Our Mission:

“To improve the health and lives of Louisianians.”
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Blue Cross’ New President and CEO

• Dr. I. Steven Udvarhelyi is Blue Cross’ new president and CEO; excited to be in Louisiana!

• Board Certified Internal Medicine physician

• 1996 became Chief Medical Officer at Independence Blue Cross and ended his career there as Executive Vice President, Health Services and Chief Strategy Officer
  • Responsibilities included oversight of all clinical operations, pharmacy, provider networks, informatics, strategy and planning, business development and innovation

• Dr. Steve has a strong passion for data, informatics and analytics

• Outgoing Blue Cross president Mike Reitz will retire in June 2016

“Dr. Steve” has a great deal of direct experience working creatively with physicians, hospital executives and other providers
Credentialing and Network Expansions
Blue Cross has comprehensive credentialing and recredentialing processes. Required application forms are available online.

Blue Cross credentials both individual providers and facilities.

To participate in our networks, providers must meet certain criteria.

The credentialing process can take up to 90 days upon Blue Cross receiving all required information.

Network providers are recredentialed every three years.

Credentialing delegation is also available to groups with 100 or more practitioners. For more information, contact Gloria Burns at 225-295-2314 or by email at Gloria.Burns@bcbsla.com.
Effective January 1, 2016:

The HMO Louisiana network is now available statewide and includes behavioral health providers.
Blue Advantage (our Medicare Advantage network) is now available for 2016 in four markets.

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

For more information on Blue Advantage, visit www.bcbsla.com/blueadvantage

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.
Providers seeing our Blue Advantage members:

Blue Advantage Frequently Asked Questions (FAQs)

Provide:

– A better understanding of the Blue Advantage network
– Key information on what Blue Advantage offers and requires of Blue Advantage network providers

This document is available on the Blue Advantage Provider Portal, through iLinkBLUE at www.bcbsla.com/iLinkBLUE
Provider’s Role in Documentation

Provider 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:
  - The 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)
Medical Chart Audits

Results identified:
• Illegible handwriting on paper charts
• Lack of chronic conditions included in documentation
• Lack of coding to the highest specificity
• Coding errors
• Lack of evidence of action taken for condition:
  • Condition noted in the problem list -not supported in the exam
  • Monitored, Evaluated, Assessed, or Treated should be noted
• Lack of clarification of whether a condition is chronic or acute
• No reference to a condition as controlled or uncontrolled
• Lack of identification for the type of diabetes
• Not documenting cause and effect relationships:
  • Notes will say Diabetes Type II and CKD Stage III;
  • but if stated “CKD III Due to Diabetes “ results in a different ICD-10 Code
Accurate Medical Records

• Improve high-risk patient identification
• Our ability to engage patients in care management programs and care prevention initiatives
• Reduce the administrative burden of medical record requests and adjusting claims for both the provider’s office and healthcare insurers
BCBSLA request records for many different reasons. We have currently partnered with Altegra Health for record request for our chart reviews in the areas of:

- Commercial Risk Adjustment
- Healthcare Effectiveness Data and Information Set (HEDIS)

You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.

- The patient’s Blue Cross agreement allows for the release of the information to Blue Cross or its designee.

**NOTE:** *Because Altegra Health is acting as a Blue Cross authorized audit agent, NO access or copy fees should be charged to Altegra Health to complete this task as agreed to in your provider contract.*
COMING THIS SUMMER!

Required through the Affordable Care Act, framework for the risk adjustment data validation (RADV) audit process for the risk adjustment program was established

• Required Audit for every insurer
  — Will be used to confirm risk reported, and
  — To confirm providers medical records substantiate the reported data and accurately reflects the care rendered and billed.

• Medical Record request will start sometime in July and continue through December

• The Accountable Care Law mandates medical records be provided.

More information to come!
Commercial Risk Adjustment (CRA) is a component of the Affordable Care Act (ACA)

- Encourages health plans to focus on Quality improvements, Efficiency and Stabilization of premiums

- CRA uses diagnosis codes reported on claims to determine the disease state or illness burden (overall health) of a patient, that allows CMS to assign a risk score to each patient
Commercial Risk Scores

Since Risk Scores are recalculated every year, diagnosis codes for all conditions must be documented by a provider every year

• Medical records **must support ALL** diagnosis codes on claims

• Report ALL applicable diagnoses on a claim and code claims with the most specific diagnoses
  
  - CMS-1500 claims can accommodate up to 12 diagnosis codes

• Include all related diagnoses, including chronic conditions you are treating the member for

• Blue Cross identifies those members with potential risk gaps by review of claims data

• Risk score gaps are identified through:
  
  • History: Prior year Dx
  • Pharmacy: Prescribed medication
  • Diagnostic: Lab or Diagnostic test
  • Other: Diagnosis with potential Co-existing Condition
Blue Cross Provider Relations can help!

• We will visit and educate your office on the risk adjustment process, providing a report of your patients with identified gaps

Provider’s Role

• Check to see if your patient has had a recent visit
  - If yes, review patient’s medical records to see if all diagnoses were included on the submitted claim; if a diagnosis code is missing, resubmit the claim with the new/missing diagnosis codes to Blue Cross
• If the patient has **NOT** had a recent visit, reach out to the patient to schedule a visit
  • During visit with patient, discuss/document medical conditions suspected as gaps from Blue Cross;
    - Submit a claim to Blue Cross with all documented/supported diagnosis codes
HEDIS
HEDIS is a set of healthcare performance measures developed by NCQA (National Committee for Quality Assurance) and used by Centers for Medicare & Medicaid Services (CMS) for monitoring managed care organizations

- A subset of HEDIS measures will be collected and reported for the Marketplace (healthcare exchanges) product lines
- HEDIS results measure performance, help us to identify quality initiatives and lead us in the development of educational programs for providers and members

- HEDIS data is collected through
  - Administrative data (claims only)
  - Hybrid data (claims data and medical record review)
  - Survey data (member and provider surveys)
Providers role in HEDIS

- Provide appropriate care to meet the criteria and timeframes of each measure
- Document care provided in the member’s medical record
- Submit accurate coding for claims
- Provide medical records during the HEDIS process to help us validate the quality of care provided to our members
  - Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed
  - HEDIS data is collected and reviewed from January to May
  - Under the Health Information and Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization
  - We appreciate your cooperation in sending the requested medical record information ASAP (ideally in 5 to 7 business days)

*Blue Cross, including HMO Louisiana, has partnered with Altegra to perform risk adjustment chart reviews on our behalf. You are required to provide us with medical records as outlined in your Blue Cross network agreement at no charge.*
Member Referrals

Network providers should **ALWAYS** refer members to **CONTRACTED** providers

- Referrals to non-network providers result in significantly higher cost-shares to our members and it 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

**Examples:**
- Laboratories
- Outpatient Facilities
- DME
- Therapists
- Hospitals

You can find network providers in our online provider directories at [www.bcbsla.com](http://www.bcbsla.com)
Out-of-network Referrals

- We continue to receive out-of-network claims for our members

- **To ensure our members receive the highest level of benefits, please refer to providers participating in the members network plan:**

  - Examples include:
    - When ordering laboratory test, the laboratory must be in network, even if an out of state lab is used
    - Some OGB (Office of Group Benefits) plans have no out-of-network benefits

- To locate participating providers you can go to the online directory on the Blue Cross website ([www.bcbsla.com](http://www.bcbsla.com) >Find a Doctor/Hospital)
Behavioral Health Referrals

- As of January 1, 2016, New Directions manages behavioral health authorizations for our members, performs all utilization and case management activities, as well as ABA case management.

- Please make sure when referring your patients to behavioral health providers that they are in our new behavioral health network.

- We require prior authorization for certain behavioral health services:
  - Inpatient Hospital (including detox)
  - Intensive Outpatient Program (IOP)
  - Partial Hospitalization Program (PHP)
  - Residential Treatment Center (RTC)
  - Applied Behavior Analysis (ABA)
Quality Blue Programs recognize those physicians and practitioners who are working in partnership with Blue Cross to transform healthcare systems and improve the way care is delivered to Blue Cross members—your patients—to help them achieve better health outcomes.

Blue Cross offers its network providers opportunities through Quality Blue:

• To Earn Recognition
• Additional Payments
• Other Incentives

**Quality Blue Programs currently offered:**

• Blue Distinction
• Hospital Quality and Value Improvement Program (HJVIP)
• Quality Blue Primary Care (QBPC)
• Quality Blue PT/OT Program
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 are only awarded to the specific facility and specific location.

Two designation levels:
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>
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<tr>
<td>Identifying those facilities that demonstrate <strong>expertise in delivering quality specialty care</strong> – safely and effectively</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Nationally <strong>established quality measures</strong> with emphasis on <strong>proven outcomes</strong></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Cost of care</strong> calculated on procedures, using episode-based allowable amounts</td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

Healthcare facilities recognized for their **expertise** in delivering specialty care

Healthcare facilities recognized for their **expertise** and **efficiency** in delivering specialty care
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

Specialty Program selection criteria can be found at:
[www.bcbs.com/healthcare-partners/blue-distinction-for-providers](http://www.bcbs.com/healthcare-partners/blue-distinction-for-providers)
2016 Blue Distinction® Centers
Meets quality – focused criteria that emphasizes patient safety and outcomes

Maternity BDC
- Abbeville General Hospital, Abbeville
- Acadian Medical Center, Eunice
- Baton Rouge General Medical Center, Baton Rouge
- BRFHH Monroe, Monroe
- Byrd Regional Hospital, Leesville
- Ochsner Medical Center Northshore, Slidell
- St. Francis Medical Center, Monroe
- West Calcasieu-Cameron Hospital, Sulphur
- Woman's Hospital, Baton Rouge
- Women's and Children's Hospital, Lafayette

Spine Surgery Center BDC
- P & S Surgical Hospital, Monroe

Cardiac Care Center BDC
- Baton Rouge General Medical Center, Baton Rouge
- Our Lady of the Lake Regional Medical Center

Transplants Center BDC
- Ochsner Medical Center, New Orleans
  - Adult Heart
  - Adult Lung
  - Adult Pancreas (includes SPK)
  - Adult Liver-Deceased (includes combination Liver-Kidney)
  - Pediatric Heart
- Tulane University Hospital & Clinic, New Orleans
  - Adult Liver-Deceased (includes combination Liver-Kidney)
  - Adult Pancreas (includes SPK)

Bariatric Surgery Center BDC - Gastric Banding
- CHRISTUS St. Frances Cabrini Hospital, Alexandria
- Lafayette General Medical Center, Lafayette
- Our Lady of Lourdes Regional Medical Center, Lafayette
- P & S Surgical Hospital, Monroe
- Southern Surgical Hospital, Slidell
- St. Elizabeth Hospital, Gonzales
Cardiac Care Center BDC+
- East Jefferson General Hospital, Metairie
- Ochsner Medical Center, New Orleans
- Ochsner Medical Center at Baton Rouge, Baton Rouge
- Willis Knighton Medical Center, Shreveport

Knee and Hip Replacement Center BDC+
- East Jefferson General Hospital, Metairie
- P & S Surgical Hospital, Monroe
- Willis Knighton Pierremont Health Center, Shreveport

Spine Surgery Center BDC+
- Ochsner Medical Center, New Orleans
- Rapides Regional Medical Center, Alexandria
- Thibodaux Regional Medical Center, Thibodaux

Bariatric Surgery Center BDC+ - 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 BDC+ - Gastric Banding
- CHRISTUS Highland Medical Center, Shreveport
- Lake Area Medical Center, Lake Charles
- Ochsner Medical Center, New Orleans
- Willis Knighton Medical Center, Shreveport

Maternity BDC+
- East Jefferson General Hospital, Metairie
- Jennings American Legion Hospital, Jennings
- Lafayette General Medical Center, Lafayette
- Lake Area Medical Center, Lake Charles
- Lake Charles Memorial Hospital, Lake Charles
- Lakeview Regional Medical Center, Covington
- Lane Regional Medical Center, Zachary
- Minden Medical Center, Minden
- Natchitoches Regional Medical Center, Natchitoches
- North Oaks Medical Center LLC, Hammond
- Ochsner Medical Center, New Orleans
- Ochsner Medical Center at Baton Rouge, Baton Rouge
- Ochsner Medical Center Kenner, Kenner
- Ochsner St. Anne General Hospital, Raceland
- Opelousas General Health System, Opelousas
- Rapides Regional Medical Center, Alexandria
- St. Tammany Parish Hospital, Covington
- Terrebonne General Medical Center, Houma
- Touro Infirmary, New Orleans
- Tulane University Hospital & Clinic, New Orleans
- West Jefferson Medical Center, Marrero
• We have implemented a cost-savings incentive for members when services are performed by a Quality Blue Primary Care (QBPC) provider

• Blue Cross waives or reduces the member’s office copayment for office visits with a QBPC-enrolled primary care doctor (this benefit applies for office visits with a nurse practitioner who works with the enrolled primary care doctor)

• To determine a member’s QBPC cost share, visit iLinkBLUE (www.bcbsla.com/ilinkblue)
# Quality Blue Primary Care

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<th>Product</th>
<th>Copayment Incentive</th>
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<td>BlueConnect*</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
</tr>
<tr>
<td>Community Blue*</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
</tr>
<tr>
<td>Preferred Care PPO and HMO products with office copayment services*</td>
<td>Copayment reduced by $15 for regular QBPC PCP office copayment services</td>
</tr>
<tr>
<td>Preferred Care PPO products without an office copayment services (e.g. deductible products such as BlueSaver)</td>
<td>No change to the QBPC PCP office cost shares. The deductible for office services is not waived or reduced.</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Louisiana employee group policies (ID cards with the group number beginning with 46210)</td>
<td>Copayment waived for QBPC PCP office copayment services</td>
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*This change is applicable for grandfathered and non-grandfathered fully insured group and individual products. It is optional for self-insured groups.*
In 2014, Blue Cross implemented the Specialty Care Insight Program, making information about cost and quality available to network physicians in the following specialties:

- Cardiology
- Orthopedics
- Otolaryngology (ENT)
- Gastroenterology
- Urology

• The Quality and Efficiency Peer Comparison report provides analytical data that allows practices to see how they compare to peers on cost of care and effectiveness (outcomes for medical conditions that physicians in that specialty commonly treat) measures
• Blue Cross is sharing data from these reports with network Primary Care Physicians enrolled in our Quality Blue Primary Care program

• The overall effectiveness and efficiency data in these specialties for the five practices to which that PCP practice most often refers patients will be shared

• Blue Cross is continuing to meet with the Louisiana societies and professional chapters for the specialties currently included in the Specialty Care Insight program to get ongoing feedback on the measures included in these reports

• For more information on the Specialty Care Insight initiative, visit www.bcbsla.com/SCI
Billing and Claims
Ambulance transportation may be covered 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

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 April 19, 2015.*
Please report Modifier SB on claims to indicate services were performed by a Certified Nurse-midwife. This allows Blue Cross to:

- Properly reimburse certified nurse-midwives for services performed
- Capture midwife claims in our reporting and analytics
Blue Cross partnered with Genesis Health Technology (GHT) in November 2015 to offer Diabetes Telemonitoring to our members

- Federal Employee Program (FEP), Office of Group Benefits (OGB), and our Blue Advantage members are excluded

Diabetes telemonitoring involves remotely monitoring diabetic members who are not at the same location as the healthcare provider

This method allows members to track their blood glucose at home and automatically uploads a member’s test results over a cellular network to a secure, online web portal accessed by the healthcare provider

Licensed Care Professionals are available 24 hours a day

- Manage Care Concepts (MCC) nurses outreach to members when glucose readings are out of range (<60, >350)

Monthly reports are provided for members who:

- Are non-compliant – who fail to test blood sugar consecutively for 2 days
- Test out of range ≥ 3 times the previous month

Secure emails of members who continually test out of range are sent to Blue Cross Care Management clinical staff.

Members will be responsible for their cost-share of the supplies
Benefits of Telemonitoring

- Accurate, real-time blood glucose data transmission
- Online access to blood glucose test results with the ability to print reports
- Ability to share test results with healthcare professionals

For more provider information, referrals of your patients to the program and for members to receive additional information, contact:

GHT Customer Service Phone: 1-888-263-0003
GHT Website: http://www.genesishealthtechnologies.com
Recently we made changes to our Drug Screening Assays policy. Effective January 1, 2016, we **only** accept claims with CPT® drug screen codes

**Presumptive drug screening:**
Blue Cross will only allow payment for one presumptive drug screen for drugs from Drug Class A and/or B (CPT codes 80300-80304) regardless of the number of services performed

**Definitive drug testing:**
For dates of service on or after January 1, 2016, Blue Cross requires that claims be filed using CPT codes 80300-80377 rather than the temporary Medicare HCPCS codes G0477-G0483. Claims filed with HCPCS codes G0477-G0483 will be denied and must be refiled with current CPT codes
NEW!

Healthier Generation Benefit

- Eligible BCBSLA members covered under a **Non-grandfathered** individual or group policy
- Children aged 3-18 with BMI ≥ 85th percentile
  - At least 4 PCP visits & 4 Registered Dietician visits at contract benefits
- Children aged 6-18 with BMI ≥ 95th percentile
  - Comprehensive and intensive behavioral interventions and counseling to promote improvements in weight status
  - 6 months full coverage begins at the diagnosis of obesity, which could take place during annual wellness visit
  - Subsequent services are covered at contract benefits

**Coverage and Treatment Overview: Non-Grandfathered policies**

<table>
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<tr>
<th>Pop. Description</th>
<th>4 PCP Visits</th>
<th>Wellness PCP Visit &amp; BMI Screening</th>
<th>4 Registered Dietician Visits</th>
<th>6 Month Intensive Counseling Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese 3-5 yo &gt;95%ile</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Obese 6-18 yo &gt;95%ile</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Overweight &gt;85%ile Any Age</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Next Steps: Communications

- Provider webpage update coming soon (www.bcbsla.com/providers)
  - Childhood obesity webpage is in development
- Pediatric Obesity and Diabetes Toolkit update coming soon
- Next Webinar on Healthier Generation Benefit scheduled for May 17th at Noon.
  - Invitations will be emailed to Primary Care Physicians
  - Provider tools enhancements will be reviewed
• Blue Cross does not recognize, nor do we reimburse separately for, a “facility fee” or “treatment room” fee when professional services are performed in an office setting. This reimbursement is included in the overhead component of the professional service(s) the member is receiving.

• Consistent with our policies regarding services that are an integral part of another service, there should be no separate charge to the member for use of a “treatment room” or “facility fee”
Member Benefit Terms

• **Fully insured group** – Group pays a fixed premium cost per class coverage each month. The funds for claims reimbursement come from Blue Cross.

• **Self-funded group** – Group pays a fixed cost each month, but they fund monthly claims payments along with funds for unexpected claims fluctuations. These groups use Blue Cross only to process claims.

• **Grandfathered** – A benefit plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.
We require that all drugs billed on medical claims must include an NDC. Effective July 1, 2016, failure to report an NDC on these claims will result in automatic denials.

For Hardcopy Claims
- On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A (the NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code, e.g. N499999999999)
- On the UB-04 claim form, report the NDC in Box 43 (description field)

For Electronic Claims
- Report the NDC in loop 2410, Segment LIN03. The code should consist of the CMS 11-digit NDC derivative with a leading zero resulting in a fixed length 5-4-2 (no hyphens) configuration. The proper format is validated during the processing period. The drug pricing information along with the corresponding unit(s) of measure should be reported in loop 2410 CTP03-05. Available measures of units include the international unit, gram, milliliter and unit.
For off-campus facility claims, Modifier PO should be reported for each service, procedure 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 non-surgical) 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.

**Effective January 1, 2016**
### Preventive Care Services Covered 100 Percent

You can view the Preventive Care Services brochure at [www.bcbsla.com/preventive](http://www.bcbsla.com/preventive) for more information on these services and other services we cover 100 percent.

<table>
<thead>
<tr>
<th>Service</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine wellness physical examination</td>
<td>All ages</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td></td>
</tr>
<tr>
<td>Fecal occult blood test</td>
<td>50-75 years: 1 per benefit period</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>50-75 years: 1 every 5 years</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>50-75 years: 1 every 10 years</td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td></td>
</tr>
<tr>
<td>Routine digital rectal exam</td>
<td>50 years and older: 1 per benefit period; Older than 40 years: As recommended by a doctor</td>
</tr>
<tr>
<td>Prostate-specific antigen (PSA) test: (not covered on all group policies)</td>
<td>50 years and older: 1 per benefit period; Older than 40 years: As recommended by a doctor</td>
</tr>
<tr>
<td>A second visit</td>
<td>Older than 40 years: For a follow-up treatment within 60 days after the visit if it is related to a condition that is diagnosed or treated during the visit and recommended by a doctor.</td>
</tr>
<tr>
<td>Mammography examination (1 every 12 months with all others processing according to your contract benefits)</td>
<td>35-39 years: Baseline (Mammograms for this age group may not be covered under all group policies)</td>
</tr>
<tr>
<td></td>
<td>40-49 years: 1 every 24 months or as a doctor prescribes</td>
</tr>
<tr>
<td></td>
<td>50 years and older: 1 every 12 months</td>
</tr>
<tr>
<td>Osteoporosis screening</td>
<td>65 years or older; Younger women with increased fracture risk</td>
</tr>
</tbody>
</table>
Subrogation

Subrogation allows healthcare insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. All claims submitted to Blue Cross must indicate if work-related injuries or illnesses are involved and if the services are related to an accident.

Providers should:
• Not require the Blue Cross member or the member’s attorney to guarantee payment of the entire billed charge
• Not require the Blue Cross member to pay the entire billed charge up front
• Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge
• Charge the member no more than is ordinarily charged other patients for the same or similar service
• Bill the member only for any applicable deductible, coinsurance, copayment and/or non-covered service

If amounts in excess of the allowable charge are collected, once identified you have 30 days to refund that amount to the member

Note: In the case of OGB claims, Blue Cross pursues recovery of claims payments and makes payments as applicable.
Telemedicine

- Reimbursement for telemedicine services may be available when provided by a network provider utilizing their own telemedicine platform.
- The appropriate place of service is based on where the member is located when the service is performed.

The following are examples of services that are not eligible for reimbursement as telemedicine services:

- Non-direct patient services (ex. coordination of care rendered before or after patient interaction).
- Services rendered by audio-only telephone communication, facsimile, email or any other non-secure electronic communication.
- Any services that are not eligible for separate reimbursement when rendered to the patient in-person.
- Presentation/origination site facility fee.
- Services/codes that are not specifically listed in your provider manual.
Telemedicine Requirements

- The telemedicine encounter must be fully documented (including all supporting diagnosis codes) in the patient’s medical record, just as if the patient were seen in person
  - For new patients, the provider must establish a medical history
  - For existing patients, the provider must maintain and update the member’s medical history
  - If the attending provider is not the patient’s primary care physician (PCP), the patient’s medical records should be made available to the patient’s PCP
- The attending provider must be licensed to practice medicine in the state where the member is located
- The attending provider must be able to prescribe medication, as applicable, or have staff on hand that can prescribe medication in the state where the member is located
- Use the most specific diagnosis codes(s) when filing the claim
- Prescribing controlled substances during a telemedicine encounter is not permitted
- Reimbursement for telemedicine services are based on each performing provider’s agreed-upon Allowable Charge and the member’s applicable benefits
- Authorizations are required for some services per the member’s benefits
- Please refer to the telemedicine section of your provider manual in reference to specific codes and billing guidelines
**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 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:**
- 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

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*Self-insured plans and plans from other states may have different timely filing guidelines*
Blue Cross Portals
We have a robust set of tools and services available to assist providers, all of which can be accessed through our website at www.bcbsla.com/ilinkblue. We encourage you to use these tools and services as your first stop when working with our members.

To ensure the best possible protection of personal health information (PHI) we have implemented another layer of security for some of our tools and services. You will hear more about future enhancements as they become available.

We want to give our providers full control over who has access to your sensitive information and PHI.

To achieve this, we must establish 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.
The processes for Blue Advantage differ from our other provider network processes. This portal is only used for Blue Advantage members.

• While you log into iLinkBLUE to get to your Blue Advantage provider resources, you will NOT use iLinkBLUE to manage those resources. You will simply use iLinkBLUE to access the Blue Advantage Provider Portal.

• Access to the secure information on the Blue Advantage Provider Portal requires a separate sign-on and password from your iLinkBLUE sign-on and password.

• You cannot access Blue Advantage information from any other tool within iLinkBLUE.

• Blue Advantage network providers will have access to the following resources via the portal:
  – Provider Administrative Manual
  – Quick Reference Guide
  – Provider Directory
  – Drug formulary search
  – Member eligibility inquiry
  – Claim inquiry
  – Provider forms
Blue Advantage Provider Portal

Attention

CMS requires Medicare Advantage plans maintain an up to date provider directory, please notify us immediately if you have any demographic changes that need to be reported.

2016 Guides & Resources
- Benefits
- Pharmacy Benefit Resources
- Provider Directory
- Evidence of Coverage
- Provider Administrative Manual
- Provider Quick Reference Guide
- Member Handbook
- Medical Necessity Criteria

Forms
- Prior Auth Request Forms
- Part D Prescription Drug Coverage Determination Request Forms
- Voluntary Refund Explanation Form
- Waiver of Liability

Claims
- Billing Guidelines
- Electronic Claims
- Electronic Payment & Remit

Additional Features (Login required)
- Member Eligibility
- Member ID Card
- Claims Inquiry
- Authorization Inquiry
- Lumens AQSP

Help Documents
- Provider Portal Quick User Guide
- FAQs for Network Contracted Specialist
- Tips for PCPs Making Auths
- DME and O&P Prior Auth List

Helpful Links
- Compliance Program
- BMI Calculator
- Secure Mail
- Secure File Transfer
Blue Advantage Provider Administrative Manual:
  – policies and procedures
  – reference information required of our Blue Advantage network providers

Provider Quick Reference Guide For Blue Advantage:
  – key information about the Blue Advantage network
  – services requiring authorization
  – information on our Blue Advantage electronic tools

These documents are available on the Blue Advantage Provider Portal, available through iLinkBLUE at www.bcbsla.com/ilinkblue
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
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!

Read your detailed newsletter on all the functions of iLinkBLUE. It is available online at www.bcbsla.com/providers >News.

www.bcbsla.com/ilinkblue
The Claims Entry option allows for the direct data entry of certain UB-04 (hospital) and CMS-1500 (professional) claims for all commercial business. (Not applicable to Blue Advantage)

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 1-800-216-BLUE (1-800-216-2583) 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.”

Note: Blue Advantage claims must be submitted using standard Medicare guidelines. Blue Advantage accepts the CMS-1500 and UB-04 forms and electronically submitted claims from Change Healthcare.
Various Authorizations
Prior Authorizations

• Listings of services that require authorization are available in your office 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 where available or by calling the authorization number on the member’s ID card
Prior Authorizations

You must have the following available when calling for an authorization:

1. Patient/member name, current address, date of birth, BCBS member ID number and relationship of the patient to the member
2. Physician name, NPI, address and telephone number
3. Name of the facility where the service will be rendered
4. Anticipated date of service
5. Requested length of stay (if applicable)
6. Diagnosis (ICD-10 codes), major procedures (related CPT® and/or HCPCS codes), plan of treatment, medical justification for services, supplies, complications
7. Caller name and phone number

When requesting an authorization, it is important that the place of treatment is accurately reported so it matches claims received
Prior Authorizations

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.

Effective January 1, 2016, the authorizations requirements have been updated for our HMO Louisiana, BlueConnect and Community Blue members.

- Dialysis* – 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)* – Removed
- Outpatient Surgical Procedures not performed in a physician’s office* – Removed

*These services still require an authorization for our OGB benefit plans.

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

Note: Authorization requirements may vary slightly by product
OGB Authorizations

For a list of OGB authorization requirements please refer to the OGB Speed Guide [www.bcbsla.com/providers](http://www.bcbsla.com/providers) >Education on Demand

OGB authorization requirements are different and the member has NO benefits if an authorization is not obtained.

Our data indicates that these services are denied most often for OGB members because no authorization was obtained:

- **Outpatient NON-Surgical procedures if done anywhere OTHER THAN a physician’s office (place of service 11)**
  - Excludes x-rays, lab work, physical therapy, occupational therapy, speech therapy and chiropractic services
- **Outpatient High Tech imaging** – examples; PET, CT, MRI, SPECT
- **Outpatient surgery**
Urgent Care Authorizations

• The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received.

• If the request is approved, the contact person/practitioner is notified by telephone and a confirmation letter is sent to the member, physician and hospital, as applicable.

• If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the expedited appeal process. A letter listing appeal rights is sent to the member, physician and hospital, if applicable, within one business day of the determination.

The authorization process is designed only to evaluate the medical necessity of the service.

The Authorization is not a guarantee of payment or a confirmation of coverage for benefits.
Blue Advantage network providers are required to provide notification for Blue Advantage members’ inpatient admissions and discharges.

Blue Advantage providers must submit clinical documentation to Blue Advantage within one business day of admission to complete the notification process and receive an authorization.

Blue Advantage providers can report inpatient admissions to Medical Management by phone at 1-866-508-7145, option 5, option 4 or by fax at 1-877-528-5818.

The phones are forwarded to a voice mail system during non-business hours and the fax is available 24 hours a day, 7 days a week.
• Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment.

• Providers who are denied payment because notification was not received, may not bill the member.

• For assistance with inpatient and discharge admission notification, you may contact the Blue Advantage Medical Management team at 1-866-508-7145, option 5, option 4.
Imaging Authorizations

Blue Cross and HMO Louisiana are partnered with AIM Specialty Health (AIM), an independent company, to provide review and prior authorization for the diagnostic imaging services.

- AIM also administers a radiology benefit management, advanced imaging and radiation therapy consultative program for our Blue Advantage members

**Ordering physicians** are required to contact AIM or use the online option in iLinkBLUE to complete a review and obtain a notification number for these outpatient, non-emergent imaging services:

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

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Blue Advantage providers only use AIM for their Blue Advantage members’ authorizations for advanced radiological imaging or radiation therapy service. Other authorizations should be requested through the Blue Advantage Portal.
The following additional cardiovascular services were added to be reviewed by AIM Specialty Health for most *Anthem BlueCross BlueShield* members:

*Arterial Ultrasound – *As of January 1, 2016*
*Cardiac Catheterization – *As of January 1, 2016*
*Percutaneous Coronary Intervention (PCI) – *As of January 1, 2016*

**Note:** This is a separate program from the AIM programs offered to Blue Cross and Blue Shield of Louisiana members. It is for members of Anthem BlueCross BlueShield, including those residing or seeking medical services in Louisiana.
The ordering physician should always use AIM’s *ProviderPortal* \(^{SM}\) in iLinkBLUE to set up an authorization.

Using AIM’s *ProviderPortal* \(^{SM}\) is the best method to ensure that the authorization is accurate, especially when you do not know the rendering provider’s NPI or TIN.

If the situation requires that you must call AIM directly, always later verify (through the *ProviderPortal* \(^{SM}\)) that the authorization has the correct servicing provider/facility.

It is equally important that the servicing provider verify the authorization through the *ProviderPortal* \(^{SM}\) prior to performing services to ensure it is accurate.

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Top reasons for claim denials related to outpatient imaging authorizations:

- No authorization on file
- Facility location (place of treatment) does not match authorization
- Servicing provider does not match authorization
Medical Appeals
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

Please remember to check the medical policies section on iLinkBLUE to view the most current medical policies. Benefit determinations are made based on the medical policy in effect at the time of the provision of services.

- You 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
Disputing Claims
We recognize that disputes may arise between providers and Blue Cross regarding covered services.

Examples of issues that qualify as disputes include:

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

Use the “Disputing Claims” tidbit as a 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
Use the “Claims Dispute” form to properly request a review of your claim. This form replaces the Reimbursement Review Form.

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

Be sure to place the form on top of your claim when submitting the documents for review. Please only send the original dispute once. Sending duplicate copies slows down the process.

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

The Reimbursement Review Form will no longer be accepted after June 1.
Submitting corrected claims electronically can be easy when the appropriate steps are followed.

Please follow the following steps so your claims will not deny as duplicates or process incorrectly.

Clearly indicate that your CMS-1500 claim is a corrected claim as follows:

- EDI/1500/Professional claim forms submitted as “corrected claims” can be submitted electronically.
- In Loop 2300 ~ CLM05-03 must contain a “7 or 8” REF01 must contain an “F8” and REF02 must contain the Original Reference Claim Number.
- The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.
Blue Cross Support
We have an interactive map of provider representatives:

- Network Development
- Provider Relations
- Statewide

View the Provider Representative Map, located at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) >Provider Tools.
The Provider Page

Is designed to meet your provider needs

www.bcbsla.com/providers

• Credentialing
• Education on Demand
• Forms for Providers
• Imaging Authorizations
• Newsletters
• Pharmacy Management
• Quality Blue
• Provider Tools
• And more!
Home to your professional manuals. These are extensions of your network agreement(s).

www.bcbsla.com/providers >Newsletters, current and archived.

www.bcbsla.com/providers >Education On Demand
Home to your **Speed Guides**; quick guides to network authorization requirements and billing guidelines.

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

www.bcbsla.com/provider >Education on Demand
Is your correspondence email address and contact information correct?

It is important to provide the appropriate correspondence email address of the contact person responsible for disseminating information for your practice.

Submit your new information via our online interactive Provider Update Form: www.bcbsla.com/providers >Forms for Providers
EDI Department

iLinkBLUE Provider Suite
www.bcbsla.com/ilinkblue
1-800-216-BLUE (1-800-216-2583) or 225-293-LINK (225-293-5465)
ilinkblue.providerinfo@bcbsla.com

Electronic Funds Transfer
Network Administration
1-800-716-2299, option 3 or 225-297-2758
network.administration@bcbsla.com

EDI Clearinghouse Services
EDI Clearinghouse Support Desk
225-291-4334
ediclearinghousesupport@bcbsla.com
Blue Advantage Customer Service
1-866-508-7145

Blue Advantage Provider Portal Customer Support
Email: customersupport@lumeris.com

Lumeris Technical Help Desk (If you are locked out of the Blue Advantage Provider Portal)
1-866-397-2812
Important OGB Contacts

OGB Customer Service
Ph. 1-800-392-4089
Fax 1-225-298-7772
ogbhelp@bcbsla.com

MedImpact
Ph. 1-800-788-2949

Express Scripts, Inc. (ESI)
Ph. 1-866-781-7533

Behavioral Health
Authorizations by
New Directions
Ph. 1-800-991-5638

Hardcopy Claims Address
P.O. Box 98029
Baton Rouge, LA 70898

Medical Authorizations
Ph. 1-800-586-2299

EDI Clearinghouse
Ph. 225-291-4334

iLinkBLUE & EFT
1-800-216-BLUE (1-800-216-2583)
iLinkBLUE.Providerinfo@bcbsla.com
Provider Call Centers

Provider Services  1-800-922-8866
FEP Dedicated Unit  1-800-272-3029
OGB Dedicated Unit  1-800-392-4089
Blue Advantage  1-866-508-7145

For information NOT available on iLinkBLUE

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. You can remain anonymous. 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
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 1-800-922-8866 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 1-800-922-8866.

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
Provider Relations

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manager

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Darnell Kling
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provider.relations@bcbsla.com | 1-800-716-2299, option 4
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dayna.roy@bcbsla.com
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Baton Rouge

Jill Taylor
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New Orleans

network.development@bcbsla.com | 1-800-716-2299, option 1
Doreen Prejean | Mary Landry | Karen Armstrong
# 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>
</tr>
<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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<td><strong>Lafayette, Lake Charles and Alexandria Regions</strong></td>
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<tr>
<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>
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<td>Linda Denicola – provider file</td>
<td>A-L</td>
<td>(225) 298-1537</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) 295-2301</td>
<td><a href="mailto:hope.pace@bcbsla.com">hope.pace@bcbsla.com</a></td>
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<tr>
<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) 295-2262</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>
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<td>(225) 297-2873</td>
<td><a href="mailto:cheryl.ward@bcbsla.com">cheryl.ward@bcbsla.com</a></td>
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<td>Shakeysha Gray – provider file</td>
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1-800-716-2299 • option 2 – credentialing • option 3 – provider file

Fax: 225-297-2750 • network.administration@bcbsla.com
Multimedia Contacts

- Connect with us on Facebook: www.facebook.com/bluecrossla

- Follow Blue Cross on Twitter: www.twitter.com/BCBSLA

- Watch us on YouTube: www.youtube.com/bluecrossla
Questions