Growing New Ideas

2013 Educational Workshops for Network Providers & Their Staff

Agenda

- Member Engagement Initiative
- Network
- Office of Group Benefits (OGB)
- Healthcare Reform
- iLinkBLUE & EFT
- Clear Claims Connection (C3)
- ICD-10 Transition
- AIM Specialty Health
- BlueCard®
- Filing Claims
- Provider Page
- Provider Support
our Mission:

To improve the lives of Louisianians by providing health guidance and affordable access to quality care.

Member Engagement Initiative

- Member Reviews
- Estimated Treatment Cost Tool
Member Reviews

Our consumer-driven culture and industry changes are driving the demand for more credible member review information.

- Based on the reviews submitted to BCBSLA, approximately 90% of member reviews are positive.
- The market demand for member review is growing, fueled by the new and expanding individual retail health insurance market.

Encouraging all of your Blue patients to add to these reviews will help assure overall positive results.

How to leave a review...

1. Member logs into their Blue Cross account via the secure member portal at www.bcbsla.com.
2. Member must access a specific claim on file to comment on an encounter with the physician who provided the service.
3. Member then must respond to a core set of member review questions.
4. Comments are checked for appropriateness before being displayed.

**ONLY ONE MEMBER REVIEW PER CLAIM IS PERMITTED**
Core Review Questions

- Questions about member's experience and recommendation are required for the review to be displayed.

- The remaining questions are available and optional, including member written comments.

- Optional responses are viewable, but not included in calculating the overall physician rating.

- All submitted reviews are posted within two business days.

Review Ratings

- The summary “star rating” is an aggregate of the available member review ratings for overall patient experience and includes a breakdown by the level of satisfaction.

- Consumers can see the number of reviews available and the percentage of members who would recommend the physician.

Individual patient ratings, details, and comments are also viewable.
Multiple moderation check points are in place to prevent the display of inappropriate comments or private member information, such as ID number.

- Audited by human reviewers and by software for appropriateness before displayed
- Providers can respond once per review displayed via iLinkBLUE
- Posted reviews cannot be edited
- Reviews are displayed for 24 months

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

- Costs are displayed on the national BCBSA Hospital & Doctor FinderSM website
- The Tool features the costs and volumes associated with 359 elective/planned procedures.

It is important to note that only elective and/or planned procedures will be available

This service will expand to include our HMOLA members in the future
Estimated Treatment Cost Tool

Cost Estimates
Are composited from BCBSLA historical claims to reflect combined data that enables members to understand the total cost for a service without complications

There are four methodologies for creating cost estimates:

1. **PROFESSIONAL**
   - For professional office visits, primary CPT code(s) identify each treatment category
   - For chiropractic and physical therapy, all costs for the visit are summed to create the estimate
   - For other categories, weighted average costs per CPT code(s) create the estimate

2. **INPATIENT**
   - For inpatient procedures, primary DRG codes(s) related to each treatment category are combined with the professional, diagnostic and other related costs for the category and the total is displayed

3. **OUTPATIENT**
   - For outpatient procedures, primary CPT® code(s) identify each treatment category and all costs for that member that day are summed to create the estimate

4. **DIAGNOSTIC**
   - For diagnostic services, both the technical and professional component are combined

Network

- Who’s Joining Our Networks
- Incident-to Billing
- HMO Louisiana, Inc. Network
- Community Blue & BlueConnect
- Blue Benefit Services (BBS)
- Dental & Vision
- Member Referrals
- Pass-thru Lab
Who Is Joining Our Networks?

Several provider types now have the option to participate in our provider networks:

**Nurse Practitioners**
We accept claims for Nurse Practitioner services in one of two ways:

- **Option 1** - Directly based on the NP’s network reimbursement
- **Option 2** - Indirectly when billed on the collaborating physician’s claim using Modifier –SA

(see incident-to billing guidelines slide or our Professional Provider Office Manual)

**Registered Dietitians**
Dietitian billing guidelines are available in the Professional Provider Office Manual

**Audiologists**
Just like Nurse Practitioners and Dietitians, Audiologists must be credentialed to be in our provider network(s)

Full credentialing information is available online at www.bcbsla.com > I’m a Provider > Credentialing

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Incident-to Billing

Effective Jan. 1, 2013, BCBSLA follows CMS’ incident-to guidelines

“In incident-to” means services must be furnished as an integral, although incidental, part of a physician’s personal professional services in the course of diagnosis or treatment of an injury or illness

**Requirements to be considered incident-to:**

- Service provided must be reasonable & medically necessary
- Service must be within the practitioner’s scope of practice
- Service must be performed in collaboration with a physician
- Supervising physician must be physically present in same office & be available to render assistance if necessary
- Office must have identifiable boundaries when part of another facility & services must be furnished within those boundaries; where this office is one room, the physician must be in it to supervise
- Physician’s service reflects active participation in & management of course of treatment
- The professional identity of the staff furnishing the service must be documented & legible; a counter signature alone is not sufficient to show that the incident-to requirements have been met

These guidelines are available in our Professional Provider Office Manual, online at:

www.bcbsla.com

> I’m a Provider
> Education on Demand
> Manuals.
HMO Louisiana, Inc. Network

- HMO Louisiana, Inc. (HMOLA) has 3 service regions
- On January 1, 2013, St. Mary Parish was added to the HMOLA New Orleans region
- Online directories have been updated to include St. Mary Parish HMO providers

### Baton Rouge Region:
- Ascension
- Assumption
- East Baton Rouge
- East Feliciana
- Iberville
- Livingston
- Pointe Coupee
- St. Helena
- West Baton Rouge
- West Feliciana

### New Orleans Region:
- Jefferson
- Lafourche
- Orleans
- Plaquemines
- St. Bernard
- St. Charles
- St. James
- St. John the Baptist
- St. Mary
- St. Tammany
- Tangipahoa
- Terrebonne
- Washington

### Shreveport Region:
- Bossier
- Caddo
- Claiborne
- Desoto
- Red River
- Webster

BMS ⇔ BBS Transition

**Benefit Management Services (BMS)*** groups transitioning to Blue Benefit Services (BBS)

- BBS is the new Blue Cross department specializing in the needs of the self-funded market
- BBS groups will no longer be referred to as BMS groups *(they will be referred to as Blue Cross self-funded groups)*
- Transition scheduled to be completed by August 2014
- Providers may use iLinkBLUE to access BBS eligibility, claims information, and more

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* *BMS is a third-party administrator and a department of Southern National Life Insurance Company, Inc. (SNL). SNL is a subsidiary of Louisiana Health Service & Indemnity Company d/b/a/ Blue Cross and Blue Shield of Louisiana.
BMS \(\Rightarrow\) BBS Claims

Benefit Management Services (BMS) groups transitioning to Blue Benefit Services (BBS)

- BBS members have the Cross and Shield on their member ID cards
- Payment information will be shown on the Blue Cross payment registers
- Provider 1099 processes will not change
- Claims for dates of service prior to a groups' transition should be filed to BMS
- BBS members will access providers through the Blue Cross and HMOLA directories

Dental & Vision

United Concordia Dental (UCD)

- To prepare for Healthcare Reform and the Health Insurance Marketplace available October 1, 2013, BCBSLA has partnered with United Concordia Dental® (UCD)
- UCD currently administers dental benefits for 6 million members in all 50 of the United States, as well as the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands
- Through our partnership with UCD, we are now able to offer an individual dental product to our members

Davis Vision

On January 1, 2013, we began offering our group members a new stand-alone routine vision product

This benefit option includes coverage for:
- Routine Vision Exams
- Eyeglasses
- Contact Lenses

Members must obtain services from a Davis Vision Network Provider

This benefit option does not cover non-routine (medical) vision services. Non-routine vision services are subject to the member's medical benefits.
Member Referrals

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

*Referrals to non-contracted provider results in significantly higher cost-shares to our members*

**Examples:**
- laboratories
- outpatient facilities
- DME providers
- therapists
- hospitals

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Pass-through Lab

**NOT PERMITTED**

Occurs when ordering provider bills the total component for a lab service, but the lab service was not performed by the ordering provider

Per our policy, providers may only bill for the following indirectly performed services:

1. The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider
2. The service is provided by an employee of a physician or other professional provider (Please use appropriate modifiers when billing)
• Since July 2010, Blue Cross has administered OGB’s HMO Plan benefits for Louisiana state employees, retirees and dependents

• Effective January 1, 2013, Blue Cross is the healthcare administrator for OGB’s PPO and Consumer Driven Health Plan (CDHP) benefit plans

**OGB PPO, HMO & CDHP**

**PPO Benefit Plan**
Utilizes the OGB Preferred Care 2013 network of providers and is available to active OGB employees, retirees with Medicare and non-Medicare retirees

**HMO Benefit Plan**
Utilizes our OGB Preferred Care 2013 network of providers even though this is an HMO product. This plan is available to active OGB employees, retirees with Medicare and non-Medicare retirees

**Consumer Driven Health Plan (CDHP) with HSA option**
Utilizes our OGB Preferred Care 2013 network of providers. This plan is available to active OGB employees. OGB employees enrolled in the plan have a high deductible and may open a health savings account (HSA).
### OGB Member IDs & Claim Filing

**Use Appropriate OGB Member IDs**

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>For dates of service:</th>
<th>on and after January 1 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OGB PPO Benefit Plan</strong></td>
<td>File to BCBSLA with Subscriber’s SSN as the member ID</td>
<td>File to BCBSLA with Member ID Number including 3 character alpha prefix</td>
</tr>
<tr>
<td><strong>OGB HMO Benefit Plan</strong></td>
<td>File to HMOLA with Member ID Number including 3 character alpha prefix</td>
<td>File to HMOLA with Member ID Number including 3 character alpha prefix</td>
</tr>
<tr>
<td><strong>OGB CDHP Benefit Plan</strong></td>
<td>File to Former Healthcare Carrier</td>
<td>File to BCBSLA with Member ID Number including 3 character alpha prefix</td>
</tr>
<tr>
<td><strong>OGB LaCHIP Affordable Plan</strong></td>
<td>File to BCBSLA with Subscriber’s SSN as the member ID</td>
<td>File to Current Healthcare Carrier</td>
</tr>
</tbody>
</table>

*“Run-in” claims submitted with a Blue Cross member ID will be returned for the subscriber’s SSN. Blue Cross accepts “Run-in” claims electronically.*
OGB Care Management Program

Care Management programs for OGB members are administered by Blue Cross and Blue Shield of Louisiana

Disease Management - 1.800.363.9159 OGB members diagnosed with one or more of these conditions (diabetes, coronary artery disease, heart failure, asthma or chronic obstructive pulmonary disease) are eligible to participate in Blue Cross’ disease management program. This program provides access to a personal nurse or healthcare professional who can—along with the member’s physician and other healthcare professionals—help them address their current health status as well as their long term health.

Case Management - 1.800.317.2299 Physicians may refer patients for our case management program, which is designed to help members with complex health issues through education and coordination of services and resources to reduce barriers for good health outcomes.

More information about our Case and Care Management programs is available online at www.bcbsla.com >I’m a Provider >Care Management.

OGB COB for Medicare Claims

Copayment/Coinsurance is printing incorrectly on provider payment registers for OGB members when Medicare is primary and BCBSLA pays full member liability

When Medicare applies a member liability that is less than the maximum BCBSLA payment amount, BCBSLA pays the secondary liability in full

To determine if a copayment/coinsurance should be applied, BCBSLA first calculates the claim based on our maximum allowable payment

We apply any applicable copayment/coinsurance only when the member’s primary liability is more than BCBSLA’ maximum payment, had we paid primary

A copy of this notice is enclosed in your workshop folder
Healthcare Reform

• The Market Place
• Grace Period for Members
• Risk Adjustments
• Member ID Card Changes
• Women’s Preventive Services
• LHEC Coalition

The Marketplace

• Healthcare reform—and the implementation of the Affordable Care Act (ACA)—is a dominant theme in 2013 for businesses, providers and the health insurance industry

• Beginning Oct. 1, 2013, during open enrollment, individuals and small businesses can start buying their insurance online (for an effective date of Jan. 1, 2014) on the Health Insurance Marketplace (this will be an Expedia-like site where people can shop online for insurance and compare prices and plans)

• Health insurance plans in the new marketplace are required to offer the same essential benefits and comprehensive coverage, from doctors to medications to hospital visits
The ACA identified 10 service categories that must be covered under essential health benefits

These are listed as:

• Ambulatory patient services
• Emergency room services
• Hospitalization
• Laboratory services
• Maternity and newborn care
• Mental health and substance abuse disorders
• Pediatric services, including oral and vision care
• Prescription drugs
• Preventive and wellness services and chronic disease management
• Rehabilitative and habilitative services and devices

The Marketplace Products

The products in the marketplace will fall under four categories or "metal levels"

Below is a summary of the metal levels and a look at their targeted markets

• **Platinum level** – Targeted to individuals who are higher utilization users who need care, and the premium cost is worth the advantage of low-deductible and first-dollar coverage

• **Gold level** – Targeted to individuals willing to pay more for coverage that offers a lower deductible and rich benefits

• **Silver level** – Targeted to individuals eligible for cost-sharing reductions and those willing to pay slightly higher premium to reduce out of pocket costs

• **Bronze level** – Targeted to individuals looking for a low-cost product option with high deductibles & coinsurance
Grace Periods for Members

Under the new healthcare reform laws, members—who are eligible for the Advance Premium Tax Credit (APTC)—will have an extended (3 month) eligibility grace period for delinquent premiums

- Blue Cross will notify providers when the member is in the 2nd and 3rd month of their delinquent grace period (watch for coming iLinkBLUE updates on this)
- During the 1st month of the grace period, claims WILL NOT deny or pend
- During the 2nd and 3rd month of the grace period, claims WILL pend
- If the member remains delinquent the 2nd and 3rd month pended claims WILL deny as “member not eligible”

Risk Adjustments

What does risk adjustment mean?
Risk adjustment is the stabilizing process for determining the disease burden of a member

WHAT IS CRA?
1 of 3 new risk stabilization programs established by the Affordable Care Act (ACA) for the individual & small group commercial markets slated to kick-off in January 2014
A tool used to predict healthcare costs based on the relative actuarial risk of enrollees in risk adjustment-covered plans

WHAT IS THE PURPOSE OF CRA?
To minimize the incentive to select enrollees based on their health status
To stabilize risk and prevent adverse selection among insurers

HOW DOES THE CRA PROGRAM OPERATE?
State or Federal DHH is responsible for operating risk-adjustment models
Insurers pay in/out based on risk associated with their individual and small group enrollees
Risk-adjustment model redistributes money from insurers with healthier patient populations to those with sicker patient populations
Risk Adjustments

Why is the PROVIDER role critical?

Risk adjustment relies on providers to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient.

Opportunities to Improve Care

Accurate risk capture improves high-risk patient identification and the ability to reach out/engage patients in care management programs & care prevention initiatives.

It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.

Financial Health

Accurate medical records and diagnosis codes captured on claims help reduce the administrative burden of adjusting claims.

Accurate Medical Record Documentation & Code Capture

Medical coding of patient encounters is only as good as the underlying medical record documentation.

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Diagnoses cannot be inferred from physician orders, nursing notes or lab or diagnostic test results; diagnoses need to be in the medical record.
- Chronic conditions need to be reported every calendar year (e.g., leg amputation status must be reported each year).
- Each diagnosis needs to conform to the ICD-9 coding guidelines until transition to ICD-10.
- Medical records need to be legible, signed, credentialed and dated by the physician.
- Patient's name and date of service need to appear on all pages of the record.
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.
Risk Adjustments

Provider Role: Illustrative Example of the Implications of Coding Errors

Estimated cost for a provider to resubmit an adjusted or corrected claim ranges, on average, from $15 to $25 per claim.

Just 100 claim resubmissions could result in a loss of $1500.

In addition to wasted provider resources, other system stakeholders are forced to use already strapped resources to resolve claim issues.

Member ID Card Changes

2014 Health ID Card Changes:

- **Removal of dollar amounts (copay, coinsurance, deductible)**
  
  This change is due to the multiple cost-sharing arrangements that will be available as the result of healthcare reform.

- **Removal of Information**
  
  The statement, “Authorizations required for some services,” has been removed for all ID cards and the statement “Restricted Lab Networks” has been removed from the BlueConnect and Community Blue ID cards.

- **Added Telephone Number**
  
  The BCBSA “Find a Provider” toll-free number is being added to all ID cards. This number allows the caller to locate a network provider in any state/location.

- **Added Claims Filing Instructions**
  
  Claims Filing Instructions (varied based on product/network) will be included on the back of member ID cards.

  Use iLinkBLUE for eligibility and benefits information.
Beginning August 1, 2012, (for new policies and as policies renew) Blue Cross and HMOLA now cover certain Women’s Preventive Services at no cost to the member when rendered by a network provider

- Patient Protection and Affordable Care Act (PPACA) requirement
- Not required for ALL members
- Copayment, coinsurance and deductible will not be applied to these services when performed by an in-network provider
- Medical services that are submitted for the same date of service/claim, will be subject to the member’s applicable cost-share

Please always verify the member’s benefits prior to performing services

Benefits for Women’s Preventive Services include:

- Contraceptive methods and counseling
- At least one well-woman visit, annually
- Counseling for sexually transmitted infections when services are provided at well-woman visit
- Counseling & screening for HIV when services are provided at well-woman visit
- Screening & counseling for interpersonal/domestic violence when services are performed at well-woman visit
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing for women age 30 and older, once every three years
- Breastfeeding support, supplies & counseling in conjunction with each birth
LHE Coalition

The Louisiana Healthcare Education Coalition (LHEC) was founded to help Louisianians better understand the Patient Protection and Affordable Care Act (PPACA).

As a civic organization committed to providing unbiased healthcare and wellness information, LHEC provides education on the major drivers of healthcare costs, the critical importance of personal wellness and the need for access to quality healthcare, by working with healthcare providers, small businesses, faith-based institutions, employers, community leaders, patient advocacy groups and the public.

More information is available online at http://lhec.net/

LHEC exists solely as an educational resource. It neither endorses nor seeks to create public policy.

iLinkBLUE & EFT

- iLinkBLUE Message Board
- iLinkBLUE Main Page
- Signing Up for iLinkBLUE
- Electronic Funds Transfer
- Updated EFT Application
The message board is the first screen you encounter after logging into iLinkBLUE. The iLinkBLUE message board is one way we notify providers of Blue Cross current events. As we continue to enhance iLinkBLUE, the message board will also be the place where you get personal notifications based on your provider number.

**iLinkBLUE Message Board**

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**iLinkBLUE Main Page**

**Required for All Network Providers**

**iLinkBLUE** is a FREE service gives you access to:

- Coverage (eligibility & benefits) Information for BCBSLA members
- Claim status research
- Pending medical record requests for BlueCard® members
- Allowable Charges
- Imaging Authorization Requests & Reviews
- Remittance Advices / EFT Deposits
- Confirmation Reports
- Remittance Advices
- BlueCard claim status and eligibility
- Manuals
- BCBSLA medical policies
- Estimated Treatment Cost
- And More!!!

iLinkBLUE is required to view and print your payment registers. We no longer mail hardcopy payment registers.

More information is available online at **www.bcbsla.com**

> I'm a Provider
> Electronic Services
Access to iLinkBLUE involves two easy steps:

1. Complete the application and agreement forms for your provider location (this is only done once per location)
   - The iLinkBLUE application includes the EFT application and is available online at www.bcbsla.com > I’m a Provider > Electronic Services

2. Once security access is granted, or you already have access and would like to register additional staff:
   - Go to www.bcbsla.com/ilinkblue/ and select “New User? Click here”
   - Enter all appropriate information to create user name (must be done for each user)
   - A temporary password will be mailed to the correspondence address we have on file for you
   - After you receive your temporary password, go to www.bcbsla.com/ilinkblue/, click “Enter iLB” and log on

For questions regarding iLinkBLUE or EFT, please email ilinkblue.providerinfo@bcbsla.com or contact the LINKline at 1.800.216.BLUE (2583).

Electronic Funds Transfer

REQUIRED FOR NETWORK PROVIDERS

Blue Cross requires that network providers have electronic funds transfer (EFT)

EFT is a FREE service that provides you with:

- payments faster
- BCBSLA payments deposited electronically in your account
- No more trips to the bank or lost checks
- It’s a Free service
- iLinkBLUE is required for this service

More information is available online at www.bcbsla.com
> I’m a Provider
> Electronic Services
Updated EFT Application

Electronic Funds Transfer Application and Guide

The EFT Application now includes the newly created Guide to Completing the EFT Application to assist in completing the form

Also included as part of the iLinkBLUE agreements; available online at www.bcbsla.com

> I'm a Provider
> Electronic Services
> iLinkBLUE

C3
(Clear Claim Connection)
Clear Claim Connection (C3) is a Web-based code auditing reference tool designed to audit and evaluate code combinations.

C3 includes the following edits or overrides as they apply to a single code or code pairs:
- Modifier 25, 59 and 57 Edit Overrides
- Age Edits
- Gender Edits
- Duplicate Edits
- Mutually Exclusive Edits
- Incidental Edits
- Visit Processing Edits
- Assistant Surgeon Edits
- Pre/Post OP Processing Edits

After clicking on “Clear Claim Connection,” you must accept the terms and conditions.

The Claim Entry screen opens.

Enter the patient’s gender and date of birth.

Enter procedure code(s), date of service and applicable modifier(s).

Click the Review Claim Audit Results button.
Click the **Review Claim Audit Results** button

*No edit results are generated when all codes are compatible*

Click on the “Disallow” button to see a full description of claim edit
Clear Claim Connection

Summary of claim edit is printable

ICD-10

- Why the change to ICD-10?
- ICD-10 Mandate
- ICD-10 Facts
- Who does the transition affect?
- Preparing for ICD-10
- ICD-10 Impact
- ICD-10 BCBSLA Webpage
Why the change to ICD-10?

- Outdated and obsolete terminology
- Inconsistent with current medical practices

Who does this change affect?
ICD-10 affects diagnosis and inpatient procedure coding for everyone per HIPAA, not just those who submit Medicare and Medicaid claims.

This includes:
- Providers
- Payers
- Clearinghouses
- Billing Services

ICD-10 Mandate

- HHS announced the final rule that delayed the ICD-10 compliance date from October 1, 2013 to October 1, 2014
- BCBSLA will implement ICD-10 by the compliance date
- BCBSLA will only accept ICD-10 codes as of the compliance date
ICD-10 Facts

ICD-10 CM for diagnosis coding

– For use in all US healthcare settings
– Uses 3 to 7 digits instead of the 3 to 5 digits

ICD-10-PCS for inpatient procedure coding

– For use in US patient hospital settings only
– Uses 7 alphanumeric digits instead of the 3 or 4 numeric digits
– Much more specific and substantially different

Preparing for ICD-10

- Identify your current systems & work processes that use ICD-9 codes
- Assess staff training needs
- Discuss implementation plans with your clearinghouses, billing services & payers to ensure a smooth transition
- Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials & training
- Conduct test transactions using ICD-10 codes with your payers and clearinghouses
- Identify potential changes to work flow and business processes
Preparation for ICD-10

**Blue Cross Preparation Milestones**

- Blue Cross has completed a company/system wide impact assessment to ensure all system changes are in place for the mandated switch to ICD-10 on October 1, 2014.
- We have completed internal system testing and are in the early stages of system integration testing.
- We will regularly survey the provider community to assess partner readiness. **Your participation is important.**
- We will begin external provider testing in 1st quarter of 2014.

**More on ICD-10 is available in our ICD-10 Resource Guide**

**ICD-10 Impact**

**Claims for services on and after October 1, 2014, filed with ICD-9 Codes will be rejected**

Examples:
- ICD-9s after the compliance date
- ICD-10s before the compliance date

**Electronic claims** not adhering to the guidelines will be rejected on the Electronic **Not Accepted Report**

**Paper claims** not adhering to the guidelines will be returned to the provider.
ICD-10 BCBSLA Webpage

BCBSLA.com
ICD-10 Conversion Page

• Latest Communications
  – For Providers
  – For Trading Partners
  – Website Links
  – FAQs

• Checklists & Timelines
  – Small / Medium Practice
  – Large Practice
  – Small Hospital

ICD-10 Conversion
The industry-wide move to the 10th version of the ICD will occur on October 1, 2014. As we prepare for this change, we have provided a few of our preparation milestones:

- Blue Cross has completed a company/system review
- Blue Cross is currently performing initial internal testing
- Blue Cross will regularly survey technology providers
- Blue Cross will begin external provider testing

Latest ICD-10 Communications
- For Providers
- For Trading Partners
- Website Links
- FAQs

ICD10ProviderCommunications@bcbsla.com

AIM Specialty Health
(American Imaging Management)

• Imaging Authorizations
• Obtaining Authorizations
• OptiNet Radiology Program
• OptiNet Scoring
Imaging Authorizations

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

**Ordering physicians** are required to contact AIM 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

Obtaining Authorizations

The ordering physician should always use AIM’s **Provider Portal** in iLinkBLUE to set up an authorization.

Using AIM's **Provider Portal** 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 **Provider Portal**) that the authorization has the correct servicing provider/facility.

It is equally important that the servicing provider verify the authorization through the **Provider Portal** prior to performing services to ensure it is accurate.

Top reasons for claim denials related to outpatient imaging authorizations:

- No authorization on file
- Facility location does not match authorization
- Servicing provider does not match authorization
OptiNet Radiology Program

OptiNet is a REQUIRED online assessment tool available on iLinkBLUE (www.bcbsla.com/ilinkblue)

Blue Cross, in collaboration with AIM Specialty HealthSM (AIM), is gathering information about the capabilities of certain Blue Cross contracted providers (see next slide for list of providers) such as:

- Provider training related to technical imaging services
- Technical imaging services
- Imaging equipment
- Capacity and site accessibility
- Information related to compliance with industry standards such as those established by The Joint Commission (formerly JCAHO) and the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC)

OptiNet Radiology Program

Program participation is required for network providers who perform the technical component for the following diagnostic services:

- Computed Tomography (CT/CTA)
- Magnetic Resonance Imaging (MRI/MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- Ultrasound (Obstetrics, Gynecological, Abdominal)
- X-Ray
- Echocardiography
- Mammography
OptiNet Scoring

Blue Cross REQUIRES a maintained score of **80%** or better per modality performed

We work with providers who score below 80% on any modality, to help achieve the required 80%

Provider’s responsibility to ensure a score of 80% or better is maintained as scores drop when accreditations or licenses expire

Free-standing facilities that score less than 80% are subject to removal from our network(s)

How often will I be asked to participate in this assessment process?

Providers will receive an email notification when their assessment information is expiring, then again after expiration

If changes to provider capabilities occur prior to this time (e.g., new equipment, new physicians, etc.), you may update your information using OptiNet at any time

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BlueCard®

- Medical Record Request
- Ancillary Services
- BlueCard Subrogation
- BlueCard Appeals
- BlueCard Refund Requests
Medical Record Requests

Now available on iLinkBLUE

• Providers now have a new feature in iLinkBLUE
  • After logging into iLinkBLUE, a box similar to the one below will appear on the iLinkBLUE message board when you have a pending/open medical record request for a BlueCard member

![Box showing medical record requests]

• You can research and manage these open medical record requests from within iLinkBLUE

  This feature is not currently available for BCBSLA and HMOLA members

Once in iLinkBLUE, you may click the link in the box on the message board

or

You may access medical record request directly from the iLinkBLUE menu under “Medical Record Requests – Out Of Area”

2nd and reopened requests are highlighted in red and appear at the top of your outstanding request list

A 2nd request is displayed when Blue Cross requests records more than once and have not received records

A reopened request appears when Blue Cross receive medical records from the provider but records are incomplete or incorrect
Medical Record Requests

When sending medical records to Blue Cross, print and include the “Outstanding Requests Details” page

The Outstanding Requests Details page includes information such as the provider number, provider name, patient name, patient date of birth, date of service, claim number and an address for where to send the medical records

There are two other phases of this enhancement coming in 2014

1. Paper request for medical records will stop. For now, you will continue to get paper requests which are the same as what you can view in iLinkBLUE.

2. You will be able to upload medical records directly into iLinkBLUE.

Ancillary Services

Where to file the claim...

A Blue member living in Mississippi purchases retail DME equipment from a Louisiana DME provider in the BCBSMS network. File to Louisiana.

A Blue member living in Texas mail-orders DME equipment from a Louisiana DME provider in the BCBSTX network. The equipment is shipped to the Texas address. File to Texas.

A BCBSLA member sees a BCBSMS network physician. The BCBSLA member has their lab work drawn by a Louisiana Lab in the BCBSMS network. File to Mississippi.

As of October 14, 2012, the process for filing ancillary claims has changed

The local plan is defined as the state where:

- the equipment is purchased as retail
- the equipment is shipped to
- the referring physician is located even when the specimen is drawn in another state
BlueCard® Subrogation

- Each Blue Plan handles subrogation for their own members
- The rules and regulations for processing subrogation claims also vary among the Blue Plans
- BCBSLA’s subrogation standard is to pay then pursue; however, some Blue Plans instead reject suspected subrogation-related claims first then investigate to verify if third-party insurance is involved
- For best practice, always inquire about the Blue member’s subrogation policy when obtaining eligibility and benefits for subrogation-related services

BlueCard® Appeals

**All appeals should include:**
- Clear instructions on why appeal is being initiated
- Claim number
- Date of service
- Member ID and alpha prefix
- The remittance showing the denial

Appeals for members of other Blue Plans should be submitted to Blue Cross and Blue Shield of Louisiana

Please include clear instructions on why the appeal is being initiated

Appeals should **NOT** be submitted as a duplicate claim or include a corrected claim or unsolicited medical records
BlueCard® Refund Requests

How to handle a BlueCard claim overpayment:

Provider Discovers
The provider suspects an overpayment on a BlueCard claim
After 10 business days of receipt of payment the provider may:
• Notify BCBSLA via an iLinkBLUE action request OR
• Complete & submit an Overpayment Notification Form notifying BCBSLA of the overpayment

BCBSLA Discovers
Upon discovery (or provider notice of the overpayment), BCBSLA’s BlueCard department sends the provider an overpayment notification letter
Provider then has 30 days to respond to the overpayment notification letter
Confirmed overpayments are then automatically deducted from providers BCBSLA payment registers

The “Don’t” List for BlueCard Refund Requests
1. Do NOT send refund checks to BCBSLA or the member’s Blue Plan. Our BlueCard department does not accept unsolicited refund checks. They will be returned without being processed, thus delaying the refund process.
2. BCBSLA does NOT process partial refund requests.

BlueCard® Refund Requests

The Refund Request Guidelines for BlueCard® is available online at www.bcbsla.com
> I’m a Provider
> Tidbits

The Overpayment Notification Form is available online at www.bcbsla.com
> I’m a Provider
> Forms for Providers

A copy of this guide is enclosed in your workshop folder
Filing Claims

- Place of Treatment
- Required Info on Claims
- NPI Required
- Modifiers -25, -74 & -75
- Behavioral Health Codes
- Timely Filing
- A Guide for Disputing Claims
- Reimbursement Review Form
- Coordination of Benefits
- Subrogation
- Claims Assistance

Place of Treatment

Blue Cross does not convert the place of treatment

**Common Place of Treatment Codes:**

- **11** = Office
- **21** = Inpatient Hospital
- **22** = Outpatient Hospital

**Example:** Previously we would convert claims filed with the letter **O** or **3, 15, 26 or 54** to place of service **11**

- **O** = not a valid place of service
- **3** = School
- **15** = Mobile Unit
- **26** = Military Treatment Facility
- **54** = Intermediate Care Facility/Mentally Challenged
### Place of Treatment

Below is a listing of valid place of treatment codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-Standing Facility</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-Based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-Standing Facility</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-Based Facility</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s Home</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>17</td>
<td>Retail Health Clinic</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance Air or Water</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Mentally Challenged</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>58</td>
<td>Addiction Facility Partial Hospitalization</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>65</td>
<td>End Stage Renal disease Treatment Facility</td>
</tr>
<tr>
<td>71</td>
<td>Sate or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
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<tr>
<td>99</td>
<td>Other Unlisted Facility</td>
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<td>99</td>
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</tr>
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</table>

### Required Info on Claims

The information submitted on claims is key to successful processing. Claims received without required info must be returned to the provider.

**Fields that should ALWAYS be completed on claim forms:**

<table>
<thead>
<tr>
<th>Field on Form</th>
<th>CMS-1500</th>
<th>UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rendering Provider NPI</td>
<td>Block 24</td>
<td>Block 76</td>
</tr>
<tr>
<td>Rendering Provider Tax ID</td>
<td>Block 25</td>
<td>Block 5</td>
</tr>
<tr>
<td>Rendering Provider Name</td>
<td>Block 31</td>
<td>Block 76</td>
</tr>
<tr>
<td>Mailing Address for Payment</td>
<td>Block 33</td>
<td>Block 2</td>
</tr>
<tr>
<td>Clinic NPI</td>
<td>Block 33a</td>
<td>n/a</td>
</tr>
<tr>
<td>Facility NPI</td>
<td>n/a</td>
<td>Block 56</td>
</tr>
<tr>
<td>Referring Physician Name*</td>
<td>Block 17</td>
<td>Block 78</td>
</tr>
<tr>
<td>Referring Physician NPI*</td>
<td>Block 17b</td>
<td>Block 78</td>
</tr>
</tbody>
</table>

*when applicable

For electronic claims, use electronic field equivalents.

A copy of this guide is enclosed in your workshop folder.
Required info on claims

The information submitted on claims is key to successful processing

Claims received without required info must be returned to the provider

Taxonomy Codes

- When filing claims for subunits that share one NPI with their providers, it is required to also include the appropriate taxonomy code in Block 81 of the UB-04 claim form or Block 19 of the CMS-1500 form (or their corresponding electronic data fields)

- Taxonomy codes are used to clearly identify the providers subunit(s) that rendered the services. Not reporting the taxonomy code for services rendered by a subunit may cause the claim to reject or pay incorrectly.

NPI Required

Blue Cross requires accurate NPIs for ALL claims, both electronic and paper, regardless of the provider’s network participation

- Claims submitted without a valid NPI for the rendering or ordering physician will be rejected, furthermore, the referring physician NPI must be reported on claims, when applicable...

referring physician NPI...

<table>
<thead>
<tr>
<th>Hardcopy Claims</th>
<th>Electronic Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500: Block 17</td>
<td>837P: 2310A loop</td>
</tr>
<tr>
<td>Block 17a - Enter the referring physician’s ID number other than NPI</td>
<td>NM1 segment with the qualifier for DN in the NM101 element</td>
</tr>
<tr>
<td>Block 17b – Enter the referring physician’s NPI</td>
<td>8371: 2310D loop</td>
</tr>
<tr>
<td>UB-04: Block 78</td>
<td>Enter the referring physician’s NPI, last and first name</td>
</tr>
</tbody>
</table>
NPI Required

In addition to NPIs being required on claims, providers without a valid NPI on file with us will not be allowed to make any updates, including but not limited to:

- Address Changes
- Reimbursement
- New Tax Identification Numbers (TIN)

You must have your NPI on file with us to be able to file claims (hardcopy or electronically), access benefits, claims status or a customer service representative.

How to Report Your NPI

You have options:

1. Submit your NPI, name & TIN or SSN printed on your office letterhead:
   - 225.297.2750
   - BCBSLA – Network Administration
     PO Box 98029; BR, LA 70898-9029
   - network.administration@bcbsla.com

2. Complete our online interactive Provider Update Form at www.bcbsla.com -> I’m a Provider -> Form for Providers

3. Initially on your patient’s claim form

Claims submitted with an NPI not already reported, will be rejected.
When calling Provider Services (1.800.922.8866), you are required to enter a valid NPI & appropriate member ID prior to being connected to correct department.

Without your NPI and the member’s ID number, you are unable to call for:

- Customer Service Representatives
- Claims Status
- Benefits & Eligibility

**Scenario:**
- Member schedules and goes in for a wellness visit
- Member has wellness benefits that cover at 100%
- Doctor finds a medical condition
- Doctor files claim as a sick visit
- Member is upset that services did not cover under wellness

**Solution:**
You can bill both the wellness & sick visits for the same date of service:
- Bill the wellness E/M visit code on the claim with the appropriate diagnosis
- Bill the sick visit code on the same claim with Modifier -25 and the appropriate diagnosis

**How the Claim will Pay:**
- Wellness visit will process under wellness benefits
- Sick visit will process under sick benefits

Modifier -25 is used to report significant, separately identifiable E&M services by the same physician on the day of a procedure.

Please fully document the patient’s medical records to support both charges.
Modifier -52

**Partially reduced or eliminated procedures**

Currently, Blue Cross reduces the allowable charge by 20 percent for services billed with **Modifier -52**

Effective July 1, 2013, the percentage for outpatient facility charges will be reduced from 20 to 50 percent of the allowable charges.

**Example:**

Services were modified mid-procedure at the physician’s discretion such that the service furnished was less than usually required charges.

The professional reimbursement will continue to be reduced at 20 percent of the allowable charge.

Modifiers -73 & 74

**Discontinued Services**

*Report Modifier -73*

When a procedure is discontinued and anesthesia WAS NOT administered. Blue Cross applies the allowed amount at a 50 percent reduction.

*Report Modifier -74*

When a procedure is discontinued and anesthesia WAS administered. Blue Cross applies the full allowed amount *(no reduction is applied).*
Behavioral Health Codes

BCBSLA implements new behavioral health evaluation and management (E&M) code billing changes:

*Effective January 1, 2013*

- Psychiatrists and psychologists may bill E&M codes, if appropriate for the service provided and licensed to do so.
- New psychotherapy codes bundle as mutually exclusive to all E&M codes.

Note: Behavioral health providers contracted with Magellan, ValueOptions or any other healthcare carrier, should adhere to guidelines set forth by those carriers, as applicable, for their claims.

- When psychotherapy and E&M codes are billed on same claim, payment is applied to the line with the highest billed charge.
- Pharmacologic management CPT code 90863 will bundle as incidental to psychotherapy codes, which are already incidental to E&M codes.

Timely Filing

**BCBSLA & HMOLA Claims**
- must be filed within 15 months* of date of service.
- Claims received after 15 months* are denied & Blue member and Blue Cross are held harmless.

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

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

* Self-insured plans and plans from other states may have different timely filing guidelines.

* Self-insured plans and plans from other states may have different timely filing guidelines.

* Self-insured plans and plans from other states may have different timely filing guidelines.

* Self-insured plans and plans from other states may have different timely filing guidelines.
A Guide for Disputing Claims

Use this guide to inquire about:

- Corrected claims
- Rejection as a duplicate
- Authorization penalty
- Coordination of benefits
- Bundling
- Appeal that affects member’s cost-share
- Disputes that affect provider’s cost-share
- Medical policy denial
- All other claims processing inquiries

Reimbursement Review Form

Revised in March 2013

Use this form when:

- You disagree with how codes were bundled and/or denied
- Claim did not paid according to fee schedule and/or reimbursement amount is incorrect

Form should have clear instructions for dispute
Do not submit form with copy of claim
Do not submit form with a corrected claim
COB means coordinating with other health insurance coverage 
(where a patient is covered by two or more insurance plans)

Coordinating Benefits:
- Ask your patients about other coverage each time you provide services
- Indicate other insurance in Block 9 on the HCFA-1500 claim form
- File claims with the primary insurance carrier first
- After the primary carrier EOB is received, then file to the secondary carrier, attaching the primary EOB

Medicare Primary Coordination of Benefits
Blue Cross coordinates with Medicare like we do with any other carrier that is the primary carrier

We accept electronic COB-837 Facility & Professional claims
- COB claims can now be identified on electronic claims when a member has a primary commercial carrier and Blue Cross is the secondary payer
- This does not include Medicare-primary claims as they are already being received automatically in the electronic Medicare crossover process

COB Questionnaire Form

Coordination of Benefits Questionnaire
If you have a Blue patient who might have other health insurance coverage, give them a copy of the questionnaire during their visit

Ask the member to complete the form and send it to the Blue Plan where they have coverage

Members will find the appropriate address on their member ID card

This form may be used for BCBSLA and BlueCard® Out-of-State members

Available online at www.bcbsla.com
> I'm a Provider
> Forms for Providers

A copy of this guide is enclosed in your workshop folder
Coordination of Benefit (COB) information is available on the existing iLinkBLUE Coverage Information > Coverage Summary screen, located under the Coverage Information menu option.

Once the list of members appears, if COB information is available for the member, then a COB button will appear to the right of the Coverage Report button.

- Exceptions to the display of COB information:
  - FEP Contracts
  - Office of Group Benefits (OGB state employees)
  - Non-group contracts (we do not coordinate benefits for non-group contracts)

- The most current and relevant records will display. If a record has been terminated for greater than two years it will not display.

- BCBSLA periodically requests updated COB information from our membership. If we are awaiting COB information, then we will display an alert to let users know that we need information and that claims could pend or reject if we do not receive a response.
Subrogation

ALL claims submitted to BCBSLA MUST indicate if work-related injuries or illnesses or if services are related to an accident

Providers SHOULD bill the member only for any applicable deductible, coinsurance, co-pay and/or non-covered service

Providers should NOT:
• require the member or their attorney to guarantee payment of the entire billed charge
• require the member to pay the entire billed charge up front
• bill the 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

If amounts in excess of the reimbursement amount/allowable charge were collected, you should refund that amount to the member

See BlueCard Subrogation slide for more on out-of-state Blue members

Claims Assistance

• iLinkBLUE
  – Research claims, benefits, and member eligibility
  – Send Action Request on claim specific questions
  – 24/7 availability
    • For iLinkBLUE access call 1.800.216.2583 or email ilinkblue.providerinfo@bcbsla.com

• Provider Services 1.800.922.8866
  – For claims that cannot be resolved through iLinkBLUE
Contacting Provider Relations

The protocol for Provider Relations involvement in claims resolution is:

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

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

3. If claim is still not resolved, place a 2nd call to Provider Services. Ask for a supervisor to escalate claim for correct processing. An additional reference/task number will be issued. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

4. If the claim is still not resolved to your satisfaction, contact your Provider Relations representative. You will need to provide the pertinent information along with no less than two reference/task numbers and/or date(s) Action Request(s) was(were) submitted.

5. The Provider Relations representative then escalates the issue to the manager of the appropriate unit for handling. The unit manager will be responsible for the follow up and response to the provider.

1.800.217.9922, option 4 • provider.relations@bcbsla.com
Education on Demand

The Education on Demand page is the home for all network Manuals, Speed Guides, Tidbits and more...

Education on Demand

Provider Manuals give detailed descriptions of our programs and networks. View Speed Guides for a quick reference to common network codes and insurance. Tidbits are reference guides designed to the quick reference to the insurance codes.

Office Manuals – available at www.bcbsla.com & on iLinkBLUE

Hospital Manual – available only on iLinkBLUE
Speed Guides

Speed guides are typically one-page guides to networks, authorization requirements, billing guidelines and programs

(available online at www.bcbsla.com > I’m a Provider)

Tidbits

Tidbits are quick guides to help providers stay informed of our current business processes

• Availability Standards for Blue Cross Providers
• Becoming an iLinkBLUE User
• Blue surgical Safety Checklist
• General Provider FAQs
• Guide for Disputing Claims
• Identification Card Guide
• IVR Navigation Guide (Automated Benefits & Claim Status)
• Medical Record guidelines for BlueCard®
• Medicare Crossover Claims
• Pre-Authorization Hints
• Preparing for ICD-10
• Refund Request Guidelines for BlueCard

We will continue to develop additional Tidbits as processes are created or changed.
Currently available online are the iLinkBLUE Tutorials:

- Allowable Charges
- Authorizations
- BlueCard® - Out of Area
- Confirmation Reports
- Contract Number Search
- Coverage Information in iLinkBLUE
- Electronic Funds Transfer Messages
- Logging on to iLinkBLUE for the First Time
- Medical Code Editing
- Medical Policy Coverage Guidelines, Pre-Authorization/Pre-Certification
- Remittance Advice
- Setting Up a User ID in iLinkBLUE

The Education on Demand page is the home for provider Newsletters, current and archived

Available online at www.bcbsla.com > I’m a Provider > News
Emails & Addresses

Snail-mail Slowing You Down?

We often send out notifications via e-mail only and providers without a correspondence e-mail address on file with Blue Cross miss these communications.

2 easy ways to submit your correspondence e-mail address:

1. Via our online interactive Provider Update Form: www.bcbsla.com > I’m a Provider > Forms for Providers

2. Send an e-mail to provider.communications@bcbsla.com. Include your provider name, provider number and a contact name and phone number.
Provider Addresses

Is Your Snail-mail Address Correct?

Want to let us know of an address, phone, fax and/or email address change? Submit your new information via our online interactive Provider Update Form: www.bcbsla.com > I’m a Provider > Forms for Providers.
Provider Call Centers

Provider Services 1.800.922.8866
FEP Dedicated Unit 1.800.272.3029
OGB Dedicated Unit 1.800.392.4089

Other Provider Phone Lines

BlueCard Eligibility Line® – 1.800.676.BLUE (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 your provider file record
Option 2 – for question regarding credentialing/recredentialing
Option 3 – for questions regarding provider contracts
Option 4 – for questioning regarding provider relations

We have an interactive map of provider representatives:

- Network Development
- Provider Relations
- Statewide

Located under the “Provider Tools” section of our Provider Page at www.bcbsla.com.
Provider Relations

Wade Russell – wade.russell@bcbsla.com or 225.298.7639
manager

Anna Granen – anna.granen@bcbsla.com or 504.832.5842
Jefferson, Plaquemines, Orleans, St. Bernard, St Charles, St. James, St. John the Baptist, St Tammany, Washington

Jami Richard – jami.richard@bcbsla.com or 225.297.2653
Caldwell, E. Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, W. Carroll, and
E. Baton Rouge

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Acadia, Evangeline, Iberia, Jefferson Davis, St. Landry, St. Martin, Vermillion
Statewide e-Business Representative – assists with EFT and iLinkBLUE set-up

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Doreen Prejean • Mary Landry • Mary Reising
# Credentialing Team

**Credentialing Contact Information**

| Toll Free Number: 1.800.716.2299, option 2 (credentialing) and option 3 (provider file) |
| Fax Number: 225.297.2750 Email: Network.Administration@bcbsla.com |

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<thead>
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<tbody>
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**EDI (Electronic Provider Services)**

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

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

- **EDI Clearinghouse Services**
  - EDI Clearinghouse Support Desk
  - (225) 291-4334
  - ediclearinghousesupport@bcbsla.com
Multimedia Contacts

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

- Follow Blue Cross & CEO Mike Reitz on Twitter:
  www.twitter.com/BCBSLA
  www.twitter.com/MikeReitzCEO
  www.twitter.com/DrCarmouche

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

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InHealth
Care Management

- Blue Health Services  (disease management)
- Blue Touch  (case management)

See handouts in folder for more information on our Care Management programs
See handout in folder for more information on our Quality Blue programs

Q & A