Believe in BLUE
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Quick Reference Guide to Important Addresses and Phone Numbers

Claims Addresses
All completed claim forms should be forwarded to the following addresses for processing:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

FEP claims should be mailed to:

BCBSLA – FEP Claims
P. O. Box 98028
Baton Rouge, LA 70898-9029

Provider Network Administration
☎ Participation/Contracting/Credentialing Questions: (800) 716-2299 or (225) 297-2758
☎ Provider Relations: (225) 298-1552

Electronic services
☎ (225) 293-LINK (5465)

Appeals and Grievances/Provider Dispute Resolution
☎ Blue Cross and Blue Shield of Louisiana – Customer Service Unit
Appeals and Grievance Coordinator
P.O. Box 98045
Baton Rouge, LA 70898-9045
☎ (800) 376-7741 or (225) 293-0625

Provider Inquiries/Benefits/Eligibility
☎ (800) 392-4076
Section I: Blue Cross and Blue Shield of Louisiana Network Overview

Introduction

Participating providers are those physicians and allied health providers who have entered into a provider agreement with Blue Cross and Blue Shield of Louisiana (Blue Cross). As a participating provider in our Key Physician, Preferred Care PPO and/or Advantage Blue Networks, you join other providers linked together through a business relationship with Blue Cross.

Our networks emphasize the primary roles of the participating provider and Blue Cross and Blue Shield. They are designed to create a more effective business relationship among providers, consumers and Blue Cross and Blue Shield. Our participating provider networks:

- Facilitate providers and Blue Cross working together to voluntarily respond to public concern over costs
- Continue to give Blue Cross and Blue Shield subscribers freedom to choose their own providers
- Demonstrate providers’ support of realistic cost-containment initiatives
- Continue to assure providers of an equitable reimbursement and protect the fee-for-service concept
- Limit out-of-pocket expenses for patients to predictable levels and reduce their anxiety over the cost of medical treatment
Participating Provider Agreements

Your responsibilities and agreements as a participating provider are defined in your provider agreement(s). You should always refer to your agreement when you have a question about your network participation. As a participating provider, you are responsible for:

### Submitting claims for Blue Cross and Blue Shield subscribers.

This includes claims for inpatient, outpatient and office services. To ensure prompt and accurate payment, it is important that you provide all patient information on the HCFA-1500 claim form (or the UB-92 claim form for certain allied providers) including appropriate Physicians’ Current Procedural Terminology (CPT®) codes and ICD-9-CM diagnosis codes. Also, remember to include your Blue Cross provider number. The Claims Submission section of this manual gives specific information about completing the claim form as well as CPT® and ICD-9-CM coding information. The Allied Health Providers section gives specific information about completing the UB-92 claim form.

### Accepting Blue Cross’s payment plus the subscriber’s deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.

Blue Cross’s payment for covered services is based on your charge not to exceed Blue Cross’s allowable charge. You may bill the subscriber for any deductible, coinsurance, copayment and/or non-covered service. However, you agree not to collect from the subscriber any amount over Blue Cross’s allowable charge.

The Provider Payment Register summarizes each claim and itemizes patient liability, the amount above the allowable charge and other payment information. Additional information concerning the payment register is included in the Reimbursement section of this manual.

### Cooperating in Blue Cross’s cost-containment programs where specified in the Subscriber Contract/Certificate and not billing the subscriber or Plan for any services determined to be not Medically Necessary, unless the provider has notified the subscriber in advance in writing that certain not medically necessary services will be the subscriber’s responsibility. Generic or all-encompassing notifications will not be deemed to meet the specific notification requirement mentioned above.

Certain Plan Subscriber Contracts/Certificates include cost-containment programs such as prior authorization, concurrent review and case management. The subscriber’s identification card will contain telephone numbers for prior authorization. Also, the subscriber should inform you if his/her benefit program includes cost-containment provisions or incentives.

*CPT is a registered trademark of the American Medical Association.*
Blue Cross Network Overview

For more than 70 years, Blue Cross has worked to develop business relationships with doctors, hospitals and other health care providers throughout Louisiana. These relationships have allowed us to develop the largest, most comprehensive provider networks in the state.

With the number of insurance companies and network programs available, it can be quite challenging for providers to navigate the various administrative requirements of these programs. To help you better understand the Blue Cross networks in which you may participate, we are providing an overview of our provider network programs.

Traditional Managed Indemnity

This is our core network of Member Hospitals, Key Physicians and Participating Allied Providers. Providers who participate in this network agree to accept the negotiated reimbursement amount (allowable charge) as payment in full for covered services and agree not to collect from our subscribers any amount above the allowable charge. All Blue Cross participating providers agree to file claims for Blue Cross and Blue Shield (BCBS) subscribers and cooperate in cost-containment programs such as prior authorization, concurrent review and case management. Our Managed Indemnity subscribers carry ID cards with the traditional Blue Cross logo as shown, above.

Preferred Care PPO

Our Preferred Care PPO network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.

Providers participating in the Preferred Care PPO Network have signed a special agreement and agreed to an allowable charge different from the allowable charge paid when treating a Traditional Managed Indemnity subscriber.
A special Preferred Care logo distinguishes Preferred Care PPO subscribers from our other subscribers. This logo is located at the top right corner of the ID card as shown. The “PPO” in a suitcase logo identifies the nationwide BlueCard® Program.

Advantage Blue POS

Our Advantage Blue Point of Service (POS) includes:

- **Allied Providers**
- **Hospitals**
- **Primary Care Physicians** (PCPs) specializing in:
  - family practice
  - general practice
  - internal medicine
  - obstetrics/gynecology
  - pediatrics
- **Referral Specialists** (representing all medical specialties)

The Advantage Blue POS program encourages subscribers to select a PCP to coordinate their health care needs. When subscribers follow the guidelines of this program, they receive the highest level of benefits. However, they may seek care from a non-network provider at a greater cost to themselves. Subscribers with Advantage Blue POS carry the ID card above.

Federal Employee Program

The Federal Employee Program (FEP) provides benefits to federal employees and their dependents. These members access the Preferred Care PPO Network.

FEP members have two benefit plans from which they may choose: Standard Option and Basic Option. Under Standard Option, members receive the highest level of benefits when they receive care from in-network providers and reduced benefits when they receive care from out-of-network providers. Members with Basic Option receive no benefits when they receive care from out-of-network providers except for select situations such as emergency care.

For more information on FEP benefits, please see Section V: Benefit Information, page 57.
HMO Louisiana, Inc.

HMO Louisiana, Inc. (HMOLA) is a wholly owned subsidiary of Blue Cross. The HMOLA provider network is a select group of physicians, hospitals and allied providers who provide services to individuals and employer groups seeking managed care benefit plans.

Louisiana Blue Health Plans (LBHP), a managed care portfolio offered through HMOLA, allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a lower copayment when they receive services from PCPs. LBHP members carry an ID card similar to the ones shown here.

Please note: HMOLA providers should follow the guidelines set forth in this manual. Differences and additional guidelines can be found in the HMOLA Provider Office Manual, which is a supplement to this office manual.
BlueCard® Program

The BlueCard® Program links participating providers and the independent Blue Cross and Blue Shield (BCBS) Plans across the country and abroad with a single electronic network for professional, outpatient and inpatient claims processing and reimbursement. The program allows BCBS participating providers in every state to submit claims for patients who are enrolled through another Blues Plan to their local BCBS Plan.

You should submit claims for BCBS members (including Blue Cross only and Blue Shield only) visiting you from other areas directly to Blue Cross and Blue Shield of Louisiana. Blue Cross and Blue Shield of Louisiana is your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries.

How to Identify BlueCard Members

When out-of-area BCBS members arrive at your office or facility, be sure to ask them for their current membership ID card. The two main identifiers for BlueCard members are the alpha prefix and a “suitcase” logo.

Alpha Prefix

The three-character alpha prefix of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the Blue Plan or the national account to which the member belongs.

There are three types of alpha prefixes: plan-specific, account-specific and international.

Plan-specific alpha prefixes are assigned to every BCBS Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.

Account-specific prefixes are assigned to centrally-processed national accounts. National accounts are employer groups with offices or branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

Occasionally, you may see ID cards from foreign BCBS members. These ID cards will also contain three-character alpha prefixes. For example, “JIS” indicates a Blue Cross and Blue Shield of Israel member. The BlueCard claims process for international members is the same as that for domestic BCBS members.
ID cards with no Alpha Prefix

Some ID cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for information on how to file these claims. If that information is not available, call the BlueLine at (800) 392-4076.

“Suitcase” Logo

BlueCard® Traditional is a national program that offers members traveling or living outside of their Blue Plan’s area the traditional or indemnity level of benefits when they obtain services from a provider or hospital outside of their Blue Plan’s service area. Members are identified by the “empty suitcase” logo on their ID card.

BlueCard® PPO offers members traveling or living outside of their Blue Plan’s area the PPO level of benefits when they obtain services from a provider or hospital designated as a BlueCard PPO provider. Members are identified by the “PPO in a suitcase” logo on their ID card.

HMO patients serviced through the BlueCard® Program

In some cases, you may see BCBS HMO members affiliated with other BCBS Plans seeking care at your office or facility. You should handle claims for these members the same way you handle claims for Blue Cross and Blue Shield of Louisiana members and BCBS Traditional and PPO patients from other Blue Plans — by submitting them through the BlueCard Program. Members are identified by the “empty suitcase” logo on their ID card.

BlueCard members throughout the country have access to information about participating providers through BlueCard Access, a nationwide toll-free number (800) 810-BLUE [2583]) that allows Blue Cross and Blue Shield of Louisiana to direct patients to them. Members call this number to find out about BlueCard providers in another Blue Plan’s service area. You can also use this number to get information on participating providers in another Blue Plan’s service area.

How the Program Works

1. You may verify the patient’s coverage by calling BlueCard Eligibility at (800) 676-BLUE (2583). An operator will ask you for the alpha prefix on the member’s ID card and will connect you to the appropriate membership and coverage unit at the member’s plan. If you are unable to locate an alpha prefix on the member’s ID card, check for a phone number on the back of the ID card, and if that’s not available, call the BlueLine at (800) 392-4076.

2. After you render services to a BCBS subscriber, you should file the claim (according to your contractual arrangements) with Blue Cross and Blue Shield of Louisiana. Reminder: The claim must be filed using the three-character alpha prefix and identification number located on the patient’s ID card.
3. Once the claim is received, Blue Cross and Blue Shield of Louisiana electronically routes it to the subscriber’s own independent BCBS Plan.

4. The subscriber’s plan adjudicates the claim and transmits it to Blue Cross and Blue Shield of Louisiana, either approving or denying payment.

5. Blue Cross and Blue Shield of Louisiana reconciles payment and forwards it to you according to your payment cycle.

6. The subscriber’s local Blue Plan sends a detailed Explanation of Benefits report to the subscriber.

**Types of claims filed through the program**

All professional claims as well as facility inpatient and outpatient claims for BCBS out-of-state subscribers should be filed to Blue Cross and Blue Shield of Louisiana.

**BlueCard Claims Submission**

Submit claims to:

\[$^5\] BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

If you contract directly with the member’s BCBS Plan, you should file the claim directly to the member’s Plan. When calling to authorize an admission or other services, you should continue to call the telephone numbers listed on the subscriber’s ID card.
RxBLUE: Our Medicare Part D Plan

On January 1, 2006, Medicare began offering insurance coverage for prescription drugs through a new program called Medicare Part D. Blue Cross and Blue Shield of Louisiana participates in the Part D program through a Prescription Drug Plan (PDP) called RxBLUE.

RxBLUE benefits are tied to a closed formulary that is a smaller subset of our commercial formulary, among other differences. Providers can view the RxBLUE formulary online at the special RxBLUE page of www.bcbsla.com. Additionally, RxBLUE is available through ePocrates at www.epocrates.com.

Medicare beneficiaries who are entitled to Part A and/or enrolled in Part B and residing in Louisiana are eligible for RxBLUE.

Initial enrollment began on November 15, 2005, and will continue through May 15, 2006. Eligible beneficiaries who delay enrollment after May 15, 2006, may pay a penalty and may be locked out of enrolling until the next open enrollment period (i.e. November 15, 2006 - December 31, 2006). For individual beneficiaries who are newly entitled to Medicare, the Part D initial enrollment period is the same as the Part B enrollment period.

For more information about Medicare Part D, visit the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/medicareform.

Credentialing Program

Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers. This process consists of two parts: credentialing and recredentialing.

Credentialing Process

Credentialing consists of an initial full review of a provider’s credentials at the time of application to our networks.

1. If a provider applies for participation in any of our networks, he/she must be credentialed before being approved for participation. A Louisiana Standardized Credentialing Application (LSCA) is forwarded to the provider upon receipt of his/her request for participation in our networks.

2. The form is completed by the provider and submitted to Blue Cross for approval.

3. Upon receipt of the completed LSCA, credentialing staff verify the provider’s state license, professional malpractice liability insurance, Federal DEA Certificate, etc., according to the Plan’s policies and procedures and American Accreditation Healthcare Commission/Utilization Review Accreditation Committee (URAC) standards.
4. Blue Cross staff and the Credentialing Subcommittee, review the provider’s credentials to ascertain compliance with the following credentials criteria. All participating providers must maintain this criteria on an ongoing basis:
   - Unrestricted license to practice medicine in Louisiana as required by state law
   - Agreement to complete regular credentialing and recredentialing forms
   - Agreement to participate in the Blue Cross quality of care and utilization review programs
   - Agreement to maintain a comprehensive outpatient medical record on each Blue Cross patient
   - Professional liability insurance in force that meets required amounts
   - Malpractice claims history that is not suggestive of a significant quality of care problem
   - Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours
   - Absence of patterns of behavior to suggest quality of care concerns
   - Utilization review pattern consistent with peers and congruent with needs of managed care
   - No sanctions by either Medicaid or Medicare
   - No disciplinary actions either pending or imposed
   - No felony or serious misdemeanor convictions
   - No current drug or alcohol abuse

5. Based upon compliance with the criteria, Blue Cross staff will recommend to the Credentialing Subcommittee that a provider be approved or denied participation in our networks.

6. The Credentialing Subcommittee, comprised of network practitioners, will make a final recommendation of approval or denial of a provider’s application.

**Recredentialing**

After a provider has completed the initial credentialing process, he/she will undergo recredentialing approximately every three years thereafter.

The recredentialing process is conducted in the same manner as outlined in the Credentialing section above.

**Status Changes**

A provider is required to report changes to his/her credentialing criteria to Blue Cross within 30 days from the date of occurrence. Failure to do so may result in immediate termination.
Provider Administrative Dispute Resolution and Arbitration Processes

Blue Cross has established a general dispute resolution process to resolve any problems and disputes concerning Blue Cross’s right of offset and/or recoupment. To initiate the general dispute resolution process, providers should send a written notice with a brief description of the matter in dispute to:

Blue Cross and Blue Shield of Louisiana
ATTN: Appeals/Grievance Coordinator
P. O. Box 98045
Baton Rouge, LA 70898-9045

If the provider is not satisfied with the resolution of the matter, the matter in controversy shall be submitted to the Executive Management of Blue Cross, at which time the disputed matter will be considered and the provider will be afforded an opportunity to present supporting statements and documentation. The Executive Management of Blue Cross shall review the dispute within thirty (30) days of receipt of written notice and make a recommendation within fifteen (15) days after the review and the submission of evidence submitted by the parties.

However, in the event any dispute arises from the terms and conditions set forth in the provider agreement, and the dispute is not resolved within a reasonable time, Blue Cross and the provider agree to binding arbitration as fully described in the provider agreement and as generally described as follows: The arbitration process may be initiated by either the provider or Blue Cross and Blue Shield of Louisiana sending a written notice setting forth the basis of the dispute and the party’s desire to arbitrate to the other party. The process follows the rules and procedures of either the American Arbitration Association or the American Health Lawyers’ Association or another nationally recognized arbitration association acceptable to Blue Cross. The arbitration process is conducted in Baton Rouge before a panel of three arbitrators: one arbitrator selected by each party and the third arbitrator chosen by the first two arbitrators. The decision of the arbitrators is final and is binding on the parties and enforceable under the laws of the state of Louisiana.

The general dispute resolution process and arbitration processes described above does not supersede or replace the member appeals and grievances process for medical necessity and appropriateness, investigational, experimental or cosmetic coverage determinations as described in Section VI.
Provider Availability Standards

Blue Cross is committed to providing high quality health care to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. Within this context and with input and approval from various network providers who serve on our Medical Quality Management Committee, we developed the following Provider Availability Standards and Acute Care Hospital Availability Standards.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>ACCESS STANDARD</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate access, 24 hours a day, 7 days a week</td>
<td>• Loss of consciousness&lt;br&gt;• Seizures&lt;br&gt;• Chest pain&lt;br&gt;• Severe bleeding&lt;br&gt;• Trauma</td>
</tr>
<tr>
<td>Urgent</td>
<td>30 hours or less</td>
<td>• Severe or acute pain&lt;br&gt;• High fever in relation to age and condition</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>5 to 14 days</td>
<td>• Backache&lt;br&gt;• Suspicious mole</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>6 weeks or less</td>
<td>• Routine physical&lt;br&gt;• Well baby exam&lt;br&gt;• Annual Pap smear</td>
</tr>
</tbody>
</table>

Additional Availability Standards

- Network physicians are responsible for assuring access to services 24 hours a day, 365 days a year other than in an emergency room for non-emergent conditions. This includes arrangements to assure patient awareness and access after hours to another participating physician.
- All network providers must offer services during normal working hours, typically between 9 a.m. and 5 p.m.
- Average office waiting times should be no more than 30 minutes for patients who arrive on time for a scheduled appointment.
- The physician’s office should return a patient’s call within four to six hours for an urgent/acute medical question and within 24 hours for a non-urgent issue.
Acute Care Hospital Availability Standards

- Acute care hospitals are responsible for assuring access to services 24 hours a day, 365 days a year.
- All contracted hospitals must maintain emergency room or urgent care services on a 24-hour basis and must offer outpatient services during regular business hours, if applicable.
Blue Cross and Blue Shield of Louisiana
Provider Directories

As a participating provider, your name is included in Blue Cross’s product-specific provider directories, which are distributed to all subscribers and featured at our website, www.bcbsla.com. Participating providers are listed in the directories by parish in alphabetical order under their specialty(ies).

We make every effort to ensure the information in our provider directories is current and accurate. If new providers join your practice, if providers in your clinic retire or move or if you close/merge a practice, please notify Provider Network Administration in writing. A Provider Update Request Form is provided on the following page and can be used to notify us of changes or additions to provider directories. You may also complete the update form online at www.bcbsla.com. Simply highlight the drop-down menu beneath “Provider” and click on “Forms for Providers.” Then select the Provider Update Form.
Use this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include tax identification number changes, address changes, etc. Please type or print legibly in black ink. If you need more space, attach additional sheets and reference the question(s) being answered.

**GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Provider’s Last Name</th>
<th>First Name</th>
<th>Middle</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Name</td>
<td></td>
<td></td>
<td>Tax ID Number</td>
</tr>
<tr>
<td>Office Hours</td>
<td>Age Range</td>
<td></td>
<td>National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>Name of Individual Completing This Form</td>
<td>Phone Number</td>
<td>Fax Number</td>
<td></td>
</tr>
</tbody>
</table>

**BILLING ADDRESS** (address for payment registers, reimbursement checks, etc.)

<table>
<thead>
<tr>
<th>Former Billing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, State and Zip Code</td>
</tr>
</tbody>
</table>

**New Billing Address**

<table>
<thead>
<tr>
<th>City, State and Zip Code</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail Address</td>
<td>Effective Date of Address Change</td>
<td></td>
</tr>
</tbody>
</table>

**CORRESPONDENCE ADDRESS CHANGE** (address for manuals, newsletters, etc.)

<table>
<thead>
<tr>
<th>Former Correspondence Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, State and Zip Code</td>
</tr>
</tbody>
</table>

**New Correspondence Address**

<table>
<thead>
<tr>
<th>City, State and Zip Code</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail Address</td>
<td>Effective Date of Address Change</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL ADDRESS CHANGE**

<table>
<thead>
<tr>
<th>Former Physical Address</th>
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</thead>
<tbody>
<tr>
<td>City, State and Zip Code</td>
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</tbody>
</table>

**New Physical Address**

<table>
<thead>
<tr>
<th>City, State and Zip Code</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail Address</td>
<td>Effective Date of Address Change</td>
<td></td>
</tr>
</tbody>
</table>
TAX IDENTIFICATION NUMBER CHANGE

<table>
<thead>
<tr>
<th>Former Clinic/Group Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Former Tax ID Number</td>
<td>Through Date of Former Tax ID Number</td>
</tr>
<tr>
<td>New Clinic/Group Name</td>
<td></td>
</tr>
<tr>
<td>New Tax ID Number</td>
<td>Effective Date of New Tax ID Number</td>
</tr>
</tbody>
</table>

Please attach a copy of your new IRS Employer Identification Number Letter.

NETWORK TERMINATION

<table>
<thead>
<tr>
<th>Terminated Network</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>Provider Number</td>
<td>Tax ID Number</td>
<td></td>
</tr>
<tr>
<td>Reason for Termination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NETWORK TERMINATION (all networks)

| Terminated Address |  |
|--------------------|  |
| City, State and Zip Code | Phone Number |  |
| Provider Number | Tax ID Number |  |
| Reason for Termination | Effective Date |  |

COMMENTS

Please return this form to:

Attn: Network Operations
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

(225) 297-2750 (fax)

If you have any questions about this form, please call Network Operations at:

(800) 716-2299, Option 3
(225) 297-2758 (Baton Rouge Area)
Section II: Claims Submission

Filing Claims

As a participating provider, you agree to submit claims for Blue Cross and Blue Shield subscribers on the HCFA-1500 Health Insurance Claim Form. All applicable information should be completed in full, including CPT® codes, ICD-9-CM diagnosis codes and applicable medical records to support the use of modifiers or unlisted codes with a charge greater than $300 to ensure payment is made to you accurately and without delay.

The following pages contain an example of a claim form and instructions on completing the HCFA-1500 claim form.

All completed claim forms should be forwarded to the following addresses for processing:

| Blue Cross and Blue Shield of Louisiana                      |
| P. O. Box 98029                                             |
| Baton Rouge, LA 70898-9029                                  |

FEP claims should be mailed to:

| BCBSLA – FEP Claims                                       |
| P.O. Box 98028                                            |
| Baton Rouge, LA 70898-9028                                |

Timely Filing and Refunds Process

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

Please note: Not all Subscriber Contracts/Certificates follow the 15-month claims filing limit. FEP claims must be filed by December 31 of the year after the year the service was rendered. Medicare claims must be filed within 24 months of the date of service. Self-insured plans and plans from other states may have different timely filing guidelines. Please call the BlueLine at (800) 392-4076 to determine what the claims filing limits are for your patients.

There may be times when Blue Cross must request refunds of payments previously made to providers. When refunds are necessary, Blue Cross notifies the provider of the claim in question 30 days prior to any adjustment. The notification letter explains that Blue Cross will deduct the amount owed from future payment registers unless the provider contacts us within 30 days. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the claim’s date of payment. Blue Cross and the participating provider agree to hold each other and the subscriber harmless for underpayments or overpayments discovered after 15 months from the date of payment.

CPT is a registered trademark of the American Medical Association.
If Blue Cross has made any omissions or underpayments, the Plan will make payment for such errors as soon as they are discovered or within 30 days of written notice from the participating provider regarding the error.

We make every effort to pay claims in a timely manner; however, when a clean claim is not paid on time, we follow the late payment penalty guidelines outlined in House Bill 2052/Regulation 74. Providers automatically receive penalty payment for claims that are not processed in the time frames set forth by House Bill 2052/Regulation 74. The additional payment will almost always appear on the same payment register as the claims payment and can be identified by the status code “ST, Statutory Adjustment.”

Please note: House Bill 2052/Regulation 74 does not apply to FEP, self insured plans, insured ERISA plans, worker’s compensation plans or state employee group benefit programs. Also, the late payment penalty does not apply if the claim is delayed through the fault of the claimant.

**Provider Number**

Each participating provider should use his/her ten-position provider number (individual Social Security Number with a suffix) when filing claims to ensure payment is made accurately and on time. Clinics also should use each provider’s individual ten-position provider number when filing claims.

The provider number is used for internal claims processing and reporting. Claims payments are reported to the Internal Revenue Service (IRS) using the individual provider’s or clinic’s tax identification number (TIN). An exception to the above occurs if a provider does not have a TIN and uses his/her Social Security Number to report income.

The ten-position provider number should be placed in Block 33 on the HCFA-1500 claim form when billing for services provided by one provider. When billing for services by two or more providers, each provider’s ten-position provider number should be placed in block 24K of the HCFA-1500 claim form, and the TIN should be placed in block 25.

If you have any questions about your provider number, please contact Provider Network Administration at (800) 716-2299, option 3 or (225) 297-2758.

**Please note:** Effective May 23, 2007, all covered entities must use the National Provider Identifier (NPI) to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Centers for Medicare and Medicaid Services (CMS) began assigning NPIs on May 23, 2005. For more information on how to obtain an NPI, visit [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov) or [www.cms.hhs.gov](http://www.cms.hhs.gov).
Procedure and Diagnosis Codes and Guidelines

Blue Cross uses Physicians’ Current Procedural Terminology (CPT®), ICD-9-CM and HCPCS codes for processing claims. Because medical nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please ensure that your office is using the current edition of the code book, reflective of the date of service of the claim. The applicable code books include, but are not limited to, ICD-9-CM Volumes 1, 2 and 3; CPT® and HCPCS.

New CPT® codes will be accepted by Blue Cross as they become effective.

Helpful Hints for Diagnosis Coding

- Always report the primary diagnosis code on the claim form.
  Principal Diagnosis – “Reason for service or procedure”
- Report up to four diagnosis codes when services for multiple diagnoses are filed on the same claim form.
- Report all digits of the appropriate ICD-9-CM code(s).
- Report the date of accident if the ICD-9-CM code is for an accident diagnosis.
- HIPAA regulations require valid ICD-9-CM diagnosis codes.

_CPT is a registered trademark of the American Medical Association._
Modifiers

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

To ensure you receive the most accurate payment for services you render, Blue Cross recommends using modifiers when you file claims. For Blue Cross claims filing, modifiers, when applicable, always should be used by placing the valid CPT® or HCPCS modifier(s) in Block 24D of the HCFA-1500 claim form. A complete list of valid modifiers is listed in the most current CPT® or HCPCS code book. Please ensure that your office is using the current edition of the code book reflective of the date of service of the claim. If necessary, please submit medical records with your claim to support the use of a modifier.

Please use the following tips to avoid the possibility of rejected claims:

- Use valid modifiers. Blue Cross considers only CPT® and HCPCS modifiers that appear in the current CPT® and HCPCS books as valid.
- Indicate the valid modifier in Block 24D of the HCFA-1500. We collect up to four modifiers per CPT® and/or HCPCS code.
- Do not use other descriptions in this section of the claim form. In some cases, our system may read the description as a set of modifiers and this could result in lower payment for you.
- Avoid excessive spaces between each modifier.
- Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion of Block 24D.

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## Modifier Guidelines

The table below lists many of the modifiers that Blue Cross accepts. If you have any questions about billing with modifiers, please call the Provider Network Administration at (800) 716-2299, option 3 or (225) 297-2758.

<table>
<thead>
<tr>
<th>CPT/HCPCS Modifiers</th>
<th>Description</th>
<th>Blue Cross use</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual procedural service</td>
<td>A 15 to 20 percent additional payment will be considered for minor additional circumstances; 25 percent additional payment will be considered for very unusual additional circumstances.</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated evaluation and management service by the same physician during a postoperative session</td>
<td>Pays separate allowable charge.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service</td>
<td>Pays separate allowable charge.</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>Pays professional component of the allowable charge.</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Payment based on 150% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
<td>Generally pays primary or highest allowable procedure at 100% of allowable charge and rest at 50% of allowable charge.</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
<td>Allowable charge will be reduced by 20 percent.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure</td>
<td>Pays 50% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
<td>Pays 80% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>55</td>
<td>Post-operative management only</td>
<td>Pays 20% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>56</td>
<td>Pre-operative management only</td>
<td>Pays 10% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>Pays separate allowable charge.</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
<td>If allowed, pays 120% of allowable charge divided between both surgeons.</td>
</tr>
<tr>
<td>78</td>
<td>Returns to the operating room for a related procedure during the post-operative period</td>
<td>Pays 80% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>CPT/HCPCS Modifiers</td>
<td>Description</td>
<td>Blue Cross use</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
<td>Pays 20% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon</td>
<td>Pays 20% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
<td>Pays 20% of allowable charge for applicable codes.</td>
</tr>
<tr>
<td>AK</td>
<td>Nurse practitioner, rural, team member</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>AL</td>
<td>Nurse practitioner, non-rural, team member</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>AN</td>
<td>PA services for other than assistant-at-surgery, non-team member</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>AS</td>
<td>Physician assistant, nurse practitioner, or clinical nurse specialist for assistant at surgery</td>
<td>Pays at 85% of assistant surgeon allowable charge for applicable codes.</td>
</tr>
<tr>
<td>AU</td>
<td>Physician assistant for other than assistant-at-surgery, team member</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>AV</td>
<td>Nurse practitioner, rural, non-team member</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>MS</td>
<td>Six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty</td>
<td>Pay rental amount once every six months after purchase price reached for applicable codes.</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
<td>Payment based on purchase allowable charge.</td>
</tr>
<tr>
<td>RR</td>
<td>Rental</td>
<td>Payment based on rental allowable charge up to purchase allowable charge.</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
<td>Pays 85% of allowable charge.</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
<td>Pays technical component of the allowable charge.</td>
</tr>
</tbody>
</table>

**Billing Modifiers -22, -24 and -25**

When using modifier -22 (unusual procedural services), -24 (unrelated evaluation and management service by the same physician during a postoperative session) or -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), please attach to the claim form a medical or operative report and an explanation of why the modifier is being submitted or copies of applicable medical records. Without this information, the modifier will not be recognized and the standard allowable charge will be applied without review or consideration of the modifier.

It is not appropriate to bill modifier -22 for an office visit, X-ray, lab or evaluation and management services.
Billing for Surgical Assistant Services

The following provider types may be reimbursed for procedures approved to have an assistant at surgery:

- Certified registered nurse first assistants (CRNFA)
- Nurse practitioners
- Physician’s assistants
- Registered nurse first assistants (RNFA)

FEP contracts will pay for registered nurse surgical assistant services for those procedures approved to have an assistant at surgery.

The above provider types should file claims using the supervising physician’s Blue Cross 10-digit individual provider number and they should use the -AS modifier when billing for surgical assistant services. They should not use modifiers -80, -81 or -82. These modifiers should be used by physicians only. Reimbursement will be 85 percent of the assistant surgeon allowable charge.

Unlisted Codes

To expedite claims processing and payment, providers should submit the following information when filing unlisted codes:

- Description of service and operative report if surgery is involved
- Invoice if durable medical equipment (DME) is involved
- National Drug Code (NDC) and drug name if submitting a J code or other drug code and invoice for the drug(s) if billed charges on a single date of service for injectable drug(s) exceeds $200.

Radiology, Pathology and Laboratory

Modifiers are used to report both the professional and technical components for radiology, pathology and laboratory services. Professional component only or technical component only codes do not require modifier -26 or -TC.

Modifier rules are as follows:

- Use modifier -26 when billing separately for the professional component of a service.
- Use modifier -TC when billing separately for the technical component of a service.
- Total component (global) billing does not require a modifier.
• To ensure prompt and correct payment for your services, always use the appropriate modifier.

When billing for diagnostic and therapeutic hospital-based physician services, you should only bill the professional component and such billing should be submitted on the HCFA-1500 claim form. Blue Cross will not reimburse technical components associated with hospital inpatient and outpatient services.

The technical and/or professional components for all radiology and other imaging services may be billed by the PHYSICIAN only if he/she actually renders the service. The PHYSICIAN may not bill Blue Cross for the technical and/or professional component of any diagnostic test or procedure, including but not limited to, X-rays, ultrasound, or other imaging services, computerized axial tomography, or magnetic resonance imaging by utilizing another entity’s provider number. The referring provider may not receive compensation, directly or indirectly, from the provider who rendered the service.

Multiple Surgical Procedures

Multiple surgical procedures are procedures performed during the same operative session. Bilateral procedures are considered multiple procedures.

When multiple procedures are performed, the primary or major procedure is considered to be the procedure with the greatest value based on the allowable charge and may be reimbursed up to the allowable charge. The CPT® code modifier used to report multiple procedures is -51. The CPT® code modifier to report bilateral procedures is -50.

If a service includes a combination of procedures, one code should be used rather than reporting each procedure separately. If procedures are coded separately, Blue Cross may bundle the procedures and apply the appropriate allowable charge.

Secondary covered procedures are reimbursed up to 50 percent of the allowable charge.

Equipment, Devices and Supplies

Blue Cross will not reimburse non-hospital providers for equipment, devices or supplies used in conjunction with hospital inpatient or outpatient services. Reimbursement for these services is included in the hospital’s payment.

Code Editing: Billing Practices Subject to Reduction

Unbundling occurs when two or more CPT® or HCPCS codes are used to describe a procedure performed when a single, more comprehensive code exists that accurately describes the entire
procedure. The unbundled procedures will be rebundled for assignment of the proper comprehensive code as determined by Blue Cross. The allowable charge includes the rebundled procedure or service. Blue Cross will provide benefits according to the proper comprehensive code for the rebundled procedure or service, as determined by Blue Cross.

Reductions in payment for multiple surgical, bilateral and combined procedures are considered above allowable amounts and appear on the payment register in the above allowable amount column. These amounts are not collectable from the BCBS subscriber.

Co-Surgery is defined as two surgeons of different specialties operating together to perform a single surgery, usually expressed under one CPT® code. For co-surgeries, Blue Cross allows 120 percent of the allowable charge and divides that amount equally between the two surgeons. Additional assistants are not covered, since contract benefits have already been paid.

Incidental covered procedures, such as the removal of appendix at the time of other intra-abdominal surgery with no pathology, are not reimbursed separately. The incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the more extensive procedure. The allowable charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

Mutually exclusive procedures are two or more procedures that usually are not performed at the same session on the same patient on the same date of service. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the physician should be submitting only one of the codes.

Evaluation and Management (E&M) rules apply to the E&M services included in CPT® code ranges 99201-99499 and Miscellaneous Services codes 99024 and 99025. The separate billing of an E&M service will not be allowed when a substantial diagnostic or therapeutic procedure has been performed on the same date of service by the same provider.
Sample HCFA-1500 Claims Filing Form
Health Insurance Claim Form (HCFA-1500) Explanation

1. **Type(s) of Health Insurance** - Indicate coverage applicable to this claim by checking the appropriate block(s).

   1a. **Insured’s I.D. Number** - Enter the subscriber’s Blue Cross and Blue Shield identification number, including their three-character alpha prefix, exactly as it appears on the identification card.

2. **Patient’s Name** - Enter the full name of the individual treated.

3. **Patient’s Birth Date** - Indicate the month, day and year. **Sex** - Place an X in the appropriate block.

4. **Insured’s Name** - Enter the name from the identification card except when the insured and the patient are the same; then the word “same” may be entered.

5. **Patient’s Address** - Enter the patient’s complete, current mailing address and phone number.

6. **Patient’s Relationship to Insured** - Place an X in the appropriate block. Self - Patient is the subscriber. Spouse - Patient is the subscriber’s spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the subscriber’s grandchild, adult-sponsored dependent or of relationship not covered previously.

7. **Insured’s Address** - Enter the complete address; street, city, state and zip code of the policyholder. If the patient’s address and the insured’s address are the same, enter “same” in this field.

8. **Patient Status** - Check the appropriate block for the patient’s marital status and whether employed or a student (single, married, other; employed, full-time student, part-time student).

9. **Other Health Insurance Coverage** - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).

10. **Is patient’s condition related to:** a. Employment (current or previous)?: b. Auto Accident?: c. Other Accident?:. Check appropriate block if applicable.

11. Not required.

12. **Patient’s or Authorized Person’s Signature** - Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or “Signature on File” and date required. “Signature on File” indicates that the signature of the patient is contained in the provider’s records.
13. **Insured’s or Authorized Person’s Signature** - Payment for covered services is made directly to participating providers. However, you have the option of collecting for office services from subscribers who do not have a copayment benefit and having the payments sent to the patients. **To receive payment for office services when the copayment benefit is not applicable, Block 13 must be completed. Acceptable language is:**

   a. Signature in block
   b. Signature on file
   c. On file
   d. Benefits assigned
   e. Assigned
   f. Pay provider

   **Please Note:** Assignment language in other areas of the HCFA-1500 claim form or on any attachment is not recognized. If this block is left blank, payment for office services will be sent to the patient. Completion of this block is not necessary for other places of treatment.

14. **Date of Current** - Enter the date of the first illness, injury or pregnancy.

15. **Same or Similar Illness or Injury** - Indicate appropriate date(s).

16. **Dates of Disability** - Enter dates, if applicable.

17. **Name of Referring Physician** - Enter the referring physician’s complete name, if applicable.

   17a. **Not required.**

18. **For Services Related to Hospitalization** - Enter dates of admission to and discharge from hospital.

19. Not required.

20. **Laboratory Work Performed Outside Your Office** - Enter, if applicable.

21. **Diagnosis or Nature of Illness or Injury** - Enter the ICD-9-CM code and/or description of the diagnosis.

22. Not required.

23. **Required for Advantage Blue POS and HMOLA** - Enter the authorization number obtained from Blue Cross/HMOLA, if applicable.

24. A. **Date(s) of Service** - Enter the “from” and “to” date(s) for service(s) rendered.

   B. **Place of Service** - Enter the appropriate place of service code. Place of service codes are:
C. **Type of Service** - Enter the Type of Service code that represents the services rendered.

D. **Procedures, Services, or Supplies** - Enter the appropriate CPT® or HCPCS code. Please ensure your office is using the most current CPT® and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.

E. **Diagnosis Code** - Enter the numeric code that corresponds with the diagnosis code in Block 21 when more than one diagnosis is given. Refer to the Procedure and Diagnosis Codes and Guidelines section of Section II: Claims Submission of this manual for more information.

F. **Charges** - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.

G. **Days or Units** - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents.

H. Not Required - For Blue Cross office use only.

I. Not Required - For Blue Cross office use only.

J. Not Required - For Blue Cross office use only.

K. Each provider’s ten-position provider number should be indicated in this block when billing for multiple physicians’ services on the same claim.

25. **Federal Tax I.D. Number** - Enter the provider’s/clinic’s federal tax identification number to which payment should be reported to the Internal Revenue Service.

26. **Patient’s Account Number** - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register only if it is indicated on the claim form.

27. **Accept Assignment** - Not applicable - Used for government claims only.

28. **Total Charge** - Total of all charges in Item F.

29. Not Required.

30. Not Required.
31. **Signature of Provider** - Provider’s signature required, including degrees and credentials. Rubber stamp is acceptable.

32. **Name and Address of Facility** - Required, if services were provided at a facility other than the physician’s office.

33. **Physician’s Name, Address, Provider Number, Etc.** - Enter complete name, address, telephone number, and provider number. **Your Blue Cross ten-position provider number is essential for claims processing purposes.**
Claims Filing Guidelines

Blue Cross scans all paper claims to eliminate the need to manually enter the claims data into our system. Please follow the guidelines below to ensure that your claims will be scanned properly, which will allow you to benefit from faster, more accurate claims processing.

- Laser printed claims produce the best scanning results. If you use a dot-matrix printer, please use a standard 10 or 12 font ribbon when the type begins to fade.
- Use HCFA-1500 forms that are printed on good quality paper. When the paper is too thin, the claim cannot be scanned properly.
- Type or computer print all information within the appropriate blocks on the HCFA-1500 claim form. Information should not overlap from one block into another.
- Type or computer print Block 14. This information cannot be handwritten because only typed information can be scanned and converted to text file for our system to process.
- If there is a signature in Block 31, it should not overlap into Block 25 (Federal Tax ID number) because the Tax ID number cannot be read.
- Do not use any stamps or stickers on your claim forms. The scanning equipment has a lamp that distorts stamps with black ink and completely removes any information with red ink. Therefore, stamps with pertinent information in red ink, such as “Benefits Assigned” or “Corrected Copy,” will be lost if the claim is scanned.
Electronic Data Interchange

Providers can decrease paperwork and increase operating efficiency with Electronic Data Interchange (EDI). EDI is the fastest, most efficient way to exchange eligibility information, payment information, claims and other transactions related to the business operation of a health care organization. Blue Cross’s experienced EDI staff is ready to help providers determine the best electronic solution for their needs.

System-to-System Electronic Transactions

Various health care transactions can be submitted electronically to the Blue Cross clearinghouse in a system-to-system arrangement. Blue Cross does not charge a fee for electronic transactions; however, the trading partner is responsible for its own expenses incurred for sending and/or receiving electronic communications.

You can send your transactions to Blue Cross via indirect submission through a clearinghouse or through direct submission to the BCSBLA EDI Clearinghouse.

For more information about system-to-system electronic transactions, please call EDI at (225) 291-4334.

ACTS 2000

ACTS 2000 (Automated Claims Transfer System) is a claims entry and transmission software package designed and distributed by Blue Cross. Blue Cross, Medicare and Medicaid professional claims can be billed electronically through ACTS 2000. The claims are transmitted to the Blue Cross EDI Clearinghouse. Your Blue Cross claims are then forwarded to one of our various systems for processing. Medicare and Medicaid claims are bundled with claims from other submitters and forwarded to the respective payer on a daily basis.

ACTS 2000 offers the capabilities of creating a database, which stores patient information for later transmission (referred to as batch submission). The stored patient information can be easily recalled for subsequent claims submissions, thus eliminating repetitive data entry. Claim editing capabilities reduces rejected claims. Users receive a transmission response file once the claims are successfully received by Blue Cross.

ACTS 2000 means faster payments and faster collections. This software package is user-friendly, even for people with no computer experience.

For more information about ACTS 2000, please call EDI at (225) 293-LINK (5465).
iLinkBLUE Provider Suite

iLinkBLUE Provider Suite is a website that allows providers to verify members’ eligibility, coinsurance and deductible information, file claims electronically, check claims status, and more from an Internet connection.

iLinkBLUE features more than 30 applications and allows providers to have immediate access to Blue Cross subscriber, claims and authorization data from any Internet-ready desktop. Using iLinkBLUE, providers can:

- Verify eligibility and benefit coverage.
- Verify dollar amounts remaining for deductible and out-of-pocket expenses. This information is updated daily.
- Electronically submit HCFA-1500 and UB-92 claims for Louisiana subscribers, FEP subscribers, out-of-state members, Medicare and Medicaid patients.
- Obtain status of paid, rejected and pended claims and authorization verification.
- Submit inquiries electronically.
- View and print current accepted/not accepted claims reports.
- View and print payment registers on Monday. Providers who do not use iLinkBLUE are mailed their registers on Wednesday of each week.
- View fee schedules online.
- And much more!

iLinkBLUE is free of charge for physicians and professional providers.

To learn more about iLinkBLUE, please call EDI at (225) 293-LINK (5465) or e-mail ilinkblue.providerinfo@bcbsla.com.
Electronic Funds Transfer (EFT)

Blue Cross requires all providers to be a part of our electronic funds transfer (EFT) program. EFT means faster payment and no more waiting for mail delivery or time-consuming bank deposits. With EFT, Blue Cross deposits your payment directly into your checking or savings account. EFT, like iLinkBLUE, is a free service to physicians and professional providers.

With EFT, your Weekly Provider Payment Register will be available for viewing in the iLinkBLUE Provider Suite. You will not receive a payment register in the mail, and you must have iLinkBLUE Provider Suite to be eligible for EFT.

For more information on EFT, please call (225) 293-LINK (5465) or e-mail ilinkblue.providerinfo@bcbsla.com.

Electronic Remittance Advice (ERA)

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Payment Register. Once downloaded at the provider’s office, the remittance file can be uploaded into an automated posting system, thus eliminating a number of manual procedures. The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible. Providers who receive payment checks directly from Blue Cross can still expect to receive a copy of the payment register with the payment check.

Fees

ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an upfront fee from your vendor for programming. From that point, you may receive the Blue Cross weekly remittance advice at no charge. For more information, please contact EDI at (225) 291-4334.
Coordination of Benefits (COB)

Other health insurance coverage information is important in the coordination of benefits (COB) process. COB occurs when a subscriber is covered by two or more insurance plans.

You can assist in the COB process by asking your BCBS patients if they have other coverage and indicating this information in Block 9 on the HCFA-1500 claim form.

When COB is involved, claims should be filed with the primary insurance carrier first. When an Explanation of Benefits (EOB) is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier EOB.

If claims are filed with the primary and secondary insurance carrier at the same time and Blue Cross is the secondary carrier, claims will be pending for applicable other coverage information from the member. If the requested information cannot be obtained from the primary carrier’s explanation of benefits or the member has not provided a response to our other coverage questionnaire, the claim will be rejected within 21 days. Once a rejection appears on the payment register, the patient may be billed for the total charge.

Subrogation

Subrogation is a contract provision that allows health care insurers to recover all or a portion of claims payments if the subscriber is entitled to recover such amounts from a third party. The third party’s liability insurance carrier normally makes these payments. A third party is another carrier, person or company that is legally liable for payment from the treatment of the claimant’s illness or injury.

All claims you submit 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 subscriber or the subscriber’s lawyer to guarantee payment of the entire billed charge.
- **Not** require the Blue Cross subscriber to pay the entire billed charge up front.
- **Not** bill the Blue Cross subscriber for amounts above the reimbursement amount/allowable charge.
- Charge the subscriber no more than is ordinarily charged other patients for the same or similar service.
- Bill the member only for any applicable deductible, coinsurance, co-pay and/or non-covered service.

If amounts in excess of the reimbursement amount/allowable charge were collected, you should refund that amount to the subscriber.
Medicare Supplemental Claims

In most cases, Medicare supplemental claims will automatically cross over to Blue Cross and you do not have to file claims.

In the crossover process, as benefits are processed the claim and payment information is electronically transmitted to Blue Cross. We then process the claim for supplemental benefits according to the Subscriber Contract/Certificate.

Please allow sufficient time for your crossover claims to be received and processed before submitting a claim to Blue Cross. If your intermediary submits crossovers daily, you should allow at least 15 days for your payment to be processed. If your intermediary submits crossovers weekly, you should allow at least 21 days for your payment to be processed. Please do not submit a claim to Blue Cross until you have verified that the claim did not cross over automatically from the Medicare payer.

Please make sure to submit your correct Medicare provider number. When Blue Cross has a Medicare provider number or a tax identification number that is different from the information that Medicare has, it delays claims processing. To help us process your Medicare cross over claims, here are a few things that you can do:

If your Medicare provider number changes, or if you have not previously given Blue Cross your Medicare provider number, please submit your current Medicare provider number to us. You may do so by calling (800) 716-2299, option 3 or you can fax the number to (225) 297-2750, Attn: Network Operations.

Be sure to give prior notification to Blue Cross and Medicare if you tax identification number changes. To notify Blue Cross, you may fax a copy of your Employer Identification Number Letter to (225) 297-2750, Attn: Network Operations.

Please Note: Your Medicare provider number is **not** the same as your Blue Cross provider number.

If for any reason these claims do not cross over, you may contact the *BlueLine* at (800) 392-4076 for assistance.
Section III: Anesthesia Billing Guidelines

Anesthesia services billed by anesthesiologists or CRNA’s must be filed using the appropriate anesthesia CPT code (beginning with “0”).

Beginning May 1, 2005, one of the following modifiers must be submitted with each anesthesia service billed. The modifier billed will not affect the allowable—it will only be used for data analysis purposes; however, failure to submit one of the modifiers may result in a returned claim. When two providers are involved in the same anesthesia case, the first complete claim received will be processed first and the remaining allowable, if any, will be applied to the second claim. Clinical editing is applicable to all anesthesia services.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Billed by physician when personally providing the anesthesia service</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician; more than four concurrent anesthesia procedures</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QX</td>
<td>Billed by CRNA when providing the anesthesia service while being supervised by physician</td>
</tr>
<tr>
<td>QY</td>
<td>Billed by physician when supervising a CRNA providing the anesthesia service</td>
</tr>
<tr>
<td>QZ</td>
<td>Billed by CRNA when providing unsupervised anesthesia services</td>
</tr>
</tbody>
</table>

To ensure proper reimbursement when billing for anesthesia services, anesthesiologists and CRNA’s must include:

1. Number of minutes of administration;

2. CPT anesthesia (00100-01999) codes with one of the above required modifiers, plus any additional modifiers as appropriate;

3. ASA modifier code(s) for physical status (Section C1) and qualifying circumstances (Section C2), if appropriate.

Please refer to Section F (page 43) for a claims example.
Definitions

A. Base Units

The Base Unit is the value assigned to each CPT code and includes all usual services except the time actually spent in anesthesia care and the qualifying factors. This usually includes pre-op and post-op visits. When multiple anesthesia services are performed, only the anesthesia service with the highest base unit value should be filed with total time for all services reported on the highest base unit value code.

B. Time Units

Anesthesia time must be reported in minutes. If anesthesia time is reported in units, incorrect payment will result. Minutes will be converted to units by assigning one unit to each 15 minutes of time, or any part of a 15-minute period that anesthesia was administered (exception is CPT 01967, which is based on a 60-minute unit). Extracted from ASA’s Relative Value Guide, “anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.” No additional time units are payable for add-on codes; therefore, total time must be reported on the primary procedure code. In the case where multiple procedures are performed, time for lower base unit value codes should be reported on the highest base unit value code.

The number of time units is calculated using the following table:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 minute - 15 minutes</td>
<td>1 unit</td>
</tr>
<tr>
<td>16 minutes - 30 minutes</td>
<td>2 units</td>
</tr>
<tr>
<td>31 minutes - 45 minutes</td>
<td>3 units</td>
</tr>
<tr>
<td>46 minutes - 60 minutes</td>
<td>4 units</td>
</tr>
<tr>
<td>61 minutes - 75 minutes</td>
<td>5 units</td>
</tr>
<tr>
<td>etc.</td>
<td></td>
</tr>
</tbody>
</table>

C. Qualifying Factors

1. Physical Status

If physical status modifiers are applicable, the modifier should be indicated on the claim form by the letter P followed by a single digit from 1 to 6. Additional units may be allowed when the claim indicates any of the following:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal patient</td>
<td>0 units</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0 units</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>1 unit</td>
</tr>
</tbody>
</table>
P4 - A patient with severe systemic disease that is a constant threat to life 2 units
P5 - A moribund patient who is not expected to survive for 24 hours with or without the operation 3 units
P6 - A declared brain dead patient whose organs are being removed for donor purposes 0 units

2. Qualifying Circumstances

When any of the CPT codes defined in Section C2 are provided in addition to anesthesia procedures, the fee schedule allowance is the basis for reimbursement. Do not bill these procedures with anesthesia modifiers, physical status modifiers, or anesthesia minutes; otherwise, delay or rejection of payment may occur.

a. Qualifying circumstances are those factors that significantly affect the anesthesia services. Examples are the extraordinary condition of the patient, notable operative conditions and unusual risk factors. These procedures would not be reported alone but as additional procedures qualifying an anesthesia procedure or service and should not be billed with an anesthesia modifier, physical status modifier, or anesthesia minutes. Doing so may result in a delay in payment, rejection of charges, or return of the claim.

Each qualifying circumstance is listed below:

99100 - Anesthesia for patient of extreme age, under 1 or over 70.
99116 - Anesthesia complicated by utilization of total body hypothermia.
99135 - Anesthesia complicated by utilization of controlled hypotension.
99140 - Anesthesia complicated by emergency condition (an emergency is defined as existing when delay in treatment of the patient would lead to significant increase in the treatment of life or body part).

b. Specialized forms of monitoring also fall into the category of Qualifying Circumstances. Those that qualify are listed below. Although there are other forms of monitoring that are not listed here, these are the only ones for which an additional amount will be allowed. Any other charges should be combined with the total charge without an additional allowable. When billed in conjunction with an anesthesia procedure, the following CPT codes or combination of CPT codes are reimbursed over and above the anesthesia procedure based on the provider's fee schedule allowable.

Arterial line (36620 or 36625)
Central venous line (36555, 36556, 36568, 36569, 36580, or 36584)
Swan Ganz line (93503)
3. Obstetrical Anesthesia/Epidural

Obstetrical anesthesia/epidural procedures are reimbursed as indicated below, effective with dates of service on or after May 1, 2005.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Allowable Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
<td>7 units</td>
</tr>
<tr>
<td>01967</td>
<td>Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)</td>
<td>8 units plus $50 per hour</td>
</tr>
<tr>
<td>01968</td>
<td>Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia</td>
<td>3 units (no additional time allowed)</td>
</tr>
</tbody>
</table>

Note: CPT 01968 is an add-on code to CPT 01967. If a cesarean delivery is performed after neuraxial labor analgesia/anesthesia, bill CPT 01967 with total time, plus CPT 01968.

An additional allowable for emergency conditions may apply to reimbursement for epidural anesthesia. (Please refer to Qualifying Circumstances section.)

4. Pain Management

Pain management codes should not be billed using anesthesia modifiers, physical status modifiers, or anesthesia minutes. If claims are filed as such, delay in payment or incorrect payment may occur.

a. Outpatient Pain Management

An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral, single level should be coded 64483 and paid based on the appropriate allowable charge. Code 64484 should be billed for each additional level.

An injection of anesthetic agent and/or sterpid, transforaminal epidural, lumbar or sacral is considered a surgical procedure for benefit purposes. The injection must be performed by an M.D. for diagnostic or therapeutic purposes. If an injection is provided on the same day the surgery is performed, the service will be included in the base units and time charged for the administration of anesthesia. If an injection is provided on a day subsequent to the surgery, the procedure will be considered a surgical service and appropriate benefits allowed.
b. Post-operative Pain Management

i. Epidural

Daily management of epidural or subarachnoid drug administration should be coded 01996 for the professional charge, and the medication should be billed by the hospital as an ancillary charge.

CPT Code 01996 should be utilized to bill for a pain management service when drug administration is being monitored by the provider or an injection is inserted into an existing catheter. Payment will be based on a maximum of 3 units per day for a maximum of three days of epidural management, including the day of surgery. Billing anesthesia minutes, anesthesia modifiers, or physical status modifiers with CPT 01996 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

ii. IV PCA

Provider should bill CPT Code 01999 for the IV PCA daily management. Two (2) units are allowed per day, including the day of surgery. The set-up charge is included in the allowance of the daily management and should not be billed separately. Billing anesthesia minutes, anesthesia modifiers, or physical status modifiers with CPT 01999 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

iii. Pump Setup

The pump setup is included in the allowable charge for the daily management fee for both IV PCAs (CPT 01999) and Epidural PCAs (CPT 01996), and should not be billed separately.

iv. Nerve block injections (or any other types of pain management procedures not specifically addressed in this section) are considered incidental to the surgical anesthesia service and are subject to clinical editing.

D. Unit Value

Please review your Provider Agreement to determine your specific Unit Value for each product.

E. Conscious Sedation

Conscious sedation is considered an integral component to the primary (surgical) procedure and an additional allowable will not be considered when performed by performing physician.
F. Claims Example

A Blue Cross and Blue Shield of Louisiana member has a cholecystectomy that requires 50 minutes of anesthesia. Due to the fact that the member is over age 70, CPT 99100 is also billed. The claim submitted by the anesthesiologist to Blue Cross and Blue Shield of Louisiana should include the appropriate information explained above. The claim for covered services is processed as follows:

Formula:
(Base Units + Time Units + Physical Status Modifier Units) x Unit Value = Allowable Charge

**CPT-4 Code 00790**

<table>
<thead>
<tr>
<th>Base Units</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Time Units (50 mins.)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Units</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>x</strong> Unit Value*</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$440</strong></td>
</tr>
</tbody>
</table>

**CPT-4 Code 99100** (payment is based on the fee schedule allowable)

The $440.00 total is the allowable charge for the anesthesia procedure without modifiers. Additional reimbursement for CPT 99100 will be based on the provider’s fee schedule allowance. If the patient’s deductible has been met and the member’s contract provides an 80 percent benefit, Blue Cross and Blue Shield of Louisiana would pay 80 percent of the allowable, and the member would be responsible for 20 percent of the allowable. The difference between the provider’s charge and the allowable charge is not collectable from the member.

If any modifiers were applicable for physical status, those units would be added to the above calculation.

*This unit value is for illustration purposes only. Please review your Provider Agreement to determine your specific unit value for each product.

The allowable amounts represent the total amount collectable from Blue Cross and Blue Shield of Louisiana and the member (if deductible, copayment, and/or coinsurance apply). The difference between the provider’s charge and the allowable amount is not collectable from the member.

If you have any questions concerning these guidelines, please contact Network Administration at (225) 295-2430.
Section IV: Reimbursement

Allowable Charges

Blue Cross reimburses participating providers based on allowable charges. The allowable charge is the lesser of the submitted charge or the amount established by Blue Cross as the maximum amount allowed for provider services covered under the terms of the Subscriber Contract/Certificate.

You should always bill your usual charge to Blue Cross regardless of the allowable charge, for the following reasons:

- It enables us to determine allowable charges for procedures and maintain allowances that are fair and equitable.
- Billing one standard charge to all insurance companies helps reduce the chance of billing errors.
- If more than one insurance company has liability for a claim, your standard charge eliminates confusion and helps to ensure proper payment.

Allowable charges are provided to participating providers to help avoid refund situations. They are for informational purposes and not intended to establish fees.

Blue Cross regularly audits our allowable charge schedule to ensure that the allowable charge amounts are accurate. From time to time we must adjust an allowable charge because it may have been incorrectly loaded into our system or the CPT® code description has changed. Allowable charges are added periodically due to new CPT® codes or updates in code descriptions.

Blue Cross typically updates allowable charges for physician office injectables and administration codes three times a year. Notification of these updates is made through the provider newsletter or through messages on the Provider Payment Register or iLinkBLUE Bulletin Board.

If you need the allowable charge for a select code or group of codes, please call Network Administration at (800) 716-2299, option 3 or (225) 297-2758.

Member Cost-Sharing

Deductibles, coinsurance and copayments are the member’s contribution toward all services. As a participating provider you have agreed to not waive these amounts. When the charge for an office visit is less than the member’s copayment, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the subscriber the excess amount collected.
Reimbursement Review

Blue Cross recognizes there may be times when participating providers disagree with the way a claim was adjudicated. In those instances, providers may complete the Reimbursement Review Form (see following page). Please be sure to complete the entire form and include any supporting documentation. Please return the form to Customer Service, P. O. Box 98029, Baton Rouge, LA 70898-9029.

Tips for Completing the Reimbursement Review Form

1. Be sure to check the box that most closely matches your provider specialty.
2. Check the reason for your appeal. You may choose from the following reasons:
   - Disagree with Medical Coding Edit or Denial (i.e. assistant surgeon) – check this box if you disagree with how codes were bundled and/or denied. Please include your coding logic or applicable operative notes.
   - Claim not paid according to fee schedule and/or reimbursement amount is incorrect – check this box if you believe that the wrong allowable charge amount was used to pay the claim. Please include the fee schedule amount that you believe should have been used.
3. Include the appropriate supporting documentation along with the Reimbursement Review Form. For assistance in what to attach, please review the box with the heading, “If these services were rendered you must submit the following information:”
4. Always attach a copy of the claim.
Sample Reimbursement Review Form

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>PROVIDER NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBSCRIBER NAME</td>
<td>PATIENT NAME</td>
</tr>
<tr>
<td>CONTRACT NUMBER</td>
<td>CLAIM NUMBER</td>
</tr>
<tr>
<td>PROVIDER CONTACT NAME</td>
<td>PROVIDER CONTACT NUMBER</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS**

Please complete the following information and return this form with supporting documentation (including medical records). If the supporting documentation is not received, your claim will not be reconsidered. Please return this to the address printed at the bottom of this form along with a copy of the Blue Cross and Blue Shield of Louisiana card.

**Reason for Appeal** (Attach Additional Explanation If Necessary)
- Disagree with medical code editing and/or disagree with denial - i.e. assistant surgeon
- Claim not paid according to fee schedule and/or reimbursement amounts incorrect

Please send any supporting documentation with this form.

Please submit a hard copy of all claim(s). The decision rendered will be reflected on the member's Explanation of Benefits/Payment Register and/or reported to you via office correspondence, if necessary.

**IF THESE SERVICES WERE RENDERED YOU MUST SUBMIT THE FOLLOWING INFORMATION:**

<table>
<thead>
<tr>
<th>A) SURGERY, ASSISTANT SURGERY, ANESTHESIA</th>
<th>B) DOCTOR'S HOSPITAL VISITS</th>
<th>C) DOCTOR'S OFFICE/CLINIC VISITS</th>
<th>D) OTHER SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Discharge Summary</td>
<td>1) Hospital Progressive Notes</td>
<td>1) Entire office notes of visit</td>
<td>X-RAYS, LAB, PHYSICAL THERAPY</td>
</tr>
<tr>
<td>2) Operative Report</td>
<td>2) History and Physical Notes</td>
<td>2) History and Physical Notes</td>
<td>1) Physical Therapy Notes and Radiology/Lab Report</td>
</tr>
<tr>
<td>3) Pathology Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Anesthesia Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Pre-Op History and Physical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Asst. Surgeon Credentials (If Not M.D.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For Blue Cross and Blue Shield of Louisiana Office Use Only:
- Correspondence Unit
- Medical Review
- Provider Audit
- Reimbursement (Facility)
- Reimbursement (Professional)
- AR Sequence #

Customer Service
P.O. Box 98029
Baton Rouge, LA 70896-9029

Please be sure to address your envelope this way

23XX9507 R11/04 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company.
## Sample Weekly Provider Payment Register

<table>
<thead>
<tr>
<th>S</th>
<th>PATIENT'S NAME</th>
<th>CONTRACT NO</th>
<th>PAT ACCT</th>
<th>DAYS</th>
<th>ADMIT DT/ DISCH DT</th>
<th>CLAIM NUMBER</th>
<th>TOTAL CHARGES</th>
<th>MD CD</th>
<th>CONTRACT BENEFITS</th>
<th>CPT4 REV</th>
<th>NOT COVERED DED/COI/INEL</th>
<th>ABOVE ALLOWABLE AMOUNT PAID</th>
<th>STAT CD</th>
<th>COB</th>
<th>PERFORMING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DOE SUZIE Q</td>
<td>1234567890</td>
<td>98765</td>
<td>001</td>
<td>02/21/04</td>
<td>500001</td>
<td>63.00</td>
<td>40.79</td>
<td>90213</td>
<td>15.00</td>
<td>7.21 KEY</td>
<td>40.79</td>
<td>0987654321A</td>
<td>K</td>
<td>PROVIDER J</td>
</tr>
<tr>
<td>2</td>
<td>DOE JANE</td>
<td>4567890123</td>
<td>10000</td>
<td>001</td>
<td>02/21/04</td>
<td>500044</td>
<td>95.00</td>
<td>60.30</td>
<td>17000</td>
<td>6.70</td>
<td>28.00 KEY</td>
<td>60.30</td>
<td>0987654321A</td>
<td>K</td>
<td>PROVIDER J</td>
</tr>
<tr>
<td>3</td>
<td>DOE JANE</td>
<td>2345678901</td>
<td>78900</td>
<td>001</td>
<td>02/21/04</td>
<td>500025</td>
<td>207.00</td>
<td>93.07</td>
<td>17003</td>
<td>10.34</td>
<td>103.59 KEY</td>
<td>93.07</td>
<td>0987654321A</td>
<td>K</td>
<td>PROVIDER J</td>
</tr>
<tr>
<td>4</td>
<td>BOUDREAUX JOHN</td>
<td>3456789012</td>
<td>11110</td>
<td>001</td>
<td>03/06/04</td>
<td>500125</td>
<td>49.35</td>
<td>34.35</td>
<td>90213</td>
<td>15.00</td>
<td>0.00</td>
<td>34.35</td>
<td>0987654321A</td>
<td>K</td>
<td>PROVIDER J</td>
</tr>
<tr>
<td>5</td>
<td>THIBODAUX JOHN</td>
<td>1234567899</td>
<td>33220</td>
<td>001</td>
<td>02/20/04</td>
<td>500134</td>
<td>35.14</td>
<td>90212</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td>0987654321A</td>
<td>PROVIDER J</td>
<td></td>
</tr>
</tbody>
</table>

### Summary
- **PREVIOUS CREDIT BALANCE:** 0.00
- **TOTAL SCB:** 449.49
- **SCC:** 228.51
- **BALANCE:** 47.04
- **TOTAL:** 138.80
- **PAID:** 228.51

---

*Note: All charges are examples.*
CODE EXPLANATIONS

PR  THIS IS THE AMOUNT DETERMINED BY BLUE CROSS TO BE THE RESPONSIBILITY OF THE PATIENT.

OA  THE LIABILITY FOR THIS AMOUNT IS NOT DETERMINED ON THIS PROCESSING BECAUSE THIS AMOUNT HAS PREVIOUSLY BEEN PROCESSED OR MAY BE PROCESSED IN THE FUTURE.

K  BECAUSE YOU ARE A PARTICIPATING PROVIDER, THE “ABOVE ALLOWABLE AMOUNT” IS NOT BILLABLE TO THE PATIENT.

316  BEFORE WE CAN MAKE A DETERMINATION CONCERNING THESE CHARGES, WE NEED A COPY OF THE ORIGINAL EXPLANATION OF MEDICARE BENEFITS FORM THAT SHOWS HOW MUCH OF THESE CHARGES MEDICARE HAS PAID.

KEY  BECAUSE YOUR HEALTH CARE PROVIDER PARTICIPATES IN OUR NETWORK, YOU DO NOT OWE THIS AMOUNT
Provider Payment Register

Following is a description of each item on the Blue Cross Weekly Provider Payment Register. A copy of the payment register appears on the preceding page.

1. **Patient’s Name** - The last name and first five letters of the first name of the patient.

2. **Contract No** - The subscriber’s Blue Cross and Blue Shield identification number.

3. **Pat Acct.** - The patient identification number assigned by the provider’s office. This information will appear only if provided on the claim.

4. **Days** - The number of visits that the line item charge represents.

5. **Admit Dt/Disch Dt** - The beginning and ending date(s) of service for a claim.

6. **Claim Number** - The number assigned to the claim by Blue Cross for document identification purposes. **NOTE: When making inquiries about a specific payment, always refer to this number.**

7. **Total Charges** - The charge for each service and the total claim charges submitted to Blue Cross and Blue Shield.

8. **Contract Benefits** - The benefit amount payable by Blue Cross and Blue Shield according to the subscriber’s contract.

9. **CPT® Code** - The code used to describe the services performed by the provider.

10. **Not Covered/DED/COI/NEL** - The total amount owed by a patient for each claim including deductible, coinsurance, copayment, non-covered charges, etc.

11. **Above Allowable Amount** - The amount above the allowable charge. **NOTE: This amount cannot be collected from the member.**

12. **Amount Paid** - The amount paid by Blue Cross.

13. **Stat CD** - A one- or two-position alpha code that describes the above allowable (if applicable) followed by a three-position alpha reject code that indicates why a claim was not paid (if applicable).

14. **COB** - An asterisk in this column denotes that Blue Cross and Blue Shield is the secondary carrier.

15. **SCH DRG** - Not applicable to providers.

16. **Performing Provider** - The name and ten-position provider number of the provider who performed the service.
17. Previous Credit Balance - This amount indicates the total of previous overpayments made to the provider.

18. Totals - The total of days, charges, contract benefits, patient liability, above allowable amount, and amount paid for all patients listed.

19. Total SCB - Not applicable to providers.

20. SCC - Not applicable to providers.

21. Balance - The amount adjusted by Blue Cross to recover any overpayments made to the provider.

22. Provider Name - Provider/Clinic name and address to which payment is made.

23. Paid Prov. - Provider’s/Clinic’s Blue Cross provider number under which payment is made.

24 Date - Date the Provider Payment Register is generated by Blue Cross.

25. Check No. - The number assigned to the check mailed with the payment register.
Facets Payment Registers

Blue Cross and Blue Shield of Louisiana has implemented a new operating system called Facets. Effective December 1, 2005, we began processing claims for select HMO Louisiana, Inc. groups in Facets, which is the first stage of transition into our new operating system.

The Weekly Provider Payment Register for claims processed through Facets will look slightly different than the payment register you receive for claims processed through Legacy. Legacy, our existing operating system, will be phased out over a three-year period. This means that you will be receiving two different styles of payment registers simultaneously for at least three years. The following information will help you understand how to read payment registers that are generated from Facets.

Below are some changes on the Provider Payment Register for Facets compared to those from Legacy; see the following pages for a sample weekly payment register and explanation of codes:
- Patients listed alphabetically with no sub-sections
- New Column order
- Other Carrier Information
  - Other Carrier Amount Paid
  - OC Code: C = Commercial Carrier, M = Medicare
- Calculations should balance; see examples below:

<table>
<thead>
<tr>
<th>Total Charges</th>
<th>COB</th>
<th>OC Pay</th>
<th>OC Code</th>
<th>Above Allow Amt</th>
<th>Not Covered Ded-Coin-Inel</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 120.00</td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$0.00</td>
<td>$120.00 DED-PR</td>
<td>$0.00</td>
</tr>
<tr>
<td>$ 225.00</td>
<td>$88.78</td>
<td>C</td>
<td>$79.39</td>
<td>$25.00</td>
<td>$25.00 CPY-PR</td>
<td>$31.83</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>($104.39 PXN-CO ($25.00 OCR-OA)</td>
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</tr>
<tr>
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<td></td>
<td>$25.00 CPY-PR</td>
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</tr>
<tr>
<td>$ 65.00</td>
<td>$14.20</td>
<td>C</td>
<td>($1.70)</td>
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<td></td>
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<td>($12.50 PXN-CO ($14.20 OCR-OA)</td>
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<td></td>
<td>$35.00 CPY-PR</td>
<td></td>
</tr>
</tbody>
</table>

For complete details on Facets, please visit the Provider page at www.bcbsla.com. You will also find Facets updates on the iLinkBLUE bulletin board.

If you have any questions about the changes resulting from the implementation of Facets, please call the BlueLine at (800) 392-4076.
**Sample Weekly Provider Payment Register Generated from Facets**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Contract Number</th>
<th>Patient Acct</th>
<th>Performing Provider</th>
<th>Days/Units</th>
<th>Admit Dis Dt</th>
<th>Claim Number</th>
<th>CPT4 Rev</th>
<th>Sch Drg</th>
<th>COB</th>
<th>Total Charges</th>
<th>Above Allow Amt</th>
<th>MD CD</th>
<th>Contract Benefits</th>
<th>Not Covered Ded-Coin-Indl</th>
<th>Amount Paid</th>
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<tr>
<td>PUBLIC, J. Q. XUH08765432</td>
<td>1234567890</td>
<td>Deaux, John</td>
<td>1</td>
<td>09/15/2005 09/15/2005</td>
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<td>$0.00</td>
<td>$155.00</td>
<td>$155.00 HCC-CO</td>
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<td>$0.00</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PUBLIC, SU XUH123456789</td>
<td>12346</td>
<td>Deaux, John</td>
<td>1</td>
<td>09/22/2005 09/22/2005</td>
<td>000000 00000</td>
<td>$0.00</td>
<td>$125.00</td>
<td>$5.08</td>
<td>$5.08 PXN-CO</td>
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<td>$20.00 CPY-PR</td>
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<td></td>
</tr>
<tr>
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<td>Deaux, John</td>
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<td>09/22/2005 09/22/2005</td>
<td>000000 00000</td>
<td>$0.00</td>
<td>($4,840.00)</td>
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<td>$0.00</td>
<td>($4,840)</td>
<td>($4,840)</td>
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<td></td>
<td></td>
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<tr>
<td>SMITH, JOHN XUH345678901</td>
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</tr>
<tr>
<td>SMITH, JANE XUH456789012 INTEREST PENALTY</td>
<td>1234567890</td>
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<td>$190.44 PDC-CO</td>
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<td></td>
<td></td>
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<td>$350.52</td>
<td>$301.21</td>
<td>$456.27</td>
<td>$303.23</td>
<td></td>
</tr>
</tbody>
</table>

HCC – The Provider did not obtain Preservice Authorization for this service.
Member Copy/Poissurance is payment in full. No other member liability.
CO – This amount is determined by Blue Cross to be the responsibility of the provider.
PXF – Network Std Fee Schedule
PR – This is the amount determined by Blue Cross to be the responsibility of the patient.
PDC – The charge has been reduced based on a discount arrangement with the provider of service.
*ST – Statutory Adjustment

***All dollar amounts and medical codes are examples.***
CODE EXPLANATIONS

PR  THIS IS THE AMOUNT DETERMINED BY BLUE CROSS TO BE THE RESPONSIBILITY OF THE PATIENT.

OA  THE LIABILITY FOR THIS AMOUNT IS NOT DETERMINED ON THIS PROCESSING BECAUSE THIS AMOUNT HAS PREVIOUSLY BEEN PROCESSED OR MAY BE PROCESSED IN THE FUTURE.

CO  THIS AMOUNT IS DETERMINED BY BLUE CROSS TO BE THE RESPONSIBILITY OF THE PROVIDER.

PMX THE CHARGE EXCEEDS THE ALLOWED AMOUNT FOR THIS SERVICE.

N02 PROCEDURE IS MUTUALLY EXCLUSIVE TO ANOTHER PROCEDURE.

000 THE PAYMENT FOR THIS CLAIM IS LIMITED BY THE TERMS OF YOUR CONTRACT. THE AMOUNT SHOWN IS THAT PORTION NOT COVERED.

PDC THE CHARGE EXCEEDS THE ALLOWED AMOUNT FOR THIS SERVICE.

PMP THE CHARGE EXCEEDS THE ALLOWED AMOUNT FOR THIS SERVICE.

346 DUPLICATE CLAIM TO ONE PREVIOUSLY PROCESSED.

N55 MAXIMUM DAILY OCCURRENCE OF PROCEDURE OR SERVICE, ACROSS CLAIMS.
### Sample NASCO Provider Check Voucher

#### PROVIDER CHECK VOUCHER

<table>
<thead>
<tr>
<th>SUB. ID</th>
<th>PATIENT'S NAME</th>
<th>PATIENT ACCOUNT NUMBER</th>
<th>SERVICE DATES FROM / TO</th>
<th>PROCEDURE CODE</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED AMOUNT</th>
<th>SUBSCRIBER'S LIABILITY</th>
<th>APPROVED TO PAY AMOUNT</th>
<th>AMOUNT PAID</th>
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</thead>
<tbody>
<tr>
<td>4355263410</td>
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<td>1 3 99252</td>
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<td>93.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CLAIM TOTAL----</td>
<td>115.00</td>
<td>93.00</td>
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<td>0.00</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>TRADITIONAL PAID CLAIM SUBTOTALS---</td>
<td>115.00</td>
<td>93.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**TOTAL**

115.00 93.00 0.00 0.00 52.08 52.08

---

**Blue Cross Blue Shield of Louisiana**

**NASCO UNIT**

P. O. BOX 98029

BATON ROUGE, LA 70898-9029

---

**FOR RELATED INQUIRIES PLEASE CALL OR WRITE:**

BOB SMITH MD

123 MAIN STREET

ANY TOWN LA 00000

---

**Blue Cross Blue Shield of Louisiana**

**NASCO DEDICATED UNIT**

P. O. BOX 98029

BATON ROUGE, LA 70898-9029

1-800-258-3245
NASCO Provider Check Voucher

Following is a description of each item on the NASCO (National Accounts Service Company) Provider Check Voucher. NASCO is a national accounts membership and claims processing system used by Blue Cross. A copy of the check voucher appears on the preceding page.

1. **Sub. ID** - The subscriber’s identification number also referred to as contract number.

2. **Patient’s Name** - Patient’s last name and first three letters of his/her first name.

3. **Patient Account** - The account number assigned to the patient by the provider’s office. This information will appear only if provided on the claim.

4. **Prescription No.** - Pharmacy claims only.

5. **Claim No.** - The number assigned to the claim by Blue Cross and Blue Shield for document purposes.

6. **Service Dates From/To** - The beginning and ending date(s) of service for a claim.

7. **Procedure Code** - The CPT® procedure code(s) for the service(s) billed.

8. **CVD/NCVD** - The amount of charges that are covered or non-covered by a subscriber’s policy.

9. **Total Charges** - The charge for each service submitted to Blue Cross and Blue Shield.

10. **Allowed Amount** - The lesser of the provider’s charge or allowable charge on which benefits were based.

11. **NCVD CHG** - The amount not covered by a subscriber’s health benefits contract. This amount is collectible from the subscriber.

12. **Subscriber’s Liability** - The amount owed by a patient for each claim.

13. **Co-Pay/Ded.** - The total of copayment and/or deductible. This is the amount owed by a patient for each claim.

14. **Approved To Pay Amount** - The benefit amount payable by Blue Cross and Blue Shield according to the subscriber’s contract.

15. **Amount Paid** - The amount paid by Blue Cross and Blue Shield.

16. A message that provides pertinent information about the claim.
17. **Traditional Paid Claim Subtotals** - The subtotals of charges, allowed amount, non-covered charges, subscriber liability, copayment/deductible, approved to pay amount and amount paid for all claims listed on the Provider Check Voucher.

18. **Total** - The total charges, allowed amount, non-covered charges, subscriber liability, copayment/deductible, approved to pay amount and amount paid for all claims listed on the Provider Check Voucher.

19. **Provider Number** - The number assigned to a provider/clinic for NASCO claims processing purposes.

20. **Tax ID** - The tax identification number under which claims payments are reported to the Internal Revenue Service for the physician/clinic to whom payment was made.

21. **Payment Date** - The date the Provider Check Voucher was generated.

22. **For Related Inquiries Please Call or Write** - The name, address and telephone number to which NASCO claims and inquiries should be directed.

23. **Provider’s/Clinic’s name and address.**
Section V: FEP Benefit Information

The FEP Service Benefit Plan is based on a Preferred Provider Organization plan that has benefit incentives encouraging the use of Preferred Care PPO Providers. FEP members may choose from two types of coverage: **Standard Option** and **Basic Option**.

**Standard Option**

With **Standard Option**, members do not need referrals for any provider, including out-of-network providers. However, if a member chooses to use non-Preferred Care PPO providers, their out-of-pocket expenses will be greater.

**Office Visits:** $15 co-pay for members that use Preferred Care PPO providers.

**Routine Physicals and Screenings:** Members pay $15 for periodic routine physicals performed by a Preferred Care PPO provider. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings.

**Maternity Care:** Members pay nothing for covered physician and hospital services related to maternity care when they use Preferred Care PPO providers. Newborn visits for healthy babies are paid in full.

**Basic Option**

With **Basic Option**, members use Preferred Care PPO providers for all their medical care. Benefits are only available for care provided by non-network providers in certain situations, such as emergency care. Under Basic Option, there is no calendar year deductible. Basic Option benefits are paid in full or in full after members pay a copayment amount when they use Preferred Care PPO providers.

**Office Visits:** Members pay $20 for office visits to Preferred Care PPO providers who are PCPs. If members go to a Preferred Care PPO specialist, they pay $30 for the office visit. Members’ copayments also cover any laboratory tests and X-rays billed by the provider.

**Routine Physicals and Screenings:** Members pay $20 for periodic routine physicals performed by a Preferred Care PPO provider who is a PCP. During these visits, members are also covered at 100 percent for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings.

**Maternity Care:** Members pay nothing for covered pre-natal and post-natal care rendered by a preferred provider. The delivery by a Preferred Care PPO provider is paid in full after the member pays her $100 copayment. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the
member pays a $100 per day copayment (maximum of $500). Members pay $20 for newborn visits for healthy babies.

**Additional FEP Benefit Information**

Please Note: If the member receives these services from a non-Preferred Care provider, the following limits apply:

**Breast Cancer Screening**
Mammograms are covered for women age 35 and older as follows:
- From age 35 through 39, one mammogram screening during this five-year period.
- From age 40 through 64, one mammogram screening annually.
- At age 65 or over, one mammogram screening every two consecutive calendar years.

**Cervical Cancer Screening**
Annual coverage of one Pap smear for women of any age.

**Colorectal Cancer Screening**
- Annual coverage of one fecal occult blood test for members age 40 and older.
- One sigmoidoscopy every five years starting at age 50.

**Prostate Cancer Screening**
Annual coverage of one Prostate Specific Antigen (PSA) test for men age 40 and older.
Section VI: Medical Management

Overview

Medical management is a system for a comprehensive approach to health care delivery. Blue Cross established the Care Management Department to ensure that our subscribers receive the highest quality health care that is medically appropriate and cost-effective.

MNRO

Blue Cross is authorized as a Medical Necessity Review Organization (MNRO) and therefore follows the regulations promulgated by the Department of Insurance that govern these entities. However, certain employer groups, primarily self-funded employer groups and the Federal Government plan, are not subject to the legislation that created these regulations. Since Blue Cross handles a wide range of fully funded and self-funded employer groups, it is not possible to have a uniform policy in all instances. The following descriptions note where differences occur.

Authorization Process

The authorization process ensures that subscribers receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

A Blue Cross nurse reviews all pertinent information submitted by physicians and providers and applies defined criteria to determine if a service is medically appropriate. The criteria used by the nurses is reviewed and approved by physicians at least every two years, and more often if indicated. If the information received from a physician or other provider varies from the defined criteria, a nurse will forward the information for review by a Blue Cross physician.

Pre-service Authorizations

A pre-service authorization is the review and authorization of a procedure prior to the service being rendered. The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed. For a listing of procedures that require authorization, please see page 62. Authorization requirements may vary slightly by product. The following describes the process and procedural steps for obtaining pre-service authorizations:

- The provider must initiate the authorization process at least 48 hours prior to the service by calling the Authorization Unit at one of the following toll-free numbers:

  (800) 392-4085
  (800) 334-9416 (FEP Subscribers only)
• The Authorization Coordinator will request the following information:

1. Patient/Subscriber name, current address, date of birth, BCBS ID/contract number and relationship of the patient to the subscriber;

2. Physician’s name, BCBSLA provider number, address and telephone number;

3. Name of the facility at which the service will be rendered;

4. Anticipated date of service;

5. Requested length of stay (if applicable);

6. Diagnosis (to include ICD-9-CM codes), major procedures (and related CPT and/or HCPCS codes), plan of treatment, medical justification for services or supplies and complications or other factors requiring the requested setting; and

7. Caller’s name and phone number.

• The initial request received prior to a scheduled inpatient admission or outpatient procedure is classified as a pre-service authorization. Decisions are made within 15 calendar days of receipt of claim, regardless of whether all information is received.

• If the request is approved, the contact person is notified within 24 hours of the determination. Confirmation for continued hospitalization or services includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review point, and the new total number of days or services approved. Types of notification include verbal (by telephone at the time of the call) voice mail or electronic means including email and fax. A letter of confirmation is also sent to the subscriber, physician and hospital, if applicable, within two working days of the decision being made.

• If the decision is to non-certify the authorization, the contact person is notified of the principal reasons for determination not to certify and appeal rights verbally (by telephone or voice mail) within 24 hours of the determination. A non-certification letter is sent to the subscriber, physician and hospital, if applicable, within one working day of the decision. The letter will list appeal rights based on regulatory guidelines.

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 subscriber, physician and hospital, if 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 is sent to the subscriber, physician and hospital, if applicable, within one business day of the determination. The notification will list appeal rights based on regulatory guidelines.

NOTE: The authorization process is designed only to evaluate the Medical Necessity of the service. AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OR A CONFIRMATION OF COVERAGE FOR BENEFITS. Payment of benefits remains subject to all other Subscriber Contract/Certificate terms, conditions, exclusions and the patient’s eligibility for benefits at the time expenses are incurred.

Notification of Admission/Status Change

A pre-service authorization is valid for 15 days. Occasionally, it may be necessary to change or cancel a service, or the circumstances may require an adjustment to the anticipated length of stay. When a change in the nature, duration or reason(s) for a pre-authorized service occurs, the provider should notify the Authorization Unit of the change. This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service. Another certification must be obtained if the approved service does not occur within 15 days of the originally scheduled admission date.
Concurrent Review

The Concurrent Review Unit evaluates the medical and service needs of patients confined to an inpatient facility. Concurrent review promotes and works to ensure optimal outcomes, continuity of care, development of a timely discharge plan and ongoing quality of care.

The Concurrent Review Nurse is the central focus and link of communication between a hospitalized member, a Member Provider and the Care Management Department. Concurrent Review nurses conduct telephonic review of all new admissions or continued care cases prior to the end of an approved length of stay. Concurrent Review nurses use clinical information made available and nationally recognized criteria to authorize extensions for additional inpatient care. If the Concurrent Review nurse is not able to authorize an extension based on medical necessity with the clinical information made available and the criteria, the case is referred to a Blue Cross Medical Director for a determination.

If additional services or days are requested, the provider should contact the Concurrent Review Unit. You may either contact the Concurrent Review Nurse assigned to your facility or you may contact the Concurrent Review Unit at (800) 523-6435. A Concurrent Review Nurse, in collaboration with the Medical Director, will conduct a review of the information provided to document the medical necessity for continued stay. This review will be done either in person or by telephone.

A decision is made within one working day of receiving all necessary information from the provider. If the decision is to approve the continued stay or course of treatment, the provider rendering the service is notified by telephone or via fax. If a decision to deny the continued stay or course of treatment is made, the provider rendering the service is immediately notified and given the reason for the denial and the procedure for initiating the appeal process.

Self-funded employer groups handled by Blue Cross will generally be handled in the same way as fully funded groups for operational efficiency. Insureds not subject to MNRO regulations may have denial determinations issued on a retrospective basis if a review is not requested prior to discharge from service or prior to receipt of the initial claim for payment.
Case Management

The Case Management Unit systematically identifies high-risk subscribers and assesses opportunities to coordinate and manage total care. The focus of case management is to respond to overall care requirements by coordinating services and resources for subscribers with catastrophic or chronic health conditions.

Case Management nurses encourage collaborative relationships among a subscriber’s health care providers, and they help subscribers and their families maximize efficient utilization of available health care resources.

Subscribers can be referred to Case Management and Disease Management through a variety of sources, including direct referrals from practitioners, claims data or referrals from inpatient and outpatient utilization review nurses. Subscribers who may benefit from case management include:

- Patients with a newly diagnosed chronic condition, such as diabetes mellitus
- Patients with an acute phase of an illness requiring coordination of multiple services
- Patients with unstable chronic illnesses
- Patients identified by Health Risk Assessments
- Patients and families who experience catastrophic illness
- Patients with depression having an adverse affect on medical outcomes

After a subscriber has been referred to Case Management, the Case Management nurse conducts a thorough and objective assessment of the subscriber’s current status. Using this data, the nurse identifies the immediate, short-term and long-term needs of the subscriber, as well as whether or not the member’s needs can be best be met in a disease management or case management program.

You may contact Case Management by calling (800) 317-2299.

Retrospective Review

Blue Cross’s Retrospective Review Unit reviews claims to ensure that the services rendered were medically appropriate and meet the definition of covered services under the Subscriber Contract/Certificate. A retrospective review may be performed to assess the medical need and correct billing level for services that have already been performed.

Registered nurses handle retrospective review. These nurses examine diagnoses, treatments or procedures, including but not limited to cosmetic, experimental or investigational procedures, that may be limited or excluded by the Subscriber’s Contract/Certificate. The nurses also conduct medical reviews for possible pre-existing conditions.
Medical Policy Inquiry

Provider inquiries related to medical policy coverage eligibility guidelines or investigational status determination of treatments, procedures, devices, drugs or biological products will be considered upon written request by a member provider.

Requests for consideration must be accompanied by peer-reviewed scientific evidence-based outcomes that substantiate why the specific treatment, procedure, device, drug or biological product is addressed within a medical policy.

Supporting data will be assessed against the following criteria:
- have final approval from the appropriate government regulatory body;
- have the scientific evidence which permits conclusions concerning the effect of the technology on health outcomes; or
- improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings

Procedure:

1. Member providers who contact Blue Cross to address coverage eligibility or investigational status of a treatment, procedure, device, drug or biological product addressed in a Blue Cross medical policy will be directed to submit:
   - a written request that includes the nature of their inquiry; AND
   - pertinent peer-reviewed scientific evidence-based outcomes specific to the coverage eligibility guidelines or investigational status of the treatment, procedure, device, drug or biological product addressed within the medical policy.

A. Written requests must include a return address or fax contact number and should be submitted to:
   Medical Director of Medical Policy
   Blue Cross and Blue Shield of Louisiana
   P. O. Box 98031
   Baton Rouge, LA 70809-9031
   Or
   (225) 298-3041 Attn: Medical Director of Medical Policy

B. Supporting data will be reviewed by the Medical Director of Medical Policy and or appropriate Plan medical directors and consultants.

C. Upon determination of review outcome written notification will be directed to the requesting provider within 60 days of receipt of request.
Direct Access

Direct Access allows Advantage Blue POS members to receive care through their network PCP or they may go directly to the network specialist of their choice without a referral.

As a part of the Direct Access Program, Advantage Blue POS members are responsible for different copayments for physician services—one for PCPs, one for specialists, one for urgent care clinics and one for emergency room services. This means that members will pay a lower copayment when they receive services from PCPs.

The following provider specialties are considered primary care under Advantage Blue POS. Physicians who specialize in these areas of medicine and who are classified as PCPs by Blue Cross should collect the PCP copayment from members with Direct Access:
- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- OB/GYNs (who are PCPs for Advantage Blue members)

Please note: The following specialties also should collect the PCP copayment when they perform services for members with Direct Access:
- Chiropractors
- Federally Qualified Rural Health Clinics
- Occupational Therapists
- Physical Therapists
- Therapy Assistants

The member’s identification card will list the copayment amount you should collect.

Authorizations are still required for some services under the Direct Access Program. Please review the following lists of services that require authorization from the Plan. Authorization requirements may vary by group. To obtain an authorization, please call our Authorization Department at (800) 392-4085.

For any questions about the Direct Access Program, please call the BlueLine at (800) 392-4076.
Services Requiring Prior Authorization or Plan Review

The following services require Plan review for benefits determination or prior authorization for medical necessity, appropriateness of setting and level of care for most groups and individuals. To obtain Plan approval, call (800) 392-4085.

**Preferred Care PPO**

- Home Health and Private Duty Nursing
- Hyperbarics
- Injections/Infusions – Includes: Actimmune, Actiq Amevive, Botox, Enbrel, Growth Hormone, Humira, Hyalgan, Intron, IVIG, Oxycotin (quantities over 90 units/month), Pegasys, Peg-Intron, Raptiva, Rebetron, Remicade, Serostim, Supartz, Synagis, Synvisc and Xolair
- Inpatient Hospital Services (*except routine maternity stays)
- Non-emergency air ambulance
- PET Scans
- Prosthetics
- Speech Therapy
- Transplant Evaluations

**Advantage Blue POS**

- Chiropractic Services
- Covered Dental Services (major medical only)
- Dialysis
- DME – Plan approval is required for DME that exceeds $300.
- Home Health and Private Duty Nursing
- Hyperbarics
- Infusion Therapy – Plan approval is required when infusion therapy is administered in settings other than the physician’s office (except as listed below under “Injections/Infusions”).
- Injections/Infusions – Includes: Actimmune, Actiq Amevive, Botox, Enbrel, Growth Hormone, Humira, Hyalgan, Intron, IVIG, Oxycotin (quantities over 90 units/month), Pegasys, Peg-Intron, Raptiva, Rebetron, Remicade, Serostim, Supartz, Synagis, Synvisc and Xolair
- Inpatient Hospital Services (*except routine maternity stays)
- Low protein food products
- Mental/Alcohol/Drug Abuse Treatment
- MRI/MRA
- Non-Emergency Transportation
- Orthotics/Prosthetics
• Out-of-Network Services
• Outpatient Services (except X-ray and lab) – when performed in an outpatient setting (hospital/ambulatory facility).
• PET Scans
• Therapy (physical, occupational, speech)
• Transplant Evaluations

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

Providers should maintain current, organized, well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members.

Blue Cross performs office reviews and Ambulatory Medical Record Review (AMRR) as a commitment to quality improvement. AMRR and site reviews may be conducted for any provider in the following circumstances:

- When requested by one of the medical directors based on quality indicator or provider corrective action processes; or
- At the discretion of the Health and Quality Management staff.

The purpose of the review will be to:

- Objectively monitor and evaluate the structural and operational aspects of the office site; and
- Conduct an overview discussion and assessment regarding the adequacy of medical record practices.

Results from the record keeping review will be used to initiate actions to improve practice management or medical record documentation.
**Adult and Pediatric Ambulatory Medical Review**

**Definition of Guidelines**

**Pediatric:** Any child between infancy and puberty.

**Adult:** A fully grown and mature person

**Time Frame:** Review all entries for the two years preceding the last visit.

**Part I – Demographic Guidelines**

1. All pages with entries in the record contain patient identification.
   
   Definition: Name, social security number or other unique patient identifier is on all pages with entries.

2. Personal biographical data.
   
   Definition: The personal biographical data should include: address, employer, home and work telephone numbers and marital status. If the patient has no phone, the record should state “no phone.” For pediatric cases, the employer of at least one parent, as well as the home and work phone numbers of at least one parent should be included.

**Part II – Documentation Guidelines**

1. Each entry in the record contains the author’s name or initials.
   
   Definition: An entry means documentation in the progress notes. This may include medication renewals and telephone orders. Author identification may be handwritten signature, an initials-stamped signature, or unique electronic identifier. Each entry has the author’s name or initials. Documentation entered by other than the practitioner, must be counter-signed or counter-initialed.

2. Each entry is dated.
   
   Definition: This includes progress notes, problem list, medication list, assessment form, etc.

3. Each entry is legible.
4. Smoking habits and history of alcohol or substance abuse usage is noted.
   Definition: For patients 14 years and older, smoking habits, ETOH use and
   substance abuse are noted in the history and physical progress notes. Counseling
   in reference to avoiding tobacco use, underage drinking, and illicit drug use
   including, but not limited to, avoiding ETOH/drug use while swimming,
   boating, etc., are noted. For patients seen three or more times, query a substance
   abuse history.

5. A history and physical is noted for each visit.
   Definition: The reason for the visit or chief complaint is noted. There is
   appropriate subjective and objective information noted pertinent to the patient’s
   presenting complaints to include but not limited to height, weight and blood
   pressure.

6. Labs and other studies are ordered as appropriate.

7. Each encounter has follow-up care, calls or visits noted.
   Definition: Each physician encounter has a notation regarding follow-up care,
   calls, or visit, unless there is a notation that previous problem has been resolved.
   The specific time of return is noted in days, weeks, months or PRN.

8. At each encounter, problems from previous visits are addressed, if applicable.

   Definition: There is evidence of continuity and coordination of care between
   primary and specialty physician. There is evidence of appropriate use of
   consults.

10. Consultant’s report or note from consultant is received, if applicable.
    Definition: If there was consult, there is a report of the consult in the record.

11. Consultation, lab and imaging reports filed in the chart are initialed and signify
    review.

12. Immunization.
    Definition: There should be an up-to-date immunization record for children. For
    adults, an appropriate history should be made.

13. Preventive Health Care
    Definition: Documentation that preventive screenings and services are offered
    in accordance with current Preventive Health Guidelines (see page 78).
Guidelines – Critical Elements

1. The record contains an updated, completed problem list or summary of health maintenance exams.

Definition: An updated, completed problem list summarizing significant illnesses, medical conditions, past surgical procedures, or chronic health problems that is updated as new problems are encountered, as evidenced in the progress notes. The problem list can be in a separate section or can be listed as a problem in the progress notes. If no past or current illnesses, conditions, or past surgical procedures, there is a statement that no current or past problems are noted. In this case, there is a summary of health maintenance exams such as well woman exam, well child exam, routine check up or complete physical exam.

2. Allergies and adverse reactions to medications are prominently displayed.

Definition: The patient’s medication allergies and adverse reactions must be conspicuously listed in the ambulatory medical record or on the front or inside cover of the medical record folder. If allergies to medications are absent, “No Known Allergies” (NKA) or “NA” or “None” is conspicuously documented in the ambulatory medical record or on the front or inside cover of the medical record folder. Conspicuously means in an obvious location, e.g., upper corner or left or right side of the progress note. You should not have to search for this information.

3. There is a past medical history in the record.

Definition: For patients seen three or more times, a past history should be easily identified. “Easily identified,” means it should be in one central area, not scattered throughout the chart. An inpatient history and physical taken by the provider, is acceptable. For children and adolescents under the age of 18, past medical history will relate to prenatal care, operations, childhood illnesses, and birth, to include, but not limited to: evidence of Hemoglobinopathy screening, Phenylalanine level, T4 and/or TSH and ocular prophylaxis. For patients seen less than 3 times, there is a past history noted for the current condition. For example, when there is a visit for hypertension, a family history, a patient history and a progress note for hypertension will be documented. (For females more than 18 years of age, there must be an obstetrics and gynecological history.) If there has been no break in the patient/physician relationship and there is a past history in the chart that was completed while the patient had another form of insurance, the guideline is satisfied.

4. Working diagnoses are consistent with findings.

5. Treatment plans are consistent with diagnoses.

6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.
Appeals

We recognize that disputes may arise between subscribers and Blue Cross regarding covered services. An appeal is a written request from the subscriber to change a prior decision that Blue Cross has made. Examples of issues that qualify as appeals include denied authorizations, denied claims or determinations of medical necessity.

Member appeals processes vary at the current time due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the subscriber or the subscriber’s employer. In some instances this is state law, and in others, it is federal law. The subscriber’s contract or certificate describes the appeals processes applicable to the subscriber. We will follow the language in the subscriber’s contract or certificate, should there be any variance between that language and what is printed below.

Blue Cross has been authorized by the Louisiana Department of Insurance as a medical necessity review organization (MNRO). At the present time, MNRO laws apply to individual contracts of insurance, employer insurance plans that are not governed by ERISA, and non-federal government insurance plans. Blue Cross generally refers to these processes as “Non-ERISA” processes. We will follow MNRO laws set out in La. R.S. 22:3070 et seq. and applicable regulations for these types of plans. We will follow the appeal rules for ERISA plans as set out in 29 CFR 2560 et seq. If the laws that affect appeals for any type of plan change, we will revise our process to maintain compliance.

There are some plans that are not governed by either the MNRO laws or the ERISA laws. Examples are some plans for whom we provide administrative services only and the Federal Employee Program. For these subscribers, we will follow the appeals processes stated in their subscriber contracts. The bulk of appeals should fall within the ERISA or non-ERISA (MNRO) processes.

Both ERISA and non-ERISA appeals processes are outlined below. If subscribers are unsure which process applies to them, they should contact their employer, Plan Administrator, Plan Sponsor or Blue Cross at (800) 376-7741 or (225) 293-0625. Members and providers are encouraged to provide Blue Cross with all available information and documentation to help us completely evaluate the appeal.

All appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana – Customer Service Unit
Appeals and Grievance Coordinator
P.O. Box 98045
Baton Rouge, LA 70898-9045

If a subscriber has questions or needs assistance putting the appeal in writing, the subscriber may call our Customer Service Department at (800) 376-7741 or (225) 293-0625.
Informal Reconsideration

We have a process that allows providers to discuss utilization management decisions with our medical directors. An informal reconsideration is the provider’s telephone request to speak to our medical director or peer reviewer about a utilization management decision. An informal reconsideration typically is based on submission of additional information or a peer-to-peer discussion. It is available only for initial determinations that are requested within ten (10) days of the denial or concurrent review determination. We will conduct informal reconsiderations within one (1) working day of receipt of the request.

Appeals Process for Non-ERISA Members (MNRO)

The standard appeals process has two internal standard levels, including review by a committee at the second level. There is also an expedited appeals process for an expedited review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the subscriber’s life, health, or ability to regain maximum function. Both the standard appeals process and the expedited appeals process allow for an external review for cases involving medical necessity.

The subscriber has the right to appoint an authorized representative to represent the subscriber in the appeals process. An authorized representative is a person to whom the subscriber has given written consent to represent the subscriber in an internal or external review of a denial. The authorized representative may be the subscriber’s treating provider if the subscriber appoints the provider in writing and the provider agrees and waives in writing any right to payment from the subscriber other than applicable copayment and/or coinsurance amounts. Providers will be notified of the appeal results only if the provider filed the appeal.

First Level of Internal Appeal

- A subscriber, the subscriber’s authorized representative or provider acting on the subscriber’s behalf, must submit a request to appeal the decision in writing. The subscriber has 180 days following the receipt of an adverse determination to request an Appeal. Requests submitted to us after 180 days of the denial will not be considered.

- Health care professionals, including a physician not previously involved in the initial decision, will review all appeals of medical necessity denials.

- The first-level appeals decision will be mailed within thirty (30) calendar days of the request for appeal, unless the subscriber or the subscriber’s authorized representative and Blue Cross have agreed to a longer period of time. If the claim continues to be denied at the conclusion of the first-level appeal, Blue Cross will inform the subscriber of his/her right to begin the second-level appeal process.

Second Level of Internal Appeal

- The subscriber or the subscriber’s authorized representative must initiate the second-
level appeal in writing within sixty (60) days of the first-level appeal decision.

- The Member Appeals Committee reviews all second-level appeals. The review meeting is normally held within forty-five (45) working days of our receipt of the request for second-level appeal.

- The subscriber or the subscriber’s authorized representative may attend the review meeting for medical necessity appeals.

- For medical necessity appeals, a clinical peer in the same or similar specialty as would typically manage the case being reviewed must concur with any adverse determination made by the Committee.

- The Member Appeals Committee will mail its decision regarding the appeal within five (5) working days after the review meeting. This decision is final and binding for administrative appeals. For medical necessity appeals only, if the subscriber is not satisfied with the decision at the second-level appeal, the appeal can be reviewed by an independent external review organization.

**Independent External Review**

- With the concurrence of the treating provider, the subscriber may request an independent external appeal conducted by a non-affiliated independent review organization (IRO) if the subscriber disagrees with the second-level decision.

- The request for review by an IRO must be made in writing to Blue Cross within sixty (60) days of the second-level appeal determination.

- The review will be completed by the IRO within thirty (30) days of the receipt of information, unless both parties agree to a longer period of time. If the request is urgent or emergent in nature, the IRO review will be completed within seventy-two (72) hours after the appeal is commenced. The IRO decision will be considered a final and binding decision.

**Expedited Internal Appeal**

- An expedited internal appeal may be initiated by the covered person or an authorized representative, with the consent of the covered person’s treating provider, or the provider acting on behalf of the covered person. The notation “Expedited Appeal” should be placed on the letter or envelope to assist in routing to the proper department. Decisions will be made no later than seventy-two (72) hours after the review commences.

- The expedited internal appeal is only for requests concerning admissions, availability of care, continued stay, or health care services for a covered person who is requesting emergency services or has received emergency services but has not been discharged from a facility. These reviews are not available for review of services previously provided.

- Expedited appeals should be sent to Blue Cross, Customer Service Unit – Expedited Appeal, Appeals and Grievance Coordinator, P.O. Box 98045, Baton Rouge, LA 70895-9045.

**Expedited External Review**
An expedited external review must be made within sixty (60) days of the initial denial that is the subject of review.

An expedited external review is a request for immediate review by an independent review organization (IRO) of an adverse initial determination not to authorize continued services for subscribers currently in the emergency room, under observation in a facility, or receiving inpatient care. This review is available if by pursuing the standard level of appeal, the subscriber could seriously jeopardize his life, health, or ability to regain maximum function.

The subscriber must have the concurrence of his treating provider to request this level of review. This review is not available for a review of services previously rendered.

We will forward all pertinent information to the IRO so the review is completed no later than seventy-two (72) hours once the review commences. All external review decisions are binding on us and on the subscriber for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

Appeals Process for ERISA Members

ERISA subscribers usually have two levels of appeal. The subscriber is required to complete the first level of appeal prior to instituting any civil action under ERISA section 502(a). The second level of appeal is usually voluntary. The two levels of review for administrative appeals are internal. The first level of review for medical necessity appeals is internal, and the second-level medical necessity appeal is usually handled by an IRO that is not affiliated with Blue Cross.

The subscriber has the right to appoint an authorized representative to represent him in any appeal. An authorized representative is a person to whom the subscriber has given written consent to represent the subscriber in an internal or external review.

Persons not involved in previous decisions regarding the subscriber’s claim will decide all appeals. A physician who is not subordinate to any previous decision maker on the subscriber’s claim will review medical necessity appeals.

First Level of Internal Appeals Process

- A subscriber, the subscriber’s authorized representative or provider acting on the subscriber’s behalf, must submit a request to appeal the decision in writing within 180 days following the receipt of an adverse benefit determination. Requests submitted after 180 days will not be considered.

- In the case of a claim involving urgent care as defined below, we will expedite the review process. The subscriber may request an expedited review orally or in writing. All necessary information may be transmitted between the parties by telephone, facsimile, or other similarly expeditious means.

- We will review the subscriber’s appeal promptly. The following describes the time
frames applicable to urgent care claims, pre-service claims and post-service claims:

- **Urgent care claims** will be decided as soon as reasonably possible taking into account medical exigencies, but no later than 72 hours after we receive the subscriber’s request for an appeal of an adverse benefit determination. “Urgent care claim” means any claim that the application of time periods for non-urgent care determinations (a) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Pre-service claims** will be decided no later than 30 days after receipt of the subscriber’s appeal of an adverse benefit determination. Pre-service claim means any claim for a benefit under the plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval or authorization of the benefit in advance of obtaining care or treatment.

- **Post-service claims** will be decided no later than 60 days after receipt of the subscriber’s appeal of an adverse benefit determination. Post-service claim means any claim for a benefit under the plan that is not an urgent care claim or a pre-service claim as defined above. Blue Cross may extend the period of review for a post-service claim by 60 days prior to the end of the initial 60-day review period if special circumstances require an extension of time. The subscriber will be notified in writing, and the letter will give the date by which we expect to make our decision.

- If we do not overturn our initial decision, the subscriber will be notified in writing of his right to begin the voluntary second level appeal process and any other ERISA rights that may be available to the subscriber at that time.

**Second Level Administrative Appeal (Voluntary)**

- Within 60 calendar days of the date of our first level Medical Necessity Appeal decision, a subscriber, who is not satisfied with the decision, may initiate a voluntary second level of the Appeal process. Requests submitted to us after sixty (60) days of the denial will not be considered. The subscriber does not have to complete this voluntary process in order to bring a civil action under ERISA section 502 (a).

- The second-level appeal will involve a committee review not previously involved in the subscriber’s claim determination.

- The committee will mail its decision regarding the appeal within five (5) working days after the meeting. The result of this committee is the final review for claims not involving medical necessity determinations.

**Second Level Medical Necessity Appeal (Voluntary)**

- A non-affiliated external IRO will perform the second-level medical necessity appeal. The subscriber may request this level of appeal by sending Blue Cross a written request for an external review within 60 days of receipt of the first-level denial.

- The IRO will complete the review within 30 days from the IRO’s receipt of all necessary documentation from Blue Cross, and the IRO will notify the subscriber or
the subscriber’s authorized representative and the subscriber’s health care provider of its decision. Members are entitled to only one IRO appeal.

- The subscriber’s provider may request an expedited external review if the subscriber’s medical condition is of an urgent or emergent nature. Expedited reviews will be completed within 72 hours after the appeal is commenced. Otherwise, the subscriber will need to have the concurrence of his/her treating physician to request the external review.
Section VII: Preventive Medicine Guidelines

The following Preventive Medicine Guidelines are based on industry standards, and they are reviewed by the Plan’s Medical Quality Management Committee, which consists of network physicians, the Blue Cross Medical Director and other Blue Cross representatives. The guidelines are a reference for providers to encourage the appropriate provision of preventive services to patients, based on age, gender and risk level. They include screening tests for early detection of disease, immunizations to prevent infections or disease, counseling to reduce risks and prenatal care recommendations.

The guidelines are divided into six tables based on age and/or special conditions, e.g. pregnancy, and a chart of the recommended childhood immunizations.
### TABLE 1. BIRTH TO 10 YEARS (Schedule 2, 4, 6, 12, 18 months, 4-6 years)*

<table>
<thead>
<tr>
<th>Interventions Considered and Recommended for the Periodic Health Examination</th>
<th>Leading Causes of Death Conditions originating in perinatal period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital anomalies</td>
</tr>
<tr>
<td></td>
<td>Sudden infant death syndrome (SIDS)</td>
</tr>
<tr>
<td></td>
<td>Unintentional injuries (non-motor vehicle)</td>
</tr>
<tr>
<td></td>
<td>Motor vehicle injuries</td>
</tr>
</tbody>
</table>

### INTERVENTIONS FOR THE GENERAL POPULATION

#### SCREENING
- Height and weight
- Blood pressure
- Vision screen (age 3-4 years)
- Hemoglobinopathies screen (birth)
- Phenylalanine level (birth)
- T4 and/or TSH (birth)
- Hemoglobin and hematocrit
- Urinalysis for bacteriuria

#### COUNSELING
- **Injury Prevention**
  - Child safety care seats (age < 5 years)
  - Lap-shoulder belts (age > 5 years)
  - Bicycle helmet, avoid bicycling near traffic
  - Smoke detector, flame retardant sleepwear
  - Hot water heater temperature < 120-130°F
  - Window/stair guards, pool fence
  - Safe storage of drugs, toxic substances, firearms and matches
  - Poison control phone number

- **Substance Abuse**
  - Effects of passive smoking
  - Anti-tobacco message

- **Diet and Exercise**
  - Breast-feeding, iron-enriched formula and foods (infants and toddlers)
  - Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits and vegetables (age > 2 years)
  - Regular physical activity

- **Dental Health**
  - Floss, brush with fluoride toothpaste daily
  - Regular visits to dental care provider
  - Advice about baby bottle tooth decay

- **IMMUNIZATIONS**
  - Diphtheria-tetanus-acellular pertussis (DTaP)
  - IPV (polio vaccine)
  - H. influenza type b (Hib) conjugate
  - Measles-mumps-rubella (MMR)
  - Hepatitis B
  - Varicella
  - PCV (pneumococcal vaccine)
  - Influenza
  - Hepatitis A

- **CHEMOPROPHYLAXIS**
  - Ocular prophylaxis (birth)

---

*Six visits are required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).

1. Annually calculate and plot BMI.
2. Whether screening should be universal or targeted to high-risk groups will depend on the proportion of high-risk individuals in the screening area and other considerations.
3. Done during the first 24 hours of life, repeat by age two weeks.
4. Optimally between day 2 and 6, but in all cases before newborn nursery discharge.
5. Once during infancy.
6. Once between ages 4-6 years.
7. 2, 4, 6 and 12-18 months, once between ages 4-6 years.
8. 2, 4, 6-18 months, and once between ages 4-6 years.
9. 2, 4, 6 and 12-15 months; no dose needed at 6 months if PPP-OMP vaccine used for first two doses.
10. 12-15 months and 4-6 years.
11. Birth, 1 month, 6 months, or 1-2 months later and 6-18 months.
12. 12-18 months, or any child without history of chickenpox or previous immunization. Include information on risk in adulthood, duration of immunity and potential need for booster doses.
13. 2, 4, 6 months, and once between 12-15 months.
14. Annually, 6-23 months.
15. 12 -23 months, with 2nd dose administered at least 6 months apart.
## INTERVENTIONS FOR HIGH-RISK POPULATIONS

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>POTENTIAL INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm or low birth weight</td>
<td>Hemoglobin/hematocrit (HR1)</td>
</tr>
<tr>
<td>Infants of mothers at risk for HIV</td>
<td>HIV testing (HR2)</td>
</tr>
<tr>
<td>Low income; immigrants</td>
<td>Hemoglobin/hematocrit (HR1), PPD (HR3)</td>
</tr>
<tr>
<td>TB contacts</td>
<td>PPD (HR3)</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>Hemoglobin/hematocrit (HR1), PPD(HR3), hepatitis A vaccine (HR4), pneumococcal vaccine (HR5)</td>
</tr>
<tr>
<td>Travelers to developing countries</td>
<td>Hepatitis A vaccine (HR4)</td>
</tr>
<tr>
<td>Residents of long-term care facilities</td>
<td>PPD (HR3), hepatitis A vaccine (HR4), influenza vaccine (HR6)</td>
</tr>
<tr>
<td>Certain chronic medical conditions</td>
<td>PPD (HR3), pneumococcal vaccine (HR5), influenza vaccine (HR6), Meningococcal vaccine [(MCV4)(HR11)]</td>
</tr>
<tr>
<td>Increased individual or community lead exposure</td>
<td>Blood lead level (HR7)</td>
</tr>
<tr>
<td>Inadequate water fluoridation</td>
<td>Daily fluoride supplement (HR8)</td>
</tr>
<tr>
<td>Family history of skin cancer, nevi, fair skin,</td>
<td>Avoid excess/midday sun, use protective clothing (HR9)</td>
</tr>
<tr>
<td>hair</td>
<td></td>
</tr>
<tr>
<td>Children at risk for hearing impairment</td>
<td>Hearing test (HR10)</td>
</tr>
</tbody>
</table>

### OVERVIEW

**HR 1** = Infants age 6-12 months who are: living in poverty, black, Native American or Alaska Native, immigrants from developing countries, preterm and low birth weight infants, infants whose principal dietary intake is unfortified cow’s milk.

**HR 2** = Infants born to high-risk mothers whose HIV status is unknown. Women at high-risk include: past or present injection drug use; persons who exchange sex for money or drugs and their sex partners; injection drug-using, bisexual, or HIV-positive sex partners currently or in the past; persons seeking treatment for STDs; blood transfusion during 1978-1985.

**HR 3** = Persons infected with HIV, close contacts of persons with known or suspected TB, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), residents of long-term care facilities.

**HR 4** = Persons > 2 years living in or traveling to areas where the disease is endemic and where periodic outbreaks occur (e.g., countries with high or intermediate endemicity; certain Alaska Native, Pacific Island, Native American, and religious communities). Consider for institutionalized children aged < 2 years Clinicians should also consider local epidemiology.

**HR 5** = Immunocompetent persons > 2 years with certain medical conditions, including chronic cardiac or pulmonary disease, diabetes mellitus, and anatomic asplenia. Immunocompetent persons > 2 years living in high-risk environments or social settings (e.g., certain Native American and Alaska Native populations).

**HR 6** = Annual vaccination of children > 6 months who are residents of chronic care facilities or who have chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.
**HR 7** = Children about age 12 months who: 1) live in communities in which the prevalence of lead levels requiring individual intervention, including residential lead hazard control or chelation, is high or undefined; 2) live in or frequently visit a home built before 1950 with dilapidated paint or with recent or ongoing renovation or remodeling; 3) have close contact with a person who has an elevated lead level; 4) live near lead industry or heavy traffic; 5) live with someone whose job or hobby involves lead exposure; 6) use lead-based pottery; or 7) take traditional ethnic remedies that contain lead.

**HR 8** = Children living in areas with inadequate water fluoridation (<0.6 ppm).

**HR 9** = Persons with a family history of skin cancer, a large number of moles, atypical moles, poor tanning ability, or light skin, hair and eye color.

**HR 10** = Children with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birth weight below 1,500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

**HR 11** = Children aged ≥ 2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups.
**TABLE 2. AGES 11-24 YEARS (Schedule: 11-12 years old)**

<table>
<thead>
<tr>
<th>Interventions Considered and Recommended for the Periodic Health Examination</th>
<th>Leading Causes of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Motor vehicle/other unintentional injuries</td>
</tr>
<tr>
<td></td>
<td>Homicide</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td>Malignant neoplasms</td>
</tr>
<tr>
<td></td>
<td>Heart diseases</td>
</tr>
</tbody>
</table>

**INTERVENTIONS FOR THE GENERAL POPULATION**

**SCREENING**
- Height & weight
- Blood pressure
- Papanicolaou (Pap) test (females)
- Chlamydia screen (females < 25 years)
- Rubella serology or vaccination history (females > 12 years)
- Assess for problem drinking
- Fasting lipoprotein profile

**COUNSELING**

**Injury Prevention**
- Lap/shoulder belts
- Bicycle/motorcycle/ATV helmets
- Safe storage/removal of firearms
- Smoke detector

**Substance Abuse**
- Avoid tobacco use
- Counsel parents who smoke regarding effects of passive smoking on children’s health
- Avoid underage drinking and illicit drug use
- Avoid alcohol/drug use while driving, swimming, boating, etc.

**Sexual Behavior**
- STD prevention, abstinence, avoid high risk behavior, condoms/female barrier with spermicide
- Unintended pregnancy, contraception

**Diet and Exercise**
- Limit fat and cholesterol; maintain caloric balance: emphasize grains, fruits, vegetables
- Adequate calcium intake (females)
- Regular physical activity

**Dental Health**
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

**IMMUNIZATIONS**
- Tetanus and diphtheria toxoids (Td) booster
- Tetanus and diphtheria toxoids and acellular pertussis (Tdap)
- Hepatitis B (11-12 years)
- MMR (11-12 years)
- Rubella (females > 12 years)
- Varicella (≥13 years)
- Meningococcal conjugate vaccine (MCV4)

**CHEMOPROPHYLAXIS**
- Multivitamin with folic acid (females planning/capable of pregnancy)

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*One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical and no reliable history of discretion (except as indicated in other footnotes).*

1 Annually calculate and plot BMI in all adolescents.
2 Periodic BP for persons ages 21.
3 Should begin approximately 3 years after first sexual intercourse, or by age 21, whichever comes first, then annually.
4 If sexually active.
5 Serologic testing, documented vaccination history, and routine vaccination against rubella (preferable with MMR) are equally acceptable alternatives.
6 Every 5 years in adults aged 20 years or older.

7 If not previously immunized, current visit, 1 and 6 months later.
8 If no previous second dose of MMR.
9 If not previously immunized, and no reliable history of chickenpox. Should receive 2 doses 4 weeks apart.
10 Every 10 years
11 Age 11-12 years, If the recommended childhood DTP/DTaP vaccination series has been completed, and no previous Td booster received. Adolescents aged 13-18 years who have completed the DTP/DTaP recommended childhood vaccination series, but missed the age 11-12 year Td/Tdap booster.
12 All children age 11-12 years and unvaccinated adolescents entering high school, age 15 years.
## INTERVENTIONS FOR HIGH RISK POPULATIONS

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>POTENTIAL INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk sexual behavior</td>
<td>RPR/VDRL (HR1), screen for gonorrhea (female) (HR2), HIV (HR3), chlamydia (female) (HR4), hepatitis A vaccine (HR5)</td>
</tr>
<tr>
<td>Injection or street drug use</td>
<td>RPR/VDRL (HR1), HIV screen (HR3), hepatitis A vaccine (HR5), PPD (HR6), advice to reduce infection risk (HR7)</td>
</tr>
<tr>
<td>TB contacts: immigrants, low income</td>
<td>PPD (HR6)</td>
</tr>
<tr>
<td>Native American/Alaska Natives</td>
<td>Hepatitis A vaccine (HR5), PPD (HR6), pneumococcal vaccine (HR8)</td>
</tr>
<tr>
<td>Travelers to developing countries</td>
<td>Hepatitis A vaccine (HR5), meningococcal vaccine [(MCV4) (HR16)]</td>
</tr>
<tr>
<td>Certain chronic medical conditions</td>
<td>PPD (HR6), pneumococcal vaccine (HR8), influenza vaccine (HR9), meningococcal vaccine (MCV4)(HR16)</td>
</tr>
<tr>
<td>Settings where adolescents and young adults congregate</td>
<td>Second MMR (HR10), meningococcal vaccine [(MCV4 or MPSV4) (HR16)]</td>
</tr>
<tr>
<td>Susceptible to varicella, measles, mumps</td>
<td>Varicella vaccine (HR11), MMR (HR12)</td>
</tr>
<tr>
<td>Blood transfusion between 1975-1985</td>
<td>HIV screen (HR3)</td>
</tr>
<tr>
<td>Institutionalized persons, health care/lab workers</td>
<td>Hepatitis A vaccine (HR5), PPD (HR6), influenza vaccine (HR9)</td>
</tr>
<tr>
<td>Family history of skin cancers, nevi, fair skin, eyes, hair</td>
<td>Avoid excess/midday sun, use protective clothing (HR13)</td>
</tr>
<tr>
<td>Prior pregnancy with neural tube defect</td>
<td>Folic acid 4.0 mg (HR14)</td>
</tr>
<tr>
<td>Inadequate water fluoridation</td>
<td>Daily fluoride supplement (HR15)</td>
</tr>
<tr>
<td>Receiving health care in certain clinical settings</td>
<td>HIV screen (HR3)</td>
</tr>
</tbody>
</table>

## OVERVIEW

**HR 1** = Persons who exchange sex for money or drugs and their sex partners; persons with other STDs (including HIV); men who have sex with other men and engage in high-risk sexual behavior; and sexual contact with persons with active syphilis. Clinicians should also consider local epidemiology.

**HR 2** = Females who are under the age of 25 years, including sexually active adolescents; history of previous gonorrhea infection; other sexually transmitted infections; new or multiple sexual partners; inconsistent condom use; sex work; and drug use. Clinicians should also consider local epidemiology.

**HR 3** = Males who had sex with males after 1975; persons having unprotected sex with multiple partners; past or present injection drug use; persons who exchange sex for money or drugs or who have sex partners who do; persons whose past or present sex partners were HIV-infected, bisexual, injection drug users; blood transfusion during 1978-1985; persons seeking treatment for STDs. Clinicians should also consider local epidemiology.
High-risk settings include STD clinics, correctional facilities, homeless shelters, tuberculosis clinics, clinics serving men who have sex with men, and adolescent health clinics with a high prevalence of STDs.

**HR 4** = Sexually active females with multiple risk factors including: history of prior STD; new or multiple sex partners; age under 25; non-use or inconsistent use of barrier contraceptives; cervical ectopy. Clinicians should consider local epidemiology of the disease in identifying other high-risk groups.

**HR 5** = Persons living in, traveling to or working in areas where the disease is endemic and where periodic outbreaks occur (e.g., countries with high or intermediate endemicity; certain Alaska Native, Pacific Island, Native American and religious communities); men who have sex with men; injection or street drug users. Vaccine may be considered for institutionalized persons and workers in these institutions; military personnel; and day-care, hospital and laboratory workers. Clinicians should also consider local epidemiology.

**HR 6** = HIV positive, close contacts of persons with known or suspected TB, health care workers, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), alcoholics, injection drug users and residents of long-term facilities.

**HR 7** = Persons who continue to inject drugs.

**HR 8** = Immunocompetent persons with certain medical conditions, including chronic pulmonary disease, diabetes mellitus and anatomic asplenia. Immunocompetent persons who live in high-risk environments or social settings (e.g., certain Native American and Alaska Native populations).

**HR 9** = Annual vaccination of residents of chronic care facilities; persons with chronic cardiopulmonary disorders (including asthma); chronic metabolic diseases (including diabetes mellitus); hemoglobinopathies; immunosuppression (including immunosuppression caused by medication or human immunodeficiency virus [HIV]); renal dysfunction; persons who have any condition (e.g. cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration; persons who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza infection; and all health care providers for high-risk patients.

**HR 10** = Adolescents and young adults in settings where such individuals congregate (e.g., high schools and colleges), if they have not previously received a second dose.

**HR 11** = Healthy persons age > 13 years without a history of chickenpox or previous immunization. Consider serologic testing for presumed susceptible persons aged > 13 years.

**HR 12** = Persons born after 1956 who lack evidence of immunity to measles or mumps (e.g., documented receipt of live vaccine on or after the first birthday, laboratory evidence of immunity or a history of physician-diagnosed measles or mumps).

**HR 13** = Persons with a family or personal history of skin cancer, a large number of moles, atypical moles, poor tanning ability, or light skin, hair and eye color.

**HR 14** = Women with prior pregnancy affected by neural tube defect who are planning pregnancy.

**HR 15** = Persons age < 17 years living in areas with inadequate water fluoridation (<0.6 ppm).

**HR 16** = College freshman living in dormitories; adolescents with terminal complement deficiencies or anatomic or functional asplenia; military recruits; travelers to areas where Neisseria meningitis is hyperendemic or epidemic, especially the “meningitis belt” of sub-Saharan Africa during the dry season (Dec. – June).
TABLE 3. AGES 25-64 YEARS (Schedule: every 1-3 years)*

<table>
<thead>
<tr>
<th>Interventions Considered and Recommended for the Periodic Health Examination</th>
<th>Leading Causes of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Malignant neoplasms</td>
</tr>
<tr>
<td></td>
<td>Heart diseases</td>
</tr>
<tr>
<td></td>
<td>Motor vehicle and other unintentional injuries</td>
</tr>
<tr>
<td></td>
<td>Human immunodeficiency virus (HIV) infection</td>
</tr>
<tr>
<td></td>
<td>Suicide and homicide</td>
</tr>
</tbody>
</table>

### INTERVENTIONS FOR THE GENERAL POPULATION

**SCREENING**
- Blood pressure
- Height and weight
- Fasting lipoprotein profile
- Papanicolaou (Pap) women
- Fecal occult blood test
- Sigmoidoscopy or colonoscopy
- Mammogram
- Clinical breast exam
- Assess for problem drinking
- Rubella serology or vaccination history (women of childbearing age)
- Clinical testicular exam
- Digital rectal exam
- PSA test
- Chlamydia screen (females < 25 years if sexually active)

**COUNSELING**
- **Substance Use**
  - Tobacco cessation
  - Counsel parents who smoke regarding effects of passive test smoking on children’s health
  - Avoid alcohol/drug use while driving, swimming, boating, etc.

- **Diet and Exercise**
  - Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables
  - Adequate calcium intake (women)
  - Regular physical activity

- **Injury Prevention**
  - Lap/shoulder belts
  - Motorcycle/bicycle/ATV helmets
  - Smoke detector
  - Safe storage/removal of firearms

- **Sexual Behavior**
  - STD prevention; avoid high-risk behavior; condoms/female barrier with spermicide

- **Dental Health**
  - Regular visits to dental care provider
  - Floss, brush with fluoride toothpaste daily

- **CHEMOPROPHYLAXIS**
  - Multivitamin with folic acid (women planning or capable of pregnancy)
  - Discuss hormone prophylaxis (peri- and post-menopausal women)
  - Aspirin chemoprevention

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*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.
1 Every 5 years.
2 Annually ages 25-29 years. Beginning at age 30 years, every 2-3 years in women who have had 3 consecutive, normal Pap tests.
3 Annually from age 50 years.
4 Every 5 years from age 50 years.
5 Every 10 years from age 50 years.
6 Initial exam between 35-40 years, then every 1-2 years for women ages 40-49, then annually.
7 Every 3 years for women ages 25-39 years, then annually.
8 Serology testing documented, vaccination history, and routine vaccination (preferably with MMR) are equally acceptable.
9 Every 1-3 years under age 40 years, then annually.
10 Every 10 years.
11 Men older than 40 years, postmenopausal women, and younger people with risk factors for coronary heart disease.
### INTERVENTIONS FOR HIGH-RISK POPULATIONS

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>POTENTIAL INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk sexual behavior</td>
<td>RPR/VDRL (HR1); screen for gonorrhea (female) (HR2); HIV (HR3); chlamydia (female) (HR4); hepatitis B vaccine (HR5); hepatitis A vaccine (HR6)</td>
</tr>
<tr>
<td>Injection or street drug use</td>
<td>RPR/VDRL (HR1); HIV screen (HR3); hepatitis B vaccine (HR5); hepatitis A vaccine (HR6); PPD (HR7); advice to reduce infection risk (HR8)</td>
</tr>
<tr>
<td>Low income; TB contacts; immigrants; alcoholics</td>
<td>PPD (HR7)</td>
</tr>
<tr>
<td>Native American/Alaska Natives</td>
<td>Hepatitis B vaccine (HR5); hepatitis A vaccine (HR6), pneumococcal vaccine (HR9)</td>
</tr>
<tr>
<td>Travelers to developing countries</td>
<td>Hepatitis B vaccine (HR5); hepatitis A vaccine (HR6), meningococcal vaccine (HR 15)</td>
</tr>
<tr>
<td>Certain chronic medical conditions</td>
<td>PPD (HR7); pneumococcal vaccine (HR9); influenza vaccine (HR10); hepatitis A vaccine (HR6); meningococcal vaccine (HR 15)</td>
</tr>
<tr>
<td>Blood product recipients</td>
<td>HIV screen (HR3); hepatitis B vaccine (HR5)</td>
</tr>
<tr>
<td>Susceptible to measles, mumps, rubella, or varicella</td>
<td>MMR (HR11); varicella vaccine (HR12)</td>
</tr>
<tr>
<td>Institutionalized persons</td>
<td>Hepatitis A vaccine (HR6); PPD (HR7); pneumococcal vaccine (HR9); influenza vaccine (HR10)</td>
</tr>
<tr>
<td>Health care/lab workers</td>
<td>Hepatitis B vaccine (HR5); hepatitis A vaccine (HR6); PPD (HR7); influenza vaccine (HR10)</td>
</tr>
<tr>
<td>Family history of skin cancer; fair skin, eyes and hair</td>
<td>Avoid excess/midday sun, use protective clothing (HR13)</td>
</tr>
<tr>
<td>Certain occupations and/or residential settings</td>
<td>Meningococcal vaccine (HR 15)</td>
</tr>
<tr>
<td>Previous pregnancy with neural tube defect</td>
<td>Folic acid 4.0 mg (HR14)</td>
</tr>
<tr>
<td>Receiving health care in certain clinical setting</td>
<td>HIV (HR 3)</td>
</tr>
<tr>
<td>Women at increased risk for osteoporotic fractures</td>
<td>Central bone density measurement (HR 16)</td>
</tr>
</tbody>
</table>

### OVERVIEW

**HR 1** = Persons who exchange sex for money or drugs and their sex partners; persons with other STDs (including HIV); men who have sex with men and engage in high-risk sexual behavior; and sexual contacts of persons with active syphilis. Clinicians should also consider local epidemiology.

**HR 2** = Women who exchange sex for money or drugs, or history of previous gonorrhea infection; other sexually transmitted infections; new or multiple sex partners, inconsistent condom use; sex work; and drug use. Clinicians should also consider local epidemiology.
HR 3 = Men who had sex with men after 1975; unprotected sex with multiple partners; past or present injection drug use; persons who exchange sex for money or drugs and their sex partners; persons seeking treatment for STDs; blood transfusion during 1978-1985; bisexual or HIV-positive sex partner currently or in the past; and persons who receive health care in a high-risk clinical setting. Clinicians should also consider local epidemiology.

HR 4 = Sexually active women with multiple risk factors including: history of STD, new or multiple sex partners, nonuse or inconsistent use of barrier contraceptives, cervical ectopy. Clinicians should also consider local epidemiology.

HR 5 = Blood product recipients (including hemodialysis patients); persons with frequent occupational exposure to blood or blood products; men who have sex with men; injection drug users and their sex partners; persons with more than one sex partner in the previous 6 months; persons with other STDs (including HIV), household contacts and sex partners of persons with chronic hepatitis B infection; clients and staff of institutions for the developmentally disabled; all clients of STD clinics; inmates of correctional facilities; or travelers to countries with high or intermediate prevalence of chronic HBV infection > 6 months.

HR 6 = Persons living in, traveling to, or working in areas where the disease is endemic and where periodic outbreaks occur (e.g., countries with high or intermediate endemicity, certain Alaska Native, Pacific Island, Native American, and religious communities), men who have sex with men, injection or street drug users. Persons working with hepatitis A virus HAV-infected primates or with HAV in a research laboratory setting. Clinicians should also consider local epidemiology. Persons with clotting factor disorders or chronic liver disease.

HR 7 = HIV positive, close contacts of persons with known or suspected TB, health care workers, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), alcoholics, injection drug users and residents of long-term facilities.

HR 8 = Persons who continue to inject drugs.

HR 9 = Chronic cardiovascular disease; chronic disorders of the pulmonary system excluding asthma; diabetes mellitus; chronic liver disease, including liver disease as a result of alcohol abuse; chronic renal failure or nephritic syndrome; functional or anatomic asplenia; immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids; and cochlear implants; Alaska Native and certain American Indian populations; residents of nursing homes and long-term care facilities.

HR 10 = Annual vaccination of residents of nursing homes, long-term care and assisted living facilities; persons with chronic cardiopulmonary disorders, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or HIV); any condition (e.g., cognitive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorder) that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration; and health care workers and employees of long-term care and assisted living facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home household contacts, and caregivers of children birth through 23 months of age with high-risk conditions).

HR 11 = Persons born after 1956 who lack evidence of immunity to measles or mumps (e.g., documented receipt of live vaccine on or after the first birthday, laboratory evidence of immunity or a history of physician-diagnosed measles or mumps); recent exposure to measles or in an outbreak setting; previous vaccination with killed measles vaccine; vaccination with an unknown type of measles vaccine during 1963-1967; students in postsecondary educational institutions; work in a healthcare facility; plan to travel internationally.

HR 12 = No evidence of immunity to varicella. Special consideration should be given to those who have close contact with persons at high risk for severe disease (healthcare workers and family contacts of immunocompromised persons); high risk for exposure or transmission (e.g., teachers of young children, child care employees, residents and staff members of institutional settings, including correctional facilities, college students, military personnel, adolescents and adults living in households with children, nonpregnant women of childbearing age, and international travelers. Consider serologic testing for presumed susceptible adults.
HR 13 = Persons with a family or personal history of skin cancer, a large number of moles, atypical moles, poor tanning ability, or light skin, hair and eye color.

HR 14 = Women with previous pregnancy affected by neural tube defect who are planning pregnancy.

HR 15 = Anatomic or functional asplenia, or terminal complement component deficiencies; college freshman living in dormitories; microbiologists who are routinely exposed to isolates of Neisseria meningitides; military recruits; persons who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, especially the “meningitis belt” of sub-Saharan Africa during the dry season (Dec. – June), particularly if contact with the local populations will be prolonged.

HR 16 = Age 60-64 years; lower body weight (< 70kg); no current use of estrogen therapy; smoking; weight loss; family history; personal history of fracture as an adult; current fracture; history of fracture in first-degree relative; inactive lifestyle; alcohol or caffeine use; or low calcium and vitamin D intake; use of certain medications (i.e., corticosteroids, chemotherapy, anticonvulsants, and others); Caucasian or Asian background.
## TABLE 4. AGES 65 AND OLDER YEARS (Schedule: every year)*

<table>
<thead>
<tr>
<th>Interventions Considered and Recommended for the Periodic Health Examination</th>
<th>Leading Causes of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heart diseases</td>
</tr>
<tr>
<td></td>
<td>Malignant neoplasms (lung, colorectal, breast)</td>
</tr>
<tr>
<td></td>
<td>Cerebrovascular disease</td>
</tr>
<tr>
<td></td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td></td>
<td>Pneumonia and influenza</td>
</tr>
</tbody>
</table>

### INTERVENTIONS FOR THE GENERAL POPULATION

#### SCREENING
- Blood pressure
- Height and weight
- Fecal occult blood test<sup>1</sup>
- Sigmoidoscopy<sup>2</sup> or colonoscopy<sup>3</sup>
- Mammogram (women)<sup>1</sup>
- Clinical breast exam (women)<sup>1</sup>
- Papanicolaou (Pap) test (women)<sup>4</sup>
- Digital rectal exam<sup>1</sup>
- Clinical Testicular Exam (men)<sup>1</sup>
- Vision screening
- Assess for hearing impairment
- Assess for problem drinking
- PSA test<sup>1</sup>
- Fasting lipoprotein profile<sup>2</sup>
- Abdominal aortic Ultrasound (men)<sup>5</sup>
- Central bone density measurement (women)<sup>6</sup>
- Assess for fall risk<sup>7</sup>

#### INJURY PREVENTION
- Lap/shoulder belts
- Motorcycle and bicycle helmets
- Fall prevention
- Safe storage/removal of firearms
- Smoke detector
- Set hot water heater to <120-130°F
- CPR training for household members

#### DENTAL HEALTH
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

#### SEXUAL BEHAVIOR
- STD prevention, avoid high-risk sexual behavior, use condoms

#### COUNSELING

##### SUBSTANCE USE
- Tobacco cessation
- Avoid alcohol/drug use while driving, swimming, boating, etc.

##### DIET AND EXERCISE
- Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables
- Adequate calcium intake (women)
- Regular physical activity

##### IMMUNIZATIONS
- Pneumococcal vaccine
- Influenza<sup>1</sup>
- Tetanus and diphtheria toxoid (Td) booster<sup>3</sup>

##### CHEMOPROPHYLAXIS
- Discuss hormone prophylaxis (peri- and postmenopausal women)
- Aspirin chemoprevention<sup>8</sup>

*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1 Annually.
2 Every 5 years.
3 Every 10 years.
4 Every 2-3 years in women who have had 3 consecutive, normal Pap tests. Beginning at age 70 years, women who have had 3 or more consecutive normal Pap tests and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening.
5 One-time screening for abdominal aortic aneurysm in men aged 65-75 years who have ever smoked (at least 100 cigarettes/lifetime).
6 Every 2 years beginning at age 65 years.
7 Annual fall history with balance and gait screening if one fall is reported.
8 Men older than 40 years, postmenopausal women, and younger people with risk factors for coronary heart disease.
### INTERVENTIONS FOR HIGH-RISK POPULATIONS

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>POTENTIAL INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized persons</td>
<td>PPD (HR1), hepatitis A vaccine (HR 2), amantadine/rimantadine (HR 4)</td>
</tr>
<tr>
<td>Certain chronic medical conditions; TB contacts; low-income; immigrants; alcoholics</td>
<td>PPD (HR1), hepatitis A vaccine (HR 2); meningococcal vaccine (HR 13)</td>
</tr>
<tr>
<td>Persons reporting &gt; 1 fall</td>
<td>Fall prevention/intervention (HR 5)</td>
</tr>
<tr>
<td>Cardiovascular disease risk factors</td>
<td>Consider cholesterol screening (HR 6)</td>
</tr>
<tr>
<td>Family history of skin cancer; nevi; fair skin, eyes, hair</td>
<td>Avoid excess/midday sun, use protective clothing (HR 7)</td>
</tr>
<tr>
<td>Native Americans/Alaska Natives</td>
<td>PPD (HR1), hepatitis A vaccine (HR 2)</td>
</tr>
<tr>
<td>Travelers to developing countries</td>
<td>Hepatitis A vaccine (HR 2), hepatitis B vaccine (HR 8), meningococcal vaccine (HR 13)</td>
</tr>
<tr>
<td>Blood product recipients</td>
<td>HIV screen (HR3), hepatitis B vaccine (HR 8)</td>
</tr>
<tr>
<td>High-risk sexual behavior</td>
<td>Hepatitis A vaccine (HR 2), HIV screen (HR 3), hepatitis B vaccine (HR 8), RPR/VDRL (HR 9)</td>
</tr>
<tr>
<td>Injection or street drug use</td>
<td>PPD (HR1), hepatitis A vaccine (HR 2), HIV screen (HR 3), hepatitis B vaccine (HR 8), RPR/VDRL (HR 9), advice to reduce infection risk (HR 10)</td>
</tr>
<tr>
<td>Health care/lab workers</td>
<td>PPD (HR1), hepatitis A vaccine (HR 2); amantadine/rimantadine (HR 4), hepatitis B vaccine (HR 8)</td>
</tr>
<tr>
<td>Persons susceptible to varicella, measles, mumps</td>
<td>Varicella vaccine (HR11), MMR (HR 12) and rubella</td>
</tr>
<tr>
<td>Receiving health care in a certain clinical settings</td>
<td>HIV screen (HR 3)</td>
</tr>
</tbody>
</table>

**OVERVIEW**

**HR 1** = HIV positive; close contacts of persons with known or suspected TB; health care workers; persons with medical risk factors associated with TB; immigrants from countries with high TB prevalence; medically underserved, low-income populations (including homeless); alcoholics; injection drug users; and residents of long-term care facilities.

**HR 2** = Persons living in, traveling to or working in areas where the disease is endemic and where periodic outbreaks occur (e.g., countries with high or intermediate endemicity, certain Alaska Native, Pacific Island, Native American and religious communities); men who have sex with men; injection or street drug users. Persons working with hepatitis A virus HAV-infected primates or with HAV in a research laboratory setting. Persons with clotting factor disorders or chronic liver disease. Clinicians should also consider local epidemiology.
HR 3 = Men who had sex with men after 1975; unprotected sex with multiple partners; past or present injection drug use; persons who exchange sex for money or drugs and their sex partners; bisexual or HIV-positive sex partner currently or in the past; blood transfusion during 1978-1985; persons seeking treatment for STDs; and persons who receive health care in a high-risk clinical setting. Clinicians should also consider local epidemiology.

HR 4 = Consider for persons who have not received influenza vaccine or are vaccinated late; when the vaccine may be ineffective due to major antigenic changes in the virus; for unvaccinated persons who provide home care for high-risk persons; to supplement protection provided by vaccine in persons who are expected to have a poor antibody response; and for high-risk persons in whom the vaccine is contraindicated.

HR 5 = Persons aged 75 years and older or aged 70-74 with one or more additional risk factors including: muscle Weakness; history of falls; use of assistive device; visual deficit; arthritis; impaired ADL; depression; use of certain psychoactive and cardiac medications (e.g., benzodiazepines, antihypertensives), use of more than four prescription medications, impaired cognition, strength, balance or gait. Intensive individualized home-based multifactorial fall prevention intervention is recommended in settings where adequate resources are available to deliver such services.

HR 6 = Although evidence is insufficient to recommend routine screening in elderly persons, clinicians should consider cholesterol screening on a case-by-case basis for persons ages 65-75 with additional risk factors (e.g., smoking, diabetes or hypertension).

HR 7 = Persons with a family or personal history of skin cancer, a large number of moles, atypical moles, poor tanning ability or light skin, hair and eye color.

HR 8 = Blood product recipients (including hemodialysis patients); persons with frequent occupational exposure to blood or blood products; men who have sex with men; injection drug users and their sex partners; persons with more than one sex partner in the previous 6 months; persons with other STDs (including HIV); household contacts and sex partners of persons with chronic hepatitis B infection; clients and staff of institutions for the developmentally disabled; all clients of STD clinics; inmates of correctional facilities; and travelers to countries with high or intermediate prevalence of chronic HBV infection > 6 months.

HR 9 = Persons who exchange sex for money or drugs and their sex partners; men who have sex with men and engage in high-risk sexual behavior persons with other STDs (including HIV); and sexual contacts of persons with active syphilis. Clinicians should also consider local epidemiology.

HR 10 = Persons who continue to inject drugs.

HR 11 = No evidence of immunity to varicella. Special consideration should be given to those who have close contact with persons at high risk for severe disease (healthcare workers and family contacts of immunocompromised persons); high risk for exposure or transmission (e.g., teachers of young children, child care employees, residents and staff members of institutional settings, including correctional facilities, military personnel, adults living in households with children, and international travelers. Consider serologic testing for presumed susceptible adults.

HR 12 = Persons born after 1956 who lack evidence of immunity to measles or mumps (e.g., documented receipt of live vaccine on or after the first birthday, laboratory evidence of immunity or a history of physician-diagnosed measles or mumps); recent exposure to measles or in an outbreak setting; previous vaccination with killed measles vaccine; vaccination with an unknown type of measles vaccine during 1963-1967; work in a healthcare facility; plan to travel internationally.

HR 13 = Anatomic or functional asplenia, or terminal complement component deficiencies; microbiologists who are routinely exposed to isolates of Neisseria meningitides; persons who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, especially the “meningitis belt” of sub-Saharan Africa during the dry season (Dec. – June), particularly is contact with the local populations will be prolonged.
# TABLE 5. PREGNANT WOMEN**
Interventions Considered and Recommended for the Periodic Health Examination

## INTERVENTIONS FOR THE GENERAL POPULATION

<table>
<thead>
<tr>
<th>SCREENING</th>
<th>COUNSELING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Visit</strong></td>
<td><strong>Tobacco cessation, effect of passive smoking</strong></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Alcohol/other drug use</td>
</tr>
<tr>
<td>Hemoglobin/hematocrit</td>
<td>Nutrition, including adequate calcium intake</td>
</tr>
<tr>
<td>Hepatitis B surface antigen (HBsAg)</td>
<td>Encourage breastfeeding</td>
</tr>
<tr>
<td>RPR/VDRL</td>
<td>Lap/shoulder belts</td>
</tr>
<tr>
<td>Rubella serology or vaccination history</td>
<td>Infant safety car seats</td>
</tr>
<tr>
<td>(Rh) D typing, antibody screen</td>
<td>STD prevention, avoid high-risk sexual behavior, use of condoms</td>
</tr>
<tr>
<td>Offer CVS (&lt;13 weeks)(^2) or amniocentesis (15-18 weeks)(^3) (age &gt; 35 years)</td>
<td></td>
</tr>
<tr>
<td>Offer hemoglobinopathy screening</td>
<td>IMMUNIZATIONS</td>
</tr>
<tr>
<td>Assess for problem or risk drinking</td>
<td>Influenza(^3)</td>
</tr>
<tr>
<td>Offer HIV screening(^1)</td>
<td></td>
</tr>
<tr>
<td>Cervical cytology</td>
<td>CHEMOPROPHYLAXIS</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Multivitamin with folic acid(^4)</td>
</tr>
</tbody>
</table>

| Follow-up Visits | |
| Blood pressure | |
| Urine culture | |
| Offer amniocentesis (15-18 weeks)\(^2\) | |
| Offer multiple marker testing\(^2\) (15-18 weeks) | |
| Offer a serum a-fetoprotein\(^2\) (16-18 weeks) | |
| Glucose tolerance test or postprandial blood sugar (24-28 weeks) | |
| Vaginal culture for B-strep (36 weeks) | |

---

\(^1\) Universal screening is recommended for areas (states, counties or cities) with an increased prevalence of HIV infection among pregnant women. In low-prevalence areas, the choice between universal and targeted screening may depend on other considerations.

\(^2\) Women with access to counseling and follow-up services, reliable standardized laboratories, skilled high-resolution ultrasound, and, for those receiving serum marker testing, amniocentesis capabilities.

\(^3\) For women without chronic diseases/conditions, vaccinate if pregnancy will be at second or third trimester during influenza season. For women with chronic diseases/conditions, vaccinate at any time during pregnancy.

\(^4\) Beginning at least one month before conception and continuing through the first trimester.

**See Tables 2 and 3 for other preventive services recommended for women of this age.
## INTERVENTIONS FOR HIGH-RISK POPULATIONS

### POPULATION

<table>
<thead>
<tr>
<th>High-risk sexual behavior</th>
<th>Screen for chlamydia (first visit) (HR1), gonorrhea (first visit) (HR2), HIV (first visit) (HR3), HBsAg (third trimester) (HR4), RPR/VDRL (third trimester) (HR5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion 1978-1985</td>
<td>HIV screen (first visit) (HR3)</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>HIV screen (HR3), HBsAg (third trimester) (HR4), advice to reduce infection risk (HR6)</td>
</tr>
<tr>
<td>Unsensitized D-negative women</td>
<td>D(Rh) antibody testing (24-28 weeks) (HR7)</td>
</tr>
<tr>
<td>Risk factors for Down syndrome</td>
<td>Offer amniocentesis (15-18 weeks), folic acid 4.0mg, (HR9)</td>
</tr>
<tr>
<td>Women with uncertain menstrual histories or risk factors for intrauterine growth retardation (IUGR)</td>
<td>Ultrasound exam (second trimester, early third trimester for IUGR) (HR10)</td>
</tr>
</tbody>
</table>

### OVERVIEW

**HR 1** = Women with history of STD or new or multiple sex partners. Clinicians should also consider local epidemiology. Chlamydia screen should be repeated in third trimester if at continued risk.

**HR 2** = Women under age 25; new or multiple sex partners; or whose sex partner has multiple sexual contacts; women who exchange sex for money or drugs; history of previous gonorrhea infection; other sexually transmitted infections; inconsistent condom use; sex work; and drug use. Gonorrhea screen should be repeated in the third trimester if at continued risk. Clinicians should also consider local epidemiology.

**HR 3** = In areas where universal screening is not performed due to low prevalence of HIV infection, pregnant women with the following individual risk factors should be screened: past or present injection drug use; women who exchange sex for money or drugs; bisexual or HIV-positive sex partner currently or in the past; blood transfusion during 1978-1985; persons seeking treatment for STDs; unprotected sex with multiple partners; persons who receive health care is a high-risk clinical setting. Clinicians should also consider local epidemiology.

**HR 4** = Women who are initially HBsAg negative who are at high risk due to injection drug use, suspected exposure to hepatitis B during pregnancy, multiple sex partners.

**HR 5** = Women who exchange sex for money or drugs, women with other STDs (including HIV), and sexual contacts of persons with active syphilis. Clinicians should also consider local epidemiology.

**HR 6** = Women who continue to inject drugs.

**HR 7** = Unsensitized D-negative women.

**HR 8** = Prior pregnancy affected by Down syndrome, advanced maternal age (>35 years), known carriage of chromosome rearrangements.
HR 9 = Women with previous pregnancy affected by neural tube defect.

HR 10 = Women with uncertain menstrual histories or risk factors for intrauterine growth retardation (e.g., hypertension, renal disease, short, material stature, low pregnancy weight, failure to gain weight during pregnancy, smoking, alcohol and other drug abuse, and history of a previous fetal death or growth-retarded baby).
**TABLE 6. Conditions for which Clinicians Should Remain Alert**

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms of peripheral arterial disease</td>
<td>Older persons; smokers; diabetic persons</td>
</tr>
<tr>
<td>Skin lesions with malignant features</td>
<td>General population, particularly those with established risk factors</td>
</tr>
<tr>
<td>Symptoms and signs of oral cancer and premalignancy</td>
<td>Persons who use tobacco; older persons who drink alcohol regularly</td>
</tr>
<tr>
<td>Subtle or nonspecific symptoms and signs of thyroid dysfunction</td>
<td>Older persons; postpartum women; persons with Down syndrome</td>
</tr>
<tr>
<td>Signs of ocular-misalignment</td>
<td>Infants and children</td>
</tr>
<tr>
<td>Symptoms and signs of hearing impairment</td>
<td>Infants and young children (&lt; 3 years)</td>
</tr>
<tr>
<td>Large spinal curvatures</td>
<td>Adolescents</td>
</tr>
<tr>
<td>Changes in functional performance</td>
<td>Older persons</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>Adolescents; young adults; persons at increased risk for depression</td>
</tr>
<tr>
<td>Evidence of suicidal ideation</td>
<td>Persons with established risk factors for suicide</td>
</tr>
<tr>
<td>Various presentations of family violence</td>
<td>General population</td>
</tr>
<tr>
<td>Symptoms and signs of drug abuse</td>
<td>General population</td>
</tr>
<tr>
<td>Obvious signs of untreated tooth decay or mottling, inflamed or cyanotic</td>
<td>General population</td>
</tr>
<tr>
<td>gingiva, loose teeth, and severe halitosis</td>
<td></td>
</tr>
<tr>
<td>Evidence of early childhood caries: mismatching of upper and lower</td>
<td>Children</td>
</tr>
<tr>
<td>dental arches, dental crowding or malalignment, premature loss or primary</td>
<td></td>
</tr>
<tr>
<td>posterior teeth (baby molars) and obvious mouth breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Recommended Childhood Immunization Schedule

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>24 mos</th>
<th>4-6 yrs</th>
<th>11-12 yrs</th>
<th>13-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hepatitis B</td>
<td>HepB #1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diphtheria, Tetanus, Pertussis, Haemophilus Type B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inactivated Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles, Mumps, Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccines below this line are for select populations</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).
Section VIII: Allied Health Providers and Other Provider Types

Allied health providers are licensed and/or certified health care providers other than a primary care physician, specialist physician or hospital, and may include a clinical laboratory, managed mental health care company, optometrist, chiropractor, podiatrist, psychologist, therapist, durable medical equipment supplier, ambulatory surgical center, diagnostic center and any other health care provider, organization, institution or such other arrangement as recognized by Blue Cross.

Please Note: The Allied Health Provider section of the Participating Provider Manual outlines information specific to allied health providers. Most sections of the Participating Provider Manual pertain to allied health providers as well.

Ambulance Provider Billing Guidelines

Blue Cross covers and processes two types of ambulance claims:
- Ground
  - ALS – advanced life support
  - BLS – basic life support
- Air

In addition to the participating provider responsibilities outlined on page 5 of this manual, ambulance providers should:
- File only the codes listed in their contracts. This will prevent returned claims and/or delays in claim processing.
- File claims for members even if you do not have the patient’s signature. Patient signatures are not required for filing claims. Claim payment will be based on assignment of benefits.

Ambulance Modifiers

D Diagnostic or therapeutic site other than P or H when these are used as origin codes
E Residential, domiciliary or custodial facility
G Hospital-based dialysis facility
H Hospital
I Site of transfer between modes of ambulance transport
J Non-hospital based dialysis facility
N Skilled nursing facility (SNF)
P Physician’s office
R Residence
S Scene of accident or acute event
X Intermediate stop at physician office on the way to the hospital (destination code only)
AS ambulance trip to an out-of-state hospital (Medicaid only)
EE Ambulance trip from an ECF or nursing home to another ECF or nursing home
EH Ambulance trip from an ECF or nursing home to a hospital
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP</td>
<td>Ambulance trip from an ECF or nursing home to a physician’s office</td>
</tr>
<tr>
<td>ER</td>
<td>Ambulance trip from an ECF or nursing home to a patient’s residence</td>
</tr>
<tr>
<td>HE</td>
<td>Ambulance trip from a hospital to an ECF or nursing home</td>
</tr>
<tr>
<td>HH</td>
<td>Ambulance trip for discharge/transfer from one hospital to another hospital</td>
</tr>
<tr>
<td>HR</td>
<td>Ambulance trip from a hospital to a patient’s residence</td>
</tr>
<tr>
<td>HT</td>
<td>Ambulance trip from one hospital to another for diagnostic and/or therapeutic services and return</td>
</tr>
<tr>
<td>JN</td>
<td>Ambulance trip from a non-hospital based dialysis facility to a skilled nursing facility</td>
</tr>
<tr>
<td>NJ</td>
<td>Ambulance trip from a skilled nursing facility to a non-hospital based dialysis facility</td>
</tr>
<tr>
<td>PH</td>
<td>Ambulance trip from a physician’s office to a hospital</td>
</tr>
<tr>
<td>QL</td>
<td>Patient pronounced dead after ambulance call</td>
</tr>
<tr>
<td>QM</td>
<td>Ambulance service provided under arrangement by a provider of services</td>
</tr>
<tr>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
</tr>
<tr>
<td>RA</td>
<td>Ambulance trip from the patient’s residence to a physician’s office</td>
</tr>
<tr>
<td>RE</td>
<td>Ambulance trip from the patient’s residence to an ECF or nursing home</td>
</tr>
<tr>
<td>RH</td>
<td>Ambulance trip from the patient’s residence to a hospital</td>
</tr>
<tr>
<td>SH</td>
<td>Ambulance trip from the scene of an accident to a hospital</td>
</tr>
<tr>
<td>XX</td>
<td>Ambulance trip from the patient’s residence, ECF or nursing home to a physician’s office and then to a hospital</td>
</tr>
</tbody>
</table>
Dialysis Billing Guidelines

Effective January 2006, Dialysis providers should adhere to the following guidelines when filing claims for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. (HMOLA) members:

- Providers must file dialysis claims under the appropriate revenue code for the type treatment provided as a single line item.
- The service units field must be used to indicate the number of treatments provided within the dates of service that appear on the claim.
- All other billed charges for services or products rendered must be itemized and the appropriate HCPCS code should be included on the claim.
- Providers should use one of the following revenue codes for the dialysis procedure when submitting a UB-92 claim form. CPT codes are not required when billing for dialysis services.

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Type of Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>821</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>831</td>
<td>Intermittent Peritoneal Dialysis</td>
</tr>
<tr>
<td>841</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>851</td>
<td>Continuous Cycling Peritoneal Dialysis</td>
</tr>
</tbody>
</table>

- Providers should use one of the following revenue codes for Epogen when submitting a UB-92 claim form:

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>634</td>
<td>EPO, less than 10,000 units</td>
</tr>
<tr>
<td>635</td>
<td>EPO, 10,000 or more units</td>
</tr>
</tbody>
</table>

HCPCS codes are required for Epogen. Providers should use J0886 when billing for Epogen along with the appropriate revenue code listed above. The service units field (line 46 of the UB-92 claim form) should include the appropriate units per the HCPCS code description for the total units provided, e.g. if 60,000 units are provided then “60” (60,000 divided by 1,000) should be entered in line 46.

- The per diem only applies to the day(s) that the treatment is provided.
- Any services related to dialysis treatments, but rendered on dates of service other than the date of service for dialysis treatment, are included in the per diem and are not separately reimbursable.
- All other Blue Cross filing requirements remain in effect.
- Please note: Blue Cross may expand and/or modify the Reimbursement Schedule for new, deleted or modified codes developed subsequent to the effective date of your Allied Health Professional Agreement. Blue Cross will notify providers 30 days prior to the effective date of the schedule change.
Durable Medical Equipment (DME) Billing Guidelines

Durable medical equipment (DME) are items that are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness, injury or disease, and appropriate for use in the patient’s home.

DME benefits are not provided for repair or maintenance of rented equipment. The repair or maintenance of rented DME is the responsibility of the participating DME supplier at no additional charge to the subscriber. The subscriber is responsible for DME repair and maintenance of purchased equipment (subject to warranty provisions or medical necessity).

For purchased DME, the participating DME supplier must provide a one-year warranty agreement to the subscriber. This warranty agreement may include some nominal monetary fee that is billable to the subscriber. The participating DME supplier must always inform the subscriber about any DME warranty provided by the manufacturer.

The DME supplier agrees to provide all DME services and supplies and orthotic and prosthetic devices, if applicable, according to the following standards:

- Free delivery
- Free installation
- Seven day-a-week, 24-hour emergency services by both technicians and professionals
- Rental equipment repair and maintenance service (same day service, if required)
- Clinical professionals for patient education and home management, and, where necessary, written graphically-illustrated patient education and instruction manuals
- Availability of standard/economical models that meet the patient’s needs and quality standards

DME Benefits

Benefits for DME are provided in accordance with the benefit provisions of the specific subscriber contract. Benefits will be provided if the DME is covered by the subscriber’s contract and the prescribed equipment meets the Plan’s DME and medical necessity requirements. Most subscriber contracts provide for the rental of DME not to exceed the purchase allowance.

Rental vs. Purchase

Blue Cross has the option of approving either rental or purchase of DME. Based on medical necessity, rental may be approved for a specified number of months, rental may be approved up to the purchase allowance, or purchase may be approved.
Deductible, Coinsurance and Non-Covered Services

After the subscriber’s deductible has been met, Blue Cross will pay a specified benefit percentage of the remaining rental or purchase allowance for covered DME. The deductible and benefit amounts will vary according to the subscriber’s contract.

The subscriber is responsible for payment of any deductible, coinsurance and non-covered services. However, the DME provider cannot bill the subscriber for any amount that exceeds the Blue Cross allowable charge for rented or purchased DME.

Payment Allowance

Benefit payment for the rental of DME is based on the Blue Cross monthly rental allowance (not to exceed the purchase allowance). Benefit payment for the purchase of DME is based on the Blue Cross purchase allowance.

Rented DME is considered purchased once the monthly rental allowance equals the purchase allowance. The patient then owns the DME and neither the subscriber nor Blue Cross can be billed for additional rental or purchase of the equipment.

Deluxe and Special Features

Certain DME is considered “deluxe” equipment due to its mechanical or electrical feature(s), i.e., electric hospital beds. Deluxe equipment is covered only if Blue Cross determines that the deluxe equipment is both medically necessary and therapeutic in nature. Deluxe equipment ordered primarily for the subscriber’s comfort and convenience and determined to be not medically necessary and therapeutic will not be paid.

When the subscriber requests deluxe equipment, and the medical necessity for the deluxe feature(s) of covered DME is not documented, benefits will be based on the rental or purchase allowance for standard/economical equipment.

Due to certain conditions, illnesses, or injuries, medical necessity may require DME with special or customized features. All equipment of this type is subject to individual payment consideration and prior approval of Blue Cross.

Charges for rental equipment accessories should be included in the rental price of the equipment when billing Blue Cross. All DME requests for special or customized features should be submitted to the Blue Cross Medical Review Department for prior approval using the Medical Certification Form.
Billing for Customized Wheelchairs

Please follow the billing guidelines below when you bill Blue Cross for customized wheelchairs.

- You may file a wheelchair claim using either of the following ways:
  1. File the appropriate HCPCS codes for those components that have specified HCPCS codes. These components will be reimbursed based on the Blue Cross allowable charge. For those components without a specified HCPCS code, file them using code K0108. We will reimburse those components at the Manufacturer’s Suggested Retail Price (MSRP) minus a 25 percent discount of charges.

  OR

  2. You may file the entire wheelchair claim using HCPCS code E1220, and we will reimburse the entire claim at MSRP minus 25 percent discount of charges.

- Evaluation and set-up fees will not be reimbursed separately.

- Use E1340 to bill for equipment maintenance that is not covered under the warranty. Reimbursement will be based on the allowable charge.

If you have any questions about how to bill for customized wheelchairs, please call the BlueLine at (800) 392-4076.

DME Certification Form

All initial claims for the rental or purchase of DME must be filed with a DME Certification form (See page 102). When prescribing DME, the patient’s physician should complete the DME Certification form. In some cases, additional medical records and documentation may be requested from the prescribing physician, including the following:

- A clinical assessment, in narrative form, including past and present history and signs and symptoms expected to improve with the use of the equipment

- Reports of any clinical/diagnostic tests (i.e., pulmonary function, CBC, oxygen and saturation, etc.) that show evidence of the diagnosis and need for the equipment.

- Verification, in writing, that other methods of treatment such as drug therapy, gravity feeding and supplemental oxygen, etc., have been tried and have proven unsuccessful or were not clinically indicated.

- For obstructive sleep apnea, a report of polysomnography study documenting a diagnosis of obstructive sleep apnea. The report should indicate at least a four-hour sleep session and a session using the monitor documenting a significant improvement.

The DME Certification form should be presented to the participating DME supplier by the subscriber, along with his/her ID card, and must be attached to the initial claim form for the rental or purchase of DME. All initial claims received without a DME Certification form will be rejected.
For certain DME, a re-certification to determine medical necessity of continued use may be required after the equipment has been rented for a specified number of months, e.g., SIDS Apnea Monitor. It is the subscriber’s responsibility to ensure re-certification takes place. The subscriber and the participating DME supplier will be notified of the re-certification requirements when the initial length of rental is approved. Any claims received beyond this approved period without a re-certification of medical necessity will not be covered.

DME Certification forms are available by calling the BlueLine at (800) 392-4076.
Sample DME Certification Form

**BlueCross BlueShield of Louisiana**

**DURABLE MEDICAL EQUIPMENT CERTIFICATION**

THIS FORM MUST BE COMPLETED BY THE PHYSICIAN PRESCRIBING THE EQUIPMENT AND ATTACHED TO THE CLAIM FILED BY THE SUPPLIER.

<table>
<thead>
<tr>
<th>PATIENT'S NAME</th>
<th>AGE</th>
<th>CONTRACT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQUIPMENT PRESCRIBED</th>
<th>CPT CODE</th>
<th>DATE PRESCRIBED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIAGNOSIS**

MEDICAL INDICATION FOR THE EQUIPMENT

**LIMITATIONS (CHECK ALL CONDITIONS APPLICABLE):**

- ☐ Weakness of arm(s)
- ☐ Confined to chair
- ☐ Other (list)

- ☐ Weakness of leg(s)
- ☐ Confined to bed

- ☐ Unable to ambulate
- ☐ Confined to home

**HOW LONG WILL THE PATIENT NEED THIS EQUIPMENT? (BE SPECIFIC, E.G., RENTAL MONTHS/PURCHASE.)**

**IF THE EQUIPMENT IS FOR OXYGEN/OXYGEN SUPPLIES, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

<table>
<thead>
<tr>
<th>FREQUENCY OF USE</th>
<th>MEDICAL NEED FOR THE EQUIPMENT</th>
<th>EXPECTED BENEFIT OF OXYGEN THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF THE EQUIPMENT IS FOR HOME BLOOD GLUCOSE MONITORING SYSTEM, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

<table>
<thead>
<tr>
<th>IS THE PATIENT TAKING INSULIN?</th>
<th>☐ YES ☐ NO</th>
<th>IF YES, FREQUENCY</th>
<th>DEGREE OF DIABETIC CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>KETOACIDOSIS?</td>
<td>☐ YES ☐ NO</td>
<td>INSULIN REACTIONS?</td>
<td>☐ YES ☐ NO</td>
</tr>
<tr>
<td>ARE OTHER DIABETIC COMPLICATIONS PRESENT? (BE SPECIFIC:)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN'S NAME</th>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN'S PHONE NO.</th>
<th>PHYSICIAN'S SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
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</table>

23XX6409 06/09

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

**Participating Provider Manual** 104  **Rev. March 2006**
DME Notification Letter

All initial and re-certified DME claims will be reviewed by Blue Cross to determine medical necessity and DME coverage status. Once the review is completed, a DME notification letter is mailed to the subscriber with a copy to the participating DME supplier.

The DME notification letter will provide one of the following:

- Approval of rental for a specified number of months (including re-certification requirements)
- Approval of rental up to purchase allowance
- Approval of purchase
- Denial of rental or purchase

The DME notification letter does not guarantee payment of benefits. It only confirms approval/denial of the medical necessity of the DME. Benefit payment is always subject to the terms of the subscriber contract.
Home Health Agency Billing Guidelines

Blue Cross recognizes the need to maintain consistency of billing requirements for both Blue Cross and Medicare wherever possible. Therefore, we require home health agencies to file claims using the UB-92 claim form (see page 111 for more information) in accordance with Medicare guidelines with the following exceptions:

1. The revenues codes accepted by Blue Cross and which may be entered in UB-92 field 42 have been limited, and revenue code descriptions for field 43 have been modified. These modifications are necessary due to subscriber contract/certificate variations.

   Revenue codes 551 and 559 and their respective descriptions have been changed to identify services provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). This change is necessary because program rates are different for RNs and LPNs.

   Revenue code 261, IV Therapy Pump, requires a modifier in order for the correct type of service to be assigned (see Appendix A, page 108).

   The revenue codes with descriptions accepted by Blue Cross from participating home health agencies are shown on pages 105-106. The appropriate HCPCS or CPT code must be included in field 44 of the UB-92 when billing revenue codes with double asterisks (**), shown under the column heading “Code Req’d.” This is necessary for proper pricing and payment of the service. (Please refer to your Blue Cross Home Health Agency Member Provider Agreement and Reimbursement Appendix for information on reimbursement.)

2. Accumulative billing of services will be accepted by utilizing a “From” and “Through” date with the total units of service for a specific revenue code or HCPCS code. However, some subscriber contracts/certificates and/or groups require that the individual date of service be shown for each day on which services were provided. When this situation applies, you will be notified when you pre-authorize services and also via the written confirmation of the pre-authorization.

Authorization is required for all home health care. Blue Cross requires 48 hours advance notice of all home health care to be provided. The pre-authorization will include the service and/or code to be provided and in some cases, the quantity/units of services authorized. HCFA Forms 485, 486 and 487 will be helpful to obtain the information required for authorization of planned home health care services. The services that we will generally approve are shown on pages 107-108 and include the range of HCPCS/CPT codes that should be billed with the revenue code. To obtain authorization, please call (800) 523-6435.
# Home Health Agency Revenue Codes Accepted by Blue Cross and Blue Shield of Louisiana

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>HCPCS/ CPT Range</th>
<th>Code Reqd</th>
<th>Program Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>258</td>
<td>Pharmacy - IV Solutions</td>
<td>J0000 thru J9999, B4102 thru B5200</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>261</td>
<td>IV Therapy - Infusion Pump</td>
<td>E0779 thru E0784, E1520, A4220 and K0455</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>264</td>
<td>IV Therapy - IV Therapy Supplies</td>
<td>A4221 thru A4223, A4230 thru A4232, B4034 thru B4086, B9000 thru B9999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>271</td>
<td>Medical/Surgical Supplies and Devices, <em>Nonsterile Supply</em></td>
<td>A4000 thru A8999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>272</td>
<td>Medical/Surgical Supplies and Devices, <em>Sterile Supply</em></td>
<td>A4000 thru A8999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>274</td>
<td>Medical/Surgical Supplies and Devices, <em>Prosthetic/Orthotic Devices</em></td>
<td>L0000 thru L4999, L5000 thru L9999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>291</td>
<td>DME (Other than Renal), <em>Rental</em></td>
<td>E0100 thru E1406, E1700 thru E9999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>292</td>
<td>DME (Other than Renal), <em>Purchase of New DME</em></td>
<td>E0100 thru E1406, E1700 thru E9999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>293</td>
<td>DME (Other than Renal), <em>Purchase of Used DME</em></td>
<td>E0100 thru E1406, E1700 thru E9999</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>294</td>
<td>DME (Other than Renal) - Supplies/Drugs for DME Effectiveness</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>300-319</td>
<td>Laboratory (and related services)</td>
<td>80048 thru 89399, 36400 thru 36425</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
<td>HCPCS/ CPT Range</td>
<td>Code Req'd</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>------------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>421</td>
<td>Physical Therapy - Visit Charge</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>424</td>
<td>Physical Therapy - Evaluation or Reevaluation</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>431</td>
<td>Occupational Therapy - Visit Charge</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>434</td>
<td>Occupational Therapy - Evaluation or Reevaluation</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>441</td>
<td>Speech-Language Pathology - Visit Charge</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>444</td>
<td>Speech-Language Pathology - Evaluation or Reevaluation</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>551</td>
<td>Skilled Nursing - Visit Charge (Registered Nurse)</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>552</td>
<td>Skilled Nursing - Hourly Charge (Registered Nurse)</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>559</td>
<td>Skilled Nursing - Visit Charge (can be used for Licensed Practical Nurse)</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>560</td>
<td>Skilled Nursing - Hourly Charge (can be used for Licensed Practical Nurse)</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>561</td>
<td>Medical Social Services - Visit Charge</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>571</td>
<td>Home Health Aide - Visit Charge</td>
<td>Allowable</td>
<td></td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>601-604</td>
<td>Oxygen (Home Health)</td>
<td>E1353 thru E1406, E0424 thru E0484, E0500, E0600, E0601</td>
<td>**</td>
<td>Allowable Charge</td>
</tr>
<tr>
<td>990-999</td>
<td>Patient Convenience Items</td>
<td></td>
<td></td>
<td>Allowable Charge</td>
</tr>
</tbody>
</table>

Note: Allowable charges for revenue codes that are not specifically listed above will be established periodically.
Visit charge is defined as a consecutive period of time up to two hours during which home health care is rendered. Hourly charges exceeding two hours require additional authorization from Blue Cross.

Hourly charges for home health aides and private duty nursing (in shifts of at least eight continuous hours) must be billed using the revenue codes below appropriate to the level of professional training.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>552</td>
<td>Skilled Nursing – Hourly Charge – Registered Nurse (Private Duty Nursing)</td>
</tr>
<tr>
<td>550</td>
<td>Skilled Nursing – Hourly Charge – Licensed Practical Nurse (Private Duty Nursing)</td>
</tr>
<tr>
<td>572</td>
<td>Home Health Aide – Hourly Charge</td>
</tr>
</tbody>
</table>

The allowable charge for revenue codes 552, 550 and 572 for private duty nursing and/or home health aide services will be established at the time private duty nursing and/or home health aide services are authorized.

Services and procedures (HCPCS/CPT) not listed on the above schedule will be reimbursed at the lesser of the billed charge or an amount established by Blue Cross. The presence of a revenue code or fee on this listing is not to be interpreted as meaning that the patient has coverage or benefits for that service.

The allowable charge for revenue codes 551 and 559 for skilled nursing includes but is not limited to:

1. Pre- and post-hospital assessment
2. IV infusion
3. Administration of medication: PO, IM, SQ
4. Training and educating patient, family and caregiver
5. Wound care management
6. Patient monitoring
7. Laboratory blood drawing
8. Physician case conference
9. Discharge assessment
10. All medical equipment and supplies associated with one through nine above whether re-usable or non-re-usable including, but not limited to:
   - Alcohol prep sponge
   - Band-Aids
   - Gloves
   - Incontinent cleaners
   - Lotion
   - Non-sterile gauze
   - Non-sterile specimen
   - Over the counter – for skin tears
   - Personal care items
   - Sharps disposable containers
   - Tape
   - Thermometer cover
   - Vacutainers with needles
The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to, the following HCPCS/CPT codes

<table>
<thead>
<tr>
<th>A4649</th>
<th>99070</th>
<th>A4206-4210</th>
<th>A4212</th>
<th>A4215</th>
<th>A4244-4246</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4250</td>
<td>A4254</td>
<td>A4259</td>
<td>A4328</td>
<td>A4330</td>
<td>A4335</td>
</tr>
<tr>
<td>A4364</td>
<td>A4365</td>
<td>A4398</td>
<td>A4402</td>
<td>A4421</td>
<td>A4454</td>
</tr>
<tr>
<td>A4455</td>
<td>A4510</td>
<td>A4630</td>
<td>A4631</td>
<td>A4670</td>
<td>A5051-5055</td>
</tr>
<tr>
<td>A5081</td>
<td>A5082</td>
<td>A6216-6221</td>
<td>A4490</td>
<td>A4550</td>
<td>A4635-4637</td>
</tr>
<tr>
<td>A4770</td>
<td>A5061-5065</td>
<td>A5093</td>
<td>A6260</td>
<td>A4495</td>
<td>A4554</td>
</tr>
<tr>
<td>A4640</td>
<td>A4913</td>
<td>A5071-5075</td>
<td>A5119</td>
<td>A6263-6265</td>
<td>A4500</td>
</tr>
<tr>
<td>A4627</td>
<td>A4663</td>
<td>A4927</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Appendix A**

The following is a list of modifiers that must be included with revenue code 261:

**BP** – The beneficiary has been informed of the purchased and rental options and has elected to purchase the item.

**BU** – The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision.

**BR** – The beneficiary has been informed of the purchase and rental option and has elected to rent the item.

**LL** – Lease/rental (use the LL modifier when DME equipment rental is to be applied against the purchase price).

**NU** – New equipment.

**QR** – Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test value(s) (separate specimens taken in separate encounters).

**RR** – Rental (use the RR modifier when DME is to be used).

**UE** – Used durable medical equipment.

**NR** – New when rented (use the NR modifier when DME that was new at the time of rental is subsequently purchased).
Infusion Billing Guidelines

General Guidelines

Blue Cross recognizes the need to maintain consistency of billing requirements between Blue Cross and Medicare whenever possible. Therefore, we require infusion providers to file claims using the HCFA-1500 claim form in accordance with Medicare guidelines, with the following exceptions:

- Authorization is required for all infusion services. Blue Cross requires 48 hours advance notice of all infusion services to be provided. The authorization will include the service and/or code to be provided and, in some cases, the quantity/units of services authorized. The services we will generally approve are shown in Exhibit A – Reimbursement/Services Schedule of the Allied Health Provider Agreement.

To obtain authorization, please call (800) 317-2299.

To determine if BlueCard members require authorization, please call BlueCard Eligibility at (800) 676-BLUE (2583).

- Accumulative billing of services will be accepted by utilizing a “From” and “Through” date with the total units of service for a specific HCPCS code.

- When billing for drugs, please be sure to report the same unit of measure in the Days/Unit field (Item 24g) of the HCFA-1500 claim form as is listed in the code description. For example, if the code description lists one unit as 50 mg, be sure to report 50 mg as one unit on the claim form. If you administered 100 mg, you would list two units on the claim form.

- Blue Cross will reimburse infusion providers for services and procedures (HCPCS/CPT) listed in Exhibit A – Reimbursement/Services Schedule in accordance with the subscriber’s contract. Services and/or procedures not listed in Exhibit A – Reimbursement/Services Schedule should be specially negotiated when authorizing services with our Medical Management Department. The presence of a code or fee on the schedule does not mean that the patient has coverage or benefits for that service.

- Please note: Blue Cross may expand the Reimbursement/Services Schedule for new HCPCS/CPT codes. Any new amount on the Reimbursement/Services Schedule established for new codes will be communicated to the infusion provider.

- As a participating provider, you are responsible for the following:
  - Submitting claims for Blue Cross and Blue Shield subscribers
  - Accepting Blue Cross’s payment plus the subscriber’s deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.
  - Cooperating in Blue Cross’s cost-containment programs where specified in the subscriber contract/certificate.
Home Infusion Guidelines

- A Nursing Service Visit is defined as a consecutive period of time up to two hours during which home infusion services are rendered. The first two hours will be reimbursed at the per visit rate, which is defined in Exhibit A – Reimbursement/Services Schedule of the Allied Health Provider Agreement. Hourly charges exceeding two hours will require additional authorization from Blue Cross and will be reimbursed at the reduced hourly rate, which is also defined in Exhibit A – Reimbursement/Services Schedule.

- A Nursing Service Visit should be billed as one unit per visit in the Units field of the HCFA-1500 claim form or claims transmittal form. When billing for additional hours beyond the Nursing Service Visit (2 hours), home infusion providers must include the number of additional hours for the services rendered in the Units field of the HCFA-1500 or claims transmittal form.

Infusion Suite Guidelines

- Infusion suite providers are required to bill an “Office” place of service (code 11) in the place of service field of the HCFA-1500 or claims transmittal form to ensure appropriate reimbursement is allowed.
SAMPLE UB-92 Claim Form

The following sample UB-92 claim form and instructions are given for those providers who should file claims using a UB-92 claim form, specifically dialysis and home health providers.
UB-92 Claim Form Instructions

Block 1  Enter provider name and address.

Block 3  Patient Control: Enter the number or code that is used by your facility to retrieve or post records.

Block 4  Type of Bill: This is a three-position code that indicates the type of facility, the bill classification and the frequency.

Block 5  Fed. Tax ID: Enter the tax identification number of the facility.

Block 6  Statement Covers Period: Enter the first date associated with this claim in the “From” box and enter the final date of the claim in the “Through” box.

Block 7  Cov’d: This field is not required for outpatient claims.

Block 8  N-C D: This field is not required for outpatient claims.

Block 12  Patient Name: Enter the patient’s name with the surname first, first name and middle initial, if any. Do not use titles or nicknames.

Block 13  Address: Patient address must be completed.

Block 14  Birthdate: Enter the patient’s actual date of birth in MM-DD-YYYY format.

Block 15  Sex: An “M” for male or an “F” for female must be present.

Block 16  MS: Marital status must be completed for all out-of-area claims. Please use the following codes:
M  married   U  unknown
S  single    P  life partner
D  divorced  X  legally separated
W  widowed

Block 17  Admission Date: This field is not required for outpatient claims.

Block 18  HR: This field is not required for outpatient claims.

Block 19  Type: This field is not required for outpatient claims.

Block 20  SRC: This field is not required for outpatient claims.

Block 22  STAT: Enter the applicable discharge status code. This field is not required for outpatient claims, but can be present.
**Block 23**  Medical Record Number: Enter the number used to retrieve this patient’s medical records.

**Blocks 24-31** Condition Codes: The condition code(s) is a two-position code that identifies conditions, if any, relating to this bill that may affect payer processing.

**Blocks 32-35** Occurrence Code and Occurrence Date: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the subscriber contract/certificate. The occurrence date is the date that corresponds with the preceding occurrence code. The date must be in MM-DD-YYYY format and is required if occurrence codes are used.

**Block 36** Occurrence Span Code: This field is used when the patient was seen as an outpatient for follow-up treatment. In the “From” field, enter the first date the patient was treated for this condition. In the “Through” field, enter the last date the patient was treated for this condition. This field is not required for inpatient claims.

**Blocks 39-41** Value Code/Amount: Value code(s) identify data necessary for processing claims. The value amount is the dollar amount or number associated with the corresponding value code. A value amount must be present for each value code. If the amount does not represent a dollar amount, two zeros should be entered following the number. Example: If the patient received three units of blood, enter 300.

**Block 42** Rev CD: The revenue code is the code that best identifies a particular accommodation/ancillary service that was rendered to the patient. Revenue codes can be duplicated only if the rates differ.

**Block 44** HCPCS/Rates: The rate is the actual charge for the services rendered. If rates are different, duplicate the revenue code to show the different rates. Revenue codes can only be duplicated when the rates are different. Rate multiplied by units must equal charges.

**Block 46** Service Units: Service units are the number of times a service was rendered.

**Block 47** Total Charge: Enter the amount charged for each of the revenue codes given. If rates and units are present, multiply these to get the total charges except when rates are zeros.

**Block 50** Payer: This field is required only on second or third payer line when indicating other payer information.

**Block 51** Provider Number: Enter your Blue Cross-assigned five-digit provider number in this field.
**Block 52** REL INFO: The release information field must be “Y” if you are filing electronically. This indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits. If “N,” you must file hardcopy.

**Block 53** ASG BEN: Enter one of the following codes to indicate who will receive payment for the claim:

Y Assignment/payment to provider  
N Assignment/payment to subscriber

**Block 58** Insured’s Name: If the patient is not the insured, enter the subscriber’s name exactly as it appears on the BCBS identification card.

**Block 59** P REL: If the patient and insured are the same, this field is not required. If the patient is not the insured, enter one of the following codes that identifies the patient’s relationship to the contract holder:

- 01 Patient is contract holder
- 02 Spouse
- 03 Natural child
- 04 Natural child/no responsibility
- 05 Stepchild
- 06 Foster child
- 07 Ward of the court
- 10 Handicapped dependent
- 13 Grandchild
- 16 Sponsored dependent

**Block 60** CERT-SSN-HIC-ID Number: Enter the subscriber’s identification number exactly as it appears on the ID card.

**Block 62** Insurance Group: This field is not required.

**Block 63** Treatment Authorization Codes: Enter the Blue Cross authorization number when available.

**Block 65** Employer Name: Enter the patient’s employer in this field. If patient is a housewife, retired, unemployed or a student in college, enter this. Do not enter the subscriber’s employer, unless the patient is the employer.

**Block 67** PRIN DIAG CD: The principal diagnosis code must be entered in this field. You must use ICD-9-CM codebook. The first position should contain “V” or a numeric character. The second and third positions must be numeric with no punctuation. Fourth and fifth positions must be numeric or blank.

**Blocks 68-75** Other Diag. Codes: These fields should be used when additional conditions exist at the time of admission or develop subsequently and affect the treatment received or the length of stay. Follow the coding guidelines for the principal diagnosis code.

**Block 76** ADM DIAG CD: Enter the ICD-9-CM diagnosis code related to the patient’s admission.
Block 80  Principal Procedure Code/Date: The principal procedure should be entered in this field. This is the procedure that was performed for treatment rather than diagnostic or exploratory purposes, or the procedure that is most related to the principal diagnosis. The procedure coding method must be ICD-9-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.

Block 81  Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-9-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.

Block 82  Attending Physician ID: Enter the name of the physician who rendered the services.

Block 84  Remarks: The remarks field must be completed if the type bill is “XX5” or “XX6” or if the third digit of a revenue code is “9” or if revenue codes 920 or 940 are present.

If the claim is for a federal employee contract and therapy revenue codes 42X, 43X or 44X are present, the actual dates of service for each revenue code must be entered in the remarks field.
Section IX: Communicating with Blue Cross and Blue Shield of Louisiana

BlueLine - Voice Response Telephone System

You may call the BlueLine, our self-service tool available through our voice response telephone system, to obtain a subscriber’s claims status, eligibility, and deductible/coinsurance/copayment amounts or to check on the status of an authorization request. Just call (800) 392-4076. Instructions are provided throughout the call to guide you through the steps to obtain the information you need.

How to Use the BlueLine
1. Have your Blue Cross provider number, the subscriber’s Blue Cross ID number, the subscriber’s eight-digit date of birth and the date of service ready when you place your call.
2. Once you have called the IVR, say 1 to enter the BlueLine menu.
3. Then, follow the instructions for a subscriber’s benefits fax, claims status fax, a voice summary of in-network copayments or deductible or to check the status of an authorization request.

BlueLine Helpful Hints
• Speaker telephones and loud background noise will inhibit the performance of the BlueLine.
• Speak numeric “zero,” instead of alpha “O.”
• The BlueLine will accept three efforts to identify provider and/or member contracts; after the third attempt, the BlueLine will route your call to the appropriate representative.
• Facility providers must say or key the five-digit Blue Cross provider number. Professional providers must say or key the 10-digit regional provider number.

Claim Status Hints
• If the BlueLine is unable to match the date of service with the patient or provider number, you will receive a fax back notification that states, “Your request for information could not be processed via the BlueLine. When you call again, please opt to speak to a representative for assistance with this policy.”
• Fax back information should be received within 15 minutes of your request.
• Status information for contracts that begin with prefixes other than XU is not currently available.
• Claims must be paid or rejected in order to receive a claim status fax back.
• Claim Status Summaries are formatted to resemble your provider register.
• The summary will include the actual register date of your payment if you were paid.

• If benefits were paid to your patient, your summary will not reflect a date in the “Date Paid” field.

• You may inquire on up to ten dates of service per member.

• FEP (identified with an “R” in the first position of the contract number) must be keyed with a “0” in the last position of the contract number.

Benefit Summary Hints

• Benefit information on BlueCard and NASCO contracts (contracts with prefixes that begin with other than XU) is not available through the BlueLine.

• Groups with non-standard or “special” benefits are routed to a representative for benefit information.

• The BlueLine is specifically designed to provide in-network benefits only.

• Organize your Benefit Summary requests by products (for example, HMO, POS, etc.) prior to beginning your request for benefit summaries.

The BlueLine is available for your convenience twenty-four hours a day, seven days a week. For information not offered by the BlueLine, you will need assistance from a provider inquiry representative.

Electronic Benefit Verification

If you submit claims electronically, you may verify benefits and inquire about claims status using this system. Providers who access the iLinkBLUE Provider Suite can use the website to:

• Research Blue Cross patient eligibility.

• Research coverage and deductible information.

• Research paid and/or rejected claims and rejection reasons.

• View and print Weekly Provider Payment Registers.

If you need assistance with your electronic system, please contact the EDI Service Department at (225) 295-2085, or if you would like to file claims electronically and access iLinkBLUE Provider Suite, please call (225) 293-LINK (5465) or e-mail iLinkBLUE.providerinfo@bcbsla.com.

Customer Service

If your patients have questions about their health care benefits, you may refer them to the Customer Service Center at (225) 291-5370 or (800) 599-2583.
Preadmission Authorization

For admission authorization requests, please call our Authorization Unit at:

- Regular Business: (800) 392-4085
- Federal Employee Program: (800) 334-9416
- Authorization Unit fax: (225) 295-2532

Provider Services

If you need assistance with any of the material contained in this manual, you may call Provider Network Administration at (800) 716-2299, option 3.
Section X: Definitions

Allowable Charge/Professional Allowance – the lesser of the submitted charge or the amount established by Blue Cross, or negotiated based on an analysis of providers’ charges, as the maximum amount allowed for physician services covered under the terms of the Subscriber Contract/Certificate.

Allied Health Provider – a licensed and/or certified health care provider other than a physician or hospital, which may include a clinical laboratory company, managed mental health care company, optometrist, chiropractor, podiatrist, psychologist, therapist, licensed professional counselor (LPC), board certified substance abuse counselor (BCSAC), licensed clinical social worker (LCSW), durable medical equipment supplier, diagnostic center, and any other health care provider, organization, institution or such other arrangement as recognized by Blue Cross provider allied health services and agrees to provide or arrange for the provision of covered services to subscribers.

Alpha Prefix – a three-digit prefix to the subscriber’s identification number that identifies the BCBS Plan or the national account in which the subscriber is enrolled.

Authorization – a determination by Blue Cross regarding an admission, continued stay, or other health care service for the purpose of determining Medical Necessity, appropriateness of the setting, or level of care.

Benefit(s) – the amount Blue Cross is obligated to the Subscriber to satisfy, under the terms of a Subscriber Contract/Certificate, for Covered Services exclusive of applicable Deductible, Coinsurance, and Copayment amounts.

Billed Charges – the total charges made by the Member Provider for all services and supplies provided to the Subscriber.

Blue Cross – refers to Blue Cross and Blue Shield of Louisiana

Clean Claim – a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special or additional treatment that prevents timely payment from being made on the claim.

Coinsurance – The sharing of eligible charges for covered services between Plan and subscriber. The sharing is expressed as a percentage. Once the subscriber has met any applicable deductible amount, the subscriber’s percentage will be applied to the allowable charges for covered services to determine the subscriber’s financial responsibility. Plan’s percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Coordination of Benefits (COB) – Determining primary/secondary/tertiary liability between various health care benefit programs and paying benefits in accordance with established
guidelines when subscribers are eligible for benefits under more than one health care benefits program.

**Copayment (Co-pay)** – that portion of charges for Covered Services, usually expressed as a dollar amount that must be paid by the Subscriber and usually collected by a physician at the time of service.

**Covered Services** – those medically necessary health care services and supplies for which Benefits are specified under a Subscriber Contract/Certificate.

**Current Procedural Terminology (CPT®)** – a system of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

**Deductible** – a specific amount of Covered Services, usually expressed in dollars, that must be incurred by the Subscriber before Blue Cross is obligated to Subscriber to assume financial responsibility for all or part of the remaining Covered Services under a Subscriber Contract/Certificate.

**Electronic Funds Transfer** – allows payment to be sent directly to iLinkBLUE enrolled providers’ checking or savings accounts. Also, Weekly Provider Payment Registers are viewed in iLinkBLUE, as enrollees no longer receive a payment register in the mail.

**Emergency** – a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: a) placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

**Experimental/Investigational** – the use of any treatment, procedure, facility, equipment, drug, device or supply not yet recognized by the National Association of Blue Cross and Blue Shield Plans as accepted practice for treatment of the condition. **Note:** Blue Cross makes no payment for Experimental/Investigational Services.

**Explanation of Benefits (EOB)** – a notice sent to the Subscriber after a claim has been processed by Blue Cross that explains the action taken on that claim.

**Federal Employee Program (FEP)** – A health care benefits plan designed for personnel employed by the Federal Government.

**Identification Card** – The card issued to the subscriber identifying him/her as entitled to receive Benefits under a Subscriber Contract/Certificate for services rendered by health care providers and for such providers to use in reporting to Blue Cross those services rendered to the Subscriber.
Identification Number – The number assigned to the subscriber and all of his/her Blue Cross records. This number a unique number selected at random, has a three-letter alpha-prefix in the first three positions, and is noted on the Identification card.

International Classification of Diseases, 9th Revision (ICD-9-CM) – A numerical classification descriptive of diseases, injuries and causes of death.

Medically Necessary/Medical Necessity – Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a subscriber for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
   a. in accordance with nationally accepted standards of medical practice;
   b. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient’s illness, injury or disease; and
   c. not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

National Provider Identifier (NPI) – a 10-digit number unique to each provider that is issued by the Centers of Medicare and Medicaid Services. The NPI will be required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans as of May 23, 2007.

Network/ Participating Providers – (also called “Key” providers) a licensed physician who has met the minimum credentials verification requirements of Blue Cross and who as entered into an agreement with Blue Cross wherein the Key Physician, as a member provider, agrees to render health care services to Blue Cross Subscribers.

Non-Covered Service – a service and/or supply (not a Covered Service) for which there is no provision for either partial or total Benefit/payment under the Subscriber Contract/Certificate.

Physician Advisory Committee – A committee made up of participating physicians throughout the state that meets on a periodic basis with Blue Cross to discuss and make recommendations concerning policies and procedures affecting the Blue Cross and HMOLA networks.

Plan – Blue Cross and Blue Shield of Louisiana also referred to as Blue Cross or BCBSLA

Plan Review – A determination by the Plan regarding a health care service for the purpose of applying benefit coverages and limitations and medical policies to determine medical necessity, if the service is cosmetic, investigational or experimental in nature and/or if the service is covered under the member’s benefit plan.
**Professional Allowance/Allowable Charge** – The lesser of the submitted charge or the amount established by the Plan as the maximum amount allowed for physician services covered under the terms of the Subscriber Contract/Certificate.

**Provider Number** – the unique five-position number assigned to a facility provider or the unique ten-position number assigned to a professional provider that should be used when filing claims and making inquiries to Blue Cross.

**Provider Payment Register** – a claims summary identifying all claims paid or denied, along with payment, is provided to the provider by electronic means when set up with EFT or by mail when not set up with EFT.

**Subscriber/Member** – Employees or individuals and their enrolled dependents covered under a Subscriber Contract/Certificate who are entitled to receive health care benefits as defined in and pursuant to a Subscriber Contract/Certificate.

**Subscriber Contract/Certificate** – a contract/certificate or health benefit plan which provides for payment in accordance with the provider agreement and which is issued or administered by or through Blue Cross, its subsidiaries and affiliates, and includes any national and regional group accounts of Blue Cross and Blue Shield of Louisiana or any other Blue Cross Plan, Blue Shield Plan, or the Blue Cross and Blue Shield Association having a Benefit provision for which Blue Cross acts as the control plan, a participating plan or service plan in providing those benefits. It also includes any health plans or programs sponsored, provided, indemnified, or administered by other entities or persons who have made arrangements with Blue Cross, such as network access-only agreements, to access and utilize the provider in connection with their managed care health plans or programs. Such entities or persons may avail themselves of the same access to service and related rights as Blue Cross, and such entities or persons shall be bound to the same payment responsibilities in regard to their Subscribers as Blue Cross is for their respective Subscribers under the provider agreement. The participating provider will provide these services and look only to each joined entity or person for the Professional Allowance/Allowable Charge in the manner it would look to Blue Cross. The Subscriber Contract/Certificate or health benefit plan entitles Subscribers/Members to receive health care benefits as defined in and pursuant to a Subscriber Contract/Certificate or health benefit plan.

**Unbundled** – Filing claims with two or more reimbursement/medical codes to describe a procedure performed when a single, more comprehensive reimbursement/medical code exists that accurately describes the entire procedure.