Our Mission

To improve the health and lives of Louisianians
Agenda

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Risk Adjustment

- Commercial Risk Adjustment
- Impact Specific Coding Has on Risk Adjustment
- Provider’s Role Toward Risk Adjustment
- Changes that Affect Facility Claims
Commercial Risk Adjustment

- Commercial Risk Adjustment (CRA) is one of three premium stabilization programs
  - Established by the Affordable Care Act (ACA)
  - Individual and small group commercial markets
  - Products sold on and off the exchange
- CRA encourages health plans to focus on:
  - Quality improvements
  - Efficiency
  - Stabilizing of premiums designed to prevent adverse selection

The Impact Specific Coding Has on Risk Adjustment

- CMS requires health plans to report complete and accurate diagnostic information on their members.
- Medical records must support ALL diagnosis codes on claims.
- Always report ALL applicable diagnosis codes on a claim and code claims with the most specific diagnoses.
  - UB-04 claims can accommodate up to 26 diagnosis codes.
- Always include all related diagnoses, including chronic conditions you are treating the member for.
- We discourage from filing “not otherwise specified” (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.
Provider’s Role Toward Risk Adjustment

- Providers must perform accurate medical record documentation and coding practices to capture the complete risk profile of each individual patient.
  - Accurate risk-capture improves high-risk patient identification.
  - Our ability to engage patients in care management programs and care prevention initiatives.
- Accurate coding helps reduce the administrative burden of medical record requests and adjusting claims for both the provider’s office and healthcare insurers.

Changes that Affect Facility Claims

- We do not accept interim billings for inpatient services billed on a UB-04 claim form. **Exception:** An interim bill will be accepted only if the total charge is $800,000 or greater and at least 60 days of service.*
- The only acceptable bill types are xx1 and xx7.
  - Bill type xx7 can be used to adjust original claims to capture additional diagnosis.
- We will reject facility claims received with the bill type ending with one of the following numbers:
  - xx2 – xx5
  - xx3 – xx6
  - xx4 – xx9

* If you meet the criteria to file an interim bill, please call Kent Graves at (225) 297-2654 to discuss how to submit your bill.
ICD-10

- ICD-10 is Here!
- Specificity of Codes
- Filing ICD-10 Claims
- Have an ICD-10 Question or Need Help?

ICD-10 is Here!

ICD-10 was implemented on Oct. 1, 2015:

- Blue Cross **WILL NOT ACCEPT** claims that contain both ICD-9 and ICD-10 codes on a single claim.
- Blue Cross **WILL REJECT** electronic claims not adhering to these guidelines/conditions on the electronic Not Accepted Report.
- Blue Cross **WILL REJECT** paper claims not adhering to the guidelines/conditions above. Claims will be returned to the provider in a “send back” letter.
- For inpatient claims:
  - The grouper will compute DRGs based on the Discharge Date.
  - Benefits and reimbursement will be based on the Admit Date.

Make sure claims include the most specific ICD-10 codes and can be supported by the patient’s medical records
Specificity of Codes

Example of specific ICD-10 coding:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M86.44</td>
<td>Chronic osteomyelitis with draining sinus, hand</td>
</tr>
<tr>
<td>M86.441</td>
<td>Chronic osteomyelitis with draining sinus, right hand</td>
</tr>
<tr>
<td>M86.442</td>
<td>Chronic osteomyelitis with draining sinus, left hand</td>
</tr>
<tr>
<td>M86.449</td>
<td>Chronic osteomyelitis with draining sinus, unspecified hand</td>
</tr>
</tbody>
</table>

* Header codes are considered incomplete and are not billable codes

Only bill the unspecified code when no other code is appropriate

Filing ICD-10 Claims

Facility Inpatient Claims

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Claim Coding Requirements</th>
<th>Claim Processing Rules</th>
</tr>
</thead>
</table>
| Admit and Discharge Dates before Oct. 1, 2015       | The claim should be coded with ICD-9 codes | 1. The claim will be accepted for processing by Blue Cross if it is coded with ICD-9 codes  
2. The claim will be rejected by Blue Cross if it is coded with ICD-10 codes and will need to be resubmitted using ICD-9 codes |
| Admit Date before Oct. 1, 2015, and Discharge Date on or after Oct. 1, 2015 | The claim should be coded with ICD-10 codes | 1. The claim will be accepted for processing by Blue Cross if it is coded with ICD-10 codes  
2. The claim will be rejected by Blue Cross if it is coded with ICD-9 codes and will need to be resubmitted using ICD-10 codes |
| Admit and Discharge Dates on or after Oct. 1, 2015  | The claim should be coded with ICD-10 codes | 1. The claim will be accepted for processing by Blue Cross if it is coded with ICD-10 codes  
2. The claim will be rejected by Blue Cross if it is coded with ICD-9 codes and will need to be resubmitted using ICD-10 codes |
Filing ICD-10 Claims

Facility Outpatient Claims

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Claim Coding Requirements</th>
<th>Claim Processing Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement From and Through Dates before Oct. 1, 2015</td>
<td>The claim should be coded with ICD-9 codes</td>
<td>1. The claim will be accepted for processing by Blue Cross if it is coded with ICD-9 codes 2. The claim will be rejected by Blue Cross if it is coded with ICD-10 codes and will need to be resubmitted using ICD-9 codes</td>
</tr>
<tr>
<td>Statement From Date before Oct. 1, 2015, and Statement Through Date on or after Oct. 1, 2015</td>
<td>Claim should be split: 1. Services provided before Oct. 1, 2015, should be coded on the first claim with ICD-9 codes 2. Services provided on or after Oct. 1, 2015, should be coded on the second claim with ICD-10 codes</td>
<td>1. The claim will be rejected by BCSBLA if it is not split and contains services spanning the ICD-10 implementation date of Oct. 1, 2015 2. The claim which contains services provided before Oct. 1, 2015, will be accepted for processing by Blue Cross if it is coded with ICD-9 codes and rejected if it is coded with ICD-10 codes 3. The claim which contains services provided on or after Oct. 1, 2015, will be accepted for processing by Blue Cross if it is coded with ICD-10 codes and rejected if it is coded with ICD-9 codes 4. The rejected claims will need to be resubmitted with the appropriate version of ICD codes</td>
</tr>
<tr>
<td>Statement From and Through Dates on or after Oct. 1, 2015</td>
<td>The claim should be coded with ICD-10 codes</td>
<td>1. The claim will be accepted for processing by Blue Cross if it is coded with ICD-10 codes 2. The claim will be rejected by BCSBLA if it is coded with ICD-9 codes and will need to be resubmitted using ICD-10 codes</td>
</tr>
</tbody>
</table>

Have an ICD-10 Question or Need Help?

Blue Cross ICD-10 Open Forums
Ask our panel of experts questions about ICD-10

2015 October 16 11:30 a.m. - 12:30 p.m.
2015 October 23 11:30 a.m. - 12:30 p.m.
2015 October 30 11:30 a.m. - 12:30 p.m.

The link to access the Open Forum will be online at www.bcbsla.com/providers >ICD-10 Conversion.
Claims

- Timely Filing
- Filing Claims Through iLinkBLUE
- Original Claim Forms
- Disputing Claims
- Reimbursement Review Form
- Bill Types
- Taxonomy of Codes
- Contacting Us About Claims

Timely Filing

**Blue Cross, HMO Louisiana, BlueConnect & Community Blue:**
- Claim must be filed within 15 months* of date of service.
- Claims received after 15 months* are denied & the member and Blue Cross are held harmless.

**FEP:**
- Claim must be filed by December 31 of the following year after the service was rendered.
- Claims received after the filing period are denied & the member and Blue Cross are held harmless.

**OGB:**
- Claim must be filed within 12 months of the date of service.
- Claims received after 12 months are denied & the member and Blue Cross are held harmless.

**Self-insured & BlueCard®:**
- Timely filing standards may vary. Always verify the member’s benefits, including timely filing standards.
Filing Claims Through iLinkBLUE

The Claims Entry option allows for the direct data entry of certain UB-04 (hospital) and CMS-1500 (professional) claims.

To submit claims, your user ID must be authorized for claims entry access.

To get iLinkBLUE access for claims entry or to become an iLinkBLUE user call the LinkLine at (800) 216-BLUE (2583) or send an email to iLinkBlue.providerinfo@bcbsla.com.

Detailed manuals on how to submit claims through iLinkBLUE are under the “Manuals” section of iLinkBLUE.

• The Blue Cross UB-04 Claims Entry Manual is under “Hospital.”
• The Blue Cross Professional Claims Entry Manual is under “Professional.”

Original Claim Forms

If it is necessary that you must file a claim hardcopy, we only accept original claim forms.

• We no longer accept faxed claims.
• We only accept RED original claim forms.

The fastest method of claims submission and payment is electronic submission.
Disputing Claims

We recognize that disputes may arise between providers and Blue Cross regarding covered services.

Examples of issues that qualify as appeals include:

- Claims issues related to authorizations
- Claims based on adverse determinations of medical necessity or benefit determinations
- Reimbursement reviews

Use the “Disputing Claims” guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross

Available online at www.bcbsla.com/providers >Education on Demand

Reimbursement Review Form

Use the “Reimbursement Review” form to properly request a review of how your claim was reimbursed.

Use the Reimbursement Review Form when:

- You disagree with Medical Coding Edit or Denial (i.e. assistant surgeon) such as how codes were bundled and/or denied (include your coding logic or applicable operative notes).
- The claim did not pay according to fee schedule and/or reimbursement amount is interpreted as incorrect. Providers must include clear details on why your facility interprets the claim reimbursement as incorrect and specifics on how it should have been reimbursed.
- A reason of “I disagree with the payment” is not acceptable.

Available online at www.bcbsla.com/providers >Forms for Providers

Be sure to place the reimbursement review form on top of your claim when submitting the documents for review.
Bill Types

Facility claims must be submitted with a type of bill. This three digit code represents specific information about the claim being filed.

The third digit of the type of bill indicates frequency. There ARE exclusions related to the frequency digit.

- Blue Cross will not accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. We do not accept interim billings for inpatient.
  
  Exception: An interim bill will be accepted only if the total charge is $800,000 or greater and at least 60 days of service.*

- Any interim bills or late charge claims should be aggregated into one final claim and be submitted using a frequency code of 1.
- For submission of adjustments or replacement claims the frequency code 7 is acceptable.

* If you meet the criteria to file an interim bill, please call Kent Graves at (225) 297-2654 to discuss how to submit your bill.

These guidelines are outlined in the Member Provider Policy & Procedure Manual, available on iLinkBLUE (www.bcbsla.com/ilinkblue/) under the Manuals section.

Acceptable Bill Types:

- Bill Type 111 (hospital, inpatient, admit through discharge)
- Bill Type 211 (skilled nursing, inpatient, admit through discharge)
- Bill Type 187 (swing bed, inpatient, replacement/adjustment claim)

Unacceptable Bill Types:

- Bill Type 112 (hospital, inpatient, interim-first claim)
- Bill Type 113 (hospital, inpatient, interim-continuing claim)
- Bill Type 114 (hospital, inpatient interim-final)
- Bill Type 215 (skilled nursing, inpatient, late charge)
Taxonomy of Codes

If your NPI is shared between sub-units, it is very important to also include the appropriate taxonomy code that clearly identifies the sub-unit in which services were provided.

Example: Multi-specialty facilities that provide acute, psychiatric, etc. should select the appropriate taxonomy code based on the services being billed.

Failure to use a specific taxonomy will cause payment to be directed to the wrong sub-unit, be paid incorrectly and/or may cause the claims to reject on the Not Accepted Report.

Contacting Us About Claims

Claims issues, you must FIRST:
• Submit an Action Request through iLinkBLUE.
• Request the claim be reviewed for correct processing.
• Be specific and detailed.
• Allow 10-15 working days.
• Check iLinkBlue for a claims resolution.
• Contact Provider Services at (800) 922-8866 for immediate assistance.

If you have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers by Provider Services you may then email an overview of the issue and the two reference numbers to: provider.relations@bcbsla.com

Claims status and benefit questions:
• Immediate answers are available through iLinkBLUE at www.bcbsla.com/ilinkblue.
• Call Provider Services at (800) 922-8866.

Electronic claims submissions/clearinghouse issues:
• Visit the Electronic Services section of our Provider page. (www.bcbsla.com/providers)
• Call our Electronic Data Interchange (EDI) department at (225) 291-4334.
• Email edich@bcbsla.com.
• You can also view our EFT FAQs at www.bcbsla.com/providers >Electronic Services >EFT
# Billing Guidelines

- Elective Delivery of Pregnancy
- Ambulance Transportation
- Air Ambulance Claims
- Patient Transfers
- Other Billing Reminders

## Elective Delivery of Pregnancy

Elective deliveries, whether Vaginal or Cesarean, prior to 39 weeks are:

- Considered not medically necessary and are not reimbursable
- Not billable to the member
  - Includes the delivery provider, anesthesiologist and facility

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>GB</td>
<td>Report when delivery is 39 weeks or more, whether spontaneous or elective</td>
</tr>
<tr>
<td>AT</td>
<td>Report when delivery is less than 39 weeks and medically necessary</td>
</tr>
<tr>
<td>GZ</td>
<td>Report when delivery is less than 39 weeks and NOT medically necessary</td>
</tr>
<tr>
<td>No Modifier</td>
<td>Claim will DENY for incomplete information</td>
</tr>
</tbody>
</table>

Note: The associated professional claims require specific modifiers when billed.

*Effective for claims with a date of service on or after Sept. 1, 2014*
Ambulance Transportation

Ambulance transportation may be covered to a member when:

- The transportation is medically necessary.
- Any other means of transportation is contraindicated.
- The destination is to the nearest appropriate facility that can treat the member’s condition.

The following coverage requirements apply to Air ambulance transports:

1. The transport is medically reasonable and necessary;
2. A BCBSLA member is transported;
3. The destination is local; and
4. The facility is appropriate.

*Please refer to the ambulance speed guide for authorization specifics.*

Air Ambulance Claims

It is required ambulance providers must include the 5-digit zip code of the point of pickup. This applies for:

- Emergent and non-emergent air ambulance services.
- Medicare crossover claims when Medicare’s benefits do not cover the claim.

Where to file air ambulance claims for dates of service on and after April 19, 2015:

- If the pickup location zip code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana.
- If the pickup location zip code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pickup.
- If the pickup location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the BlueCard Worldwide Program (www.bluecardworldwide.com).

Claims that do not include the point of pickup zip code on the claim will be denied for insufficient information.

*Effective for claims with a date of service on or after Apr. 19, 2015.*
### Other Billing Reminders

#### Network Providers

- Referrals to non-participating providers result in significantly higher cost-shares to our members and it is a breach of your Blue Cross provider contract.

- All providers participating in the network should refer members to participating reference lab vendors when lab services are needed and are not performed in the facility.

- The ordering/referring provider NPI is required on all laboratory claims otherwise the claim will be returned requesting the claim be resubmitted with the ordering provider’s NPI number.

  Place the NPI in the indicated blocks of the referenced claim forms:

  - UB-04: Block 78
  - 837I: 2310D loop, segment NM1 with qualifier of D in the NM101 element

  Blue Cross discourages hospital billing for services as a reference lab when they are not contracted as a reference lab with us.

#### Hospital-based Providers

The Health Care Consumer Billing & Disclosure Act (or Consumer’s Right to Know Act) requires that facilities (acute and ambulatory surgery centers) inform health plans of their hospital-based physicians in the specialties of:

- Anesthesia
- Emergency Medicine
- Neonatology
- Pathology
- Radiology

According to the legislation, health insurers must be notified of any future changes made to this information within 30 days of the change.
Other Billing Reminders

- Blue Cross asks that network facilities submit changes on the Consumer’s Right to Know Facility Reporting Form every time there is a change in hospital-based physician for any specialties listed above.
- Email completed forms to Network.Development@bcbsla.com.
- Forms may be faxed to (225) 297-2750, Attn: Network Development.
- Forms may be mailed to Network Development, BCBSLA-NAD, P.O. Box 98029, Baton Rouge, LA 70898-9029
- The form is located at www.bcbsla.com/providers
  >Forms for Providers.

Other Billing Reminders

Subcontracted Services

Services furnished to patients by providers other than by the facility where 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, etc.

- The reimbursement outlined in the Member Provider Agreement is intended to cover all Hospital Services rendered to a patient, including those services that are performed by subcontracted providers.
- Subcontracted providers should seek payment solely from the facility.
- Subcontracted providers should not bill Blue Cross or the Member for such services.
- Full information is included in our Member Policy & Procedures Manual available on iLinkBLUE (www.bcbsla.com/iilinkblue) under the Manual section.
Other Billing Reminders

• Facilities should not bill the member or plan a separate facility charge for an examining room, treatment room or any other facility charge that is normally included in the practice component of the service rendered by the physician.

Off-campus Services

Effective Jan. 1, 2016

Facility:

For off-campus facility claims, Modifier PO should be reported for each service, procedure and/or surgery performed at off-campus provider-based outpatient departments.

Professional:

• Report place of service code 19 when a patient obtains services from a portion of the hospital’s off-campus provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.

• Report place of service code 22 when a patient obtains services from a portion of the hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.

* Blue Cross is adopting CMS guidelines for off-campus services and will publish additional information as we have more details.
Patient Transfers

- EMTALA (The Emergency Medical Treatment and Active Labor Act)

EMTALA applies to facilities that:
1. Provide emergency room services
2. Accept payment from Medicare

We want to ensure we are able to secure the member the highest level of benefits by using network providers whenever possible. Thus we work with the facilities to transfer patients when appropriate.

- EMTALA does not impose any legal responsibility on health insurance issuers.
- It requires facilities to screen, treat and stabilize any patient that shows an emergency medical condition, disregarding whether the patient has health insurance coverage or the capability to pay for his treatment.
- Facilities cannot turn away, refer or transfer those patients to another facility until they have been properly stabilized according to the facility’s capabilities.
- EMTALA requires any transfer to another facility be done taking into consideration the best interests and wellbeing of the patient.
- We are under no obligation to pay for services rendered by a facility in furtherance of its EMTALA obligations, unless the patient has coverage and the services provided are covered.
- We do not have any obligations under EMTALA to pay for emergency services rendered by a non-network facility as if they had been rendered in-network.
Authorization Portal

- We Now Have an Authorization Portal
- What is an Administrative Representative
- Designating an Administrative Representative
- What’s Next for the Authorization Portal

We Now Have an Authorization Portal!

Advantages of our Authorization Portal:

- Submit authorizations and upload clinical documents 24 hours a day, seven days a week
- Likely to get an automatic approval for your authorization request
- Accessed through iLinkBLUE
- Immediate ability to view request decision, Length of Stay assigned, and reason for pending decision
- Eliminates time on the phone for notifications
- Discharges can be entered without faxing
- Ability to view and print denial letters
What is an Administrative Representative?

Each facility must designate an Administrative Representative.

The role of an administrative representative is to serve as the key person at your organization who will:

- delegate electronic access to appropriate users.
- ensure those appropriate users adhere to our guidelines.
- only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.
- promptly terminate employee access at such time as an employee changes roles or terminates employment with the organization.

1. Each designated administrative representative must complete the Administrative Representative Acknowledgment Form and associated spreadsheet. To obtain these documents, email our Provider Relations department at provider.relations@bcbsla.com.

2. Once all completed documents have been received, Blue Cross’ IT Security Team will then set up each administrative representative with access to our Security Setup Tool. To obtain your secure password and Security Set-up Guide, you must activate the secure email sent to you by Blue Cross.

3. The designated administrative representative will then begin the delegation process of giving appropriate employees at your facility access to our online tools.

4. Use the Authorization Portal (AP) Users spreadsheet to chart who in your organization is a delegated staff member.
What’s Next for the Authorization Portal?

• In the near future, you will have the option to electronically request, review and sometimes receive authorizations for BlueCard® members using the new Pre-service Review for Out-of-Area Members application. (Additional details will be provided when this resource is available.)

• Beginning January 1, 2016, our Blue Advantage network providers will have access to applications that require a separate sign-in process for:

  • Blue Advantage services – This application must be accessed to manage eligibility, benefits, claims and more through iLinkBLUE. Without the designation of an administrative representative, Blue Advantage network providers will not be able to access their online resources (eligibility, benefits, claims and more) for Blue Advantage members.

Medical Appeals

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract.
Blue Cross receives large volumes of medical necessity appeals.

- We require network providers to disclose ineligible services to members prior to performing or ordering services.
- Investigational or experimental procedures are not considered medically necessary according to our policy.
- The advanced waiver of liability will allow providers to collect payment from the member if they are performing services or enable them to provide the performing diagnostic provider with the information that the patient has been notified in advance of the investigational status and waived liability.

Please remember to check the medical policies section on iLinkBLUE to ensure the member has either a benefit for the service or a waiver of liability with advance notice will be necessary.

- Providers can easily search for medical policies using the index within iLinkBLUE.
- Our medical policies includes:
  - coverage eligibility,
  - background information related to technology,
  - devices and treatments,
  - technology assessments,
  - literature sources and
  - the rationale for coverage determinations

For medical necessity appeals, providers must send a written request to:

Blue Cross Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837

HMO Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
Fax (225) 298-1837
Blue Distinction Specialty Care Centers are part of a national designation program that recognizes facilities demonstrating expertise in delivering quality specialty care, safely and effectively. These designations can only be awarded to the facilities where the members services are being performed.

Two designation levels:
BlueDistinction®
Specialty Care

Two Specialty Care Designation Levels Based on Robust, Nationally Consistent Criteria

<table>
<thead>
<tr>
<th>Evaluation Criteria for Participation Focused on:</th>
<th>Blue Distinction Center</th>
<th>Blue Distinction Center+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying those facilities that demonstrate expertise in delivering quality specialty care – safely and effectively</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nationally established quality measures and emphasis on proven outcomes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cost of care calculated on procedures, using episode-based allowable amounts</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Specialty designations are awarded in High Cost/Risk Areas. The current programs are:

- Bariatric Surgery
  - Gastric Banding
  - Gastric Stapling
- Cardiac Care
- Knee and Hip Replacement
- Maternity (NEW)
- Spine Surgery
- Transplants

Previous Specialty Program selection criteria can be found at:
www.bcbs.com/healthcare-partners/blue-distinction-for-providers

NOTE: New designations for Cardiac Care, Knee/Hip Replacement, Maternity and Spine Surgery should be released Fall 2015 with an expected effective of Jan. 1, 2016.
Transplants Meets 2015 Spine and Cardiac Bariatric Development outcomes. 30% for Program Hospital Quality Program • Ochsner • Southern • Baton • Tulane • West • CHRISTUS • Our Lafayette • Blue • Rouge • Adult • Surgery quality more improving 3) Patient 2) Effectiveness 1) Safety 4) Outcomes • Ochsner Medical Center New Orleans • Rapides Regional Medical Center Alexandria • Thibodaux Regional Medical Center Thibodaux Cardiac Care Center BDC+ • Ochsner Medical Center New Orleans • West Jefferson Medical Center Marrero • Willis Knighton Medical Center Shreveport Knee and Hip Replacement Center BDC+ • Baton Rouge General Medical Center Baton Rouge • East Jefferson General Hospital Metairie • Ochsner Medical Center New Orleans • West Caldwell Cameron Hospital Lake Charles Bariatric Surgery Center BDCs – Gastric Stapling • CHRISTUS Highland Medical Center Shreveport • CHRISTUS St. Frances Cabrini Hospital Alexandria • Lafayette General Medical Center Lafayette • Lake Area Medical Center Lake Charles • Ochsner Medical Center New Orleans • Our Lady of Lourdes Regional Medical Center Lafayette • P & S Surgical Hospital Monroe • Southern Surgical Hospital Slidell • St. Elizabeth Hospital Gonzales • Willis Knighton Medical Center Shreveport Bariatric Surgery Center BDCs – Gastric Banding • CHRISTUS Highland Medical Center Shreveport • Lake Area Medical Center Lake Charles • Ochsner Medical Center New Orleans • Willis Knighton Medical Center Shreveport

The Blue Cross Hospital Quality Program (HQP) rewards acute hospitals with financial incentives for improving in these four aims: 1) Safety 2) Effectiveness 3) Patient Experience 4) Outcomes Hospitals may earn incentives by either improving their current performance slightly or by achieving high performance. The program allocates 35% of incentives toward improving safety, 30% to improving effectiveness, 15% to improving patient experience and 20% toward Blue Cross outcomes.

For more information about the Hospital Quality Program, contact your Network Development representative, at (800) 716-2299, option 1 or email qualityblue@bcbsla.com.
The **Hospital Scorecard** contains the Hospital Quality Program (HQP) outcomes measures and the scores for your facility using the two most recent full calendar years of claims based data from Blue Cross. The scorecard will be provided twice a year.

**HQP Outcomes Measures:**
- Risk Adjustment Mortality Index (RAMI)
- Potentially Preventable Readmissions (PPR)
- Potentially Preventable Complication (PPC)

The **Hospital Performance** is the result that will be utilized to award points to facilities participating in the HQP. It is calculated by comparing the hospital’s actual rate to the expected rate.

An informational packet can be viewed online [www.bcbsla.com/providers >Quality Blue >Hospital Quality and Value Improvement](http://www.bcbsla.com/providers).
Expanding Our HMO Network

**Today:**
- The HMO Louisiana, Inc. (HMO Louisiana) network is available in the Shreveport, Baton Rouge, Northshore and New Orleans areas only.

**Effective Jan. 1, 2016:**
- The HMO Louisiana network will be available statewide.

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Pre-service Authorizations Guidelines for HMO Changes

- The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed to determine the member’s available benefits prior to services being rendered.

- Listings of services requiring authorization are available in Blue Cross Facility Provider manuals (in iLinkBLUE and online at www.bcbsla.com/providers >Education on Demand).

- Authorization requirements may vary slightly by product.

- The provider must initiate the authorization process at least 48 hours prior to the service by:
  - Using the online authorization portal or;
  - Calling the authorization number on the member’s ID card.

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The services below will be removed and/or changed effective Jan. 1, 2016.

- Dialysis – Will be removed
- Orthotic Devices greater than $300 – Added "greater than $300"
- Outpatient Non-Surgical Services (except X-ray, lab, chiropractic services and physical, occupational and speech therapy) – when performed in an outpatient setting (hospital/ambulatory facility) – Will be removed
- Outpatient Surgical Procedures not performed in a physician’s office – Will be removed
Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract.

Blue Advantage (our Medicare Advantage network) is available for 2016 in four markets:

- Ascension, E. Baton Rouge, W. Baton Rouge, Livingston, St. Helena
- St. Tammany, Washington
- Lafayette, St. Landry
- Jefferson, Orleans, St. Charles, St. James, St. John the Baptist

Blue Advantage Workshops - Dec. 2015
invitations will be sent to facilities who participate in our Blue Advantage network)
iLinkBLUE is your one-stop for:
- Benefits
- Eligibility
- Claims Research
- Payment Information
- Authorizations
- Electronic Funds Transfer
- BlueCard Medical Record Requests
- Medical Policies
- Manuals
- Allowable Charges
- Estimated Treatment Cost
- Grace Period Notices
- Medical Code Editing
- And so much more!

www.bcbsla.com/ilinkblue
Finding Medical Policies in iLinkBLUE

We regularly develop and revise Medical Policies in response to rapidly changing medical technology. Benefit determinations are made based on the medical policy in effect at the time the services are performed.

You can easily search for a medical policy using keywords, a CPT® Procedure Code or our alpha-index.

www.bcbsla.com/ilinkblue

Finding Medical Policies in iLinkBLUE

Medical policy coverage indications include the following categories:

- **C** Eligible for coverage with medical criteria
- **I** Investigational
- **N** Not medically necessary
- **R** Retired
- **A** Archived

Note: Often medical policies have more than one coverage criteria indicator.

In addition to being available on iLinkBLUE, medical policy updates are published in every quarterly Network Newsletter (available online at www.bcbsla.com/providers >News).

www.bcbsla.com/ilinkblue
Provider Cost Data on iLinkBLUE

The Estimated Treatment Cost Tool enables our Preferred Care PPO members to view information about the value you bring to the healthcare community.

- Costs are displayed on the national BCBSA Hospital & Doctor Finder™ website.
- As of 2015, the tool features the costs and volumes associated with over 1200 treatment categories.

It is important to note that only elective and/or planned procedures are available. This service will expand to include HMOLA members in the future.

www.bcbsla.com/ilinkblue

The Provider Page

- The Provider Page
- Credentialing/Recredentialing
- Manuals & Newsletters
- Speed Guides & Tidbits
- Provider Representative Map

www.bcbsla.com/providers
The Provider Page

Is designed to meet provider needs.

www.bcbsla.com/providers

Credentialing/Recredentialing

• Blue Cross has comprehensive credentialing and recredentialing information and forms available online.

• Blue Cross credentials both individual providers and facilities.

• To participate in our networks, we require providers to meet certain criteria.

• The credentialing/recredentialing process can take 30-60 days when all required information is received.

• Network providers are recredentialied every three years.

www.bcbsla.com/providers >Credentialing
Manuals & Newsletters

Home to Provider professional manuals. These are extensions of Provider network agreement(s).

Home to provider Newsletters, current and archived.

www.bcbsla.com/providers

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Speed Guides & Tidbits

Home to Speed Guides; quick guides to network authorization requirements and billing guidelines.

Home to Provider Tidbits, quick guides to help you stay informed of our current business processes.

www.bcbsla.com/providers
Provider Representative Map

We have an interactive map of provider representatives:
- Network Development
- Provider Relations
- Statewide

Located under the “Provider Tools” section www.bcbsla.com/providers.

Roll over parish to see names and phone numbers of representatives for your service area.

Provider Addresses

Is Your Correspondence Address Correct?
It is important to let us know of an address, phone, fax and/or email address change.
Submit your new information via our online interactive Provider Update Form:
www.bcbsla.com/providers >Forms for Providers.
Support Teams

- EDI Contact Information
- Provider Call Centers
- Provider Relations
- Network Development
- Network Operations

EDI Contact Information

**iLinkBLUE Provider Suite**
https://www.bcbsla.com/ilinkblue/
(800) 216-BLUE (2583) or (225) 293-LINK (5465)
ilinkblue.providerinfo@bcbsla.com

**Electronic Funds Transfer**
Network Administration
(800) 716-2299, option 3 or (225) 297-2758
network.administration@bcbsla.com

**EDI Clearinghouse Services**
EDI Clearinghouse Support Desk
(225) 291-4334
edich@bcbsla.com
Provider Call Centers

Provider Services  (800) 922-8866
FEP Dedicated Unit  (800) 272-3029
OGB Dedicated Unit  (800) 392-4089

Other Provider Phone Lines

BlueCard Eligibility Line® – (800) 676-BLUE (2583)
For out-of-state member eligibility and benefits information.

Fraud & Abuse Hotline – (800) 392-9249
Call 24/7. You can remain anonymous. All reports are confidential.

Network Administration – (800) 716-2299
  Option 1 – for questions regarding provider contracts
  Option 2 – for questions regarding credentialing/recredentialing
  Option 3 – for questions regarding your provider file record
  Option 4 – for questions regarding provider relations

Protocol for Contacting Provider Relations

1. Research claim on iLinkBLUE.

2. Submit an Action Request through iLinkBLUE & request that claim be reviewed for correct processing. Be specific and detailed. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

3. If no satisfactory resolution, contact Provider Services (number on back of member ID card). Provider Services will issue a reference/task number. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

4. If claim is still not resolved, place a second call to Provider Services. Ask for a supervisor to escalate claim for correct processing. An additional reference/task number will be issued. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

5. If you have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers by Provider Services you may then email an overview of the issue and the two reference numbers to provider.relations@bcbsla.com.
Provider Relations

Merle Francis – merle.francis@bcbsla.com
director

Kim Gassie – kim.gassie@bcbsla.com
manager

Anna Granen
anna.granen@bcbsla.com
Jefferson, Plaquemines, Orleans, St. Bernard, St Charles, St. James, St. John the Baptists, St Tammany, Washington

Jami Zachary
jami.zachary@bcbsla.com
Calcasieu, Cameron, Calcasieu, Louisiana, Lafayette, Terrebonne, St. James, St. Mary, Tangipahoa, St Tammany, Washington

Kelly Smith
kelly.smith@bcbsla.com
Acadia, Evangeline, Iberia, Jefferson Davis, St. Landry, St. Martin, Vermilion | Statewide e-Business Representative – assists with EFT and LinkBLUE set-up

Marie Davis
marie.davis@bcbsla.com
Allen, Beauregard, Calcasieu, Cameron, Lafayette

Mary Guy
mary.guy@bcbsla.com
Ascension, Assumption, E. Feliciana, Bienville, LaFourche, Livingston, Point Coupes, St. Helena, St. Mary, Tangipahoa, Terrebonne, W. Baton Rouge, W. Feliciana and E. Baton Rouge

Patricia O’Gwynn
patricia.ogwynn@bcbsla.com
Avoyelles, Bienville, Bossier, Caddo, Catahoula, Claiborne, Concordia, De Soto, Grant, Lafitte, Natchitoches, Rapides, Red River, Sabine, Vermiion, Webster, Winn

Network Development

Shannon Taylor – shannon.taylor@bcbsla.com
director

Vicki Hughes – vicki.hughes@bcbsla.com
manager

Dayna Roy
dayna.ro@bcbsla.com
Alexandria/Lake Charles

Jason Heck
jason.heck@bcbsla.com
Shreveport/Monroe

Mary Reising
mary.reising@bcbsla.com
Northshore/New Orleans

Mica Toups
mica.toups@bcbsla.com
Lafayette

Sue Condon
sue.condon@bcbsla.com
Baton Rouge

New Orleans Area
network.development@bcbsla.com or
(800) 716-2299, option 1
## Network Operations

**Vicki Jones**  [Manager] — Vicki.Jones@bcbsla.com or (225) 298-1842  
**Rhonda Dyer**  [Supervisor] — Rhonda.Dyer@bcbsla.com or (225) 295-2068

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Alpha</th>
<th>Phone</th>
<th>Email</th>
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<tbody>
<tr>
<td><strong>Baton Rouge Region</strong></td>
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<tr>
<td>Linda McKay — credentialing</td>
<td>A-Z</td>
<td>(225) 298-1558</td>
<td><a href="mailto:linda.mckay@bcbsla.com">linda.mckay@bcbsla.com</a></td>
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<tr>
<td>Mert Terrance — provider file</td>
<td>A-Z</td>
<td>(225) 297-2639</td>
<td><a href="mailto:mercedes.terrance@bcbsla.com">mercedes.terrance@bcbsla.com</a></td>
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<tr>
<td><strong>Lafayette, Lake Charles and Alexandria Regions</strong></td>
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<td>Eve Jupiter — credentialing</td>
<td>A-L</td>
<td>(225) 298-7871</td>
<td><a href="mailto:eve.jupiter@bcbsla.com">eve.jupiter@bcbsla.com</a></td>
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<tr>
<td>vacant — credentialing</td>
<td>M-Z</td>
<td>(225) 298-1537</td>
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<tr>
<td>Linda Denicola — provider file</td>
<td>A-L</td>
<td>(225) 295-2301</td>
<td><a href="mailto:linda.denicola@bcbsla.com">linda.denicola@bcbsla.com</a></td>
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<tr>
<td>Hope Pace — provider file</td>
<td>M-Z</td>
<td>(225) 298-3162</td>
<td><a href="mailto:hope.pace@bcbsla.com">hope.pace@bcbsla.com</a></td>
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<td><strong>Monroe and Shreveport Regions/Out-of-State Facilities</strong></td>
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<tr>
<td>Kim Walker — credentialing</td>
<td>A-Z</td>
<td>(225) 298-1440</td>
<td><a href="mailto:kimberly.walker@bcbsla.com">kimberly.walker@bcbsla.com</a></td>
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<tr>
<td>Dannay Bourgeois — provider file</td>
<td>A-Z</td>
<td>(225) 295-2362</td>
<td><a href="mailto:dannay.bourgeois@bcbsla.com">dannay.bourgeois@bcbsla.com</a></td>
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<tr>
<td><strong>New Orleans Region</strong></td>
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<tr>
<td>Jiquisha Huston — credentialing</td>
<td>A-L</td>
<td>(225) 295-2046</td>
<td><a href="mailto:jiquisha.huston@bcbsla.com">jiquisha.huston@bcbsla.com</a></td>
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<tr>
<td>Cheryl Ward — credentialing</td>
<td>M-Z</td>
<td>(225) 297-2873</td>
<td><a href="mailto:cheryl.ward@bcbsla.com">cheryl.ward@bcbsla.com</a></td>
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<tr>
<td>Shakeysha Gray — provider file</td>
<td>A-L</td>
<td>(225) 297-2756</td>
<td><a href="mailto:shakeysha.gray@bcbsla.com">shakeysha.gray@bcbsla.com</a></td>
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<tr>
<td>Dana Mitchell — provider file</td>
<td>M-Z</td>
<td>(225) 298-3162</td>
<td><a href="mailto:dana.mitchell@bcbsla.com">dana.mitchell@bcbsla.com</a></td>
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</tbody>
</table>

(800) 716-2299  •  option 2 – credentialing  •  option 3 – provider file  
Fax: (225) 297-2750  •  network.administration@bcbsla.com

## Multimedia

- Connect with us on Facebook:  
  [Facebook Link](http://www.facebook.com/bluecrossla)

- Follow Blue Cross & CEO Mike Reitz on Twitter:  
  [Twitter Link 1](http://www.twitter.com/BCBSLA)  
  [Twitter Link 2](http://www.twitter.com/MikeReitzCEO)

- Watch us on YouTube:  
  [YouTube Link](http://www.youtube.com/bluecrossla)
Questions