Welcome to Blue Cross
(a webinar for facility providers)

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

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

How to submit questions:
- Open the chat feature at the top of your screen to type your question related to today’s training webinar
- In the “Send to” field, select “Webinar Host”
- Once your question is typed in, hit the “Send” button to send it to the presenter
- We will address submitted questions at the end of the webinar
Welcome to Blue Cross
(a webinar for facility providers)

December 7, 2016

Presented by Mary Guy
Provider Relations Department
Blue Cross and Blue Shield of Louisiana

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

CPT only copyright 2016 American Medical Association. All rights reserved.
Health delivery organizations (HDO) that meet our required criteria can become participating facilities in our networks:

- Valid license, as applicable to type of facility
- Professional Malpractice Liability Insurance certificate(s)
- Accreditation certificate, as applicable (we require certain facility types to be accredited; in some instances a site visit may be allowed in lieu of accreditation)
- OptiNet score of 80 percent or higher for each modality performed. This applies to diagnostic radiology providers, acute care hospitals and charity hospitals only.
- Signed and dated attestation/release to obtain primary source verification for the organization
If you meet our criteria, you must submit a Health Delivery Organization (HDO) Information Form and current copies of the following documents, as applicable:

- Current state license, as applicable
- Signed and dated attestation/release to obtain primary source verification for the organization
- Occupational or Operational license, as applicable
- Accreditation certificate, as applicable Professional Malpractice Liability Insurance certificate(s) or Louisiana Patient's Compensation Fund participation
- CLIA certificate, as applicable
- Employer Identification Number (EIN) Letter
- Electronic Funds Transfer (EFT) application and a copy of a preprinted voided check
- iLinkBLUE, Business Associate Agreement appropriate for your practice as well as the Administrative Representative Registration Form and Administrative Acknowledgment Form (only if you do not already have an established AR for your organization)
- Provider Network Agreements, as applicable
- W-9 Form
- Hospital Quality Program Commitment to Patient Safety Attestation (applicable for hospitals with greater than 50 beds)

Contact Credentialing by:
Phone: 1-800-716-2299, option 2
Email: network.administration@bcbsla.com
Fax: (225) 297-2750
HDO Information Form and Attachments

One of the following attachments is required with the HDO Form based on the facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital or Ambulatory Surgical Center
- HDO Attachment D: Urgent Care Clinic/Walk-In Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health Clinics
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

Required credentialing application forms are available online at www.bcbsla.com/providers, then click on “Credentialing”
Credentialing Process

• The credentialing process can take up to 90 days
• Facilities will remain non-participating in our networks until its HDO Form has been approved by our credentialing subcommittee
• The subcommittee meets monthly
• Facilities are recredentialed every three years from the last credentialing acceptance date

Credentialing questions or issues can be emailed to Network Operations at network.administration@bcbsla.com
Standards under the Affordable Care Act require Qualified Health Plan Issuers for plan years beginning on or after January 1, 2017, that contract with a hospital with greater than 50 beds to verify that the hospital:

- Utilizes a patient safety evaluation system and implements a mechanism for comprehensive person centered hospital discharge to improve care coordination and healthcare quality for each patient

OR

- Implements an evidence-based initiative to improve healthcare quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission or improves care coordination

In cases where the first option above is not met, additional documentation is required. It must be in the form of an agreement with a PSO, QIO, HEN or other initiative that is consistent with the National Quality Strategy, such as The Joint Commission accreditation. The additional documentation must have effective dates within the 2017 calendar year.
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 its hospital-based physicians in the specialties of:

- Anesthesia
- Emergency Medicine
- Neonatology
- Pathology
- Radiology

According to the legislation, facilities must notify health plans of any changes made to this information within 30 days of the change.
Submitting Changes to Hospital-based Providers

• 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 previously.

• Return completed forms to our Network Development department

   Email: network.development@bcbsla.com
   Fax:    (225) 298-7698
   Attn. Network Development
   Mail:   Network Development, BCBSLA
           P.O. Box 98029
           Baton Rouge, LA 70898-9029

• The Consumer’s Right to Know Facility Reporting Form is located at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) >Forms for Providers
Network Overview

Blue Cross has developed some of the largest, most comprehensive provider networks in the state.

Included on the next slides are brief overviews of our networks so you can better understand your patients’ coverage:

- Preferred Care PPO
- HMO Louisiana
- Blue Connect
- Community Blue
- Federal Employee Program (FEP)
- Blue Advantage (HMO)
- Office of Group Benefits (OGB) plans

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

Alpha Prefix: Varies

- Our Preferred Care PPO Network is available statewide.
- Members with PPO benefits receive the highest level of benefits when they receive services from PPO providers.
- A special Preferred Care logo at the top right corner of the member’s ID card distinguishes Preferred Care PPO members from our other members.
- The “PPO” in a suitcase logo identifies the nationwide BlueCard® Program.

For more information, view the Preferred Care PPO Network Speed Guide, available online at www.bcbsla.com/providers, then click on “Education on Demand.”
HMO Louisiana

Alpha Prefix: Varies

- Our HMO Louisiana Network is available statewide
- HMO Louisiana is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana
- This network offers individuals and employer groups seeking managed care benefit plans two options:
  - Point of Service (POS)
  - Health Maintenance Organization (HMO)
- Members receive a lower level of benefits (POS) or no benefits (HMO) when using providers not in the HMO Louisiana network
- Member ID cards indicate the product type as either an HMO or POS plan

For more information, view the HMO Louisiana Network Speed Guide, available online at www.bcbsla.com/providers, then click on “Education on Demand”
Blue Connect

Alpha Prefix: XUF, XUG, XUU, XUV

• Blue Connect is available to groups and individuals in Jefferson, Orleans and St. Tammany parishes

• Expanding to include Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion parishes effective January 1, 2017

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

For more information, view the Blue Connect Speed Guide, available online at www.bcbsla.com/providers, then click on “Education on Demand”
Community Blue

Alpha Prefix: XUD, XUJ, XUT

- Community Blue is available to members residing in Ascension, Bossier, Caddo, East Baton Rouge and West Baton Rouge parishes

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

For more information, view the Community Blue Speed Guide, available online at www.bcbsla.com/providers, then click on “Education on Demand”
Federal Employee Program

Alpha Prefix: R (followed by 8 digits)

- The Federal Employee Program (FEP) provides benefits to federal employees and their dependents

- These members access the Preferred Care PPO Network

- FEP members have two benefit plan options:
  - Standard Option – members receive the highest level of benefits when they receive care from in-network providers and reduced benefits when they receive care from out-of-network providers
  - Basic Option – members receive no benefits when they receive care from out-of-network providers except for select situations such as emergency care
Blue Advantage (HMO)

Alpha Prefix: XUM

- Blue Advantage (HMO) is our Medicare Advantage product and is available to our senior members residing in the following parishes:
  
  Ascension  St. James  
  East Baton Rouge  St. John the Baptist  
  Jefferson  St. Helena  
  Livingston  St. Landry  
  Lafayette  St. Tammany  
  Orleans  Washington  
  St. Charles  West Baton Rouge

- Blue Advantage members must use Blue Advantage network providers except for select situations such as emergency care.

- More information about Blue Advantage is accessed through the Blue Advantage Provider Portal, available through iLinkBLUE (www.bcbsla.com/ilinkblue)

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.
Blue Cross administers benefits for the Office of Group Benefits’ (OGB’s) state of Louisiana employees, retirees and dependents. There are five benefit plan types currently available for OGB members:

**Pelican HRA 1000** (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- Consumer-driven health plan with health reimbursement arrangement
- Utilizes our OGB Preferred Care PPO provider network

**Pelican HSA 775** (Active Employees Only)
- Prefix: OGS
- Consumer-driven health plan with health savings account
- Utilizes our OGB Preferred Care PPO provider network

**Magnolia Local** (Active Employees & Retirees with and without Medicare)
- HMO Point of Service
- Utilizes our Blue Connect (prefix: LZB) or Community Blue (prefix: LXS) provider networks
- There is no coverage for services performed by non-network providers

**Magnolia Local Plus** (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- HMO benefit design that utilizes our OGB Preferred Care PPO provider network
- There is no coverage for services performed by non-network providers

**Magnolia Open Access** (Active Employees & Retirees with and without Medicare)
- Prefix: OGS
- OGB’s PPO benefit plan
- Utilizes our OGB Preferred Care PPO provider network
For more information about our OGB benefit plans as well as important plan requirements, view the OGB Speed Guide, available online at www.bcbsla.com/providers, then click on “Education on Demand”
The BlueCard® Program links participating providers and the independent Blue Cross and Blue Shield (BCBS) Plans across the country and abroad

- Blue Cross and Blue Shield of Louisiana is your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries

- Louisiana providers should submit all BCBS member claims directly to Blue Cross and Blue Shield of Louisiana

- BlueCard members are identified by the alpha prefix or the “suitcase” logo

BlueCard PPO offers members traveling or living outside of their Blue Plan’s area, PPO-level benefits when services are obtained from a BlueCard PPO provider

The empty suitcase logo does not guarantee the HMO member has benefits. Most HMO members must get an authorization to see a provider outside of their service area.

You can find additional BlueCard guidelines in the BlueCard Program Provider Manual, available online at www.bcbsla.com/providers, then click on “Education on Demand”
iLinkBLUE is our most valuable resource for providers. It is a secure Web portal available at no cost for healthcare providers, designed to help you quickly complete important functions:

- 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 much more

www.bcbsla.com/ilinkblue
iLinkBLUE has a message board that appears after you first log in.

This area contains posts for:

- Upcoming Events
- New Features
- System Outages
- Holiday Notices
- And other important bulletins

The message board also displays an alert message when there are open BlueCard® (out-of-area) medical record requests for your patients.
The “Coverage Information” menu option allows providers to check Blue Cross and Federal Employee Program (FEP) members:

- Eligibility (active, pending, canceled)
- Copays
- Deductibles
- Detailed Contract Information
- Coordination of Benefits Information

Note: Blue Advantage (HMO) member coverage and eligibility is checked through the Blue Advantage Provider Portal.
The “Claims Entry” option allows for the direct data entry of certain* UB-04 (facility) 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, call the LinkLine at 1-800-216-BLUE (1-800-216-2583) or send an email to iLinkBlue.providerinfo@bcbsla.com.

*Note: Dental, DME, home health and hospice claims cannot be submitted through iLinkBLUE. Blue Advantage (HMO) claims must be filed through the Blue Advantage Provider Portal.
Detailed manuals on how to submit claims through iLinkBLUE are under the “Manuals” section:

- The *Blue Cross UB-04 Claims Entry Manual* is under “Hospital”
- The *Blue Cross Professional Claims Entry Manual* is under “Professional”
• **Claims Status** – provides information on paid, rejected and pended claims. Display the amounts applied toward the deductible, ineligible amounts or coinsurance amount for a specific claim.

• **ITS Out of Area Claims** – provides the same claims information for BlueCard® (out-of-area) members

• **Action Request Inquiry** – allows you to view Action Requests submitted on any pended, processed or rejected claims

• **Check Information** – displays the specifics of the payment information once the payment is issued
Providers can view or print payment registers through the **Remittance Advice** option

Reports for the current week will appear at the bottom of your remittance listing (separate reports for each applicable line of business; Blue Cross, HMO Louisiana, OGB and FEP)

**Remittance Advice Total** - allows you to query and view the total payment from all your remittances for a given week
The Allowable Charges option allows professional providers to look up a single code or a range of codes. Facility providers currently are unable to use this function to research allowables.
Facility providers can find listings for some allowable charges under the “Manuals” section:

- Drug and Administrative Allowable for Standard Facility
- HCPCS Allowable Charges for DME
Our authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

Authorization requirements may vary slightly by product.

Providers should initiate the authorization process at least 48 hours prior to the service being rendered.

Research, view and submit some authorization requests from iLinkBLUE using the “Authorizations and Medical Policy” menu option*

Review Medical Policies for both Blue Cross and Blue Shield of Louisiana and BlueCard® (out-of-area) members on iLinkBLUE.

*Note: Blue Advantage (HMO) providers should review the Provider Quick Reference Guide available in the Blue Advantage Provider Portal to identify the authorizations processes for Blue Advantage members.
The ordering physician should always use AIM’s ProviderPortalSM available through iLinkBLUE, to request high-tech diagnostic imaging authorizations.

AIM Specialty Health – allows you to submit and receive pre-authorizations over the Web on a real-time basis, eliminating the need to call AIM for the following outpatient high-tech diagnostic imaging services:

- Computerized Tomography Scans (CT)
- Computerized Tomographic Angiography (CTA)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron Emission Tomography (PET) Scans

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or 23-hour observations are not included in this radiology program.

Blue Advantage (HMO) providers only use AIM for their Blue Advantage members’ authorizations for advanced radiological imaging or radiation therapy services.
Blue Cross offers our network providers the resources to request authorizations electronically through iLinkBLUE Authorization applications that are available:

- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members

The applications under our Authorizations Portal require a higher level of security access. Someone at your organization must agree to be a security administrative representative for the purpose of managing and self-delegating secure access to these applications.
The processes for Blue Advantage (HMO) differ from our other provider network processes. We have created a separate portal for Blue Advantage providers to access those processes.

If you are a contracted Blue Advantage provider, you will need access to the Blue Advantage Provider Portal.

The Blue Advantage Provider Portal is available through iLinkBLUE and requires a separate username and password from the one you use to gain access to iLinkBLUE.

In order to access the Blue Advantage Provider Portal you must register a security administrative representative.
The Blue Advantage Provider Portal offers resources such as:

- Office Manuals
- Guides
- Forms
- Eligibility
- Claims and Authorization Inquiries
- Accountable Delivery Services Platform (ADSP) for primary care physicians (PCPs) only.
A New iLinkBLUE in 2017

We are updating iLinkBLUE to better serve your online needs:

• Today, there are 60 menus and submenus to navigate in iLinkBLUE

• In 2017, a new design will consolidate, streamline and enhance many of the features already available today

• The newly designed iLinkBLUE will be under a higher level of security. Like with our authorization applications available today in iLinkBLUE, in 2017, users will not be able to access iLinkBLUE if your organization does not have a security administrative representative.

• Please register your administrative representative before the end of 2016 to ensure you have access to the new iLinkBLUE in 2017

More details on the new iLinkBLUE including training opportunities are coming soon
Who and why you need an Administrative Representative?

• A person at your organization who will serve as the key person for delegating access to appropriate users for the provider

• A person who agrees to adhere to Blue Cross’ guidelines

• A person who will only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities

• A person who promptly terminates employee access at such time as an employee changes roles or terminates employment
Your administrative representative grants access to employees at your facility to fulfill their job responsibilities.

Designated Administrative Representative

- BCBSLA Authorizations
- Behavioral Health Authorizations
- Blue Advantage Provider Portal
- Pre-Service Review

All designated users must have iLinkBLUE access.
Does Your Facility Already Have an Administrative Representative?

- Many facility providers that work with Blue Cross have already registered a security administrative representative for case management services to manage access to our authorization applications available in iLinkBLUE.

- Your facility may want to register an additional security administrative representative for your business office or administrative area to manage access to the business functions of the new iLinkBLUE coming in early 2017 (i.e. claims entry, coverage verification, remittance advice, etc.)
The Provider Identity Management Team is a dedicated team to help you establish and manage system access to our secure electronic services.

**What they will do for you:**

- Set up administrative representatives
- Educate and assist administrative representatives
- Outreach to providers without administrative representatives to begin the setup process

The PIM Team is also working with existing security administrative representatives to transition users through additional security changes coming to iLinkBLUE in 2017.
How do I register an Administrative Representative?

- Select the appropriate individual(s) at your organization for the security administrative representative role
- Complete the Administrative Representative Registration Packet that can be found on our Provider page (www.bcbsla.com/providers)
- Return the completed application to our Provider Identity Management Team
  
  Email:  ProviderIdentMgmt@bcbsla.com
  
  Fax:  1-800-515-1128
  Attn. Provider Identity Management

  Mail:  BCBSLA - Provider Identity Management
  P.O. Box 98029
  Baton Rouge, LA 70898-9029

To learn more about administrative representatives and the setup process, please attend one of our administrative representatives webinars being held throughout December. Registration and a full list of webinar dates can be found in the invite that was emailed to you. If you did not receive an email invite and would like to attend, please email provider.relations@bcbsla.com.
Decrease paperwork and increase operating efficiency with Electronic Data Interchange (EDI)

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

Electronic Transaction Exchange

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

For more information about system-to-system electronic transactions, please contact EDI at EDICH@bcbsla.com or (225) 291-4334
HIPAA 835 Transaction

• Providers who submit claims electronically can receive an electronic file containing their Weekly Provider Remittance Advice/Payment Register (ERA)

• The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible

• ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an upfront fee from your billing system vendor for programming.

• From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge

For more information, please contact Blue Cross EDI at EDICH@bcbsla.com or (225) 291-4334
Electronic Fund Transfer

• Electronic Funds Transfer (EFT) is a free provider service where Blue Cross deposits your payment directly into your checking account

• With iLinkBLUE, you will have access to EFT notifications and Payment Registers/Remittance Advices (can be printed directly)

• All Blue Cross providers that sign up for iLinkBLUE, must also be part of our EFT program

• To initiate EFT, please complete the EFT Application, available online www.bcbsla.com/providers, then click on “Forms for Providers”

The EFT Application includes a guide with detailed instructions on how to complete the form
Other Ways to File Claims - Hardcopy

- UB-04 (facility)
- CMS-1500 (professional)

Mailing Addresses

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue & OGB Claims:
BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898

For FEP Claims:
BCBSLA
P.O. Box 98028
Baton Rouge, LA 70898

For Blue Advantage (HMO) Claims:
Blue Advantage HMO Louisiana
P.O. Box 32406
St. Louis, MO 63132

• If it is necessary to file a hard copy claim, we only accept RED original claim forms
• We no longer accept faxed claims

The fastest method of claim submission and payment is electronic submission
Bill Types

• Facility claims must be submitted with a type of bill. Bill types are three-digit codes that represent specific information about the claim being filed.

• Blue Cross does not exclude any first or second digits of the bill type. However, there ARE exclusions related to the frequency digit (third position of bill type).

• Blue Cross does not accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. We do not accept interim billings for inpatient services.

  Exception: An interim bill will be accepted only if the total charge is $800,000 or greater and at least 60 days of service*

• Interim bills or replacement claims for submission should have a frequency code of 1 or 7

• Void claims should use a frequency code of 8

* If you meet the above exception criteria for filing an interim bill, please contact Kent Graves at (225) 297-2654 to discuss how to submit your claim

These guidelines are outlined in the Member Provider Policy & Procedure Manual, available on iLinkBLUE (www.bcbsla.com/ilinkblue) under the “Manuals” section
Use the Claims Dispute Form to request a review of your claim

Available online at www.bcbsla.com/providers, then click on “Forms for Providers”

Use the Claims Dispute Form when:

- Claim rejected as duplicate
- Claim denied for bundling
- Claim denied for medical records
- Claim denied as investigational or not medically necessary
- Claim payment/denial affects the provider's reimbursement
- Claim payment affects the member's cost share
- Claim denied for a BlueCard® Member

Be sure to attach the form on top of your claim when submitting it for review.

Please only send the original dispute once. Sending duplicates slows down the process.
Timely Filing Requirements

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

Blue Advantage (HMO):
- 12 months from the date of service to file an initial claim
- 12 months from the date the claim was processed (remit date) to resubmit or correct the claim

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

Self-insured & BlueCard®:
- Timely filing standards may vary so always verify the member’s benefits, including timely filing standards, through iLinkBLUE
Medical Documentation – Provider’s Role

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

- Each page of the patient’s medical records should include the following for a face-to-face visit:
  - Patient’s name
  - Date of birth or other unique identifier
  - Date of service including the year

- The provider’s signature (must be legible and include credentials)

- Report ALL applicable diagnoses on a claim and code claims with the most specific diagnoses and include chronic conditions

- CMS-1500 claims can accommodate up to 12 diagnosis codes
- UB-04 claims can accommodate up to 26 diagnosis codes
Blue Cross has a responsibility to provide our members with access to the best care for the best price.

To help fulfill this obligation, we review medical records and audit claims to ensure:

- Adherence to our medical policies
- Coding practices are accurate and current
- Claims are paid correctly
From time to time, you may receive a medical record request from us or one of our vendors to perform medical record chart audits on our behalf

- Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf.
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.
- The Blue Cross subscriber’s contract allows for the release of the information to Blue Cross or its designee.
NDC Required on Drug Claims

• We require all clinician-administered drugs billed on professional and outpatient claims to include a National Drug Code (NDC) for the drugs

• Providers are required to report NDCs on claims with any associated HCPCS or CPT® codes, including immunizations (HCPCS codes beginning with the letter “A” are excluded from this requirement)

Failure to report an NDC on these claims will result in automatic rejections
Use the following billing guidelines to report NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

- NDC code editing will apply to any clinician-administered drug billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT® code (except HCPCS codes beginning with the letter “A”).

- Each clinician-administered drug must be billed on a separate line item.

- Claims that do not meet the requirements will be rejected and returned on your “Not Accepted” report. Units indicated would be “1” or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT® code appended for the individual drug.

- Providers may bill multiple lines with the same CPT® or HCPCS code to report different NDCs.

- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim:
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC
For Hard Copy Claims
On the UB-04 claim form, report the NDC and the quantity in Box 43 (description field). We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g. N49999999999. The drug quantity and measurement/qualifier should be included.

For Electronic Claims 837i
Report the NDC in loop 2410, Segment LIN03 of the 837. The code should consist of a CMS 11-digit NDC in a fixed length 5-4-2 (no hyphens) configuration. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBLUE Claims
NDC codes cannot be filed on facility outpatient claims via iLinkBLUE at this time. This capability will be offered in the near future. Any iLinkBLUE facility outpatient claim that requires an NDC code should be filed via hard copy claim until this capability has been added.
Reporting NDCs on Facility Claims

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

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

<table>
<thead>
<tr>
<th>10-Digit Format on Package</th>
<th>10-Digit label format Example</th>
<th>11-Digit Format</th>
<th>11-Digit Format Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-4-2</td>
<td>99999-9999-99</td>
<td>5-4-2</td>
<td>099999-9999-99</td>
</tr>
<tr>
<td>5-3-2</td>
<td>999999-9999-99</td>
<td>5-4-2</td>
<td>999999-0999-99</td>
</tr>
<tr>
<td>5-4-1</td>
<td>999999-9999-9</td>
<td>5-4-2</td>
<td>999999-9999-09</td>
</tr>
</tbody>
</table>

If the NDC is not submitted in the correct format, the claim will be denied.
Blue Cross to Implement a Closed Formulary in 2017

- Blue Cross is updating its list of covered drugs—or closed formulary—to support safe, effective, lower-cost drugs
- The change begins January 1, 2017, and goes into effect when most individual and small group members renew their plans throughout the year
- The new drug list includes thousands of generic and brand drugs identified by independent Louisiana doctors and pharmacists, along with input from Blue Cross clinical staff
- Please check to see if a drug is covered before prescribing it
- Key Changes to Drug Coverage in 2017 include:
  - Non-formulary drugs will not be covered
  - Select drugs with over-the-counter options will not be covered
  - Select drug kits that include or are packaged with a non-prescription product will not be covered, but the prescription drug may be covered when purchased alone

You and your patients can check the new drug list and find up-to-date information about drug coverage at [www.bcbsla.com/pharmacy](http://www.bcbsla.com/pharmacy)
Network providers should **ALWAYS** refer members to **CONTRACTED** providers

- Referrals to non-network providers result in significantly higher cost-shares (deductibles, coinsurance and copayments) for our members and is a breach of your Blue Cross provider contract

- Providers who consistently refer to non-network providers will be audited and may be subject to a **REDUCTION** in their network reimbursement
Laboratory Referrals

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

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

- Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO participating hospitals or the member’s selected hospital.

- Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by HMO Louisiana participating hospitals.

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

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

- Please make sure when referring your patients to behavioral health providers that they are in their behavioral health network.
- We have partnered with New Directions for their expertise in the provision of mental health services.
- New Directions manages authorizations for our members, performs all utilization and case management activities, as well as ABA case management.
- Request authorizations online through iLinkBLUE using the Behavioral Health Authorizations application.
- New Directions’ team of mental health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.
You can find network providers to refer members to in our online provider directories at www.bcbsla.com, then click on “Find a Doctor or Drug”
Refer Blue Advantage members to network providers by using the “Provider & Pharmacy Search” feature of the Blue Advantage Provider Portal (accessed through iLinkBLUE)
Resources – The Provider Page

Designed to meet your provider needs

- Credentialing
- Education on Demand
- Forms for Providers
- Imaging Authorizations
- Newsletters
- Pharmacy Management
- Quality Blue
- Provider Tools
- And More

www.bcbsla.com/providers
Our manuals are an extension of your member provider agreement

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

- Reimbursement Information
- Claims Submission
- Billing Guidelines
- Medical Management
- Appeals and Disputes
- Network Overviews
- Authorization Requirements
- And Much More
• *Network News* is our quarterly newsletter for network providers

• Every issue contains Medical Policy Updates and information and tips on changes to processes, such as claims filing procedures or reimbursement changes, along with a number of featured articles

[www.bcbsla.com/providers](http://www.bcbsla.com/providers), then click on “News”
Speed Guides offer quick reference to network authorization requirements, policies and billing guidelines.

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

www.bcbsla.com/providers, then click on “Education on Demand”
Provider workshops and webinars are held throughout the year to offer training and updates on Blue Cross policies and procedures.

Invites to attend are sent to the provider’s correspondence email address we have on file.

PDF copies of our workshops and webinars are available online.

www.bcbsla.com/providers, then click on “Education on Demand”
If you are not sure who your Blue Cross representative is, we have an interactive map of provider representatives:

- Network Development
- Provider Relations

www.bcbsla.com/providers, then click on “Provider Tools”
Provider Relations

Provider Education & Onsite Training

Kim Gassie  manager

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard and St. Charles

Jami Zachary
East Baton Rouge, Livingston, St. Helena, St. Tammany, Tangipahoa and Washington

Mary Guy
Ascension, Assumption, Concordia, East Feliciana, Iberville, Lafourche, Pointe Coupee, St. James, St. John the Baptist, St. Mary, Terrebonne, West Baton Rouge and West Feliciana

Marie Davis
Avoyelles, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion

Patricia O’Gwynn
Bienville, Bossier, Caddo, Caldwell, Catahoula, Claiborne, DeSoto, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides, Red River, Richland, Tensas, Union, Webster, West Carroll and Winn

Kelly Smith
Acadia, Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis, Sabine and Vernon

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

Glenda Denn  Angela Jackson  Darnell Kling
Contacting Provider Relations About Claims

For Claims Issues:
Submit an Action Request through iLinkBLUE or a Claims Dispute Form
• Request a review for correct processing
• Be specific and detailed
• Allow 10-15 working days
• Check iLinkBLUE for a claims resolution
• Contact Provider Services at 1-800-922-8866 for immediate assistance

Claims Status & Benefit Questions:
• Use iLinkBLUE (www.bcbsla.com/ilinkblue) for current information
• Call Provider Services at 1-800-922-8866

Electronic Claims Submissions & Clearinghouse Issues:
• Visit the “Electronic Services” section of our Provider page (www.bcbsla.com/providers)
  – EFT FAQs
  – EDI Enrollment Information
  – Companion Guides
• Call our Electronic Data Interchange (EDI) department at (225) 291-4334
• Email EDICH@bcbsla.com

Once 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 along with your two reference numbers to provider.relations@bcbsla.com
Network Development

Provider Contracting

Jennifer Caveny — jennifer.caveny@bcbsla.com
director

Jode Burkett — jode.burkett@bcbsla.com
manager

Dayna Roy
dayna.roy@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

Jill Taylor
jill.taylor@bcbsla.com
New Orleans

network.development@bcbsla.com | 1-800-716-2299, option 1
Doreen Prejean | Mary Landry | Karen Armstrong
To create more efficiency and reduction in processing time, information emailed and faxed to Network Operations should be sent as separate documents.

Example:
1. Contract
2. Application and supporting documentation (licenses, education, etc.)
3. EFT & iLinkBLUE agreements
Electronic Services

iLinkBLUE Provider Suite
www.bcbsla.com/ilinkblue
1-800-216-BLUE (1-800-216-2583)
ilinkBlue.providerinfo@bcbsla.com

Electronic Funds Transfer
Network Administration
1-800-716-2299, option 3
network.administration@bcbsla.com

EDI Clearinghouse Services
EDI Clearinghouse Support Desk
(225) 291-4334
EDICH@bcbsla.com

Provider Identity Management Team
Administrative Representative Support
1-800-716-2299, option 5
ProviderIdentMgmt@bcbsla.com
Customer Care Center

Provider Services  1-800-922-8866
FEP Dedicated Unit  1-800-272-3029
OGB Dedicated Unit  1-800-392-4089
Blue Advantage (HMO)  1-877-250-9167

Other Provider Phone Lines

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

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

Network Administration – 1-800-716-2299
  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
  option 5 – for questions regarding administrative representative setup
How to Update Your Info

It is important we always have your most current contact information in our files. If you have an address, phone, fax or email address change, submit your new information on our Provider Update Request Form.

It is available online at www.bcbsla.com/providers, then click on “Forms for Providers”
At this time, we will address the questions you submitted electronically through the webinar platform.