PET Scans**
- Procedures and services that may be investigational or experimental in nature
- Procedures that are potentially cosmetic in nature
- Sleep Studies
- Stereotactic Radiosurgery, including, but not limited to, gamma knife and cyberknife procedures
- Transplant Evaluations
- Transportation (Non-Emergency)
- Vacuum Assisted Wound Closure Therapy

*Maternity admissions to in-network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.

**Request authorization for these services online through iLinkBLUE.

Exclusion for pre-implantation genetic determination: Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination are excluded from coverage.

Authorization Penalties for HMOLA/POS Providers

If a provider fails to obtain a required authorization for an HMOLA member, Blue Cross will reduce the provider's benefit payment by 30 percent of the allowable charge. This penalty applies to all services and supplies requiring an authorization, other than inpatient charges. The HMOLA provider is responsible for all charges not covered and for the penalty amount. The HMOLA member remains responsible for the member's copayment, deductible amount and applicable coinsurance percentage. If a service is determined as not medically necessary, the service or supply is not covered.

There is a \$1,000 penalty toward the allowable charge to HMOLA/POS inpatient network facilities for failure to obtain an authorization for inpatient facility confinements. No 30 percent penalty or \$1,000 penalty will be applied to the professional services for the inpatient stay. There is no penalty for professional services rendered during the inpatient stay.

For new group HMOLA/POS plans with deductibles, there is no copay. Therefore, the \$1,000 penalty will be applied to Blue Cross' payment based on the deductible/co-insurance benefit.

Preferred Lab Program

HMOLA uses a statewide preferred lab program with multiple lab vendors. Laboratory services provided to HMOLA members must be submitted to these labs. The lab vendors are:

- LabCorp
- Quest Diagnostics, Inc.
- Woman's Hospital in Baton Rouge (select services)

Program Requirements

Laboratory services provided to HMOLA members must be submitted to LabCorp, Quest Diagnostics or Woman's Hospital. However, physicians may perform a selection of lab tests in their offices, which may be covered under the member's office copayment.

See the in-office lab list on the right side of this page. Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by HMOLA participating hospitals.

Handling Fee

To compensate physicians for their time and effort associated with handling lab tests sent to LabCorp, Quest or Woman's Hospital, physicians will be paid a \$3 handling fee per member/per visit for tests routed correctly to one of the preferred labs. To be paid the \$3 handling fee, you must bill CPT® code 36415 or 99000. Please note: Physicians are not eligible for the handling fee when they refer lab work to labs other than our preferred labs, and they will not be paid for the handling fee in addition to their fee-for-service reimbursement for lab tests performed in their offices.

Working with our Preferred Labs

If you need the necessary forms to submit lab work to LabCorp, Quest or Woman's Hospital, you may contact them at the following numbers or visit them online:

- LabCorp: 800.888.4758 or 225.926.9173 www.labcorp.com
- Quest: 800.654.9050 (Central and North Louisiana) www.questdiagnostics.com
800.669.0920 (Southeast Louisiana)
- Woman's Hospital: 225.924.8271

Physicians who do not collect specimens in their offices may send their HMOLA patients to the Preferred Lab draw sites. You may use our online provider directories available at www.bcbsla.com to locate Preferred Lab draw sites.

Special Arrangements

To make special arrangements for weekend or after-hour pickups, please call the labs at the numbers listed above.

Provider Inquiries and Satisfaction

Providers can access member's benefits, eligibility and allowable charges using the iLinkBLUE Provider Suite. If you have questions regarding a member's coverage, please call Provider Services at 800.922.8866. Please let us know if any quality issues arise so we can work with the appropriate lab to improve service and ensure that you and your patients receive the service you expect and deserve.

In-Office Lab Services

Providers may perform a selection of lab tests in their office. Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by HMOLA participating hospitals.

10021	85027
10022	85032
38220	85610
38221	85651
81000	85652
81001	86308
81002	86403
81003	86485
81015	86490
81025	86510
82044	86580
82270	86586
82272	86756
82565	87172
82570	87177
82947	87205
82948	87210
82951	87220
82952	87275
82962	87276
83013	87430
83014	87804
83026	87880
83037	89100
83518	89105
84030	89130
84132	89132
84437	89135
84830	89136
85007	89140
85008	89141
85013	89190
85014	89220
85018	89230
85025	

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For More Information

Provider Office Manuals

PLEASE NOTE: HMOLA providers should follow the guidelines set forth in the Professional Provider Office Manual found online at www.bcbsla.com and the Member Provider Policies & Procedures Manual found online on our iLinkBLUE Provider Suite at www.bcbsla.com/ilinkblue. Differences and additional guidelines are found in this manual, which is a supplement to the manuals listed above.

Provider Services Voice Response Telephone System (Call Center)

800.922.8866

Option 1 - Fax or voice summary of benefits or claim status

Option 2 - Calling to set up a new authorization

Option 3 - Out-of-state policy

Option 4 - Federal Employee Policy (FEP)

Option 5 - All other calls - Network Administration

Customer Service

If your patients have questions about their healthcare benefits, you should tell them to call the number on their ID card. If they don't have their card, you may refer them to the Customer Service Center at 800.376.7741 or 225.293.0625.

Provider Network Administration

If you need assistance with any of the material contained in this manual, you may call Provider Network Administration at 800.716.2299, option 3 or e-mail us at network.administration@bcbsla.com.

Provider Relations Services

Provider Relations Representatives assist providers and their office staff and provide information about Blue Cross and its programs and procedures. To determine who your Provider Relations Representative is, see the Provider Representatives map at www.bcbsla.com under Provider Tools. Please do not call your Provider Relations Representative with routine claim or benefit questions. You may obtain immediate answers to those questions through iLinkBLUE or by calling the Provider Services at 800.922.8866 as directed above.

How do I update my practice information with HMOLA?

Please notify us if you have changes to your name, address or tax identification number (TIN). If your TIN changes, we will have to assign new provider numbers for claims filing. Please notify HMOLA by sending a copy of your IRS Employer Identification Number Letter to the address below prior to the effective date of the new TIN.

HMO Louisiana, Inc.
Network Administration
P.O. Box 98029
Baton Rouge, LA 70898-9029

800.716.2299, option 3 or 225.297.2758
225.297.2750 (fax)
www.bcbsla.com
network.administration@bcbsla.com



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BlueCross BlueShield of Louisiana

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Your Health. Our Commitment.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

www.bcbsla.com

Network Administration Division

Provider Communications

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