Behavioral Health Workshop

2018

Provider Relations Department
provider.relations@bcbsla.com

Louisiana

18-134_H6453_C

Our Mission

To improve the health and lives of Louisianians

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

To serve Louisianians as the statewide leader in offering access to affordable healthcare by improving quality, value and customer experience

Today's Strategy

Provider Relations Team

Your Provider Relations Team at Blue Cross and Blue Shield of Louisiana

Left to right: Marie Davis, Melonie Martin, Anna Granen, Patricia O'Gwynn, Jami Zachary, Mary Guy, Kelly Smith, Lisa Roth

New Directions Team

Debbie Crabtree
Provider Relations Coordinator

Michelle Sims, LPC, LMFT
Clinical Network Manager

Credentialing
&
Provider Data

Credentialing Process

- Blue Cross credentials both professional and facility providers
- To participate in our networks, providers must meet certain criteria as regulated by our accreditation body and the Blue Cross and Blue Shield Association
- The credentialing process can take up to 90 days once Blue Cross receives all required information
- Providers will remain non-participating in our networks until their application has been approved by the credentialing subcommittee
- Network providers are recredentialed every three years from their last credentialing acceptance date
- Required credentialing and recredentialing packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

After 90 days, you may inquire about your credentialing status by contacting our Credentialing department at 1-800-716-2299, option 2

New Credentialing & Provider Data Policy

Effective April 9, 2018, Blue Cross implemented a new policy for credentialing and provider data maintenance requests to help ensure completed requests are processed timely

- Requests to join our networks or maintain network participation, including the credentialing and recredentialing processes, must be submitted on appropriate applications
- Requests for provider data maintenance must be submitted on the appropriate Blue Cross form

Requests that are incomplete, missing information or submitted on the incorrect form will be returned. The processing time will start over once all required information is received.

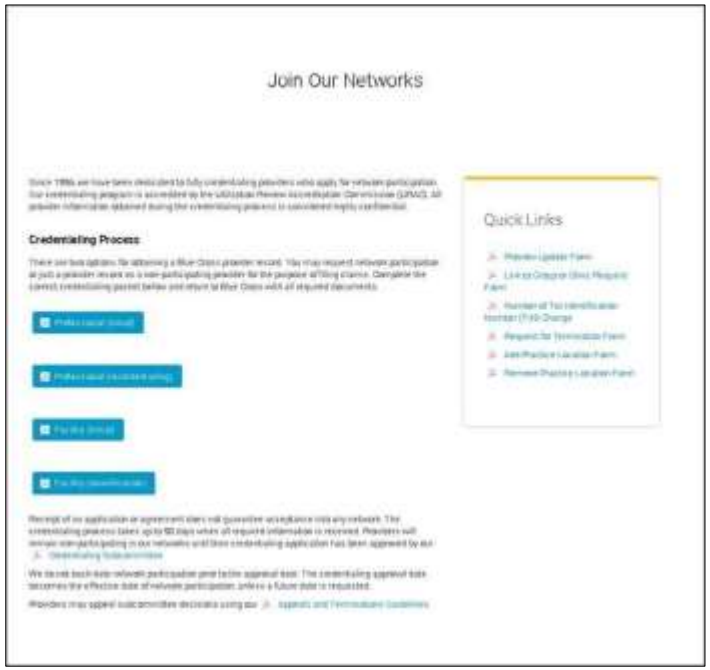
All forms and credentialing packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

Incomplete Applications

Below are the most common reasons applications are returned upon receipt:

- No original signature on application *(stamped or typed signatures are not accepted)*
- No application signature date *(stamped or typed signature dates are not accepted)*
- Application signature is 180 days old or greater
- No effective date listed
- Professional provider does not submit the current version of the Louisiana Standardized Credentialing Application
- Facility does not submit the Health Delivery Organization (HDO) Information Form
- An alternative application is submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*

New Credentialing Webpage



Visit our "Join Our Networks" page to find:

- Credentialing packets for professional and facility providers
- Recredentialing packets for professional and facility providers
- Checklists with all required documents for participating or non-participating providers *(submit the applicable completed checklist with all indicated documents)*
- Quick Links to provider update forms
- Credentialing Criteria for professional, facility and hospital-based providers

www.BCBSLA.com/providers >Provider Networks >Join Our Networks

How to Update Your Information

It is important that we always have your most current information in our files. Our Provider Data unit manages demographic changes to your provider record.

These forms are required for making the indicated changes to your record:

Use our **Provider Update Form** if you have an address, phone, fax, email address or hours of operation change

Use our **Link to Group or Clinic Request Form** when an individual provider is linking to a provider group or clinic

Use our **Notice of Tax Identification Number (TIN) Change Form** to report a change in your tax ID number

These forms are located online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

These forms are <u>required</u> for making the indicated changes to your record:

Use our **Request for Termination** to request termination from one or more of our networks

Use our **Add Practice Location Form** when an individual provider is adding a practice location(s)

Use our **Remove Practice Location Form** when an individual provider is removing a practice location(s)

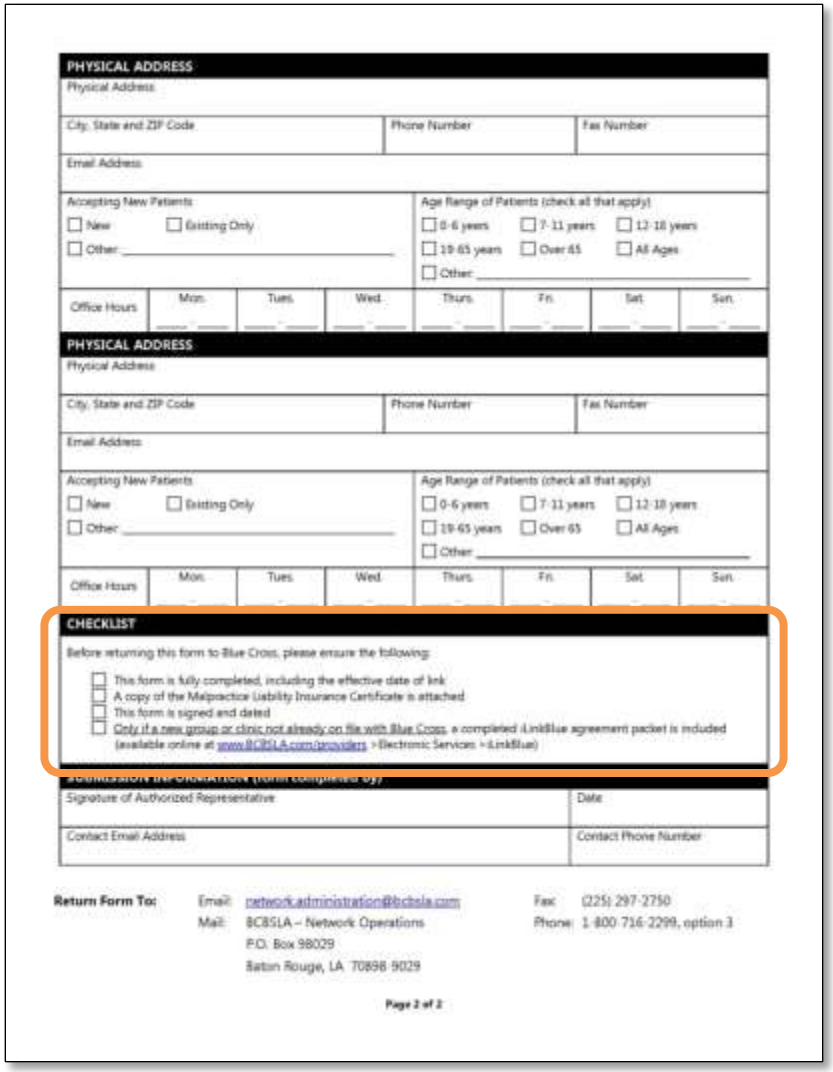
After 90 days, you may inquire about your demographic change by contacting our Provider Data Management unit at 1-800-716-2299, option 3

These forms are located online at **www.BCBSLA.com/providers** >Resources >Forms

How to Update Your Information

Complete the checklist:

- Our provider update forms include a checklist of **required** supporting documentation needed for us to complete your request
- Please ensure **all** requested items on the checklist are included or completed before submitting
- Submissions that are missing checklist items will be returned
- Submit a copy of the completed checklist



PHYSICAL ADDRESS

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

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.

PHYSICAL ADDRESS

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

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.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ This form is fully completed, including the effective date of link
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ This form is signed and dated
- ☐ Only if a new group or clinic not already on file with Blue Cross, a completed LinkBlue agreement packet is included (available online at www.BCBSLA.com/providers >Electronic Services >LinkBlue)

Signature of Authorized Representative | Date

Contact Email Address | Contact Phone Number

Return Form To:

Email: network.administration@bcbsla.com

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: (225) 297-2750

Phone: 1-800-716-2299, option 3

Page 2 of 2

How to Submit Your Information

Submit completed applications and forms by:

Email: network.administration@bcbsla.com

recredentialingapplication@bcbsla.com
(recredentialing applications only)

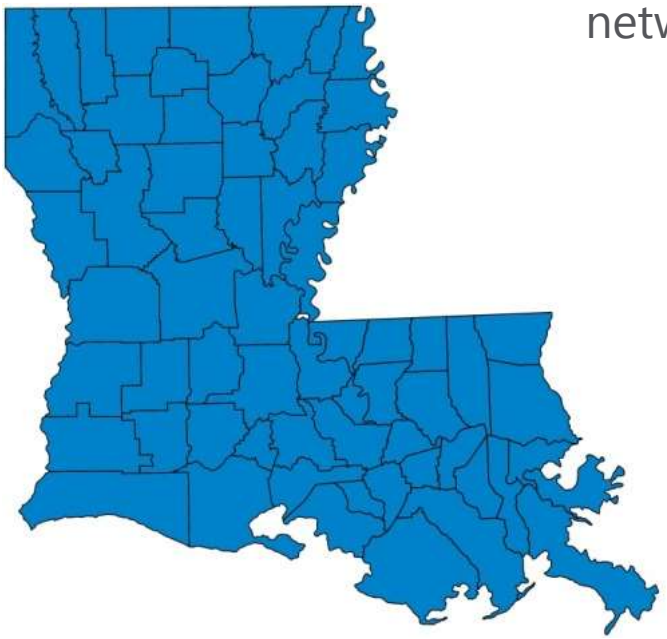
Fax: (225) 297-2750

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

The best method of submission is via email. This allows us to process your requests faster than when faxed or mailed.

Our Networks

Our Provider Networks



Preferred Care PPO and **HMO Louisiana, Inc.** networks are available statewide to members

Louisiana

HMO Louisiana

We have a Provider Tidbit to help identify members' applicable network when looking at the member's ID card. The *Identification Card Guide* is available online at **www.BCBSLA.com/providers** then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Our Provider Networks

Blue Connect

New Orleans area

Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes

Lafayette area

Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

Shreveport area

Bossier and Caddo parishes

Baton Rouge area

(Beginning July 2019)

Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Community Blue

Baton Rouge area

Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Signature Blue

New Orleans area

Jefferson and Orleans parishes

Blue Connect, Community Blue and Signature Blue member ID cards include the HMO Louisiana, Inc. logo in the top left corner and the network name in the top right corner

Blue Advantage (HMO) Network

Blue Advantage is our Medicare Advantage product currently available to seniors in 30 parishes. In 2019, this product will expand to the entire state of Louisiana and include HMO and PPO.

BlueCard® Program

BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area

The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

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

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

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

National Alliance

(South Carolina Partnership)

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC)
- BCBSLA taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC
- Claims are processed through the BlueCard® program

Our *Identification Card Guide* provider tidbit can help you identify and better understand our policies that are handled directly through the National Alliance program. The guide is available online at **www.BCBSLA.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Member ID Prefixes

- As of April 15, 2018, providers may have started seeing prefixes on member ID cards that contain numeric characters
- Due to growth in the number of products being sold by Blue Plans nationwide, the Blue Cross Blue Shield Association has determined the need to expand the prefixes to be alpha-numeric
- Prefixes can be alpha only or a combination of alpha and numeric characters in one of the combinations shown in the example
- The prefix is the first three characters of the member number that appears on the member ID card. It is required for claims processing and is critical for member eligibility and benefit inquiries. The prefix identifies which Blue Plan and product the member has.

Example:

A2A	2AA	22A
AA2	2A2	A22

Billing & Claims

Filing Claims Hardcopy

If it is necessary to file a hardcopy claim, we only accept original claim forms

UB-04

CMS-1500 (02-12)

- We no longer accept faxed claims
- We only accept **RED** original claim forms

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Signature Blue, FEP & OGB:

Mail hardcopy claims to:

BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898

For Blue Advantage (HMO):

Until 12/31/2018, mail hardcopy claims to:

Blue Cross and Blue Shield of LA
/HMO Louisiana
P.O. Box 32406
St. Louis, MO 63132

Beginning 1/1/2019, mail hardcopy claims to:

Blue Cross and Blue Shield of LA
/HMO Louisiana
P.O. Box 7003
Troy, MI 48007

The fastest method of claim submission and payment is electronic submission

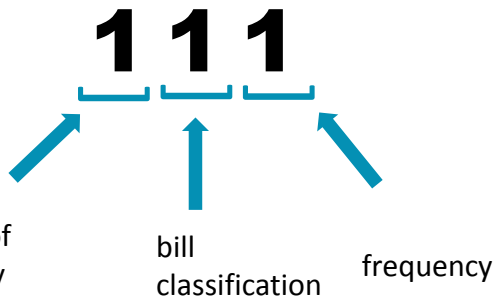
Facility Billing

These guidelines are outlined in the *Member Provider Policy & Procedure Manual,* available on iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Resources" section

- Facility claims must be submitted with a UB-04 form. Bill types are three digits and each digit position represents specific information about the claim being filed.
- Blue Cross does not exclude any first or second digits of the bill type. However, there ARE exclusions related to the frequency digit (third position of bill type).
- **Blue Cross will not accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. We do not accept interim billings for inpatient.**

  *Exception: an interim bill will be accepted only if the total charge is $800,000 or greater and at least 60 days of service**
- Any interim bills or late charge claims should be aggregated into one final claim and be submitted using a frequency code of 1
- For submission of adjustments or replacement claims the frequency code 7 is acceptable
- Use frequency code of 8 for void claims

*If you meet the criteria to file an interim bill, please call Brian West at (225) 297-2654 to discuss how to submit your bill



Taxonomy Codes

If your NPI is shared between sub-units, it is very important to also include the appropriate taxonomy code that clearly identifies the sub-unit in which services were provided

You must file the code for the services on the authorization from New Directions

Example: Residential and substance abuse facilities that share a single NPI and tax ID for **substance abuse** should use a residential or chemical dependency units taxonomy code as appropriate based on the services being billed

Failure to use a specific taxonomy code will cause payment to be directed to the wrong sub-unit, be paid incorrectly and/or may cause the claims to reject on the Not Accepted Report

IOP & PHP

We include billing guidelines for Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP) services in our ***Member Provider Policy & Procedure Manual***

Available only on iLinkBlue (www.BCBSLA.com/ilinkblue), then click on Manuals

Billing Guidelines Include:

- General IOP and PHP coverage criteria
- IOP-specific patient eligibility criteria
- PHP-specific patient eligibility criteria
- Frequency and duration of IOP/PHP services
- Individualized treatment plan
- Physician supervision and evaluation
- Discharge planning
- Expectation of improvement
- Documentation requirements and physician supervision
- Billing instructions

IOP & PHP Billing

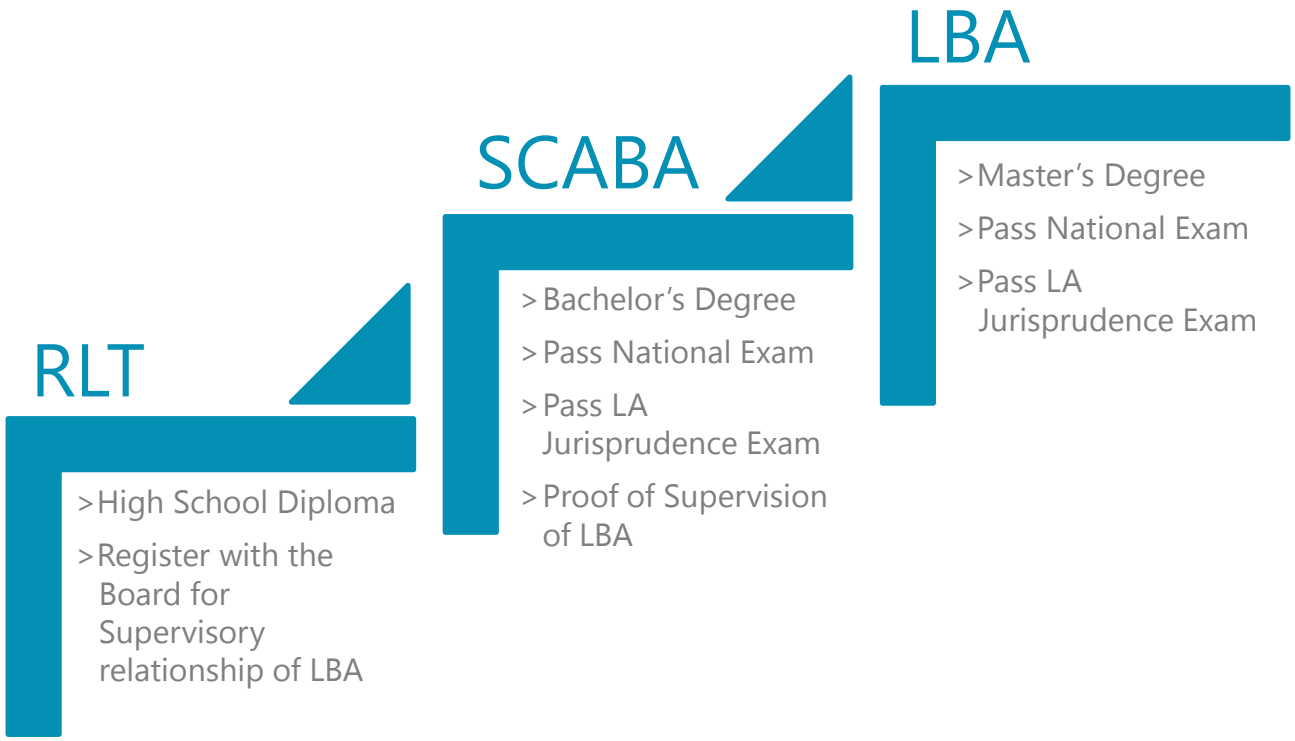
When filing a UB-04 claim for IOP/PHP services, the following combination of HCPCS/revenue codes are appropriate to ensure accurate reimbursement per your provider contract. The combination will be determined based on the primary reason the member is receiving IOP/PHP services:

Level of Care	Type of Service	Revenue Code	Required HCPCS Code	Service Units
IOP	Psychiatric	905	**S9480**: intensive outpatient psychiatric services, per diem	1
IOP	Chemical Dependency	906	**H0015**: alcohol and/or drug services; intensive outpatient treatment	1
PHP	Chemical Dependency or Psychiatric	912 (Less intensive)	**H0035**: mental health partial hospitalization treatment less than 24 hours	1
PHP	Chemical Dependency or Psychiatric	913 (Intensive)	**H0035**: mental health partial hospitalization treatment less than 24 hours	1

Only one IOP/PHP revenue code is allowed per day with a unit of "1"

Claims should not be billed with individual therapy codes

ABA Provider Types



- All levels must pass a criminal background check
- Application fees and procedures can be found on the Louisiana Behavior Analyst Board website: www.lababoard.org

ABA Billing Guidelines

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
- Services must be billed with Modifier TF

Registered Line Therapists (RLT)

- Cannot bill directly
- Services must be billed through the supervising licensed behavior analyst (LBA) with the appropriate code and no modifier

Claim payments will be based on your:

- Licensure
- Certification
- Registration

(as designated by the state Behavior Analyst Board)

Provider	Billable Modifier
LBA	TG
SCABA	TF
RLT	none

ABA Coding

Code	Time	Clinician Type	Modifier
0359T	1 hour*	LBA SCABA	TG TF
0360T	30 min	LBA SCABA TECH	TG TF
0361T	30 min	LBA SCABA TECH	TG TF
0364T	30 min	LBA SCABA TECH* TECH	TG TF HN
0365T	30 min	LBA SCABA TECH* TECH	TG TF HN
0366T	30 min	LBA SCABA TECH	TG TF
0367T	30 min	LBA SCABA TECH	TG TF
0368T	30 min	LBA SCABA	TG TF
0369T	30 min	LBA SCABA	TG TF
0370T	1 hour	LBA SCABA	TG TF
0371T	1 hour	LBA SCABA	TG TF
0372T	1 hour	LBA SCABA	TG TF

*Registered Line Technicians with a bachelor's degree should report Modifier HN.

Subrogation

Subrogation is a contract provision that allows healthcare insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. All claims submitted to Blue Cross must indicate if injuries or illnesses are the result of an accident.

Providers should:

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

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

Timely Filing

Blue Cross, HMO Louisiana, Blue Connect, Community Blue & Signature Blue:

- Claims must be filed within 15 months of the date of service

FEP:

- Claims must be filed by December 31 of the following year after the service was rendered

Blue Advantage:

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

* (unless the individual provider agreement states otherwise)

OGB:

- Claim must be filed within 12 months of the date of service

Self-insured & BlueCard®:

- Timely filing standards may vary so always verify the member's benefits, including timely filing standards, through iLinkBlue

Claims received after the timely filing deadline will be denied and the member and Blue Cross are held harmless

Payment Integrity Program

Claims Auditing

- We routinely audit claims to validate the accuracy of our payments, including the verification of the diagnosis and procedure codes submitted on each claim form
- To perform these reviews, we have authorized various vendors to request and receive supporting medical or billing documentation on behalf of Blue Cross
- Failure to comply with requests for medical records or billing documentation within 30 days may result in denial of any previous claim payment made for the requested case. Previous payments will be recovered through offsets to future payments.

You are required to provide us with medical records at no charge as outlined in your Blue Cross network agreement

Member Benefit Terms

- Fully-insured group – Group pays a fixed premium cost per class coverage each month. The funds for claims reimbursement come from Blue Cross.
- Self-funded group – Group pays a fixed cost each month, but they fund monthly claims payments along with funds for unexpected claims fluctuations. These groups use Blue Cross only to process claims.
- Grandfathered – A benefit plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by the Patient Protection and Affordable Care Act (PPACA). New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Non-discrimination (Section 1557)

- Blue Cross does not discriminate on the basis of race, color, national origin, sex, age or disability
- Policies affected: All fully insured policies
- Your Blue Cross patients may contact the Section 1557 Coordinator to file discrimination complaints:
  - Email: **section1557coordinator@bcbsla.com**
  - Phone: 1-800-711-5519 (TTY 711)
  - Fax: (225) 298-7240

Correcting or Disputing Claims

Correcting Claims Tidbit

- Submitting corrected claims can be easy when the appropriate steps are followed
- Use the *Submitting Corrected Claims* tidbit as a guide to properly adjust or void a claim so it does not deny as duplicate or process incorrectly
- The tidbit outlines the steps for submitting a corrected claim by paper or electronically (via clearinghouse or iLinkBlue)
- Available online at **www.BCBSLA.com/providers** >Resources


Supporting our providers and their staff.

PROVIDER TIDBITS

Louisiana

Submitting Corrected Claims

Available online at **www.BCBSLA.com/providers** >Resources >Tidbits

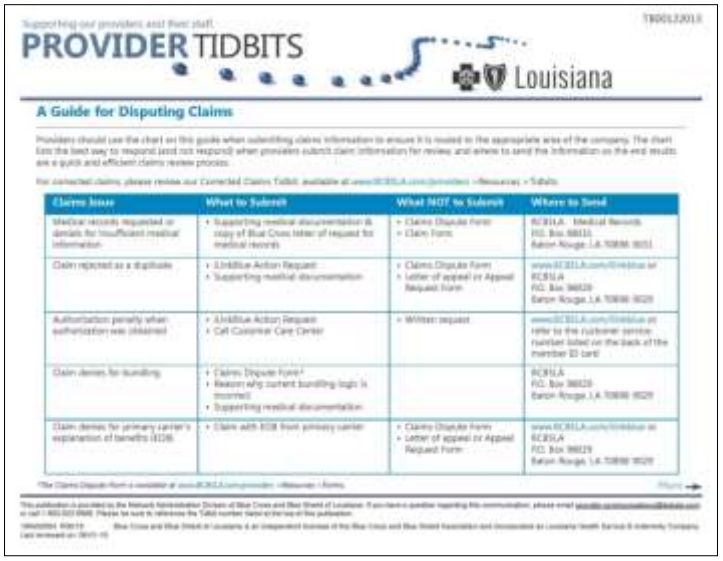
Electronic Corrected Claims

Submitting corrected claims electronically can be easy when the appropriate steps are followed:

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

- Corrected claims submitted in the 837I (facility) or 837P (professional) format should include the following:
- In Loop 2300 Segment CLM05-03, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Loop 2300 in the REF segment, use “F8” as the qualifier and enter the original claim reference number

Disputing Claims Tidbit


PROVIDER TIDBITS

Louisiana

A Guide for Disputing Claims

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or details for insufficient medical information	• Supporting medical documentation & copy of Blue Cross letter of request for medical records	• Claims Dispute Form • Claim Form	BCBSLA Medical Records P.O. Box 98010 Baton Rouge, LA 70898-9010
Claim rejected as a duplicate	• Untitled Action Request • Supporting medical documentation	• Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/tidbits or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	• Untitled Action Request • Call Customer Care Center	• Written request	www.BCBSLA.com/tidbits or refer to the customer service number listed on the back of the member ID card
Claim denies for bundling	• Claims Dispute Form* • Reason why current bundling logic is incorrect • Supporting medical documentation		BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/tidbits or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029

*The Claims Dispute Form is available at www.BCBSLA.com/providers >Resources >Forms.

- We recognize that disputes may arise between providers and Blue Cross regarding covered services
- Use the "Disputing Claims" tidbit as a guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross
- Examples of issues that qualify as disputes:
  - Claims issues related to authorizations
  - Claims based on adverse determinations of medical necessity or benefit determinations
  - Reimbursement reviews

Available online at **www.BCBSLA.com/providers** >Resources >Tidbits

Claims Dispute Form

- Use the Claims Dispute Form to properly request a review of your claim
- Be sure to place the form on top of your claim when submitting for review to ensure it is routed to the appropriate area of the company
- Use the Claims Dispute Form when:
  - Claim rejected as duplicate
  - Claim denied for bundling
  - Claim denied for medical records
  - Claim denied as investigational or not medically necessary
  - Claim payment/denial affects the provider's reimbursement
  - Claim payment affects the member's cost share
  - Claim denied for a BlueCard® member


Louisiana

Claims Dispute Form

PROVIDER INFORMATION

PATIENT INFORMATION

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

Available online at **www.BCBSLA.com/providers** >Resources >Forms

Resolving Claims Issues

Submit an Action Request through iLinkBlue or contact Customer Care at 1-800-922-8866

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 working days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 working days for second request

When to Contact Provider Relations for Claims Help

You may email an overview of the issue along with your two reference numbers to **provider.relations@bcbsla.com** after the allotted timeframes if one of the following applies:

- You have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers/action request dates, or
- It is a system issue affecting multiple claims

Medical Necessity Appeals

First-level appeals

Send directly to New Directions:

New Directions Behavioral Health
ATTN: Appeals Coordinator
P.O. Box 6729
Leawood, KS 66206

Fax: 1-816-237-2382

New Directions conducts medical necessity reviews:

- **Decision to Overturn Denial** – Letter is sent to member and provider letting them know denial was overturned and processing instructions are communicated to Blue Cross to pay claim
- **Decision to Uphold Denial** – Letter is sent to member and provider directing them on how and where to file a second-level appeal request

Medical Necessity Appeals

Second-level appeals

Second-level appeals are handled one of two ways:

1. By Blue Cross
2. By the member's group (applies for some self-funded groups)

Upon receipt of the second-level appeal, Blue Cross or the member's group 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

Pharmacy

NDC Billing Guidelines on Claims

Use the following billing guidelines to report required NDCs on professional CMS-1500 claims and outpatient facility UB-04 claims:

- NDC code editing will apply to any clinician-administered drugs 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

Failure to report NDCs on claims will result in automatic denials

NDC Reporting Clarification

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

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

10-Digit Format on Package	10-Digit label format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

If the NDC is not submitted in the correct format, the claim will be denied

CII and CIII Opioid Coverage Policy

#6	Louisiana has the sixth highest opioid prescription per capita rate, making the state 1 of only 8 that have more opioid prescriptions dispensed in a year than they have residents
861	More than 800 Louisiana residents died from opioid overdoses, both prescription and illicit, in 2015. From 2014 to 2015, opioid overdoses increased by 12% in the state, according to the Louisiana Department of Health.
2M	In 2015, 20.5 million Americans 12 or older had a substance use disorder. Two million of them had a substance use disorder involving prescription pain relievers.

Opioid Louisiana Laws in Effect

Among the bills that the Louisiana legislature passed during the 2017 Regular Session that addressed the opioid epidemic in Louisiana were two that affect prescribing:

Act 82 (House Bill 192)

- Effective August 1, 2017, implements a 7-day prescription limit for first-time fills on opioid drugs to treat pain. The bill exempts the limit for people with certain conditions like cancer or chronic pain, and allows doctors to override the limit in certain cases, such as for medical necessity.

Act 76 (Senate Bill 55)

- Provisions effective beginning January 1, 2018, tightens Louisiana's Prescription Monitoring Program, which is a database doctors and pharmacists can check to make sure patients do not have dispensing records that indicate potential abuse. The law requires healthcare providers to check the database before prescribing opioids to a patient and recheck it every 90 days, if the prescription continues beyond that period.

References: The Associated Press | The Center for Public Integrity | American Society of Addictions Medicine | National Safety Council

Prescribing Opioids

3.7%	Opioids account for 3.7% of prescription claims
21%	21% of members with our pharmacy benefits had at least one claim for an opioid prescription in 2016
94%	94% of opioid prescriptions are for short-acting opioids
	Top prescribing specialties include (in no particular order): primary care specialties, pain management, orthopedists, dentists/oral surgeons and others

Based on Blue Cross 2016 Claims Data. Excludes opioids prescribed by oncologists.

Blue Cross 2018 Opioid Policy

In order to set appropriate coverage guidelines, Blue Cross developed this policy after considering a breadth of:

- clinical guidelines
- industry best practices
- state regulatory requirements
- our own member population

OUR GOALS:

1. Decrease the amount of opioids in the community
2. Minimize the number of opioid-naïve patients becoming chronic users

The policy:

- places safety edits for acetaminophen, ibuprofen and aspirin on all short-acting opioid prescriptions
- requires prior authorization for short-acting opioids more than a certain days' supply, within a set period of time
- requires prior authorization for new users of long-acting opioids

Certain exceptions or adjusted limitations will apply for existing users within a set time and members with cancer or receiving end-of-life care based on claims history and/or provider information.

Blue Cross 2018 Opioid Policy

TARGET DRUG	POLICY
Acetaminophen (Tylenol®) Safety Edit	▪ Limits all Tylenol containing medications to 3 grams or less of Tylenol per day. ▪ No exceptions. ▪ Applies to opioid and non-opioid drugs.
Ibuprofen Safety Edit	▪ Limits all ibuprofen/short-acting opioid medications to 5 tabs or less per day. ▪ No exceptions.
Aspirin Safety Edit	▪ Limit all aspirin/short-acting opioid medications to 4 grams or less of aspirin per day. ▪ No exceptions.
Short-acting Opioids (examples: Percocet® and generics, Lortab® and generics, codeine, oxycodone)	▪ Prior authorization required for fills longer than 7-day supply. ▪ Prior authorization required for fills longer than a cumulative 21-day supply within 60 days' time. ▪ Existing users who filled prescriptions for a preferred opioid in the previous 130 days may be grandfathered. ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information.
Long-acting Opioids (examples: Butrans®, fentanyl patch, OxyContin®, MS Contin®, morphine ER, Oxycodone ER)	▪ Prior authorization required for new users. ▪ Existing users who filled prescriptions for a preferred opioid in the previous 130 days may be grandfathered. ▪ Certain exceptions will apply for members with cancer or receiving end-of-life care based on claims history and/or provider information.

Physician Education: Opioid Prescribing Toolkit

Available at www.BCBSLA.com/providers >Pharmacy

Member Education

- Direct Customer Communication and Broad Education
- Engage Health Coaches
- Support Community and Statewide Initiatives
- And more as needed

Documentation

Benefits of Proper Documentation

- Allows identification of high-risk patients
- Allows opportunities to engage patients in care management programs and care prevention initiatives
- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross
- Reduces costs associated with submitting corrected claims

Provider Role in Documenting

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

- Each page of the patient's medical records should include the following for a face-to-face visit:
  - Patient's name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials)
- Report ALL applicable diagnoses on claims and report at the highest level of specificity
- Include all related diagnoses, including chronic conditions you are treating the member for
- Medical records **must support ALL** diagnosis codes on claims

Common Errors

Common errors found in medical chart audits include:

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

Medical Record Requests

From time to time, you may receive a medical record request from us or one of our vendors to perform medical record chart audits on our behalf

- Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee

Blue Cross is currently partnered with these vendors to assist us in conducting medical record reviews

- Centauri
- Health Data Vision, Inc. (HDVI)
- Inovalon
- Varis

Referrals

Member Referrals

Network providers should always refer members to contracted providers

- Referrals to non-network providers result in significantly higher cost shares to our members and it is a breach of your Blue Cross provider contract
- Providers who consistently refer to out-of-network providers will be audited and may be subject to a **REDUCTION** in their network reimbursement
- The ordering/referring provider NPI is required on all laboratory claims. Place the NPI in the indicated blocks:
  - CMS-1500: Block 17B
  - UB-04: Block 78
  - 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element
  - 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

Examples:

- Outpatient Facilities
  - LTAC, SNF, Behavioral Health, Home Health
- Therapists
- Hospitals
- DME
- Laboratories

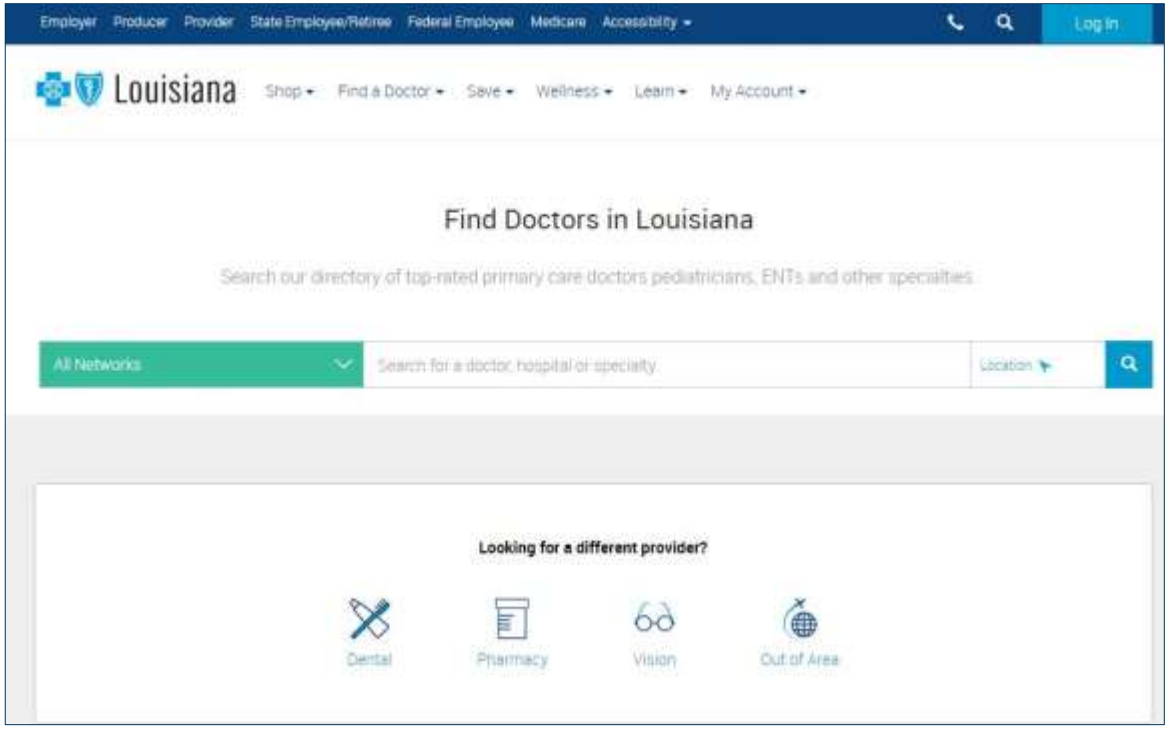
Out-of-network Referrals

The impact on your patients when you refer Blue Cross members to out-of-network providers:

- Out-of-network member benefits often include higher copayments, coinsurances and deductibles
- Some members may have no benefits for services provided by non-participating providers
- Non-participating providers can balance bill the member for all amounts not paid by Blue Cross

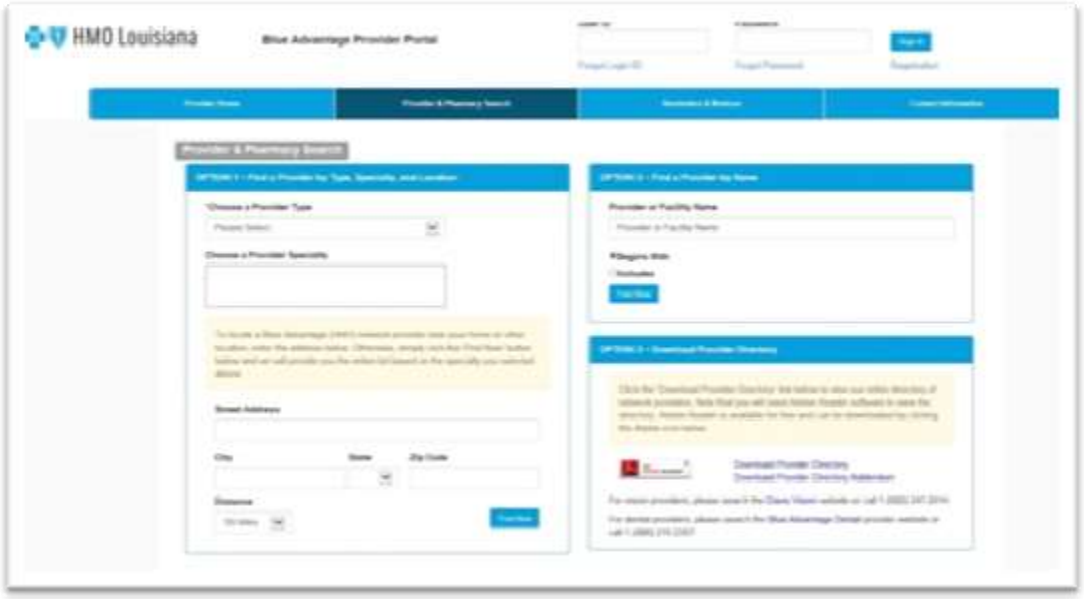
Finding Participating Providers

You can find network providers to refer members to in our online provider directories at **www.BCBSLA.com** >Find a Doctor



Finding Participating Providers for Blue Advantage (HMO)

To refer Blue Advantage (HMO) members to other providers, use the “Provider & Pharmacy Search” feature of the Blue Advantage Provider Portal (accessed through iLinkBlue)



Preferred laboratories for all specimens for the Blue Advantage network

- Clinical Pathology Labs (CPL)
- Quest Diagnostics
- Lab Corp

Our Secure Online Services

Accessing Our Secure Online Services

We offer many online services that require secure access. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (BlueCard® members)
- and more (as we develop new services)

We require that each provider organization designate at least one administrative representative to self-manage user access to our secure online services

Administrative Representative

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online tools
- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- If you do not have an administrative representative registered with Blue Cross, please fill out and submit the Administrative Representative Registration Packet, which can be found on our Provider page (**www.BCBSLA.com/providers**)

Administrative Representative

- A person designated to serve as the key person for delegating access to appropriate users for the provider
- A person who agrees to adhere to Blue Cross' guidelines
- A person who will only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities as well as promptly terminate employee access at such time as an employee changes roles or terminates employment

Provider Identity Management Team

Need help?

Provider Identity Management (PIM) is a dedicated team to help you establish and manage system access to our secure electronic services

If you have questions regarding the administrative representative setup process, please contact our PIM Team

Email: **PIMTeam@bcbsla.com**

Phone: 1-800-716-2299, option 5

What they will do for you:

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

Common issues the PIM Team is asked to help with:

How do I change my administrative representative phone number?

This can be done with a phone call to the PIM Team

How do I change my administrative representative email address?

Because your email address is your username, you must submit a new Administrative Representative Registration Packet

How do I terminate my administrative representative?

This requires a written notification be sent to the PIM Team

Inactivity Policy

iLinkBlue and Sigma Security Setup Tool accounts that have not been accessed for a period of time will be suspended as follows:

- iLinkBlue user account suspends upon 90 days of inactivity
- iLinkBlue user account that remains inactive for 120 days will be terminated
- Sigma account suspends upon 90 days of inactivity
- Sigma account that remains inactive for one year will be terminated

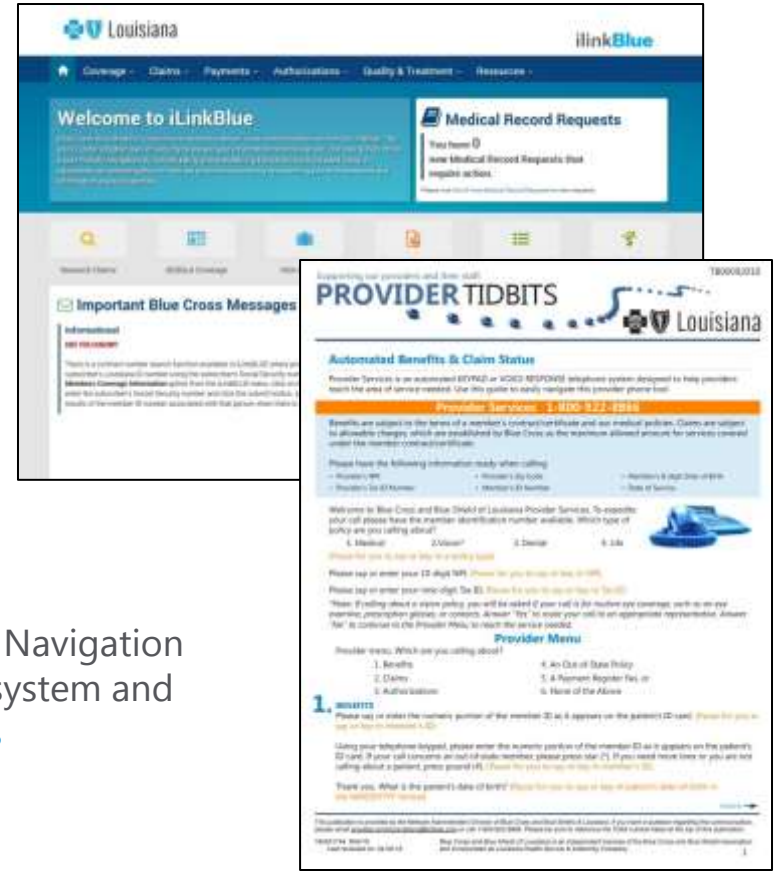
When an account has been inactive for 60 days, the user will receive an email alert of the inactivity. Once suspended, to reactivate an account, iLinkBlue users must contact their administrative representative. Administrative representatives with suspended accounts must contact our PIM Team at **PIMTeam@bcbsla.com**.

Provider Self-service Initiative

Providers are now required to use our self-service tools for:

- member eligibility
- claim status inquiries
- professional allowable searches
- medical policy searches

These services will no longer be handled directly by our Customer Care Center



Self-service tools available to providers:

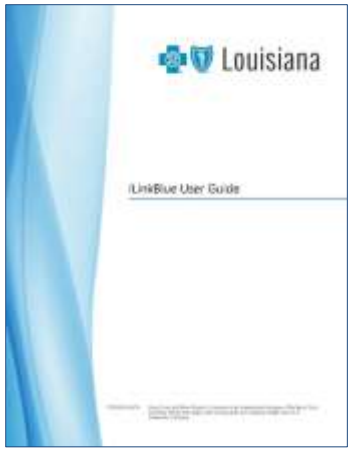
- iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- Interactive Voice Recognition (IVR) (1-800-922-8866)
  - The Automated Benefits & Claim Status (IVR Navigation Guide) Tidbit will help you navigate the IVR system and is available at **www.BCBSLA.com/providers** >Resources >Tidbits
- HIPAA 27x transactions

Included in your folder is a **Provider Self-service Quick Reference Guide** that provides more information about using these provider tools

iLinkBlue

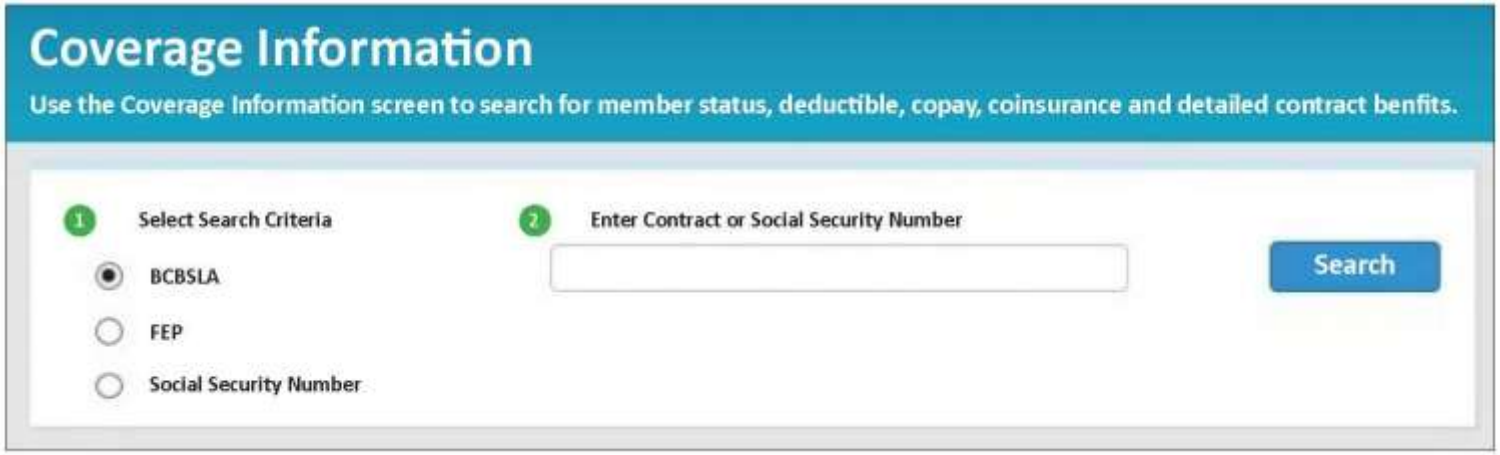
- iLinkBlue offers user-friendly navigation to allow easy access to many secure online tools:
  - Coverage & Eligibility
  - Benefits
  - Coordination of Benefits (COB)
  - Claims Status (BCBSLA, FEP and Out-of-Area)
  - Medical Code Editing
  - Payment Registers/EFT Notifications
  - Allowables Search
  - Authorizations
  - Medical Policy
  - 1500 Claims Entry
- UB-04 Claims Entry is no longer available
- For iLinkBlue training and education, contact **provider.relations@bcbsla.com**

www.BCBSLA.com/ilinkblue



We have an *iLinkBlue User Guide* available online at **www.BCBSLA.com/providers**, then click on "Resources"

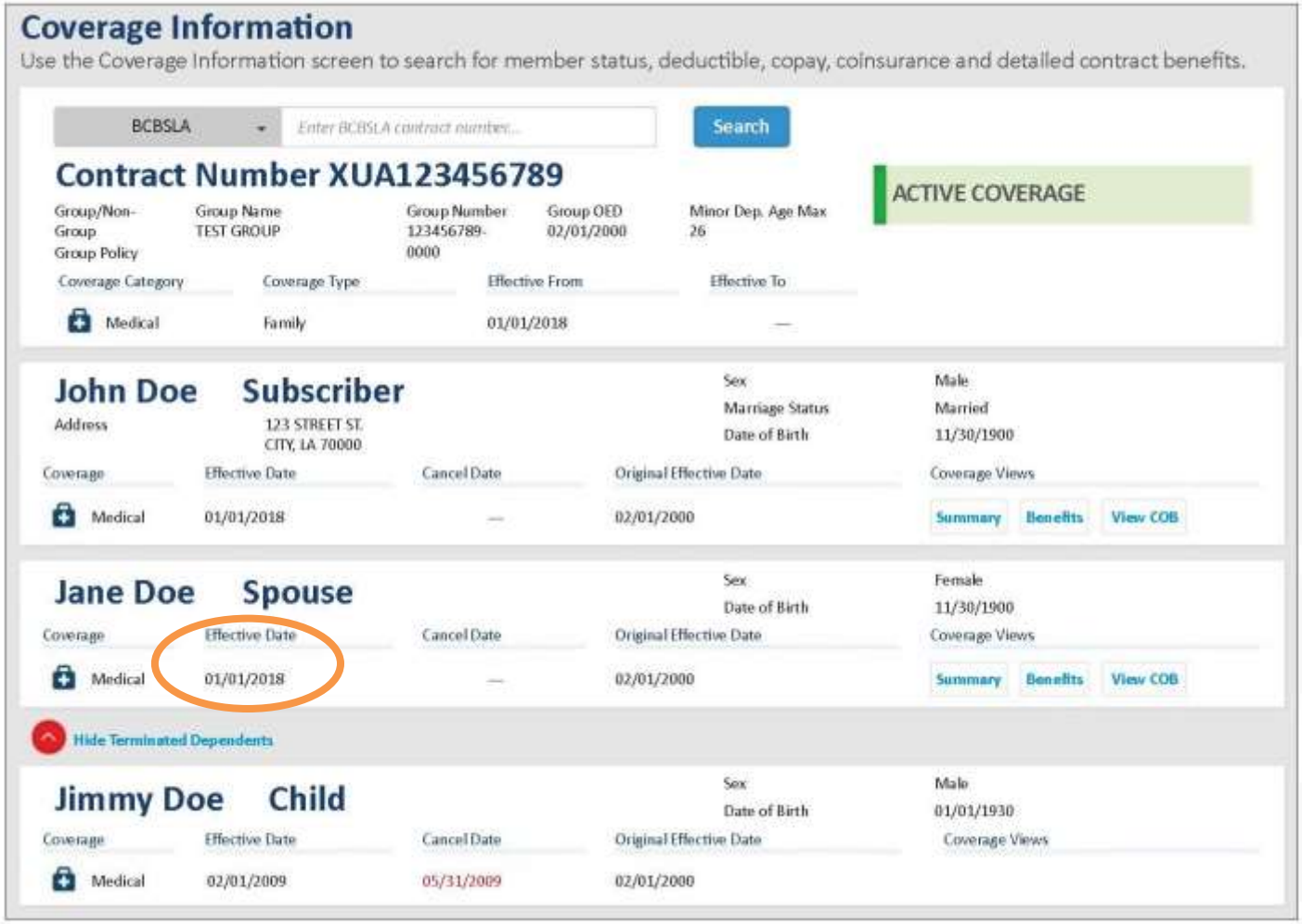
iLinkBlue - Coverage & Eligibility

1. 

Use the "Coverage" menu option to research Blue Cross and Federal Employee Program (FEP) member eligibility, copays, deductibles, coinsurance and detailed contract information

iLinkBlue - Coverage & Eligibility

2.



iLinkBlue - Coverage & Eligibility

3.

Medical Benefits Summary

Contract Number XUA123456789

ACTIVE COVERAGE
Medical Effective Date 01/01/2018

Subscriber Name	John Doe
Member Name	John Doe
Member Date of Birth	11/30/1900
Relation to Subscriber	Self
Sex	Male
Contract Type	HMOLA POS

Copays

		EPO Copays	QBPC Copays
Office Visit	$30.00	—	$15.00
Office Visit Specialist	$45.00	—	—
Outpatient Surgical	$500.00	—	—
Emergency Room	$100.00	—	—
Inpatient Hospital (In-network)	$300.00	—	—
Inpatient Hospital Maximum	$1,500.00	—	—
Inpatient Hospital (Out-of-network)	—	—	—
Outpatient XRay & Lab	—	—	—
Outpatient Physical Therapy	$30.00	—	—
Outpatient Speech Therapy	$30.00	—	—
Cardiac Rehab	$30.00	—	—
Vision Services	$30.00	—	—
Outpatient Professional	—	—	—

Accumulations

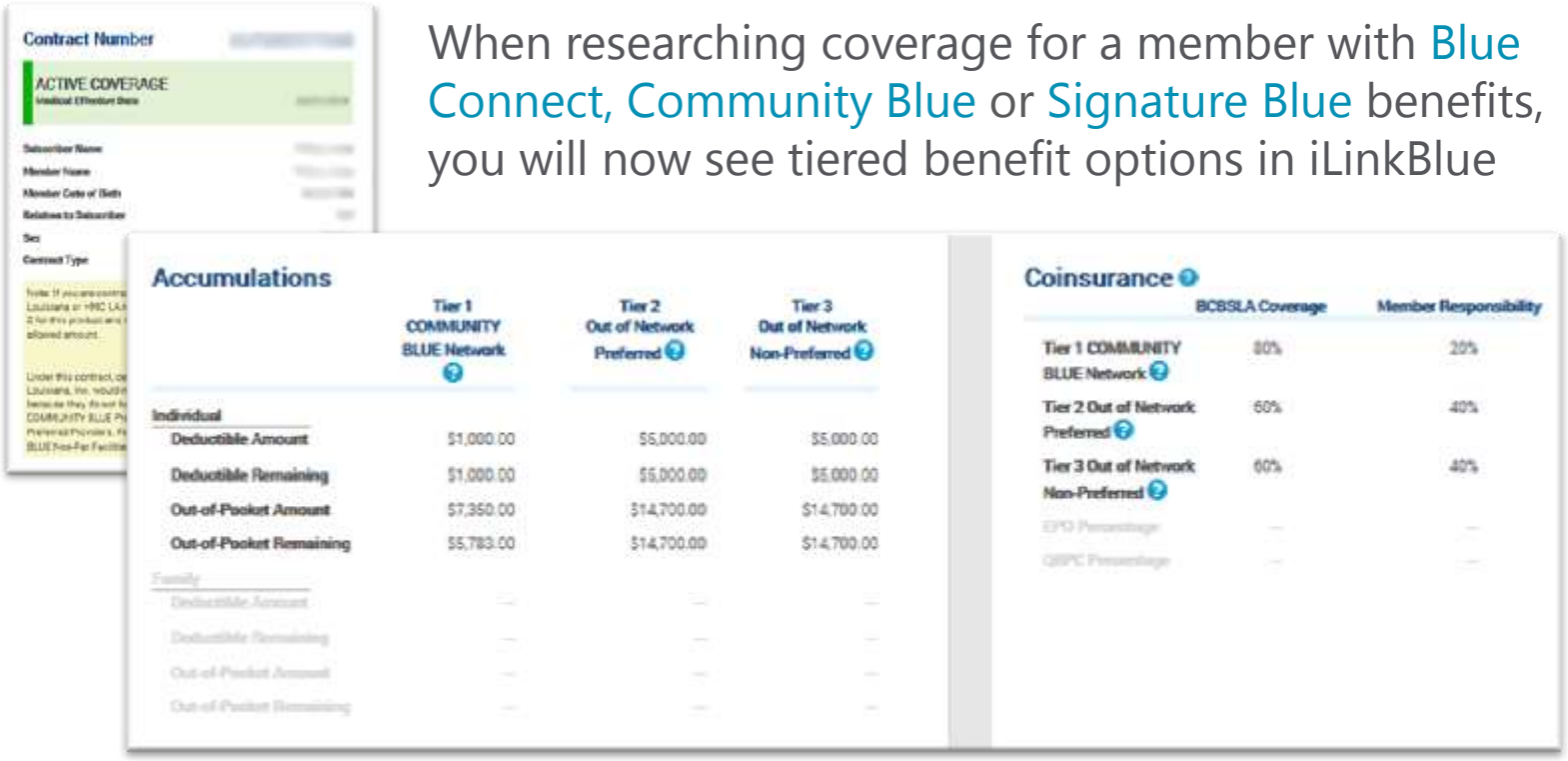
	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	—
Deductible Remaining	$0.00	$1,750.00	—
Out-of-Pocket Amount	$3,000.00	$6,000.00	—
Out-of-Pocket Remaining	$3,000.00	$6,000.00	—

Coinsurance

	BCBSLA Coverage	Member Responsibility
Par Percentage	90%	10%
Non-Par Percentage	70%	30%
EPO Percentage	—	—
QBPC Percentage	—	—

iLinkBlue - Coverage & Eligibility

Tiered Benefits for Select Networks



When researching coverage for a member with Blue Connect, Community Blue or Signature Blue benefits, you will now see tiered benefit options in iLinkBlue

Tiered benefits do not display for members with Preferred Care PPO or HMO benefits

iLinkBlue - Coverage & Eligibility

Tiered Benefits for Select Networks

Tier 1 In-Network Preferred

Applies to providers participating in the member's select network

Example Scenario:

- A Community Blue member sees a Community Blue provider
- The member copay and accumulators identified under 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 Preferred Care PPO provider
- The member copay and accumulators identified under 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

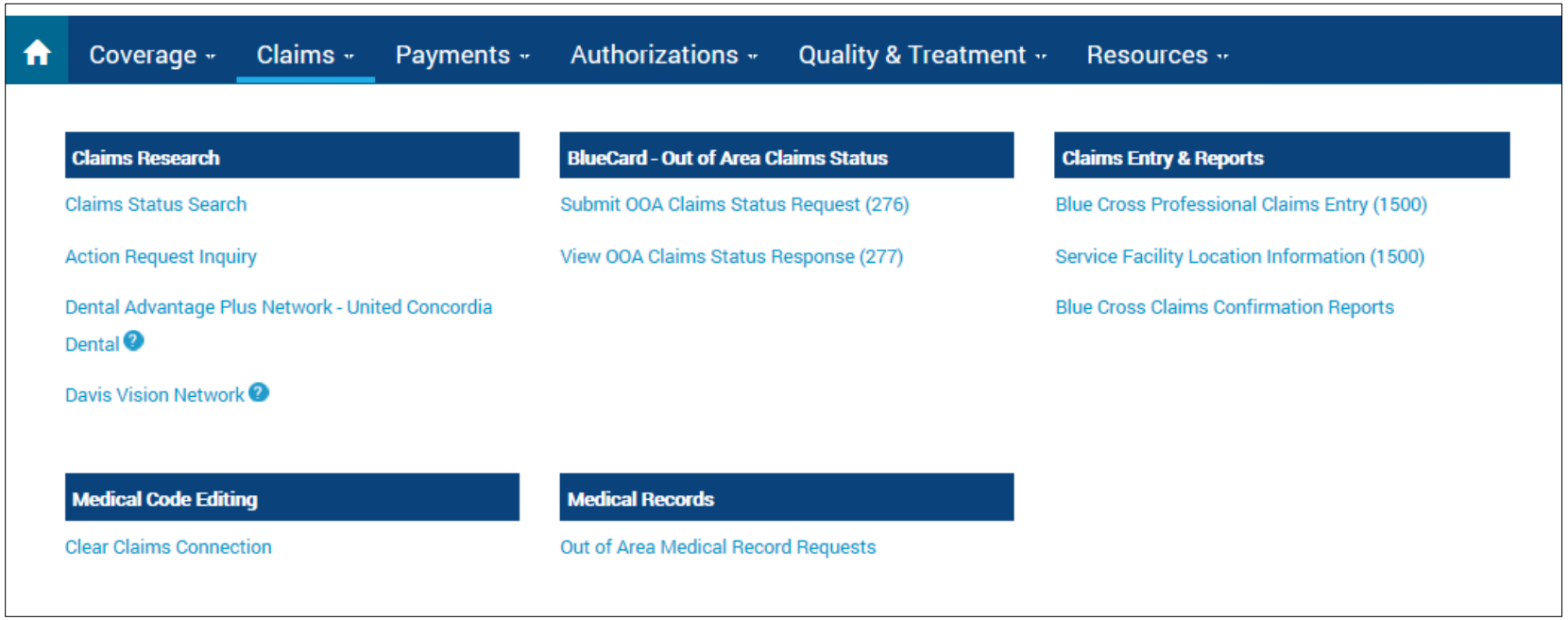
Applies to providers who do not participate in any Blue Cross network

Example Scenario:

- A Community Blue member sees a non-participating provider
- The member copay and accumulators identified under Tier 3 should be applied
- Provider can bill the member for all amounts over the allowed amount

Filing Claims in iLinkBlue

The "Claims Entry" option allows for the direct data entry of CMS-1500 (professional) claims

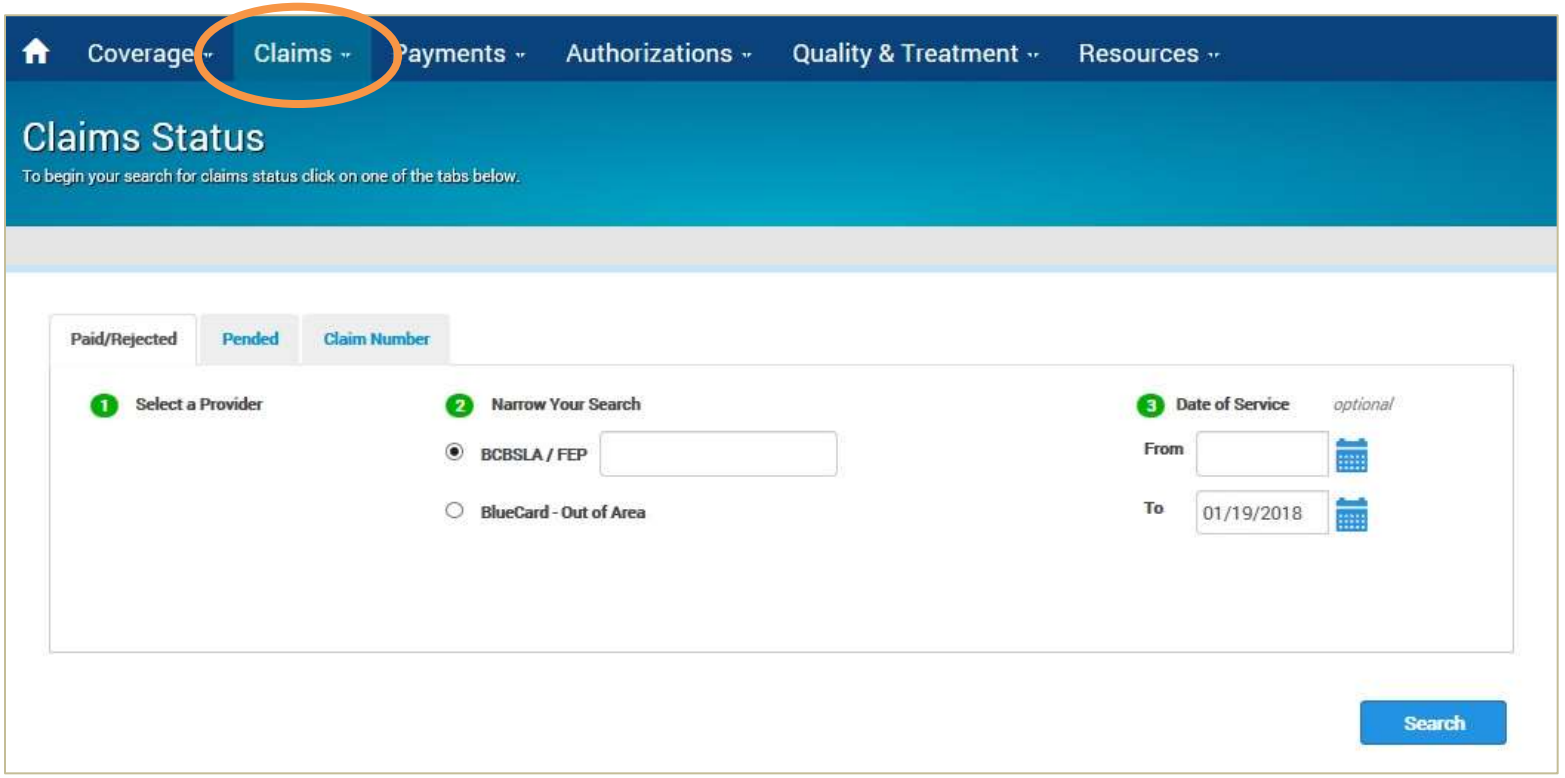


A detailed manual on how to submit claims through iLinkBlue is under the "Resources" section of iLinkBlue:

- The *Blue Cross Professional 1500 Manual* is under the "Manuals" tab

* UB-04 claims can only be filed hardcopy or by electronic claims using HIPAA 837I

iLinkBlue – Claims Research



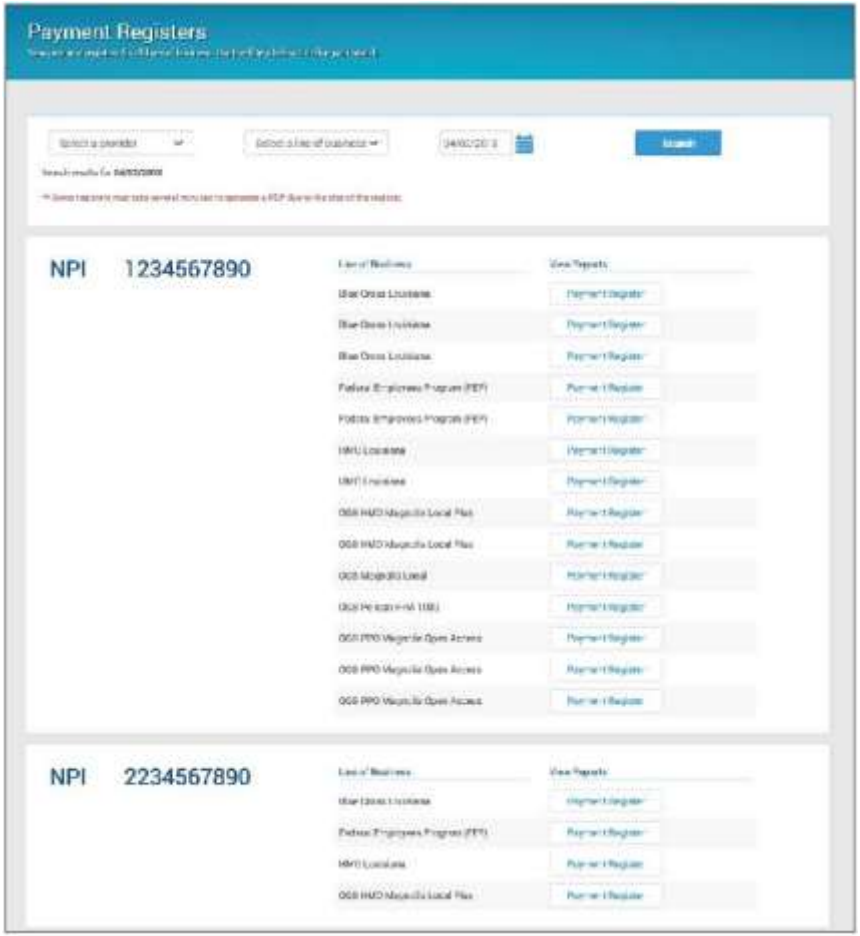
- Use the “Claims” menu option to research paid, rejected and pended claims
- You can research BCBSLA, FEP and Out-of-area claims submitted to Blue Cross for processing

iLinkBlue – Claims Research

Submitting Action Requests

- Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim
- On each claim, providers have the option to submit an Action Request to request a review for correct processing
- You may 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

iLinkBlue – Payment Registers



- Use the “Payments” menu option to find your Blue Cross payment registers
- Payment registers are released weekly on Mondays
- Notifications for the current week will automatically appear on the screen
- You have access to a maximum of two years of payment registers in iLinkBlue
- If you have access to multiple NPIs, you will see payment registers for each

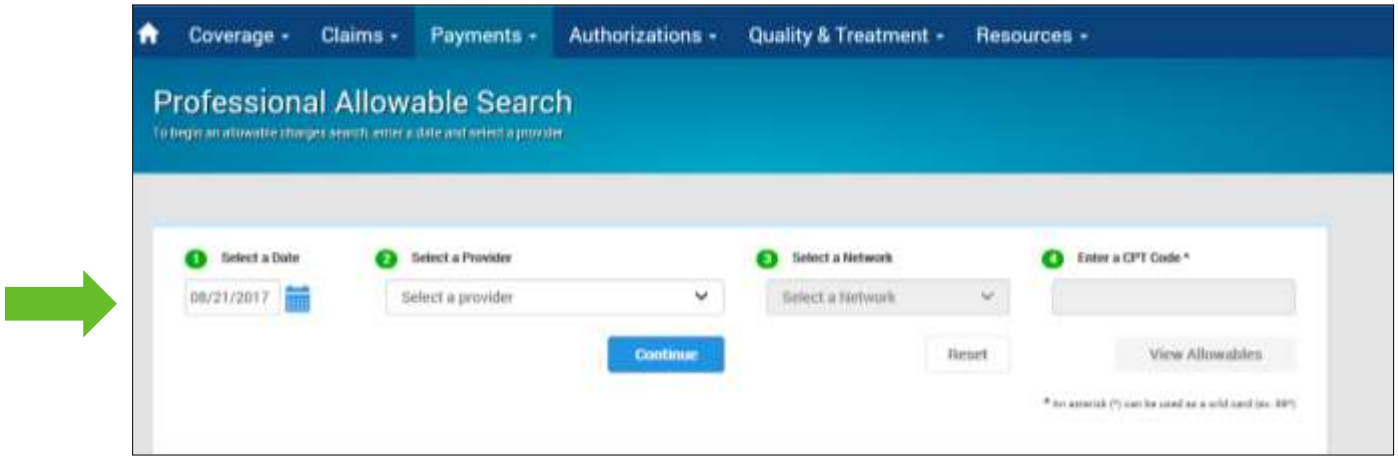
iLinkBlue – Authorizations

- Use the "Authorizations" menu option to access our authorization tools
- An administrative representative must grant a user access to the following applications before a request can be submitted:
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Pre-Service Review

Allowable Charges

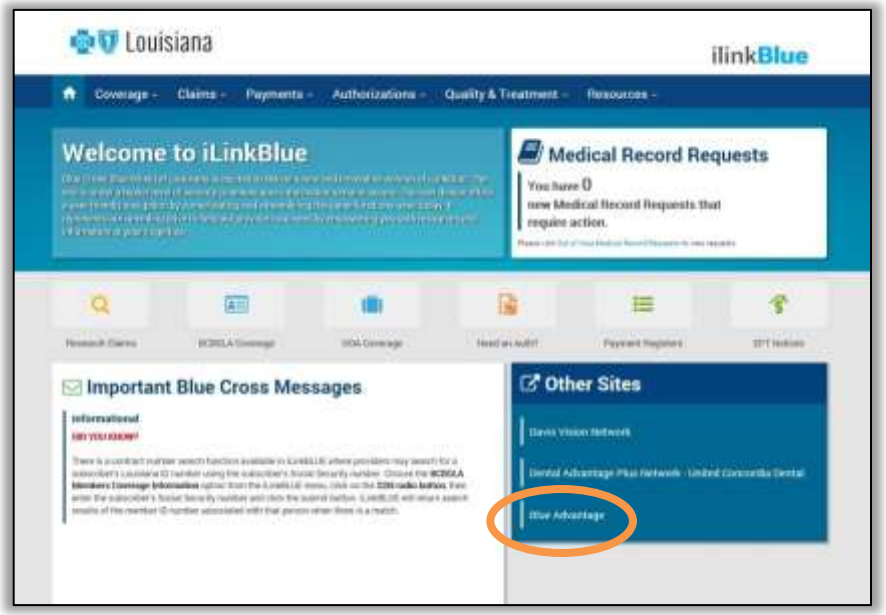
You can use iLinkBlue to look up allowables for a single code or a range of codes

single code example:	90833	(allowable results for 90833 only)
code range examples:	908*	(allowable results include all codes beginning with 908)
	90*	(allowable results include all codes beginning with 90)
	9*	(allowable results include all codes beginning with 9)



* This search is for professional providers only

Accessing the Blue Advantage Provider Portal



- The processes for Blue Advantage (HMO) differ from our other provider network processes
- We have created a separate portal for these contracted providers to access those processes
- You must access the Blue Advantage Provider Portal through iLinkBlue (**www.BCBSLA.com/ilinkblue**)
- The Blue Advantage Provider Portal also requires a higher level of security access that must be assigned to users by your organization's security administrative representative

Future Enhancements

New provider tools coming in 2019

- Facility outpatient providers will soon have an **Allowable Charges Search** tool to research their allowables
- We are in the process of implementing a new **Claims Editing System (CES)** for both facility outpatient and professional providers
  - CES is an auditing system used to manage reimbursement, medical policy, benefit rules and industry standard coding
  - CES will help ensure accurate and consistent payments
  - Many existing edits will remain the same, however there will be some differences to conform to changes in coding standards, updated reviews of existing code editing logic and enhanced functionality of the new system. As a result, you may see changes in your payment once CES is implemented.

We will communicate additional information about these enhancements through future mailings and our provider newsletter

Authorizations

OGB Authorizations

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

OGB PLAN SERVICES REQUIRING AUTHORIZATION

Failure to obtain prior authorization for these services for OGB members will result in denial of payment for services.

- The list of OGB authorization requirements can be found in our provider manuals located on iLinkBlue
- The list also appears on the OGB Speed Guide located on **www.BCBSLA.com/providers** >Resources

Early Notification for Inpatient Admissions

- Early notification of inpatient admissions is essential to determination of authorization requests and to ensure the most appropriate and effective care for members
- For OGB members, notification is required within 48 hours
- We encourage early notification for all members

Blue Advantage (HMO) Inpatient Admissions & Discharges

Blue Advantage network providers are required to provide notification of Blue Advantage members' inpatient admissions within 24 hours of inpatient admission and for observation cases longer than 48 hours

Blue Advantage providers must submit clinical documentation supporting the requested level of care to Blue Advantage within 24 hours of notification

Blue Advantage providers may call or fax admission and/or discharge information (date & disposition) to the Blue Advantage Medical Management team:

Phone: 1-866-508-7145

Fax: 1-877-528-5818

The phones are forwarded to a secure voice mail system during non-business hours and the fax is available 24 hours a day, 7 days a week

Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment.

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

Online Authorization Requests

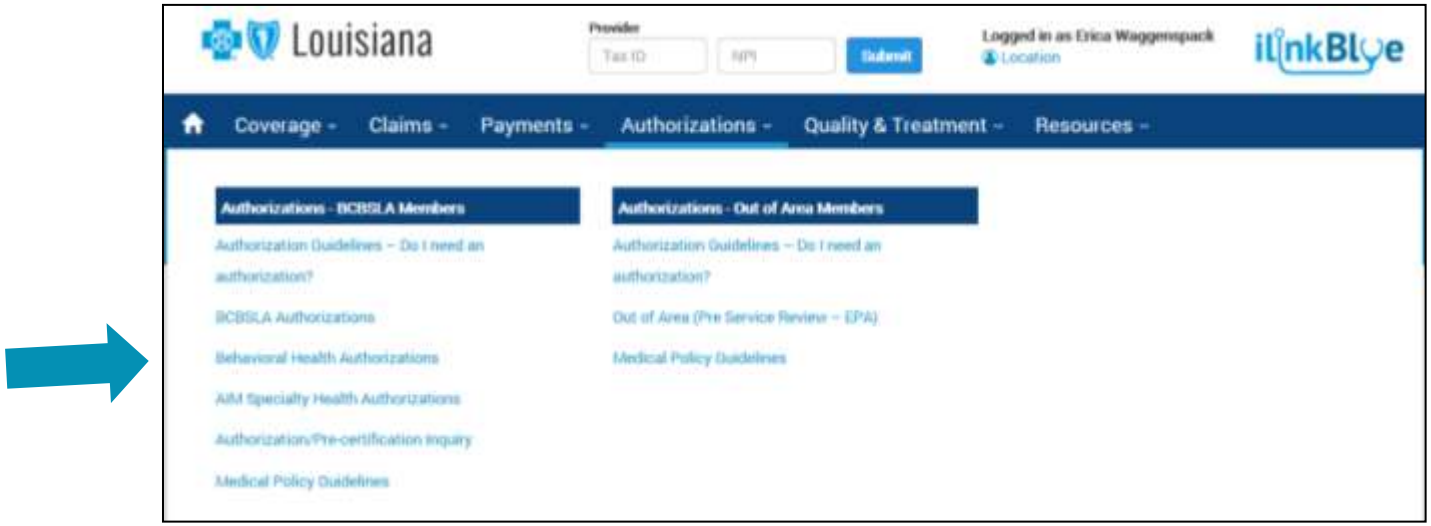
Providers can electronically submit authorization requests for behavioral health services through New Directions' **WebPass Portal**

- Available through iLinkBlue (**www.BCBSLA.com/ilinkblue**) >Authorizations >Behavioral Health Authorizations
- Without access to iLinkBlue, you cannot access the Authorizations Portal
- An administrative representative is required to access the Authorizations Portal

Accessing WebPass

Log into iLinkBlue and select the Behavioral Health Authorizations link under the "Authorizations" tab

www.BCBSLA.com/ilinkblue



Even if you have access to the Authorizations Portal, you must also be granted application-level access by your administrative representative to use each application

WebPass Portal Assistance

If you are unable to complete a form or have technical issues, please email prwebpass@ndbh.com

If you receive any error messages, please include the error message (screenshot), date and time:

- Please do not send any confidential information in this email
- Email is not an instant response
- Please allow one business day for a response to your email

If you need to know an immediate decision for any request for services, call the number on the back of the member's ID card

Failure to Obtain an Authorization

Failure to obtain a prior authorization can result in:

- A 30 percent penalty imposed on Preferred Care PPO and HMO Louisiana, Inc. network providers for failing to obtain authorization prior to performing an outpatient service that requires authorization
- A $1,000 penalty applied to inpatient hospital claims if the patient's policy requires an inpatient stay to be authorized *(Note: some policies contain a different inpatient penalty provision)*
- The denial of payment for services for our Office of Group Benefits (OGB) members

Authorization penalty amounts or services that are denied for no authorization are not billable to the member

NEW DIRECTIONS®

PROVIDER COLLABORATION FORUM

Working collaboratively to improve our local system of care

Agenda

- Introduction to New Directions
- Future Initiatives
- NDBH Website
- Substance Use Disorder
- Suicide Education and Prevention Initiative
- Follow up After Hospitalization
- Questions and Answers

New Directions At A Glance

16 million members
in fifty states
and internationally

7 partnerships
with Blue Cross and
Blue Shield health plans

2,500+
EAP clients

674+
employees

Accreditation Status

URAC Accreditation for Health Utilization Management

Accredited through September 2021

NCQA Full Accreditation as a Managed Behavioral Healthcare Organization

Accredited through February 2019

URAC Accreditation for Case Management

Accredited through December 2019

*"Genuineness and sincerity of staff in doing the **right thing** at the **right time**... team members were particularly impressive, going **above and beyond** in all that they do."*

-2015, URAC Surveyor

Collaboration with BCBSLA

- **Overall utilization management program**
- **POD participation**
- **Collaboration with substance use providers**
- **Ongoing meetings with Blue Cross and Blue Shield of Louisiana**
  - Care management teams
  - Leadership
  - Special projects
  - Quality-based meetings
  - Network meetings

Coming In The Future

Blue Cross is currently leading a few exciting pilots in the behavioral health space in collaboration with our behavioral health partner, New Directions Behavioral Health

Behavioral Health Telehealth Pilot: Launching soon. We are working with a high-volume behavioral health facility to utilize their own providers in a telehealth setting for discharge follow up appointments when appropriate.

Transportation Pilot: Utilizing UBER Health/LYFT ride share services, members in the Baton Rouge Region who have a transportation barrier to attending an outpatient behavioral health follow-up appointment will have access to this service. Discharge planners, New Directions Behavioral Health Case Managers and Blue Cross Care Management team will work collaboratively to set up a ride for the member.

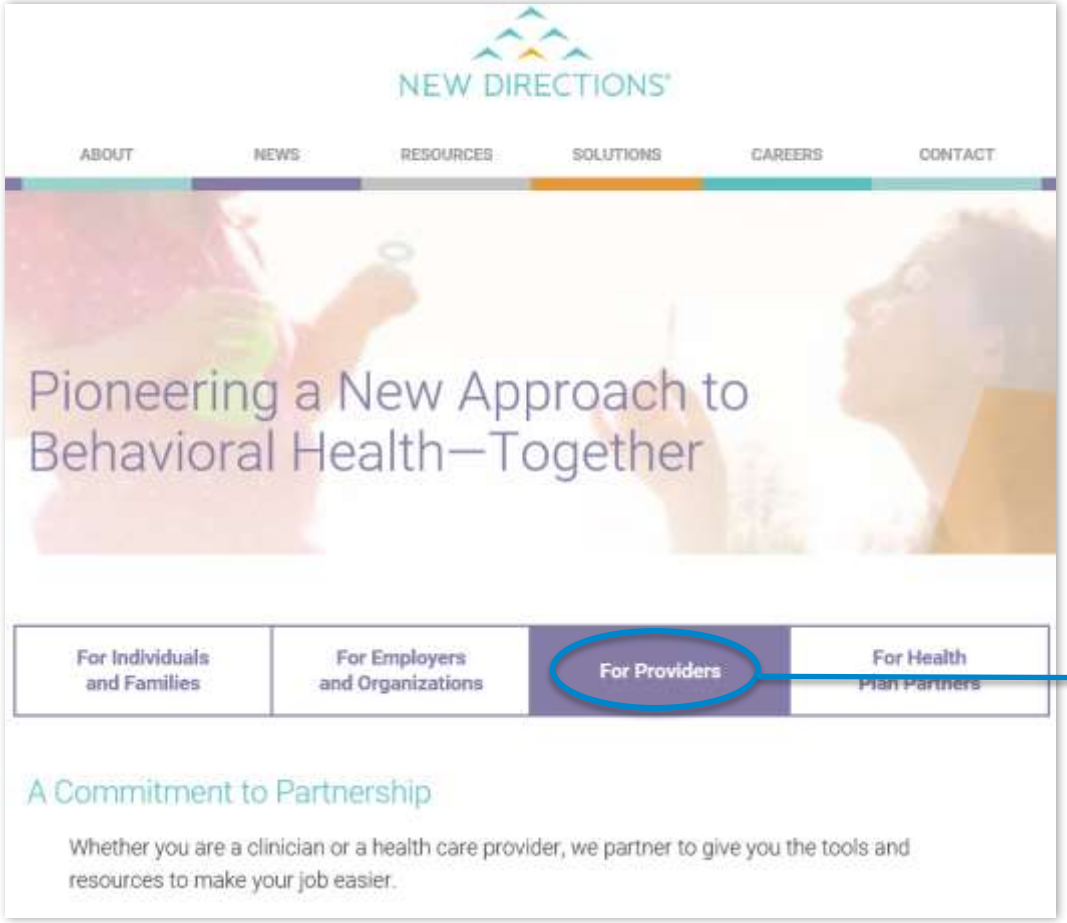
Integrated Healthcare: Piloting with a large Primary Care Provider group in the state. When a member attributed to this provider group has an eligible mental health diagnosis and is admitted to an inpatient facility for a behavioral health diagnosis, New Directions works to refer the member back to an embedded social worker in the PCP group follow-up after hospitalization if the member is not currently established with a behavioral health provider. Admissions are monitored daily.

Coming In The Future

- We hope to expand these pilot programs to other areas for the benefit of our members in need of these services
- New Directions will begin reaching out to the smaller/low-volume facilities to offer assistance with any needs they may have


LET'S
EXPLORE THE
RESOURCES
AT NDBH.COM

ND Offers Online Provider Resources



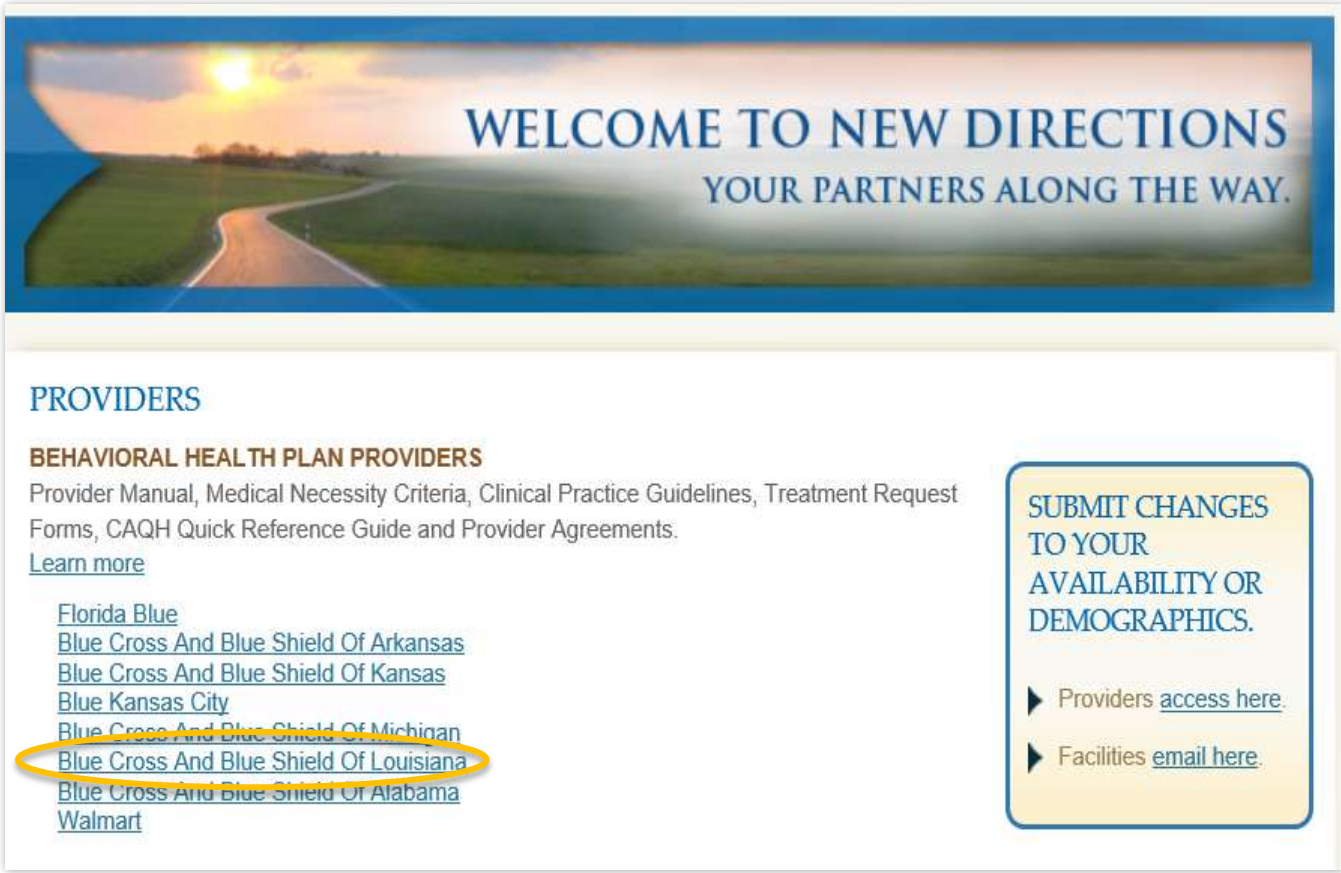
This is the first screen you will see. Scroll down and click on "For Providers"

ND Offers Online Provider Resources

Click on "Enter" to be directed to provider resource area

Please note: Blue Cross providers must access WebPass through iLinkBlue.

There Is a Link To BCBSLA Plan Partners



Let's See What Is In Louisiana…

BLUE CROSS AND BLUE SHIELD OF LOUISIANA

AUTISM DOCUMENTS

- Effective 3/1/18 LA Medical Policy for ABA for the treatment of ASD (Effective 3-1-18 for BCBS of Louisiana)
- Initial Assessment Request (PDF Version - MS Word Version)
- Care Request for ABA (PDF Version - MS Word Version)

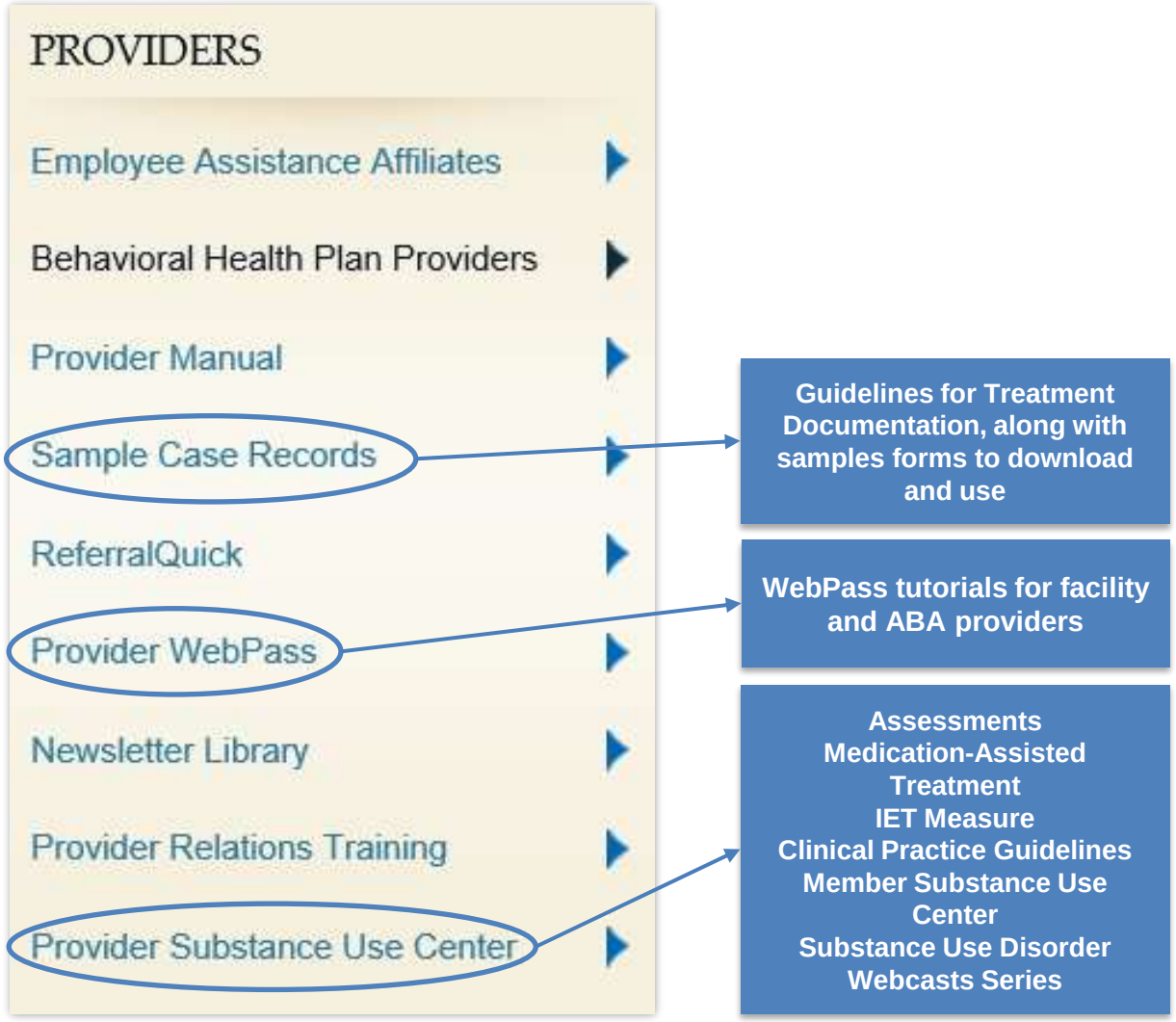
FEP

- Effective 3/1/18 FEP Medical Policy for ABA for the treatment of ASD (Effective 3-1-18 for BCBS of Louisiana)
- Initial Assessment Request (PDF Version - MS Word Version)
- Care Request for ABA (PDF Version - MS Word Version)

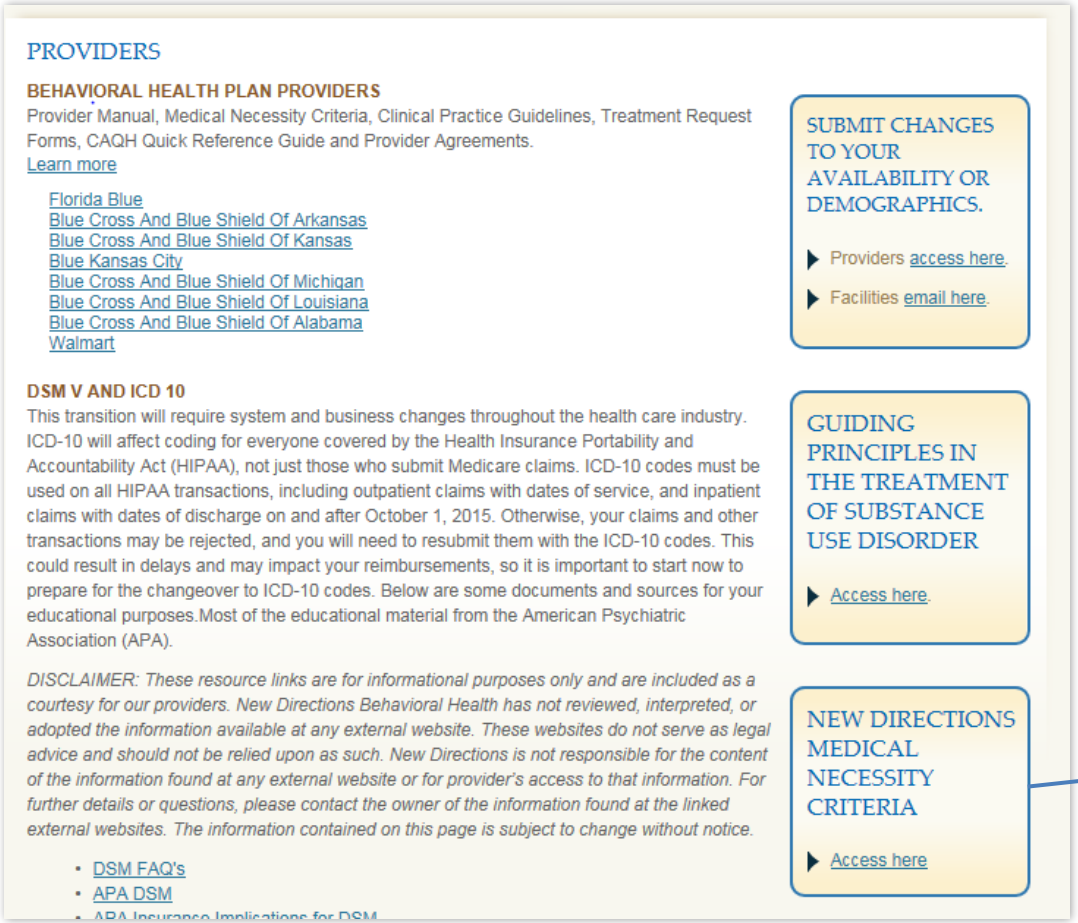
OTHER DOCUMENTS

- Repetitive Transcranial Magnetic Stimulation Blue Cross and Blue Shield of Louisiana Medical Policy
- Repetitive Transcranial Magnetic Stimulation Initial Treatment Request Form
- Repetitive Transcranial Magnetic Stimulation Continuation Treatment Request Form
- Provider Information Form
- Psychological Testing Request

Note: If you are experiencing difficulty using these forms, please try downloading the form by right-clicking on link, and selecting "Save target/link as". You may then save and fill out the form.


PROVIDERS
Employee Assistance Affiliates
Behavioral Health Plan Providers
Provider Manual
Sample Case Records
ReferralQuick
Provider WebPass
Newsletter Library
Provider Relations Training
Provider Substance Use Center
Guidelines for Treatment Documentation, along with samples forms to download and use
WebPass tutorials for facility and ABA providers
Assessments
Medication-Assisted Treatment
IET Measure
Clinical Practice Guidelines
Member Substance Use Center
Substance Use Disorder Webcasts Series

Everyone Needs A "Guide" When You Travel



PROVIDERS

BEHAVIORAL HEALTH PLAN PROVIDERS

Provider Manual, Medical Necessity Criteria, Clinical Practice Guidelines, Treatment Request Forms, CAQH Quick Reference Guide and Provider Agreements.
Learn more

- Florida Blue
- Blue Cross And Blue Shield Of Arkansas
- Blue Cross And Blue Shield Of Kansas
- Blue Kansas City
- Blue Cross And Blue Shield Of Michigan
- Blue Cross And Blue Shield Of Louisiana
- Blue Cross And Blue Shield Of Alabama
- Walmart

DSM V AND ICD 10

This transition will require system and business changes throughout the health care industry. ICD-10 will affect coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare claims. ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2015. Otherwise, your claims and other transactions may be rejected, and you will need to resubmit them with the ICD-10 codes. This could result in delays and may impact your reimbursements, so it is important to start now to prepare for the changeover to ICD-10 codes. Below are some documents and sources for your educational purposes.Most of the educational material from the American Psychiatric Association (APA).

DISCLAIMER: These resource links are for informational purposes only and are included as a courtesy for our providers. New Directions Behavioral Health has not reviewed, interpreted, or adopted the information available at any external website. These websites do not serve as legal advice and should not be relied upon as such. New Directions is not responsible for the content of the information found at any external website or for provider's access to that information. For further details or questions, please contact the owner of the information found at the linked external websites. The information contained on this page is subject to change without notice.

- DSM FAQ's
- APA DSM
- APA Insurance Implications for DSM

SUBMIT CHANGES TO YOUR AVAILABILITY OR DEMOGRAPHICS.

- Providers access here.
- Facilities email here.

GUIDING PRINCIPLES IN THE TREATMENT OF SUBSTANCE USE DISORDER

- Access here.

NEW DIRECTIONS MEDICAL NECESSITY CRITERIA

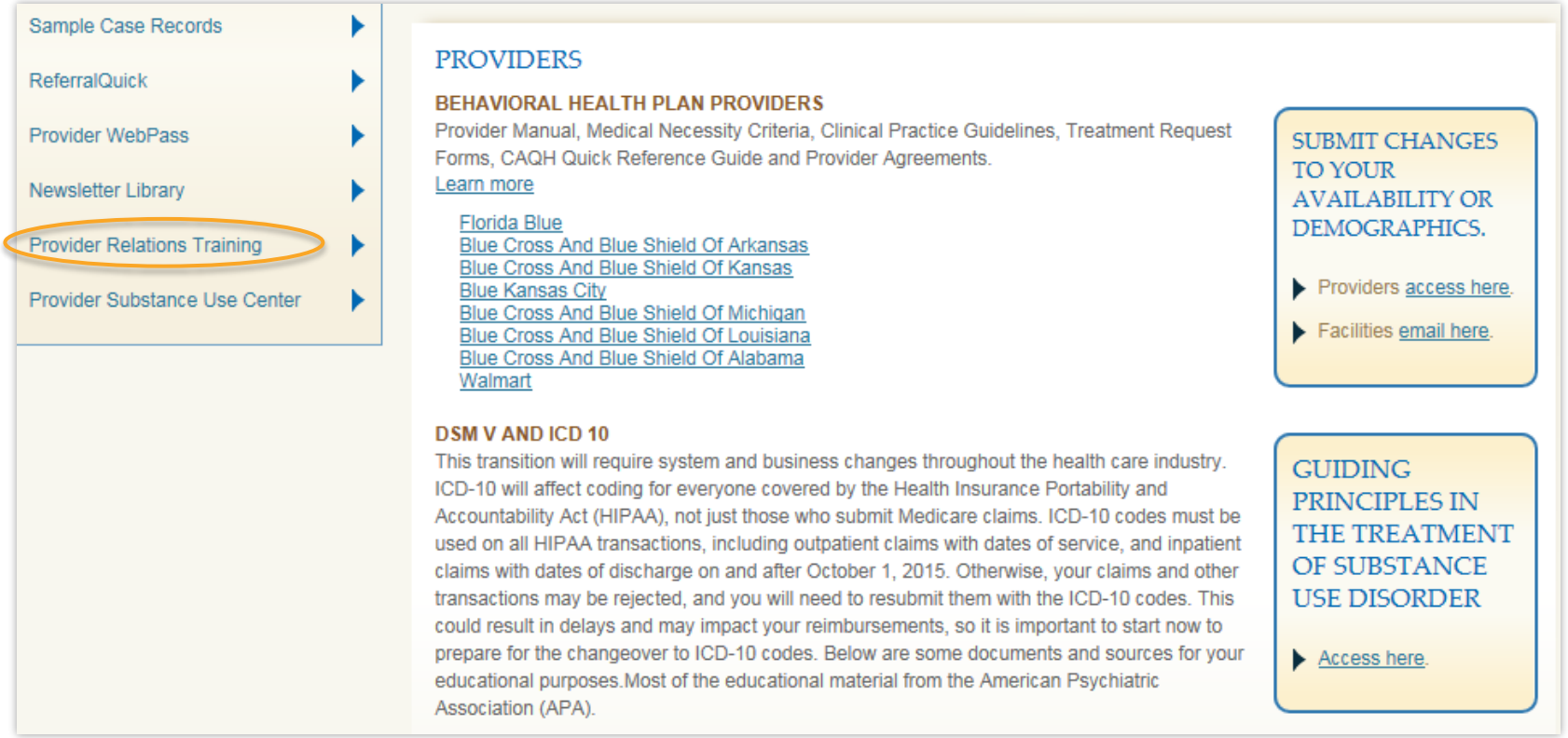
- Access here

View medical necessity criteria for all levels of care and services

Medical Necessity Criteria Table of Contents

If you are searching for information on a specific level of care, simply click on the title and go directly to that section.

Provider Relations Training



Provider Substance Use Center

PROVIDER SUBSTANCE USE CENTER

ASSESSMENTS

- CAGE: Screening Test for Alcohol Dependence
- DAST: Drug Abuse Screening Test

MEDICATION-ASSISTED TREATMENT

- Medication-Assisted Treatment for Opioid Addiction
- Challenging The Myths About Medication-Assisted Treatment

IET MEASURE

Treatment engagement is an intermediate step between initial assessment and the completion of care for drug and substance abuse. The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence (AOD) who initiated treatment within 14 days of diagnosis and had two or more additional services of AOD treatment within 30 days of the initial visit.

CLINICAL PRACTICE GUIDELINES

- New Directions Substance Use Disorder Clinicial Practice Guidelines

MEMBER SUBSTANCE USE CENTER

- Member Substance Use Center

SUBSTANCE USE DISORDER WEBCAST SERIES

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Medication Assisted Treatment
- Evidence-Based Practices
- Recovery-Oriented Systems of Care
- Case Management
- Transition Planning

SUBSTANCE USE DISORDER

Substance Use Disorder Epidemic

91 Americans
die every day from an opioid overdose

More than
6 out of 10
drug overdose deaths involve an opioid

Nearly **80%**
of individuals with an OUD do not receive treatment

4 out of 5
new heroin users begin with prescription opioids

Sources: CDC; U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, ***Facing Addiction in America, The Surgeon General's Report on Alcohol, Drugs and Health****. Washington, D.C: HHS, November 2016.*

OVERDOSE DEATHS

2014 | 43,225

2015 | 52,404

2016 | 63,600

Heroin overdoes have tripled between 2010 and 2014

Alcohol abuse contributes to 88,000 deaths in the U.S. each year

52% increase in ED visits due to drug abuse, between 2004 and 2011

$179 billion estimated in 2010 in lost productivity due to excessive alcohol use

About 20.8 million people have substance abuse disorders

Sources: National Survey on Drug Use and Health, 2014; U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America, The Surgeon General's Report on Alcohol, Drugs and Health. Washington, D.C: HHS, November 2016.; cdc.gov; Drug Abuse Warning Network; NIDA, 2017; HHS; ASAM; CDC Wonder

The Challenge In Treating SUD

1. Opioid **overprescribing** and pain

In 2012, **259 million** prescriptions were written for opioids
ASAM Opioid Addiction 2016 Facts and Figures

2. **Stigma** associated with addiction

21% of persons 12 years or older with an OUD received treatment at a specialty facility in the past year
National Survey on Drug Use and Health (NSDUH); Substance Abuse and Mental Health Services Administration (SAMSHA) 2016

3. **Too few** prescribing MAT

16% of psychiatrists have waivers, **3%** of PCPs have waivers, 30 million in rural settings without access to Buprenorphine (Bup)
Rosenblatt, Roger A. et al. "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder." Annals of Family Medicine 13.1 (2015): 23–26.

4. **Lack of recognition** as chronic condition, disease model

27% of facilities offered Bup MAT in 2016
National Survey of Substance Abuse Treatment Services (N-SSATS): SAMSHA 2016

5. **Limited adoption** of EBT in SUD tx, abstinence oriented

Detox to zero remains **prevailing practice** for opioid withdrawal

Substance Use Disorders

Our 2018 Priority

WHAT WORKS IN TREATING SUD?

Particularly OUD

- ✓ EBTs: Chronic Care Model Condition
- ✓ Medication-MAT
- ✓ Individualized care, informed consent, home area, family

WHAT CAN WE DO?

NEW DIRECTIONS SUBSTANCE USE GUIDING PRINCIPLES

Purpose of Guiding Principles

New Directions has summarized current evidence about SUD treatment. Our purpose is to foster dialogue with stakeholders in an effort to obtain their commitment to:

- Adopt evidence-based SUD treatment practices
- Innovate to address unmet needs of substance users
- Collaborate with New Directions to improve systems of care for members with SUDs

Guiding Principles Document

Key Concepts In Standard Of Care For SUD – What Works In Treating SUD?

- **Principles of Recovery and Chronic Care Model** – ongoing recovery management approach, includes recovery support services (peer support), development of a recovery and relapse prevention plan
- **Evidenced-based practices** – treatment that has been designed for the specific condition and which has been scientifically shown to be effective, individualized treatment plan (MI, CBT, CM, Educated Support, Relapse Prevention)
- **Medication Assisted Treatment**
- **Informed Consent, Individualized Treatment, Engagement**
- **UDT and PDMP**
- **Home Community** – participating in treatment in everyday life, allows the benefit of connections with enduring (not temporary) peer support and identification of recovery services that can provide a long-term support. The challenge of recovery is maintaining recovery in daily life, where and with whom one lives, where one works, where the activities of daily living occur.

Disease and Chronic Care Model

- Individuals do not choose to be addicted
- Addicted individuals may manifest physical changes to the brain system in the course of addiction, similar to that of hearts of people with heart disease. According to NIDA, "long-term drug use results in significant changes in brain function that can persist long after the individual stops using drugs."[37]
- The chronic nature of disease means that symptoms may recur, relapse is likely and does not indicate the previous treatment has failed, but rather indicates the need for reinstated, adjusted or alternative treatment.[38]
- For these reasons, and consistent with other chronic illnesses, recovery is an ongoing, long-term process that requires coordinated, continuous and systemic approaches

[37]National Institute on Drug Abuse. (2012, December 1).
[38] McLellan, A. T., Lewis, D. C., O'Brien, C. P. & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13). p. 1689-1695. Retrieved from http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/chronicdisease/

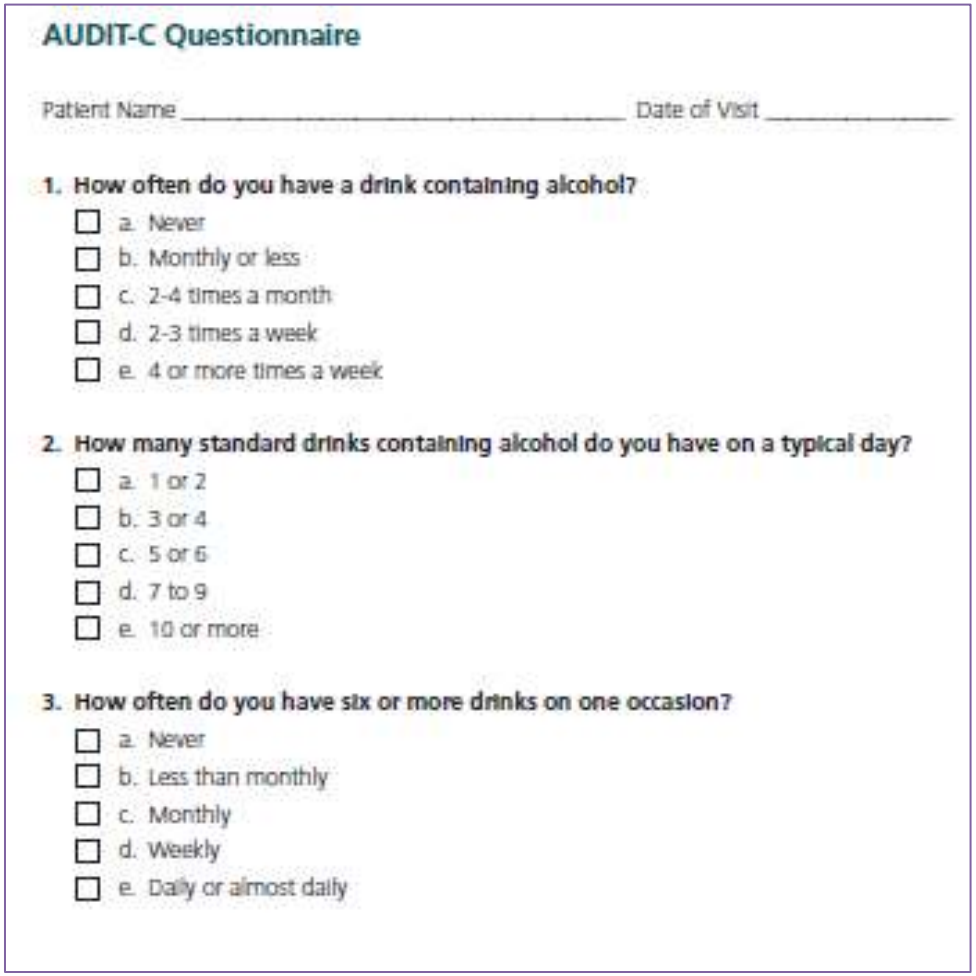
Substance Use Screening Tools

Health professional screens at the initial visit and episodically thereafter using a structured instrument. Recommended instruments include:

- **Alcohol Use Disorders Identification Test (AUDIT)**
- **(CAGE) Substance Abuse Screening Tool** – name is derived from the four questions of the tool: Cut down, Annoyed, Guilty and Eye-opener
- **Drug Abuse Screening Test (DAST)**

AUDIT-C Questionnaire

- Use the AUDIT-C alone or in combination with the CAGE to screen for alcohol
- Use AUDIT-C is designed to identify hazardous drinking and focuses on recent drinking behaviors
- The AUDIT-C can be found at www.cqaimh.org/pdf/tool_auditc.pdf



AUDIT-C Questionnaire

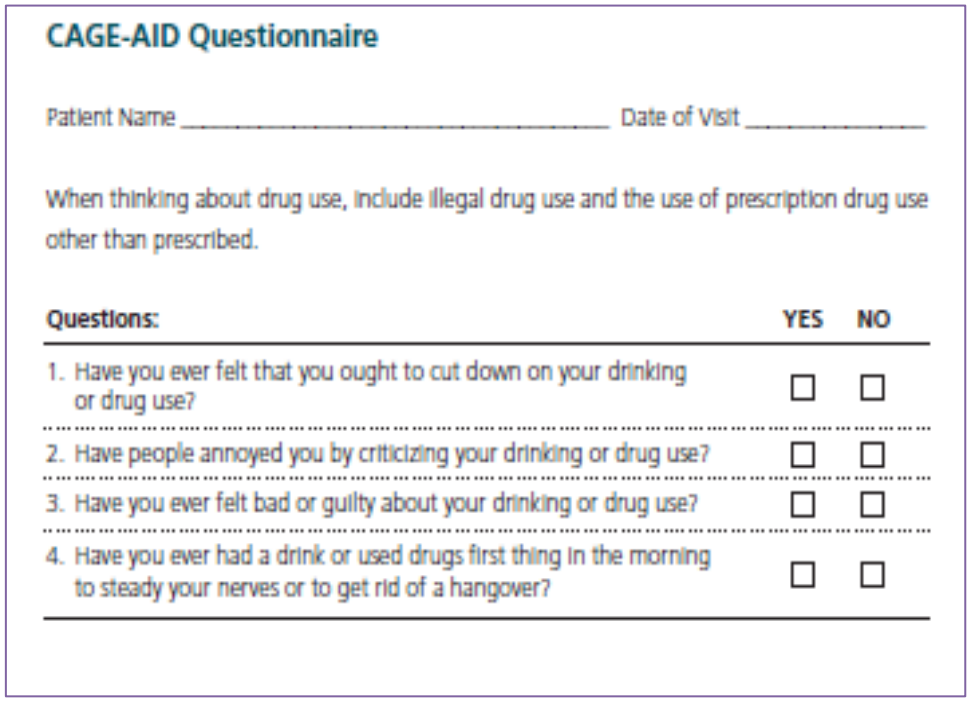
Patient Name _____ Date of Visit _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

CAGE Substance Abuse Screening Tool



CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

- The name is derived from the four questions of the tool: Cut down, Annoyed, Guilty and Eye-opener
- The CAGE is best at detecting alcohol dependence. It can be used in combination with the DAST.
- The CAGE can be found at www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

Drug Abuse Screening Test (DAST)

- Use the DAST to screen for drug use. This tool profiles the frequency of substance use behavior.
- The DAST can be found at www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

Adult Version

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

Meets DSM Criteria

At the initial visit and episodically thereafter, professional healthcare screens should be conducted using a structured instrument.
Recommended instruments include:

1. Alcohol Use Disorders Identification Test (AUDIT)
2. Drug Abuse Screening Test (DAST)
3. (CAGE) Substance Abuse Screening

Member has overt symptoms of withdrawal, or these are reasonably expected with abstinence

Evaluate for appropriate level of care for detox management. Plan for compliance with HEDIS IET for follow-up after detox is complete

If screening is positive, obtain a full history of drug and ETOH use

If screening is positive and results of evaluation confirm current DSM diagnosis of abuse or dependencies. Plan an initial visit for SUD treatment within 14 days, and two follow-up visits within 30 days of the initial visit (HEDIS IET Measure)

Not currently engaged in SUD treatment

Assess for appropriate level of rehabilitation and medication assisted treatment and refer

Continue regular visits and if applicable, medicated-assisted therapy compliance

Currently engaged in SUD treatment

Assess for compliance with treatment and assess for medication-assisted treatment

Continue regular visits and if applicable, medicated-assisted therapy compliance

Does Not Meet DSM Criteria

At the initial visit and episodically thereafter, professional healthcare screens should be conducted using a structured instrument.
Recommended instruments include:

1. **Alcohol Use Disorders Identification Test (AUDIT)**
2. **Drug Abuse Screening Test (DAST)**
3. **(CAGE) Substance Abuse Screening**

If screening is positive, obtain a full history of drug and ETOH use

If screening is positive, but a current DSM diagnosis of abuse or dependence is not met, employ Screening, Brief Intervention and Referral for Treatment (SBIRT) for problem drinking

If screening is negative and there are no suspicions of withholding information, then no further action is needed. However, in circumstances where there is reasonable doubt as to accuracy of the screening results, confirmation with a significant other is urged to gain confidence in the screening result.

What Is MAT?

Medication-Assisted Treatment (MAT) is the use of medications, in addition to counseling, cognitive behavioral therapies and recovery support services, to provide a comprehensive approach to the treatment of substance use disorders

There are several medications currently approved by the FDA for alcohol and opioid dependence

Opioid dependence can be helped with the following medications:

- Generic Suboxone (buprenorphine/naloxone – film) – Blue Cross-preferred agent*
- Generic Suboxone (buprenorphine/naloxone – pill)
- Zubsolv (buprenorphine/naloxone) – Blue Cross-preferred agent*
- Suboxone (buprenorphine/naloxone – film) – Blue Cross-preferred agent*
- Subutex (buprenorphine)
- Sublocade (buprenorphine LAI) – medication is covered on the medical benefit*
- Probuphine (4-42 mm rods surgically implanted in arm, duration 6 months) – medication is covered on the medical benefit*
- Methadone (only available in an licensed outpatient opioid treatment program)
- Vivitrol (naltrexone LAI) – medication is covered on the medical benefit*

Alcohol dependence has three FDA–approved medications

- Revia
- Vivitrol (naltrexone LAI) – medication is covered on the medical benefit*
- Campral (acamprosate) – Blue Cross covers generic forms of this medication
- Antabuse (disulfiram) – Blue Cross covers generic forms of this medication

* These medications do not require prior authorization

Benefits of MAT

- ✓ MAT has been shown to **stabilize physical cravings, as well as reduce behaviors** that may lead to relapse
- ✓ WHY MAT? Per the Substance Abuse and Mental Health Services Administration (SAMSHA) **80% of people with OUD do not get treatment**, of those treated, few are offered MAT (EBT)
- ✓ Substance use treatment, like the treatment for many chronic medical conditions, such as asthma or hypertension, requires a **comprehensive range of treatment options**
- ✓ Education regarding the full range of treatment options supports individual **engagement in the recovery process**
- ✓ Buprenorphine offers members a good chance of success because it is **partial agonist, satisfies receptors to alleviate cravings, addresses withdrawal symptoms quickly**, allows engagement in recovery education and activities

MAT: A Chronic Condition Approach

Success rates increase with MAT - 60% opioid free on MAT (1)

Only 7% were successful without MAT (2)

- Using medications for opioid withdrawal management is recommended over abrupt cessation of opioids (ASAM)
- Detoxification without MAT increases the risk of overdose (due to loss of tolerance) and other adverse events

Successful recovery requires individualized, coordinated network of community based system of care (ROSC), including Recovery Support Services (RSS)

1-Smith Connery, H. *Medication-assisted treatment of opioid use disorder: review of the evidence and future directions* Harv Rev Psychiatry. 2015 Mar-Apr;23(2):63-75.
2- Weiss, R.D., Potter, J.S., Griffin, M.L. et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. *Drug and Alcohol Dependence* 150:112-119, 2015
3-American Society of Addiction Medicine (2015). National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Chevy Chase, MD: American Society of Addiction Medicine.

What Is the Goal of Treating Opioid Use Disorder?

1. Individualized treatment goals based on:
   - **Overdose and death prevention**
   - Harm reduction –minimize harms from use
   - Reduction or cessation of OUD symptoms
   - Improvement in medical and behavioral health

2. Skill acquisition to cope with cravings, impulses, stressors, life events without drug use

3. Self management – help patients take responsibility for managing their condition

4. Long-term recovery – with or without medication

Alternative Resources

SAMHSA provides a treatment locator for prescribers of buprenorphine

www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

Providers from this list can be cross-referenced using **www.BCBSLA.com** to verify the network status of the prescriber

SUICIDE EDUCATION AND PREVENTION INITIATIVE


45,000
PEOPLE DIE BY SUICIDE EVERY YEAR
10th
LEADING CAUSE OF DEATH
The facts about suicide
1 MILLION
SUICIDE ATTEMPTS ARE MADE EVERY YEAR
$70B
ANNUAL COST OF SUICIDE
SUICIDE CAN BE PREVENTED
It's up to everyone to learn the warning signs and reach out and help those with suicidal thoughts and feelings.
NEW DIRECTIONS®
ndbh.com
CMPG-1361-20180810
SEPTEMBER IS SUICIDE AWARENESS MONTH
*Statistics for United States. Source: sourced from Centers for Disease Control

How to Spot Warning Signs and Help Someone Who Is Suicidal

Every day 117 people die by suicide in America; more than 225 seriously consider it. It is up to everyone to learn the warning signs and help those with suicidal thoughts and feelings.

Suicide Warning Signs

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Giving away prized possessions
- Increasing the use of alcohol or drugs
- Acting anxious or agitated: behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

How To Help Others

- Ask them if they are thinking about wanting to die or to kill themselves (Do not hesitate. This will not put the idea into their head or make it more likely that they will attempt suicide).
- Listen without judging and show you care
- Do not leave the person alone. Stay with them or make sure they are in a private, secure place with another caring person until you can get further help.
- Remove any objects that could be used in a suicide attempt
- Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) and follow their guidance
- If danger for self-harm seems imminent, call 911
- Your help can ring hope, you might even save a life
- If you have lost a loved one to suicide, the impact can be intense and overwhelming. Talk to a caring professional or joining a support group can help to provide healing as you move forward.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)

COLLABORATION BETWEEN FACILITIES AND COMMUNITY PROVIDERS

Follow-up After Hospitalization

Healthcare Effectiveness Data and Information Set (HEDIS) is an annual performance measurement created by the National Committee for Quality Assurance (NCQA) to help improve quality of healthcare and establish accountability

One measure is ensuring that patients who have had inpatient treatment for mental illness have a **follow-up visit with a behavioral health professional within 7 days of discharge.** We track appointments made within 7 days, but also want patients to attend those appointments.

Blue Cross and New Directions collaborate to promote member quality care that can **increase the HEDIS FUH7** (follow up after hospitalization) measure

Providers can use the following guidelines and tips to help the patient as well as meet the HEDIS measure

How Can We Meet These Measures?

FACILITY

- Begin discharge planning on the day of admission. Include utilization review, discharge planner, New Directions care transitions team, the patient and his/her family, significant others, guardian or others desired by patient.
- Seeking New Directions assistance with any scheduling challenges before the patient is discharged, if needed
- Scheduling the first follow-up appointment for the patient
- Coordinating care by notifying the patient's primary care provider of the recent hospitalization and providing a current list of all prescribed medications

BEHAVIORAL HEALTH PROFESSIONALS

- Schedule patients within seven days of discharge from an inpatient stay
- If you are an established provider for a patient, please accommodate a follow-up appointment within 7 days of discharge
- Allow New Directions staff to schedule appointments for members on their behalf, if needed

Questions related to HEDIS?
Please Contact the Blue Cross Health and Quality Department: QualityBlue@BCBSLA.com

FUH Measure Guidelines

The behavioral health professional can be a:

- ✓ **Psychiatrist**
- ✓ **Psychiatric Nurse Practitioner**
- ✓ **Licensed Psychologist**
- ✓ **Licensed Clinical Social Worker**
- ✓ **Licensed Professional Counselor**
- ✓ **Licensed Addiction Counselor**
- ✓ **Licensed Marriage and Family Therapist**

An intensive outpatient (IOP) or partial hospitalization (PHP) counts toward a follow-up visit

Scheduling 7-day Appointments

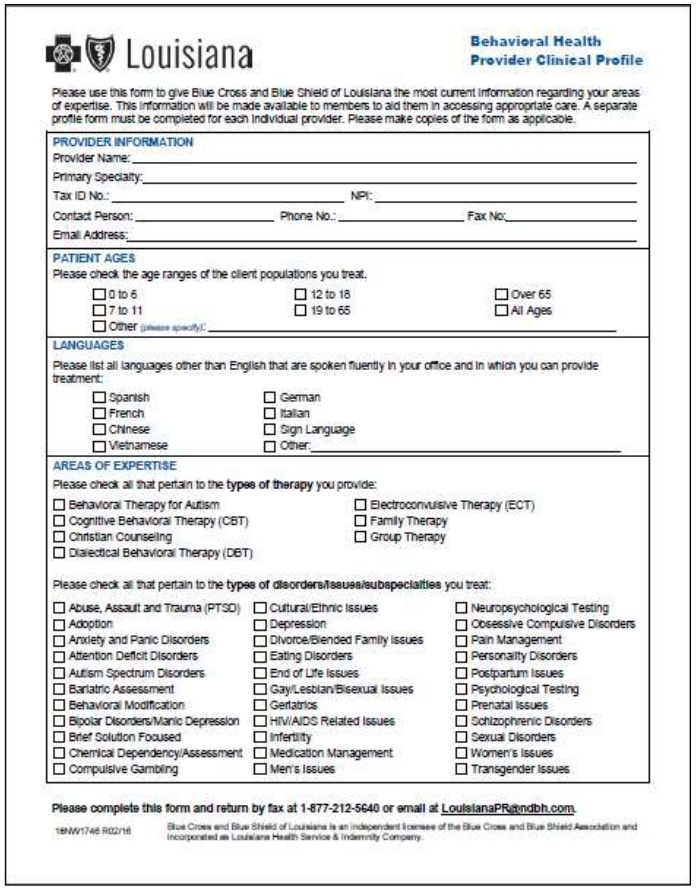
Reach the CM team directly for assistance

Scheduling - New Directions realizes that scheduling member appointments within seven days can be difficult for discharge planners who have many patients to serve for various insurance companies. If your facility would like New Directions to schedule 7-day appointments for inpatient Blue Cross members, please call 1-877-300-5909 or send an email to Louisiana_CM@ndbh.com. Include facility name, contact name of the facility staff member, and phone number. So we may protect member PHI, please do not include patient information in emails. A New Directions employee will return your call or email promptly.

Behavioral Health Rainmakers

- New Directions actively seeks outpatient behavioral health professionals who can schedule appointments for patients being discharged from an inpatient setting, within 7 days
- The Rainmaker list is used as a “first call” list for discharge planners at the facilities and the New Directions case managers and care transitions staff
- We are constantly looking to add providers to our Rainmaker list, in particular there is a need for prescribing providers at this time. If interested in becoming a Rainmaker, please email LouisianaPR@ndbh.com.

Behavioral Health Clinical Profile Forms



Louisiana

Behavioral Health Provider Clinical Profile

Please use this form to give Blue Cross and Blue Shield of Louisiana the most current information regarding your areas of expertise. This information will be made available to members to aid them in accessing appropriate care. A separate profile form must be completed for each individual provider. Please make copies of the form as applicable.

PROVIDER INFORMATION

Provider Name: _____

Primary Specialty: _____

Tax ID No.: _____ NPI: _____

Contact Person: _____ Phone No.: _____ Fax No: _____

Email Address: _____

PATIENT AGES

Please check the age ranges of the client populations you treat.

☐ 0 to 6 ☐ 7 to 11 ☐ 12 to 18 ☐ 19 to 65 ☐ Over 65 ☐ All Ages

☐ Other (please specify): _____

LANGUAGES

Please list all languages other than English that are spoken fluently in your office and in which you can provide treatment:

☐ Spanish ☐ French ☐ Chinese ☐ Vietnamese ☐ German ☐ Italian ☐ Sign Language ☐ Other: _____

AREAS OF EXPERTISE

Please check all that pertain to the **types of therapy** you provide:

☐ Behavioral Therapy for Autism
☐ Cognitive Behavioral Therapy (CBT)
☐ Christian Counseling
☐ Dialectical Behavioral Therapy (DBT)
☐ Electroconvulsive Therapy (ECT)
☐ Family Therapy
☐ Group Therapy

Please check all that pertain to the **types of disorders/issues/subspecialties** you treat:

☐ Abuse, Assault and Trauma (PTSD)
☐ Adoption
☐ Anxiety and Panic Disorders
☐ Attention Deficit Disorders
☐ Autism Spectrum Disorders
☐ Bariatric Assessment
☐ Behavioral Modification
☐ Bipolar Disorders/Manic Depression
☐ Brief Solution Focused
☐ Chemical Dependency/Assessment
☐ Compulsive Gambling
☐ Cultural/Ethnic Issues
☐ Depression
☐ Divorce/Blended Family Issues
☐ Eating Disorders
☐ End of Life Issues
☐ Gay/Lesbian/Bisexual Issues
☐ Geriatrics
☐ HIV/AIDS Related Issues
☐ Infertility
☐ Medication Management
☐ Men's Issues
☐ Neuropsychological Testing
☐ Obsessive Compulsive Disorders
☐ Pain Management
☐ Personality Disorders
☐ Postpartum Issues
☐ Psychological Testing
☐ Prenatal Issues
☐ Schizophrenic Disorders
☐ Sexual Disorders
☐ Women's Issues
☐ Transgender Issues

Please complete this form and return by fax at 1-877-212-5640 or email at LouisianaPR@ndbh.com.

18NW1746 R02/18

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.

Sent out twice a year

- Only needs to be returned if information has changed or for new providers
- This form provides us valuable information and helps us to match members to providers

Send completed form to:

fax: 1-877-212-5640

email: LouisianaPR@ndbh.com

This form is available online at **www.BCBSLA.com/providers** >Resources >Forms

Support & Resources

Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary supervisor

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard

Kelly Smith
Acadia, Ascension, Calcasieu, Cameron, Iberville, Jefferson Davis, Livingston, Pointe Coupee, St. Landry, St. Martin, Vermilion, West Baton Rouge

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn

Marie Davis
Assumption, Iberia, Lafayette, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana

Melonie Martin
East Baton Rouge

Patricia O'Gwynn
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll

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

Angela Jackson **Darnell Kling** **Jennifer Aucoin**

Network Development

Provider Contracting

Jode Burkett – **jode.burkett@bcbsla.com**
manager

Cora LeBlanc – **cora.leblanc@bcbsla.com**
Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne

Dayna Roy – **dayna.roy@bcbsla.com**
Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Grant, Jefferson Davis, LaSalle, Natchitoches, Rapides, Sabine, Vernon, Winn

Jason Heck – **jason.heck@bcbsla.com**
Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Red River, Richland, Tensas, Union, Webster, West Carroll

Jill Taylor – **jill.taylor@bcbsla.com**
Jefferson, Orleans, Plaquemines, St. Bernard

Mary Reising – **mary.reising@bcbsla.com**
St. Tammany, Tangipahoa, Washington

Mica Toups – **mica.toups@bcbsla.com**
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion

Sue Condon – **sue.condon@bcbsla.com**
Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge, West Feliciana

Shannon Taylor – **shannon.taylor@bcbsla.com**
Blue Advantage, Special Projects

network.development@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean **Karen Armstrong** **Mary Landry**

Network Operations

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Wendy Barber provider data manager

Gloria Burns credentialing manager

The **network.administration@bcbsla.com** email address should be used by providers as an electronic option for submitting contracts, applications and forms

Recredentialing applications can be emailed to **recredentialingapplication@bcbsla.com**

These email addresses should not be used to submit general inquiries

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Network Operations Department by calling 1-800-716-2299

To create more efficiency and reduction in processing time, information emailed and faxed to Network Operations should be sent as separate documents

Example:

1. Contract
2. Application and supporting documentation (licenses, education, etc.)
3. EFT & iLinkBlue agreements

1-800-716-2299 • option 2 – credentialing • option 3 – provider data management
Fax: 225-297-2750 • **network.administration@bcbsla.com**

Call Centers

Customer Care	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-877-250-9167**

For information NOT available on iLinkBlue

Other Provider Phone Lines

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

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

Network Administration – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing/recredentialing
- **option 3** – for questions regarding your provider data management
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding administrative representative setup

New Directions Contact Information

- Please complete Event Survey
- For assistance, please contact:

Michelle Sims

Clinical Network Manager

Email: msims@ndbh.com

Phone: 1-816-416-7672

Debbie Crabtree

PR Coordinator

Email: dcrabtree@nbdh.com

Phone: 1-904-371-6942


THANK
YOU!