Louisiana

2023

Professional Provider Office Manual

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Blue Cross and Blue Shield of Louisiana
Professional Provider Office Manual

This manual is designed to provide information you will need as a participant in a Blue Cross and Blue Shield of Louisiana provider network—it is an extension of your agreement(s).

To use this manual, first familiarize yourself with the Quick Reference Guide and Definitions sections.

Periodically, we send newsletters and informational notices to providers. Please keep such information and a copy of your respective provider agreement(s) along with this manual for your reference. Updated office manuals and provider newsletters may be found on the Provider page of our website (www.bcbsla.com/providers >Resources).

If you have questions about the information in this manual or your participation as a network provider, please email provider.contracting@bcbsla.com.

Blue Cross and Blue Shield of Louisiana

Carelon Medical Benefits Management (Carelon) is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Lucet is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. The *Professional Provider Office Manual* and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Quick Reference Guide

This reference guide contains the contact information for the services listed within this manual. Please refer to this guide as needed when reading this manual.

Appeals	Please mail appeals to the appropriate address: **Standard Administrative Appeal** Medical Benefits: BCBSLA Appeals and Grievance P.O. Box 98045 Baton Rouge, LA 70898-9045 Pediatric Dental Care Benefits: (applicable to non-grandfathered individual and small group only) BCBSLA Dental Customer Service P.O. Box 69420 Harrisburg, PA 17106-9420 Pediatric Vision Care Benefits: (applicable to non-grandfathered individual and small group only) BCBSLA c/o Davis Vision P.O. Box 791 Latham, NY 12110 **Standard Medical Appeal** (if it is an expedited medical appeal, please include Attn: Expedited Medical Appeal) BCBSLA Medical Appeals P.O. Box 98022 Baton Rouge, LA 70898-9022 Fax: (225) 298-1837

Appeals (continued)	**Behavioral Health Medical Necessity Appeal** (send first-level appeals directly to Lucet) Lucet ATTN: Appeals Coordinator P.O. Box 6729 Leawood, KS 66206 Fax: 1-816-237-2382
Authorizations	To request prior authorization for services, providers are required to use our authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). Blue Cross requires providers to submit prior authorization requests, including new requests and extensions, through our online BCBSLA Authorizations application. Exceptions include transplants, dental services covered under medical and most out-of-state services. Behavioral Health Use the Behavioral Health Authorizations application for inpatient and outpatient behavioral health services that require an authorization. This is Lucet's WebPass Portal. Utilization Management Programs Use the Carelon application for our high-tech imaging, cardiology, musculoskeletal (MSK) and radiation oncology programs. This is the Carelon ***Provider****Portal*$_{SM}$. Authorization Phone Numbers BCBSLA Authorizations Department: **BCBSLA:** 1-800-523-6435 / **fax:** 1-800-586-2299 For behavioral health services: **Lucet:** 1-800-991-5638 For our Utilization Management programs: **Carelon:** 1-866-455-8416Drug To request prior authorization for a drug, use the Drug Authorization Form, available online at www.bcbsla.com/providers >Pharmacy. A sample of this form is provided in Appendix II Forms at the end of this manual. You may also call: For Pharmacy Benefit Drug Authorizations: • Express Scripts, Inc. at 1-800-842-2015

Authorizations (continued)	For Medical Benefit Drug Authorizations: • Targeted Medications – Express Scripts, Inc./Care Continuum at 1-800-842-2015 • Non-targeted Medications – Blue Cross at 1-800-523-6435 BCBSLA Authorizations Application Issues For errors involving: • Internal server error message – call EDI Customer Operations at 1-800-716-2299, option 3 • Internet errors on provider landing page – call EDI Customer Operations at 1-800-716-2299, option 3 • Unable to submit or locate a submitted authorization – call Provider Relations at 1-800-716-2299, option 4 • Internet errors within the portal – email caremgtsys@bcbsla.com For gaining access to the BCBSLA Authorizations application in iLinkBlue: • Reach out to the administrative representative at your facility or organization to discuss your security roles in iLinkBlue • If you do not have an administrative representative, contact the Provider Identity Management (PIM) Team at 1-800-716-2299, option 5 or PIMteam@bcbsla.com Full information on how to access iLinkBlue, including the registration application, is available online at www.bcbsla.com/providers >Electronic Services >iLinkBlue. Retrospective Review Authorizations To request a retrosepective authorization, use the Retrospective Review Authorization Form available at www.bcbsla.com/providers >Resources >Forms. You may request a retrospective review in one of two ways: • Fax the Retrospective Review Authorization Form to 1-800-515-1150. • Upload the Retrospective Review Authorization Form and medical records through iLinkBlue. Click on the Document Upload link on the home page, then select “Medical Records for Retrospective or Post Claim Review” from the department dropdown.

BlueCard® Eligibility	Call BlueCard Eligibility to verify patient eligibility and benefits. You can receive real-time responses to your eligibility requests for out-of-area members between 6 a.m. and midnight, Central Time, Monday – Saturday. **phone:** 1-800-676-BLUE (1-800-676-2583)
Care Management Programs	Blue Cross offers many long-standing, results-driven programs to support your patient relationships and help our mutual customers—your patients, our members—achieve their health and wellness goals. Help your patients be stronger than their diagnosis. There is no out-of-pocket cost to a patient to work with a Blue Cross health coach. Patients can learn more about our available programs and clinical staff at www.bcbsla.com/stronger. Providers can refer Blue Cross members by: • Calling Population Health at 1-800-317-2299, Monday – Friday, 8 a.m. to 5 p.m. (except holidays) • Faxing the Population Health Referral Form to (225) 298-3184. Locate the form online at www.bcbsla.com/providers >Programs >Care Management >CMDM Referral Form. Blue Cross members can self-refer by calling 1-800-821-2749, Monday – Friday, 8 a.m. to 5 p.m. (except holidays). Patients who are already in a Blue Cross Care Management Program and do not wish to continue participating can call the number above to opt out.

Claims	**Electronic:** Please submit electronic claims through Blue Cross-approved clearinghouse locations. For more information about filing claims through Blue Cross approved clearinghouse locations, visit the Clearinghouse section of our Provider page (www.bcbsla.com/providers >Electronic Services >Clearinghouse Services). CMS-1500 electronic claims also may be submitted through iLinkBlue (www.bcbsla.com/ilinkblue). **Hardcopy:** BCBSLA Claims Department P.O. Box 98029 Baton Rouge, LA 70898-9029 **FEP Claims:** BCBSLA Claims Department P.O. Box 98028 Baton Rouge, LA 70898-9028
Customer Care Center	Providers are required to use our self-service tools for member eligibility, claim status inquiries, professional allowable searches and medical policy searches. Our self-service options are: • iLinkBlue (www.bcbsla.com/ilinkblue) • Interactive Voice Recognition (IVR) - (1-800-922-8866) • HIPAA 27x Transactions For all other inquiries, please have your NPI, the member ID number, patient date of birth and the date of service when calling. **phone:** 1-800-922-8866

Disputes	Please mail disputes to the appropriate address. Please include the Provider Dispute Form and/or a detailed reason for the claims dispute. Find the Provider Dispute Form on our Provider page (www.bcbsla.com/providers >Resources >Forms). Participating provider claims disputes for Blue Cross and Blue Shield of Louisiana members can be submitted in the following ways: **Hardcopy:** BCBSLA Provider Disputes P.O. Box 98021 Baton Rouge, LA 70898-9021 **Fax:** (225) 298-7035 **iLinkBlue** (www.bcbsla.com/ilinkblue)**:** Select "Document Upload" from the Home page or "Claims" and then "Medical Records" menu options. In the Document Upload tool, choose "Provider Disputes" in the drop-down menu. Participating provider claims disputes for BlueCard® members (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana) can be submitted in the following ways: **Hardcopy:** BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 **Fax:** (225) 297-2727
EDI Services	Claims may be submitted electronically to Blue Cross directly from your office or through a Blue Cross-approved clearinghouse. For more information about filing claims electronically and/or approved clearinghouse locations, please contact our EDI Customer Operations: **email:** EDIservices@bcbsla.com **phone:** 1-800-716-2299, option 3

Electronic Funds Transfer (EFT)	All providers must be part of our EFT program. With EFT, Blue Cross deposits your payment directly into your checking or savings account. For more information on EFT, visit the EFT section of the Provider page at www.bcbsla.com/providers >Electronic Services >Electronic Funds or contact us: **email:** PCDMstatus@bcbsla.com **phone:** 1-800-716-2299, option 2
iLinkBlue	iLinkBlue is a free online provider tool that includes services such as: • Eligibility verification • Benefits (copayments, deductible and coinsurance) • Claims status (paid, rejected and pended) • Allowable charges • Action requests • Payment registers • Medical policies • Authorization requests • and more! **iLinkBlue:** www.bcbsla.com/ilinkblue For questions regarding iLinkBlue please contact EDI Services: **email:** EDIservices@bcbsla.com **phone:** 1-800-716-2299, option 3
Medical Policy Inquiry	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. **Hardcopy:** BCBSLA - Medical Director of Medical Policy P.O. Box 98031 Baton Rouge, LA 70809-9031

Overpayments	If you believe an overpayment has occurred on a claim, you may submit a review of the claim as follows: 1. Submit an Action Request (AR) through iLinkBlue (www.bcbsla.com/ilinkblue) 2. Complete and submit the Overpayment Notification Form, available online at www.bcbsla.com/providers >Resources >Forms. For full details on overpayments, see the Claims Resolution section of this manual.
Provider Contracting	Provider Contracting supports inquiries related to your provider agreement(s). **email:** provider.contracting@bcbsla.com **phone:** 1-800-716-2299, option 1
Provider Credentialing & Data Management	Blue Cross partners with Vantage Health Plan for the processing of provider credentialing and recredentialing activities. Credentialing packets and criteria are available on our Provider page at www.bcbsla.com/providers >Provider Networks >Join Our Network >Professional Providers >Join Our Network. The Blue Cross Provider Credentialing & Data Management team handles demographic changes. To change your address, phone number, Tax ID number, etc., please use the Provider Update Request Form, located on our Provider page (www.bcbsla.com/providers >Resources >Forms). For more information on our credentialing and data management process, including frequently asked questions, visit www.bcbsla.com/providers >Provider Networks >Join Our Networks >Professional Providers >Join Our Network. For all other inquiries: **email:** PCDMstatus@bcbsla.com **phone:** 1-800-716-2299, option 2

Provider Identity Management Team (PIM)	PIM is a dedicated team that helps establish and manage system access to our secure electronic services, including the setup process for administrative representatives. **email:** PIMteam@bcbsla.com **phone:** 1-800-716-2299, option 5
Provider Page	Our Provider page is designed to serve provider needs. Use this page to help locate important information such as: • Authorizations • Credentialing • Resources • Newsletters • Office of Group Benefits (OGB) • Pharmacy Management • Provider Tools • Quality Blue **website:** www.bcbsla.com/providers
Provider Relations	Provider Relations representatives assist providers and office staff with information about Blue Cross and its programs and procedures. Provider Relations representatives do not handle routine claim inquiries and benefit questions. These question should be directed to our Customer Care Center if they cannot be answered using our other available resources. **email:** provider.relations@bcbsla.com **phone:** 1-800-716-2299, option 4

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SECTION 1: NETWORK OVERVIEW

of the Professional Provider Office Manual

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This section provides information about provider networks. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

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Section 1: NETWORK OVERVIEW

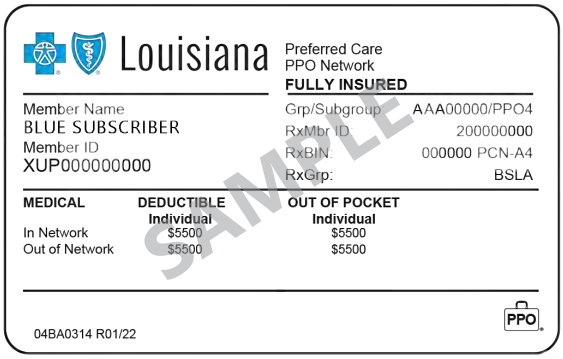
Blue Cross has worked to develop business relationships with doctors, hospitals and other health care providers throughout Louisiana. These relationships have allowed us to develop some of the largest, most comprehensive provider networks in the state.

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. You will also see examples of member ID cards associated with the various networks.

For more information on reviewing member eligibility, benefits and limitations, please use iLinkBlue (www.bcbsla.com/ilinkblue).

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.



Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on their member ID cards. The "PPO" in a suitcase logo identifies the nationwide BlueCard® Program. For more information, view the Preferred Care PPO Provider Speed Guide, available on our Provider page.

Preferred Care PPO member ID cards are issued to each member on the policy. Member ID cards are used for both medical and dental coverage when a dental network is indicated. The Preferred Care PPO network is offered statewide.

HMO LOUISIANA, INC.

HMO Louisiana is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. Since 1996, HMO Louisiana has worked to develop business relationships with doctors, hospitals and other health care providers throughout Louisiana. The HMO Louisiana provider network is a select group of physicians, hospitals and allied health providers who provide services to individuals and employer groups seeking managed care benefit plans. Our HMO Louisiana network is offered statewide.

Please Note: HMO Louisiana providers should follow the guidelines set forth in this manual. Differences and additional guidelines are indicated.

HMO Louisiana Offers Two Managed Care Benefit Plans

HMO Louisiana allows members to choose an HMO-HMO or Point of Service (POS) benefit plan. Members pay a lower copayment when they receive services from primary care providers (PCPs) and receive the highest level of benefits when they receive care from in-network providers. Fully insured HMO Louisiana members must select a primary care provider.

Health Maintenance Organization (HMO-HMO)

This benefit design is similar to the POS benefit design in that members with either an HMO-HMO or HMO-POS benefit plan access the same network of providers and have the same type of benefits, except there is no out-of-network option with the HMO-HMO benefit.

- Uses HMO Louisiana providers.
- Member is responsible for any applicable coinsurance, deductible and/or copayment.
- Member receives high-level benefits for in-network providers with authorization (if necessary).
- Member has no benefits for out-of-network providers (without Plan approval).

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. When we both issue an authorization that the services are medically necessary, and approve a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member's out-of-pocket expenses.

HMO and HMO-POS members do not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility.

Point of Service (HMO-POS)

Allows members to choose each time they need care—at the point of service—whether to use a network provider or go out-of-network and receive reduced benefits. Members with a HMO-POS benefit plan receive the highest level of benefits when using network providers with the proper authorization (when services require plan approval) and a lower level of benefits when receiving care that is not authorized or from providers who are not in the HMO Louisiana network.

- Uses HMO Louisiana providers
- Member is responsible for any applicable coinsurance, deductible and/or copayment
- Member receives high-level benefits for in-network providers with authorization (if necessary)

Members usually pay significant costs when using non-participating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating and HMO Louisiana providers. In addition, participating and HMO Louisiana providers waive the difference between the actual billed charge for covered services and the allowable charge, while non-participating providers do not. The member will pay the amounts shown in the "out-of-network" column on their schedule of benefits, and the provider may balance bill the member for all amounts not paid by Blue Cross.

There is a $1,000 penalty toward the allowable charge to HMO Louisiana POS inpatient network facilities for failure to obtain an authorization for inpatient facility confinements. No 30% penalty or $1,000 penalty will be applied to the professional services for the inpatient stay. There is no penalty for professional services rendered during the inpatient stay. For new group HMO Louisiana POS plans with deductibles, there is no copayment. Therefore, the $1,000 penalty will be applied to the Blue Cross payment based on the deductible/coinsurance benefit.

Please Note: The member's benefit plan is an agreement between the member and Blue Cross or HMO Louisiana only. Providers cannot waive the member's cost sharing obligations, such as deductibles, coinsurance (including out-of-network differentials), penalties or the balance of the bill. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged, and will be reduced by the total amount waived.

Non-participating Hospital Penalty

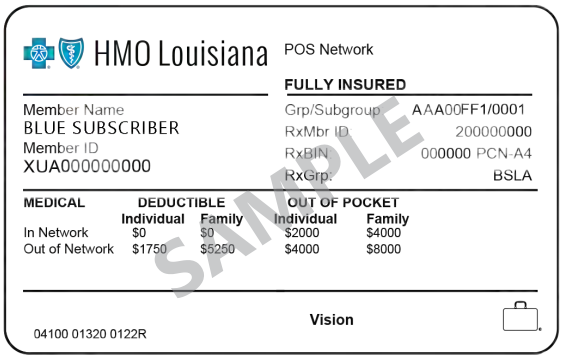
When a HMO-POS member receives covered services from a non-participating hospital, the benefits that are paid under the member's benefit plan will be reduced by 30%. This penalty is the member's responsibility. The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.

HMO Louisiana Service Area

The HMO Louisiana Network is offered statewide. We rely on the vast amount of health care data at our disposal to identify providers who are delivering the highest-quality, most cost-efficient care among their peers. These are the providers we contract with for our HMO Louisiana network.

Identifying HMO Louisiana Members

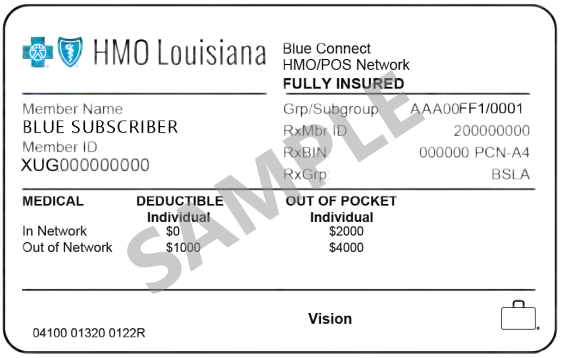
When HMO Louisiana members arrive at your office, be sure to ask them for their current HMO Louisiana member ID card. The main identifier for these members is the HMO Louisiana logo in the top left corner of the card, which also indicate the product type as either an HMO Plan or Point of Service (POS) Plan. HMO Louisiana members carry an ID card similar to the one shown here. ID cards are issued with the same member ID number for each covered member.



BLUE CONNECT

Blue Connect is an HMO-POS select network product available to groups and individuals in:

- Lafayette Area: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes
- New Orleans Area: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes
- Shreveport Area: Bossier and Caddo parishes



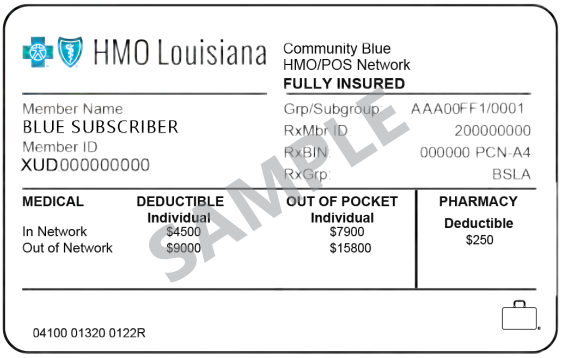
Members with Blue Connect may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Blue Connect. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers not in the Blue Connect network. Fully insured Blue Connect members must select a primary care provider. The Blue Connect network name on the member ID card identifies the member as participating in this network.

Please Note: While the Blue Connect product is offered in the Lafayette, New Orleans and Shreveport areas only, Blue Connect members may still access Blue Connect network providers located in other parishes.

COMMUNITY BLUE

Community Blue is an HMO-POS select network product available to groups and individuals in the:

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

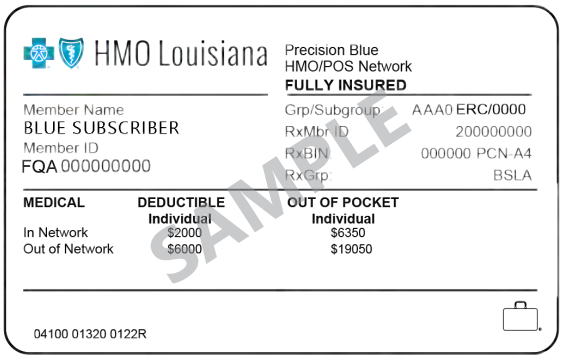


Members may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Community Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers not in the Community Blue network. Fully insured Community Blue members must select a primary care provider. The Community Blue network name on the member ID card identifies the member as participating in this network.

PRECISION BLUE

Precision Blue is an HMO-POS select network product available to groups and individuals in the:

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston, Pointe Coupee and West Baton Rouge parishes
- Greater Monroe/West Monroe Area: Caldwell, Morehouse, Ouachita, Richland and Union parishes

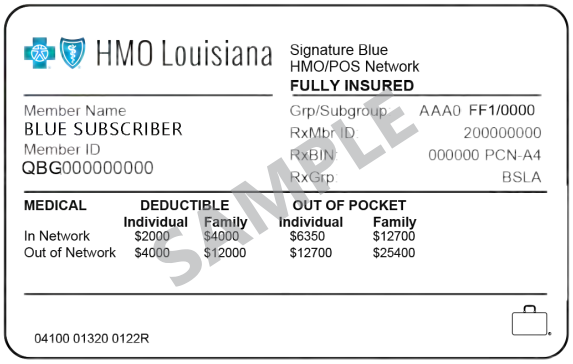


Members may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Precision Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. In-network benefits will apply to Enhanced Tier 1 and Tier 1 Precision Blue network providers. Enhanced Tier 1 providers may have a lower member cost share for primary care provider and specialist office visits. Facilities are not included in Enhanced Tier 1. Members receive a lower level of benefits when using providers not in the Precision Blue network. Fully insured Precision Blue members must select a primary care provider. The Precision Blue network name on the member ID card identifies the member as participating in this network.

SIGNATURE BLUE

Signature Blue is an HMO-POS select network product available to groups and individuals in the:

- New Orleans Area: Jefferson and Orleans parishes



Tiered benefits apply to members of Signature Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers not in the Signature Blue network. Fully insured Signature Blue members must select a primary care provider. The Signature Blue network name on the member ID card identifies the member as participating in this network.

TIERED BENEFITS FOR SELECT NETWORKS

There are different benefit tiers for members in our select networks. Please always verify the member's eligibility, benefits and limitations prior to rendering services. To do this, use iLinkBlue.

When researching coverage for a member with Blue Connect, Community Blue, Precision Blue or Signature Blue, you will see tiered benefit requirements on the Medical Benefits Summary page in iLinkBlue. The provider must participate in the member-patient's specific select network to be considered a Tier 1 provider for that member.

Please Note: Precision Blue will identify four benefit tiers for members and will only apply in-network benefits to Enhanced Tier 1 and Tier 1 providers. The other select networks will identify three benefit tiers and will only apply in-network benefits to a Tier 1 provider.

Enhanced Tier 1 In Network Preferred

For Precision Blue only: Applies to select providers in the Precision Blue network.

Example Scenario:

- A Precision Blue member sees a select Precision Blue network provider.
- The member accumulations and copayments identified for Enhanced Tier 1 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 1 In Network Preferred

Applies to providers participating in the member's specific network.

Example Scenario:

- A Community Blue member sees a Community Blue network provider.
- The member accumulations, copayments and coinsurance identified for Tier 1 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 2 Out of Network Preferred

Applies to providers participating in-network with Blue Cross but NOT in the member's specific network.

Example Scenario:

- A Community Blue member sees a Signature Blue network provider.
- The member accumulations, copayments and coinsurance identified for Tier 2 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 3 Out of Network Non-Preferred

Applies to providers who do not participate in any Blue Cross network.

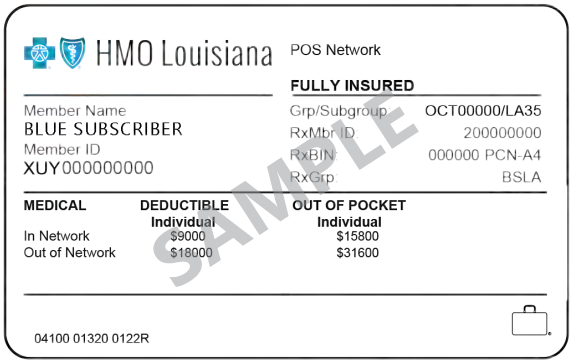
Example Scenario:

- A Community Blue member sees a non-participating provider.
- The member accumulations, copayments and coinsurance identified for Tier 3 should be applied.
- Provider can bill the member for any amount over the allowed amount.

View our *iLinkBlue User Guide* for more information on researching member coverage information. It is available on our Provider page at www.bcbsla.com/providers >Resources >Manuals.

BRIDGE BLUE SHORT-TERM MEDICAL

Customers can enroll for Blue Cross and HMO Louisiana individual medical policies through the health care marketplace (the exchange) or buy off-exchange policies during open enrollment only, for a January 1 effective date. Once open enrollment ends, these customers are unable to purchase individual policies until the next open enrollment period. HMO Louisiana offers individual short-term medical (STM) policies to qualifying customers. We accept applications anytime throughout the year.



Members may carry up to 11 months of coverage with underwriting approval. These policies may be renewed. Individuals can maintain health care coverage until the next open enrollment in the marketplace. Exclusions and limitations apply for these STM policies.

We offer four individual benefits products:

- Bridge Blue POS - accesses the HMO Louisiana network
- Bridge Community Blue POS - accesses the Community Blue network
- Bridge Blue Connect POS - accesses the Blue Connect network
- Bridge Precision Blue POS - accesses the Precision Blue network

BLUE HIGH PERFORMANCE NETWORK

Blue High Performance Network$_{SM}$ (BlueHPN) is a national network focused on enhancing the quality of care and delivery of cost savings to large self-funded employer groups. This network allows eligible employer groups with employees located throughout the country seamless access to a quality and affordable health care network nationwide.

HMO Louisiana, Inc. offers a BlueHPN network and member benefit option. Our BlueHPN members have access to other providers participating in the BlueHPN network across the nation.

BlueHPN members must access BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to the BlueHPN contract with BCBSLA.

BlueHPN is an Exclusive Provider Organization (EPO). This means benefits are only covered for care by in-network providers. It is important to note that for non-BlueHPN providers, benefits for services incurred are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. Benefit limitations are included on the back of the BlueHPN member ID card. If you are a non-BlueHPN provider but participate in the Preferred Care PPO network, you will be reimbursed for services provided to BlueHPN members according to your PPO allowable charges.

BlueHPN members are recognizable by:

- The Blue High Performance Network name on the front of the member ID card.
- The BlueHPN in a suitcase logo in the bottom right hand corner of the member ID card.

OFFICE OF GROUP BENEFITS (OGB) BENEFIT PLANS

Blue Cross and Blue Shield of Louisiana administers benefits for the Office of Group Benefits (OGB) state of Louisiana employees, retirees and dependents. Five benefit plans are available: Pelican HRA 1000, Pelican HSA 775, Magnolia Local, Magnolia Local Plus and Magnolia Open Access. These products are plans that use our networks of doctors, hospitals and other medical care providers, as well as Blue providers nationwide.

Pelican HRA 1000 (active employees & retirees with and without Medicare)

This is a consumer-driven benefit plan (CDHP) paired with a health reimbursement arrangement (HRA). This benefit plan uses the OGB Preferred Care network, which is Blue Cross' Preferred Care PPO provider network.

Pelican HSA 775 (active employees only)

This is a consumer-driven benefit plan that is paired with a health savings account (HSA) option. The Pelican HSA 775 benefit plan uses the OGB Preferred Care Network, which is Blue Cross' Preferred Care PPO provider network.

Magnolia Local (active employees & retirees with and without Medicare)

This benefit plan uses our Blue Connect or Community Blue provider network. Magnolia Local is an HMO Point of Service product that allows members to choose each time they need care—at the point of service—whether to use a primary care provider (PCP) or a specialist without a referral. This benefit plan is only available as follows:

Blue Connect network

- Lafayette Area: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes
- New Orleans Area: Jefferson, Orleans Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes
- Shreveport Area: Bossier and Caddo parishes

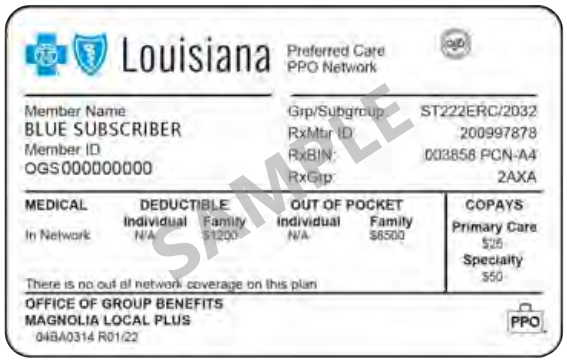
Community Blue network

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Magnolia Local members in Blue Connect parishes do not have coverage if they choose to see Community Blue providers, just as Magnolia Local members in the Community Blue parishes do not have coverage if they choose to see Blue Connect providers. With this benefit plan, there is no coverage for services performed by non-network providers. Please refer your patients to providers within their network to ensure they receive the highest level of benefits available.

Magnolia Local Plus (active employees & retirees with and without Medicare)

This benefit plan has an HMO benefit design but through a PPO network. Members with this benefit plan are not limited to a local-area only network. Members who choose the Magnolia Local Plus benefit plan have access to the OGB Preferred Care network, which is Blue Cross' statewide Preferred Care PPO network. With this benefit plan, there is no coverage for services performed by non-network providers.



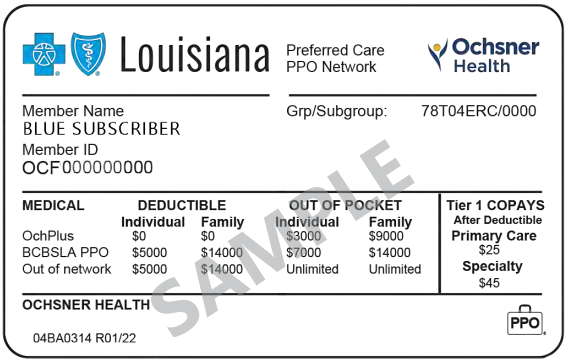
Magnolia Open Access (active employees & retirees with and without Medicare)

This benefit plan is OGB's PPO benefit plan. Members with this benefit plan have access to the OGB Preferred Care PPO network.

OCHPLUS

The OchPlus Network consists of a select group of physicians, hospitals and other allied providers that service Ochsner Clinic Foundation or Southern Regional Medical Corporation employees.

Some OchPlus Network providers are contracted for limited services only. Please refer OchPlus Network members to providers within the network so they receive the highest level of benefits.



The Ochsner Health name and logo on the member ID card identifies the member as participating in this network.

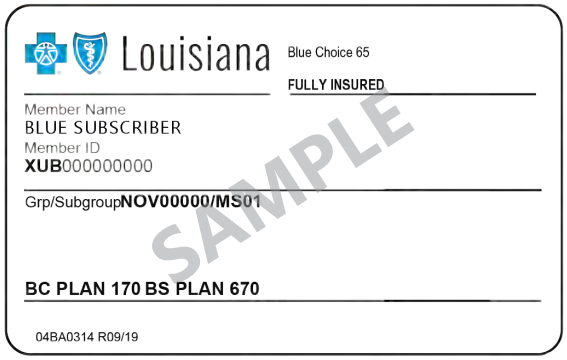
BLUECHOICE 65

Blue*Choice 65* is a series of Medicare supplement plans and are designed to pay for many of the expenses Medicare does not pay. Some of the options in this series include:

- Part A deductible coverage
- Part B deductible coverage, coinsurance and excess charges
- Skilled nursing coinsurance

Blue*Choice 65 Select* plans feature lower premiums and a select network of hospitals that have agreed to waive the Part A deductible and coinsurance.

Please Note: Blue*Choice 65* refers to certain contracts and is not connected with or endorsed by the U.S. government or the federal Medicare program.



NATIONAL ALLIANCE

Blue Cross and Blue Shield of Louisiana (BCBSLA) has several self-funded groups with unique member benefit plans. For these benefits, we are partnered with Blue Cross and Blue Shield of South Carolina (BCBSSC) and use their National Alliance program to administer services.

For more on this member benefit product, please refer to our Identification Card Guide provider tidbit available on our Provider page at www.bcbsla.com/providers >Resources >Tidbits.

A complete listing of our National Alliance groups and prefixes is available on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Resources" section.

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 members who are enrolled through another Blue 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.

Please Note: Providers should follow the guidelines set forth in this manual and those that are included in the *BlueCard Program Provider Manual*, which is a supplement to this office manual and is located on our Provider page.

How to Identify BlueCard Members

When members from other Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the prefix, a blank suitcase logo, and for eligible PPO members, the "PPO in a suitcase" logo.

A correct member identification number includes the three-character prefix in the first three positions and all subsequent characters up to a total of 17 positions. Some member identification numbers may include alphabetic characters within the body of the number. These alphabetic characters are part of the member's identification number and are not considered to be part of the three-character prefix.

Member ID Prefixes

The three-character prefix at the beginning of the member's ID number is the key element used to identify and correctly route out-of-area claims. It is also critical for confirming a patient's membership and coverage. The prefix identifies the Blue Plan or national account to which the member belongs.

It is very important to capture all identification card data at the time of service. If the information is not captured correctly, you may experience a delay in claims processing. We suggest that you always make copies of the front and back of the member ID cards and pass this key information on to your billing staff and any other providers you refer the member to, for example, lab, X-ray, etc. Do not make up prefixes.

Do not assume that the member ID number is a Social Security number. All Blue Plans replaced Social Security numbers on member ID cards with alternate, unique identifiers.

Member ID Cards with no Prefix

Some member ID cards may not have a prefix or suitcase logo, which may indicate that claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the card for how to file claims. If that information is not available, call the customer service number indicated on the member ID card.

"Suitcase" Logo

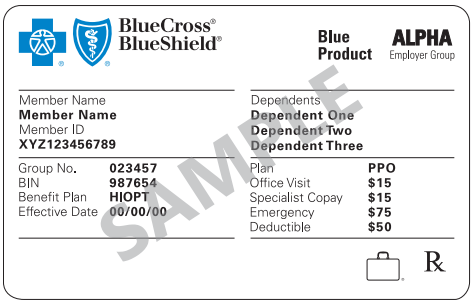
A blank "suitcase" logo on a member ID card indicates that the member has Blue Cross and Blue Shield Traditional, POS or HMO benefits delivered through the BlueCard Program.

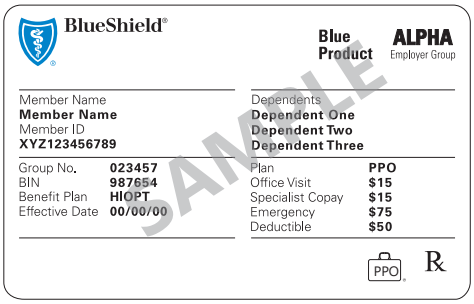
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

The BlueHPN suitcase logo indicates the member is enrolled in a Blue High Performance Network (BlueHPN) or BlueHPN EPO product.





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 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 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 (1-800-810-2583). 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 on iLinkBlue or by calling BlueCard Eligibility® Line. An operator will ask you for the prefix on the member ID card and will connect you to the appropriate membership and coverage unit at the member's Blue Plan. If you are unable to locate a prefix on the member ID card, check for a phone number on the back of the member ID card, and if that is not available, call the Customer Care Center.

2. After you render services to a BCBS member, you should file the claim (according to your contractual arrangements) with Blue Cross and Blue Shield of Louisiana.
   Please Note: The claim must be filed using the three-character prefix and identification number located on the member ID card.

3. Once the claim is received, Blue Cross and Blue Shield of Louisiana electronically routes it to the member's Blue Plan.

4. The member's Blue Plan applies benefits, adjudicates the claim and transmits it back to Blue Cross and Blue Shield of Louisiana, either approving or denying payment. The processing time of the claim may take longer than most Blue Cross processes.

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

6. The member's Blue Plan sends a detailed explanation of benefits (EOB) report to the member.

Types of Claims Filed Through the BlueCard Program

All professional claims as well as facility inpatient and outpatient claims for BlueCard members should be filed to Blue Cross and Blue Shield of Louisiana. Medicare primary could be paid differently by each Blue plan. Blue Cross and Blue Shield of Louisiana pays according to the member's participation with us and their participation with Medicare. If the member is of Medicare age and does not indicate that Medicare is primary, we will pay as if Blue Cross is primary.

The Federal Employee Program (FEP) and other Blue Cross plans will pay according to the member's contract language. However, if it is determined that the member should have been set up initially with Medicare as primary, the provider will be asked to return any reimbursement and the claim will have to be reprocessed with Medicare as primary.

Ancillary Claims Filing Instructions for BlueCard Claims

Ancillary claims for Independent Clinical Laboratory, Durable/Home Medical Equipment and Supply, and Specialty Pharmacy are filed to the Local Plan in whose service area the ancillary services were rendered—if these services were performed in Louisiana, the Local Plan is Blue Cross and Blue Shield of Louisiana.

- Independent Clinical Laboratory: Local plan is the plan in whose service area the specimen is drawn. This is determined by the state where the referring physician is located.

- Durable/Home Medical Equipment (DME/HME): Local Plan is the plan in whose service area the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy: Local Plan is the plan in whose service area the ordering physician is located.

Please Note: Complete instructions on filing ancillary claims for BlueCard members are included in *The BlueCard® Program Manual*, which is a supplement to this office manual and is located on our Provider page.

FEDERAL EMPLOYEE PROGRAM (FEP)

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

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

FEP Standard Option

With FEP 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: Members have a $25 copayment when they see a PCP. If members go to a specialist, they have a $35 copayment for the office visit.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers.

Maternity Care: Members pay nothing for covered physician and hospital services related to maternity care when they use Preferred Care PPO providers.

FEP Basic Option

With the FEP Basic Option, members must use preferred providers for all their medical care. Benefits are only available for care provided by out-of-network providers in certain situations, such as emergency care. With FEP Basic Option, there is no calendar year deductible. FEP 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 have a $30 copayment for office visits to PCPs. If members go to a specialist, they pay $40 for the office visit.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers. During these visits, members are also covered at 100% for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

Maternity Care: Members pay nothing for covered prenatal and postnatal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a $175 copayment.

FEP Blue Focus

With FEP Blue Focus, members must use preferred providers for all their medical care. Benefits are only available for care provided by out-of-network providers in certain situations, such as emergency care. With FEP Blue Focus, there is a $500 calendar year deductible.

Office Visits: Members have a $10 copayment per visit for the first 10 office visits (PCP and/or specialist) per calendar year. All subsequent office visits are subject to deductible and coinsurance, as applicable.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers.

Maternity Care: Members pay nothing for covered prenatal and postnatal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a $1,500 copayment.

Cancer Screening

There are no age or frequency limitations applicable to covered cancer screenings.

Provider Tips

- Determine the member's financial responsibility by viewing member benefits on iLinkBlue.
- Ask members for their ID card regularly.
- First check eligibility and benefits through iLinkBlue.

FEP Non-network or No Network Claims Processing

Blue Cross pays FEP members directly for all services performed by any provider who does not have an agreement with us.

There are two classifications of non-contracted providers:

1. A non-participating provider is defined as one that has chosen not to sign a network agreement with Blue Cross.

2. A non-network or no network provider is a provider/specialty type that Blue Cross does not offer network agreements to.

Please Note: An out-of-network provider is defined as a provider that has signed a network agreement with Blue Cross but is not in the specific network tied to the member's benefit.

CONSUMER-DIRECTED HEALTH CARE

Consumer-directed health care (CDHC) is a movement in the health care industry designed to empower members, reduce employer costs and change consumer health care purchasing behavior. CDHC provides the member with additional information to make informed and appropriate health care decisions through the use of member support tools, provider and network information, and financial incentives. CDHC includes many different benefit plans and services including consumer-directed health plans (CDHP), high deductible health plans and the option to use debit cards for payment. In conjunction with these plans, members may have a health reimbursement account (HRA), health savings account (HSA) or flexible spending account (FSA).

When the consumer is paying more of the bill, you may need to devote resources to conducting pre-service work with patients. Consumers on a high deductible health plan may require more specialized service work due to the questions on cost and options.

When the Consumer Is Paying More of the Bill			
Sales/Marketing Fulfillment	Pre-Service	At Point of Service	Post-Service
• Seeks education about choices. • Selects health plan. • Selects network/ providers.	• Seeks information. • Estimates costs to compare providers and treatment options. • Seeks quality information about providers.	• Knows what they owe. • Can apply payment from a variety of sources, including access to credit.	• Seeks help with next steps of treatment plan: - Health information/ coaching - Efficient sources
• Promotion to consumers. • Performance information for consumers.	• Determines member eligibility and benefits. • May estimate member responsibility for upcoming service. • May inform member of estimate in advance.	• Determines eligibility, benefits and specific member responsibility. • Collects correct amount from the source selected by the member.	• Provides feedback on performance. • Seeks improvements: - Administrative - Clinical

Consumer Directed Health Plans

High-deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs)—such as an HSA, an HRA, or a FSA—form a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

Once members have met their deductible, covered expenses are paid based on the member's benefit plan. As a participating provider, you should treat these members just as you would any other Blue Cross member:

- You should accept the Blue Cross reimbursement amount/allowable charge (up to the member's deductible amount) and any coinsurance amount, if applicable, as payment in full.

- If you collect billed charges up front, you must refund the member the difference between your charge and the Blue Cross reimbursement amount/allowable charge within 30 days.

Examples of what to collect from members:		
1) Member's Total Deductible	$2000	
Member's Deductible Applied	$2000	
Allowable Charge	$ 100	**Member Has Met Deductible**
Amount to be collected from member	**$ 0**	
Blue Cross Pays	$ 100	
2) Member's Total Deductible	$2000	
Member's Deductible Applied	$1000	**Member Has NOT Met Deductible**
Allowable Charge	$ 100	
Amount to be collected from member	**$ 100**	
3) Member's Total Deductible	$2000	
Member's Deductible Applied	$2000	
Allowable Charge	$ 100	**Member with Coinsurance**
Member's Coinsurance (20%)	$ 20	
Amount to be collected from member	**$ 20**	
Blue Cross Pays	$ 80	

BlueCard members whose plan includes a debit card can pay for out-of-pocket expenses by swiping the card through any debit card swipe terminal. These cards are used just like any other debit card. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to accept any other signature debit card.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their debit cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

Blue*Saver* Claims Filing Tips

Below are some helpful tips that will guide you when processing claims for and payments from Blue members with a CDHP like Blue*Saver*:

- Commit to pre-service work with patients. Contact to confirm appointment and ask them to bring a copy of their current member ID card. Offer to discuss out-of-pocket expenses prior to their visit.
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Verify the member's eligibility or benefits through iLinkBlue and provide the prefix, or use electronic capabilities.
- Carefully determine the member's financial responsibility before processing payment.

- If the member presents an HSA or HRA debit card or debit/ID card, be sure to verify the member's cost sharing or out-of-pocket amount before processing payment.
- Please do not use the card to process full payment up front.
- File claims for all members with CDHPs (including those with BlueCard) to Blue Cross.

Please Note: If you have any questions about the health care debit card processing instructions or payment issues, please contact the debit card administrator's toll-free number on the back of the card.

Members with Consumer Directed Health Plans Like Blue*Saver*

Many consumer directed health care (CDHC) members carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Some cards are "stand-alone" debit cards that cover out-of-pocket costs, while others also serve as a member ID card and include the member ID number. The combined card will have a nationally recognized Blue logo, along with the logo from a major debit card company such as MasterCard® or Visa®.

Members can use their cards to pay outstanding balances on billing statements. If your facility currently accepts credit card payments, there is no additional equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit cards.

If the member presents a debit card (stand-alone or combined), be sure to verify the member's cost share amount before processing payment. Do not use the card to process full payment up front.

Please Note: If you have questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

BLUE ADVANTAGE (HMO) AND BLUE ADVANTAGE (PPO)

Blue Advantage is our Medicare Advantage product. For information to aid you in servicing members with Blue Advantage health care benefits, please refer to the *Blue Advantage Provider Administrative Manual*. It is located on the Blue Advantage Provider Portal, available through iLinkBlue.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

MEDICARE ADVANTAGE MEMBERS FROM OTHER BLUE PLANS

For information to aid you in servicing Medicare Advantage members from other Blue plans, please refer to *The BlueCard® Program Provider Manual,* available online on our Provider page.

HEALTHY BLUE AND HEALTHY BLUE DUAL ADVANTAGE

We offer consumers in Louisiana two Healthy Blue options of coverage:

Healthy Blue

This is our Medicaid product designed to help consumers eligible for Medicaid or LaCHIP get health care coverage. Members are eligible for all covered services including physical health and mental health services.

Healthy Blue Dual Advantage (HMO D-SNP)

Healthy Blue Dual Advantage is available to our dual coverage (Medicaid and Medicare Advantage) special needs product (SNP). It is available to Blue Advantage members with who are also eligible for Medicaid. Healthy Blue Dual Advantage includes supplemental benefits for items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the plan in addition to what Medicare covers.

Healthy Blue and Healthy Blue Dual Advantage (HMO D-SNP) are managed by Elevance Health, on behalf of Blue Cross and Blue Shield of Louisiana. For more information, go to https://providers.healthybluela.com.

For more on this member benefit product, please refer to our Identification Card Guide provider tidbit available on our Provider page at www.bcbsla.com/providers >Resources >Tidbits.

SECTION 2: NETWORK PARTICIPATION

of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about network participation. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 2: NETWORK PARTICIPATION

Participating providers are those physicians, allied health providers and facilities who have entered into a provider agreement with Blue Cross and Blue Shield of Louisiana, including HMO Louisiana, Inc., (herein referred to as Blue Cross or Plan). As a participating provider in our 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. They are designed to create a more effective business relationship among providers, consumers and Blue Cross. Our participating provider networks:

- Facilitate providers and Blue Cross working together to voluntarily respond to public concern over costs.
- Continue to give Blue Cross members freedom to choose their own providers.
- Demonstrate providers' support of realistic cost-containment initiatives.
- Limit out-of-pocket expenses for patients to predictable levels and reduce their anxiety over the cost of medical treatment.

As applicable, providers are encouraged to comply with Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH Act.

As applicable, provider agrees to maintain a notice of HIPAA privacy practices, as required by HIPAA, at the point where a Plan member would enter provider's website or web portal.

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 also have the following responsibilities to our members—your patients:

- **Submitting claims for members.**
  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 CMS-1500 claim form (or the UB-04 claim form for certain allied providers) including appropriate Physicians' Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes. National Provider Identifiers (NPIs) are required on all claims (Blue Cross-assigned provider numbers are no longer used). The Claims Submission section of this manual gives specific information about completing the claim form as well as CPT and ICD-10-CM coding information. The Allied Health Providers section gives specific information about completing the CMS-1500 and UB-04 claim forms.

- **Accepting Blue Cross payment plus the member deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.**
  Blue Cross' payment for covered services is based on your charge not to exceed the Blue Cross allowable charge. You may bill the member for any deductible, coinsurance, copayment and/or non-covered service. However, you agree not to collect from the member any amount over the Blue Cross allowable charge.

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

- **Cooperating in Blue Cross' cost-containment programs where specified in the member contract/certificate and not billing the member or Plan for any services determined to be not medically necessary or investigational, unless the provider has notified the member in advance in writing that certain not medically necessary or investigational services will be the member's responsibility.** Generic or all-encompassing notifications to member will not meet the specific notification requirement mentioned here.

  Certain Plan member contracts/certificates include cost-containment programs such as prior authorization, concurrent review and case management. The member ID card will contain telephone numbers for prior authorization. Also, the member should inform you if his/her benefit program includes cost-containment provisions or incentives.

- **Informing Blue Cross of your possible involvement in a concierge or membership program.** Such involvement must be communicated in writing to your Network Representative before our members are contacted about this new process. Blue Cross will discuss with you your intentions and plans for the concierge or membership program and how it will impact our members.

AMENDMENTS TO PROVIDER AGREEMENTS

Blue Cross has the right to amend provider agreements by making a good faith effort to notify the provider at least 60 days prior to the effective date of the change.

ALLIED HEALTH PROVIDERS

Allied health providers are licensed and/or certified health care providers other than a physician, or hospital, and may include a clinical laboratory, urgent care center, managed mental health care provider, 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.

A separate provider contract should be signed for allied health providers to participate in our networks.

RECIPROCAL BILLING AND FEE-FOR-TIME COMPENSATION ARRANGEMENTS (*formerly referred to as locum tenens*)

In the instance a regular provider (physician or physical therapist who has a professional practice) is unable to provide services to members, Blue Cross allows the provider to **temporarily** hire a "like" provider (physician of the same specialty and/or licensure or physical therapist) as a replacement for the regular provider. The regular provider may be absent for reasons such as illness, pregnancy, vacation or continuing medical education.

These services should be furnished under an arrangement that is either:

- reciprocal billing
  or
- fee-for-time compensation

Both providers entering into the reciprocal billing arrangement or the fee-for-time compensation arrangement must already be credentialed Blue Cross and Blue Shield of Louisiana providers.

Blue Cross recognizes reciprocal billing arrangement or fee-for-time compensation arrangement services for the following provider types:

- doctor of medicine
- doctor of osteopathic medicine
- doctor of dental medicine
- doctor of dental surgery
- doctor of podiatric medicine
- doctor of optometry
- chiropractor
- physical therapist – only available for outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA) or in a rural area.

A **reciprocal billing arrangement** can be used when a "like" provider enters into the **temporary** agreement to have services furnished to regular patients on an "occasional reciprocal basis" during an absence. The provider identifies the reported services by applying Modifier Q5 on the CMS-1500 claim form. These can be informal arrangements.

A **fee-for-time compensation arrangement** can be used when a "like" provider enters into the **temporary** agreement to have services furnished to regular patients. This involves a formal arrangement that is for a continuous specified time period, not to exceed 60 continuous days. The provider identifies the reported services by applying Modifier Q6 on the CMS-1500 claim form.

Reciprocal billing and fee-for-time compensation arrangements are not allowed to extend beyond a 60-day continuous time period unless the physician or physical therapist is called to active duty as a member of a reserve component of the Armed Forces.

Blue Cross follows the CMS reciprocal billing arrangement or fee-for-time compensation arrangement billing requirements, which can be found at www.cms.gov.

NON-PARTICIPATING PROVIDERS

Non-participating providers do not have a contract with Blue Cross and Blue Shield of Louisiana, HMO Louisiana network or any other Blue Cross and Blue Shield plan. These providers are not in our networks. We have no fee arrangements with them. We establish an allowable charge for covered services rendered by non-participating providers. We use this allowable charge to determine what to pay for a member's covered services when a member receives care from a non-participating provider.

Members usually pay significant costs when using non-participating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating and HMO Louisiana providers. In addition, participating and HMO Louisiana providers waive the difference between the actual billed charge for covered services and the allowable charge, while non-participating providers do not. The member will pay the amounts shown in the "Non-Network" column on their schedule of benefits, and the provider may balance bill the member for all amounts not paid by Blue Cross or HMO Louisiana.

Please Note: The member's policy is an agreement between the member and Blue Cross or HMO Louisiana only. The member will receive a lower level of benefits because care was not received from a participating provider. Providers cannot waive the member's cost sharing obligations, such as deductibles, coinsurance (including out-of-network coinsurance differentials), penalties or the balance of the bill except for services covered under the No Surprises Act. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged, and will be reduced by the total amount waived.

PPO and HMO Point of Service Members

When a member receives covered services from a non-participating hospital, the benefits that Blue Cross will pay under the member's benefit plan will be reduced by 30%, except for services covered under the No Surprises Act. This penalty is the member's responsibility.

The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.

HMO Louisiana Members

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. Our authorization department will (1) determine if the services are medically necessary, and (2) approve a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member's out-of-pocket expenses. There is no guarantee of benefits.

HMO-HMO and HMO-POS members do not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility.

No Surprises Act Open Negotiation

One regulatory provision of the Consolidated Appropriations Act (CAA) 2021 is the No Surprises Act Open Negotiation process.

The No Surprises Act protects consumers from surprise bills or balance billing when a non-participating provider bills a member for more than what Blue Cross pays plus the member cost-share.

Non-participating providers cannot charge members an unexpected bill when the member is not able to choose who treats them. Non-participating providers who render services to members in a true health emergency cannot balance bill members for more than the Blue Cross allowable charge.

When balance billing is not allowed, the member also has the following protections. The member is only responsible for paying any copayments, coinsurance or deductible that they would pay if the provider was in their network. Blue Cross will process claims for non-participating providers and facilities as follows:

- Cover emergency services without requiring the member to get approval for services in advance (prior authorization).
- Cover emergency services by non-participating providers.
- Count any amount the member pays for emergency services or non-participating provider services at in-network facilities toward the member's in-network deductible and out-of-pocket limit.

Members are protected from balance billing for:

- Emergency services: If a member must get care in a true emergency from a non-participating provider, the most the provider may bill that member is the member's copayment, coinsurance or deductible for in-network care. The member cannot be balance billed for these emergency services. This includes care the member may get after they are in stable condition unless that member gives written consent and gives up their protections not to be balanced billed.
- Certain services at a network hospital or ambulatory surgical center: When a member gets services from an in-network hospital or ambulatory surgical center, certain providers there may be non-participating. In most cases, non-participating providers who see the member in a network hospital cannot send that member a surprise bill unless they obtained consent from the member.

Those non-participating providers rendering services covered by the No Suprises Act may negotiate with Blue Cross for more than the allowable charges for services. The 30-day open negotiation period is available within 30 business days of the date of receipt of the initial claim payment.

To start the open negotiation period, the non-participating provider must complete and submit the No Surprises Act Open Negotiation Notice form. It is available online at www.bcbsla.com/providers >Resources >Forms. Send completed forms to providerdisputesCAA@bcbsla.com.

For more information about the federal law, visit www.cms.gov/nosurprises.

Notice for Patient Consent Requirements

If a member gets other care at in-network facilities, non-participating providers cannot balance bill the member unless the member gives written consent and gives up these protections. Our members are not required to get care from non-participating providers, and the CAA's No Surprises Act protects members from surprise bills in the situations outlined above.

Eligible non-participating providers must include written notice to the patient within the timeframes defined by applicable law. The Centers for Medicare and Medicaid Services (CMS) has published a consent waiver form that non-participating providers can use. The federal Standard Notice and Consent Documents Under the No Surprises Act (consent form) is available at www.cms.gov/nosurprises >Policies and Resources >Overview of Rules & Fact Sheets >Guidance & Technical Resources. The patient must sign and date the consent and acknowledge receipt of written notice about the payment and how it may affect cost sharing.

The following non-participating providers cannot ask the member to give up their balance-billing protections:

- Anesthesiologists
- Emergency room physicians
- Neonatologists
- Pathologists
- Radiologists
- And other providers of ancillary services as defined by applicable law

Submitting Patient Notice & Consent

Providers can submit claims electronically or hardcopy. Providers must also submit a copy of the consent waiver to Blue Cross as documentation that the patient is waiving their protective rights for balance billing. When billing electronically, there is not an option to include attachments. To ensure that Blue Cross properly receives the consent documentation, please follow the claims filing guidelines below:

For Electronic Claims:

- Submit the claim electronically.
- Submit a copy of the signed consent waiver by mail, fax or email at the same time.
- Complete and include the Blue Cross CAA Consent Submission Form as a cover sheet. It is available at www.bcbsla.com/providers >Resources >Forms. Submission instructions are included on the form.

  Please Note: The Blue Cross CAA Consent Submission Form is not a patient consent waiver. Our form simply allows Blue Cross to obtain additional information to match the patient consent waiver to your electronic claim.

For Paper Claims:

- Submit the signed consent waiver as an attachment to your hardcopy claim form.

Servicing Facility Claim Requirements

To ensure that Blue Cross can identify claims involving members who receive non-emergency out-of-network services in connection with an in-network facility visit, professional providers must include the servicing facility on all submitted claims. The claim will deny if it does not include the name, address and NPI number of the servicing facility.

Please enter the servicing facility information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 32

Electronic 837P, Professional Claims:

- Servicing Facility – Claim Level: 2310C loop

CREDENTIALING PROGRAM OVERVIEW

Blue Cross fully credentials providers who apply for network participation. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC). All provider information obtained during the credentialing process is considered highly confidential.

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. Participation is available for professional providers and facilities.

The credentialing program includes initial credentialing as well as recredentialing every three years. Blue Cross partners with Vantage Health Plan for the processing of these activites.

For more information on our credentialing and data management process, including frequently asked questions, visit www.bcbsla.com/providers >Provider Networks >Join Our Networks >Professional Providers .

Credentialing Applications

The credentialing packets and criteria are available on our Blue Cross Provider page at www.bcbsla.com/providers >Provider Networks >Join Our Network >Professional Providers >Join Our Network. All packets include an application for iLinkBlue and Electronic Funds Transfer. iLinkBlue is our secure online tool for professional and facility health care providers.

We return incomplete or incorrect credentialing applications and stop the application process. The process starts over once all completed documents are received.

Initial Credentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. When a fully completed credentialing packet and required supporting documentation are received, the credentialing process can take up to 90 days. Our credentialing staff verify the provider's credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to our policies and procedures and URAC standards.

Providers will remain non-participating in our network(s) until the application has been approved by the Blue Cross Credentialing Committee. Once approved by the Blue Cross Credentialing Committee, providers will remain non-participating until they sign and execute an agreement through our Provider Contracting Department for participation.

After 90 days, providers may inquire about their credentialing status by contacting the Provider Credentialing & Data Management Department at PCDMstatus@bcbsla.com.

Recredentialing

After the initial credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by the Blue Cross Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified. Vantage may contact Blue Cross providers to submit your recredentialing application or supply additional information for recredentialing.

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Credentialing Committee

The Blue Cross Credentialing Committee meets to review credentialing twice per month. Based upon compliance with the criteria below, the Blue Cross Credentialing Committee reviews the provider's credentials to ascertain compliance with the following criteria. The Blue Cross Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's application.

All participating providers must maintain these criteria (as applicable for provider type) on an ongoing basis:

- Unrestricted license to practice medicine in Louisiana as required by state law.
- Agreement to participate in the Blue Cross networks.
- Professional/malpractice liability insurance 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.
- No convictions of a felony or instances where a provider committed acts of moral turpitude.
- No current drug or alcohol abuse.

Professional Credentialing

Professional providers requesting Blue Cross network participation must complete the initial professional credentialing application packet, which includes a checklist of required documents as well as the Louisiana Standardized Credentialing Application (LSCA). All providers, regardless of network participation, must include their NPI(s) on the application.

Reimbursement During Credentialing (for professional providers only)

Professional health care providers can be reimbursed for claims at network allowable charges and member benefit options during the credentialing process and the claims are paid directly to the provider. Blue Cross sets up qualifying providers for this reimbursement when they meet the following criteria:

- Provider must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Cross. This provision does not apply for solo practitioners.
- Provider must have admitting privileges to a network hospital or an approved exception. Provider must list this information in the hospital affiliations section on the appropriate credentialing application.
- Blue Cross credentialing policy allows certain eligible providers to have an arrangement with a hospitalist group to admit their patients in lieu of their own hospital privileges. Note: Nurse practitioners and physician assistants must submit a current collaborative agreement.

View our *How to Request Reimbursement During Credentialing* guide for more information on the process. It is available on our Provider page at www.bcbsla.com/providers >Resources >Forms.

CLIA Certification Required

Professional providers who perform laboratory testing procedures in the office, are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

Credentialing Process and Provider Specialty Network Provider Directory

As a network provider, you may only participate in the Blue Cross networks and be listed in the network provider directory as the primary specialty you identified to Blue Cross on your credentialing application. For example, providers may not participate in our networks as one of the following specialties of general practice, family practice, internal medicine or pediatrics unless they practice in a full primary care provider (PCP) capacity. For more information on our credentialing process, visit our Provider page. For more information on our network provider directory, see the Provider Directories section of this manual.

Facility Credentialing

Facilities requesting network participation must complete the initial facility credentialing application packet, which includes a checklist of required documents as well as the Facility Credentialing Application. Select facility types must also complete a Facility Information Form:

- Facility Information Form A: Ambulance Company
- Facility Information Form B: DME Supplier or Pharmacy
- Facility Information Form C: Ambulatory Surgical Center, Hospital, IOP/PHP Psych/CDU, Skilled Nursing Facility, Long Term Acute Care, Rehabilitation Center
- Facility Information Form D: Urgent Care Clinic/Walk-in Clinic
- Facility Information Form E: Diagnostic Radiology (Free Standing)
- Facility Information Form F: Retail Health Clinics
- Facility Information Form G: Laboratory
- Facility Information Form H: Outpatient Cath Lab

Freestanding Diagnostic Imaging Facilities

Blue Cross requires that all freestanding diagnostic imaging facilities and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a facility performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from all Blue Cross networks in which they participate.

Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear Cardiology

An ***Opti****Net*® score of 80% or more for each modality is required. ***Opti****Net* is a Carelon online registration tool for gathering modality-specific data on imaging providers in areas such as facility qualifications, technologist and physician qualifications, accreditation and equipment. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

Blue Cross reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Cross within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Blue Cross' credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging facility no longer performs a modality that requires accreditation or performs another modality that does not require accreditation.

This credentialing policy applies for freestanding (not hospital-based) diagnostic imaging facilities only.

Medical Staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Certified Registered Nurse First Assistant (CRNFA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), Physician Assistant (PA) or Psychologist can be set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital reimbursement and will not be set up independently under the hospital agreement.

Subcontracted Providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to: EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, initial hearing screens for newborns, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all hospital services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Blue Cross or the member for such services.

For those instances when Member Providers may need to send a member to another facility when the member is inpatient, the Member Provider should bill Blue Cross for that service. The other facility should not bill Blue Cross separately for the services rendered.

For example, a member, who is an inpatient at ABC Hospital, needs hyperbaric oxygen therapy, but ABC Hospital does not have the necessary equipment. Therefore, ABC Hospital sends the member to XYZ Hospital. Once the procedure is completed, the member returns to ABC Hospital. In this case, ABC Hospital should bill Blue Cross for the hyperbaric oxygen therapy XYZ Hospital should not bill Blue Cross or the member.

At least annually, Member Providers should furnish Blue Cross with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement.

Please Note: Blue Cross will not pay for initial hearing screens done on newborns when performed after discharge from the facility of birth. Initial hearing screens are inclusive of the hospital stay.

Statute: R.S. 46:2264(A) The office of public health in the Department of Health and Hospitals shall establish, in consultation with the advice of the Louisiana Commission for the Deaf and the advisory council created in R.S. 46:2265, a program for the early identification and follow-up of infants at risk, hearing impaired infants, and infants at risk of developing a progressive hearing impairment.

Source: Senate Bill No. 436.

Status Changes

A provider is required to report changes in their credentialing criteria to Blue Cross within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

Examples of status changes providers are required to report include, but are not limited to:

- Change in Hospital Admitting Privileges
- Suspension/revocation of any license
- Change in Collaborative/Supervising Physician Agreement

iLinkBlue and Electronic Funds Transfer

iLinkBlue is our secure online tool for professional and facility health care providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The iLinkBlue Application and Electronic Funds Transfer Form are included in our credentialing packets. These documents are required to become a participating provider.

TERMINATIONS

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Voluntary Termination

While Blue Cross makes reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in our networks. **Providers must do so by providing at least 90 days advance written notice per notification in their network agreement.**

Upon receiving a contract termination notice for a PCP or a specialist, Blue Cross will close the PCP's panel to new members and notify affected members of the forthcoming contract termination. Blue Cross will provide assistance, as needed, to transition care to another participating PCP or specialist. The resigning provider is responsible for the continued care of Blue Cross patients during the 90-day notification period.

To request network termination, use the Provider Update Request Form and select the "Termination Request" option. The form is available online at www.bcbsla.com/providers >Resources >Forms. This form can be completed, signed and submitted digitally with DocuSign. We will advise you if additional information is necessary to process your request.

Involuntary Termination

Blue Cross may terminate the participation of an individual provider for cause. Blue Cross shall gives notice in accordance with the terms and conditions of the applicable Participation Agreement.

Blue Cross reserves the right to terminate a provider's network participation due to lack of claims activity over a given 24 month period. Blue Cross shall give notice in accordance with the terms and conditions of the applicable Participation Agreement.

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.

Type	Access Standard	Examples
Emergency		
Medical situations in which a member would reasonably believe his/her life to be in danger, or that permanent disability might result if the condition is not treated.	Immediate access, 24 hours a day, 7 days a week	• Loss of consciousness • Seizures • Chest pain • Severe bleeding • Trauma
Urgent Care		
Medical conditions that could result in serious injury or disability if medical attention is not received.	30 hours or less	• Severe or acute pain • High fever in relation to age and condition
Routine Primary Care		
Problems that could develop if untreated but do not substantially restrict a member's normal activity.	5 to 14 days	• Backache • Suspicious mole
Preventive Care		
Routine exams	6 weeks or less	• Routine physical • Well baby exam • Annual Pap smear

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.

DIGITALLY SUBMITTING CREDENTIALING & DEMOGRAPHIC FORMS

Providers can complete, sign and submit many Blue Cross applications and forms digitally with DocuSign®. This replaces the need to print and submit hardcopy documents to the Provider Credentialing & Data Management (PCDM) Department. Through this enhancement, providers can electronically upload support documentation and even receive alerts (reminding them to complete applications) and confirm receipt.

The documents below are available in DocuSign format only.

- Professional Credentialing Packet (includes LCSA Attachment A)
- Facility Credentialing Packet (includes all Facility Information Forms)
- iLinkBlue Agreement Packet
- Electronic Funds Transfer (EFT) Enrollment Form
- Provider Update Request Form

Please Note: When submitting DocuSign documents, please do not also separately email them to Blue Cross. Double submissions (submitting through DocuSign and sending an email of the completed form) could delay the processing time for your request.

If you have any questions on submitting DocuSign forms to Blue Cross, you may contact the PCDM Department at PCDMstatus@bcbsla.com.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

PROVIDER DIRECTORIES

As a participating provider, your name is included in the Blue Cross product-specific provider directories featured on our website. Participating providers are listed in the directories by parish in alphabetical order under their specialty(ies).

Thousands of health care professionals and facilities across the state are in our networks. You can find the one you need quickly with our easily searchable directories online. Listings are updated daily. We make every effort to ensure the information in our provider directories is current and accurate.

You must notify Provider Credentialing & Data Management if you have any changes within your practice. To do so, use the Provider Update Request Form. It is available online at www.bcbsla.com/providers >Resources >Forms. It is a DocuSign® form, which allows you to complete, sign and digitally submit it directly to our Provider Credentialing & Data Management Department.

The form includes the following change request options:

- Demographic Information (i.e., new or updated email address, change of address, different operating hours, etc.)
- Electronic Funds Transfer (EFT)
- Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
- Termination Request
- Tax ID Number Change
- Add New Practice Location (existing Tax ID)
- Remove Practice Location (existing Tax ID)

We will advise you if additional information is necessary to process your request.

Please Note: The Blue Cross and Blue Shield of Louisiana online provider directory is developed using information from network providers and facilities. Blue Cross does its best to post the most accurate, up-to-date information. However, because we continually add providers to our network, and providers occasionally decide to discontinue their participation, we cannot guarantee the accuracy or currency of our information at the time of your search. For the most current information, please contact the Customer Care Center.

PROVIDER DIRECTORY INFORMATION

A part of our commitment to serving our members is to provide them with current comprehensive information about our network providers.

Provider directory information includes demographic information such as medical school(s) attended and graduation year, gender, race/ethnic background (voluntarily reported), languages spoken and whether a physician's office is accepting new patients. Other information like providers' specialties, board certifications, hospitals where they admit and certain accreditation information is also available.

PROVIDER DIRECTORY VERIFICATION

Under the Consolidated Appropriations Act (CAA) 2021, providers are required to verify their demographic information in our online provider directories every 90 days. This ensures that the information published is accurate for member/patient use.

Blue Cross implemented a process to verify the information providers already have on file with us. Providers are sent a pre-populated Provider Attestation Form via DocuSign. Providers must attest that the information is correct/incorrect. If any of the data on the form is incorrect, the provider must complete the Provider Update Request Form to report updated information.

Should a provider fail to verify their information, they will be removed from Blue Cross' online provider directories. Network participation will not be affected, but a person searching our provider directories will not have access to your information.

PROVIDER DIRECTORY LOCATIONS POLICY

Blue Cross and Blue Shield of Louisiana limits the published practice locations of professional providers in our online provider directories as follows:

- Professional providers must be available to schedule patient appointments at a minimum of 8 hours per week at the location listed.
- A member must also be able to call and schedule a patient appointment at the location listed in the directory.

Each professional provider must report patient appointment availability for each location reported to Blue Cross. This information should be reported for new providers on the Louisiana Standardized Credentialing Application (LSCA) Attachment A – Location Hours. Existing network providers must report this information on the Recredentialing Application during the recredentialing process.

Additionally, professional providers are asked to report this information when completing the Provider Update Request Form to make the following changes:

- Updating your physical address
- Joining a new provider group or clinic
- Changing your Tax ID number
- Adding a new practice location

SECTION 3: MEMBER ENGAGEMENT

of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about our member engagement initiatives. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 3: MEMBER ENGAGEMENT

OVERVIEW

Our member engagement initiative is designed to give our members the tools they need to become more active in managing their own health care. Our plan is to work hand-in-hand with our network providers to get our members clear, understandable and easily accessible information to make smarter health care choices. Two of these tools are the Estimated Treatment Cost Tool and Member Reviews. Additional tools will be launched in the future.

ESTIMATED TREATMENT COST TOOL

With this tool, Preferred Care PPO members may view PPO cost displayed on the national Blue Cross Blue Shield Association (BCBSA) Hospital & Doctor Finder℠ website. The tool features the costs and volumes associated with 1,721 elective/planned procedures. Total cost of care estimates display bundled service and facility charges that are typically a standard part of a procedure or treatment.

Cost Estimates

Cost estimates are developed from our historical claims with updates, as needed, to reflect current arrangements and combined data that enables members to understand the total cost for a service without complications. These estimates are created in four ways:

- For inpatient procedures primary Diagnostic Related Group (DRG) codes(s) related to each treatment category should reflect the professional, diagnostic and other related costs for the category per line and the total displayed.
- For outpatient procedures primary CPT code(s) identify each treatment category and all costs for that member on the same date of service are summed to create the estimate.
- For diagnostic services both the technical and professional component are combined.
- For professional office visits, primary CPT code(s) identify each treatment category. For chiropractic and physical therapy, all costs for the visit are summed to create the estimate. For other categories, weighted average costs per CPT code(s) created the estimate.

Viewing Cost Estimates

A report of cost estimates is available to providers on iLinkBlue under the menu item "Quality & Treatment." You must have access to iLinkBlue in order to view your cost data, as this information will not be mailed. The report contains the cost ranges calculated for the facility or professional providers and frequently asked questions. Cases may be excluded from this estimate based on criteria, such as volume, network participation status, provider type, place of service and completeness.

For inpatient, outpatient and diagnostic treatment categories, figures displayed are a total PPO cost and include facility and professional costs. For professional office visit treatment categories, the costs are average provider-specific costs for services defined to the treatment category. The member will see the approximate cost range for the selected treatment category with fees associated for the service. In addition, the member will be able to view the name, address and phone number of the provider.

Reconsideration Process

Providers have 30 days from the date of notice that the data is available to review the cost data and request a reconsideration. To request reconsideration, complete the Estimated Treatment Cost Reconsideration Form located on iLinkBlue (www.bcbsla.com/ilinkblue) >Quality & Treatment, then click on the specific treatment description in the question. Follow the instructions on the screen to complete the form. Prior to submitting the form, you will have the option to print a copy for your records. All required fields must be completed, and forms must be submitted electronically. Faxed or mailed forms will not be accepted. The Electronic Reconsideration Form will only be available to providers during the reconsideration period prior to each cost data submission. During times outside this window, the link to the form will be inactive. Resource documents are available on iLinkBlue. Click on the Quality & Treatment menu to see the following:

- Frequently Asked Questions
- Treatments Codes Listing

MEMBER REVIEWS

Patient reviews are seen as a quality and transparency domain in proposed health care reform measures. The market demand for member review is growing, fueled by the new and expanding individual retail health insurance market. Approximately 85 to 90% of patient reviews are positive. Encouraging all of your Blue patients to add to these reviews will help assure an overall positive score. Key components of patient reviews are:

- Members must first log in to their online account on our website.
- Members are then authenticated during login before being able to submit reviews.
- Members must access a specific claim on file to comment on an encounter with the physician.
- Members then respond to a core set of member review questions.
- Member-written comments are checked for appropriateness before posting to our website.
- The review is then displayed in the comments section on our online directory for the physician.
- Physicians are able to give one response to each patient review.

In most instances, this can be a good marketing tool for your practice given that there is such positive feedback.

SECTION 4: MEDICAL MANAGEMENT

of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about medical management. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 4: 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 members receive the highest quality health care that is medically appropriate and cost-effective. See the end of this section for an overview of our Quality Management Program.

UTILIZATION REVIEW ORGANIZATION

Blue Cross is authorized as an Utilization Review Organization (URO) and therefore follows the regulations promulgated by the Department of Insurance that governs 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 sections note where differences occur.

CONCURRENT REVIEW

The Concurrent Review Unit evaluates the medical and service needs of patients admitted 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, the provider and the Care Management Department. Concurrent review nurses conduct a 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.

Blue Cross has streamlined its processes for requesting authorizations by requiring all prior authorization requests, with the exception of transplants and most out-of-state services, to be submitted exclusively through the BCBSLA Authorizations application available on iLinkBlue (for more information, see the Authorization Application Mandate entry in this manual section). This includes all levels of care, such as acute, skilled nursing and rehabilitation services. This change allows providers to request authorization for services 24 hours a day, seven days a week, in real time. All inpatient care facilities are required to use the BCBSLA Authorizations application to request additional services or days with the exception of transplants cases and out-of-state services. 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.

A decision is made within one business 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 via telephone, fax or portal. 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 insured groups for operational efficiency. Insureds not subject to URO 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.

RETROSPECTIVE REVIEW

The Blue Cross 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.

As part of this review process, staff members examine diagnoses, treatments or procedures.

For retrospective authorization requests, upload medical records and the Retrospective Review Authorization Form in iLinkBlue, using the document upload feature. Click on the "Document Upload" link on the home page, then select "Medical Records for Retrospective or Post Claim Review" from the department drop down. The Retrospective Review Authorization Form is available online at www.bcbsla.com/providers, click "Resources" and then "Forms."

When a provider does not obtain authorization for certain services, Blue Cross' Medical Management Department reviews claims if the member's policy allows for retrospective review.

Do not submit a request for retrospective review if you filed a claim. If we require additional medical records, Medical Management will request them using the Medical Records Request for Claim Review form.

Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. If you are unsure if a policy allows for retrospective review, contact the Customer Care Center at the number found on our Quick Reference Guide in the front of this manual.

You may request a retrospective review in one of two ways:

- Fax the Retrospective Review Authorization Form to the Medical Management retrospective authorization fax number found on our Quick Reference Guide.
- Upload the Retrospective Review Authorization Form and medical records through iLinkBlue (www.bcbsla.com/ilinkblue). Click on the "Document Upload" link on the home page, then select "Medical Records for Retrospective or Post Claim Review" from the department dropdown.

AUTHORIZATION PROCESS

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

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 annually, 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.

Authorization Application Mandate

Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application. Blue Cross will not accept authorization requests via phone or fax, with a few exceptions.

- Newborn Sick Babies or "Temporary Members": A newborn sick baby often requires services that cannot be attributed to the mother's hospital stay. Parents have 30 days to add babies to a current plan or to sign them up for their own plan and eligibility is often not visible right away. Providers may call Blue Cross to set up the initial authorization. Once Blue Cross completes the initial setup of the baby as a temporary member for authorization purposes only, providers must then access the BCBSLA Authorizations application to upload clinical reviews.
- Most Out of State Providers (OOS): Authorizations for out-of-state services performed by out-of-state providers should be requested by phone or fax.
- Transplant Authorizations: Requests for transplant evaluations, listings and the actual transplant should be called or faxed to the Blue Cross Authorizations Department.
- Dental Services Covered Under Medical: Dentist performing services that are covered under medical should be called or faxed to the Blue Cross Authorizations Department.
- Blue-on-Blue Coverage: When a member has two Louisiana Blue Cross polices that require the coordination of benefits, the provider should call Blue Cross for prior authorization. Once the initial authorization has been created, the provider must access to BCBSLA Authorizations application to upload clinical reviews.
- Carelon Inpatient Authorization Extensions and Discharges: Carelon reviews select inpatient services such as spine surgery, total hip replacements and total knee replacements. When the authorization is issued by Carelon, providers must still call the Blue Cross Authorization Department and follow the inpatient prompts to provide either a discharge date or continued stay information because these authorizations will not be visible via the BCBSLA Authorizations application. Carelon authorization numbers do not begin with AA (as Blue Cross authorization numbers do). Carelon authorization numbers are in number-only format.

With our online process you have the capability to get an immediate approval without Blue Cross personnel intervention. Please remember, if the requested services are to treat a condition that may arise from a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity. Providers are responsible for checking member eligibility and benefits.

An example of this would be a member experiencing complications after a non-covered gastric bypass. These complications would not be covered under the member's policy regardless of medical necessity, even if an authorization is obtained via the BCBSLA Authorizations application. If you have a situation similar to this example, please submit the clinical information via the BCBSLA Authorizations application for a review, rather than applying InterQual criteria.

Providers can supply the necessary clinical information in one of the three ways outlined below:

- Complete criteria review via InterQual (IQ). You may receive an online approval when IQ is completed, and criteria are met. Some services will require additional review, such as a benefit review or a medical policy review regardless of an IQ approval. Completing an IQ review is not required.
- Upload clinical information to the authorization request through the BCBSLA Authorizations application.
- Document the clinical information in the notes section of the authorization request in the BCBSLA Authorizations application. You must then generate an activity within the request. If an activity is not generated, the clinical information will not be available for Blue Cross to review.

Authorization Application Resources

For information on how to use our BCBSLA Authorizations application, please refer to the *BCBSLA Authorizations Applications Facility User Guide*, available on iLinkBlue under the "Resources" tab, then click "Manuals." For information on using iLinkBlue, refer to the *iLinkBlue User Guide*, available at www.bcbsla.com/providers, click "Resources," then "Manuals."

Pre-service Authorizations – BCBSLA

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. A listing of services that require authorization is provided in this manual. 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:
  - Submitting an authorization request using the authorization applications available on iLinkBlue, or
  - Calling the appropriate authorization number on the member ID card for services excluded from being loaded via the BCBSLA Authorizations application.

- The following information is required to complete a pre-service authorization:
  1. Patient/member name, date of birth, member ID number;
  2. Physician's name, NPI, 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-10-CM codes), procedures (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. Name and phone number of person requesting authorization.
- 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) voicemail, web or electronic means including email and fax. A letter of confirmation is mailed to the member and faxed to the 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 voicemail) within 24 hours of the determination. A non-certification letter is sent to the member, 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 – BCBSLA

- 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/or a confirmation letter is mailed to the member and faxed to the 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 appeal process. A letter is sent to the member, physician and hospital, if applicable, within one business day of the determination. The notification will list appeal rights based on regulatory guidelines.

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, limitations, exclusions and the patient's eligibility for benefits at the time expenses are incurred. Check an individual's benefits, limitations and eligibility immediately prior to providing a benefit or service. You may log into iLinkBlue or call the customer service number on the member ID card for specific information.

Notification of Admission/Status Change

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 an authorized service occurs, the provider should notify the Authorization Unit by accessing the case via the BCBSLA Authorizations application and generating a "Provider Request" activity with the details related to your change. This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service.

Routine Maternity Admissions

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 caesarean section delivery. Inpatient services for newborn well-baby services are included in the mother's stay. However, authorization is required for inpatient sick-baby services.

Home Health Authorizations

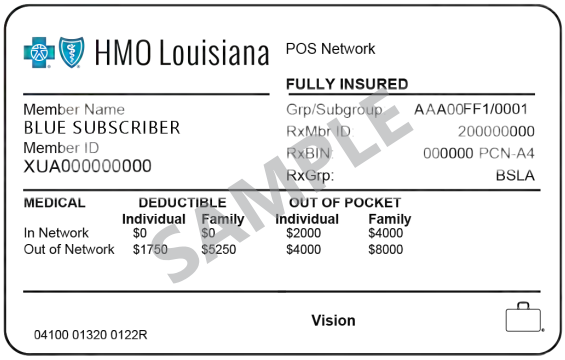
Home health providers are required to request all authorizations for home health services through the BCBSLA Authorizations tool on iLinkBlue. Authorizations for home health services will not be taken via phone or fax unless one of the exceptions to the Authorizations Tool Mandate applies. This includes new service requests and extensions.

Providers will need to supply the necessary clinical information in one of the three ways outlined below:

- Complete a criteria review via InterQual (IQ). Completing an IQ review is not required, but if one is completed and criteria is met the provider will receive approval online. Most cases will get an automatic approval when an IQ review is done. Some self-funded members will not get an automatic approval due to benefit limits.
- Upload clinical information to the authorization request through the BCBSLA Authorizations application.
- Document the clinical information in the notes section of the request in the BCBSLA Authorizations application. This option requires the provider to generate an activity to "Provider Request" within within the case. If an activity is not generated, the clinical information will not be available for the Blue Cross staff to review.

AUTHORIZATION PENALTIES FOR PROVIDERS

Outpatient Authorization Penalty

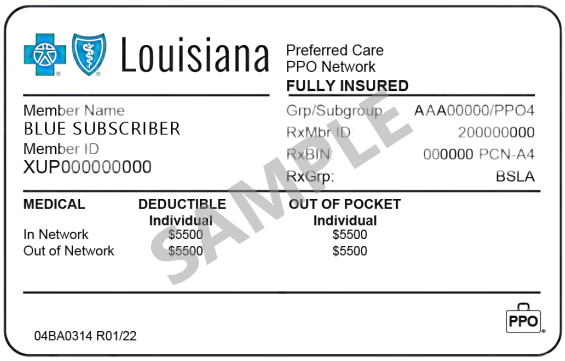


For Fully Insured BCBSLA PPO and HMO/POS Members:
Penalties for failure to obtain an authorization prior to performing outpatient services that require authorization will be 30%. This penalty will be applied to the network provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount and agrees to hold the member harmless for such penalties incurred. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or non-covered services. This does not apply to PPO providers of other Blue Plans.

For Fully Insured BCBSLA HMO/HMO Members and OGB Members:
Failure to obtain prior authorization of service(s) will result in a claim denial.

For Self-funded PPO and HMO Members:
Authorization requirements vary for self-funded members. Penalties for failure to obtain an authorization prior to performing outpatient services that require authorization will be 30%, unless the member's policy contains a different penalty. Always verify authorization requirements and benefits on iLinkBlue, prior to rendering services.

Inpatient Authorization Penalty



For Fully Insured BCBSLA PPO and HMO/POS Members:
For Blue Cross or HMO Louisiana, a $1,000 penalty will be applied to inpatient hospital claims if the network provider fails to obtain authorization for the services prior to the inpatient admission. This penalty will be applied to inpatient stays of members covered by any Blue Plan or subsidiary when the member's policy requires a pre-service authorization, and the provider agrees to hold the member harmless for such penalties incurred.

When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied before the terms of the member's policy.

For Fully Insured HMO/HMO Members and OGB Members:
Failure to authorize service(s) will result in a claim denial. OGB does not authorize Blue Cross to reconsider these denials at the appeal level.

For Self-funded PPO and HMO/POS Members:
For Blue Cross or HMO Louisiana, a $1,000 penalty will be applied to inpatient hospital claims if the network provider fails to obtain authorization for the services prior to the inpatient admission, unless the member's policy contains a different penalty for failure to authorize an inpatient stay, in which event, the terms of the member's policy will apply.

When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied prior and in addition to application of any penalty in the terms of the member's policy.

PPO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services may require Blue Cross approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

Preferred Care PPO

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic and Molecular Testing
- Hip Arthroscopy*
- Hearing Aids age 18 & older (no benefit without prior authorization)
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Inpatient Hospital Services (except routine maternity stays)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies (except for those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application.

* High-tech imaging & utilization management program services are authorized through the Carelon ***Provider****Portal*$_{SM}$ by clicking the "Carelon Authorizations" link.

** Behavioral health services are authorized through the Lucet WebPass Portal by clicking the "Behavioral Health Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

HMO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services and/or procedures may require HMO Louisiana approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue, Signature Blue and Bridge Blue

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation*
- Cellular Immunotherapy
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic and Molecular Testing
- Hearing Aids age 18 & older (no benefit without prior authorization)
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Inpatient Hospital Services (except routine maternity stays)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a physician office)
- Orthotic Devices greater than $300
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application.

* High-tech imaging & utilization management program services are authorized through the Carelon ***Provider****Portal*$_{SM}$ by clicking the "Carelon Authorizations" link.

** Behavioral health services are authorized through the Lucet WebPass Portal by clicking the "Behavioral Health Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

OGB PLAN SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required for occupational therapy greater than 50 visits, physical therapy greater than 50 visits and bariatric surgery benefit (enrollment and surgery). Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans.

INPATIENT

- Hospital Admissions (except routine maternity stays)
- Mental Health/Substance Use Disorder Admissions**
- Organ, Tissue and Bone Marrow Transplant Services
- Skilled Nursing Facility

OUTPATIENT

- Air Ambulance – Non-emergency (no benefit without prior authorization)
- Applied Behavior Analysis**
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bariatric Benefit (enrollment & surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic and Molecular Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: physician's office, unless the drug to be infused may require authorization)
- Intensive Outpatient Programs**
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300)
- Partial Hospitalization Programs**
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.bcbsla.com/providers >Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers**
- Resting Transthoracic Echocardiography*
- Sleep Studies (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplant
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application.

* High-tech imaging & utilization management program services are authorized through the Carelon ***Provider****Portal*$_{SM}$ by clicking the "Carelon Authorizations" link.

** Behavioral health services are authorized through the Lucet WebPass Portal by clicking the "Behavioral Health Authorizations" link.

For OGB members, failure to obtain prior authorization, when required, will result in the denial of payments for services.

OCHPLUS SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services may require Blue Cross approval for OchPlus benefit plans. If authorization is not requested prior to admission or receiving outpatient services requiring an authorization, the plan has the right to determine if the admission or outpatient services are medically necessary. If determined not medically necessary, the admission or outpatient services will not be covered and the member will be responsible for all charges.

If the admission or outpatient services are medically necessary, benefits will be provided based on the participating status of the provider rendering the services.

OchPlus

- Air Ambulance Non-emergency – no benefit without prior authorization
- Applied Behavior Analysis**
- Bariatric Surgery
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment – greater than $750
- Electric & Custom Wheelchairs
- Enteral Formula
- Gender Reassignment Services and Surgery
- Gene Therapy
- Home Health Care – all charges will be denied if authorization is not obtained
- Hospice – all charges will be denied if authorization is not obtained for in-network (outpatient only) and out-of-network (inpatient and outpatient) facilities
- Hyperbarics
- Implantable Medical Devices over $2,000 – including but not limited to defibrillators
- Inpatient Hospital Services – except routine maternity stays
- Interventional Spine Pain Management*
- MRI/MRA*
- Nuclear Cardiology*
- Orthotic Devices – greater than $750
- PET Scans*
- Private Duty Nursing
- Prosthetic Appliances – greater than $750
- Pulmonary Rehabilitation
- Residential Treatment Centers**
- Sclerotherapy for Varicose Veins
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery*
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transplant Evaluation and Transplants
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application.

* High-tech imaging & utilization management program services are authorized through the Carelon ***Provider****Portal*$_{SM}$ by clicking the "Carelon Authorizations" link.

** Behavioral health services are authorized through the Lucet WebPass Portal by clicking the "Behavioral Health Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

FEP SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required for the following services for FEP members. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue.

Standard/Basic Option

- Air Ambulance (non-emergent)
- Applied Behavior Analysis*
- Blood/Marrow Stem Cell Transplants
- Certain High-cost Drugs Obtained Outside of a Pharmacy Setting – a complete list of these drugs is available at www.fepblue.org/highcostdrugs
- Certain Prescription Drugs and Supplies (including medical foods)
- Gender Reassignment Surgery
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing (including BRCA/LGR services)
- Hospice Care
- Inpatient Hospital Services (except routine maternity stays)
- Intensity-Modulated Radiation Therapy (IMRT)
- Organ/Tissue Transplants and Transplant Travel (including autologous pancreas islet cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas kidney; excluding cornea and kidney transplants)
- Oral/Maxillofacial Procedures (except when related to an accidental injury and provided within 72 hours of the accident)
- Proton Beam Therapy
- Residential Treatment Center*
- Skilled Nursing Facility
- Sleep Studies (when performed outside the home)
- Stereotactic Radiosurgery
- Stereotactic Body Radiation Therapy
- Surgical Correction of Congenital Anomalies
- Surgical Treatment for Morbid Obesity

Failure to obtain prior authorization for these services will result in a $500 penalty for inpatient services.

FEP Blue Focus Option

- Air Ambulance (non-emergent)
- Applied Behavior Analysis*
- Blood/Marrow Stem Cell Transplants
- Breast Reduction Augmentation (not related to the treatment of cancer)
- Cardiac Rehabilitation
- Certain High-cost Drugs Obtained Outside of a Pharmacy Setting – a complete list of these drugs is available at www.fepblue.org/highcostdrugs
- Certain Prescription Drugs and Supplies (including medical foods)
- Cochlear Implants
- CT Scan
- Gender Reassignment Surgery
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing (including BRCA/LGR services)
- Hospice Care
- Inpatient Hospital Services (except routine maternity stays)
- Intensity-Modulated Radiation Therapy (IMRT)
- MRI
- Oral/Maxillofacial Procedures (except when related to an accidental injury and provided within 72 hours of the accident)
- Organ/Tissue Transplants (including autologous pancreas islet cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas kidney; excluding cornea and kidney transplants)
- Orthognathic Surgery Procedures
- Orthopedic Procedures
- Outpatient Residential Treatment Center*
- PET Scan
- Prosthetic Devices
- Proton Beam Therapy
- Pulmonary Rehabilitation
- Reconstructive Surgery (not related to the treatment of breast cancer)
- Rhinoplasty
- Septoplasty
- Stereotactic Radiosurgery
- Stereotactic Body Radiation Therapy
- Surgical Correction of Congenital Anomalies
- Surgical Treatment for Morbid Obesity
- Specialty DME Services
- Travel Benefits
- Varicose Vein Treatment

Failure to obtain prior authorization for these services will result in a $100 penalty for outpatient services and a $500 penalty for inpatient services.

To Request Prior Authorization

Please use the authorizations applications that are available on iLinkBlue (www.bcbsla.com/ilinkblue). They are located under the "Authorizations" menu option. Blue Cross no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online BCBSLA Authorizations application.

* Behavioral health services are authorized through the Lucet WebPass Portal by clicking the "Behavioral Health Authorizations" link.

CARELON UTILIZATION MANAGEMENT PROGRAMS

Blue Cross has several utilization management programs that are administered by Carelon Medical Benefits Management (Carelon), an independent company that serves as an authorization manager for Blue Cross and HMO Louisiana members. For these programs, prior authorization requests should be made directly to Carelon using its ***Provider****Portal*$_{SM}$, which is available under the "Authorizations" section of iLinkBlue.

Ordering physicians (whether a primary care provider or specialist) are required to provide Carelon with basic clinical information and patient demographics to obtain the authorization. PCPs are not expected to obtain the authorization if a specialist orders the service. Hospitals and freestanding facilities may check the status of an authorization request through the Carelon ***Provider****Portal*$_{SM}$ on iLinkBlue. They may also obtain authorization if they have all relevant information required for the authorization process.

Carelon clinical appropriateness guidelines are available online at www.guidelines.carelonmedicalbenefitsmanagement.com. If a request for authorization is denied, Carelon notifies the ordering physician of the denial and the process for appeals. Reconsideration of a denied authorization should be submitted directly to Carelon. Please allow ample time in scheduling diagnostic services to ensure the authorization process is completed and approved before the patient receives services. Services that do not meet criteria will be denied and are not billable to the member.

Reminders for navigating Carelon's review process:

- If you file a claim for a service that requires prior authorization, but prior authorization was not done, the claim will deny with one of the following codes: WI7, WJA or WJ3. Contact Carelon to complete a retrospective medical necessity review. Resubmit the claim after Carelon reviews the retrospective request.
- Provide medical records to Carelon during the review process. If you send medical records to Blue Cross, we will not forward them to Carelon. We will send them back to you and advise you to contact Carelon. This is because Blue Cross does not perform these reviews.
- You can initiate these reviews through the Carelon ***Provider****Portal*$_{SM}$, on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Authorizations" tab, or by contacting Carelon at 1-866-455-8416.

High-tech Imaging Services Program

This program applies for the following office and outpatient, non-emergent imaging services:

- Computerized Tomography (CT) Scans
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI) – Please Note: authorizations for CPT 70336 are handled directly by Blue Cross. Most Blue Cross member contracts do not cover this service; however, a few large employers do provide some level of coverage.
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron-Emission Tomography (PET) Scans

Please Note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or observation stays are not included in this high-tech imaging program.

Cardiology Program

This program applies for the following office and outpatient non-emergent services:

- Diagnostic Services:
  - Echocardiography
  - Coronary arteriography/cardiac catheterization (Note: Coronary arteriography/cardiac catheterization for management of acute coronary syndrome is excluded from this program)
  - Arterial ultrasound
- Interventional Services:
  - Percutaneous coronary interventions (PCIs) such as coronary stents and balloon angioplasty

Musculoskeletal (MSK) Program

This program applies for the following inpatient and outpatient non-emergent services performed in certain locations:

- Interventional Pain Management (when performed in an ambulatory surgical center, physician's office or outpatient hospital)
  - Epidural steroid injections
  - Facet injections
  - Spinal cord stimulators
  - Radiofrequency ablation
- Joint Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Joint Replacement (hip, knee and shoulder)
  - Arthroscopy and Open Procedures (shoulder and knee)

  - Hip Arthroscopy
  - Meniscal Allograft Transplantation of the Knee
  - Treatment of Osteochondral Defects
- Spine Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Bone grafts
  - Bone growth simulators
  - Cervical/lumbar spinal fusions
  - Cervical/lumbar spinal laminectomies
  - Cervical/lumbar spinal discectomies
  - Cervical/lumbar spinal disc arthroplasty (replacement)
  - Spinal deformity (scoliosis/kyphosis)
  - Vertebroplasty/kyphoplasty

Radiation Oncology Program

This program applies for the following office, outpatient and free-standing facility services:

- 2D/3D conformational radiation therapy
- Intensity-modulated radiation therapy
- Intraoperative radiotherapy (IORT)
- Stereotactic radiosurgery
- Stereotactic body radiotherapy
- Brachytherapy
- Proton beam therapy
- Hypo fractionation for bone metastases, non-small cell lung cancer and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image Guidance Radiation Therapy (IGRT)

Who are in these programs?

Below are general guidelines to help identify the members that are a part of our utilization management programs. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

- Fully insured members are a part of all programs. Fully insured members can be identified by the words "Fully Insured" on the member ID card.
- Self-Funded members (ASO plans) have an option to be in these programs or not. Self-funded member ID cards will include the group name but will NOT include the words "Fully Insured."
- Small Business Funded (SBF) members are a part of all programs. SBF members have "SBF" in the group number in the Group/Subgroup section of their member ID card.
- Office of Group Benefits (OGB) members are a part of all programs.

DRUG AUTHORIZATIONS

Authorization Requirements

As part of our drug utilization management program, prior authorization is required for certain prescription drugs. Providers may access this list of targeted medications under the Pharmacy section of our Provider page (www.bcbsla.com/providers).

For details on how to request a prior authorization, please see the Authorizations information in the Quick Reference Guide at the front of this manual.

Appeals for drugs denied for medical necessity or experimental/investigational are handled by ESI or Blue Cross based on the member's benefit plan.

Pharmacy Benefit Drugs

Blue Cross is contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for pharmacy benefit drugs. Ordering physicians are required to contact ESI to complete authorizations for pharmacy benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Medical Drugs

Blue Cross is contracted with Express Scripts, Inc. (ESI), a pharmacy benefit manager, to perform prior authorizations for targeted medical benefit drugs. Ordering physicians are required to contact ESI to complete authorizations for targeted medical benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Prior authorization for non-targeted medications are handled by Blue Cross. Please do not contact ESI for these medications.

Please refer to the Reporting National Drug Code (NDC) on Claims guidelines in the Billing and Reimbursement section of this manual for full billing and claims details.

For more information on covered drugs, go to the Pharmacy section of our Provider page.

Step Therapy Program

Step Therapy requires the member to try one or more Step 1 drugs, within select drug classes, prior to trying a more costly Step 2 drug. A benefit of this program is to lower out-of-pocket costs, ultimately decreasing the member's likelihood to stop taking medications due to the cost.

Step 1 – The member first tries one or more Step 1 drugs to treat a medical condition before Blue Cross/HMO Louisiana will cover* a Step 2 drug for that condition.

Step 2 – If Step 1 drugs are not clinically appropriate or have been tried and do not work for the member, then Blue Cross/HMO Louisiana will cover* a Step 2 drug for that condition.

The following drug categories are examples of prescription drugs that are included in the Step Therapy program:

• Acne Treatment Medications	• Oral Diabetes Medications
• Blood Pressure Medications	• Pain and Inflammation Medications
• Bone Medications	• Respiratory/Allergy Medications
• Cholesterol Medications	• Sleep Medications
• Depression Medications	• Stomach Acid Medications
• Frequent Urination Medications	• Triptan Migraine Medications
• Long-Acting Pain Medications	

For information on drug authorizations, visit the Pharmacy section of our Provider page. When a provider writes a prescription for a Step 2 drug within the classes listed above for a member with Step Therapy, the prescription will be denied at the point of sale at the pharmacy if the member has not already tried one or more Step 1 drugs. The pharmacy will inform the member and then contact the provider and advise of the member's Step Therapy benefits. If the provider determines Step 1 drugs aren't appropriate for the member, then the provider can complete the Drug Prior Authorization Form found on our Provider page for an authorization, and if approved, the provider can prescribe a Step 2 drug. If the providers' request does not meet the necessary criteria to start a Step 2 drug without first trying one or more Step 1 drugs, or if the provider or member insists on the Step 2 drug, then the member is responsible for the full cost of the drug.

For information on specific drugs under the program, visit the Pharmacy section of our Provider page.

* Coverage determination is subject to the member's eligibility and benefits. Please always verify member benefits prior to rendering services.

BEHAVIORAL HEALTH AUTHORIZATIONS

Lucet is an independent company that serves as the behavioral health manager for Blue Cross. Lucet manages behavioral health services for our members for authorizations, utilization management, case management and Applied Behavioral Analysis (ABA) case management.

Requests for behavioral health authorization should be submitted directly to Lucet via the WebPass Portal, available through iLinkBlue, under the "Authorizations" menu option. You may also contact Lucet at 1-800-991-5638.

The Lucet medical necessity criteria for behavioral health services can be found on the Lucet website at www.lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana under "Policies & Manuals."

Behavioral Health Medical Necessity Appeals

First-level appeals on behavioral health services denied for medical necessity should be sent directly to Lucet at the address found on our Quick Reference Guide. If the decision is made to overturn the denial, a letter is sent to member and provider letting them know the denial was overturned and processing instructions are communicated to Blue Cross to pay the claim. If the decision is made to uphold the denial, a letter is sent to the member and provider directing them how and where to file a second-level appeal request.

Upon receipt of the second-level appeal, Blue Cross or the member's group (applies for some self-funded groups) will have an Independent Review Organization (IRO) review the case. This is a specialty-matched review. If the IRO upholds the denial, a letter is sent to the provider and member and appeals are exhausted. If the IRO overturns the denial, claims are paid.

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.

Cloned or Template Generated Documentation

Medical record documentation must be specific to the patient's situation at the time of the service. Each patient will have a unique set of problems, symptoms and treatments, so the expectation is that documentation would not look exactly the same across patients. The expectation would also be that medical record entries for a patient would not be worded exactly alike or similar to previous entries. Please be cautious when using templates to generate the medical record to ensure that what is documented in the medical record actually occurred for that patient.

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 initialed stamped signature or unique electronic identifier. Each entry has the author's name or initials. Documentation entered by someone other than the practitioner, must be counter-signed or counter-initialed. All signatures should be completed prior to billing for the service.

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 usage is noted.

   Definition: For patients 14 years and older, smoking habits, ethyl alcohol (ETOH) use and substance use 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 use 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 visits, unless there is a notation that previous problem has been resolved. The specific time of return is noted in days, weeks, months or PRN (as needed).

8. At each encounter, problems from previous visits are addressed, if applicable.
9. Review of underutilization and overutilization of consultants.

   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 Medicine Guidelines. See our Provider page.

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 three 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.

Clinical Criteria

Blue Cross and Blue Shield of Louisiana's medical management team may use InterQual criteria or medical policy criteria when reviewing authorization requests.

InterQual criteria is integrated into the BCBSLA Authorizations application that is available through iLinkBlue (www.bcbsla.com/ilinkblue). Within this application, providers can access the criteria within the member's authorization.

Blue Cross medical policy criteria is available through iLinkBlue (www.bcbsla.com/ilinkblue) under the Resources section.

If your authorization was performed by one of our vendors you can access their criteria by visiting their website:

- Behavioral health services are reviewed by Lucet Behavioral Health. The Lucet medical necessity criteria for behavioral health services can be found on the Lucet website at www.lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana under "Policies & Manuals."
- Blue Cross has several utilization management programs administered by Carelon. Carelon clinical appropriateness guidelines are available online at www.guidelines.carelonmedicalbenefitsmanagement.com.

MEDICAL POLICY

Medical Policy Review

Blue Cross and Blue Shield of Louisiana develops medical polices to provide consistent determination of the medical appropriateness of treatments, procedures, devices, drugs and biological products.

Services with an applicable medical policy and services that require prior authorization are NOT the same.

There are many services with an applicable medical policy that do not require a prior authorization. There are also many services that require a prior authorization, but do not have an applicable medical policy.

Services with an applicable medical policy can be reviewed prior to the service being rendered, whether it requires a prior authorization or not. This is done by the provider requesting a pre-determination prior to the service(s) being rendered. To initiate a request, access the BCBSLA Authorizations application through iLinkBlue (www.bcbsla.com/ilinkblue) under the "Authorizations" menu option.

Notes:

- Services with an applicable medical policy will be reviewed, either pre-service by the provider requesting a pre-determination or post service when the claim is submitted. All services with an applicable medical policy will be reviewed prior to claims payment. Services that are not medically necessary or investigational will not be reimbursed, and these services are not billable to the member.
- Services with an applicable medical policy rendered during an observation stay will be reviewed prior to claims payment.

Medical Policy Inquiry

Provider inquiries related to medical policy will be considered upon written request by a member's provider. All current medical policy coverage guidelines are available on iLinkBlue.

Requests for consideration must be accompanied by the supporting clinical information that is addressed within the medical policy.

Supporting Data Will be Assessed Against the Following Criteria:

- Have final approval from the appropriate government regulatory body;
- Have the scientific evidence that 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

Providers that 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.

Additionally:

- Written requests must include a return address or fax contact number.
- Supporting data will be reviewed by the medical director of the Medical Policy department and or appropriate Plan medical directors and consultants.
- Upon determination of review outcome written notification will be directed to the requesting provider within 60 days of receipt of request.

Observation Stay Medical Policy Reviews

The payment of observation services is limited to a maximum of 48 hours of observation. The 48-hour count commences when outpatient services begin. This is when the member arrives at the facility for treatment, not when the observation status begins.

Observation stays do not require prior authorization. However, Blue Cross will review services provided during an observation stay against applicable medical policies prior to claims payment. Service that are not medically necessary or investigational will not be reimbursed, and these services are not billable to the member.

Providers are encouraged to request a pre-determination review of medical policy services that will be performed during an observation stay prior to the service(s) being rendered. To initiate a request, access the BCBSLA Authorizations application through iLinkBlue (www.bcbsla.com/ilinkblue) under the "Authorizations" menu option.

Carelon reviews a subset of Blue Cross medical policies, but not in the observation setting. If Carelon reviews and denies a service related to medical policy in a setting other than observation, Blue Cross will not reimburse the same service even though performed in the observation setting. If your original plan of care includes services with applicable medical policy and criteria that are now planned for the observation setting, contact Blue Cross directly.

If you would like to review specific medical policy coverage guidelines, access our medical policy index on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Authorizations" section. Policies are listed in alpha order or you may search by keyword, procedure code, policy name or policy number.

QUALITY MANAGEMENT (QM) PROGRAM

The goal of the QM Program is to continuously maximize and improve the health care services delivered to members.

The scope of the QM Program is a commitment to the continued development of ongoing systems to monitor and enhance health care services delivered to members in all settings. Activities reviewed, supported, performed and/or monitored by the program include, but not limited to, the following:

- Accreditation
- Affordable Care Act Requirements
- Committee functions
- Quality of care issues
- Grievance resolution
- Member satisfaction
- Credentialing and re-credentialing
- Performance measures: including Healthcare Effectiveness Data and Information Set (HEDIS), Quality Star Ratings (QRS)
- Utilization and management of services
- Health management and wellness activities to include Care Management
- Clinical, non-clinical and safety related quality improvement activities
- Preventive care guidelines
- Medical Management Process Audits
- Oversight of delegated functions including but not limited to pharmacy and radiology services as well as behavioral health

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of health care performance measures developed by National Committee for Quality Assurance (NCQA) and used by Centers for Medicare & Medicare Services (CMS) for monitoring health plans and physicians to evaluate their performance in terms of clinical quality and customer service. Blue Cross participates in annual HEDIS reporting as a requirement to maintain our health plan accreditation and a subset of HEDIS measures is reported to CMS as a condition of certification and participation in the marketplace for Quality Rating System (QRS).

- HEDIS is a common set of comparable measurements that relates to current national clinical priorities. Measurement results are used for implementing interventions to close gaps in care and quality improvement projects/programs.
- QRS is a subset of HEDIS measures plus one Pharmacy Quality Alliance measure that is used for our STARS ratings.
- HEDIS data is collected in three different ways:
  - Administrative data (claims only)
  - Hybrid data (claims database and medical record review)
  - Survey data (member and provider surveys)

Provider's Role in HEDIS

- Provide appropriate care to meet the criteria and timeframes of each measure.
- Document care provided in the member's medical record.
- Submit accurate coding for claims.
- Provide medical records during the HEDIS process to help us validate the quality of care provided to our members.
  - Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed.
  - HEDIS data is collected and reviewed from January to May.
  - Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization.
  - Receiving all requested medical records (ideally in 5-7 business days) ensures that our results are an accurate reflection of care provided.
  - Provider agreements allow for the release of medical information to Blue Cross or its designee at no cost for quality improvement efforts.

QUALITY BLUE PROGRAM

Quality Blue is an innovative health care quality improvement program. Blue Cross has taken a leadership role in developing programs that reward providers for quality improvements that get better health results for patients while making health care more affordable.

The Quality Blue program promotes and enhances preventive wellness and disease management. In addition, Quality Blue encourages value-based (as opposed to volume-based) practice methods by equipping providers with a performance-based payment structure. Practices may be eligible to receive financial incentives for successfully achieving quality and total cost of care goals as outlined in their Quality Blue Program Participation Agreements. Each attribute of Quality Blue was designed to successfully facilitate the necessary transformation to improve the health and lives of Louisianians.

POPULATION HEALTH

The Centers for Disease Control and Prevention (CDC) views population health as an interdisciplinary customizable approach "that brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population." Blue Cross operates within this framework to establish programs that help to achieve positive health outcomes for members.

Key Components of the Population Health Improvement Model Include

- Population identification strategies and processes.
- Comprehensive needs assessments that assess physical, psychological, economic and environmental needs.
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles.
- Patient-centric health management goals and education, which may include primary prevention, behavior modification programs and support for concordance between the patient and the primary care provider.
- Self-management interventions aimed at influencing the targeted population to make behavioral changes.
- Routine reporting and feedback loops which may include communications with patient, physicians, health plan and ancillary providers.
- Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health.

The Population Health Improvement Model

- Encourages patients to have a provider relationship where they receive ongoing primary care in addition to specialty care.
- Complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end-of-life care.
- Assists unpaid caregivers, such as family and friends, by providing relevant information and care coordination.
- Offers physicians additional resources to address gaps in patient health care literacy, knowledge of the health care system and timeliness of treatment.
- Assists physicians in collecting, coordinating and analyzing patient specific information and data from multiple members of the health care team including the patients themselves.
- Assists physicians in analyzing data across entire patient populations.
- Addresses cultural sensitivities and preferences of individuals from disparate backgrounds.
- Promotes complementary care settings and techniques such as group visits, remote patient monitoring, telemedicine, telehealth and behavior modification and motivation techniques for appropriate patient populations.

CARE MANAGEMENT PROGRAMS

Your patients are stronger than any disease or diagnosis. Blue Cross' clinical team stands with you, ready to support your patients on their journey to optimal health. We have multi-disciplinary teams of clinical professionals, including doctors, nurses, pharmacists, dietitians and social workers. We also offer many long-standing, results-driven programs to support your patient relationships and help our mutual customers—your patients, our members—achieve their health and wellness goals.

These programs include:

- Case Management
- Disease Management
- Rare Condition Management in partnership with Accordant, an independent health management company
- Preventative and Wellness Services
- Behavioral Health Management in partnership with Lucet, an independent behavioral health management company
- Utilization Review
- Pharmacy

Help your patients be stronger than their diagnosis. There is no out-of-pocket cost to a patient to work with a Blue Cross health coach. Patients can learn more about our available programs and clinical staff at www.bcbsla.com/stronger.

For details on how to make referrals to a program or on how patients enrolled in a Blue Cross Care Management Program can opt out, please see the Care Management information in the Quick Reference Guide at the front of this manual.

Case Management

Case Management programs encourage collaborative relationships among a member's health care providers, and help members and their families maximize efficient utilization of available health care resources. These programs include:

- **Discharge Outreach**: Nurses engage select patients at high risk of readmission within 48-72 hours of discharge to assess their needs, make sure they are taking any medication as directed, coordinate care and help them lower their risks of complications and/or readmissions.
- **ER Outreach**: Our health coaches work with your patients who go to the ER often to connect them with primary care providers who can handle most of their health needs when they are sick or injured. We want to help your patients access care in the right setting outside of office visits with you and save on their out-of-pocket cost so they get the most value out of their health plan benefits.
- **Text 4 Baby**: All pregnant women have access to educational information and resources through Text 4 Baby. This program helps moms-to-be improve pregnancy and birth outcomes. For more information about the program, visit www.text4baby.org.

- **High Utilizers/High Cost**: Blue Cross encourages all of its members to have a primary care provider who handles most of their health needs when they are sick or injured. We particularly emphasize this for patients who have a lot of health care needs. The overall goal is to help these patients with care coordination and lower their risks of admissions and readmissions.
- **Oncology Management**: We support patients who are in active cancer treatment to help them manage treatment side effects and symptoms, assess access to care and coordinate services. We also offer education on Louisiana Physician Orders for Scope of Treatment (LaPOST) and other life care-planning legal documents.
- **Tobacco Cessation**: Nurses help patients who are trying to quit smoking or using tobacco to work through the stages of this change, set and meet goals and stick to quitting. Nurses also connect these patients with primary care doctors, community resources and other support services.
- **Transplant Care Management**: We work with patients who have had organ/tissue transplants to educate them on risks, promote safety, manage comorbidities and offer support throughout their care experience. This program helps improve transplant outcomes, lower the risk for hospitalizations and readmission, and lower overall costs associated with the transplant.

Disease Management

Blue Cross health coaches are here to help your patients stay on top of their long-term health needs. These programs aim to improve the physical and psychosocial well-being of patients through cost-effective, personalized solutions. Your patients are stronger than any diagnosis, and we will empower them to reach their best health.

Blue Cross Disease Management programs are here to support your patients who have any of the following health conditions:

- Asthma
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease/Hypertension
- Diabetes
- End Stage Renal Disease
- Pre-diabetes/Metabolic Syndrome

Please Note: Blue Cross is constantly assessing the market and may add Disease Management Programs for other conditions as appropriate.

Rare Condition Management

Blue Cross offers the My Health, My Way program* in partnership with Accordant, an independent health management company, to support patients who have any of 17 rare conditions with health coaching, follow-up and education.

My Health, My Way supports patients who have any of the following 17 rare chronic conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Crohn's Disease
- Ulcerative Colitis
- Cystic Fibrosis (CF)
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- Multiple Sclerosis (MS)
- Myasthenia Gravis (MG)
- Parkinson's Disease (PD)
- Polymyositis
- Rheumatoid Arthritis (RA)
- Scleroderma
- Epilepsy (Seizures)
- Sickle Cell Disease
- Systemic Lupus Erythematosus (SLE or Lupus)

*To see if your patient is eligible for this program, please contact the Blue Cross Care Management team at the number found in our Quick Reference Guide in the front of this manual.

MATERNITY MANAGEMENT PROGRAM - HEALTHY BLUE BEGINNINGS

Our maternity management program, Healthy Blue Beginnings, helps promote early and compliant prenatal care and offers case management support when required. If a provider has patients who are pregnant or are thinking of becoming pregnant, they should notify our maternity program staff who will assess the patient for risks and provide lifestyle risk modification coaching, and reliable information resources. Locate the Care Management Disease Management (CMDM) Referral Form online at www.bcbsla.com/providers >Programs >Care Management. Providers should complete and fax it to (225) 298-3184 to have a patient enrolled. Providers may also contact us directly or have the patient call Blue Cross and ask to speak with a nurse. Once a patient is enrolled, providers will receive the following:

- Written or telephonic notification of the patient's enrollment along with the nurse's contact information.
- Notification when the Blue Cross nurse identifies the patient may be in need of health care services via a care coordination nurse call.
- Access to claims-based Blue Health Records with up to three years of claims history (through iLinkBlue).
- When members self-refer to the program who do not have an established physician relationship, providers receive a patient referral by Blue Cross nurses.

A successful maternity management program is dependent on early identification of patients planning to become pregnant, or who have recently identified they are pregnant. The physician plays a key role in the delivery of the program and this program is intended only to complement the medical care received from providers.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

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This section provides information about our billing and reimbursement guidelines. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.1 GENERAL BILLING

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GENERAL BILLING GUIDELINES

PROCEDURE AND DIAGNOSIS CODES AND GUIDELINES

Blue Cross uses Physicians' Current Procedural Terminology (CPT®), ICD-10-CM and HCPCS codes for processing claims. **Participating providers should follow the coding guidelines published in the current edition of the CPT code book when submitting claims to Blue Cross for processing. Blue Cross follows these coding guidelines unless otherwise identified in our policies.** 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-10-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 12 (four per line) diagnosis codes on the CMS-1500 and up to 26 diagnosis codes on the UB-04 when services for multiple diagnoses are filed on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- HIPAA regulations require valid ICD-10-CM diagnosis codes.

DIAGNOSIS CODE SPECIFICITY

Blue Cross requires diagnosis code specificity when filing claims. It is important to file "ALL" applicable diagnosis codes to the highest degree of specificity. Use the following specificity rules for filing claims:

- Always report the most specific diagnosis codes. Example: Only use 3-digit ICD-10 codes when 4-digit codes are not available and 4-digit codes when 5-digit codes are not available in a particular category. Always report the most specific codes.
- Always include ALL related diagnoses, including chronic conditions you are treating the member for.
- Always include an additional code when required to provide a more complete picture. For example, in etiology/manifestation coding, the underlying condition is coded first followed by the manifestation.
- Medical records must support ALL diagnosis codes on claims.

- Filing claims with NOS (not otherwise specified) and NEC (not elsewhere classified) diagnosis codes is not preferred. Filing claims with NOS and NEC codes delays claim processing and may result in Blue Cross requesting medical records. It may also result in delayed payment and possible payment reductions.
- Reporting a header code on a claim is considered to be an incomplete code and the claim will be returned to the provider as "incomplete."

Example of specific ICD-10 coding:

not billable	M86.44 Chronic osteomyelitis with draining sinus, hand	header
preferred	M86.441 Chronic osteomyelitis with draining sinus, right hand	specified
preferred	M86.442 Chronic osteomyelitis with draining sinus, left hand	specified
not preferred	M86.449 Chronic osteomyelitis with draining sinus, unspecified hand	unspecified

Commercial Risk Adjustment

Blue Cross is using the Commercial Risk Adjustment (CRA) model that the Affordable Care Act (ACA) has adopted to predict health care costs based on enrollees in risk-adjustment-covered plans. The model incorporates organized diagnosis codes also known as HCCs (hierarchical condition categories) that correlate or link to corresponding diagnosis categories. It is critical that Blue Cross receive complete and accurately coded claims to properly indicate our members' health status.

REPORTING NATIONAL DRUG CODE (NDC) ON CLAIMS

We require all clinician administered drugs billed on professional and outpatient hospital claims to be processed through the member's medical benefits, and to include the NDCs for the drugs. Providers are required to report NDCs on claims with any associated HCPCS or CPT codes, including immunizations. (HCPCS codes beginning with the letter "A" are excluded from this requirement.) Failure to report an NDC on these claims will result in automatic rejections.

Providers should use the following billing guidelines to report NDCs on professional and outpatient hospital claims:

- NDC code editing will apply to any clinician administered drug billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician administered drug must be billed on a separate line item.
- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.

- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim.
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format. If the NDC is not submitted in the correct format, the claim will be denied.

Revenue Code 250

For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) that line will not be reimbursed. This only applies to claims where Blue Cross is the primary payor.

For Hardcopy Claims

- On the CMS-1500 claim form, report the NDC in the shaded area of Block 24A. We follow CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.
- On the UB-04 claim form, report the NDC and the quantity in Block 43 (description field). We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.

For Compound Drugs

Compound drugs must be submitted hardcopy. The following information must be included when submitting a compound drug in order for the drug to be priced appropriately:

- NDC number for each drug
- Drug name(s)
- Quantity of each drug
- Total quantity of compound
- Units of measure
- Invoice - see Unlisted Codes section on Page 5.1-7

For Electronic Claims

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBlue Claims (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement.

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity
- Measurement: Select the appropriate measurement from the drop-down menu
  - F2 – International Unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit

REFER MEMBERS TO NETWORK PROVIDERS

As a participating provider in our networks, you agree to assist us in our efforts to keep our members' costs down. One way to do that is to refer our members—your patients—to providers in their network.

This is important because members may pay significant costs when using a non-participating provider. The amounts that some non-participating providers charge for their services are higher than the negotiated allowable charges participating providers have agreed to accept. When seeing a non-participating provider, the member may be responsible for the difference between the allowed amount and the billed charge.

In the interest of affordable, quality care for your patients, it is important that you refer your Blue Cross patients to providers in their network. To confirm if a provider is participating, please consult our online directories.

Note: Providers who repeatedly refer members to non-participating providers could be subject to an overall reimbursement rate reduction by Blue Cross by a certain percentage as determined by Blue Cross in its sole discretion.

INVALID PROCEDURE CODES

Blue Cross may determine that certain CPT\HCPCS codes are not valid for submission to Blue Cross and may choose to require a different code to be billed to represent those services (e.g., 97140 should be used for dry needling instead of 20560 or 20561).

Unless Blue Cross gives specific written billing instructions to use the following codes, they are considered invalid for Blue Cross purposes.

- HCPCS codes when an equivalent or similar CPT code exists describing the same service or procedure (e.g., CPT drug screen codes 80320-80377 should be billed instead of HCPCS codes G0480-G0483)
- Medicaid codes H0001-H2037 and T1000-T9999
- C1000-C9999 for providers other than hospitals

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 Member Contract/Certificate. You should always bill your usual charge to Blue Cross regardless of the allowable charge.

Codes without established fees (e.g., IC or DC) may be reviewed and reimbursed at the plan-determined professional allowance/allowable charge or a standard discount charge as determined by the Plan.

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.

Typically, Blue Cross reviews allowable charges for physician office injectables and administration codes twice a year, and HCPCS level II fees are reviewed annually. Notification of these updates is made through the provider newsletter or through messages on the Provider Payment Register/Remittance Advice.

Please Note: If you move to a new physical location within the state after signing your initial contract with Blue Cross, your allowable charges may be different. Blue Cross will notify you if there is a change once the necessary paperwork has been received and reviewed.

To research your allowable charges, please go to the Payments section of iLinkBlue.

NEW CODES

Blue Cross' policy for new code updates is to review the rationale for the change (e.g., AMA CPT sequencing changes, AMA language revision, new technology, etc.) and the updated Medicare fees for the new code and similar codes in comparison to the provider's current allowable charges for these similar codes to develop a fair payment for the new service.

Additional policy reviews, such as medical policy, multiple procedure reduction determination, code editing, etc. are performed. Any unusual findings/changes are reviewed with management and the medical director for final determination of allowable charges.

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.
- The comparable HCPCS/CPT code.
- 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) billed charges on a single date.

Unlisted Professional Drug Codes

When billing J3490, J3590, J7799 and J7999 as a compound drug and a pain pump refill the reimbursement amount will be the lesser of:

- 90% of average wholesale price (AWP) of the active ingredients plus $200 compounding fee (for supplies), or
- Invoice plus 7%

If the drug is not a compound drug or a pain pump refill the reimbursement amount will be 90% of AWP.

NOT SEPARATELY REIMBURSABLE CODES

Certain codes will deny because the services these represent are included in the reimbursement of other services. Also, Blue Cross does not reimburse separately for codes such as miscellaneous codes, CPT Category II codes and most HCPCS Documentation, Measurement and Demonstration codes. These codes should not be used as a substitute for any services, unless specifically outlined in a Blue Cross billing guideline. These services are not separately reimbursed and are not billable to our members because Blue Cross considers these services to be included in other services billed for that member.

EQUIPMENT, DEVICES AND SUPPLIES

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

MEMBER COST SHARE

Deductibles, coinsurance and copayments are the member's cost share 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 cost share, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the member the excess amount collected within 30 days of notification of the overpayment.

Participating providers have also pledged to assist us in our efforts to keep member costs down. Please be aware that members could pay higher cost shares for certain covered services performed by different types of providers and facilities. The chart below illustrates an example situation of how a member's cost share will increase if they go to an outpatient facility for services that could have been performed at a network physician's office, in-network independent lab or free-standing diagnostic imaging facility:

Example	Network Physician's Office	Network Independent Lab or Free-Standing Diagnostic Facility	Network Outpatient Facility
Charge for the covered service (i.e. low-tech X-rays, machine tests and lab work)	$300	$300	$300
Allowable charge	$200	$200	$200
Blue Cross pays	$75 (allowable charge balance)	$200 (100% Coinsurance)	$160 (80% Coinsurance)
Member pays	$25 (Copayment)	$0 (0% Coinsurance)	$40 (20% Coinsurance)

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.2 ACUPUNCTURE

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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ACUPUNCTURE

Acupuncture is reported based on 15-minute increments of personal (one-on-one) contact with the patient and not based on the duration of acupuncture needle(s) placement. Personal (one-on-one) contact means the acupuncturist is in the room with the patient performing medically necessary components of the service. The time spent in personal (one-on-one) contact must be clearly documented in the medical record.

Only one initial code should be reported per day. Either code 97810 or 97813 should be reported for the initial 15-minute increment. The initial code includes E&M components such as a pre- post-service assessment, treatment discussion, etc.

Only one code should be reported for each 15-minute increment. If no electrical stimulation is used during a 15-minute increment, code 97810 or 97811 should be used. If electrical stimulation of any needle is used during a 15-minute increment, code 97813 or 97814 should be used.

Blue Cross follows the American Medical Association CPT guidelines for billing time-based codes. Time is considered to be face-to-face contact with a patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise. For example, 15 minutes is attained when 8 minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated. If the mid-point of the unit of time is not attained, the code should not be billed.

Supplies (e.g., needles) are included in the service. Supplies should not be billed separately or directly to members.

Electrical stimulation services (97014, 97032 and G0283) should not be reported separately when related to acupuncture services.

The following codes will be allowed for licensed acupuncturists: 97810, 97811, 97813 and 97814.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

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5.3 AFTER HOURS CARE

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AFTER HOURS CARE

After hours physician CPT® codes are reimbursed as follows:

99050 – This code is separately reimbursed when the service provided is outside of the office's regularly scheduled "posted hours" of operation, or days when the office is normally closed (e.g., holidays, Saturday or Sunday) in addition to basic services.

For example, if the office is regularly open Monday through Friday, 8 a.m. to 6 p.m., and the physician is requested to see a patient in the office at 10 p.m. on a Wednesday night, then the physician may report 99050 in addition to the appropriate evaluation and management (E&M) code. The medical record should reflect the medical necessity and services rendered.

- 99050 pays separately when billed with one of the following E&M codes: 99202–99215. 99050 is only reimbursed when submitted with the E&M codes listed.

99051 – This code may be eligible for reimbursement as an add-on code when submitted by a pediatrician, family practice, general practice, internal medicine or rural health provider with the appropriate primary code, and should be used by office-based providers for reporting services that were performed during regularly scheduled evening (after 6 p.m.), weekend or holiday office hours and are adjunct to the basic service performed. This code may be billed for services started any time after the office has been opened for eight consecutive hours.

- 99051 may be eligible for reimbursement as an add-on code when submitted with the appropriate primary basic service code.

After hours services are not separately reimbursable to urgent care centers. Please refer to the Urgent Care Centers section of our provider manual for the billing guidelines and the criteria that define an urgent care center.

The provider's documentation in the medical record should support the need for these services.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

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5.4 AMBULANCE TRANSPORT BENEFIT

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AMBULANCE TRANSPORT BENEFIT

The ambulance transport benefit is a transport by an ambulance. The transport may be covered when the use of any other method of transportation is inadvisable due to the member's condition and the additional requirements discussed below are met.

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 in this manual, ambulance providers should:

- File only the codes listed in their contracts, if applicable. 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.

Report Full Ambulance Miles

The Centers for Medicare & Medicaid Services (CMS) established a new rule in 2011 regarding how to report fractional mileage amounts for ambulance services. Their rule requires ambulance providers and suppliers to bill mileage that is accurate to a tenth of a mile.

At this time, Blue Cross is not able to accommodate this CMS change; therefore, we will not accept mileage billed in increments of less than a full mile. Mileage billed with decimal places will not be recognized for claims processing.

Ambulance Modifiers

Ambulance services must be reported with a combination of two modifiers listed below—the first character representing the origin and the second character representing the destination:

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's office on the way to the hospital (destination code only)

The ambulance provider must retain all appropriate documentation on file for an ambulance transport furnished to a member. This documentation must be presented to Blue Cross upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category and any other criteria necessary for payment. The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the member's health, regardless of whether the other means of transportation is actually available.

Ground Ambulance Transports

A member may be transported on land for a reasonable and medically necessary ground ambulance transport. The following coverage requirements apply to ground transports:

- A Blue Cross member is transported.
- The destination is local.
- The facility is appropriate.
- Due to the member's condition, the use of any other method of transportation is inadvisable.
- The purpose of the transport is to obtain a Blue Cross-covered service or to return from obtaining such service.

Ground ambulance transports include the following:

- Basic Life Support (BLS) – Includes the provision of medically necessary supplies and services and BLS ambulance transportation as defined by the state where you provide the transport. An emergency response is one that, at the time you are called, you respond immediately. A BLS emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.
- Advanced Life Support, Level 1 (ALS1) – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the member's reported condition at the time of dispatch indicates that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the member requires an ALS level of transport. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.

- Advanced Life Support, Level 2 (ALS2) – Includes the provision of medically necessary supplies and services and:

  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)

  - At least one of the following procedures:

    - Manual defibrillation/cardioversion
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line

- Specialty Care Transport (SCT) – Includes the provision of medically necessary supplies and services beyond the scope of an EMT-Paramedic. SCT is the inter-facility transportation of a critically ill or injured member that is necessary because the member's condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).
- Paramedic Intercept (PI) – When an entity that does not provide the ambulance transport provides ALS services. PI may be required when a provider can provide only a BLS level of service and the member requires an ALS level of service (such as electrocardiogram monitoring, chest decompression or intravenous therapy).

Air Ambulance Transports

A member may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport. The following coverage requirements apply to air transports:

- The member's medical condition requires immediate and rapid ambulance transport.
- It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the members' survival or seriously endangers his or her health.
- The point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in remote or sparsely populated areas). POP is the location of the member at the time he or she is placed on board the ambulance. The ZIP code of the POP or the nearest ZIP code to the POP must be reported on the claim.
- The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30-60 minutes).
- The instability of ground transportation.

The medical conditions that may justify air ambulance transport include, but are not limited to, the following (this list is not intended to justify air ambulance transport in all localities):

- Intracranial bleeding that requires neurosurgical intervention;
- Cardiogenic shock;
- Burns that require treatment in a burn center;
- Conditions that require treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Specialized medical services that are generally not available at all facilities include, but are not limited to, the following:

- Burn care
- Cardiac care
- Trauma care
- Critical care

An air ambulance transport to transfer a member from one hospital to another hospital must meet the following requirements:

- A ground ambulance transport endangers the member's health;
- The transferring hospital does not have the needed hospital or skilled nursing care for the member's illness or injury; and
- The second hospital is the nearest appropriate facility.

Include ZIP Codes on Air Ambulance Claims:

Ambulance providers must include the 5-digit ZIP code of the point-of-pick-up. This is required for both emergent and non-emergent air ambulance services. This claims filing requirement also applies for Medicare crossover claims when Medicare's benefits do not cover the claim.

- For claims filed electronically through a clearinghouse, include the pick-up location ZIP code in the 2310E Ambulance Pick-up Location loop of the ASC X12N Health Care Claim (837).
- For hardcopy and iLinkBlue-filed claims, include the pick-up location ZIP code in Block 23 of the CMS-1500 claim form.

Claims that do not include the point-of-pick-up ZIP code on the claim will be denied for insufficient information.

Where to file air ambulance claims:

If the pick-up location ZIP code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana.

If the pick-up location ZIP code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pick-up.

If the pick-up location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the Blue Cross Blue Shield Global Core Program.

Non-transport Ambulance Services

In situations where an ambulance is called to transport a patient and upon arrival the patient is able to be stabilized by the ambulance personnel, eliminating the need for transport, HCPCS code A0998 may be billed.

Participating ambulance providers non-transport pricing rules are as follows:

- When A0998 is billed without transport services, one unit per date of service is allowed.
- When A0998 is billed with other ambulance transport services and mileage, the service is considered bundled as part of the transport being billed and thus not separately reimbursable.

Each ambulance visit should be billed on separate claims. In the event that more than one visit or date of service is billed on the same claim and one visit is a non-transport while another is a transport, the non-transport will be denied. When non-transport occurs on a different date of service than transport, provider should bill on separate claims.

Non-contracted/Non-participating Ambulance Services

Payment will be made directly to the member for non-emergency related services. Please collect **ALL** payments—including any applicable copayment, coinsurance or deductible amount—directly from the member.

Payment will be made directly to the ambulance company for true emergency-related services. Please collect any applicable copayment, coinsurance and/or deductible amounts from the member.

General Transportation Rules and Definitions

A member is transported

When multiple ambulance providers and suppliers respond, payment is made only if you actually transport or treat the member. If you respond to a call for ambulance services and the member declines transportation, but you provided treatment; A0998 is the only billable service. Member benefits will be applied.

The destination is local

As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the member's condition is covered. If two or more facilities meet this requirement and can appropriately treat the member, the full mileage to any of these facilities is covered.

The facility is appropriate

An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the member's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the member's condition.

Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, there must be clear evidence indicating that an ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ambulance transport to a more distant institution include:

- The member's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the member is a patient.
- No beds are available at the nearest institution.
- A ground or air ambulance transport to a more distant hospital solely to avail the member of the services of a specific physician or physician specialist is not covered. If a member is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the member's illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility. The medical documentation must support travel to the more distant facility.

When a ground ambulance transports a member to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is covered only to the extent of the payment that would have been made to bring the service to the member.

A ground ambulance transport from an institution to the member's home is covered when the home is:

- Within the locality of the institution. Locality is the service area surrounding the institution to which individuals normally travel or expected to travel to receive hospital or skilled nursing services; or
- Outside the locality of the institution but in relation to the members home, it is the nearest appropriate facility.

Inpatient transfer temporarily for specialized care while maintaining inpatient status with initial facility

When a member is inpatient requiring medically necessary diagnostic services that are not available at the inpatient facility and requires ground ambulance transport to receive these services, the inpatient hospital lacking the needed services is responsible for the costs of the ambulance services. In this instance, the ambulance provider should not bill Blue Cross separately.

- Example - Patient is inpatient at ABC Hospital and is transported to DEF Hospital for diagnostic services not available at ABC Hospital. The ambulance service is not separately reimbursed.

Non-emergency transport

Blue Cross and HMO Louisiana member benefits may be available for ambulance services for local transportation of members for non-emergency conditions to obtain medically necessary diagnostic or therapeutic outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.), when the member is bed-confined or his/her condition is such that the use of any other method of transportation is contraindicated.

The member must meet all of the following criteria for bed-confinement:

1. unable to get up from bed without assistance; and
2. unable to ambulate; and
3. unable to sit in a chair or wheelchair

Transport by a wheelchair van is not a covered ambulance service.

Ambulance Vehicles

Ground and air ambulance vehicles must comply with state and/or local laws governing the licensing and certification of emergency medical transportation vehicles and must be designed and equipped to respond to medical emergencies. At a minimum, ambulance vehicles must be equipped with the following:

- Stretcher
- Linens
- Emergency medical supplies
- Oxygen equipment
- Other lifesaving emergency medical equipment and reusable devices (such as inflatable leg and arm splints, backboards and neckboards).
- Emergency warning lights, sirens and telecommunications equipment as required by state or local laws.
- A two-way voice radio or wireless telephone. In nonemergency situations, ambulance vehicles must be capable of transporting members with acute medical conditions.

Ambulance personnel

A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with state and/or local laws as an EMT-Basic and is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with state and/or local laws as an EMT-Intermediate or an EMT-Paramedic.

Statement about ambulance vehicles and personnel

To indicate that you meet the above requirements, include the following information about your ambulance vehicles and personnel in a statement you provide with your credentialing application:

- The first aid, safety and other patient care items with which the vehicles are equipped;
- The extent of first-aid training acquired by the personnel assigned to the vehicles;
- An agreement to notify Blue Cross of any change in operation that could affect the coverage of ambulance transports; and
- Documentary evidence (such as a letter or copy of a license, permit or certificate issued by state and/or local authorities) indicating that the vehicles are equipped as required.

HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue, Signature Blue, Bridge Blue and OGB's Magnolia Local Requirements

Emergency services (air or ground) - Prior authorization is not required but the provider is advised to submit the trip notes with the claim. Claims are reviewed for medical necessity.

Non-emergency services (air) - An authorization must be obtained prior to services being rendered. No payment will be made for non-emergency air services rendered without prior authorization and services are not billed to the member. If a member contacts you to request non-emergency air services, you must obtain an authorization from HMO Louisiana prior to rendering services.

Non-emergency services (ground) - An authorization is not required for non-emergency ground services. Please note our criteria for approval of non-emergency ambulance transport described below. If the non-emergency transport criteria listed below is not met, an authorization is recommended to determine medical necessity for the services prior to being provided. Failure to obtain an authorization of non-emergency ambulance services will result in our review for medical necessity prior to any payment determination.

Non-Emergency Transport (ground) - Member benefits may be available for ambulance services for local transportation of members for non-emergency conditions to obtain medically necessary diagnostic or therapeutic outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.) when the member is bed-confined and:

1. Unable to get up from bed without assistance; and
2. Unable to ambulate; and
3. Unable to sit in a chair or wheelchair

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.5 ANESTHESIA

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

ANESTHESIA

Definitions

- Anesthesia - the introduction of a substance into the body by external or internal means that causes loss of sensation (feeling) with or without loss of consciousness.
- Anesthesiologist - a physician (M.D. or D.O.) who specializes in anesthesiology.
- Certified Registered Nurse Anesthetist (CRNA) - a registered nurse who is licensed by the state in which the nurse practices. The CRNA must be certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists or the CRNA must have graduated within the past 24 months from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia educational programs and be awaiting initial certification.
- Concurrent Medically Directed Anesthesia Procedures - concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap one another. The physician can medically direct two, three or four concurrent procedures involving qualified CRNAs.
- Medical Direction - occurs when an anesthesiologist is involved in two, three or four concurrent anesthesia procedures or a single anesthesia procedure with a qualified CRNA.
- Medical Supervision - occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures.

Personally Performed Anesthesia

We will determine the applicable allowable charge, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time (unless otherwise stated) if:

- The physician personally performed the entire anesthesia service alone;
- The physician is continuously involved in a single case involving a student nurse anesthetist; or,
- The physician and the CRNA are involved in one anesthesia case and the services of each are found to be medically necessary upon appeal. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers through our appeal process. The physician reports Modifier AA and the CRNA reports Modifier QZ for a non-medically directed case.

Medical Direction

We will determine payment for the physician's medical direction service on the basis of 60% of the allowable charge for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified CRNAs in two, three or four concurrent cases and the physician performs the following activities that must be documented in the anesthesia record:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;

- Personally participates only in the most demanding procedures in the anesthesia plan, when clinically appropriate;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available in the operating room and/or recovery areas for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

If the physician is involved with a single case with a CRNA, we will pay the physician service and the CRNA service in accordance with the medical direction payment policy outlined in these guidelines.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate that the services were furnished by physicians and identify the physician(s) who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic—rather than continuous—monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and would not be considered medical direction.

Filing Claims

Anesthesia services by anesthesiologists or CRNAs must be filed using the appropriate anesthesia CPT code (beginning with the zero). One of the modifiers listed in this section must be submitted with each anesthesia service billed. Failure to submit one of the modifiers will result in a returned or rejected claim.

The allowable charge for medically necessary anesthesia services will be determined based on the applicable anesthesia conversion factor and the modifier submitted on the claim. The applicable anesthesia modifier will determine what percentage of the anesthesia conversion factor is to be applied to each claim, without regard to the order in which claims are received for both anesthesiologists and CRNAs.

If there are groups from which an anesthesiologist and a CRNA are working together on a case, we will continue to allow a single claim record to contain multiple line items for anesthesia services. We will also accept individual claims for each portion of the anesthesia service performed if more than one provider was involved in the anesthesia case. Each line item must indicate which provider performed the service by identifying the corresponding provider's NPI on the CMS-1500 claim form in Block 24J (or the equivalent field on electronic claims).

To ensure proper reimbursement when billing for anesthesia services, anesthesiologists and CRNAs must include:

1. Number of minutes of administration
2. CPT anesthesia (00100-01999) codes with one of the required modifiers listed in this section
3. American Society of Anesthesiologists (ASA) modifier code(s) for physical status and CPT codes appropriate for qualifying circumstances (see further in this section for details), if appropriate
4. Proper identification by including any performing provider(s) NPI on the claim form

Required Modifiers - Anesthesiologist (M.D. or D.O.)

Modifier	Modifier Description	Reimbursement
AA	Anesthesia services personally performed by an anesthesiologist.	100% of allowable charge
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures or is performing other services while directing the concurrent procedures.	3 base units with no additional units allowed for physical status modifiers, qualifying circumstances, or time
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified CRNAs.	60% of allowable charge
QY	Medical direction of one CRNA by an anesthesiologist.	60% of allowable charge

Required Modifiers - CRNA

Modifier	Modifier Description	Reimbursement
QX	Billed by CRNA when providing the anesthesia service while being medically directed by an anesthesiologist.	40% of allowable charge
QZ	Billed by CRNA when providing anesthesia services without medical direction by an anesthesiologist.	100% of allowable charge

Listing of Acceptable and Non-acceptable Modifiers for Subsequent Claims

Refer to this list when including the following modifiers, either on the same claim but on different service line(s) (in a group billing situation), or on a separate claim from a different provider.

First Claim Received for Payment Consideration	Acceptable Modifiers for Subsequent Claims	Non-acceptable Modifiers for Subsequent Claims
Performing provider No. 1 bills one of these modifiers.	Performing provider No. 2 bills one of these modifiers on a separate claim or separate service line item on the same claim.	No additional claim will be paid with these modifiers.
AA		AA, AD, QK, QX, QY, QZ
QZ		AA, AD, QK, QX, QY, QZ
AD	QX	AA, AD, QK, QY, QZ
QK	QX	AA, AD, QK, QY, QZ
QY	QX	AA, AD, QK, QY, QZ
QX	AD, QK, QY	AA, QX, QZ

Please Note: Our claims processing system edits all anesthesia claims for the appropriate use of modifiers. Should we receive a subsequent claim with inconsistent modifiers when comparing to the initial claim received, the subsequent claim will be denied. For example, if an initial claim is filed with Modifier AA indicating the service was personally performed by a physician, and a subsequent claim is received with Modifier QX indicating that a CRNA was involved in the anesthesia service, the initial claim would be the only claim expected; therefore, the CRNA claim would be denied or returned due to the inconsistent modifier. Further, if the anesthesia record reflects that more than one anesthesia provider was involved in the case, the provider who received the returned or denied claim should appeal the denial. When filing the appeal, the anesthesia record must be included as supporting documentation to justify a different reimbursement. If a decision is made to overturn the appeal in this scenario, a recoupment would be requested on the claim allowed at 100% in order to apply the appropriate payment split to both providers involved in performing the anesthesia service.

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. The base units value should never be entered in the "units" field on the claim form.

Anesthesia Time and Calculation of Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. We consider anesthesia time to begin 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 or CRNA is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision.

Anesthesia time must be reported in minutes. Failure to include anesthesia time may result in the claim being either returned or denied. 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 (exception is CPT 01967, which is based on a 60-minute unit). Time units will be rounded to two decimal places (exception is CPT 01967, which is rounded to four decimal places).

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.

Please Note: We do not recognize time units for CPT 01996 (see Pain Management section on the next page). The physician who medically directs the CRNA would ordinarily report the same time as the CRNA reports for the CRNA service.

Blue Cross/HMO Louisiana time calculation examples:

- Code 00790 for 50 minutes = 3.33 time units
- Code 01967 for 311 minutes = 5.1833 time units

Qualifying Factors

Physical Status

If physical status modifiers are applicable, the modifier should be indicated on the CMS-1500 claim form (Block 24D or the equivalent field on electronic claims) by the letter P followed by a single digit from one to six. Additional units may be allowed when the claim indicates any of the following:

Physical Status Modifier	Description	Units
P1	A normal patient.	0 units
P2	A patient with mild systemic disease.	0 units
P3	A patient with severe systemic disease.	1 unit
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 without the operation.	3 units
P6	A declared brain dead patient whose organs are being removed for donor purposes.	0 units

Qualifying Circumstances

When any of the CPT codes defined in this section are provided in addition to anesthesia procedures, the allowable charge 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.

- Qualifying circumstances are those factors that significantly affect 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. Each qualifying circumstance is listed here: 99100, 99116, 99135, 99140.
- 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 may be allowed. Any other charges should be combined with the total charge without an additional allowable charge. 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 allowable charge and medical necessity.
- Arterial line (36620 or 36625)
- Central venous line (36555, 36556, 36568, 36569, 36580 or 36584)
- Swan Ganz line (93503)

Obstetrical Anesthesia/Epidural

Obstetrical anesthesia/epidural procedures are reimbursed as indicated below. An additional allowable charge for emergency conditions may apply to reimbursement for epidural anesthesia (please refer to the Qualifying Circumstances section).

Code	Units
01961	7 base units plus time units based on standard 15-minute time calculation
01967	7 units plus time units based on 60-minute time calculation
01968	3 units (no additional time allowed)

Please 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.

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.

Outpatient Pain Management

1. 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.
2. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral is considered a surgical procedure for benefit purposes. Surgical procedures (including nerve

blocks) should be billed as "1" unit per CPT guidelines. The Base Units value should not be entered in the "units" field on your claim. The injection must be performed by an M.D. or D.O. 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.

Post-operative Pain Management

1. **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 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 three 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.

2. **IV PCA**: Provider should bill CPT 99231* for the IV PCA daily management. The allowable charge is the basis for reimbursement. The set-up charge is included in the E&M allowance of the daily management and should not be billed separately. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 99231 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

**Evaluation and Management Code 99231 is the recommended coding by the ASA and is the industry standard for this service. All components must be medically necessary and documented in the anesthesia record in order to bill this code.*

3. **Pump Setup:** The pump setup is included in the allowable charge for the daily management fee for both IV PCAs (CPT 99231) and Epidural PCAs (CPT 01996), and should not be billed separately.

4. **Nerve Block Injections**: Nerve blocks performed for postoperative pain management, provided that they are not the mode of anesthesia and are distinct procedures, are eligible for reimbursement when identified by the Modifier 59 as a distinct procedure. These services should not be included as additional anesthesia time. Reimbursement is made only for services provided by a physician/CRNA when performed outside of the intraoperative area. Postoperative pain management will be appropriate for most major intrathoracic, intra-abdominal, vascular and orthopedic procedures. The intent of the procedure should be documented as to why post-operative pain relief is not achievable through the use of alternative measures and be procedure specific as would be supported by acceptable peer-reviewed literature and guidelines. The documentation must support the medical necessity of the nerve block service performed by the anesthesiologist instead of the service being performed by the surgeon.

Nerve block services will be considered for reimbursement only when there is written documentation that the surgeon has requested such a service. Surgical procedures (including nerve blocks) should be billed as "1" unit per CPT guidelines. The base units value should not be entered in the "units" field on your claim. The surgeon should manage post-operative pain except under unique circumstances. Operative notes, anesthesia procedure notes, anesthesia record and pre/post-operative orders should be available when requested to support claim review.

Clinical editing is applicable to all anesthesia services.

Claims Example

A Blue Cross 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 should include the appropriate information explained above. The claim for covered services is processed as follows to determine the allowable charge:

M.D. Personally Performed or Non Medically Directed CRNA	M.D. Medically Directing 2-4 Concurrent Procedures	Medically Directed CRNA Claim
(Base Units + Time Units + Physical Status Modifier Units) x Unit Value = Allowable Charge	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 60% = Allowable Charge for each case being medically directed	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 40% = Allowable Charge for each case being medically directed
CPT 00790 AA (or QZ) Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Allowable Charge $413.20	**CPT 00790 QK (or QY)** Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Subtotal $413.20 x Medically Directed 60% Allowable Charge $247.92	**CPT 00790 QX** Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Subtotal $413.20 x Medically Directed 60% Allowable Charge $247.92

*For illustration purposes only.

The Base Units value should never be included in the "units" field of your claim.

CPT 99100 (payment is based on the allowable charge) – The totals noted in each of these examples do not include the payment for the qualifying circumstance CPT 99100 that was applicable in the example. Additional reimbursement for CPT 99100 will be based on the provider's allowable charge.

If any modifiers were applicable for physical status, those units would be added to the above calculations as noted in the formulas. The allowable charges represent the total amount collectable from Blue Cross and the member (if deductible, copayment and/or coinsurance apply). The difference between the provider's charge and the allowable charge is not collectable from the member.

Documentation Requirements

All billing should be supported by the anesthesia record. Records are required with claims submissions in the following cases:

- Submission of any miscellaneous procedure codes, for example, CPT 01999. Because the code does not provide sufficient information, the record is necessary to identify the actual procedure performed.
- Anesthesia administered for dental procedures. Because dental coverage guidelines may be limited, the anesthesia record will help us to make coverage determination on each case.
- If two different anesthesia services are billed on the same claim with the same performing provider identifier (NPI), the anesthesia record is needed to document that two different operative sessions occurred on the same day.
- If a procedure is billed that is not site-specific, we may request the anesthesia record to determine the site to ensure coverage should be allowed.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.6 AUTISM

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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AUTISM

Maximum Benefit Limitations

Some Blue Cross policies do not cover Autism and some cover with different maximum benefit limitations. Prior to rendering services, always verify members' benefits through iLinkBlue to determine applicable benefits and any maximum benefit limitations.

Authorization

Authorization is required for Applied Behavioral Analysis services, because the diagnosis and treatment of autism is considered a medical benefit.

Filing Claims

- **For Blue Cross Members**: Blue Cross claims related to the diagnosis and treatment of autism are filed directly to Blue Cross for processing.
- **For HMO Louisiana Members**: HMO Louisiana group policies cover the diagnosis and treatment of autism as a medical benefit. Claims related to the diagnosis and treatment of autism should be submitted directly to Blue Cross for processing. Blue Cross will apply medically necessary claims toward the member's autism maximum benefit limitations, as applicable.

For claims filed with a secondary diagnosis of autism, Blue Cross will still apply benefits based on the primary diagnosis listed on the claim.

Autism Services

We cover the diagnosis and treatment of autism on most policies.* Authorizations are required for ABA services–all reviews and authorizations related to the diagnosis and treatment of autism are handled by Lucet.

Providers must submit an initial assessment request and treatment request form on the Lucet WebPass platform.

**Autism benefits do not apply for some individual policies and may vary for self-funded groups and BlueCard® members. Always verify members' benefits to determine applicable benefits and any maximum benefit limitations, through iLinkBlue.*

Reminder: Providers can electronically submit authorization requests for behavioral health services through iLinkBlue. Click on the "Authorizations" menu option, then choose "Behavioral Health Authorizations" to access the Lucet WebPass Portal.

www.bcbsla.com/ilinkblue

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.7 BEHAVIORAL HEALTH

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BEHAVIORAL HEALTH

Our members must access network behavioral health providers based on the provider network associated with their member benefit plan for in-network benefits. Behavioral Health claims are processed directly by Blue Cross.

Blue Cross has partnered with Lucet to manage the authorization, case and disease management processes for behavioral health services.

Refer to the chart below for the appropriate provider network for each of our member benefit plans.

Benefit Plan Type	Network	Authorizations
PPO	Preferred Care PPO network of professional and facility providers	Lucet
HMO (HMO-HMO & HMO-POS)	HMO Louisiana network of professional and facility providers	
Blue Connect	Blue Connect network of professional and facility providers	
BlueHPN	Blue High Performance Network$_{SM}$ (BlueHPN$_{SM}$) of professional and facility providers	
Community Blue	Community Blue network for professional and facility providers	
Precision Blue	Precision Blue network for professional and facility providers	
Signature Blue	Signature Blue network for professional and facility providers	
Federal Employee Program (FEP)	Preferred Care PPO network of professional and facility providers	
OchPlus	OchPlus network of professional and facility providers	

Our members receive a higher level of benefits when they use providers in their network. Benefits are reduced when services are rendered outside of the network meaning the member is subject to higher cost shares. Always verify a member's benefits prior to rendering services. Patient eligibility, claim status, allowable charges, payment information and medical policies are available online through iLinkBlue.

Services provided by behavioral health facilities are paid on a per diem basis. The per diem payment includes all professional and facility services provided to the member when they are enrolled in an outpatient or inpatient program (intensive outpatient program or partial hospital program) for the entire duration. The covered services paid as part of the per diem include, but are not limited to, psychiatric treatment, group or individual therapy, lab testing (professional and technical), medication management and any other ancillary services provided on the same date of service or relative to their participation in the inpatient or outpatient program.

Authorizations

Authorizations are required for all inpatient behavioral health services. Authorizations may be required for some outpatient behavioral health services. Blue Cross has partnered with Lucet to manage the authorization process for behavioral health services requiring an authorization.

Behavioral health services that require an authorization:

- Applied Behavior Analysis (ABA)
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)

For FEP Members at RTCs:

- Facility must be licensed and accredited.
- Member must be enrolled in Care Management.
- Pre-service approval must be obtained prior to admission. FEP does not allow review for medical necessity if the member is admitted to the RTC prior to requesting authorization.

Authorization requests may be completed on iLinkBlue. Click on the "Authorizations" menu option, then choose "Behavioral Health Authorizations" to access the Lucet WebPass Portal. Facilities should use this tool to request authorizations for behavioral health services, eliminating telephone time in requesting authorizations.

Access to the behavioral health authorizations portal (WebPass) must be granted by your organization's administrative representative. Additionally, without access to iLinkBlue, you cannot access WebPass.

The Lucet medical necessity criteria for behavioral health services can be found on the Lucet website at www.lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana under "Policies & Manuals."

Behavioral Health Medical Necessity Appeals

First-level appeals on behavioral health services denied for medical necessity should be sent directly to Lucet at the address found on our Quick Reference Guide. If the decision is made to overturn denial, a letter is sent to member and provider letting them know the denial was overturned and processing instructions are communicated to Blue Cross to pay claim. If the decision is made to uphold the denial, a letter is sent to member and provider directing them how and where to file a second-level appeal request.

Upon receipt of the second-level appeal, Blue Cross or the member's group (applies for some self-funded groups) will have an Independent Review Organization (IRO) review the case. This is a specialty-matched review. If the IRO upholds the denial, a letter is sent to provider and member and appeals are exhausted. If the IRO overturns the denial, claims are paid.

Post-discharge Standards

Discharge planning should include the utilization review staff, discharge planner, the member's family, significant others, guardian or others as desired by the member.

Admitting facilities should ensure that patients are provided follow-up appointments within seven days of discharge from an acute inpatient setting with a behavioral health provider.

The seven-day appointment does not need to be with a psychiatrist; instead can be scheduled with a therapist or other behavioral health provider.

Lucet now offers post-discharge scheduling, on our behalf, to ensure our members schedule outpatient appointments. Their case managers and care transitions staff are now calling providers to schedule post-discharge appointments within seven days. To take advantage of this service, contact the Lucet After-care Follow-up Assistance Line at 1-877-300-5909.

Applied Behavior Analysis (ABA)

Effective for claims authorizations for dates of service on or after January 1, 2019, our methodology for the billing of applied behavioral analyst (ABA) services, was updated to incorporate the Category I CPT® codes put in place to address ABA.

ABA Modifier Billing Guidelines

Provider Type	Billing Guidelines	Modifier
Licensed Behavior Analyst (LBA)	• Can bill directly • Services must be billed with modifier	TG
State-certified Assistant Behavioral Analysts (SCABA)	• Cannot bill directly • Services must be billed through the supervising LBA with the appropriate codes and modifier	TF
Registered Line Technician (RLT) with a Bachelor's degree	• Cannot bill directly • Services must be billed through the supervising LBA	HN
RLT without a Bachelor's degree	• Cannot bill directly • Services must be billed through the supervising LBA	No modifier

Use one of the following CPT codes with appropriate, required modifiers for ABA services:

Code	Units	Clinician Type	Modifier
97151	15 min	SCABA	TF
		LBA	TG
97152	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97153	15 min	RLT with Bachelor's	HN
		SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97154	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97155	15 min	SCABA	TF
		LBA	TG
97156	15 min	SCABA	TF
		LBA	TG
97157	15 min	SCABA	TF
		LBA	TG
97158	15 min	SCABA	TF
		LBA	TG
0362T	15 min	SCABA	TF
		LBA	TG
0373T	15 min	SCABA	TF
		LBA	TG

Full descriptions for these codes and CPT time-rules are available from the American Medical Association.

Please Note: Failure to include a modifier may result in your claim being returned or denied.

Claims filed with a primary diagnosis of autism will be subject to the patient's autism maximum and limitations. Claims filed with a secondary diagnosis of autism will be processed according to the primary diagnosis code listed on the claim.

Concurrent billing will be allowed as follows when both services are administered simultaneously. Medical record documentation should clearly indicate that both services were administered simultaneously:

- For adaptive behavior treatment with protocol modification (97155) and adaptive behavior treatment by protocol, administered by technician (97153). The 97153 service must be face-to-face with the member and the 97155 service must be direction of the technician for protocol modification.
- For treatment with protocol modification (97155) and group adaptive treatment (97154).

Billing for the Administration of Spravato

HCPCS codes G2082 and G2083 should be used to bill Blue Cross for the administration and post-administration observation of Spravato. Code G2082 should be used for esketamine ≤56mg; and G2083 should be used for esketamine >56mg. If the drug is not supplied by the provider, then code G2082 or G2083 should be billed with Modifier CG to indicate that only the post-administration observation was performed.

Psychotherapy E&M Codes

We allow payment for E&M codes according to the following payment policies:

- Psychiatrists and psychologists may bill E&M codes, if appropriate for the service provided and licensed to do so.
- Pharmacologic management CPT code 90863 will bundle as incidental to psychotherapy codes.

Provider Responsibility Regarding 42 CFR part 2 Federal Regulations

Providers and facilities are responsible for making sure they are in compliance with 42 Code of Federal Regulations (CFR) part 2 regulations regarding the *Confidentiality of Substance Use Disorder Patient Records*.

Abiding by the part 2 regulations includes the responsibility of obtaining appropriate consent from patients prior to submitting substance use disorder claims or providing substance use disorder information to Blue Cross. Blue Cross requires that patient consent obtained by the provider include consent to disclose information to Blue Cross for claims payment purposes, treatment, and for health care operations activities, as provided for in 42 U.S.C. § 290dd-2, and as permitted by the HIPAA regulations. 42 CFR part 2, section 2.31(a) (1-9) stipulates the content that must be included in a patient consent form. **By disclosing substance use disorder information to Blue Cross, the provider affirms that patient consent has been obtained and is maintained by the provider in accordance with Part 2 regulations. In addition, the provider is responsible for the maintenance of patient consent records.**

Providers should consult legal counsel if they have any questions as to whether or not 42 CFR part 2 regulations are applicable.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.8 CHIROPRACTIC AND PHYSICAL MEDICINE SERVICES

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CHIROPRACTIC AND PHYSICAL MEDICINE SERVICES

Providers should adhere to the billing guidelines below for chiropractic and therapy services.

Date of Service

Services for a given date of service should be billed on **one claim form with each code listed one time per date of service** with the appropriate number of units. Date ranges or span dates should not be used on individual claim lines and could result in inaccurate payments.

Skilled, Reasonable and Necessary Care

Services should only be billed if they require direct or overall supervision of a therapist or provider licensed to perform skilled therapy services. Therapy services which require direct (one-on-one) patient contact (97032-97039, 97110-97150 and 97530-97546) may only be billed if provided by a physical or occupational therapist, a physical or occupational therapy assistant, or a provider licensed to perform skilled therapy services and operating within the scope of their license. For example, technicians, exercise physiologists, aides, chiropractic assistants, RNs, LPNs, etc. may assist but are not licensed to provide therapy services and therefore should not bill for those service which require direct (one-on-one) patient contact. Supervised modalities (97010-97028) do not require direct (one-on-one) patient contact and may be performed by unlicensed staff (i.e., technicians, CAs, LPNs, etc.) under the supervision of a provider licensed to perform the service.

If the service can be performed by the patient or an unskilled person without the supervision of a therapist or licensed provider, then it is not a skilled therapy service, and the service should not be billed. For example, after an exercise has been successfully taught to the patient, repeating the exercise and oversight of the completion of the exercise is not billable unless additional skilled care is provided.

Services should only be billed if they are reasonable and medically necessary. Any services rendered should be clinically appropriate for the patient's condition in regards to the type, frequency and duration of treatment. These services should fall within the generally accepted standards of care.

"Incident To" Billing of Therapy Services

Blue Cross does not follow CMS "incident-to" reimbursement rules for any provider who is eligible to contract with BCBSLA. Therefore:

- If the provider is eligible to contract with BCBSLA, then the provider is required to file claims under his/her own provider number for services rendered. This rule applies even while the provider is in the process of applying for his/her own provider number.
- "Incident-to" services are only eligible to be reimbursed under the supervising provider's number if the rendering provider is ineligible to contract with BCBSLA.

Services furnished by a physical therapist (PT) or physical therapy assistant (PTA) under the supervision of a PT, which were previously billed under the physician's or chiropractor's provider number, must be billed under the PT's provider number.

A PTA must practice under the direction and supervision of a licensed PT and not a physician or a chiropractor. Services performed by the PTA must be billed under the supervising PT's provider number.

Direct Patient Contact Required

CPT codes 97032-97039, 97110-97150 and 97530-97546 require direct patient contact. Time billed should be based on direct one-on-one constant contact by the provider with the patient. Only the actual time spent with the patient performing the service should be billed, and any time billed should be based on a clinical need for direct patient contact. Time that the patient spends resting or waiting for a piece of equipment should not be considered part of the treatment time. Supervising patients who are exercising independently is not a skilled service and is not billable.

Time Based Services

Blue Cross and Blue Shield of Louisiana follows the American Medical Association CPT guidelines for billing time-based codes. **Time is considered to be face-to-face contact with a patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise.** For example, 15 minutes is attained when eight minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated. If the mid-point of the unit of time is not attained, the code should not be billed. It is not appropriate to bill these services with the reduced services Modifier 52.

Modalities

Supervised modalities (97010-97028) should only be billed once per day regardless of the number of areas treated. Since supervised modalities do not require direct (one-on-one) patient contact, it would be acceptable for unlicensed staff (i.e., technicians, CAs, LPNs, etc.) to perform those services under the supervision of a provider licensed to perform the service.

Constant attendance modalities (97032-97036) are only reimbursable once per day. Since constant attendance modalities require direct (one-on-one) patient contact, there must be a clinical need to remain with the patient to deliver the service in order to bill these codes.

Multiple heating modalities should not be billed for the same area on the same day.

No Duplication of Treatment

If patients receive physical and occupational therapy, they must have separate goal and treatment plans. There should be no duplication of treatment.

Physical & Occupational Therapy Reevaluation

Reevaluation codes will bundle to therapy services, however, a reevaluation may be allowed upon appeal for certain circumstances. Once an initial therapy evaluation is completed, the patient is not eligible for a reevaluation until three months after the initial evaluation. If there is a significant change to the patient's diagnosis or a surgical procedure is performed, then a reevaluation is allowed sooner than the three-month waiting period. Providers should appeal with medical records for these situations.

Treatment Sessions and Documentation

Typical physical or occupational therapy treatment times per session are usually 45 to 60 minutes. Audits will be performed periodically to ensure claims are submitted appropriately. Proper coding and documentation will avoid inappropriate payments that may result in recoupment.

Documentation Elements

1. Initial Evaluation
   - Medical diagnosis
   - History
   - Exam
   - Assessment
   - Plan
2. Plan of Care
   - Medical diagnosis
   - Treatment details
   - Long-term functional goals
   - Type of services
   - Frequency of treatment
   - Duration of treatment
3. Flow sheets
   - Must be legible
   - Patient's name
   - Name of licensed performing provider rendering each service (i.e., if a PTA renders therapeutic exercise and the PT renders manual therapy on a patient, each provider should be documented in regards to the specific service they rendered)
   - Dates of service
   - CPT code and the activity performed
   - Start time and total time that supports the service rendered and clearly differentiates each service
   - Modalities to include specific locations treated

4. Daily Notes
    - Documentation in addition to and in support of the flow sheet is required for every treatment session
    - Patient feedback
    - Concrete measurements
    - Treatments performed, frequency, duration and equipment used
    - Assessment of patient's progression
    - Continued plan or discharge note
    - Licensed performing provider's signature

Multiple Procedure Reduction

Blue Cross and Blue Shield of Louisiana will apply multiple procedure reductions to codes 95851-95852, 97010-97150, 97169-97596, 97611-97799, 98940-98943 and G0283 when billed on the same day. If services are provided on the same day by providers in different specialties (i.e., physical therapy and occupational therapy), the multiple procedure reduction applies separately for each provider specialty. Multiple units will rank based on the highest per unit allowable charge across all codes eligible for a reduction.

Multiple units will be reimbursed based on the allowable charge at:

- 100% for the first unit
- 90% for the second, third and fourth unit
- 50% for the fifth unit
- 25% for the sixth unit
- 5% for seven or more units

Examples

Per Unit Allowable Charge*

97110 = $11
97140 = $10
97014 = $9
97012 = $7

**Not actual allowable charges. For illustration only.*

Code	Units	Fee
97110	2	$20.90
97140	1	$9.00
97014	1	$8.10

Code	Units	Fee
97140	2	$18.00
97110	2	$20.90

Code	Units	Fee
97140	1	$9.00
97014	1	$8.10
97012	1	$3.50
97110	2	$20.90

Please Note: Multiple procedure reductions may apply differently on coordination of benefits (COB).

Supplies are Not Billed Separately

Supplies (e.g., tape, gloves, electrical stimulation pads, hot and cold packs, needles, etc.) are included in the service. Supplies should not be billed separately or directly to members.

Hot and Cold Packs

Hot and cold packs will not be reimbursed separately. They are included in the therapy service.

Elastic Therapeutic Taping

Elastic therapeutic taping is not a separately billable. Elastic therapeutic tape is a supply, so its use is included in the reimbursement for the therapeutic procedure. Strapping codes (29000-29799) should not be used to bill for elastic therapeutic taping. Since strapping is intended to provide immobilization or restricted movement for acute injury treatment, it is not appropriate to bill elastic therapeutic taping with strapping codes.

Group Therapy

Group therapy code 97150 is not a time-based code so it is only billable once per session. Groups should contain no more than four individuals. Supervising patients who are exercising independently is not a skilled service and is not billable.

Therapeutic Activities and Neuromuscular Re-education

Codes 97530 (therapeutic activities) and 97112 (neuromuscular re-education) should not be used to describe massage therapy.

CPT code 97112 (neuromuscular reeducation) may be billed for impairments affecting the body's neuromuscular system that may result from disease or injury such as a stroke (CVA), severe trauma to the nervous system, and systemic neurological disease. Documentation for neuromuscular reeducation must show impairments which affect the neuromuscular system as described above.

Dry Needling (Intramuscular Manual Therapy)

Dry needling refers to a procedure whereby a fine needle is inserted through the skin and into a trigger point to induce a twitch response in order to relieve pain and increase range of motion. During dry needling, the needle can go deep inside muscle tissue that a provider is not able to directly manipulate. Dry needling is not acupuncture. For acupuncture billing guidelines, see subsection 5.2 of this manual.

Blue Cross does not recognize codes 20560 and 20561 for billing dry needling. CPT codes 20560 and 20561 are considered invalid for submission to Blue Cross and claims submitted with these codes will be denied. Blue Cross requires dry needling to be billed under manual therapy code 97140. In order to identify that dry needling was performed as part of manual therapy, Modifier CG should be appended to the manual therapy code.

If dry needling is performed on the same day as chiropractic manipulative treatment (CMT), Modifier 59 should be appended to 97140 so that it may be allowed for separate payment. Modifier 59 should only be appended if the midpoint of the unit of time billed for dry needling is reached. To clarify the billing of these services please review the examples in Manual and Massage Therapy Performed as Part of Chiropractic Care in this manual section.

Chiropractic Manipulative Treatment (CMT) and E&M Services

Any CMT service should be billed with the CPT code that best describes the services rendered. The codes that best describe CMT services are 98940-98943. Manual therapy (CPT 97140) and E&M codes should not be used to bill for CMT services.

Since CMT codes (98940-98943) include a pre-manipulation assessment, a separate E&M code should not be reported with a CMT service unless a significant, separately identifiable E&M service was performed. It may be appropriate to separately report an E&M service for the following situations if additional work is done above and beyond what is included in the CMT service:

- Initial evaluation of a new condition or injury.
- Significant change in the patient's condition (i.e., acute exacerbation of symptoms).

E&M codes may bundle to chiropractic or physical medicine services if they are considered an integral part of the primary procedure. Providers should appeal with medical records if there was a significant change to the patient's condition.

When billing E&M codes (i.e., 99202-99215), medical necessity of a service must be proven in addition to the required components of the code. It is not appropriate to bill a higher level E&M service when a lower level is warranted.

The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the complexity of medical decision making as documented in the record or the total time dedicated to the patient on the given date of service. The amount of documentation should not be the primary factor for what level of service is billed.

Either medical decision making or total time can be used to determine the correct code, but these two elements cannot be combined. Medical records may be required for reimbursement consideration for repeat E&M code submissions or for level 4 or 5 E&M codes.

For more information on E&M billing guidelines, refer to the Evaluation and Management Services section of this manual.

Manual and Massage Therapy Performed as Part of Chiropractic Care

Therapeutic procedures (i.e., 97124 and 97140) used to relax or prepare the patient for manipulation are considered fundamental to the manipulation and are included in the manipulation reimbursement when they are performed in the same area on the same day. Dry needling may be reimbursed separately even if performed in the same area on the same day and should be billed as code 97140 with Modifier 59 and Modifier CG.

When manual therapy (97140) or massage therapy (97124) is performed on an area of the body that is unrelated to the manipulation, services may be eligible for separate reimbursement. In order for separate reimbursement to be considered, the code must be filed with Modifier 59 and the following conditions must be met:

- Treatment must be skilled in nature and part of a specific, diagnosis-related goal. Devices such as hand-held vibrators are not considered skilled services and are not billable services.
- Manipulation should not have been performed on the same area of the body on the same day.
- The following must be documented:
    1. Specific description of the area treated and the utilized technique for treatment (i.e., manual traction, myofascial release, etc.).
    2. Time treatment began and ended along with the total number of minutes of treatment.
    3. Clinical rationale for the separate service. (i.e., contraindication to CMT).

Audits will be conducted on a periodic basis to ensure claims are submitted appropriately. Proper coding prevents inappropriate payments that eventually result in recoupment.

If a licensed massage therapist performs massage therapy incident to another provider, the service should be billed with Modifier HT.

Example 1:
Ten minutes of manual therapy (dry needling) and 10 minutes of manual therapy (not dry needling).

In this example with a total of 20 minutes of manual therapy, only one unit of manual therapy is billable. Since dry needling was performed for at least eight minutes, the midpoint of the 15 minute unit of time was reached and 97140 may be billed with Modifier 59.

Code	Modifier	Modifier	Units
97140	59	CG	1

Example 2:
Five minutes of manual therapy (dry needling) and 10 minutes of manual therapy (not dry needling) performed in the same area as CMT.

In this example with a total of 15 minutes of manual therapy, only one unit of manual therapy is billable. Since dry needling was performed for less than eight minutes, the midpoint of the 15 minute unit of time was not reached and 97140 should be billed without Modifier 59 since the remaining manual therapy was performed in the same area as CMT.

Code	Modifier	Modifier	Units
97140	CG		1

Example 3:
Ten minutes of manual therapy (dry needling) and 15 minutes of manual therapy (not dry needling) performed in different area than CMT.

In this example with a total of 25 minutes of manual therapy, two units of manual therapy are billable. Since dry needling was performed for 10 minutes, one unit of manual therapy may be billed with Modifier 59. The additional unit of manual therapy may also be billed with Modifier 59 since it was performed in a separate area from the CMT.

Code	Modifier	Modifier	Units
97140	59	CG	2

Example 4:
Ten minutes of manual therapy (dry needling) and 15 minutes of manual therapy (not dry needling) performed in the same area as CMT.

In this example with a total of 25 minutes of manual therapy, two units of manual therapy are billable. Since dry needling was performed for 10 minutes, one unit of manual therapy may be billed with Modifier 59. The additional unit of manual therapy should be billed without Modifier 59 since it was performed in the same area as CMT.

Code	Modifier	Modifier	Units
97140	59	CG	1
97140			1

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of the Professional Provider Office Manual

5.9 CODE EDITING

CODE EDITING

Claims-editing System

Claims-editing software allows for effective and consistent management of health care billing and reimbursement by identifying potentially incorrect coding relationships on submitted claims. System changes are based on a combination of national coding edits, CPT guidelines, specialty society guidelines, clinically-derived edits and federal regulations and Blue Cross policies.

- Blue Cross' editing system manages reimbursement policy, coding policy, medical policy, benefit rules and industry standard coding guidelines.
- It helps ensure accurate and consistent payments in accordance with coding, billing, reimbursement and clinical policies.
- It manages compliance with standard coding and billing practices between various types of services, such as medical, surgical, lab, DME and radiology.

We have a claims-editing tool available in iLinkBlue under the "Claims" menu option that will allow you to access our code-editing system logic. View our *iLinkBlue User Guide* for more information on researching code combinations in the claims-editing system tool. It is available on our Provider Page at www.bcbsla.com/providers >Resources >Manuals.

CODE EDITING: BILLING PRACTICES SUBJECT TO REDUCTION

Reductions in payment due to code editing are considered above allowable amounts and appear on the Payment Register/Remittance Advice in the above allowable amount column. These amounts are not collectable from the Blue Cross member.

Unbundling

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 are considered included in the proper comprehensive code as determined by Blue Cross and is included in the allowable charge of the comprehensive code. Blue Cross will provide benefits according to the proper comprehensive code.

Incidental Procedures

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

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. One or more of the duplicative procedures is not reimbursable as it should be reimbursed only one time.

Pre and Post-op Billing

Certain codes will deny because these services should be included in the global practice. Currently global days for Blue Cross are 10 days for minor procedures and 45 days for major procedures.

Maximum Frequency

Blue Cross applies maximum frequency limitations to claims. The allowable will be adjusted to reflect the amount allowed for the updated units. The units denied will be reflected in the rejection reason as well as on the electronic 837 record.

Rebundles

Rebundles occur when two or more codes are billed instead of one more appropriate comprehensive code. Provider can refile the correct, comprehensive code.

Evaluation and Management

Evaluation and Management (E&M) rules apply to the E&M services included in the following codes and code ranges:

- 99202-99499
- 99024 (miscellaneous services)
- 92002-92004 & 92012-92014 (ophthalmology)

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.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.10 CONCIERGE MEDICINE

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

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CONCIERGE MEDICINE

Concierge medicine, (also known as direct care or membership medicine) is a relationship between a patient and a primary care physician for which the patient pays an annual fee or retainer. In exchange for the retainer, doctors provide enhanced care, which includes boutique medicine, retainer-based medicine and innovative medical practice design services.

Some characteristics of concierge medicine may also include advanced wellness screenings and diagnostics, personalized wellness plans, one-on-one physician counseling, diabetes prevention and weight management. Concierge providers may also offer extended routine visits, same day appointments and enhanced coordination of care with specialists.

Blue Cross believes that many of the services offered as concierge medicine should already be part of the standard quality of care that our network providers give to our members without additional fees. These fees cannot include any services that are covered under the health plan.

Network providers may not ever apply any concierge fees toward services that are covered under the member's contract, nor should Blue Cross be billed for any concierge fees. In the future, Blue Cross will be looking at ways to monitor our network providers who provide concierge service to ensure that they are not charging a concierge fee for covered services.

Network providers who exclusively offer concierge services should refer Blue patients who do not wish to participate in the concierge program to another network provider.

Network providers who offer both non-concierge and concierge services should make it voluntary for Blue members and may not discriminate against the non-concierge patients in terms of reasonable access to medical care and quality or comprehensiveness of care. Also, additional administrative fees should not be charged unless it is the standard office process for all patients, regardless of retainer, and patients have first been notified in advance in writing.

Network providers must notify Blue Cross in writing of their involvement in a concierge program prior to contacting our members about your new process. Notification should be made upon signing an agreement to become a concierge provider, or as soon as the decision is made to proceed with a concierge program. Providers choosing to participate in a concierge program will not be immediately removed from our network. We will work with you to ensure that your practice patterns are not in violation with your contract. Providers also agree to periodic audits by Blue Cross to ensure all requirements are being consistently met.

Upon notification, concierge providers will be listed in our provider directories with a notation that they are providing concierge medicine. For our members who do not wish to or are unable to pay the fees associated with concierge medicine, we will help identify non-concierge providers in their network. Please send notification to the Network Administration Division. You may also speak to your Network Development representative if you have questions concerning concierge medicine.

For questions concerning concierge medicine for Blue Advantage (HMO) and Blue Advantage (PPO), please refer to the *Blue Advantage Provider Administrative Manual* found on the Blue Advantage Portal.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.11 DIALYSIS

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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DIALYSIS

Dialysis providers should adhere to the following billing guidelines when filing claims:

- 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-04 claim form. CPT codes are not required when billing for dialysis services.

Revenue Codes	Type of Dialysis
821	Hemodialysis
831	Intermittent Peritoneal Dialysis
841	Continuous Ambulatory Peritoneal Dialysis
851	Continuous Cycling Peritoneal Dialysis

Providers should use one of the following revenue codes, along with the appropriate HCPCS code, for Epogen when submitting a UB-04 claim form:

Codes	Type of Dialysis
634	EPO, less than 10,000 units
635	EPO, 10,000 or more units
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

For Example: Epogen will be reimbursed at $1.20 per 100 units for Q4081. Providers should use revenue code 634 or 635 and HCPCS code Q4081 when billing for Epogen. The per diem will only be applicable 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 is included in the per diem and is not separately reimbursable.

The service units field (Block 46 of the UB-04 claim form) should include the appropriate units per the HCPCS code description for the total units provided. For example, if billing code Q4081 and 5,000 units are provided, enter "50" on Block 46.

- The per diem reimbursement 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.

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.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.12 DIETITIAN

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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DIETITIAN

Dietitians should adhere to the following billing guidelines when filing claims for members regardless of the date of service. These billing guidelines are not an indication that services are necessarily covered. Coverage determinations are based on the member's benefits. Always verify the member's benefits prior to performing services to determine if services are covered.

Dietitian services as they pertain to member benefits are defined as follows when rendered by a registered dietitian:

1. Nutritional Counseling – counseling to develop a dietary treatment plan to treat and/or manage health-related conditions other than diabetes.
   - No visit limitation
   - A maximum benefit limitation* per benefit period
   - Services that exceed the dollar limitation are considered non-covered and will not accrue toward the member's cost share amount

     ** The maximum benefit limitation does not apply for all Blue Cross policies.*

2. Diabetes Counseling – counseling to develop a dietary treatment plan to treat and/or manage diabetes.
   - Dietitian visits related to diabetes services are not subject to the nutritional counseling maximum benefit limitation. Services billed with diabetes diagnosis codes are instead subject to a member's diabetes education and training for self-management benefits.
   - Members who have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin using diabetes need to be educated on their condition and trained to manage their condition, if prescribed by the member's physician. Coverage is available for self-treatment training and education, dietitian visits and for the equipment and necessary supplies for the training.
   - Evaluation and training programs for diabetes self-management are covered subject to the following:
     a. The program must be determined to be medically necessary by a physician and provided by a licensed health care professional who certifies that the member has successfully completed the training program.
     b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Outpatient vs. Inpatient

Outpatient/Office Services

- Services should be filed on a CMS-1500 claim form.
- Payable to the dietitian.

Inpatient Services

- Services should be filed on a UB-04 claim form.
- Payable to the facility.

Filing for Services

Providers must file dietitian claims under the appropriate CPT or HCPCS code for the type of treatment provided as a single line item. Blue Cross will accept the following codes on claims:

Code	Units
97802	Each 15 minutes
97803	Each 15 minutes
97804	Each 30 minutes
G0108	Each 30 minutes
G0109	Each 30 minutes
G0270	Each 15 minutes
G0271	Each 30 minutes
S9470	Per session
S9452	Per session

- The service units field must be used to indicate the number of sessions 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.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.13 DRUG SCREENING ASSAYS

DRUG SCREENING ASSAYS

Blue Cross requires that claims be filed using CPT codes 80305-80377 rather than the temporary Medicare HCPCS codes G0480-G0483. Claims filed with HCPCS codes G0480-G0483 will be denied and must be refiled with current CPT codes.

Presumptive drug screening: CPT codes 80305-80307

- Blue Cross will only allow payment for one presumptive drug screen for drugs from Drug Class A and/or B (CPT codes 80305-80307) regardless of the number of services performed.

To ensure you have the most up-to-date information about our coverage guidelines, please review our Urinary Drug Testing medical policy (policy no. 00387).

Please Note: This medical policy and all our other medical policies are available on iLinkBlue under the "Authorizations and Medical Policy" section.

Definitive Drug Testing:

Definitive drug testing codes will be subject to a multiple-service reduction as follows:

(for the same patient for the same encounter)

- First or initial lab will be considered for 100% of the allowable charge
- Second lab will be considered for 100% of the allowable charge
- Third lab will be considered for 50% of the allowable charge
- Fourth lab will be considered for 25% of the allowable charge
- Fifth lab and any additional labs will be considered for 5% of the allowable charge
- Multiple services for urine validity will be bundled

Please Note: Providers will not be separately reimbursed for validity testing, such as urinary pH, specific gravity, nitrates, oxidants or urine specimens used for drug testing.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.14 DURABLE MEDICAL EQUIPMENT AND SUPPLIES

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

Durable medical equipment/home medical equipment (DME/HME) refers to 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 member's home.

General Guidelines

Prior to submitting claims, there must be a valid, detailed physician order on file.

DME/HME claims must be filed to the Blue Plan where the equipment is shipped to or purchased at a retail store. The ordering provider's NPI must be included on the claim or it will be returned requesting that the claim be refiled with the ordering provider's NPI number. The DME/HME supplier shall submit a current medical certification form and any such additional information as may be requested by Blue Cross.

Electronic Claims Requirements:
837 Professional Electronic Submission:

- The patient address is populated in 2010CA loop
- The NPI of the ordering provider is populated in 2420E loop
- The POS of the member is populated in 2300 loop, CLM05-01
- The service facility location is populated in 2310C loop

Paper Claim Requirements:
CMS-1500 Health Insurance Claim Form:

- The patient address where the DME/HME was shipped to in Block 5
- The NPI of the ordering provider in Block 17B - NPI of referring provider or other source
- The place of service (POS) in Block 24B (this represents where the item is actually being used - not where dispensed)
- The service facility location in Block 32 (for retail store information or location other than the patient address)

If you are a DME/HME supplier that is not located in Louisiana, you must be a participating provider for the member's plan, in the state (Louisiana) where the equipment or supply is shipped or purchased in a retail setting in order for the member to receive the highest level of member benefits. What does this mean to your office? If you are supplying DME/HME items to Blue Cross members residing in Louisiana, and you wish to receive payment directly and be identified in our provider directories, you may want to consider participating in our network. If you wish to inquire about participating in our networks, please contact Provider Contracting.

Scenario:
A DME/HME supplier in Mississippi receives and processes a request for DME/HME for a member in Louisiana. The equipment is then shipped to Louisiana for the member for pick up and/or purchase. The claim should be filed in Louisiana; the service area where the equipment is received/purchased.

Definitions:

- Durable Medical Equipment – Items which 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 are appropriate for use in the patient's home.
- Orthotic Device – A rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- Prosthetic Appliance – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

Prescription Requirement:
DME/HME suppliers provide durable medical equipment, orthotic devices and/or prosthetic appliances and related services to members who submit a physician's prescription to secure such equipment/ services.

The DME/HME supplier provide all durable medical equipment and services to members for use in the home as prescribed by the attending physician and in accordance with the instructions issued by such physician.

Equipment Rental or Purchase:
DME/HME suppliers agree to give Blue Cross the option to either rent or purchase any item of durable medical equipment. If Blue Cross elects to rent the equipment and the total of the allowable charge for the rental of such equipment during the rental period equals the allowable charge for the purchase of such equipment, then such equipment shall be deemed purchased for and on behalf of the member. No further payments of any kind shall be due to the DME/HME supplier.

Standards:
The DME/HME supplier agrees to provide all DME/HME 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 standard.

Warranty:
For purchased DME/HME, the participating DME/HME supplier must provide a one-year warranty agreement to the member. The participating DME/HME supplier must always inform the member about any DME/HME warranty provided by the manufacturer.

If You Order DME/HME

If you refer your patients to a DME/HME supplier that is not in Louisiana, the out-of-state DME/HME supplier must be a participating provider for the member's plan in the state (Louisiana) where the equipment or supply is shipped or purchased in a retail setting in order for the member to receive the highest level of benefits. What does this mean to your office? If you are writing an order for DME/HME for your patient, please refer them to a participating DME/HME supplier for the state in which your patient's equipment/supplies will be delivered to and provide your NPI so that it may be included appropriately when the DME/HME supplier files a claim for the requested supplies. Please help us ensure our members—your patients—receive the highest level of benefits available. Repeated use of a non-participating DME/HME supplier could subject you to a lower allowable charge.

Authorization

Authorization requirements are defined based on the member's (subscriber's) contract benefits. Authorization is performed prior to services being rendered. When a claim is submitted for medical necessity, DME certification is required after the services are rendered or equipment is received. PPO does not require authorization; however, authorization is required for HMO. Please research iLinkBlue prior to any service provided to fully understand benefits, authorization requirements, limitations and exclusions for your patient. For contact information regarding authorizations, please see the Quick Reference Guide of this manual.

For certain DME, a recertification to determine medical necessity of continued use may be required after the equipment has been rented for a specified number of months (such as SIDS Apnea Monitor). It is the member's responsibility to ensure recertification takes place. The member and the participating DME supplier will be notified of the recertification requirements when the initial length of rental is approved. Any claims received beyond this approved period without a recertification of medical necessity will not be covered. DME certification forms are available by calling the Customer Care Center.

DME Notification Letter

All initial and recertified 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 member 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 recertification 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 member contract.

DME Accreditation Requirement

Blue Cross requires all new DME providers be accredited by the appropriate accrediting body as a condition of network participation. All existing DME providers must remain accredited by one of the following accrediting bodies to continue participation in the Blue Cross networks:

- Accreditation Commission for HealthCare, Inc. (ACHC)
- American Board for Certification in Orthotics & Prosthetics, Inc.
- Board of Certification/Accreditation International
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAP)
- HealthCare Quality Association on Accreditation (HQAA)
- National Association of Boards of Pharmacy (NABP)
- The Compliance Team, Inc.
- The Joint Commission
- The National Board of Accreditation for Orthotic Suppliers

Blue Cross will review each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Cross every three years in accordance with URAC standards. Providers who do not maintain the required accreditation, or do not abide by Blue Cross' credentialing guidelines, will be subject to termination from any networks in which they participate.

Proof of accreditation must be sent to Network Administration.

DME Benefits

Benefits for DME are provided in accordance with the benefit provisions of each specific member's benefit plan. Benefits will be provided if the DME is covered by the member's benefit plan and the prescribed equipment meets our DME and medical necessity requirements. Most member benefit plans provide for the rental of DME not to exceed the purchase allowance.

Deductible, Coinsurance, Copay and Non-covered Services

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

The member is responsible for payment of any deductible, coinsurance and non-covered services. However, the DME provider cannot bill the member for any amount that exceeds the Blue Cross allowable charge for rented or purchased DME pursuant to your contractual agreement with Blue Cross. Sales tax on DME is considered a non-covered charge and the member's responsibility according to most Blue Cross and HMO Louisiana member benefit plans.

Please note: for payment policies regarding DME considered a luxury item, see the Deluxe/Luxury Billing Guidelines of this manual section.

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 member nor Blue Cross can be billed for additional rental or purchase of the equipment.

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.

Billing Guidelines

DME must be billed using the most appropriate HCPCS code and appropriate modifiers in effect for the date of service. Claims billed with an inappropriate code/modifier combination will be returned to the Provider for submission of a corrected claim and will cause a delay of reimbursement.

Purchase

For purchased items, the appropriate HCPCS code must be billed with NU Modifier. See specific guidelines for insulin infusion pump and ventilator billing and modifiers.

Rentals

Daily Rental Codes
E0202 - PHOTOTHERAPY LIGHT WITH PHOTOMETER
E0935 - CONT PSV MOT EXER DEVC KNEE ONLY
E0936 - CONT PASS MOTION EXER DEVC NOT KNEE

Miscellaneous, unlisted, non-specific and not otherwise classified (NOC) codes should only be used when a more specific CPT or HCPCS code is not available. Components of the primary equipment should be billed with the most specific CPT or HCPCS code or the most specific unlisted or miscellaneous code. DME billed with unlisted, miscellaneous, non-specific and NOC codes must be billed with the name of the manufacturer, product number and quantity.

Codes for DME, medical supplies, orthotics, and prosthetics without an established allowable may require submission of the manufacturer name, product name, product number and quantity.

Charges for rental equipment accessories should be included in the rental price of the equipment with no separate or itemized billing when submitting claims for consideration to 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.

All DME/HME claims for supplies that exceed the usual and customary utilization may result in a request for medical records to determine medical necessity.

All supplies must be requested by an eligible member or caregiver. Supplies are not to be automatically dispensed on a predetermined regular basis.

Monthly Rentals

One unit should be billed for each month the item is rented, with the exception of the daily rental codes above. The maximum allowable for the rental is for a whole month. A "calendar month" is the period of duration from a day of one month to the corresponding day of the next month and is determined based on the "From" date reported on the claim. If a code is submitted with Modifier RR with units greater than 1, or multiple times during the same calendar month, Blue Cross and Blue Shield of Louisiana will only reimburse one monthly rate per calendar month to the provider except for daily rental codes as noted below.

Providers must use Modifier UE (used DME) when billing for used equipment. Used equipment will be reimbursed at a 25% discount.

Deluxe/Luxury and Special Features

Certain DME is considered "deluxe" equipment due to its mechanical or electrical feature(s). For example, electric hospital beds are considered to be deluxe equipment. 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 member's comfort and convenience and determined to be not medically necessary and therapeutic will not be paid.

When the member 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.

A DME provider may deliver deluxe/luxury items as long as they could provide a standard product and the member or her/his representative has specifically requested the excessive or deluxe items or services with knowledge of the amounts to be charged. An Advance Beneficiary Notification (ABN) is required as documentation that the member has made such an informed request. If the ABN has been obtained, the DME/HME item would be submitted to Blue Cross with a Modifier GA appended as informational. The member is financially responsible for the difference in the billed charge for the standard equipment and the billed charge for the deluxe equipment, and is not to be held financially responsible for the discounted amount agreed to in your provider contract.

The charge to the member for the difference should be calculated based on the following example:

DME offers a standard item at $500 and a deluxe item at $800. The Blue Cross allowable is $375. The member's additional out of pocket cost is $300 ($800-$500) plus any deductible, coinsurance or copayment on the $375 standard item Blue Cross allowable.

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 with no separate or itemized billing when submitting claims for consideration to 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.

DME, Prosthetic and Orthotic Equipment, and Device Recalls

There is no coverage for DME, prosthetic and orthotic equipment, and devices that are being or have been recalled and are under five years of age. Recalled DME, prosthetic and orthotic equipment, and devices that are under five years of age must be replaced at no charge to the member or Blue Cross and Blue Shield of Louisiana.

Blue Cross will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Blue Cross will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Reimbursement will be reduced by the amount of the device credit.

Breast Pumps

Hospital-grade breast pumps (E0604) are covered the same as an electronic breast pump (E0603). One electric breast pump will be reimbursed per calendar year. Prior to rendering services, always verify members' benefits through iLinkBlue to determine applicable benefits and any maximum benefit limitations. Prior authorization may be required depending on the member's (subscriber's) contract benefit.

Accessories and/or replacement parts (A4281-A4286) necessary for the effective functioning of covered DME are considered an integral part of the rental and/or purchase allowance and will not be reimbursed separately. In addition, the provider shall provide at minimum, a one-year warranty for rental and/or purchase of DME.

Donor Breast Milk

Effective for claims with dates of service on or after January 1, 2023, use the guidelines below to ensure proper reimbursement for outpatient billing of donor breast milk.

- Billing should be submitted with the baby's member information.
- Please bill with code T2101 with 1 unit per 1 oz.

CPAP Supplies

CPAP supplies will be limited as follows:

Code	Units/Month
A4604	1 per 3 months
A7027	1 per 3 months
A7028	6 per 3 months or 2 per month
A7029	6 per 3 months or 2 per month
A7030	1 per 3 months
A7031	3 per 3 months or 1 per month
A7032	6 per 3 months or 2 per month
A7033	6 per 3 months or 2 per month

Code	Units/Month
A7034	1 per 3 months
A7035	1 per 6 months
A7036	1 per 6 months
A7037	1 per 3 months
A7038	6 per 3 months or 2 per month
A7039	1 per 6 months
A7046	1 per 6 months

Hearing Aids

To ensure that your hearing aid claims are processed as quickly as possible, please follow these guidelines:

- Patient must receive medical clearance and a medically appropriate audiological evaluation from a physician.
- Hearing aids must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following the physician's medical clearance.
- Dispensing fees should be billed globally with the hearing aid charge. Dispensing fees are not payable when billed separately.
- Hearing aid claims should be filed with the appropriate Modifier LT or RT if only billing for one ear. Because binaural means both ears, it is not appropriate to bill Modifier LT and/or RT for codes with "binaural" in the description. The fee on codes for binaural hearing aids is for both ears.

Always verify member benefits and eligibility prior to rendering services. Member benefits are available anytime on iLinkBlue.

For members who are age 18-years and older:

- Authorization must be obtained prior to receiving a hearing aid.
- Benefit is subject to medical necessity.
- Only covered with network providers.
- Blue Cross will not reimburse hearing aids for levels of hearing loss that can be treated by over the counter (OTC) products.

Infusion Pumps

In an effort to appropriately align reimbursement to the types and cost of equipment provided, modifier(s) are required on infusion pump codes E0784 and E0787. These items are for purchase only.

- For **Omnipod** pumps, bill code E0784 and Modifier NU in the first position.
- For **Medtronic** pumps (not closed-loop), bill code E0784 and Modifier SC in the first position and NU in the second position.
- For Tandem pumps (not closed-loop), bill code E0784 and Modifier JB in the first position and NU in the second position.
- For **Tandem** closed-loop pumps, bill code E0787 and Modifier JB in the first position and NU in the second position.
- For Medtronic closed-loop pumps, bill code E0787 and Modifier SC in the first position and NU in the second position.
- For pumps other than Omnipod, Medtronics or Tandem, bill Modifier KD in the first position and NU in the second position.

Coding Examples for infusion pumps:

- E0784NU – Omnipod infusion pump purchase
- E0784SCNU – Medtronic (not closed-loop) infusion pump purchase
- E0787JBNU – Tandem (closed-loop) infusion pump purchase
- E0784KDNU – Infusion pump purchase **other than** Omnipod, Medtronics or Tandem brand/model

Continuous Glucose Monitoring

In an effort to appropriately align reimbursement to the types and cost of equipment provided, modifier(s) are required on continuous glucose monitoring sensor, transmitter and receiver codes A9276, A9277 and A9278. These items are for purchase only.

A9276 - Sensors

- For **Dexcom** sensors, use code A9276 and Modifier JB in the first position and NU in the second position.
- For **Medtronic** sensors, use code A9276 and Modifier SC in the first position and NU in the second position.
- For sensors **other than** Dexcom or Medtronic, report Modifier KD in the first position and NU in the second position.

Coding examples for sensors:

- A9276JBNU – Dexcom sensor purchase
- A9276SCNU – Medtronic sensor purchase
- A9276KDNU – sensor purchase other than Dexcom or Medtronic

A9277 – Transmitters

- For **Dexcom** transmitters, use code A9277 and Modifier JB in the first position and NU in the second position.
- For **Medtronic** transmitters, use code A9277 and Modifier SC in the first position and NU in the second position.
- For transmitters **other than** Dexcom or Medtronic, report Modifier KD in the first position and NU in the second position.

Coding examples for transmitters:

- A9277JBNU – Dexcom transmitter purchase
- A9277SCNU – Medtronic transmitter purchase
- A9277KDNU – transmitter purchase other than Dexcom or Medtronic

A9278 – Receivers

- For **Dexcom** receivers, use code A9278 and Modifier JB in the first position and NU in the second position.
- For receivers **other than** Dexcom, use Modifier KD in the first position and NU in the second position.

Coding examples for receivers:

- A9278JBNU – Dexcom receiver purchase
- A9278KDNU – transmitter purchase other than Dexco

Implantable Continuous Glucose Monitoring

Implantable continuous glucose monitors (e.g., Eversense) should be reported by treating providers using global CPT codes 0446T-0448T.

For medically necessary and approved services, use:

- 0446T for implantation
- 0447T for removal
- 0448T for removal with immediate replacement

CPT codes 0446T-0448T are all-inclusive and include cost of sensor and all other necessary supplies. Sensors are eligible for replacement every 180 days. Treating provider should not report additional codes for related services. No other providers (e.g., DME suppliers or pharmacies) will be reimbursed for the cost of sensor and related supplies.

To review current medical policy coverage guidelines for implantable continuous glucose monitors, access our medical policy index available on iLinkBlue under the "Authorizations" section.

Orthotics

Evaluation, measurement and/or casting and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable.

Repairs to an orthosis are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for repairs is greater than providing another entire orthosis, no payment will be made for the amount in excess.

Replacement of a complete orthosis or component is billable if medically necessary. Labor for replacing an orthosis component that is coded with a specific "L" HCPCS code is included in the allowance for that component.

Billable orthosis components and labor must be billed on the same claim form.

Oxygen Equipment

Reimbursement for stationary and portable oxygen equipment will be based on a five-year Reasonable Useful Lifetime (RUL) of the equipment. Oxygen equipment may be purchased or rented. If oxygen equipment is rented, monthly rental payments to the supplier will be limited to 36 months; however, the supplier responsibilities will extend for the RUL (60 months) of the equipment.

A new 36-month rental period may only begin if the item is irreparably damaged (fire, flood, etc.) or the item is lost or stolen. Normal wear and tear, malfunction, repair and/or routine maintenance will not begin a new rental period.

1-36 Months:

The monthly rental fee for stationary oxygen equipment (E0424, E0439, E1390, E1391) includes: stationary contents, portable contents, accessories and maintenance. If the member does not have a stationary system and rents or owns only a portable system, separate reimbursement for oxygen contents will be allowed for the portable system.

However, if stationary equipment is subsequently added, separate payment for portable contents ends since payment for portable contents is included in the stationary equipment monthly rental fee.

	Concentrator	Gaseous\Liquid Oxygen System
Stationary Monthly Payment	Yes	Yes
Oxygen Contents Fee	N/A	No
Accessories	No	No
Portable Monthly Payment	Yes	Yes
Portable Contents Fee	No	No

Supplier Responsibilities:

- The same supplier should provide both the stationary and portable equipment as needed. The member should not receive the stationary equipment from one provider and the portable equipment from a different provider.

- The supplier who provides oxygen equipment for the first month must continue to provide oxygen equipment, accessories, maintenance and contents through the 36-month rental period with the following exceptions:
  a. The member relocates outside of the supplier's area (this will not start a new 36-month rental period).
  b. The member chooses to obtain oxygen from a different supplier (this will not start a new 36-month rental period).
- The supplier cannot provide different types of oxygen equipment/modalities unless the following criteria are met:
  a. The physician orders different equipment (this will not start a new 36-month rental period).
  b. The member chooses to receive an upgrade (this will not start a new 36-month rental period).

37-60 Months:

There are no further monthly rental payments for oxygen equipment during months 37-60 of the five-year RUL of the oxygen equipment. If the portable equipment rental (E0431, E0433, E0434, E1392, K0738) began after the use of the stationary equipment began, then the reimbursement for the portable equipment may continue until 36 rental payments have been made for the portable system.

Reimbursement for stationary (E0441 or E0442) or portable (E0443 or E0444) oxygen contents begins when the rental for the stationary equipment ends. A supplier may bill on a monthly basis for oxygen contents, but no more than one unit of service for portable contents and one unit of service for stationary contents may be billed per month.

There is no separate reimbursement for accessories; however, maintenance may be reimbursed separately. Maintenance and servicing charges may be billed using HCPCS code K0740 for concentrators. This may be billed every six months beginning no sooner than six months following the end of the 36-month rental period.

If the beneficiary has a stationary concentrator, portable liquid equipment and a stationary liquid tank to fill the portable cylinders, when payment for contents begins, payment will only be made for portable liquid contents.

	Concentrator	Gaseous\Liquid Oxygen System
Stationary Monthly Payment	No	No
Oxygen Contents Fee	N/A	Yes
Accessories	No	No
Portable Monthly Payment	No	No
Portable Contents Fee	Yes	Yes

Supplier Responsibilities:

- The supplier is required to provide equipment, accessories, maintenance and contents for the remainder of the five-year RUL of the stationary equipment. The equipment and accessories should be provided without billing Blue Cross or the member.
- Criterion for providing different equipment/modalities is the same in months 37-60 as they are in the initial 36 months.

Months 61 And After:

- The supplier can begin a new 36-month rental period if replacement equipment is issued to the member.
- If the supplier chooses to discontinue service, then the member must find a new oxygen supplier and begin a new 36-month rental period.
- The supplier can continue supplying the current equipment without replacing it. Contents for portable oxygen equipment and maintenance for concentrators will be reimbursed the same as months 37-60.

Purchased Equipment:

If a member chooses to purchase oxygen equipment, the contents, accessories and maintenance will be reimbursed separately.

	Concentrator	Gaseous\Liquid Oxygen System
Stationary Monthly Payment	N/A	N/A
Oxygen Contents Fee	N/A	Yes
Accessories	Yes	Yes
Portable Monthly Payment	N/A	N/A
Portable Contents Fee	Yes	Yes

Prosthetics

The following items are not separately billable and are included in the reimbursement for a prosthesis:

- Evaluation of the residual limb and gain
- Cost of component parts and labor contained in the HCPCS codes
- Fitting of the prosthesis to include adjustments of the prosthesis or prosthetic component
- Routine periodic servicing to include testing, cleaning and checking of the prosthesis

Repair or Maintenance other than Prosthetic and Orthotic DME

The repair or maintenance of rented DME/HME is the responsibility of the participating DME/HME supplier at no additional charge to the member. Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects or aging. If the expense for repairs is greater than the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess. Repairs to member-owned DME are billable using the appropriate code (K0739 or K0740) when necessary to make the item functional. For ventilators, see section on the next page.

For facial prostheses codes L8040 thru L8047, providers must bill using Modifiers KM or KN when the prosthesis is being replaced.

- KM replacement of facial prosthesis including new impression/moulage
- KN replacement of facial prosthesis using previous master model

TENS Units and Supplies

Refer to the below chart when filing claims for transcutaneous electrical nerve stimulation (TENS) units and supplies. Payment for the codes listed is not guaranteed. Coverage is subject to the member's contract.

TENS Unit Codes	Code Description	Frequency	Billing/Reimbursement Guidelines
E0720	TENS 2 lead unit	• Rental - one per month • Purchased - determined by member's benefit	• Supplies for the unit are included in the rental allowance. • When purchased, supplies are included in the allowance for the first month of purchase.
E0730	TENS 4 lead unit	• Rental - one per month • Purchased - determined by member's benefit	• Supplies for the unit are included in the rental allowance. • When purchased, supplies are included in the allowance for the first month of purchase.
E0731	TENS Garment	N/A	Only covered with supporting documentation of medical necessity.
A4557	Lead wires	1 annually	Replacement of lead wires will be covered when they are inoperative due to damage and the TENS unit is still medically necessary.
A4595	Electrical stimulator supplies, 2 lead, per month	1 or 2 units - monthly	Purchased units only: • 1 unit per month for 2 lead • 2 units per month for 4 lead

Other supplies including but not limited to the following, will NOT be separately allowed:

- A4245 - alcohol wipes
- A4556 - replacement electrodes
- A4558 - conductive paste or gel
- A4630 - replacement batteries
- Battery charger used with a TENS unit

Ventilators

Ventilator HCPCS codes E0465 (home ventilator, any type, used with invasive interface), E0466 (home ventilator, any type, used with non-invasive interface), and E0467 (home ventilator, multi-function) are to be billed and reimbursed as rental using the Modifier RR, which includes maintenance and accessories. One unit will represent one calendar month of rental. Also, one additional rental rate at 50% (upon prior authorization) will be allowed in the same calendar month for a backup ventilator reported with a rental modifier (RR) plus Modifier TW (backup equipment), appended to HCPCS code E0465, E0466 or E0467.

Wheelchairs (customized)

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

File the entire customized wheelchair claim using HCPCS code E1220 and we will reimburse the entire claim at manufacturer's suggested retail price (MSRP) minus 25% discount of charges. These claims require detailed invoices to be submitted. To expedite this process, please submit hardcopy paper claims and supporting documents.

- Evaluation and setup fees will not be reimbursed separately.
- Use K0739 to bill for equipment maintenance that is not covered under the warranty.
- Reimbursement will be based on the allowable charge.

Specialty strollers should not be billed with HCPCS code E1220. Please bill specialty strollers with the appropriate pediatric wheelchair HCPCS code.

Wheelchairs (non-customized)

Wheelchair accessories must be billed on the same claim form as the wheelchair itself. Multiple accessories using code K0108 should each be billed on a separate line.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.15 EVALUATION & MANAGEMENT SERVICES

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

EVALUATION AND MANAGEMENT SERVICES

Level of Office Visit

- When billing evaluation & management (E&M) CPT codes 99202-99205 and 99211-99215, your medical record documentation must prove medical necessity of a service in addition to the required components of the code. It is not appropriate to bill a higher-level E&M service when a lower level is warranted.
- The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the complexity of medical decision making as documented in the record or the total time dedicated to the patient on the given date of service.
- Either medical decision making or total time can be used to determine the correct code, but these two elements cannot be combined.
- Complexity of medical decision making is based on a) Number and Complexity of Problems Addressed at the Encounter; b) Amount and/or Complexity of Data to be Reviewed and Analyzed; and c) Risk of Complications and/or Morbidity or Mortality of Patient Management.
- Time for codes 99202-99205 and 99211-99215 is defined as the total time spent by the provider on the day of the encounter. Time does not include time in activities normally performed by clinical staff. Time must be documented separately to indicate the pre-service, intraservice and post-service times.
- Upon audit, providers found to have a lack of medical decision making documented in the medical record, for the billed E&M services, will be contacted and risk recoupment of all overpaid amounts.
- Providers must follow 2021 documentation guidelines for coding all E&M services. For your convenience, these guidelines can be found both in the *CPT 2021 Professional Edition* published by the American Medical Association and at the Centers for Medicare and Medicaid Services (CMS) website www.cms.gov.

Split/Shared E&M Services

A split/shared E&M service is an encounter with a patient where a physician and a non-physician practitioner (e.g., NP, PA, CNM) each personally perform a portion of an E&M visit face-to-face with the same patient on the same date of service. Please note that providers must meet the following requirements in order to bill a split/shared E&M visit under the physician's provider number:

- The physician must provide a face-to-face visit with the patient.
- The physician must document in a separate note the E&M work that they personally performed. It is not sufficient for the physician to countersign the medical record or document "seen and agree." The physician must document the work that they personally performed during the visit.

- If time is used to select the E&M code for a split/shared visit, the time spent by the physician and other qualified health care provider is summed to determine the total visit time. Also, as outlined in the *CPT 2021 Professional Edition*, "Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient care, only the time of one individual should be counted)."
- The physician must justify their involvement in the patient care by legibly signing the medical record.

In addition, the following requirements apply to split/shared E&M services:

- Services must be rendered by the attending physician and specified non-physician practitioners: nurse practitioners, physician assistants and certified nurse-midwives.
- The attending physician and the non-physician practitioner must be part of the same group practice, either through direct employment or a contractual arrangement, which links the two individuals.

Only one provider should bill for the E&M service.

Consultation Codes

Effective for dates of service on and after March 1, 2021, Consultation CPT codes 99241-99245 and 99251-99255 will be considered invalid for submission to Blue Cross. We will follow the CMS guidelines whereby the E&M procedure codes that describe the office visit, hospital care, nursing facility care, home service or domiciliary/rest home care service should be billed instead of consultation codes 99241-99245 or 99251-99255.

Reduction for E&M Office Visit on Same Day as Preventative Visit

Effective for dates of service on and after March 1, 2021, E&M office visit reimbursement will be reduced by 50% when an E&M office visit for a member is performed by the same provider on the same day as a preventive medical exam and the service is billed to indicate a significant separately identifiable E&M service was performed.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.16 HOME HEALTH AGENCY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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HOME HEALTH AGENCY

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-04 claim form (see instructions in the Claims Submission section of this manual) in accordance with Medicare guidelines with the following exceptions:

1. The revenues codes accepted by Blue Cross and which may be entered in Block 42 of the UB-04 claim form are limited, and revenue code descriptions for Block 43 have been modified. These modifications are necessary due to member 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 reimbursement 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 the Modifier section in this manual for detailed information).

   The revenue codes with descriptions accepted by Blue Cross from participating home health agencies listed in this manual. The appropriate HCPCS or CPT code must be included in Block 44 of the UB-04 claim form when billing revenue codes with double asterisks (**), shown under the column heading "Code Reqd." This is necessary for proper pricing and payment of the service.

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 member 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 authorize services and also via the written confirmation of the 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 authorization will include the service and/or code to be provided and in some cases, the quantity/units of services authorized. The services that we will generally approve are included in this manual and include the range of HCPCS/CPT codes that should be billed with the revenue code.

Home health providers are required to request all authorizations for home health services through the BCBSLA Authorizations tool on iLinkBlue. For more on home health authorizations, refer to the Medical Management section of this manual.

Home Health Agency Revenue Codes Accepted by Blue Cross

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 appropriate to the level of professional training.

Revenue Code	Description	HCPCS/ CPT Range	Code Req'd	Program Rate
258	Pharmacy - IV Solutions	J0000 thru J9999, B4150 thru B5200		Allowable Charge
261*	IV Therapy - Infusion Pump	E0781 thru E0784, E1520, A4220		Allowable Charge
264	IV Therapy - IV Therapy Supplies	A4230 thru A4232, A4221, A4222, B4034 thru B4083, B9002 thru B9999		Allowable Charge
271	Medical/Surgical Supplies & Devices, Nonsterile Supply	A4206 thru A6404		Allowable Charge
272	Medical/Surgical Supplies & Devices, Sterile Supply	A4206 thru A6404		Allowable Charge
274	Medical/Surgical Supplies & Devices, Prosthetic/Orthotic Devices	L0000 thru L4999, L5000 thru L9999		Allowable Charge
291	DME (Other than Renal), Rental	E0100 thru E1406, E1700 thru E1830		Allowable Charge
292	DME (Other than Renal), Purchase of New DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge
293	DME (Other than Renal), Purchase of Used DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge
294	DME (Other than Renal), Supplies/ Drugs for DME Effectiveness	E0100 thru E1406, E1700 thru E1830		Allowable Charge
300-319	Laboratory	80047 thru 89398, 36415		Allowable Charge
421	Physical Therapy - Visit Charge			Allowable Charge
424	Physical Therapy - Evaluation or Re-evaluation			Allowable Charge
431	Occupational Therapy - Visit Charge			Allowable Charge
434	Occupational Therapy - Evaluation or Re-evaluation			Allowable Charge
441	Speech-Language Pathology - Visit Charge			Allowable Charge
444	Speech-Language Pathology - Evaluation or Reevaluation			Allowable Charge
550**	Skilled Nursing-Hourly Charge (Licensed Practical Nurse)			Allowable Charge
551**	Skilled Nursing-Visit Charge (Registered Nurse)			Allowable Charge

552**	Skilled Nursing-Hourly Charge (Registered Nurse)			Allowable Charge
559**	Skilled Nursing-Visit Charge (Licensed Practical Nurse)			Allowable Charge
561	Medical Social Services - Visit Charge			Allowable Charge
571**	Home Health Aide - Visit Charge			Allowable Charge
600	Oxygen (Home Health)	E0424 thru E0480, E0442-E0444, E0600, E0601, E0550 thru E0585, E1353 thru E1406		Allowable Charge
999	Other Patient Convenience Items			Allowable Charge

Please Note: Allowable charges for revenue codes that are not specifically listed above will be established periodically.

* *More on IV Therapy - Infusion pump (Revenue code 261) on the next page*

** *More on skilled nursing revenue codes below*

More on Revenue Codes for Skilled Nursing

Revenue Code	Description
550	Skilled Nursing – Hourly Charge – Licensed Practical Nurse (Private Duty Nursing)
552	Skilled Nursing – Hourly Charge – Registered Nurse (Private Duty Nursing)
572	Home Health Aide – Hourly Charge
The Allowable Charge for revenue codes 550, 552 and 572 for private duty nursing or home health aide services will be considered for approval during the private duty nursing or home health aide services authorization process. Services and procedures (CPT/HCPCS) 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 allowable charge 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 reusable or non-reusable including, but not limited to:

Alcohol prep sponge	Non-sterile gauze	Tape
Band-Aids	Non-sterile specimen	Thermometer cover
Gloves	Over the counter – for skin tears	Vacutainers with needles
Incontinent cleaners	Personal care items	
Lotion	Sharps disposable containers	

The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to, the following HCPCS/CPT codes:

99070	A4330	A4490	A4640	A5071-A5073
A4206-A4210	A4335	A4495	A4649	A5081
A4212	A4364	A4500	A4663	A5082
A4215	A4398	A4510	A4670	A5093
A4233-A4236	A4402	A4550	A4770	A5120
A4244-A4246	A4421	A4554	A4913	A6216-A6221
A4250	A4450	A4627	A4927	A6260
A4259	A4452	A4630	A5051-A5055	E2360
A4328	A4455-A4456	A4635-A4637	A5061-A5063	

Modifiers that must be included with IV Therapy - Infusion Pump (revenue code 261):

BP The beneficiary has been informed of the purchase 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 Modifier LL when DME equipment rental is to be applied against the purchase price)

NU New Equipment

Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study

RR Rental (use Modifier RR when DME is to be used)

UE Used durable medical equipment

NR New when rented (use Modifier NR when DME that was new at the time of rental is subsequently purchased)

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.17 INCIDENT-TO

INCIDENT-TO

For Provider Types Eligible for Network Participation

Effective June 1, 2019, Blue Cross updated its "Incident-to" reimbursement rules for provider types that are eligible to participate in our networks as follows:

1. If network participation is available for a provider type, then that provider type is required to file claims under their own provider number. Services should not be billed under a supervising provider.

2. Only providers who are covered by our subscriber contracts and are not offered network participation are eligible to bill incident-to services and be reimbursed under a supervising provider's Blue Cross contract number. Providers who are considered by us to be in-training (e.g., residents, post-doctoral and other students, and providers with provisional licensure) are not eligible to bill incident-to services.

Under this updated policy, provider types that are required to file claims under their own provider number include (but may not be limited to) nurse practitioner, physician assistant, dietitian, audiologist, certified nurse anesthetist and behavior analyst. These provider types are eligible to participate in our networks.

If you are one of these provider types, you should bill your services directly to Blue Cross. Claims will periodically be reviewed to ensure billing by the appropriate provider type.

For more information, refer to the Split/Shared billing guidelines in the Evaluation and Management Services section of this manual.

For Provider Types Not Eligible for Network Participation

For provider types that are not eligible for network participation, Blue Cross follows CMS Incident-to Guidelines for processing incident-to claims.

"Incident-to" means that services performed must be furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services billed directly (not part of the physician's personal professional services) are not "incident-to."

General requirements for services to be considered incident-to are as follows:

- The service provided must be reasonable and medically necessary, must be within practitioner's scope of practice as defined in state law where they are licensed to practice, and performed in collaboration with a physician.
- The practitioner must be an employee or independent contractor to the physician, physician's group or physician's employer.
- Supervising physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

- An office/clinic must have identifiable boundaries when part of another facility and services must be furnished within the identifiable boundary; where this office is one room, the physician must be in it to supervise.
- Physician has performed initial service and subsequent services of a frequency that reflect his/her active participation in and management of the course of treatment.
- The professional identity of the staff furnishing the service must be documented and legible.

Note: a counter signature alone is not sufficient to show that the incident-to requirements have been met.

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of the Professional Provider Office Manual

5.18 INFUSION THERAPY

INFUSION THERAPY

Infusion therapy providers should adhere to the following guidelines when filing claims.

Claim Form

- A CMS-1500 claim form is required to bill for both home infusion and the infusion suite services.

Referring Physician NPI

- The referring physician NPI number **must** be included in Block 17B of the CMS-1500 claim form.

Authorizations

- The member's benefits may require an authorization for services.
- Nursing visits exceeding two hours in duration will always require authorization.

It is important to file ALL applicable diagnosis codes supported by your medical record on a claim.

It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing not otherwise specified (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.

Categories of Billable Services

Service	Per Diem	Nursing Services	Drugs
Infusion	x	x	x
Injectable: Self-administered Drugs	x		x
Other Drug Administration		x	x

Please reference the executed Reimbursement/Services Schedule of your Allied Health Provider Agreement for the billable codes and allowables. Codes not listed are considered incidental to other services billed for that member on that day. The presence of a code or fee on the schedule, such as enteral therapy is not to be interpreted as meaning that the patient has coverage or benefits for that service.

Per Diems

Blue Cross allows per diem reimbursement only once each calendar day when the patient is receiving:

1. An actual infusion of medication through intravenous or other authorized drug delivery routes of infusion therapies, as prescribed by the ordering physician.

2. The administration of self-injectable drugs, as prescribed by ordering physician.
   Self-injectable: Drugs considered as self-injectable may be considered eligible for benefits under the member's drug prescription card in most cases and may not be delivered or billed by the home infusion therapy provider. Some exceptions may be made for initial member training.

Multiple per diems are reimbursable if performed concurrently and through a separate infusion administration access site. A multiple procedure reduction will apply to these per diems and will reimburse at 20% of the per diem.

For billing of per diem services, span dates may only be used for single sites. Each date of service must be billed on separate lines when billing per diems for multiple infusion administration access sites.

Catheter Maintenance

The codes below are billable for catheter care maintenance between infusion treatments and can be billed alone or with nursing service code(s) 99601/99602. Do not bill these codes when other infusion per diems are applicable. Bill only one catheter care maintenance code per date of service.

- S5498 – HIT simple cath care
- S5501 – HIT complex cath care
- S5502 – HIT interim cath care
- S5517 – HIT declotting kit
- S5518 – HIT cath repair kit

Change Items/Services Not Separately Billable

The following items/services are not separately billable under any circumstance:

- Pharmacy compounding fees
- Procurement and stocking of intravenous medication
- Equipment rental including pump and IV pole
- Delivery of medications, supplies and equipment to the member's home
- Clinical pharmacy services and kinetic dosing
- Patient care and coordination with other providers and case management if applicable
- 24 hour a day, on call availability and patient telephone consultation
- Monitoring, consultations and records maintenance by a dietitian where applicable (e.g., enteral therapy)
- Waste disposal

- Medical supplies which include but are not limited to the following: needles, syringes, tubing, flushing supplies and needleless connectors and all other supplies from the injection port out. The peripheral IV start kits or IV start catheters and dressing are also included.
- Drug administration
- Postage/shipping costs
- Training and education of patient, family and caregiver
- Laboratory blood drawing and tests done by nurse
- All services including nursing and supplies associated with self-injectable drug administration

Nursing Services

Nursing services can be billed separately using CPT codes 99601 and 99602 (additional hours) for both home infusion and infusion suite services except for self-administered injectable drugs and their related services. A nursing service visit is defined as consecutive periods of time up to two hours during which clinical nursing services are rendered. The first two hours (99601) will be reimbursed at the per visit rate identified in your agreement. Hourly nursing charges (99602) exceeding two hours require an authorization and will be reimbursed at a reduced hourly rate per your agreement terms. A nursing service visit should be billed as one unit per visit in the Block 24G of the CMS-1500 claim form. When billing for additional hours beyond the nursing service visit of two hours, the home infusion provider must include the number of additional hours for the services rendered in the Block 24G of the CMS-1500 claims form.

A nursing service visit includes but is not limited to:

- Assessments
- IV infusion and/or enteral services
- Administration of medication: PO, IM, SQ, IV and for enteral services
- Training and education of patient, family and caregiver
- Wound care management
- Patient monitoring
- Laboratory blood drawing and tests done by nurse
- Patient care and coordination with other providers and case management if applicable
- All medical equipment and supplies associated with the above services whether reusable or non-reusable

Drugs

- Most drug codes are to be billed separately. Report the appropriate CPT/HCPCS and corresponding units for appropriate compensation. Listings of the allowable charges for drug codes are available on iLinkBlue.

- Renal Failure/Dialysis: when a member is receiving dialysis for treatment due to a diagnosis of renal failure from another provider, the allied health provider will not be reimbursed for infusion of drugs (for example, Epogen, etc.), or other related services. Services not related to dialysis infusion therapy (for example, TPN) would be eligible for reimbursement in accordance with the Member Contract/Certificate when not performed at a dialysis center.
- When a member is inpatient, the inpatient facility is responsible for billing the infusion therapy services.

Implanted Pump Refill

Refilling of implanted pumps (62369 or 62370) may be billed separately when other infusion per diems or nursing services are not billed for the same date of service.

Edits

Edits will be established to ensure only the agreed upon procedure codes are priced. If the Infusion Therapy provider bills a code not shown below, the service is considered incidental to other services billed for that member on that day and is not separately payable and the member will be held harmless. Reimbursement information can be found in Reimbursement/Services Schedule of your executed Allied Health Provider Agreement.

Standard code editing logic applies.

List of Infusion Therapy Services

Codes Accepted	Description: Therapies & Conditions
Drugs:	
HCPCS	Drug(s)
Nursing Visits:	
99601	Nursing Service
99602	Nursing Service (prior approval)
Infusion Therapy - Antiviral/Antibiotics/Antifungal:	
S9497	Once every 3 hours, **per diem**
S9500	Once every 24 hours, **per diem**
S9501	Once every 12 hours, **per diem**
S9502	Once every 8 hours, **per diem**
S9503	Once every 6 hours, **per diem**
S9504	Once every 4 hours, **per diem**
Chemotherapy:	
S9330	Continuous Chemotherapy infusion (24 hours or more), **per diem**
S9331	Intermittent Chemotherapy infusion (less than 24 hours), **per diem**

Codes Accepted	Description: Therapies & Conditions
Hydration Solutions:	
S9374	Up to one liter **per diem**
S9375	More than one liter but no more than two liters, **per diem**
S9376	More than two liters but no more than three liters, **per diem**
S9377	More than three liters, **per diem**
Enteral Nutrition: *(limited benefits, please refer to our Medical Policies)*	
B4034	Enter feed supkit syr by day
B4035	Enteral feed supp pump **per diem**
B4036	Enteral feed sup kit grav by
B4081	Nasogastric tubing with stylet
B4082	Nasogastric tubing without stylet
B4083	Stomach tube-levine type
B4087	Gastro/jejuno tube, std
B4088	Gastro/jejuno tube, low-pro
B4102	EF adlt repl fl&lytes 500 ml
B4103	EF ped repl fl&lytes 500 ml
B4104	Additive for enteral formula
B4149	EF blenderized foods
B4150	EF complet w/intact nutrient
B4152	EF calorie dense>/=1.5Kcal
B4153	EF hydrolyzed/amino acids
B4154	EF spec metabolic noninherit
B4155	EF incomplete/modular
B4157	Entral f cmpl inherited dz metab
B4158	Entral f ped nutrition complete
B4159	Entral f ped nutritn cmpl soy basd
B4160	Entral f ped nutritn cmpl cal dense
B4161	Entral f ped hydrolyzed/aa proteins
B4162	Entral f ped inherited dz metab
S9340	Home Infusion therapy, enteral nutrition, **per diem**

Codes Accepted	Description: Therapies & Conditions
Total Parenteral Nutrition (T.P.N.)	
B4164	TPN Carbs 50% or less
B4168	TPN Amino Acid 3.5%
B4172	TPN Amino Acid 5.5-7%
B4176	TPN Amino Acid 7-8.5%
B4178	TPN Amino Acid >8.5%
B4180	TPN Carbs >50%
B4185	TPN per 10 grams lipids
B4187	Omegaven, 10g lipids
B4189	TPN Protein (10-51GM)
B4193	TPN Protein (52-73GM)
B4197	TPN Protein (74-100GM)
B4199	TPN Protein (Over 100GM
B4216	TPN additives
B4220	TPN supply kit, premix
B4222	TPN supply kit, home mix
B4224	TPN admin kit
B5000	TPN sol renal
B5100	TPN sol hepatic
B5200	TPN sol hepatic
S9364	Home Infusion therapy, total parenteral nutrition (TPN), **per diem**
Pain Management:	
S9326	Continuous pain management infusion (24 hours or more), **per diem**
S9327	Intermittent pain management infusion (less than 24 hours), **per diem**
S9328	Implanted pain management infusion, **per diem**
Catheter Care:	
S5498	HIT simple cath care
S5501	HIT complex cath care
S5502	HIT interim cath care
S5517	HIT declotting kit
S5518	HIT cath repair kit
S5520	Up to one liter **per diem**
S5521	More than one liter but no more than two liters, **per diem**

Codes Accepted	Description: Therapies & Conditions
Other Specific Infusion Therapies or Treatments:	
S9061	Aerosolized drug therapy (e.g. pentamidine), **per diem**
S9336	HIT cont anticoag, **per diem**
S9338	HIT immunotherapy, **per diem**
S9345	HIT anti-hemophil, **per diem**
S9346	HIT alpha-1-proteinas, **per diem**
S9347	HIT longterm infusion, **per diem**
S9348	HIT sympathomim, **per diem**
S9349	HIT tocolysis, **per diem**
S9351	HIT cont antiemetic, **per diem**
S9355	HIT chelation, per diem
S9357	HIT enzyme replace, **per diem**
S9359	HIT anti-tnf, **per diem**
S9361	HIT diuretic infus, **per diem**
S9363	HIT anti-spasmotic, **per diem**
S9490	HIT corticosteroid, **per diem**
S9538	HIT blood products, **per diem**
Other Misc. Service/Supplies:	
62369	Infusion Pump Analysis, Reprograming and Refill
62370	Infusion Pump Analysis, Reprograming and Refill (MD/QHP)
A4305	Dispbl rx del sys rate > 50 ml/hr
A4306	Dispbl rx del sys rate < 50 ml/hr
S9379	Infusion Therapies, NOC, **per diem**
S9381	HIT high risk/escort (prior approval)
S9542	HIT injection NOC per diem

Infusion Therapy Billing Examples

RSV Injection Given To Patient In Home or Suite
JXXXX
99601

Chemotherapy Infusion in Home without Nurse
JXXXX
S9330

Drug Infusion in Suite Over 2 Hours Please Note: additional nursing requires pre-service authorization
JXXXX
SXXXX
99601
99602

Self Injectable In Home or Suite
JXXXX
S9542

Chemotherapy Infusion in Home with Nurse
JXXXX
S9330
99601

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.19 IN-OFFICE PROCEDURES

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

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IN-OFFICE PROCEDURES

Blue Cross does not recognize, nor do we reimburse separately for, a facility fee, treatment room, supplies or other technical components or services in an office setting as this is included in the overhead component of the professional service(s) the member is receiving. Consistent with our policies regarding services that are an integral part of another service, there should be no separate charge to the member. For any eligible in-office procedures you are contracted to perform, you have agreed to accept your contracted allowable charge as payment in full.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.20 INTRA-OPERATIVE MONITORING SERVICES

INTRA-OPERATIVE MONITORING SERVICES

We reimburse a global allowable charge for the professional component portions of all intra-operative monitoring services. All ancillary study codes bundle to intra-operative monitoring codes 95940, 95941 and G0453. These ancillary codes include but are not limited to:

- 51785
- 95700-95726
- 95812-95813
- 95816-95830
- 95860-95872
- 95885-95887
- 95905-95913
- 95925-95939
- 95954-95962
- 95999

Intra-operative monitoring is only billable if it is provided by a physician who is not the attending surgeon. The attending surgeon is responsible for ensuring the use of a participating intra-operative monitoring provider. Physicians who repeatedly fail to refer to participating providers for intra-operative monitoring services may result in the physician's overall reimbursement rate being reduced by Blue Cross by a certain percentage as determined by Blue Cross in its sole discretion.

Blue Cross does not consider place of service 15 valid for claims submissions for intraoperative monitoring services. Bill intraoperative monitoring services with the appropriate place of service based on the member's location when services are provided. This helps ensure the appropriate benefits and reimbursement apply. Claims for intraoperative monitoring services billed with place of service 15 may reject.

The technical component of the intra-operative monitoring services is included in the fee Blue Cross pays the facility. Blue Cross will not separately pay nor reimburse any claims for the technical component of the intra-operative services provided.

Multiple Unit Reduction

Effective for dates of service on and after August 1, 2020, intra-operative monitoring codes 95940, 95941 and G0453 for the same patient for the same encounter will be subject to a multiple-unit reduction. The first hour for these service codes will be reimbursed at 100% of the allowable charge. The second and any additional hours will be reimbursed at 40% of the allowable charge.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.21 LABORATORY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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LABORATORY

Using Preferred Reference Labs

All network providers **must** refer members to preferred reference lab vendors when lab services are needed and are not performed in the provider's office. Providers who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts.

Please refer to the preferred lab requirements listed below to ensure your patients receive the maximum benefits to which they are entitled.

Preferred Labs

We use a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Blue Cross members **must** be submitted to a preferred reference laboratory in the member-patient's network, if not performed in your office.

For the most current list of statewide and regional reference labs and full details on laboratory requirements for our Preferred Care PPO products, please refer to the Preferred Care PPO Preferred Reference Lab Guide. For HMO Louisiana products, please refer to the HMO Louisiana Reference Lab Guide. These guides are available in the "Resources" section of our Provider page. You may also use our online provider directories available on our website to locate preferred reference lab draw sites.

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services for your Blue Cross patients.

Requirements for Providers

Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO or HMO Louisiana participating hospitals or the member's selected hospital but otherwise should be sent to one of our preferred reference labs.

If you perform laboratory testing procedures in your office, you must bill claims in accordance with your Clinical Laboratory Improvement Act (CLIA) certification. We require that a copy of your CLIA certification be provided along with your Louisiana Standardized Credentialing Application (LSCA) when applying for credentialing or recredentialing with Blue Cross. Providers who do not collect specimens in their offices may refer their Blue Cross patients to a preferred reference lab draw site in the member-patient's network.

Lab Testing Policies

Providers must adhere to our lab testing policies. No payment will be owed to providers for services that do not adhere to our lab testing policies and providers may not bill a member for any unpaid amounts for services that do not adhere to our lab testing policies. Providers can review the billing policies and guidelines online. Visit www.bcbsla.com and look under the Helpful Links section at the bottom of the page. Click on "Lab Reimbursement Policies." Note: Laboratory services, tests and procedures provided in emergency room, hospital observation and hospital inpatient settings are excluded from our lab testing policies.

Our lab testing policies apply to all fully insured, Federal Employee Program (FEP) and BlueCard® (out-of-area) members. Self-funded groups may be subject to our lab testing policies. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

In-office Lab List

HMO Louisiana and HMO Louisiana select networks providers may perform the following selection of lab tests (CPT codes shown) in their CLIA-certified offices.

80305	81015	82948	83861	85014	86485	87275	87590	88311	88342
80306	81025	82951	84030	85018	86490	87276	87591	88312	89190
80307	82044	82952	84112	85025	86510	87426	87635	88313	89220
80320	82247	82962	84132	85027	86580	87428	87636	88314	89230
80321	82270	83013	84437	85032	86756	87430	87637	88329	
80322	82272	83014	84702	85610	87172	87480	87660	88331	
81000	82274	83026	84830	85651	87177	87490	87804	88332	
81001	82565	83036	85007	85652	87205	87491	87807	88333	
81002	82570	83037	85008	86308	87210	87502	87811	88334	
81003	82947	83518	85013	86403	87220	87510	87880	88341	

Out-of-state Labs

If you refer your patients to a reference lab that is not in Louisiana, the out-of-state reference lab must be a participating provider for the member's plan in the state where the specimen is drawn in order for the member to receive the highest level of member benefits. If you are collecting the specimen* and sending the specimen to an out-of-state reference lab, please ensure that the out-of-state reference lab you are using is participating in the member-patient's network, otherwise your patient will be subject to a much higher cost share for this service or receive no benefits at all. In addition, providers who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts.

Scenario

An independent laboratory receives and processes the Louisiana member's blood specimen. The member's blood was drawn in Louisiana* but processed in Texas by a reference lab. The out-of-state reference lab should file the claim to Blue Cross and Blue Shield of Louisiana; the service area where the specimen was drawn. Before referring the member, please ensure that the Texas reference lab is participating with Blue Cross and Blue Shield of Louisiana in order for the member to receive the highest level of benefits.

** Providers should file the claim to the Blue Cross and Blue Shield plan in the state where the specimen is drawn.*

Ordering Provider Requirements

The ordering/referring provider's first name, last name and NPI are required on all laboratory claims. Claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information. If you are CLIA certified to provide lab services in your office and you are billing Blue Cross for these services, please include the ordering provider name and NPI information on the claim form.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

Reference Lab Billing

Blue Cross requires reference laboratory services to be billed on a CMS-1500 claim form or an 837P electronic claim.

Pass-Through Billing

Blue Cross does not permit pass-through billing. Only the performing provider should bill for services. You may only bill for lab services that you perform in your office. For more detailed information, see the Pass-through Billing and Billing for Services Not Rendered section of this manual.

Place of Service Billing for Lab Services

The place of service code for all clinical and anatomical laboratory services should reflect the type of facility where the patient was located when the specimen was taken, regardless of whether a global, technical or professional component of the service is being billed.

For example:

- If an independent laboratory bills for a lab sample where the sample was taken in its own laboratory, place of service 81 (reference lab) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an inpatient hospital setting, place of service 21 (inpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an outpatient hospital setting, place of service 22 (outpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in a physician office setting, place of service 11 (office) would be reported.

As a reminder, the referring provider name and NPI should always be listed on claims for laboratory services.

Special Arrangements

Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

Provider Inquiries and Satisfaction

Providers can access member's benefits, eligibility and allowable charges using our self-service tools: iLinkBlue (www.bcbsla.com/ilinkblue), Interactive Voice Recognition (IVR) 1-800-922-8866 and HIPAA transactions.

Please let us know if any quality issues arise so we can work with the appropriate lab to improve service and ensure that you and your patients receive the service you expect and deserve.

Genetic Testing

Prior authorization should be obtained before generic testing services are rendered. Genetic testing performed 30 days after the lab draw will be subject to the retrospective review; whether a claim has been filed or not. Authorization penalties will apply.

Authorization requests submitted within 30 days of the lab draw will be considered a pre-claim, post-service review. Prior authorization penalties will not apply.

All genetic testing is subject to medical necessity review regardless of whether it is pre- or post-claim.

Proprietary Lab Analyses (PLA)

In alignment with CPT guidelines, when a proprietary lab service has a PLA code, the service should be reported with the applicable PLA code. CPT codes other than the applicable PLA code should not be used to report the service. The PLA code includes all services required for the analysis (such as cell lysis and all nucleic acid work), so the proprietary lab service should not be billed with any additional CPT codes.

Genomic Sequencing Procedures (GSP) and Multianalyte Assays with Algorithmic Analyses (MAAA)

In alignment with CPT guidelines, when a molecular test analyses gene(s) that appear in multiple code descriptors, only the single code corresponding to the most specific test for the primary disorder (e.g., oncologic diagnosis, germline condition, syndrome) should be billed. Multiple codes should not be reported for the same gene(s).

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.22 MATERNITY CARE AND DELIVERY

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MATERNITY CARE AND DELIVERY

Elective deliveries for pregnancies less than 39 weeks gestation can pose both short- and long-term risks for the newborn. The risks that newborns face after early delivery, even at 37 and 38 weeks' gestation include, but are not limited to, increased morbidity from respiratory distress, increased rates of pneumonia, ventilator use, hypoglycemia and NICU admission. The relative risk of neonatal mortality is 2.3 times greater at 37 weeks and 1.4 times greater at 38 weeks as compared to 39 weeks.

These guidelines are an extension of your network agreement. Use these guidelines to ensure proper reimbursement and avoid denied or returned claims. Always verify members' benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.

Blue Cross considers **elective deliveries**, whether vaginal or cesarean **prior to 39 weeks** to not be covered unless shown to be medically necessary. Elective deliveries that are deemed not medically necessary are not reimbursable. This includes claims for the delivering provider, anesthesiologist and facility. Claims denied as not medically necessary are NOT billable to the member. For global delivery claims (code 59400, 59410, 59510, 59610, 59614, 59515, 59618 or 59622) that have been denied as not medically necessary, the delivering provider may refile the ante-partum (59426) or post-partum (59430) care services for separate reimbursement consideration

The provider performing the delivery is required to include a modifier. Use one of the following modifiers when billing for a delivery of pregnancy (CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622):

Modifier	Description
GB	Report when delivery is 39 weeks or more, whether spontaneous or elective.
AT	Report when delivery is less than 39 weeks and medically necessary.
GZ	Report when delivery is less than 39 weeks and NOT medically necessary.
NO MODIFIER	*Claim will DENY for incomplete information.*

All other related claims (anesthesia, facility, etc.) will be subject to recoupment of payments should the delivery be determined to not be medically necessary. Labor inductions and elective cesarean deliveries for pregnancies less than 39 weeks gestational may be considered eligible for coverage when there is an established maternal or fetal risk in which the risk of continuing the pregnancy outweighs the risks of early birth. Management decisions should balance the risks of pregnancy prolongation with the neonatal and infant risks associated with early-term delivery. Maternal-fetal-medicine consultations are encouraged in the evaluation of pregnancies considered for early-term delivery and in the assessment of the risks/benefits from such delivery.

Please Note: The maternal patient should be provided with documentation that clearly explains the risks/benefits of early delivery.

Also, it is important to file ALL applicable diagnosis codes on a claim. It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing not otherwise specified (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.

Global Billing for Maternity Care

When a sole obstetrician or obstetricians within the same group covering for each other, provide routine maternity care from the beginning of a member's pregnancy to delivery, our policy is to allow an initial evaluation and management service and a global delivery fee.

If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level evaluation and management services code as a separately payable service, outside the global delivery package. Global obstetrical care begins after the initial visit when the obstetrical record is initiated as part of the physician's comprehensive obstetrics work-up which includes the comprehensive history and physical.

The global period for the obstetrical care, represented by CPT codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 or 59622 includes all routine pregnancy-related evaluation and management office services, after the initial evaluation, and the delivery service.

If more than one obstetrician is involved in a patient's routine maternity care, Blue Cross would expect to see itemized services specific to the care delivered by the obstetrician for that patient. For example, a patient begins treatment in another state and then relocates to Louisiana and a Louisiana obstetrician begins routine care for that patient in the third trimester of pregnancy, the physician would bill the appropriate E&M code (99202-99215) or antepartum care CPT code (59425 or 59426) based on the number of visits, and the delivery code (with or without postpartum care) rather than a global delivery procedure.

Antepartum care for split providers should be billed as:

- 1 – 3 visits – bill evaluation and management codes (99202-99215)
- 4 – 6 visits – bill only CPT code 59425
- 7 or more visits – bill only CPT code 59426

For any post-partum visits on and after date of service December 1, 2017, we require obstetricians to submit a claim for the member's post-partum visit using the non-payable CPT code 0503F with a charge of $0.00. This visit should be performed no later than 60 days of the delivery date.

Multiple Births

Physicians may receive additional reimbursement of $300 (subject to applicable network discounts) when filing for multiple births. The additional reimbursement applies to both vaginal deliveries and cesarean sections. To be eligible for the additional reimbursement, claims should be filed with the following CPT codes and Modifier 76:

59400	59510	59610	59618
59409	59514	59612	59620
59410	59515	59614	59622

Only one delivery code should be billed for a member. For example, if a patient with twins delivers the first baby vaginally and the second baby by cesarean section, only the cesarean section code should be billed. Modifier 76 should be added to the cesarean section code to indicate there was a multiple birth.

For More Information

If you have any questions about the Elective Delivery of Pregnancy medical policy or if you would like a copy of another medical policy, please refer to the Medical Policy section of iLinkBlue.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

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5.23 MEDICATION SUBSTITUTION

MEDICATION SUBSTITUTION

Louisiana Senate Bill 545 of Act 396, R.S. 22: 1007 (J) states that network providers will be reimbursed when there is a need to substitute a specific medication. This only applies to brand drug substitutions required by Blue Cross, for which the provider executes the substitution. This does not apply to generic substitutions or Step Therapy Programs.

To receive reimbursement, the provider should submit the CPT code 99499 with Modifier TS appended. The use of this code must be supported in the member's medical records and is payable once per date of service to include all substitutions made. This fee is not applicable to non-participating providers. Claims submitted for this fee from providers who are non-participating will be rejected. There is no member cost share associated with this fee. The fee is subject to routine audit.

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5.24 MODIFIERS

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MODIFIERS

A modifier provides the means by which the reporting provider can indicate a service or procedure has been performed and 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 CMS-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 CMS-1500 claim form. 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 of the CMS-1500 claim form.

Modifier Guidelines

The table on the next pages lists some of the modifiers that Blue Cross accepts and their reimbursement schedule. Not all modifiers affect reimbursement.

If you have any questions about billing with modifiers, please call Provider Relations.

CPT/HCPCS Modifiers	Description	Blue Cross Use
22*	Unusual procedural service	May pay up to 20% additional payment will be considered for minor additional circumstances; 25% additional payment will be considered for very unusual additional circumstances. Additional documentation required with claim.
24	Unrelated evaluation and management service by the same physician during a postoperative session	Pays separate allowable charge. Supportive documentation required in medical record.
25*	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	May pay separate allowable charge. Supportive documentation required in medical record.

26*	Professional component	Pays professional component of the allowable charge
50*	Bilateral procedure	Payment based on 150% of allowable charge for applicable codes for primary bilateral procedures; secondary bilateral procedures are reimbursed at 75% of the allowable charge.
51	Multiple procedures	Generally pays primary or highest allowable procedure at 100% of allowable charge and rest at 50% of allowable charge
52	Reduced services	Allowable charge will be reduced by 20%
53	Discontinued procedure	Pays 50% of allowable charge for applicable codes
54	Surgical care only	Pays 80% of allowable charge for applicable codes
55	Post-operative management only	Pays 20% of allowable charge for applicable codes
56	Pre-operative management only	Pays 10% of allowable charge for applicable codes
57	Decision for surgery	Pays separate allowable charge
59*	Distinct procedural service	May pay separately
62*	Two surgeons	If allowed, pays 120% of allowable charge divided between both surgeons
78	Returns to the operating room for a related procedure during the post-operative period	Pays 80% of allowable charge for applicable codes
80*	Assistant surgeon (physician only)	Pays 20% of allowable charge for applicable codes
81*	Minimum assistant surgeon (physician only)	Pays 20% of allowable charge for applicable codes
82*	Assistant surgeon when qualified resident surgeon not available (physician only)	Pays 20% of allowable charge for applicable codes
AS*	Nurse practitioner, physician assistant or clinical nurse specialist for assistant at surgery	Pays at 85% of assistant surgeon allowable charge for applicable codes
MS	Six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Pay rental amount once every six months after purchase price reached for applicable codes
NU	New equipment	Payment based on purchase allowable charge
RR	Rental	Payment based on rental allowable charge up to purchase allowable charge
SA*	Nurse practitioner or physician assistant rendering service in collaboration with a physician	Pays at 85% of the allowable charge
SB	Nurse midwife	Pays at 85% of the allowable charge
TC*	Technical component	Pays technical component of the allowable charge

*See the end of this section for additional guidelines on how to bill this modifier.

Modifier 22

When using Modifier 22 (unusual procedural services), 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.

Modifier 25

Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. May pay separate allowable charge. Supportive documentation required in medical record.

Modifiers 26 and TC

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:

- Modifier 26 - used when billing separately for the **professional** component of a service.
- Modifier TC - used 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 CMS-1500 claim form. Blue Cross will not separately reimburse technical components associated with hospital inpatient and outpatient services. Reimbursement for these services are included in the hospital's payment.

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 NPI. The referring provider may not receive compensation, directly or indirectly, from the provider who rendered the service.

Modifier 33

Providers can append Modifier 33 to indicate that the screening colonoscopy (45378) was converted to a polypectomy (45388). In this scenario Modifier 33 is appended to 45388 to ensure that the claim is paid correctly. **Modifier 33 will impact how the claim is paid only for colonoscopy procedures**. Modifier 33 should not be applied to nonpreventive colonoscopies (done to evaluate signs, symptoms, follow-up or existing conditions).

Modifier 50 - Billing Single Bilateral Procedures

- **Single Bilateral (Modifier 50)** procedures can anatomically be done bilaterally only once per session.
- **Multiple Bilateral (Modifier 50)** procedures can anatomically be done bilaterally multiple times per session.

Correct submission of a bilateral procedure is the code on one line with Modifier 50 and "1" in the units field. Claim lines submitted with both the LT and RT modifiers will be considered incorrectly billed. Modifier 50 is not applicable to radiology services. For radiology services, please bill the appropriate number of units.

For all professional and facility claims, bilateral procedures are reimbursed as follows:

1. The primary bilateral procedures are reimbursed at 150% of the allowable charge.
2. The secondary bilateral procedures are reimbursed at 75% of the allowable charge.

Proper billing of bilateral procedures ensures correct reimbursement and eliminates the need for refund requests and payment adjustments.

Modifier RT and LT Clarification:

- Modifiers RT and LT are informational modifiers only and should not be used when Modifier 50 applies.
- Modifier 50 should be used to report bilateral procedures that are performed on both sides at the same operative session as a single line item.

Modifier 59

The primary purpose of Modifier 59 is to report two or more procedures that are being performed at different anatomic sites or for different patient encounters by the same provider on the same date of service. This modifier should not be used to bypass an edit unless the proper criteria for its use are met and documentation in the patient's medical record clearly supports this criteria and the use of Modifier 59. Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see Modifier 25.

CMS has established four HCPCS modifiers to define specific subsets for Modifier 59. For professional claims, Blue Cross may allow the same incidental and mutually exclusive edit overrides for modifiers XE, XP, XS and XU as it does for Modifier 59.

- XE - Separate Encounter - A service that is distinct because it occurred during a separate encounter.
- XP - Separate Practitioner - A service that is distinct because it was performed by a different practitioner.
- XS - Separate Structure - A service that is distinct because it was performed on a separate organ structure.
- XU - Unusual Non-Overlapping Service - The use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 62

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% of the allowable charge and divides that amount equally between the two surgeons. Additional assistants not reimbursed and are considered included in the services already paid to the physician(s).

Modifiers 73 and 74 - Discontinued Services *(postponing surgery after patient is prepped)*

- Modifier 73 - used when a procedure is discontinued and anesthesia WAS NOT administered. A 50% reduction is applied to the allowable charge.
- Modifier 74 - used when a procedure is discontinued and anesthesia WAS administered. Blue Cross applies the full allowed amount (no reduction is applied).

Modifiers TA and T1-T9 Site Specific

When billing toe or toenail surgeries, Modifiers TA and T1-T9 are necessary to ensure services are processed and paid correctly.

HCPCS Level II toe Modifiers TA and T1-T9 are anatomical modifiers that describe procedures performed on the right and left foot digits. It is incorrect to additionally append Modifiers LT and/or RT. It is also incorrect to use Modifier 59 and/or Modifier 59 subset "X modifiers" (XE, XS, XP, XU).

Failure to use these modifiers appropriately may result in claims denial. Additionally, post audits will be performed and will result in recoupments if documentation reviewed supports unbundling by incorrect use of Modifiers 59, XE, XS, XP, XU, LT and RT.

Modifiers AS, 80, 81 and 82 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)
- Physician assistants (PA)
- Nurse practitioners (NP)
- Registered nurse first assistants (RNFA)

They should bill under their provider number with Modifier AS when billing for surgical assistant service. They should not use Modifiers 80, 81 or 82. These modifiers should be used by physicians only. Reimbursement will be 85% of the assistant surgeon allowable charge. BCBSLA does not provide additional reimbursement for assistant services provided by certified surgical first assistant (CSFA).

Please Note: FEP member benefits for surgical assistant services provided and billed by qualified non-physician professionals (e.g., RNFAs or PAs) may be provided **as long as such services fall within the scope of the provider's licensure**.

Modifier SA

Nurse practitioners and physician assistants must submit claims for their services using their individual NPI. For nurse practitioners and physician assistants providing services under an urgent care center or emergency room physician number, Modifier SA should be appended to the services billed.

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5.25 MULTIPLE PROCEDURES

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MULTIPLE PROCEDURES

Multiple procedures are procedures performed during the same session/visit. The primary procedure is reimbursed at the allowable charge while the secondary procedure(s) are reimbursed up to 50% of the allowable charge

Modifier 51 can be used to report multiple procedures; however, Blue Cross considers it an informational modifier.

For Bilateral Procedures

Bilateral procedures are considered multiple procedures. To report single and multiple bilateral procedures use Modifier 50. If a session/visit includes a combination of procedures, one code should be used with a bilateral modifier rather than reporting each procedure separately. If procedures are coded separately, Blue Cross may bundle the procedures and apply the appropriate allowable charge.

Additional Multiple Procedure Guidelines

There are special multiple procedure guidelines for the services listed below. Please refer to the following sections:

- Chiropractic and Physical Medicine
- Drug Screening Assays
- Nucleic Acid Probes
- Multiple Service Reduction for Diagnostic Imaging Services

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5.26 MULTIPLE SERVICE REDUCTION FOR DIAGNOSTIC IMAGING SERVICES

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MULTIPLE SERVICE REDUCTION FOR DIAGNOSTIC IMAGING SERVICES

Blue Cross applies multiple service reduction logic to diagnostic imaging radiology services performed for the same patient encounter.

The applicable radiology services are identified by Medicare's diagnostic imaging family groupings as published in the CMS National Physician Fee Schedule Relative Value File. Blue Cross will review and update the list of services following Medicare's annual release of the CMS National Physician Fee Schedule.

For Professional Providers

The multiple service reduction applies to the technical component of diagnostic imaging radiology service.

When more than one radiology service from Medicare's diagnostic imaging family grouping is performed for the same patient encounter:

- The technical component allowable charge for the primary radiology service will be paid at 100% of the allowable charge.
- The technical component for second and subsequent services will be reduced by 50%.
- The primary radiology service will be identified as the code with the highest technical component allowable charge.

For Facility Providers

The multiple service reduction applies to outpatient diagnostic imaging radiology services.

When more than one radiology service from Medicare's diagnostic imaging family grouping is performed for the same patient encounter:

- The allowable charge for the primary radiology service will be paid at 100% of the allowable charge.
- Second and subsequent services will be reduced by 50%.
- The primary service will be identified as the code with the highest allowable charge.

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5.27 NASAL ENDOSCOPY PROCEDURES

NASAL ENDOSCOPY PROCEDURES

For CPT codes 31295-31298, bill Modifier CG on the nasal endoscopy procedure code where the balloon is initially used for appropriate reimbursement for the balloon and related supplies. Modifier CG should not be billed on multiple code lines.

For example, if a bilateral nasal endoscopy was performed of the maxillary and frontal sinuses, the codes and modifiers would be reported as follows:

Code	Modifier	Modifier
31295	50	CG
31296	50	

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5.28 NUCLEIC ACID PROBE SERVICES

NUCLEIC ACID PROBE SERVICES

Nucleic acid probe CPT codes 87471-87801 for the same patient for the same encounter will be subject to a multiple-service reduction effective for dates of service on and after November 1, 2019. The multiple-service reduction will apply as follows:

Individual CPT or HCPCS codes billed with multiple units will be reimbursed based on the allowable charge at:

- 100% for the first and second unit
- 50% for the third unit
- 25% for the fourth unit
- 5% for the fifth or any additional units

Each CPT or HCPCS code will be reimbursed based on the allowable charge at:

- 100% for the initial lab
- 100% for the second lab
- 50% for the third lab
- 25% for the fourth lab
- 5% for the fifth or any additional labs

Clinical editing and medical policy may also affect reimbursement for these codes. To review current medical policy coverage guidelines, access our medical policy index available on iLinkBlue under the "Authorizations" section.

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5.29 NURSE PRACTITIONER AND PHYSICIAN ASSISTANT SERVICES

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NURSE PRACTITIONER AND PHYSICIAN ASSISTANT SERVICES

Nurse practitioners and physician assistants are eligible to participate in our provider networks. The supervising physician must participate in the same networks as the nurse practitioner or physician assistant. Nurse practitioners and physician assistants who join our networks must complete the credentialing process.

Nurse practitioners and physician assistants must submit claims for their services using their individual NPI. Nurse practitioners and physician assistants should use Modifier AS when billing for surgical assistant services. Modifier AS reimbursement will be 85% of the assistant surgeon allowable charge.

For nurse practitioners and physician assistants providing services under an urgent care center or emergency room physician number, Modifier SA should be appended to the services billed.

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5.30 ORDERING/REFERRING PROVIDER REQUIREMENTS

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ORDERING/REFERRING PROVIDER REQUIREMENTS

The ordering/referring provider's first name, last name and NPI are required on all claims for the following provider types. Beginning March 1, 2020, claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information.

- Diagnostic Radiology Center
- Durable Medical Equipment Supplier
- Infusion Therapy
- Laboratory
- Sleep Disorder Clinic/Lab
- Specialty Pharmacy

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

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5.31 PASS-THROUGH BILLING AND BILLING FOR SERVICES NOT RENDERED

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PASS-THROUGH BILLING AND BILLING FOR SERVICES NOT RENDERED

Pass-through billing occurs when the ordering physician, professional provider, facility or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider, facility or ancillary provider. You may only bill for services that you or your staff perform.

Blue Cross does not permit pass-through billing, and you should not bill any pass-through services to our members.

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

1. The service of the performing provider is performed at the ordering provider's place of service and is billed by the ordering provider, or
2. The service is provided by an employee of a physician or other professional provider (e.g., physician assistant, surgical assistant, advanced practice nurse, clinical nurse specialist, certified nurse, midwife or registered first assistant, who is under the direct supervision of the ordering provider) and the service is billed by the ordering provider with use of the appropriate modifier when billing.

Additionally, billing for services not rendered, including lab services, is not permissible. Only the performing provider should bill for the services rendered to their patient.

We do not allow business arrangements of purchasing other entities' receivables, as this type of arrangement creates overpayments and misrepresentations in performing providers' payments.

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5.32 PLACE OF SERVICE

PLACE OF SERVICE

When filing a claim make sure to use the appropriate code for the services rendered. Below is a listing of the place of treatment codes and their descriptions.

POS	Description
01	Pharmacy
02*	Telehealth Provided Other than in Patient's Home **Please Note**: Not valid for BCBSLA claims submissions
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
10*	Telehealth Provided in Patient's Home
11	Office
12	Patient's Home
13	Assisted Living Facility
14	Group Home
15*	Mobile Unit
17	Retail Health Clinic
19*	Office (Off-Campus Outpatient Hospital) **Please Note**: Not valid for BCBSLA claims submissions
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility

POS	Description
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Intellectual Disabilities
55	Residential Substance Use Treatment Center
56	Psychiatric Residential Treatment Center
58	Addiction Facility Partial Hospitalization
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

*See the end of this section for additional guidelines on this place of service.

Place of Service 02

Blue Cross does not consider place of service 02 valid for claims submissions. This helps ensure that the appropriate benefits and reimbursement apply. Use place of service 10 for all direct to consumer (DTC) telehealth services. We define DTC telehealth as telehealth services delivered directly between the provider and patient in their home environment (e.g., residence, workplace, personal space, etc.). Bill non-DTC telehealth with the appropriate place of service based on the member's location when services are provided. For example, if the member is in the inpatient hospital setting when receiving telehealth services, bill place of service 21. Claims billed with place of service 02 may reject. For additional guidelines related to telehealth please refer to Section 5.37 Telemedicine/Telehealth of the *Professional Provider Office Manual*.

Place of Service 10

Use place of service 10 for all direct to consumer (DTC) telehealth services. We define DTC telehealth as telehealth services delivered directly between the provider and patient in their home environment (e.g., residence, workplace, personal space, etc.). For additional guidelines related to telehealth please refer to Section 5.37 Telemedicine/Telehealth of the *Professional Provider Office Manual*.

Place of Service 15

Blue Cross does not consider place of service 15 valid for claims submissions for intraoperative monitoring services. Bill intraoperative monitoring services with the appropriate place of service based on the member's location when services are provided. This helps ensure the appropriate benefits and reimbursement apply. Claims for intraoperative monitoring services billed with place of service 15 may reject.

Place of Service 19

Blue Cross does not consider place of service 19 valid for claims submission. If a service is provided in the "office" setting (see criteria below), place of service 11 should be used. If a service is provided in the "outpatient hospital" setting (on or off campus), place of service 22 should be used.

Place of service 19 should not be used for any services.

Office Setting

Blue Cross follows AMA guidelines regarding the definition of "office" setting; however, Blue Cross also defines "office" setting as:

- Any office space within a hospital or facility which is separately identifiable as a provider's private practice.
- Any office space at a hospital or facility's off-campus or freestanding location which is separately identifiable as a provider's private practice.
- Any services performed in a provider's rented office space within a hospital or facility regardless of who owns the equipment (e.g., radiology, etc.)

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service 11. Place of service 19 should not be used for any services.

Blue Cross does not recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals. For more information, please refer to the Provider Based Billing section of this manual.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.33 PROVIDER-BASED BILLING

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For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

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PROVIDER-BASED BILLING

Blue Cross does not recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals. Under provider-based billing, the office/clinic visit is split into two bills. The facility bills a clinic charge for any facility or technical component on a UB-04 claim form and the professional services are billed separately on a CMS-1500 claim form.

We do not recognize provider-based billing of office services even if the office is located on the hospital campus and/or uses the hospital Tax ID number.

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service "11." A separate facility claim on a UB-04 should not be submitted for a facility or technical fee associated with the office/clinic visit.

Facilities operating provider-based clinics should submit a global bill for all services rendered in the clinic on a CMS-1500 claim form. Payment for the professional provider's services includes any technical or facility fees.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.34 RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CLINIC

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CLINIC

Blue Cross defines a rural health clinic (RHC) as a medical clinic located in a rural (not urban) area for the purpose of providing health care services to persons in the rural area. The purpose is to service an area that does not otherwise have health care services available (medically underserved area). RHCs may be a primary care practice (offers at least one of the following: family practice, general practice, internal medicine or pediatric services).

Blue Cross defines a federally qualified health clinic (FQHC) as a medical clinic located in a rural or urban area for the purpose of providing health care services to persons who are not otherwise eligible for health care coverage and/or in a medically underserved area. FQHCs must provide primary care for all life-cycle ages; therefore, specialty practices such as pediatric- or geriatric-only clinics are not eligible for FQHC status.

We require that each health care professional associated with a RHC or FQHC be individually credentialed, allowing us to identify each provider in our directories. Claims should be reported based on the services provided by each individual health care professional within the clinic. Additionally, the rendering/performing providers NPI must be reported on RHC/FQHC claims.

The allowable charges for RHC and FQHC services are based on each individual performing provider specialty. Use iLinkBlue to view and research your allowable charges.

On the next page are Blue Cross requirements as they apply for RHCs and FQHCs.

Service	Requirement
Authorizations	• Authorizations are required for some services per the member's benefits. See the Medical Management section of this manual for the list of services that require an authorization. You may also use iLinkBlue to verify if services require an authorization or view the list of services that require an authorization in our network speed guides located on our Provider page.
Claims Filing	• Use a CMS-1500 claim form. • File claims electronically through your clearinghouse or iLinkBlue. • Report the individual services performed at the RHC/FQHC. • Report the individual provider's name and NPI as the rendering provider on claims (block 24J of the CMS-1500 claim form or the electronic equivalent). • File claims hardcopy, only when unable to bill electronically. • File ALL applicable diagnosis codes on a claim. It is important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing "not otherwise specified" (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.
Laboratory Services	RHCs and FQHCs that provide laboratory tests/services on site must comply with CLIA requirements for the actual services delivered.
Emergency Care	RHCs must provide medical emergency procedures as a first response to common injuries and acute illnesses, the same as what is commonly provided by a physician's office. FQHCs are required to provide emergency care either on site or through clearly defined arrangements for access to health care for medical emergencies during and after the regularly scheduled hours (24/7).
After-hours Coverage	Network providers are responsible for assuring access of services 24 hours a day, 365 days a year. This includes arrangements to assure coverage after hours by another participating physician.
Member Benefits	Blue Cross applies the member's primary care provider level benefits instead of referral specialist benefits, regardless of the provider type and/or specialty. *Members benefits may vary so please always verify eligibility and benefits prior to rendering services. Member benefits are available anytime on iLinkBlue.*
Credentialing	Refer to the Credentialing Program section of this manual for full information on the individual/professional credentialing process and requirements.
Provider Directories	Each health care professional associated with a RHC or FQHC is separately listed in our provider directories based on their specialty. This is in addition to the RHC/FQHC being listed in our directories.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.35 SLEEP STUDY

SLEEP STUDY

Sleep lab facilities, DME providers and physicians should adhere to the following guidelines when filing claims:

Facility-based Polysomnograms/Sleep Studies

Eligible Sleep Lab Facilities

- Free standing accredited sleep labs (non-hospital based)
- Hospital-based accredited sleep lab

Sleep Studies Payment Eligibility When:

- Services are performed in accredited sleep lab
- Services are medically necessary
- Does not meet criteria for a home sleep study

Authorization and Accreditation Required for Sleep Lab Services

All member policies, issued or renewed, require authorization for sleep lab services. It is required that facility-based sleep studies be performed in an accredited sleep center. Authorizations are not to be issued by Blue Cross to non-accredited sleep lab providers. Use the BCBSLA Authorizations application available in iLinkBlue to obtain authorization for sleep lab services.

InterQual (IQ) criteria are used in the authorization process to determine medical necessity. Unauthorized facility-based sleep study services are not eligible for benefits. Please verify member eligibility for sleep study services as authorization is not a guarantee of benefits.

Please Note: Some self-funded group policies do not require sleep center facilities to be accredited. Some self-funded group policies do not cover any sleep studies. Authorization requirements for sleep studies may differ for self-funded groups. Prior to rendering services, always verify members' benefits and authorization requirements through iLinkBlue to determine applicable benefits and any maximum benefit limitations.

Sleep Lab InterQual Guidelines

When benefits are available, InterQual criteria are used to determine if a sleep lab service is eligible for coverage. Medical records such as progress notes and Epworth sleepiness scales may be required in reviewing authorization requests.

Patients with complicated comorbidities such as heart failure, moderate to severe pulmonary disease, central sleep apnea index of five or greater, super obesity (BMI 50 or greater), impaired dexterity or mobility, cognitive impairment, history of severe obstructive sleep apnea (30 or greater AHI, RDI or REI on previous sleep study), non-diagnostic or unsuccessful home sleep test or limited channel test and neuromuscular disease affecting respiration will be considered for a facility-based sleep study.

Network Requirements & Reimbursement

Sleep centers must meet all credentialing criteria to be eligible for network participation including specific sleep center accreditation by either:

- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

In order for the medical necessity of facility-based sleep studies to be considered for authorization and maximum member benefits, services must be performed by an in-network accredited free-standing or hospital-based sleep lab that has been surveyed and approved by TJC, AASM or ACHC.

For more information regarding the credentialing process, visit our Provider page or call Provider Credentialing & Data Management.

Coding and Claims Filing

Total or technical-only components are allowed if billed by an accredited sleep lab and are medically necessary based on IQ criteria.

The professional component of a medically necessary facility-based sleep study may be billed by a physician in accordance with CPT guidelines.

Free-standing sleep centers and rehabilitation and long term acute care facilities with sleep labs should use the "office" setting place of service 11 along with their Blue Cross sleep studies provider number when filing claims.

Acute care hospital-based sleep labs should use "outpatient hospital" as the place of service 22 and the hospital's Blue Cross acute care provider number when filing claims. Please do not use other ancillary provider numbers, such as "rehab." Sleep study services filed with a provider number other than the hospital's acute care provider number will not be considered as eligible providers for sleep lab services.

Sleep lab facilities should use the appropriate CPT or HCPCS codes when submitting sleep study services.

HOME SLEEP STUDY SERVICES FOR OBSTRUCTIVE SLEEP APNEA (OSA)

When benefits are available, Blue Cross considers home sleep studies to be eligible for coverage. Home Sleep Studies (HST) do NOT require authorization, except for a few ASO groups. Always verify the member's prior authorization requirements prior to providing services.

Patients without any type of comorbidities and who are over the age of 18 will be directed to a HST.

Uncomplicated OSA patients diagnosed with a HST will be required to utilize an APAP (Auto-titrating/ Auto-adjusting CPAP) trial in the home setting.

Billing Guidelines for Home Sleep Study Services for OSA

Use the guidelines below to ensure proper reimbursement and avoid denied or returned claims. Always verify member benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.

Home sleep study claims for studies using Peripheral Arterial Tone technology (e.g., WatchPAT®) should be billed with CPT code 95800. All other home sleep study claims should be billed with HCPCS code G0398 or G0399.

Credentialing Requirements for Network DME Providers Performing Home Sleep Studies

Blue Cross recognizes two types of durable medical equipment (DME) providers; full-service DME providers and sleep study DME providers. A full list of acceptable accreditation organizations for full service DME providers can be found in the Durable Medical Equipment/Home Medical Equipment section of this manual.

Blue Cross requires that sleep study DME providers must be accredited by at least one of the following organizations in order to participate in our provider networks:

- The Joint Commission (TJC);
- American Academy of Sleep Medicine (AASM); or
- Accreditation Commission for Healthcare (ACHC)

For additional DME requirements, please see the DME section of this manual.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.36 SPECIALTY PHARMACY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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SPECIALTY PHARMACY

Specialty pharmacy typically involves the use of specialized therapeutics and biologicals for chronic, complex and/or rare diseases, ordered by a health care professional as defined by the plan.

Specialty pharmacy generally includes injectables, infusion therapies and certain oral medications that require complex and/or advanced care methodologies. Examples of major conditions these drugs treat include, but are not limited to, cancer, rheumatoid arthritis, multiple sclerosis and hemophilia.

Specialty pharmacy providers should adhere to the following guidelines when filing claims for members regardless of the date of service.

- Specialty pharmacies must be directly contracted with Express Scripts, Inc. (ESI) before consideration for participation in our networks can be made.
- Specialty pharmacy services that are covered under the Blue member's medical benefits should be filed directly to the local Blue Plan as determined by the referring/ordering physician's location, on a CMS-1500 claim form or 837 Professional Electronic Submission.
  - Report HCPCS and NDC-11 for the appropriate specialty pharmacy drug(s)
  - Include appropriate diagnosis coding to the highest level of specificity. Non-specific diagnosis may cause delay in claims adjudication.
  - Do not report administration fees separately
  - Do not report supplies separately
- Specialty pharmacy services that are covered through the Blue member's pharmacy benefits should be filed directly to their pharmacy carrier.
- The referring physician must be a Louisiana provider to file claims directly to Blue Cross.
- The referring physician NPI number must be included on Block 17B of the CMS-1500 claim form or loop 2310A on electronic submissions. Failure to include the referring/ordering physician NPI will result in your claims being returned without adjudication.
- An authorization for services may be required per the member's benefits.
- Blue Cross reviews the reimbursement of our drug code pricing biannually. Providers are notified 90 days prior to the effective date of reimbursement changes.

Ancillary Billing Guidelines for BlueCard® Claims

Ancillary Provider - Specialty pharmacies located within Blue Cross' service area are classified as ancillary providers as they have a unique opportunity to contract with other Blue plans and provide services outside of Louisiana.

Remote Provider - Specialty pharmacies located outside of Blue Cross' service area that are contracted with BCBSLA under a license agreement to act as a local provider solely for services rendered in our service area.

Where to File Claims

- The local plan is determined as the plan in whose service area the referring/ordering physician is located.
- If a remote provider contract is in place with the local plan, the claim must be filed to that plan, and it would be considered a participating provider claim.
- If a remote provider contract is not in place with the local plan, the claim must be filed to that plan, and it would be considered a nonparticipating provider claim.

Examples

Example 1: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Tennessee. The drug is ordered by a Tennessee provider. The drug is then shipped to the Blue Cross member living in Tennessee. The claim should be filed in Tennessee; the service area where the drug was ordered based on the ordering physician's location.

Example 2: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Louisiana but who has a referring/ordering physician in Texas. The drug ordered by the Texas physician would be filed to Texas.

Example 3: A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a Blue Cross member who lives in Louisiana and who has a referring/ordering physician in Louisiana. The drug ordered by the Louisiana physician would be filed to Louisiana.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.37 TELEMEDICINE/TELEHEALTH

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TELEMEDICINE/TELEHEALTH

Coverage is subject to the terms, conditions and limitations of an individual member contract and policy criteria listed below. For the purposes of this policy, the terms telemedicine and telehealth are used interchangeably.

Description

Blue Cross considers telehealth services as the health care delivery, diagnosis, consultation, treatment and transfer of medical data using interactive telecommunication technology that enables the network provider and the member at two locations separated by distance to interact via synchronous (real-time) audio or audiovisual telecommunication systems. Telehealth does not include the use of text-only telephone communication, facsimile machine, email, mobile applications and/or any other non-secure electronic communication. Please Note: Synchronous text communication may be acceptable for patients with disabilities.

Telehealth is used to support health care when the provider and patient are physically separated. Typically, the patient communicates with the provider via an interactive means that is sufficient to establish the necessary link to the provider who is working at a different location from the patient. This section documents Blue Cross' position on services defined as telehealth and identifies when these services may be eligible for reimbursement.

If you have questions or feedback about Blue Cross' telehealth policies, please contact our Provider Relations Department at provider.relations@bcbsla.com.

Definitions

- Asynchronous Telehealth Services – The transmission of a patient's pre-recorded medical information from an originating site to the provider at a distant site without the patient being present.
- Direct to Consumer (DTC) Telehealth Services – Telehealth services delivered directly between the network provider and patient in their home environment (e.g., residence, work place, personal space, etc.).
- Hybrid Telehealth Encounter – Telehealth service encounter in which a patient is seen both virtually and in-person for the same episode of care. Example scenarios and how to bill for hybrid visits are further defined in this policy.
- Synchronous Telehealth Services – The interaction between patient and provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.
- Telehealth Services – A mode of delivering health care services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from health care providers approved by us to render telehealth services. Telehealth services give providers the ability to render services when provider and patient are in separate locations.

Policy

Reimbursement for telehealth services may be available when provided through BlueCare (Blue Cross' telehealth platform) or when provided by a network provider utilizing their own telehealth platform, however, the billing rules may be different for each scenario, as discussed in the Coding and Billing section below.

Blue Cross adheres to the rules and regulations outlined by the Louisiana Board of Medical Examiners; specifically, Title 46, Section 7513 regarding telehealth prohibitions. More information is available online - go to www.lsbme.la.gov, choose the "Rules" menu option, then click on "Physicians." Provider types performing telehealth services must ensure the delivery of telehealth is within their respective scope and guidance of their relevant licensing and/or certifying boards.

The appropriate place of service is based on where the member is located when the service is performed except when performing DTC telehealth services (place of service 10 should be used for DTC). For example, if the member is in the inpatient hospital setting when the telehealth service is performed, place of service 21 should be billed. To ensure the appropriate benefits and reimbursement apply, do not bill place of service 02 to Blue Cross for telehealth services. Blue Cross does not consider place of service 02 valid for claims submission. Claims billed with place of service 02 may reject.

1. Reimbursement for telehealth services is limited to services involving the use of interactive audio-video electronic media for the purpose of diagnosis, consultation or treatment, and for those codes as listed in these guidelines.

2. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering in-person services at the presentation/origination site should report the appropriate code for the in-person services.

- Telehealth services rendered by provider types not authorized by Blue Cross are not eligible for reimbursement. Blue Cross supports the reimbursement of telehealth delivery in the ambulatory and non-ambulatory settings for the following provider types:

    - Physicians (MD/DO)
    - Midlevel providers (PA/APRN/Midwife)
    - Chiropractors
    - Podiatrists
    - Medical Psychologist
    - Social Worker
    - Psychologist
    - Counselor (LPC)
    - Dietitian/Nutritionist (RD)
    - Occupational Therapist
    - Speech and Language Therapist
    - Physical Therapist

    Telehealth services (codes, POS and modifiers) are further defined in this policy based on scope of practice, acceptable modes of delivery (ex. audio only) and place of service and modifiers.

All provider types performing telehealth services must ensure the delivery of telehealth is within their respective scope and guidance of their relevant licensing and/or certifying boards. Telehealth services that are not within the scope of the provider's license or fail to meet any standard of care compared to an in-person visit are not eligible for reimbursement. Providers must follow the Health and Human Services Office of Civil Rights (OCR) recommendations regarding security and HIPAA compliant telehealth platforms.

3. The following are examples of services that are not eligible for reimbursement as telehealth services:
   - Non-direct patient services (e.g., coordination of care rendered before or after patient interaction).
   - Services rendered by text-only telephone communication, facsimile, email, mobile applications and/or any other non-secure electronic communication. Please Note: Synchronous text communication may be acceptable for patients with disabilities.
   - In many cases, telehealth is not separately billable during the same episode of care that an in-person service is provided.
   - Triage to assess the appropriate place of service and/or appropriate provider type.
   - Any services that are not eligible for separate reimbursement when rendered to the patient in-person. Examples include routine medication refills, routine follow up calls solely for the delivery of test results, or incidental to a recent patient encounter.
   - Patient communications incidental to E&M, counseling or medical services covered by the member's policy.
   - Presentation/origination site facility fee.
   - Services/codes that are not specifically listed in this section.
4. CPT documentation requirements state that the extent of any E&M services provided over the telehealth technology includes problem-focused history and straightforward medical decision-making, as defined by the current version of the CPT manual.
5. The telehealth encounter must be fully documented (including all supporting diagnosis codes) in the patient's medical record, just as if the patient were seen in person.
   - For new patients, the provider must establish a medical history.
   - For existing patients, the provider must maintain and update the member's medical history.
   - If the attending provider is not the patient's primary care provider (PCP), the patient's medical records should be made available to the patient's PCP.
   - The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant health care regulatory board of the state where the patient is physically located.
   - The provider must document any deviation from standard of care delivered in an in-person encounter along with actions taken to fulfill gaps resulting from virtual delivery.

6. The attending provider must be licensed to practice in the state where the member is located.
7. The attending provider must be able to prescribe medication, as applicable, or have staff on hand that can prescribe medication in the state where the member is located.
8. Use the most specific diagnosis codes(s) when filing the claim.
9. Prescribing controlled substances during a telehealth encounter is prohibited unless they have had an in-person examination of patient prior to a telehealth encounter. Provider must also ensure the prescribing of controlled substances through telehealth is within the respective scope and guidance of their relevant licensing and/or certifying boards as well as Blue Cross policy on medications (e.g., opioids policy).
10. Reimbursement for telehealth services are based on each performing provider's agreed-upon Allowable Charge and the member's applicable benefits.
11. Providers must obtain verbal or written consent to treat from patients. It is acceptable to use an electronic confirmation noted in the patient medical record for each billing cycle.

Direct to Consumer (DTC) Telehealth Coding and Billing

Reimbursement for telehealth services may be available when provided by a Blue Cross provider utilizing their own telehealth platform/technology. These DTC telehealth coding and billing guidelines do not apply to physician telehealth consultation/services rendered in a facility setting. Authorizations are required for some services per the member's benefits. Use iLinkBlue to verify member benefits to determine if services require an authorization or that the member has telehealth benefits.

Those providers providing DTC telehealth services utilizing their own telehealth platform/technology, the CPT/HCPCS codes listed in this section must include Modifier GT or 95 (whichever is appropriate) to indicate a telehealth encounter was performed using real-time audiovisual technology. For audio-only telehealth services, CPT/HCPCS codes must include Modifier 93. Use place of service 10 for all DTC telehealth services.

The following codes are included in the program and are reimbursable only if they are services within the scope of an individual provider's license.

Category	Code
Office & Outpatient Visits (E&M)	99201-99205, 99211-99215
Wellness & Preventive E&M	99381-99387, 99391-99397
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 96156, 96158, 96160-96161
Applied Behavioral Analysis (ABA)	97151*, 97152*, 97153*, 97154*, 97155*, 97156*, 97157*, 97158*
Physical Therapy, Occupational Therapy and Speech Therapy	92507, 92521, 92522, 92523-92524, 92526, 92610, 96105, 97110*, 97112*, 97116*, 97161*, 97162*, 97164*, 97165*, 97166*, 97168*, 97530*, 97535*
Preventive Medicine Counseling	99401-99404
Transitional Care Management	99495, 99496
Diabetes Management	G0108-G0109
Dietary & Nutritional Therapy	97802-97804, G0270-G0271
Obesity Counseling	G0447
Alcohol & Substance Abuse Screening	99408, 99409, G0442, G0443
Smoking Cessation & Tobacco Counseling	99406-99407
Sexually Transmitted Infections & High-intensity Behavioral Counseling	G0445

Codes listed above with an asterisk (*) may be billed as audiovisual telehealth services only. All other listed codes can be billed as audiovisual or audio-only telehealth services. DTC telehealth claims billed with codes that are not specifically listed above are not eligible for reimbursement as telehealth services and may not be billed to the member.

Audio-only Telehealth

Audio-only telehealth visits can only be used if both of the following criteria is met and fully documented by the provider in the patient's medical record:

- Member is unable to connect via audio-video transmission due to lack of access to adequate technology (e.g., Wi-Fi, smart device, etc.); AND
- Provider can achieve the same quality of care as an audio-video telehealth visit.

Asynchronous Telehealth – Remote Evaluation of Pre-recorded Patient Information

Reimbursement for asynchronous telehealth services is only available for established patients, through a face-to-face examination (either in person or via virtual care). Store forward or asynchronous telehealth services between an established patient and their provider may take place when an established patient sends pre-recorded video or images to a provider via platforms compliant with OCR recommendations regarding HIPAA compliant communication at the provider's request, or when the data is transferred between two Providers on the patient's behalf.

Asynchronous telehealth services must be filed with HCPCS code G2010 and meet the following criteria, and may be filed with Modifier GT or 95:

1. Must not be part of a bundled payment option.
2. The service does not originate from a related E&M service provided within the previous seven days.
3. The service does not lead to an E&M service or procedure within the next 24 hours or soonest available appointment.

Asynchronous telehealth service can be provided as a follow up within 24 hours. Follow up is acceptable when administered via HIPAA-compliant communication.

Hybrid Telehealth

Hybrid telehealth visits include both a telehealth visit and an in-person visit to complete the entire episode of care. The visits may occur on the same day or within a few days period. This includes the following scenarios:

1. A telehealth encounter that converts to an in-person E&M visit.
    - The telehealth encounter is finished with an in-person visit (e.g., hospital, doctor's office) to complete the examination, medical decision making or treatment plan. In this scenario, the telehealth encounter does NOT meet the criteria as a stand-alone patient encounter and must convert to in-person encounter.
    - Bill using the most appropriate CPT E&M code that describes all the visits as a single encounter.

- Bill the encounter as taking place in the in-person setting. Use the appropriate place of service for the in-person visit.
- Do NOT bill with Modifier GT or 95.

2. A telehealth encounter with an additional non-E&M in-person service.
   - After the telehealth visit is completed, the patient visits the provider's office or other setting to obtain a non-E&M service or test (e.g., EKG, labs, X-ray, etc.). In this scenario, the provider bills for the telehealth visit and the in-person portion.
   - Bill the telehealth encounter using the most appropriate CPT E&M code.
   - Bill the telehealth encounter with Modifier GT or 95.
   - Bill the non-E&M services or tests with the appropriate CPT code(s) and place of service code.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.38 URGENT CARE CENTERS

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URGENT CARE CENTERS

Blue Cross recognizes urgent care centers as establishments that are similar to physician offices. We realize that physicians could rotate out of the office; therefore, we contract with urgent care centers and do not contract individually with any physician who may practice at the center.

An urgent care center is a center with extended office hours that provides urgent and minor emergency care to patients on an unscheduled basis without the need for an appointment. Blue Cross requires urgent care centers to have hours of operation that include: open until at least 8 p.m. Monday through Friday; open at least eight hours Saturday or Sunday. The urgent care center cannot be part of a participating network primary care physician or specialist's regular practice or a hospital emergency room. The urgent care center does not provide routine follow-up care or wellness examinations. Patients will be referred (through the normal referral process) back to their primary physician for such follow-up care.

Urgent care is defined as a sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of urgent care or routine care that do not qualify as emergencies include: colds and flu, sprains, stomach aches, nausea, etc.

Reimbursement for services provided in the urgent care center setting is consistent with the reimbursement for services rendered in a physician's office. CPT/HCPCS codes are used to identify the services performed, and the CMS-1500 claim form or the electronic equivalent is used to submit a claim for reimbursement. Blue Cross does not recognize, nor do we reimburse separately for a "facility fee" or "treatment room" fee in these settings as this is included in the overhead component of the professional service(s) the member is receiving. Consistent with our policies regarding services that are an integral part of another service, there should be no separate charge to the member for a "facility fee" or "treatment room" fee.

S9088 – This code may be listed in addition to the code for service. Urgent care centers should not bill this code for a "facility fee" or "treatment room" fee. The intent of this code is informational only and identifies the setting or place of treatment where the urgent care was performed. S9088 will not be separately reimbursed nor should the member be billed for this code. This is consistent with our policies regarding services that are an integral part of another service.

New Patient Visit

New visit CPT codes 99202-99205 will deny if the patient has been seen by the same urgent care center within three years from the date of the previous evaluation and management visit.

Modifier SA

For nurse practitioners and physician assistants providing services under an urgent care center, Modifier SA should be appended to the services billed.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

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5.39 COLONOSCOPY MULTIPLE PROCEDURE REDUCTION

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COLONOSCOPY MULTIPLE PROCEDURE REDUCTION

Effective for dates of service on and after October 1, 2020, Blue Cross will apply a multiple procedure reduction to colonoscopy codes assigned to the Centers for Medicare & Medicaid Services (CMS) endoscopy family with base CPT code 45378.

When multiple colonoscopy procedures assigned to CMS endoscopy family base code 45378 are performed on the same day, the multiple procedure reduction will apply as follows:

- The highest valued procedure from the family will be the primary endoscopy code reimbursed at 100% of the allowable charge.
- Any additional codes in the family will be reimbursed at 10% of the allowable charge.

If these colonoscopy procedures are billed on the same day as other procedures that are subject to a multiple procedure reduction, the primary endoscopy code may be subject to a multiple procedure reduction. As outlined in the Multiple Procedures section of this manual, the highest valued procedure will be the primary procedure reimbursed at 100% of the allowable charge, while secondary procedures will be reimbursed up to 50% of the allowable charge. Endoscopy procedures reimbursed at 10% of the allowable charge for the colonoscopy multiple procedure reduction will not be subject to additional multiple procedure reductions.

Claims Example

Code	Modifier	Allowable*	Allowable with Multiple Procedure Reductions Applied	Percentage of Allowable Applied	CMS Endoscopy Base Code
43239		$150	$75	50%	43235
45385		$300	$300	100%	45378
45380	59	$250	$25	10%	45378

*The allowable charges used in the calculation examples are for ease of illustration purposes only.

The colonoscopy multiple procedure reduction will only apply to the two codes with CMS endoscopy family base 45378. Since 45385 has the highest allowable of the two codes, it will be the primary endoscopy code reimbursed at 100% of the allowable charge, and 45380 will be reimbursed at 10% of the allowable charge.

Code 43239 was also billed on the claim example. This will require codes 43239 and 45385 to be evaluated for a multiple procedure reduction. Since 45385 has a higher allowable than 43239, 45385 will be reimbursed at 100% of the allowable charge and 43239 will be reimbursed at 50% of the allowable charge. Code 45380 will not be subject to an additional multiple procedure reduction since it was reimbursed at 10% for the colonoscopy multiple procedure reduction.

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5.40 PHARMACEUTICAL WASTE

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PHARMACEUTICAL WASTE

Blue Cross expects providers to avoid pharmaceutical wastage by appropriately using the most cost-effective vial or combination of vials to deliver a medically appropriate dosage to the member. There are two types of vials/packages:

- Single-dose: A drug or biologic package where only one dose can be taken for administration.
- Multi-dose: A drug or biologic package where more than one dose can be taken for administration.

Pharmaceutical waste refers to the amount of discarded drug or biologic not administered to any patient. A multi-dose vial\package will not be reimbursed for pharmaceutical waste; however, a single-dose vial\package may be eligible for reimbursement if the actual dose administered from a single-dose vial is more than the unit of measure represented by the HCPCS code.

For pharmaceutical waste to be eligible for reimbursement, the following criteria must be met:

- The administered dose plus the wasted dose must not exceed the vial\package amount.
- The administered dose must be more than the unit of measure represented by the HCPCS code.
- The drug or biologic package must not be available in a multi-dose form.
- The discarded drug or biologic must not be administered to another patient.
- The discarded drug or biologic must not be due to contamination, expiration, improper storage, improper administration, manufacturer defect, shipping damage or spillage\breakage.

The patient's record must have the following items documented:

- The amount of the drug\biologic administered to the patient along with the date and time it was administered.
- The amount of the drug\biologic discarded along with the reason for the wastage.

Modifier JW

The amount of pharmaceutical waste from a single-dose vial (SDV) should be reported on a separate line with Modifier JW to receive reimbursement.

For example: if 275 milligrams (mg) of a drug is administered, the HCPCS code indicates that 10 mg equals one billing unit. The drug is available in a single-use 150-mg vial. Therefore, the provider would bill 28 units of the HCPCS code on one claim line followed by two units of the HCPCS code with Modifier JW appended on the second claim line.

Or, if 80 mg of a drug is administered, and the HCPCS code indicates that 100 mg equals one billing unit. The drug is available in a single-use 100-mg vial. Therefore, the provider would bill one unit of the HCPCS code on one claim line, and the 20 mg of pharmaceutical wastage would not be billed separately since it would result in overpayment.

Minimizing Wastage

Blue Cross expects the provider to minimize wastage by using the most cost-effective vial\package or combination of vials\packages to deliver a medically appropriate dosage to the member.

For example, if the provider needs to administer 30 units of a drug where 10- and 50-unit, single-dose vials are available, the expectation is for the provider to use three of the 10-unit vials as opposed to one 50-unit vial. The first option would result in no wastage as opposed to the second option having 20 units of wastage.

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

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5.41 MASS IMMUNIZERS

MASS IMMUNIZERS

Mass immunizers are providers who only administer vaccines and immunizations. Blue Cross allows the following codes for mass immunizers. Mass immunizers shall indemnify and hold harmless both Blue Cross and member(s) for any billed charges for vaccine administration and immunization CPT/HCPCS not listed herein.

0001A	0054A	90672
0002A	0064A	90674
0003A	0071A	90682
0004A	0072A	90685
0011A	0073A	90686
0012A	90460	90687
0013A	90471	90688
0021A	90472	90694
0022A	90473	90715
0031A	90651	90732
0034A	90653	90734
0051A	90658	90736
0052A	90662	90756
0053A	90670	G0008

SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.42 DIGITAL HEALTH

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REMOTE PATIENT MANAGEMENT SERVICES

Remote patient management involves the collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. Providers should adhere to the billing guidelines below for remote patient management services.

Provider Requirements

Reimbursement for remote patient management is only available for established patients. Services can be ordered by medical doctors, doctors of osteopathic medicine, nurse practitioners or physician assistants.

Services must be provided by an in-network provider, qualified health care professional or plan contracted resource. Provider types performing remote patient management services must ensure the delivery of services is within their respective scope and guidance of their relevant licensing and/or certifying boards.

Remote patient management is a provider service. Services are not considered to be diagnostic tests. They cannot be furnished and billed by an independent diagnostic testing facility on the order of the provider.

Patient Consent

A patient must consent to remote patient management prior to or at the time services are furnished. The consent can be obtained by individuals under contract with the billing provider.

Remote Patient Monitoring Devices

A remote patient monitoring device must meet the FDA's definition of a medical device. The device must be digitally capable of uploading patient physiologic data to care team in real-time.

- Data cannot be self-recorded or self-reported by the patient.
- Use of a device to digitally collect and transmit a patient's physiologic data must be reasonable and necessary for the diagnosis or treatment of the patient's illness or injury or to improve the functioning of a malformed body member.
- Device must be used to collect and transmit reliable and valid physiologic data that allow understanding of the patient's current health status to develop and manage a plan of treatment.
- Devices and programs should be applicable to all federal, state and local mandates for privacy and safety.

The following criteria applies for remote patient monitoring device billing:

- The device must be supplied by the ordering provider or contracted DME provider.
- The provider can only bill for the device (99454) when they supply it.
- Two different providers are not allowed to bill for the same service and diagnosis, during the same time period.

- Only FDA approved remote patient monitoring devices shall be considered acceptable.
- Smart watches, Fitbits and other fitness trackers, as well as similar multifunction monitoring (non-medical) devices that are FDA approved for a metric are not considered acceptable.

Monitoring and Reporting Duration

A remote patient monitoring device must monitor and report on at least 16 days of a 30 day period to bill for services. Reporting of data to the provider must be automatic (not dependent upon patient manually uploading data).

Coding and Billing

The following codes are reimbursable for remote patient management and remote patient monitoring devices.

CPT Code	Limitations
99453	Once per lifetime
99454	Once per month
99457	Once per month
99458	Three diagnosis per month

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Section 6: OTHER COVERAGE

COORDINATION OF BENEFITS

Coordination of benefits (COB) applies to members who are covered by more than one health insurance plan.

When COB is involved, claims should be filed with the primary health insurance carrier first. When an explanation of benefits (EOB) is received from the primary health insurance carrier, the claim then should be filed with the secondary health insurance carrier, attaching the primary carrier's EOB.

If claims are filed with the primary and secondary health insurance carriers at the same time and Blue Cross is the secondary carrier, Blue Cross will suspend claims and request other coverage information from the member. Once a rejection appears on the Payment Register/Remittance Advice, the patient may be billed for the total charge.

Pursuant to state law, the provider is required to submit to Blue Cross any information it obtains regarding other coverage that may be available to the member. In addition, the law prohibits Blue Cross from denying or delaying payment of claims solely due to waiting to receive other coverage information.

You can assist in the COB process by indicating your Blue Cross patients' other coverage information in Block 9 on the CMS-1500 claim form and Block 50 on the UB-04 claim form. In addition, BCBSLA's Other Coverage Questionnaire is available online on our Provider page. Please provide this form to any patient who has other health insurance coverage.

Medicare Primary Coordination of Benefits for OGB

For OGB members, Blue Cross coordinates with Medicare like we do with any other carrier that is the primary carrier.

SUBROGATION

Subrogation is defined in the Blue Cross member contracts. Subrogation allows health insurers to recover all or a portion of claims payments if the member 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 submitted to Blue Cross must indicate if they are related to an accident or if work-related injuries or illnesses are involved.

Providers should:

- Not require the Blue Cross member or the member's attorney to guarantee payment of the entire billed charge.
- Not require the Blue Cross member to pay the entire billed charge up front.
- Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge.
- Charge the member no more than is ordinarily charged other patients for the same or similar service.
- Bill the member only for any applicable cost share (deductible, coinsurance, copayment) and/or noncovered service.

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

Please note that we do not coordinate benefits with third party liability carriers.

EMPLOYMENT-RELATED INJURIES OR ILLNESS

There are generally three types of legal remedies available to members who sustain employment-related injuries or illnesses:

- Workers' Compensation under state law – A state law provides certain benefits to an employee who is injured within the course and scope of employment.
- Longshore and Harbor Workers' Compensation Act (LHWCA) – A federal law that provides for the payment of medical care to employees disabled from on the job injuries that occur on the navigable waters of the United States, or in adjoining areas, customarily used in loading, unloading, repairing or building of a vessel.
- Jones Act – A federal law that provides remedies only to "seamen" who are injured while working on a vessel.

Blue Cross does not make any coverage determinations as to which legal remedy would apply to a member's injury. All claims for covered services, including those claims for which a third-party may be liable, must be filed directly to Blue Cross. This is important because if the service is determined not to be covered under these legal remedies or the particular contract does not exclude these types of services, you risk any future consideration by failing to meet administrative timely filing requirements by not filing the claims with Blue Cross. Please note that when you do file an initial claim, the current administrative claims process may deny the claim for employment related injuries; however, if it is later determined that the service is not covered by these legal remedies or the particular contract does not exclude these types of services, we encourage and expect you to contact the Customer Care Center so that we can work with your office to apply the appropriate member benefits.

MEDICARE SUPPLEMENTAL CLAIMS

In order to reduce the administrative expense and time involved with manual claims submission, in most cases, Medicare supplemental claims will automatically cross over to Blue Cross and you do not need to file a claim for the Blue Cross portion to be processed.

For BlueCard BCBS Members

Blue Plans may receive crossover claims for providers who are not within their state boundaries. All claims for BlueCard members will be processed by the BlueCard member's Plan listed on the member ID card.

Provider Information at Medicare and Blue Cross

To further ensure eligible Medicare supplemental claims cross over from Medicare to Blue Cross successfully, please notify us immediately of the following:

- If you have a new Tax ID number, or
- If you have not previously given Blue Cross your NPI, you must do before filing claims including your NPI. The Claims Submission section of this manual includes instructions for notifying Blue Cross of your NPI.

How to Determine if the Claim was Crossed Over from Medicare

If a claim is crossed over, you will receive a message beneath the patient's claim information on the Payment Register/Remittance Advice that indicates the claim was forwarded to the carrier.

Example 1: "Claim information forwarded to: BCBS of Louisiana-Supplemental

Example 2: "Claim information forwarded to: BCBS of Alabama

When a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting a claim to Blue Cross and Blue Shield of Louisiana. Claims you submit to the Medicare intermediary will be crossed over to Blue Cross only after they have been processed by Medicare. This process may take approximately 14 business days to occur. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days from the crossover for you to receive payment or instructions from Blue Cross.

If the remittance does not contain a message similar to the above, the claim was not crossed over to the payor. The participating provider must then file the claim along with a copy of the Medicare Remittance Advice. This claim must be filed on paper to the Plan listed on the member ID card.

The following claims are excluded from the crossover process for Blue Cross:

- Original Medicare claims paid at 100%
- 100% denied claims with no additional beneficiary liability
- Adjustment claims that are non-monetary/statistical
- Medicare Secondary Payer (MSP); claims for which other insurance exists for beneficiary
- National Council for Prescription Drug Programs (NCPDP) claims

When the Claim WAS NOT Crossed Over from Medicare

For Louisiana claims that did not crossover automatically (except for Statutory Exclusions), the provider should wait **31 days** from the date shown on the Medicare remittance to resubmit the claim. Claims submitted before 31 days will be rejected on the Blue Cross and Blue Shield of Louisiana Not Accepted Report.

After 31 days, the claim that did not crossover can be submitted electronically in the 837 format (if sending through a clearinghouse, verify your clearinghouse allows the electronic submission of these claims) or on a paper claim form (CMS-1500 or UB-04) along with a copy of the Medicare remittance advice.

Follow-up on Crossover Claims

Blue Cross Blue Shield of Louisiana:

- Wait 21 days before conducting follow-up on iLinkBlue

Blue Cross Blue Shield out-of-state plans:

- Wait 30 days before contacting the out-of-state plan

Services Excluded or Not Covered by Medicare

When a charge is considered excluded or not covered, providers are not required to wait the 31 days to file the claim. The claim should contain Modifier GY with the specific, appropriate, HCPCS code, if available. If there is not a specific HCPCS code, a not otherwise classified (NOC) code must be used with Modifier GY.

These claims can be filed electronically or on paper to Blue Cross and Blue Shield of Louisiana.

Medicare Payment Rules for Consultation Services

Medicare no longer recognizes consultation CPT codes 99241-99245 and 99251-99255. This applies for both Medicare-primary and Medicare-secondary claims.

Please Note: We have current allowable charges for these codes and any changes in allowable amounts or billing policies for these codes will be communicated to our providers with a 90-day notice. At this time, we do not anticipate any changes.

Per CMS, physicians and others must bill an appropriate E&M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

1. Bill the primary payer an E&M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E&M code, to Medicare for determination of whether a payment is due; or
2. Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E&M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Please Note: The first option may be easier from a billing and claims processing perspective.

For more on this from CMS, visit their website.

If you have any questions or require additional information on Medicare supplemental claims, please contact Customer Care Center.

Medicare Benefit Exhaust Claims Requirements

Member has Medicare Parts A & B

When a member has Medicare Parts A & B and has exhausted Part A benefits in the middle of a hospital admission or the entire hospital admission is exhausted, the required information for Medicare exhaust claims should include the following:

- UB-04 claim form with Medicare Part A charges and the paid/exhausted Medicare EOB that matches these charges.
- UB-04 claim form for Medicare Part A charges beginning with the date Medicare benefits were exhausted. It cannot include dates before the exhaust date.
- Copy of medical records.
- UB-04 claim form with Medicare Part B charges after the exhaust date and the Medicare EOB that matches these charges.

Member has Medicare Part A only

When a member has Medicare Part A only and has exhausted Part A benefits in the middle of a hospital admission or the entire admission is exhausted, the required information for Medicare exhaust claims should include the following:

- UB-04 claim form with Medicare Part A charges and the paid/exhausted Medicare EOB that matches these charges.
- UB-04 claim form for Medicare Part A charges beginning with the date Medicare benefits were exhausted. It cannot include dates before the exhaust date.
- Copy of medical records.

Member has Medicare Part B only

When a member has Medicare Part B only the provider should file two claims. (The Part A claim will come to Blue Cross for primary payment. The Part B claim will be sent to Medicare for primary payment. Once Medicare B has processed, then the claim will be filed to Blue Cross with a copy of the MEOB that matches the charges billed for secondary payment.)

The Part A claim must include the following:

- UB-04 form not to include any Part B charges.
- Copy of medical records.

SECTION 7: CLAIMS SUBMISSION

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This section provides information about claims submission. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

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Section 7: CLAIMS SUBMISSION

FILING CLAIMS

As a participating provider, you agree to submit claims for Blue Cross and Blue Shield members on the CMS-1500 Health Insurance Claim Form. These forms may be submitted electronically through iLinkBlue or mailed hardcopy. All applicable information should be completed in full, including CPT codes, ICD-10-CM diagnosis codes and applicable medical records to support the use of modifiers or unlisted codes with a charge greater than $500 to ensure payment is made to you accurately and without delay.

Claims should include all services rendered during the visit, using a place of service designation, such as 11 for office. Our reimbursement allowable for the E&M service includes the components for physician work, practice expense and malpractice insurance. No additional room usage charge should be billed by any party, since the practice expense component includes overhead expenses, and is an integral part in the E&M or procedure allowable charge. This methodology applies to hospital owned and physician owned practices, and helps ensure that contractual benefits for our members are correctly applied to claims.

An example CMS-1500 claim form and instructions on completing are provided in Appendix II Forms of this manual.

CMS-1500 CLAIM 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 are scanned properly, which will allow you to benefit from faster, more accurate claims processing:

- Blue Cross does not accept black and white hardcopy claim forms. Do not submit black and white copies, as data recognition can be affected and may delay the processing of claim payments. Black and white claims are less legible after they are scanned.
- 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 CMS-1500 claim 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 CMS-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.

TIMELY FILING

Please Note: Not all member contracts/certificates follow the 15-month claims filing limit. Always verify the member's benefits, including timely filing standards, through iLinkBlue.

Blue Cross claims must be filed within 15 months, or length of time stated in the member's contract, of the date of service. Claims received after 15 months, or length of time stated in the member's contract, will be denied, and the member and Blue Cross should be held harmless for these amounts.

Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the services were provided.

Medicare claims must be filed within one calendar year after the date of service. Self-funded plans and plans from other states may have different timely filing guidelines. Please call Customer Care Center to determine what the claims filing limits are for your patients.

Blue Cross claims for OGB members must be filed within 12 months of the date of service. Claims received after 12 months will be denied for timely filing and the OGB member and Blue Cross should be held harmless. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for health care providers. CMS has assigned national provider identifiers (NPIs) to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with Blue Cross as well as with federal and state agencies, thus eliminating the need for you to use different identification numbers for each agency or health plan.

To comply with the legislation mentioned above, all covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. Claims processing cannot be guaranteed unless you notify Blue Cross of your NPI(s) prior to filing claims using your NPI(s).

Notifying Blue Cross of Your NPI

Once you have been assigned an NPI, please notify us as soon as possible. To do so, you may use one of the following ways:

1. Include it on your Louisiana Standardized Credentialing Application (LSCA), Health Delivery Organization (HDO) Application or Blue Cross recredentialing application.
2. Include it on the online Provider Update Request Form located in the "Resources" section on the Provider page.

Filing Claims with NPIs

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Blue Cross of your NPI, by using one of the methods above, prior to filing claims. See the first part of this section for more details on how to submit claims to Blue Cross.

For more information, including **who should apply** for an NPI and **how to obtain** your NPI, visit our website or CMS website. If you have any questions about the NPI relating to your Blue Cross participation, please contact Provider Credentialing & Data Management.

Ordering/Referring Physician

The ordering/referring provider's first name, last name and NPI are required on all applicable claims filed with Blue Cross. Claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

MEDICAL CODE EDITING TOOL ON ILINKBLUE

On iLinkBlue you can find the claims-editing software (CES) system tool under the "Claims" menu option. This is a code-auditing reference tool designed to help providers calculate claim edit outcomes for both professional and outpatient facility claims. View our *iLinkBlue User Guide* for more information on researching code combinations in the CES system tool. It is available on our Provider page at www.bcbsla.com/providers >Resources >Manuals.

Please Note: The CES tool in iLinkBlue is not a pricing or claims processing tool. It is a research tool designed to evaluate code combinations in the Blue Cross claims-editing system.

ELECTRONIC PAYMENT REGISTER/REMITTANCE ADVICE (HIPAA 835 TRANSACTION)

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Electronic Remittance Advice/Register. The provider's software system can be programmed so that the ERA 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.

For more information, please contact our EDI Services.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a provider service where Blue Cross deposits your payment directly into your checking account. EFT, like iLinkBlue, is a free service to providers. With iLinkBlue, you will have access to EFT notifications and payment registers (that can be printed directly). EFT eliminates the mail time associated with the delivery of your payment register and check, as well as the time consuming task of making a manual deposit to your bank.

All Blue Cross providers who sign up for iLinkBlue, must also be a part of our EFT program. In the future, Blue Cross plans to implement mandatory use of the EFT program for all providers.

Blue Cross has created a guide for completing the EFT Application form. The guide as well as the EFT Application form are included in this manual.

To initiate EFT, please complete the EFT Application form located on our Provider Page and submit it to Provider Credentialing and Data Management.

SECTION 8: CLAIMS RESOLUTIONS
of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about claims resolutions. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 8: CLAIMS RESOLUTIONS

SUBMITTING ACTION REQUESTS TO RESOLVE CLAIMS ISSUES

Submitting an action request through iLinkBlue is a great option for getting a quick and accurate resolution for your claims issues. Action requests:

- Reduce the time it takes for providers to receive a response from Blue Cross.
- Allow providers to see responses directly from the adjustments team after review.
- Allow providers to submit additional questions once they have reviewed the action request response.

Common Reasons to Submit an Action Request

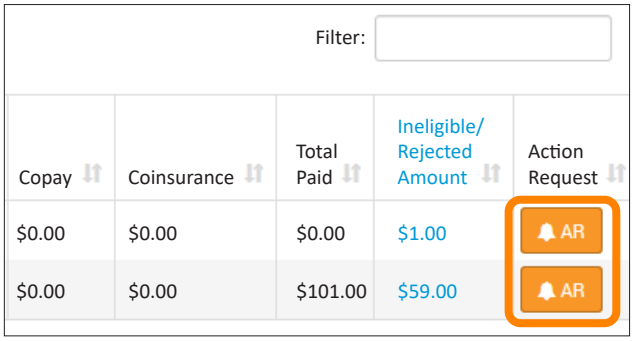
Action requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim. This can include:

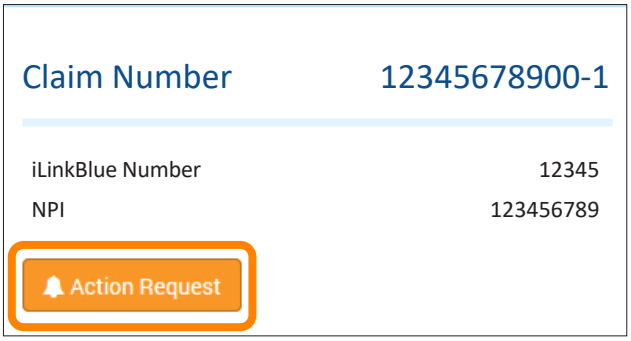
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No record of membership (effective and term date)
- Medical records receipt
- Recoupment request
- Status of an appeal
- Status of a grievance

Please Note: Action requests do not allow you to submit documentation regarding your claims review.

Submitting an Action Request through iLinkBlue

On each claim researched through the Claim Status search tool in iLinkBlue, providers have the option to submit an action request to request a review for correct processing. Click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. You only have to do one action request per claim; not one action request per line item of the claim.





When submitting an action request

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 business days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 business days for second request

If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at provider.relations@bcbsla.com. Email an overview of the issue along with two action request dates OR two customer service reference numbers if one of the following applies:

1. You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) and have allowed 10-15 business days after second request, or
2. It is a system issue affecting multiple claims.

CLAIMS RESUBMISSION (OR REFILING)

When a claim is refiled for any reason, ALL services should be placed on the claim. For example, it is inappropriate to refile a claim with only one procedure when more than one procedure was placed on the initial claim. Splitting the claim may cause adjustments to be performed.

ADJUSTMENT AND VOID CLAIM SUBMISSIONS

Adjustment and void claims can be submitted on any claim that has completed the processing cycle and appears on your Remittance Advice. The claim number assigned on the remittance will be needed to submit an adjustment or void claim.

Void Claim – The submission of a void claim is requesting that the entire claim be removed, and any payments or rejections be retracted from the member and provider's records.

Adjustment Claim – The submission of an adjustment claim requests that a previously processed claim be changed (information or charges added to, taken away or changed).

Electronic (837I & 837P) Adjustment and Void Claims

Adjustments and void claims can be submitted for all changes except for changes to the member ID number or pay-to-provider number. If these fields require change, you must submit the claim on paper, clearly indicating the old information and new information (pay-provider number and/or member ID number).

To submit these claims, you first obtain the claim number found on the payment register/remittance advice. This claim number will be used in the ICN (internal control number) field.

Ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim

- Enter the frequency code "7" in loop 2300 Segment CLM05-03.
- Enter the 10-character ICN of the original claim (assigned on the processed claim) in loop 2300 in an REF segment and use F8 as the qualifier.

Note: The adjusted claim should include all charges (not just the difference between the original claim and the adjustment).

Void the Claim

- Use frequency code "8" in loop 2300 Segment CLM05-03.
- Use the 10-character ICN of the original claim (assigned on the processed claim) in loop 2300 in an REF segment and use F8 as the qualifier.

iLinkBlue Professional CMS-1500 Adjustment and Void Claims

- Field 19A Professional Claim Adjustment/Void Indicator is required:
  A - Adjust original claim
  V - Void original claim
- Field 19B Internal Control Number (ICN Number) – The ICN Number is the claim number from the BCBSLA Remittance Advice (Provider Payment Register).

OVERPAYMENTS

We accept notification of overpayments for Blue Cross, HMOLA, FEP and BlueCard® (out-of-area) members. If you believe an overpayment has occurred on a claim, it is important to notify us of the suspected overpayment.

- For BCBSLA, HMOLA and FEP members, we can accept a payment with your notification of the overpayment
- For BlueCard members, do not send a check or payment with your notification. Submit the notification only. All adjustments will be reflected on your future payment register(s).

You may submit overpayment notifications to Blue Cross in one of the following ways:

Submit an Action Request through iLinkBlue (preferred method)

Go to the claim thought to be overpaid in iLinkBlue and submit an action request to have the claim reviewed for correct processing. To do this, click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. Please only submit one action request per claim; not one action request per line item of the claim. For more information on this process, please refer to our *iLinkBlue User Guide*, available online at www.bcbsla.com/providers >Resources >Manuals.

Submit an Overpayment Notification Form

A printable version of this Overpayment Notification Form is available online at www.bcbsla.com/providers >Resources >Forms. A sample of the form is also available in the Forms section of this manual.

For BlueCard members, do not send a check (payment) with this form. Submit the form only. All adjustments will be reflected on your future payment register(s). BCBSLA cannot accept payments for BlueCard members. If an unsolicited refund payment is received for a BlueCard member, it will be returned with a letter requesting an Overpayment Notification Form be submitted. You may instead submit an Action Request in lieu of the form.

Upon submitting the form:

- If it is determined that an overpayment did occur, you will not receive further notification from us. The claim will be adjusted, and your payment register will reflect the change.
- If it is determined that an overpayment did not occur, you will receive notification explaining that no adjustment to the claim is necessary.

When BCBSLA discovers the overpayment:

- If it is determined that a provider has received an overpayment and has not yet informed us, Blue Cross will send notification requesting the provider respond either agreeing to or appealing the overpayment within 30 days. If the provider does not respond within 30 days, Blue Cross will proceed with the deduction. For FEP members, the provider has 120 days to respond.
- After the applicable provider review period, the claim is adjusted and will be reflected on the provider's future payment register(s).

Please Note: Provider should actively work credit balances due to Blue Cross and return overpayments to Blue Cross. Refunds greater than $10,000 should be identified back to Blue Cross within 120 days from the occurrence date. This should be done even when credit balance recovery vendors are assisting with this process. Failure to do so may result in the provider being responsible for the fees incurred for the recovery.

REFUNDS PROCESS

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/Remittance Advices unless the provider contacts us in writing within 30 days. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the date of the payment of the claim. Blue Cross and the participating provider agree to hold each other and the member harmless for underpayments or overpayments discovered after 15 months from the date of payment.

If Blue Cross returns a claim or part of a claim for additional information, providers must resubmit it within 90 days or before the timely filing period expires, whichever is later.

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/remittance advice 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.

MEMBER REFUNDS

Member refunds should be based on actual payment(s) made by Blue Cross when there are two primary payers (no COB). The member's coinsurance, lifetime benefits and premiums are based on the reimbursement amount paid to the member provider. The above allowable charge amount (contractual allowance) should not be part of the member refund.

PROVIDER DISPUTES

Blue Cross recognizes there may be times when participating providers disagree with the way a claim was adjudicated. If your claim issue is one of the below reasons, then a claims dispute may be needed. This is different than an appeal or grievance. Disputes are defined as written requests from our participating network providers questioning (or disputing) a processed claim for Blue Cross and Blue Shield of Louisiana policy holders may include one of the following reasons:

- Reimbursement concerns:
  - Allowable disputes (must include breakdown of expected amount, fee schedule, etc.)
  - Bundling issues (must include medical records and reason why current bundling logic is not correct)
- Authorization issues:
  - Penalties where the provider is liable for the amount
  - Failed to obtain authorization denials (include reason why a prior authorization was not obtained).

  Please Note: If an authorization was obtained for a service, **do not** submit a provider dispute. Instead, send an action request or contact the Customer Care Center.
- Timely filing denials
- Refund disputes

Please include the Provider Dispute Form and/or a detailed reason for the claims dispute. The Provider Dispute Form is located on our Provider page (www.bcbsla.com/providers >Resources >Forms). Submit disputes using the information found on the Quick Reference Guide in the front of this manual.

Please refer to the "A Guide for Reviewing Claims" provider tidbit for complete information on submitting claims information for review to ensure it is routed to the appropriate area of the company. The guide lists the information Blue Cross needs and where to send it. The tidbit is available in the "Resources" section of our Provider page. A sample Provider Dispute Form is available in Appendix II Forms at the end of this manual.

MEMBER APPEALS

Medical appeals involve an adverse benefit determination based on medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational. All other appeals are considered administrative appeals.

Member appeals processes vary due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the member or the member's employer. There are some plans that are not governed by either the state laws or the federal laws. The member's health plan describes the appeals processes applicable to the member. Below outlines a general description of the appeal process. If there is a discrepancy between the member's health plan and what is described below, the member's health plan will control.

Standard Medical Appeals

The member, their authorized representative, or a provider authorized to act on the member's behalf, must submit a written request to appeal within 180 days following the member's receipt of an initial adverse benefit determination. Requests submitted to us after 180 days of our initial determination will not be considered.

If our initial denial is overturned on the member's medical appeal, we will process the claim and will notify the member and all appropriate providers, in writing, of the internal appeal decision. If our initial denial is upheld, we will notify the member and all appropriate providers, in writing, within 30 days of the member's request; unless the member or their authorized representative and we mutually agree that an extension of the time is warranted. At that time, we will inform the member of their right to begin the external appeal process if the claim meets the criteria.

If the member still disagrees with our determination on their claim following the internal review process, the member or their authorized representative may request an external appeal conducted by a non-affiliated Independent Review Organization (IRO). The member must send their written request for an external appeal, within 120 days* of receipt of the internal appeal decision. The member must grant permission for the request of an external review by completing and submitting at the time of external appeal request the form "I want to ask for an external appeal." Any external review requested without the required form will not be considered.

We will provide the IRO all pertinent information necessary to conduct the appeal. The IRO decision will be considered a final and binding decision on both the member and us. The external review will be completed within 45 days of our receipt of the request and the IRO will notify the member or their authorized representative and all appropriate providers of its decision.

** Requests submitted to us after 120 days of receipt of the internal appeal decision will not be considered.*

Tips for Completing Standard Medical Appeals

- Complete all information on the Provider Appeal Request Form (including contact information in case additional records are needed) that was included in the initial denial notice. Incomplete information may delay the review.
- Clearly identify service being appealed (ex: drug name, specific procedure, DME item, etc.).
- Include supporting rationale and supporting clinical records.
- Please read the "What can you do if you still disagree with our decision?" section of the initial denial letter and appeal denial letter for the appropriate appeal timeframes and instructions for the member's policy.
- We require network providers to disclose ineligible services to members prior to performing or ordering services. Our medical policies are available on iLinkBlue. Benefit determinations are made based on the medical policy in effect at the time of service.

Please Note: Peer-to-peer reviews are not available once an appeal has been initiated.

Expedited Appeals

We provide an expedited appeal process for review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the member may experience pain that cannot be adequately controlled while awaiting a standard internal appeal decision or a non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services but has not been discharged from a facility. Expedited appeals are not provided for services previously rendered.

The expedited appeal process allows for expedited appeal decisions no later than 72 hours of our receipt of an expedited appeal request that meets the criteria for expedited appeal.

In any case where the expedited internal appeal process does not resolve a difference of opinion between us and the covered person or the provider acting on behalf of the covered person, the appeal may be elevated to an expedited external appeal, if appropriate. In such cases, we will forward all pertinent information for expedited external appeal requests to the IRO so the review may be completed within 72 hours of receipt.

Please Note: Although submission of additional information is not required at the time an appeal request is requested, an explanation and/or supporting documentation for an appeal is recommended.

Multiple requests to appeal the same claim, service, issue or date of service will not be considered, at any level of review.

Tips for Completing Expedited Appeals

- If submitting with the appeal form included in the initial denial letter, the physician must clearly mark the form as "Expedited" (urgent) and sign the attestation that requested service meets the expedited criteria.
- Fax the expedited appeal request along with supporting documentation to the number found on the Quick Reference Guide in the front of this manual.

Standard Administrative Appeal

Administrative appeals involve contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), **with the member's authorization**.

The top reasons for administrative appeals are:

1. Out-of-network (OON) providers
2. Contract limitations or exclusions
3. Claims processing (how cost sharing was applied)

First Level Administrative Process

If the member is not satisfied with our claims decision (adverse benefit determination), the member, their authorized representative or a provider acting on their behalf (with signed authorizations from the member), must submit a written request to appeal within 180 days following the member's receipt of an initial adverse benefit determination. Appeals should be submitted in writing to the addresses found on the Quick Reference Guide in the front of this manual.

Please Note: Requests submitted to Blue Cross after 180 days of the denial will not be considered.

We will investigate the member's concerns. If we change our original decision at the appeal level, we will process the member's claim and notify the member and all appropriate providers, in writing, of the first level appeal decision. If our initial claims decision is upheld, we will notify the member and all appropriate providers, in writing, of our decision within 30 calendar days of the member's request; unless we mutually agree that an extension of the time is warranted. At that time, we will inform the member of the right to begin the second level appeal process, if applicable.

Second Level Administrative Process (If Applicable)

Within 60 calendar days of the date of our first level appeal decision, a member who is not satisfied with the decision may initiate the second level of appeal process. Requests submitted to us after 60 days of the denial will not be considered.

A member appeals committee not involved in any previous denial will review all second level appeals. The committee's decision is final and binding as to any administrative appeal and will be mailed to the member within five days of the committee meeting.

APPENDIX I: ONLINE RESOURCES

of the Professional Provider Office Manual

This is an appendix of the *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider Page at www.bcbsla.com/providers.

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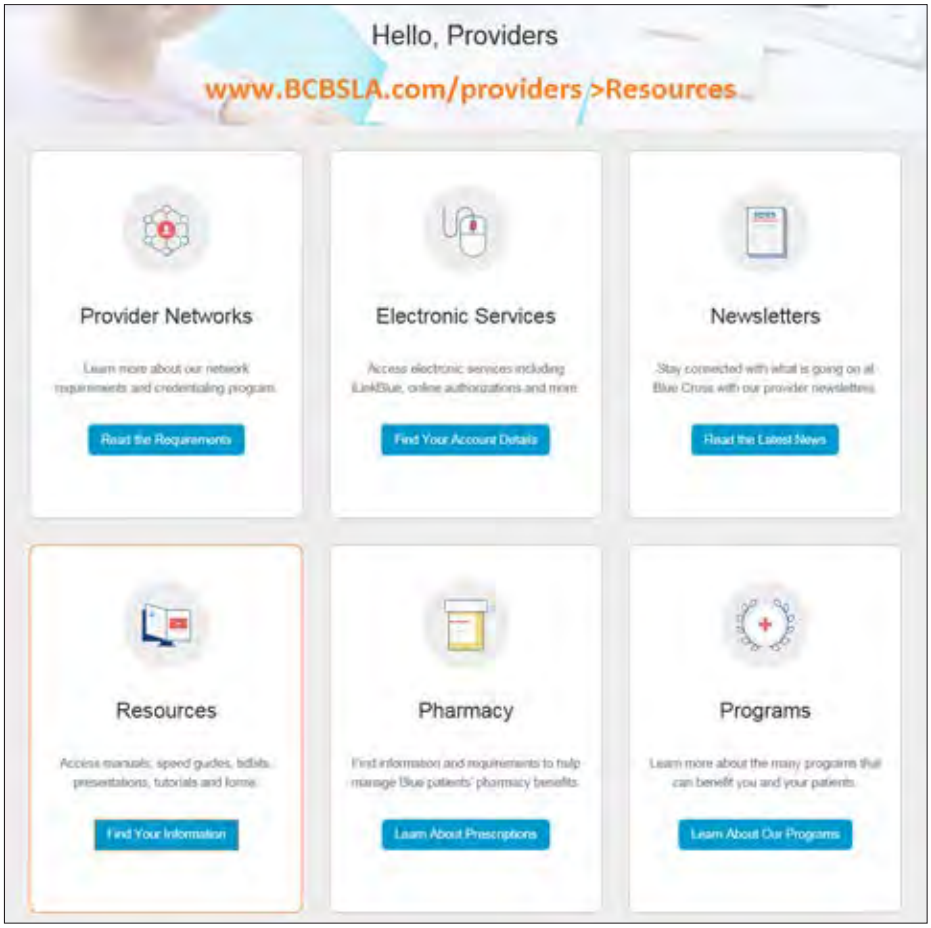
Provider Page

Blue Cross and Blue Shield of Louisiana's provider website serves our provider needs. Use this page to help locate important information.



You will find information on:

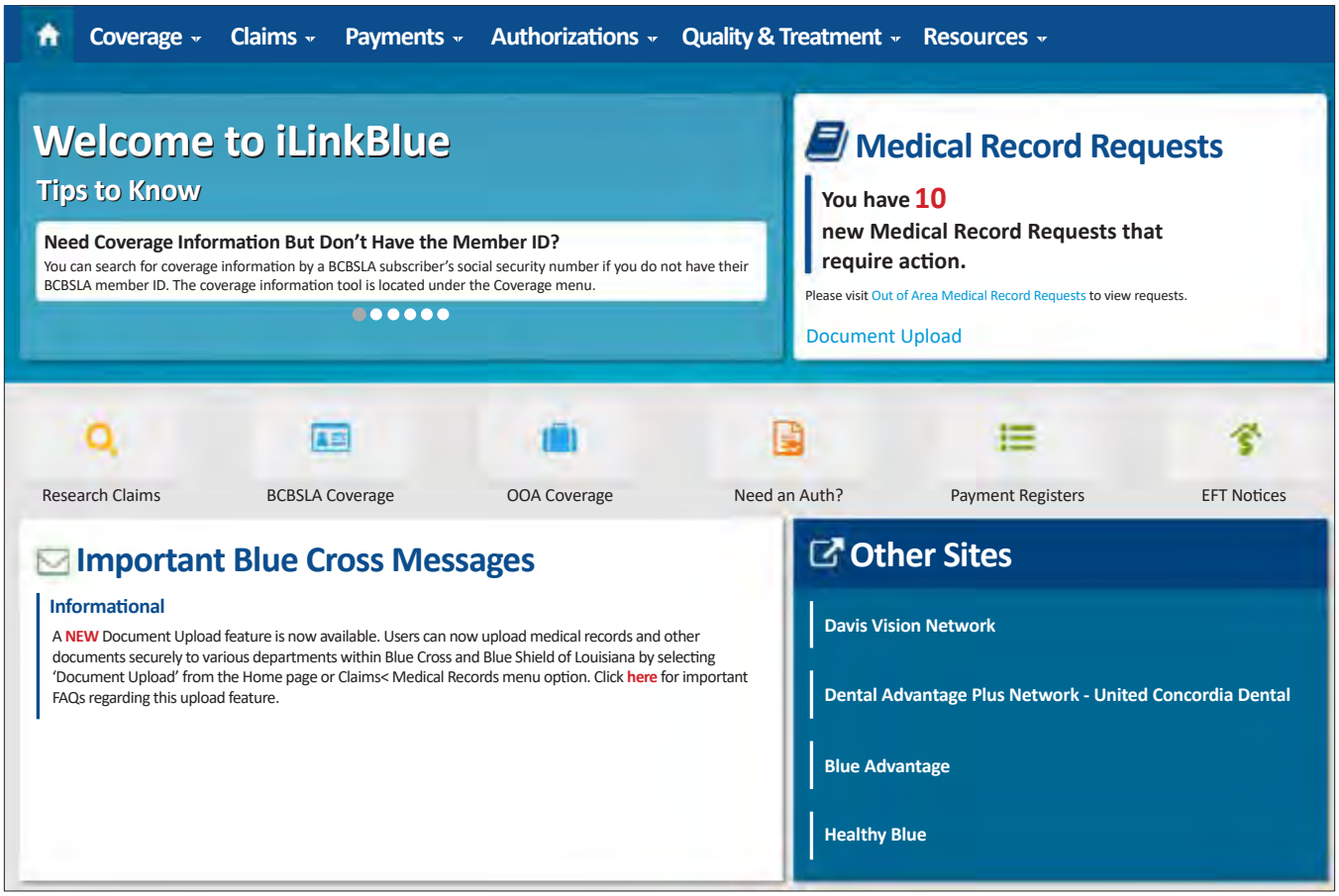
- Provider Networks
  - Credentialing
  - Provider Support
- Electronic Services
  - Learn about iLinkBlue
  - Clearinghouse Services
  - Admin Reps
  - Electronic Funds
- Newsletters
  - Network News
  - Blue Advantage Insight
  - Past Newsletters
- Resources
  - Manuals
  - Speed Guides
  - Tidbits
  - Workshops and Webinars
  - Forms for Providers
- Pharmacy
- Programs
  - Quality Blue
  - Care Management
  - Specialty Care Insight

www.bcbsla.com/providers

iLinkBlue

Blue Cross and Blue Shield of Louisiana's iLinkBlue is our secure online tool for facility and professional health care providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, and payment queries and transactions.

To gain access to iLinkBlue, you must complete the iLinkBlue agreement packet. The iLinkBlue provider agreement packet is available on our Provider page.



iLinkBlue is your one-stop for:

- Benefits
- Eligibility
- Claims Research
- Payment Information
- Authorizations
- Electronic Funds Transfer
- BlueCard Medical Record Requests
- Medical Policies
- Manuals
- Allowable Charges
- Estimated Treatment Cost
- Grace Period Notices
- Medical Code Editing
- And so much more!

www.bcbsla.com/ilinkblue

EXAMPLE
PAYMENT REGISTER/REMITTANCE ADVICE

BLUE CROSS BLUE SHIELD OF LOUISIANA
WEEKLY PROVIDER PAYMENT REGISTER

Date: 01/15/2019

Provider Name: Family Medical Clinic

(1) Patient Name	(2) Contract Number	(3) Patient Acct	(4) Days/ Units	(5) Admit/ Dis Dt	(6) Claim Number	(7) CPT4 Rev	(8) Sch Drg	(9) Total Charges	(10) Above Allow Amt	(11) COB /OC Pay	(12) OC Code	(13) Not Covered Ded-Coin-Inel	(14) Amt Paid
PUBLIC, J.Q.	XUH123456789	ABCDEFGH00	1	04/15/2018 04/15/2018	1000000	99999		$155.00	$55.00 PDC-CO			$100.00 DED-PR	$ 0.00
(15) Performing/Prov: 0123456789 (16) Prov Name: John Doe, MD													
PUBLIC, J.Q.	XUH123456789	ABCDEFGH00	1	04/15/2018 04/15/2018	1000000	99999		$ 55.00	$12.00 PDC-CO			$ 0.00 DED-PR	$43.00
Performing/Prov: 0123456789 Prov Name: John Doe, MD													
PUBLIC, SU	XUH987654321	ABCDEFGH01	1	06/30/2018 06/30/2018	1000012	99999		$120.00	$30.00 PDC-CO			$ 90.00 DED-PR	$ 0.00
Performing/Prov: 0123456789 Prov Name: John Doe, DDS													
SMITH, JOHN	XUH999999999	ABCABCAB01	1	07/15/2018 07/15/2018	1000030	99999		$175.00	$60.00 PDC-CO			$100.00 DED-PR	$15.00
Performing/Prov: 0123456789 Prov Name: John Doe, MD													
(17) Totals:			4					$505.00	$157.00			$290.00	$58.00

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 was previously processed or may be processed in the future
CO - This amount is determined by Blue Cross to be the responsibility of the provider.
PDC The charge exceeds the allowed amount for this service.

ALL NAMES, CHARGES AND CODES ARE FOR EXAMPLE PURPOSES ONLY

FAMILY MEDICAL CLINIC
111 MAIN STREET
ANYTOWN, LA 70000-0000

BLUE CROSS BLUE SHIELD LOUISIANA
P.O. BOX 98029
BATON ROUGE, LA 70898-9029

(18) PAID PROV: 0123456789
(19) DATE: 01/15/2019
(20) CHECK NO: 99999999

PAYMENT REGISTER/REMITTANCE ADVICE EXPLANATION

Following is a description of each item on the Blue Cross Weekly Provider Payment Register/ Remittance Advice.

1. **Patient's Name** - The last name and first five letters of the first name of the patient.
2. **Contract Number** - The member's Blue Cross and Blue Shield identification number.
3. **Patient Acct** - The patient identification number assigned by the provider's office. This information will appear only if provided on the claim.
4. **Days/Units** - The number of visits that the line item charge represents.
5. **Admit/Dis 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. **CPT Code** - The code used to describe the services performed by the provider.
8. **Sch Drg** - Not applicable to providers.
9. **Total Charges** - The charge for each service and the total claim charges submitted to Blue Cross and Blue Shield.
10. **Above Allowable Amount** - The amount above the allowable charge. NOTE: This amount cannot be collected from the member.
11. **COB/OC Pay** - An asterisk in this column denotes that Blue Cross and Blue Shield is the secondary carrier.
12. **OC Code** - C = Commercial Carrier, M = Medicare.
13. **Not Covered Ded-Coin-Inel** - The total amount owed by a patient for each claim including deductible, coinsurance, copayment, noncovered charges, etc.
14. **Amt Paid** - The amount paid by Blue Cross.
15. **Performing/Prov** - The name and provider number of the provider who performed the service.
16. **Provider Name** - Provider/Clinic name and address to which payment is made.
17. **Totals** - The total of days, charges, contract benefits, patient liability, above allowable amount, and amount paid for all patients listed.
18. **Paid Prov** - Provider's/Clinic's NPI under which payment is made.
19. **Date** - Date the Provider Payment Register/Remittance Advice is generated by Blue Cross.
20. **Check Number** - The number assigned to the check mailed with the Payment Register.

APPENDIX II: FORMS

of the Professional Provider Office Manual

Forms are available online at www.bcbsla.com/providers >Resources >Forms

This is an appendix of the *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Blue Cross only accepts CMS-1500 "version 02/12." No black and white copies or faxed claims are accepted.

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM (CMS-1500 VERSION 02-12) EXPLANATION

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

Block 1A Insured's I.D. Number - Enter the member's Blue Cross and Blue Shield identification number, including prefix, exactly as it appears on the identification card.

Block 2 Patient's Name - Enter the full name of the individual treated.

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

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.

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

Block 6 Patient's Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member. Spouse - Patient is the member'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 member's grandchild, adult-sponsored dependent or of relationship not covered previously.

Block 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.

Block 8 Reserved for NUCC USE - This section is reserved for NUCC use.

Block 9 Other Insured's Name - 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).

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

Block 10D When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the CMS-1500 claim form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.

Block 11 Not required.

Block 11D When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A, and 9D. Only mark one box.

Block 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.

Block 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 members 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 CMS-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.*

Block 14 Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.

Block 15 Enter another date related to the patient's condition or treatment. Enter the date in the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the applicable qualifier to identify which date is being reported.

Block 16 Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

Block 17 Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider **– Required**
2. Ordering Provider **– Required**
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.

Block 17A Other ID #. The non-NPI ID number of the referring physician, when listed in Block 17.

Block 17B **NPI – Required**. Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.

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

Block 21 **Diagnosis or Nature of Illness or Injury -** Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes for dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. Use the most specific diagnosis codes when reporting codes. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Block 23 Prior Authorization Number - Enter the authorization number obtained from Blue Cross/ HMO Louisiana, if applicable.

Block 24A Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered.

Block 24B Place of Service - Enter the appropriate place of service code. Common place of service codes are:

Inpatient - 21 Outpatient - 22 Office - 11

Block 24C EMG - Enter the Type of Service code that represents the services rendered.

Block 24D 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.

Block 24E Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as shown in Block 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.

Block 24F Charges - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.

Block 24G 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. Base units value should never be entered in the "units" field of the claim form.

Block 24J Rendering Provider ID # - Enter the NPI for the rendering physician for each procedure code listed when billing for multiple physicians' services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians, Diagnostic Radiology Center, Laboratory and Diagnostic Services, Retail Health Clinic and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed.

Block 25 Federal Tax I.D. Number - Enter the provider's/clinic's federal Tax ID number to which payment should be reported to the Internal Revenue Service.

Block 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/Remittance Advice only if it is indicated on the claim form.

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

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

Block 29 Amount Paid - Not required.

Block 30 Not required.

Block 31 Signature of Provider - Provider's signature required, including degrees and credentials. Rubber stamp is acceptable.

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

Block 32A NPI - Enter the NPI for the facility listed in Block 32.

Block 32B Other ID - The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility.

Block 33 Billing Provider Info & Ph # - Enter complete name, address, telephone number for the billing provider.

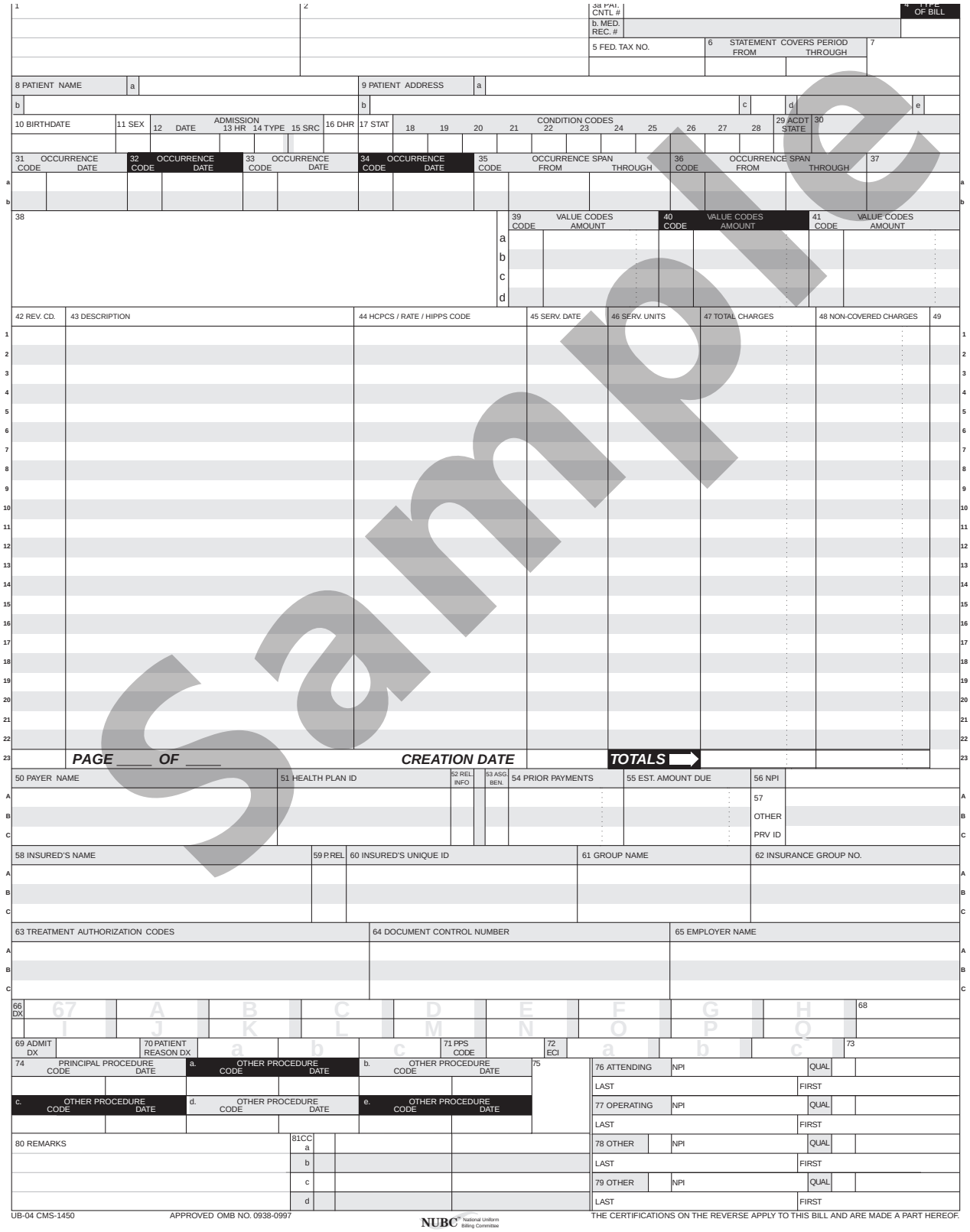
Block 33A NPI - Enter the NPI for the billing provider listed in Block 33.

Block 33B Other ID # - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.

Example

UB-04 CLAIM FORM

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.



UB-04 CLAIM FORM EXPLANATION

Block 1 Enter billing provider name and address.

Block 2 Enter pay-to provider name and address, if different than Block 1.

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

Block 3B Medical Record Number: Enter the number or code that is used by your facility to retrieve or post medical/health 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 Tax ID 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 8A-8B Patient Name: Enter the patient's name with last name first, then first name and middle initial, if any. Do not use titles or nicknames.

Block 9A-9E Address: Patient address must be completed.

Block 10 Birthdate: Enter the patient's actual date of birth in MM-DD-YYYY format.

Block 11 Sex: An "M" for male or an "F" for female must be present.

Block 12 Admission Date: This field is required for inpatient claims and not required for outpatient claims.

Block 13 HR: This field is required for inpatient claims and not required for outpatient claims.

Block 14 Type: This field is required for inpatient claims and not required for outpatient claims.

Block 15 SRC: This field is required for inpatient claims and not required for outpatient claims.

Block 16 DHR: Discharge hour field is required on all final inpatient claims except for 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge), 4 (Interim-Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.

Block 17 STAT: Enter the applicable discharge status code. This field is not required for outpatient claims, but can be present.

Blocks 18-28 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.

Block 29 Two-digit state abbreviation where the accident occurred.

Block 30 Reserved for assignment by the National Uniform Billing Committee (NUBC).

Blocks 31-34 Occurrence Codes and Occurrence Dates: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the member 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 35-36 Occurrence Span Codes and Dates: These fields are 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.

Block 37 Reserved for assignment by the NUBC.

Block 38 The name and address of the party responsible for the bill.

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 43 Description: The provider reports the NDC code. The provider enters a narrative description or standard abbreviation for each revenue code shown. This field is not required but may be present.

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 45 Serv. Date: Date of service for HCPCS code listed. If there are multiple dates of service for the same HCPCS code, each date must be listed on a separate line.

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

Blocks 42-47 Line 23: The PAGE__ of __, CREATION DATE and total charges TOTALS should be reported on all pages of the UB-04.

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 49 Reserved for assignment by the NUBC.

Block 50 Payer Name: This field is required only on lines 50 B and 50 C when indicating other payer information.

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 member

Blue Cross pays all participating providers directly unless assignment indicates to pay the member.

Block 56 NPI: Enter the appropriate national provider identifier (NPI) number in this field.

Block 57 Other Prv ID: Enter your Blue Cross assigned five-digit or ten-digit provider number in this field.

Block 58 Insured's Name: If the patient is not the insured, enter the member's name exactly as it appears on the Blue Cross 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	Spouse	18	Self
19	Child	20	Employee
21	Unknown	39	Organ donor
40	Cadaver donor	53	Life Partner
G8	Other relationship		

Block 60 Insured's Unique ID: Enter the member's identification number exactly as it appears on the ID card.

Block 61 Group Name: This field is required if known.

Block 62 Insurance Group No.: Enter the group number as it appears on the member's ID card.

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 member's employer, unless the patient is the employer.

Block 66 ICD Version Indicator: Qualifier Code "9" required on claims representing services through September 30, 2015. Qualifier Code "0" required on claims representing services on October 1, 2015, and beyond.

Block 67 Principle Diagnosis Code: The principal diagnosis code must be entered in this field. You must use ICD-10-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 67A-Q Other Diagnosis 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 68 Reserved for assignment by the NUBC.

Block 69 Admit Dx: Enter the ICD-10-CM diagnosis code related to the patient's admission.

Block 70 The ICD-CM diagnosis code describing the patient's reason for visit at the time of outpatient registration.

Block 71 The Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

Block 72 The ICD diagnosis code pertaining to external cause of injuries, poisoning or adverse effect. See ICD-10-CM Guidelines for Coding and Reporting.

Block 74 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-10-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.

Block 74A-E Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-10-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.

Block 75 Reserved for assignment by the NUBC.

Block 76 Attending: Enter the NPI, last name and first name of the attending physician who rendered the services. This field is required.

Block 77 Operating: Enter the NPI, last name and first name of the operating physician who had primary responsibility for surgical procedures. This is only required when a surgical procedure code is listed.

Block 78-79 Other: **Required**. Enter the NPI, last name and first name of referring physician, assistant surgeon, and/or rendering physician, as applicable.

Block 80 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.

Block 81 Enter B3-qualifier and then your respective taxonomy code. All claims need to be filed with a taxonomy code to ensure timely and accurate claims processing.

Remarks 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.

ILINKBLUE 1500 CLAIM ELECTRONIC ENTRY

iLinkBlue allows the electronic submission of professional 1500 claim forms giving providers the capability of submitting HCFA 1500 claims directly into the claims processing systems at Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Federal Employee Program (FEP) and BlueCard (out-of-area) members.

Please refer to the *iLinkBlue 1500 Claims Entry Manual*, which is available on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Resources" section.

PROVIDER UPDATE REQUEST FORM

The Provider Update Request Form (available at www.bcbsla.com/providers >Resources >Forms) should be used to notify Blue Cross of changes or additions to provider demographic information, including what is displayed in our provider directories.

Use this form to submit any of the following change requests to our Provider Credentialing & Data Management Department.

Provider Demographic Change
Have a change in contact information, such as a new or updated email address
New providers join your practice
Obtain a new Tax ID number
Providers in your clinic retire or move
Close a practice
Merge a practice
Change or terminate your electronic funds transfer (EFT) payment information (commercial only)

Complete, sign and submit the Provider Update Request Form digitally with DocuSign®. It is no longer necessary to print and submit this form hardcopy. The form is accepted through DocuSign only and the sample of the form on the next pages is for reference purposes.

Louisiana

Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana. Based on your Type of Change needed, DocuSign® highlights the relevant fields to your request, and those fields appear in red throughout the form.

This request applies to: ☐ Individual Provider ☐ Provider Group/Clinic

CURRENT GENERAL INFORMATION		
Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Group/Clinic Name	Group/Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? ☐ Yes ☐ No	Specialty	Date of Requested Change

If you are an authorized representative completing this form on behalf of a provider, please indicate below.

AUTHORIZED REPRESENTATIVE	
Name	
Contact Phone Number	Contact Email Address
Submission Information (form completed by)	
Signature of Authorized Representative	Date
Provider Attestation (where applicable)	
Signature of Provider	Date

TYPE OF CHANGE

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change (*does not apply for Blue Advantage EFT update*)	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2 Email: PCDMStatus@bcbsla.com

23XX7231 R09/21

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

Demographic Information

Please complete the following to change your demographic information (e.g., address, hours of operation, etc.).

NEW GENERAL INFORMATION		
New Last Name	**New** First Name	
New Group/Clinic Name		
Languages Spoken	☐ Adding Language Spoken *(please specify)*	
Current Specialty		
Changing Specialty? ☐ Yes ☐ No	If yes, please specify **New** Specialty	Are you a primary care provider (PCP)? ☐ Yes ☐ No
Changing NPI? ☐ Yes ☐ No	If yes, please specify **New** NPI	
Changing clinic to Rural Health Center (RHC) or Federally Qualified Health Center (FQHC)? ☐ Yes ☐ No	If yes, please specify ☐ RHC ☐ FQHC	If yes, please attach a copy of your DHH license for RHC or CMS approval letter for FQHC.

BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)		
Former Billing Address		
City, State and ZIP Code		Phone Number
New Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

MEDICAL RECORDS ADDRESS CHANGE (for medical records request)		
Former Medical Records Address		
City, State and ZIP Code		Phone Number
New Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

PHYSICAL ADDRESS CHANGE (must include a copy of your liability insurance showing the new address)

Former Physical Address

City, State and ZIP Code	Phone Number

New Physical Address

City, State and ZIP Code	Phone Number	Fax Number
Email Address	Effective Date of Address Change	

Current Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

New Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Health plan/Payor-owned ☐ Hospital-based ☐ Hospital-employed

Office Hours	Age Range *(if applicable, indicate age range)*

Accepting New Patients

Closing panel to new patients (No longer accepting new patients)
☐ Yes ☐ No

Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients)
☐ Yes ☐ No

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services, but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

CORRESPONDENCE ADDRESS CHANGE (Please update the address you would like us to send our Provider Communications to, including manuals, newsletters, etc.)

Former Correspondence Address

City, State and ZIP Code	Phone Number

New Correspondence Address

City, State and ZIP Code	Phone Number	Fax Number
Email Address	Effective Date of Address Change	

Electronic Funds Transfer (EFT) Termination/Change

To update your current Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT) information, please complete the following information.

TERMINATION/CHANGE REQUEST

☐ Please terminate me from the EFT program.

☐ Please change my EFT information as reflected below.

CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue.

PROVIDER INFORMATION

Provider Name		
Provider Address:		
City	State/Province	ZIP Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Tax ID Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name	Title	
Phone Number	Email Address	Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name
NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Former Financial Institution Name		
Former Type of Account at Financial Institution	**Former** Financial Institution Account Number	**Former** Financial Institution Routing Number
New Financial Institution Name		
New Type of Account at Financial Institution	**New** Financial Institution Account Number	**New** Financial Institution Routing Number

New Account Number Linkage to Provider Identifier

☐ Provider Tax ID Number (TIN): _____

☐ National Provider Identifier (NPI): _____

SUBMISSION INFORMATION

Include with Enrollment Submission

☐ Voided Check *(temporary checks are not accepted)*

or

☐ Bank Letter

Authorized Signature

☐ For change request:
This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if **any** of the above information changes.

☐ For termination request:
This information is to be removed from my account and remain in full force and effect until COMPANY has received written notification from me of new EFT information.

Page 2 of 2

Existing Providers Joining a New Provider Group

Complete the following information to link an individual provider to a provider group or clinic.

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

Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

FIRST PHYSICAL ADDRESS

Do you want this location listed as "participating" or "non-participating" in Blue Cross networks?

☐ Participating ☐ Non-participating

Physical Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Group/Clinic NPI

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients	Age Range of Patients (check all that apply)
☐ New ☐ Existing Only	☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages
☐ Other: _____	☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Do you want this location listed as "participating" or "non-participating" in Blue Cross networks?

☐ Participating ☐ Non-participating

Physical Address

City, State and ZIP Code	Phone Number	Fax Number

Email Address	Group/Clinic NPI

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ A copy of the Malpractice Liability Insurance Certificate is attached.
- ☐ Check if this is a new group or clinic not already on file with Blue Cross and complete the iLinkBlue agreement packet. *(Note: providers joining existing groups that already have iLinkBlue access do not need to complete the iLinkBlue agreement packet.)*

Termination Request

Please complete the following information to request termination from one or more of our networks. ALL applicable information must be completed before we will terminate network participation.

NETWORKS BEING TERMINATED

Full Termination

☐ Terminate Provider Record (claims can no longer be filed to Blue Cross)

Reason for termination:

☐ Left Group/Clinic ☐ Deceased ☐ Retired ☐ Closed Practice ☐ Moved Out of State

☐ Other: _____

Partial Termination

☐ Terminate this provider from ALL networks (claims can still be filed to Blue Cross as a non-participating provider)

☐ Terminate this provider from the following network(s):

☐ Preferred Care PPO
☐ HMO Louisiana, Inc.
☐ Blue Connect
☐ Community Blue
☐ Precision Blue
☐ Signature Blue
☐ Blue HPN
☐ Blue Advantage (HMO/PPO)
☐ Blue Cross Dental
☐ FEP Preferred Dental
☐ Healthy Blue Dual Advantage (HMO D-SNP)
☐ FMOL Health System
☐ Ochsner EPO

Please provide an explanation for terminating the network(s) checked above:

_____

_____

Important Note: Members who have seen the provider within the past 18 months are notified that the provider no longer participates in the applicable networks being terminated.

Office Use Only:

Provider Contracting Approval:

☐ Yes ☐ No Rep Initials: _____ Approved Term Date: _____

Tax Identification Number (TIN) Change Request

Please complete this form to report a change in your Tax ID number.

GENERAL INFORMATION		
Are you an individual changing your Tax ID? ☐ Yes ☐ No		
Former Provider Name	**Former** TIN	**Former** NPI
New Provider Name	**New** TIN	**New** NPI
Are you an entity changing your Tax ID? ☐ Yes ☐ No		
Former Entity Name	**Former** TIN	**Former** NPI
New Entity Name	**New** TIN	**New** NPI
Effective Date of Change	Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No	
What is your specialty?	Are you a primary care provider (PCP)? ☐ Yes ☐ No	

BILLING ADDRESS (for payment registers, reimbursement checks, etc.)		
Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

MEDICAL RECORDS ADDRESS (for medical records request)		
Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)		
Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

PHYSICAL ADDRESS

Physical Address

City, State and ZIP Code	Phone Number	Fax Number

Email Address

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services, but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

REQUIRED ATTACHMENTS

Professional Provider:

☐ State Licenses including current licenses held in other states, State CDS License and Federal DEA Registration
☐ Certificate(s) of Professional Liability Insurance
☐ Current Employer Identification Number (EIN) **and** Form W-9 or Federal Tax Deposit Coupon
☐ iLinkBlue **and** EFT agreements
☐ Administrative Representative Registration Form

Facilities:

☐ Health Delivery Organization (HDO) Form and applicable attachment
☐ Accrediting entity certification (JCAHO, CHAP, etc.)
☐ License (State, Occupational, CLIA, etc.)
☐ Medicare Participation Letter (if applicable)
☐ Professional Liability Insurance Certificate or Products Liability Insurance Certificate (DME providers)
☐ Louisiana Patients' Compensation Fund Certificate (if applicable)
☐ EIN Letter **and** Form W-9
☐ iLinkBlue **and** EFT agreements
☐ Administrative Representative Registration Form

Once all necessary documentation has been submitted, our Provider Contracting team will contact you with a new provider agreement to be signed and returned.

Add New Practice Location (Existing Tax ID)

Complete the information below when a provider is adding practice location(s) to an existing Tax ID.

LOCATION TO BE ADDED

Physical Address

City, State and ZIP Code	Phone Number	Fax Number

Email Address	Effective Date

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years

☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.

☐ I see patients here at least one day per month, but less than one day per week on a regular basis.

☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.

☐ I read tests or provide other services, but do not see patients at this location.

☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND LOCATION TO BE ADDED

Physical Address

City, State and ZIP Code	Phone Number	Fax Number

Email Address	Effective Date

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years

☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

THIRD LOCATION TO BE ADDED

Physical Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date

Accepting New Patients	Age Range of Patients (check all that apply)
☐ New ☐ Existing Only	☐ 0-6 years ☐ 7-11 years ☐ 12-18 years
☐ Other: _____	☐ 19-65 years ☐ Over 65 ☐ All Ages
	☐ Other: _____

Office Hours

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ A copy of the Malpractice Liability Insurance Certificate is attached.
- ☐ Check if this is a new group or clinic not already on file with Blue Cross and complete the iLinkBlue agreement packet. *(Note: providers joining existing groups that already have iLinkBlue access do not need to complete the iLinkBlue agreement packet.)*

Remove Practice Location (Existing Tax ID)

Complete the information below when a provider is removing a practice location(s) from an existing Tax ID.

GENERAL INFORMATION			
Individual Provider Last Name	First Name		Middle Initial
Individual Provider NPI		Languages Spoken	
Group/Clinic Name		Group/Clinic NPI	
Group/Clinic Tax ID Number		Effective Date	
What is your specialty?		Are you a primary care provider (PCP)? ☐ Yes ☐ No	
LOCATION TO BE REMOVED			
Physical Address			
City	State	ZIP Code	Effective Date
SECOND LOCATION TO BE REMOVED			
Physical Address			
City	State	ZIP Code	Effective Date
THIRD LOCATION TO BE REMOVED			
Physical Address			
City	State	ZIP Code	Effective Date

TIPS FOR COMPLETING THE PROVIDER DISPUTE FORM

1. Be sure to check the box that most closely matches your provider type.
2. This form should be used when you believe a claim was:
   - Rejected as a duplicate
   - Denied for bundling
   - Denied for medical records
   - Payment/denial affects the provider's reimbursement (timely filing, authorization penalty, etc.)
   - Denied for a BlueCard member
3. Include the appropriate supporting documentation along with the Provider Dispute Form. For assistance in what to attach, see the "Suggested Supporting Documentation" section on the form for guidance.
4. The dispute will not be considered or claim review could be delayed if:
   - The entire Provider Dispute Form is not completely filled out
   - More than one reason is selected on the form for requesting a claim review
   - The form is submitted to the wrong departmental address or fax number instead of the correspondence information listed on the "Where to Send" section of the form
   - The form is submitted to multiple areas of the company

Louisiana

Provider Dispute Form

Complete this form to file a provider dispute. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION		
TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:		
Provider Name		
National Provider Identifier (NPI)	Provider Tax ID	
Name of Person Completing Form	Date Form Completed	
Contact Email Address	Contact Phone Number	Contact Fax Number

PATIENT INFORMATION		
Member ID	Subscriber Name	
Patient Name	Patient Date of Birth	
Claim Number	Date(s) of Service	Amount Charged

DISPUTE DETAILS

To assist us in reviewing your dispute, please summarize the issue and action desired, and attach all supporting documentation.

_____

_____

_____

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-op History and Physical 4. Asst. Surgeon Credential (If not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

A printable PDF of this form is available online at www.bcbsla.com/providers, then click on the "Resources" section and look under Forms.

PLEASE REVIEW MY DISPUTE FOR THE FOLLOWING REASON

Check only one reason per form.

	REASON FOR REVIEW	SUGGESTED SUPPORTING DOCUMENTATION	TIME TO ALLOW RESPONSE FROM BCBSLA FROM DATE SUBMITTED	WHERE TO SEND
☐	Claim payment/denial affects the provider's reimbursement (check the appropriate boxes below): ☐ Timely filing ☐ Reimbursement/ Contractual Allowable ☐ Authorization penalty ☐ Bundling/ Unbundling issue ☐ Refund	• Provider Dispute Form including reason for dispute; if bundling issue, reason why current bundling logic is incorrect, or if reimbursement issue, expected allowable amount • Supporting medical documentation • Proof of timely filing (only if denied for timely filing)	60 days	MAIL OR FAX: BCBSLA - Provider Disputes P.O. Box 98021 Baton Rouge, LA 70898-9021 Or FAX: (225) 298-7035 ONLINE: Through iLinkBlue (www.bcbsla.com/ilinkblue), click "Document Upload," then "Provider Disputes" in the drop-down menu.
☐	Claim denied for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Provider Dispute Form including reason • Supporting medical documentation	60 days	MAIL OR FAX: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 or FAX: (225) 297-2727

FOR MEDICAL OR ADMINISTRATIVE APPEALS

If you need to submit a medical appeal, administrative appeal or grievance on behalf of a member, then instead complete the Medical Appeals Request Form or Administrative Appeal Request Form. Both are available online at www.bcbsla.com/forms-and-tools under Appeals and Claims Forms.

If Blue Cross requires medical records, the Medical Management department will request them using the Medical Records Request for Claim Review form. Medical records can be uploaded in iLinkBlue (www.bcbsla.com/ilinkblue). Click on the Document Upload link on the main page then select "Medical Records for Retrospective or Post Claim Review" from the department drop down.

FOR OTHER DISPUTES

For more information on other types of disputes (not listed above) and how to submit them, review our Guide to Disputing Claims tidbit. It is available online at www.bcbsla.com/providers, click "Resources," then "Tidbits."

Louisiana

Overpayment Notification Form

Complete this form to notify us of a possible overpayment for claims processed directly by BCBSLA for a Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA), Federal Employee Program (FEP) or BlueCard® (out-of-area) member. Please fully complete the requested information on this form to ensure proper processing.

Member ID: _____

(please include the three-character prefix or "R" for FEP members)

Do not send a check or payment with this form. Submit the form only.

Adjustments will be reflected on your future payment register(s).

PATIENT INFORMATION	
Patient's Full Name	Date of Birth
Claim Number	Patient Account Number
REFUND INFORMATION	
Date(s) of Service	Estimated Amount of Overpayment
Reason You Believe Overpayment Has Occurred	
PROVIDER INFORMATION	
Provider Name	National Provider Identifier (NPI)
Provider Address	
Name of Person Completing Form	Contact Phone Number
Date Form Completed	Contact Email Address

Please refer to the instructions on the back of this form for more ways to submit overpayment notifications to BCBSLA, as well as information on how to submit this form.

Page 1 of 2

In Lieu of Submitting this Form

You may instead submit an Action Request through iLinkBlue (www.BCBSLA.com/ilinkblue). Go to the claim thought to be overpaid in iLinkBlue and submit an Action Request to have the claim reviewed for correct processing. To do this, click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. Please only submit one Action Request per claim; not one Action Request per line item of the claim. For more information on this process, please refer to our *iLinkBlue User Guide*, available online at www.BCBSLA.com/providers >Resources >Manuals.

Instructions for BlueCard (out-of-area) Claims

For BlueCard members, do not send a check (payment) with this form. Submit the form only. All adjustments will be reflected on your future payment register(s). BCBSLA cannot accept payments for BlueCard members. If an unsolicited refund payment is received for a BlueCard member, it will be returned with a letter requesting an Overpayment Notification Form be submitted. You may instead submit an Action Request in lieu of the form.

General Refund Information

Upon submitting this form:

- If it is determined that an overpayment did occur, you will not receive further notification from us. The claim will be adjusted, and your payment register will reflect the change.
- If it is determined that an overpayment did not occur, you will receive notification explaining that no adjustment to the claim is necessary.

When BCBSLA discovers the overpayment:

- If it is determined that a provider has received an overpayment and has not yet informed us, Blue Cross will send notification requesting the provider respond either agreeing or appealing the overpayment within 30 days. For FEP members, the provider has 120 days to respond.
- After the applicable provider review period, the claim is adjusted and will be reflected on the provider's future payment register(s).

Return Form To:

BCBSLA Correspondence	or	Fax: (225) 297-2727
P.O. Box 98029		Attn: BCBSLA Correspondence
Baton Rouge, LA 70898-9029		

A printable version of this Overpayment Notification Form is available online at www.BCBSLA.com/providers >Resources >Forms.

If you have questions about this process, you may contact the Customer Care Center at 1-800-922-8866.

Louisiana

Authorization Form

Fax: 1-800-586-2299

Complete this form to submit authorizations for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members for inpatient, outpatient and offices services that require an authorization directly from our authorization department. Do not use this form for authorizations processed by Carelon Medical Benefits Management (Carelon), Express Scripts, Inc. or Lucet, etc.

Failure to fully complete this form could delay your authorization processing.

PATIENT DATA	Last Name	First Name	Middle Initial
Contract/Subscriber ID Number			Date of Birth
CLINICAL DATA	☐ Inpatient Admit/Surgery	☐ Outpatient Procedure/Service	☐ Office
Diagnosis Code(s) (ICD-10)		CPT® Code(s)	
Number of Visits Requested (If Applicable)		Date of Service/Admit Date	
REQUESTING PHYSICIAN	Last Name	First Name	Middle Initial
Address		Phone number	Fax Number
NPI (National Provider Identifier) Number:			
FACILITY INFORMATION	Name		
Address		Phone number	Fax Number
NPI (National Provider Identifier) Number:			
CONTACT PERSON	Name	Phone number	Fax Number
Additional Information:			

Note: *Maternity admissions to 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.*

The authorization process is based on medical necessity only and is *not* a guarantee of payment. Services/procedures are subject to review by Blue Cross and Blue Shield of Louisiana for contractual limitations or exclusions. Providers are required to check an individual's benefits, limitations and eligibility immediately prior to providing a benefit or service. You may log into iLinkBlue (www.bcbsla.com/ilinkblue) or call the customer service number printed on the member's ID card for specific member information.

P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 ● Phone: 1-800-523-6435 ● Fax: 1-800-586-2299

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Louisiana

Retrospective Review Authorization Form

Fax completed form to 1-800-515-1150

Complete this form to submit retrospective authorizations for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members for inpatient, outpatient and office services that require an authorization. **Retrospective review requests have up to a 30-day response time.** Do not use this form for authorizations processed by Carelon Medical Benefits Management (Carelon), Express Scripts, Inc., Lucet, etc.

Do not submit a request for retrospective review if you filed a claim. If we require additional medical records, Medical Management will request them using the Medical Records Request for Claim Review form.

Medical Records can be faxed or uploaded in iLinkBlue (www.bcbsla.com/ilinkblue). Click on the Document Upload link on the main page then select "Medical Records for Retrospective or Post Claim Review" from the department drop down. *Failure to fully complete this form could delay your authorization processing*.

PATIENT DATA	Last Name	First Name			Middle Initial	
Member ID			Date of Birth			
CLINICAL DATA	☐ Inpatient Admit/Surgery	☐ Outpatient Procedure/ Service	☐ Ambulatory Surgery	☐ Outpatient Hospital	☐ Office	☐ Home
Diagnosis Code(s) (ICD-10)			CPT® Code(s)			
Number of Visits Requested (If Applicable)			Date of Service/Admit Date: Start Date – End Date			
REQUESTING PHYSICIAN	Last Name	First Name			Middle Initial	
Address			Phone Number		Fax Number	
National Provider Identifier (NPI)						
FACILITY INFORMATION	Name					
Address			Phone Number		Fax Number	
National Provider Identifier (NPI)						
CONTACT PERSON	Name		Phone Number		Fax Number	
Additional Information:						

Note: *Maternity admissions to 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.*

The authorization process is based on medical necessity only and is not a guarantee of payment. Services/procedures are subject to review by Blue Cross and Blue Shield of Louisiana for contractual limitations or exclusions. Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. For urgent inpatient admissions, you must notify Blue Cross of that admission within 48 hours or the next business day, to avoid penalties or non-coverage. If you are unsure if a policy allows for retrospective review, contact Customer Care at 1-800-922-8866. Always verify eligibility and benefits before providing services by contacting Customer Care or using iLinkBlue (www.bcbsla.com/ilinkblue).

P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 ● Phone: 1-800-922-8866 ● Fax: 1-800-515-1150

18NW3245 R03/23

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:
Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc./Express Scripts	1-800-842-2015	1-877-251-5896	

SECTION II — PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III — PATIENT INFORMATION

Last Name, First Name MI:	DOB:	Phone:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:	

Patient is currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a psychiatric facility? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a residential substance use facility? ____ Yes ____ No Date of Discharge:_____
Patient is a long-term care resident? ____ Yes ____ No If yes, name and phone number:_____
EPSDT Support Coordinator contact information, if applicable:

SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name:

Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:

To the best of your knowledge this medication is: New therapy/Initial request
_____Continuation of therapy/Reauthorization request

For Provider Administered Drugs only:

HCPCS/CPT-4 Code:_____NDC#:_____Dose Per Administration:_____

Other Codes:_____

Will patient receive the drug in the physician's office? ____Yes ____No

– If no, list name and NPI of servicing provider/facility: _____

SECTION V — PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:

For pain-related diagnoses, pain is: _____Acute _____Chronic
For postoperative pain-related diagnoses: Date of Surgery_____

Pertinent laboratory values and dates (attach or list below):

Date	Name of Test	Value

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SECTION VI - This Section For Opioid Medications Only

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)
Cumulative daily MME_____

Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient.
			B. The patient has been **screened for substance abuse / opioid dependence**. *(Not required for recipients in long-term care facility.)*
			C. The **PMP** will be accessed **each** time a controlled prescription is written for this patient.
			D. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient.
			G. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility.)*
LONG-ACTING OPIOIDS			H. The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ____Yes ____No (If yes, please explain in Section VIII below.)

SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber:_____ Date:_____

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Louisiana

Guide to Completing the EFT Enrollment Form

Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment electronically directly into their accounts. You can complete the EFT Enrollment Form at www.bcbsla.com/providers >Resources. The following information should help you complete the form.

1 CONSENT

The consent legally allows Blue Cross to electronically transfer funds to your financial account. The provision for Blue Cross to deduct funds applies when an erroneous credit occurs to a financial account resulting, for example, from a banking error.

2 PROVIDER INFORMATION

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider

Street Address – The number and street name where a person or organization can be found

City – City associated with provider address field

State/Province – The two-character code associated with the State/Province/Region of the applicable country

ZIP Code/Postal Code – System of postal-zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and utilize electronic reading and sorting capabilities

3 PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) / Employer Identification Number (EIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity

National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Group NPI (if applicable) – If part of a provider group, please also report the NPI for your group

4 PROVIDER CONTACT INFORMATION

Provider Contact Name – Name of a contact in provider office for handling ERA issues

Title – Title of the contact person

Telephone Number – Associated with the contact person

Email Address – An electronic mail address at which the health plan might contact the provider

Fax Number – A number at which the provider can be sent facsimiles

5 RETAIL PHARMACY INFORMATION *(this section should be completed by pharmacies only)*

Pharmacy Name – Complete name of pharmacy

NCPDP Provider ID Number – The NCPDP-assigned unique identification number

6 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name – Official name of the provider's financial institution

Financial Institution Routing Number – The nine-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments (e.g., checking, savings, etc.)

Provider's Account Number with Financial Institution – The provider's account number at the financial institution to which EFT payments are to be deposited

Account Number Linkage to Provider Identifier – Choose, then enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

7 SUBMISSION INFORMATION

Reason for Submission

- **New Enrollment** – Check to indicate applying for new EFT enrollment

Include with Enrollment Submission

- **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.

  or

- **Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment

Written Signature of Person Submitting Enrollment – The (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

Printed Name of Person Submitting Enrollment – The printed name of the person signing the form

Submission Date – The date on which the enrollment is submitted

Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

CCD Record #	Field #	Field Name
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

Late/Missing EFT and ERA Transactions Resolution Procedures:

ERA (835) files are available weekly in trading partner mailboxes on Mondays, and no later than Wednesday, except during holidays or unexpected office closures. If you do not receive your ERA by close of business on Wednesday, you may contact EDI Services at 1-800-716-2299, option 3 or email EDIServices@bcbsla.com. Please include the Trading Partner ID, check number, check amount, check date and NPI.

EFT transactions are typically available at the provider's bank on Wednesday. If you have not received your deposit by close of business on Wednesday, you may contact EDI Services at 1-800-716-2299, option 3.

For questions about the ERA Form, please contact EDI Services at 1-800-716-2299, option 3. Also visit www.bcbsla.com/providers >Electronic Services >Clearinghouse.

To check the status of your ERA Form, you may submit your **request** via email to EDIServices@bcbsla.com. Please include the provider or group name, NPI, TIN or EIN and Trading Partner ID. Please allow three to five business days for setup.

To check the status of your EFT Form, you may submit your request via email to PCDMStatus@bcbsla.com. Please include the provider or group name, NPI and TIN or EIN. Please allow up to 15 business days for setup.

Provider's NPI must already be on file with Blue Cross. For more information on reporting your NPI to Blue Cross, visit www.bcbsla.com/providers >NPI or you may contact Provider Credentialing & Data Management at 1-800-716-2299, option 2.

Blue Cross does not set up ERAs for out-of-state providers.

Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See included Guide to Completing the EFT Enrollment Form for detailed instructions.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter referred to as BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue.

PROVIDER INFORMATION

Provider Name		
Provider Address: Street		
City	State/Province	ZIP Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name	Title	
Telephone Number	Email Address	Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name
NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name		
Financial Institution Routing Number	Type of Account at Financial Institution	Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

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SUBMISSION INFORMATION

Reason for Submission

- ❑ New Enrollment

Include with Enrollment Submission

- ❑ Voided Check *(temporary checks are not accepted)*

  or

- ❑ Bank Letter

Authorized Signature

I hereby acknowledge that the information provided on this form is true and correct. I further authorize COMPANY to utilize and rely on the information contained in this form until such time as I submit reasonable advance written notice to Company that this authorization has been terminated. I additionally acknowledge and agree that, in the event that any of the information I have provided on this form changes or becomes inaccurate, I must immediately submit an EFT Termination/Change Form containing such information necessary to correct such changed or inaccurate information.

_____
Written Signature of Person Submitting Enrollment

_____
Printed Name of Person Submitting Enrollment

_____
Submission Date

If you have any questions about this form or your EFT enrollment status, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2 Email: PCDMStatus@bcbsla.com

For internal use only: *iLB set up complete.*

APPENDIX III: DEFINITIONS
of the Professional Provider Office Manual

This is an appendix of the *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Definitions

Affiliated

Two companies are affiliated when one company owns less than a majority of the voting stock or interest of the other, when one company owns a portion of the voting stock or interest of the other, or when both are subsidiaries of a third corporation. A subsidiary is a company where more than 50% of the voting shares are owned by another corporation, called the parent company. A subsidiary is also an affiliate company. Two subsidiaries of the same parent company are affiliates of each other.

Allied Health Provider

A person or entity other than a hospital, doctor of medicine, or doctor of osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Blue Cross to render covered services. For coverage purposes, Allied Health Provider includes dentists, psychologists, retail health clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, certified registered nurse anesthetists, licensed clinical social workers, and any other health professional as mandated by state law for specified services, if approved by Blue Cross to render covered services.

Allowable Charge/Professional Allowance

The lesser of the billed charge or the amount Blue Cross establishes or negotiates as the maximum amount allowed for all provider services covered under the terms of your agreement.

Authorization

A determination by Blue Cross regarding an admission, continued hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for medical necessity, appropriateness of the health care setting, or level of care and effectiveness. An authorization is not a guarantee of payment. Additionally, an authorization is not a determination about the member's choice of provider.

Benefit(s)

Medical services, treatment, procedures, equipment, drugs, devices, items or supplies provided under a benefit plan. Benefits are based on the allowable charge for covered services.

Blue Advantage

Our Medicare Advantage networks that have been in effect since January 1, 2016, statewide.

Billed Charges

The total charges made by a provider for all services and supplies provided to the member.

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 Blue Cross and the member. The sharing is expressed as a percentage. Once the member has met any applicable deductible amount, the member's percentage will be applied to the allowable charges for covered services to determine the member's financial responsibility. Blue Cross' percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Consumer Directed Health Care (CDHC)

A broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

As an umbrella term, CDHC encompasses multiple models and services including Consumer Directed Health Plans, high deductible health plans, member health care accounts, debit cards, member support tools, provider cost and profile information, e-business services, and next generation networks.

Consumer Directed Health Plans (CDHP)

High deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs), such as a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA), or a Flexible Spending Arrangement (FSA), thereby forming a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

High deductible health plans vary in design (deductible thresholds, preventive coverage, and more), and are offered and administered by a health insurance company, such as a Blue Cross Plan.

Coordination of Benefits (COB)

Determining primary/secondary/tertiary liability between various health care benefit programs and paying benefits in accordance with established guidelines when members are eligible for benefits under more than one health care benefits program.

Copayment (Co-pay)

The amount of charges for covered services which a member must pay. The copayment may be collected directly from the member by a network provider each time a specified covered service is rendered.

Covered Services

Those medically necessary health care services and supplies for which benefits are specified under a member contract/certificate.

Current Procedural Terminology (CPT)

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 member before Blue Cross is obligated to member to assume financial responsibility for all or part of the remaining covered services under a member agreement.

Electronic Funds Transfer (EFT)

Allows payment to be sent directly to iLinkBlue enrolled providers' checking or savings accounts. With EFT, providers can view their Weekly Provider Payment Registers in iLinkBlue and they will not receive a Payment Register by mail.

Eligible Charges

Eligible charges are defined as total charges billed on a claim less denied charges including but not limited to claims editing and medical policy.

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 member 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.

Flexible Spending Arrangement (FSA)

Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. FSAs can also be provided to cover childcare and transit expenses, but those accounts must be established separately from medical FSAs.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was enacted as a broad congressional attempt at incremental health care reform. The "Administrative Simplification" section of that law requires the United States Department of Health and Human Services (DHHS) to develop standards and requirements for maintaining and transmitting health information.

Health Reimbursement Arrangement (HRA)

An employer-funded plan that reimburses employees for Qualified Medical Expenses (QMEs); an HRA is funded solely by the employer. Reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in an employee's income. Unused funds can be rolled over annually but are owned by the employer and thus are not portable when the employee leaves the employer's company.

Health Savings Account (HSA)

A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified health care expenses of the account beneficiary who, for the months of which contributions are made to an HSA, is covered under a high-deductible plan. An HSA is employee-owned but can be funded by the employer and/or the employee. Unused funds are owned by the employee and thus are portable when the employee leaves the employer's company.

High Deductible Health Plan (HDHP)

A descriptive term relating to a broad category of health plans that feature higher annual deductibles than other traditional health plans. Deductibles typically exceed $1,000 for individual coverage and $2,000 for family coverage. This term encompasses those CDHP plans that are HSA qualified.

HSA Qualified High Deductible Health Plan

An individual or family health plan with minimum annual deductible and maximum out-of pocket amounts indexed annually for inflation according to Internal Revenue Code (IRC) §223(c)(2) and IRC §223(g)(1).

HMO Louisiana Select Networks

A group or individual product that affords Members access to covered services through a network of select participating providers, and includes, but may not be limited to the following products: Blue Connect, Community Blue, Precision Blue, Signature Blue, or an Exclusive Provider Organization (EPO) administered by Blue Cross or its affiliates.

HMO Louisiana Select Network Provider

Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing services who has entered into a HMO Louisiana Select Network contractual agreement with HMO Louisiana to provide Covered Services to Members.

iLinkBlue

A secure Web portal available at no cost for health care providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

Identification Card

The card issued to the member identifying him/her as entitled to receive benefits under a member 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 member.

Identification Number

The number assigned to the member and all of his/her Blue Cross records. This number is a unique number selected at random, has a three-character prefix in the first three positions, and is noted on the identification card.

International Classification of Diseases, 10th Revision (ICD-10-CM)

A numerical classification descriptive of diseases, injuries and causes of death.

Medically Necessary/Medical Necessity

Health care services, treatments, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a member 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.

Member

A subscriber or an enrolled dependent.

National Drug Code (NDC)

A unique 10-digit, three-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Provider Identifier (NPI)

A 10-digit number unique to each provider that is issued by the Centers of Medicare and Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Network/Participating Providers

Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing facility, hospice, home health agency, or any other health care practitioner or provider of medical services who has entered into a contractual agreement with Blue Cross to provide covered services to members.

Noncovered 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 member contract/certificate.

Non-participating Provider

Provider that has chosen not to sign a network agreement with Blue Cross.

Non-network/No network Participating Provider

A provider/specialty type that Blue Cross does not offer network agreements to.

Notification

A message sent to confirm, validate, acknowledge, or provide information from one entity to another.

Out-of-Network Provider

A provider that has signed a network agreement with Blue Cross, but is not in the specific network tied to the member's benefit.

Participating Plan

A licensee participating in Blue Bank ownership and governance. Also means: A licensee in whose service area a national account has employee and/or retiree locations, but in which the national account headquarters is not located unless otherwise agreed in accordance with National Account Program policies and provisions.

Patient Protection and Affordable Care Act (PPACA)

PPACA is legislation (Public Law 111-148) signed by President Obama on March 23, 2010. It is commonly referred to as the health care reform law.

Personal Savings Account (PSA)

A broad term used to represent the member's portfolio of accounts: Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), Flexible Savings Account (FSA). This is also referred to as Health Care Accounts (HCA).

Physician Advisory Committee (PAC)

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 HMO Louisiana networks.

Plan

Blue Cross and Blue Shield of Louisiana also referred to as Blue Cross.

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 or if the service is covered under the member's benefit plan.

Prefix

A three-digit prefix to the member identification number that identifies the Blue Cross Plan or the national account in which the member is enrolled. FEP members' ID numbers will start with "R."

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 member contract/certificate.

Provider

A hospital, allied health facility, physician, or allied health professional, licensed where required, performing within the scope of license, and approved by Blue Cross. If a provider is not subject to state or federal licensure, we have the right to define all criteria under which a provider's services may be offered to our members in order for benefits to apply to a provider's claims. Claims submitted by providers who fail to meet these criteria will be denied.

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.

Qualified Medical Expenses (QME) Substantiation

Refers to the process of determining that expenses submitted to a PSA administrator to be paid from HRAs or FSAs meet the requirements defined by Internal Revenue Service (IRS) regulations. Eligible medical expenses are defined as those expenses paid for care as described in Section 213(d) of the Internal Revenue Code. Additionally, the IRS has allowed some over the counter drugs to qualify as eligible medical expenses. For more detailed information, please refer to IRS Publication 502. (See www.irs.gov/pub/irs-pdf/p502.pdf.)

Subscriber/Member

An eligible person who has satisfied the specifications of the agreement schedule of eligibility and has enrolled for coverage.

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 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 members as Blue Cross is for their respective members 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 member contract/certificate or health benefit plan entitles members/members to receive health care benefits as defined in and pursuant to a member 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.

SUMMARY OF CHANGES

Below is a summary of changes to the *Professional Provider Office Manual*. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document.

January 2023

Quick Reference Guide

- Authorizations – added exceptions clarification for out-of-state services, added contact information for retrospective review authorizations
- Provider Credentialing & Date Management – updated description of Vantage Health Plan partnership; updated website instructions for finding more information and credentialing packets

Network Overview

- Preferred Care PPO – updated member ID card sample
- HMO Louisiana, Inc. – updated member ID card sample
- Blue Connect – updated member ID card sample
- Community Blue – updated member ID card sample
- Precision Blue – updated member ID card sample; added Greater Monroe/West Monroe area parishes
- Signature Blue – updated member ID card sample and member benefits description
- Bridge Blue Short-term Medical – updated member ID card sample
- Office of Group Benefits (OGB) Benefit Plans – updated member ID card samples
- OchPlus – added entry and member ID card sample
- Blue*Choice* 65 – updated member ID card sample
- Federal Employee Program (FEP) – updated member ID card samples
- Blue Advantage (HMO) and Blue Advantage (PPO) – updated tagline
- Healthy Blue and Healthy Blue Dual Advantage – changed name of Anthem Blue Cross to Elevance Health

Network Participation

- Credentialing Program Overview – updated introduction to indicate Vantage Health Plan processes credentialing and recredentialing; updated web address pathway for accessing credentialing and date management; updated web address pathway for accessing the credentialing packets

- Facility Credentialing – updated packet and form names, updated list of providers who can be set up as medical staff, removed Urgent Care Centers subsection, removed ambulance transport information and example from Subcontracted Providers subsection and moved information to Section 5.3 Ambulance Transport Benefit
- Professional Credentialing – updated Reimbursement During Credentialing guidelines
- Terminations – added entry for lack of claims activity
- Digitally Submitting Credentialing & Demographic Forms – updated facility attachment name
- Provider Directories – updated instruction and description of Provider Update Request Form
- Provider Directory Locations Policy – updated practice criteria

Member Engagement

- Estimated Treatment Cost Tool – updated estimated treatment cost data with 2022 figures

Medical Management

- Concurrent Review – added clarification to indicate most out of state services are an exception to submitting through BCBSLA Authorizations
- Retrospective Review – updated description and instructions for submitting a retrospective review
- Authorization Process – changed name of Authorizations Application Mandate subsection and updated guidelines; changed name of Authorizations Application Resources subsection; updated Home Health Authorizations guidelines
- Authorization Penalties for Providers – updated Outpatient Authorization Penalty to add clarifications to indicate how fully insured and self-funded contracts apply penalties; updated Inpatient Authorization Penalty to add clarifications to indicate how fully insured and self-funded contracts apply penalties
- PPO Services That Require Prior Authorization – updated list; updated description for submitting requests through BCBSLA Authorizations
- HMO Services That Require Prior Authorization – updated list; updated description for submitting requests through BCBSLA Authorizations
- OGB Plan Services That Require Prior Authorization – updated list; updated description for submitting requests through BCBSLA Authorizations
- OchPlus Services That Require Prior Authorization – added list
- FEP Services That Require Prior Authorization – updated list
- AIM Specialty Health Utilization Management Programs – updated introduction with authorization request clarifications; added navigation reminders for AIM's review process
- Quality Blue Program – updated program name and description

Billing and Reimbursement Guidelines

- 5.0 Table of Contents – added entries for Mass Immunizers and Digital Health
- 5.4 Ambulance Transport Benefit – reorganized sections to consolidate transport information into General Transportation subsection; added entry and example for emergency room to inpatient or emergency room/observation ambulance transport; removed member/patient is inpatient entry to replace with entry on inpatient to inpatient ambulance transport; added entry and example for inpatient to inpatient ambulance transport and patient does not maintain inpatient status with initial facility transport; added entry for ambulance transport reimbursement eligibility chart
- 5.6 Autism – updated benefit limitation information in introduction; removed age coverage limitations; removed indication and examples of benefits applying before and after policy renewal date
- 5.7 Behavioral Health – added OchPlus network information to Network Chart; added PHP and IOP clarification to per diem payment information; added billing guidelines for the administration of Spravato
- 5.8 Chiropractic and Physical Medicine Services – updated code ranges in multiple procedure reduction subsection
- 5.14 Durable Medical Equipment and Supplies – renamed section name; updated General Guidelines to add subsections on definitions, prescription requirement, equipment rental or purchase, standards and warranty; updated reimbursement and authorization guidelines for breast pumps; added billing guidelines for donor breask milk; added hearing aid guidelines for members who are 18 and older; added billing guidelines for continuous glucose monitoring sensor and transmitter codes; added guidelines, added clarifications to Wheelchairs (customized) subsection for billing specialty strollers
- 5.17 Incident-to – added guidelines for student\resident and those with a provisional license
- 5.20 Intra Operative Monitoring – added Place of Service 15 code restriction
- 5.21 Laboratory – changed subsection name to Requirements for Providers; updated In-office Lab List; added authorization requirement guidelines for Genetic Testing; added guidelines for Proprietary Lab Analyses; added guidelines for Genomic Sequencing Procedures and Multianalyte Assays with Algorithmic Analyses
- 5.24 Modifiers – updated guidelines for billing Modifiers AS, 80, 81 and 82 for surgical assistant services
- 5.32 Place of Service – removed Norm POS column, added Place of Service codes 02 and 10 to listing; added guidelines for Place of Service codes 02, 10 and 15
- 5.35 Sleep Study – added notation for self-funded group requirements; added guidelines for home sleep studies using Peripheral Arterial Tone technology

- 5.37 Telemedicine/Telehealth – updated the description of services Blue Cross considers telehealth; removed instructions for accessing COVID-19 temporary telehealth services; added definition of hybrid telehealth encounter; updated policy guidelines with list of provider types, telehealth platform requirements, and examples of services not elligible for reimbursement as telehealth; updated direct to consumer code listing and guidelines; added audio-only telehealth guidelines; added hybrid telehealth guidelines
- 5.41 Mass Immunizers – added new section for mass immunizer reimbursement and billing guidelines
- 5.42 Digital Health – added new section for remote patient monitoring reimbursement and billing guidelines

Claims Submission

- Coordination of Benefit – removed indication that Blue Cross will deny claim if primary carrier's explanation of benefits (EOB) is not obtained; updated requirements in accordance with Louisiana House Bill 339 changes

Appendix II – Forms

- Provider Dispute Form – updated sample pages with revised form
- Retrospective Review Authorization Form – added sample pages of new form
- EFT Enrollment Form and Guide – updated sample pages with revised form and guide

Appendix III – Definitions

- HMO Louisiana Select Networks – updated definition

March 2023

Quick Reference Guide

- Appeals – changed name of New Directions Behavioral Health to Lucet
- Authorizations – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon

Network Participation

- Credentialing Program Overview – changed name of AIM Specialty Health to Carelon in Facility Credentialing subsection

Medical Management

- Table of Contents – changed name of AIM Specialty Health to Carelon
- Authorization Process – changed name of AIM Specialty Health to Carelon
- PPO Services That Require Prior Authorization – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon

- HMO Services That Require Prior Authorization – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon
- OGB Plan Services That Require Prior Authorization – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon
- OchPlus Services That Require Prior Authorization – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon
- FEP Services That Require Prior Authorization – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon
- Carelon Utilization Management Programs – changed name of AIM Specialty Health to Carelon
- Behavioral Health Authorizations – changed name of New Directions Behavioral Health to Lucet
- Adult and Pediatric Ambulatory Medical Review Definition of Guidelines – changed name of New Directions Behavioral Health to Lucet; changed name of AIM Specialty Health to Carelon
- Medical Policy – changed name of AIM Specialty Health to Carelon
- Care Management Programs – changed name of New Directions Behavioral Health to Lucet

Billing and Reimbursement Guidelines

- 5.6 Autism – changed name of New Directions Behavioral Health to Lucet
- 5.7 Behavioral Health – changed name of New Directions Behavioral Health to Lucet

Appendix II – Forms

- Authorization Form – updated sample page image with revised form that changed name of AIM Specialty Health to Carelon and New Directions Behavioral Health to Lucet
- Retrospective Review Authorization Form – updated sample page image with revised form that changed name of AIM Specialty Health to Carelon and New Directions Behavioral Health to Lucet

April 2023

Billing and Reimbursement Guidelines

- 5.4 Ambulance Transport Benefit – removed ground transportation eligibility criteria for Emergency room to inpatient or observation ambulance transport; removed ground transportation eligibility criteria for Inpatient to inpatient ambulance transport and patient does not maintain inpatient status with initial facility

July 2023

Billing and Reimbursement Guidelines

- 5.14 Durable Medical Equipment and Supplies – updated Continuous Glucose Monitoring subsection to add billing guidelines for receivers and implantable continuous glucose monitors

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