Behavioral Health Webinar for Facility Providers

2020

Provider Relations Department
provider.relations@bcbsla.com

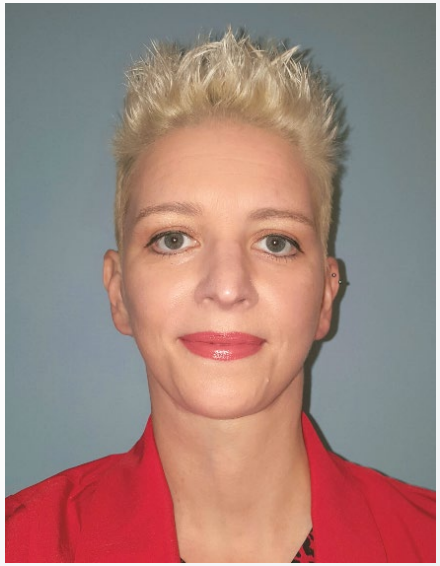
Louisiana

Presented by

Marie Davis

Provider Relations
BCBSLA

New Directions Team



Michelle Sims, LPC, LMFT
Clinical Network Manager

Debbie Crabtree
Provider Relations Coordinator

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

Agenda

- Provider Credentialing & Data Management
- Our Networks
- Telehealth
- iLinkBlue Enhancements
- Billing & Claims
- Our Secure Online Services
- New Directions

Provider Relations Team

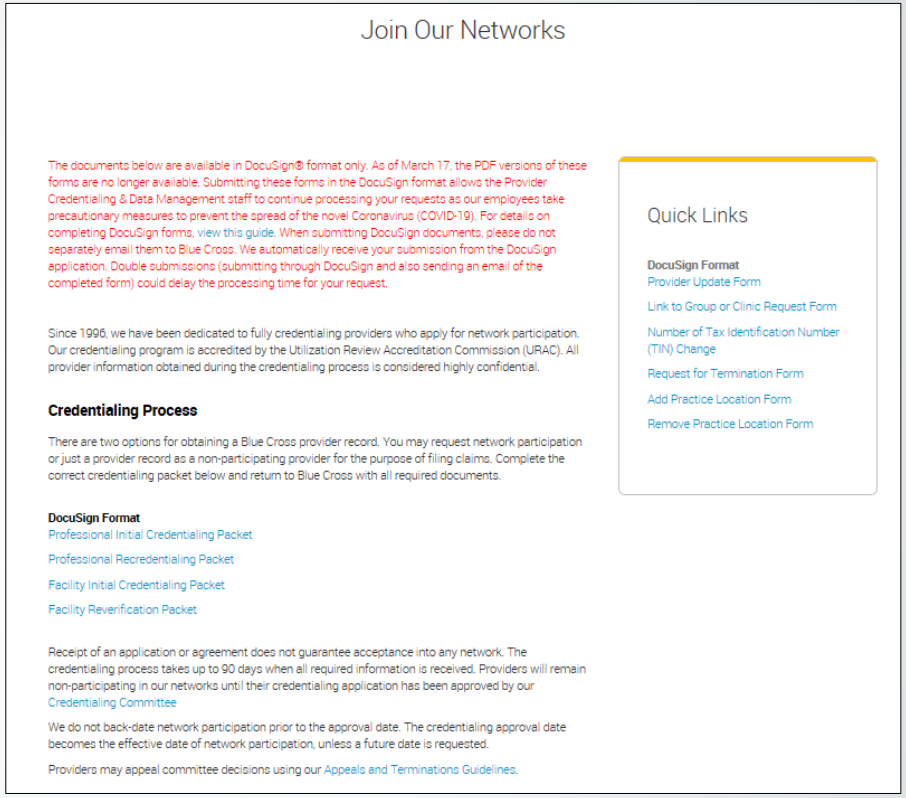
Your Provider Relations Team at Blue Cross and Blue Shield of Louisiana

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

Provider Credentialing & Data Management

Join Our Networks Webpage

- Credentialing and Recredentialing Packets *(including a checklist of all required documents)*
- Quick Links to provider update forms
- Credentialing Criteria



Join Our Networks

The documents below are available in DocuSign® format only. As of March 17, the PDF versions of these forms are no longer available. Submitting these forms in the DocuSign format allows the Provider Credentialing & Data Management staff to continue processing your requests as our employees take precautionary measures to prevent the spread of the novel Coronavirus (COVID-19). For details on completing DocuSign forms, view this guide. When submitting DocuSign documents, please do not separately email them to Blue Cross. We automatically receive your submission from the DocuSign application. Double submissions (submitting through DocuSign and also sending an email of the completed form) could delay the processing time for your request.

Since 1996, we have been dedicated to fully credentialing providers who apply for network participation. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC). All provider information obtained during the credentialing process is considered highly confidential.

Credentialing Process

There are two options for obtaining a Blue Cross provider record. You may request network participation or just a provider record as a non-participating provider for the purpose of filing claims. Complete the correct credentialing packet below and return to Blue Cross with all required documents.

DocuSign Format

Professional Initial Credentialing Packet

Professional Recredentialing Packet

Facility Initial Credentialing Packet

Facility Reverification Packet

Receipt of an application or agreement does not guarantee acceptance into any network. The credentialing process takes up to 90 days when all required information is received. Providers will remain non-participating in our networks until their credentialing application has been approved by our Credentialing Committee

We do not back-date network participation prior to the approval date. The credentialing approval date becomes the effective date of network participation, unless a future date is requested.

Providers may appeal committee decisions using our Appeals and Terminations Guidelines.

Quick Links

DocuSign Format

Provider Update Form

Link to Group or Clinic Request Form

Number of Tax Identification Number (TIN) Change

Request for Termination Form

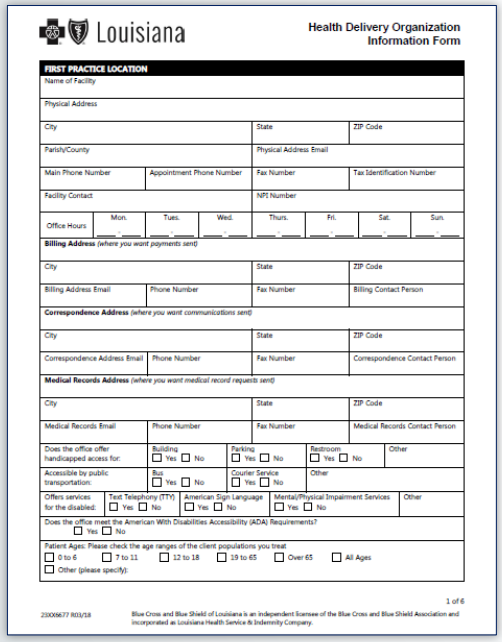
Add Practice Location Form

Remove Practice Location Form

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

Required Credentialing Applications for Facility Providers

Providers starting the credentialing process should use our **Health Delivery Organization Information Form**



Louisiana

Health Delivery Organization Information Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun.

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

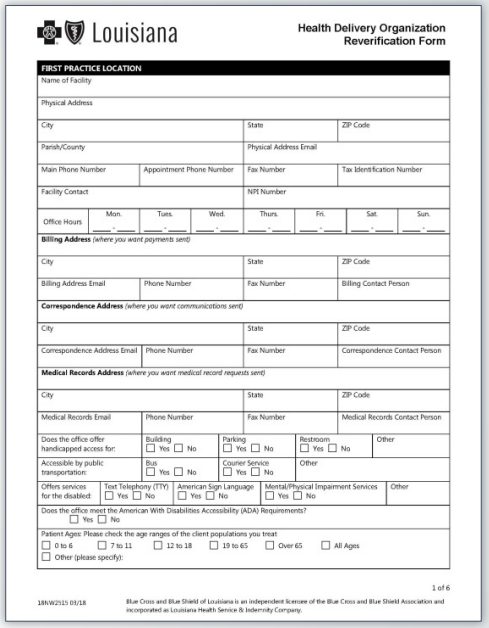
Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

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):

1 of 6

This application is part of the **Facility (initial)** credentialing packet

Current network providers seeking recredentialing should use our **Health Delivery Organization Reverification Form**



Louisiana

Health Delivery Organization Reverification Form

FIRST PRACTICE LOCATION

Name of Facility

Physical Address

City | State | ZIP Code

Parish/County | Physical Address Email

Main Phone Number | Appointment Phone Number | Fax Number | Tax Identification Number

Facility Contact | NPI Number

Office Hours | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun.

Billing Address *(where you want payments sent)*

City | State | ZIP Code

Billing Address Email | Phone Number | Fax Number | Billing Contact Person

Correspondence Address *(where you want communications sent)*

City | State | ZIP Code

Correspondence Address Email | Phone Number | Fax Number | Correspondence Contact Person

Medical Records Address *(where you want medical record requests sent)*

City | State | ZIP Code

Medical Records Email | Phone Number | Fax Number | Medical Records Contact Person

Does the office offer handicapped access for: Building ☐ Yes ☐ No | Parking ☐ Yes ☐ No | Restroom ☐ Yes ☐ No | Other

Accessible by public transportation: Bus ☐ Yes ☐ No | Courier Service ☐ Yes ☐ No | Other

Offers services for the disabled: Text Telephony (TTY) ☐ Yes ☐ No | American Sign Language ☐ Yes ☐ No | Mental/Physical Impairment Services ☐ Yes ☐ No | Other

Does the office meet the American With Disabilities Accessibility (ADA) Requirements? ☐ Yes ☐ No

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):

1 of 6

This application is part of the **Facility (reverification)** packet

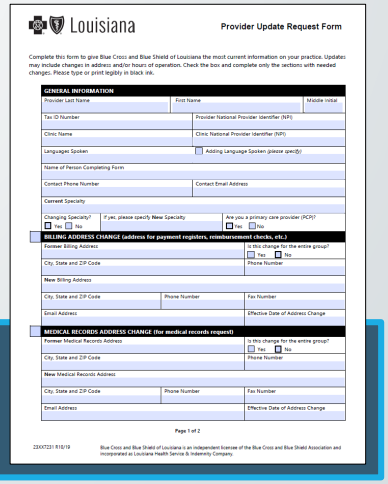
Find our credentialing links at **www.BCBSLA.com/providers**
>Provider Networks >Join Our Networks

Required Credentialing Forms for Facilities

Effective June 2020, we moved our provider recredentialing process to an entirely digital format, with forms available through DocuSign®. Providers will receive their recredential notice through an email, which contains a link to DocuSign versions of our recredentialing forms

The **HDO Information Form** may also require an HDO attachment as indicated by facility type:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facilities
- HDO Attachment D: Urgent Care Clinic/Walk-In Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health Clinics
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab


Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Languages Spoken | Adding Language Spoken (please specify)

Name of Person Completing Form

Contact Phone Number | Contact Email Address

Current Specialty

Changing Specialty? Yes No | If yes, please specify New Specialty | Are you a primary care provider (PCP)? Yes No

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

Former Billing Address | Is this change for the entire group? Yes No

City, State and ZIP Code | Phone Number

New Billing Address

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

Email Address | Effective Date of Address Change

MEDICAL RECORDS ADDRESS CHANGE (for medical records request)

Former Medical Records Address | Is this change for the entire group? Yes No

City, State and ZIP Code | Phone Number

New Medical Records Address

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

Email Address | Effective Date of Address Change

Page 1 of 2

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.

To update the email address on file for your facility use our Provider Update Request Form. This form can be found online at www.BCBSLA.com/providers >Resources >Forms.

Easily complete packets & forms with DocuSign®

The following applications and forms have been enhanced with DocuSign® capabilities:

Credentialing packets

- Professional (initial)
- Professional (recredentialing)
- Facility (initial)
- Facility (reverification)

Provider Forms

- Provider Update Request Form
- Link to Group or Clinic Request Form
- Notice of Tax Identification Number (TIN) Change Form
- Request for Termination Form
- Add Practice Location Form
- Remove Practice Location Form
- iLinkBlue Application Packet
- EFT Termination or Change Form

After submitting your documents through DocuSign, please do not send via email

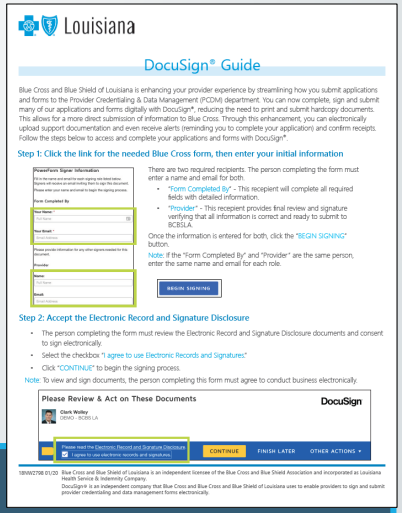
Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

Blue Cross is excited to announce that we are enhancing your provider experience by streamlining how you can submit applications and forms to the Provider Credentialing & Data Management (PCDM) Department. You can now complete, sign and submit many of our applications and forms digitally with **DocuSign**.

This enhancement will help streamline your submissions by reducing the need to print and submit hardcopy documents, allowing for a more direct submission of information to Blue Cross. Through this enhancement, you will be able to electronically upload support documentation and even receive alerts reminding you to complete your application and confirm receipt.

What is DocuSign?

An innovator in e-signature technology, that helps organizations connect and automate how various documents are prepared, signed and managed


Louisiana

DocuSign® Guide

Blue Cross and Blue Shield of Louisiana is enhancing your provider experience by streamlining how you submit applications and forms to the Provider Credentialing & Data Management (PCDM) department. You can now complete, sign and submit many of our applications and forms digitally with DocuSign®, reducing the need to print and submit hardcopy documents. This allows for a more direct submission of information to Blue Cross. Through this enhancement, you can electronically upload support documentation and even receive alerts (reminding you to complete your application) and confirm receipts. Follow the steps below to access and complete your applications and forms with DocuSign®.

Step 1: Click the link for the needed Blue Cross form, then enter your initial information

There are two required recipients. The person completing the form must enter a name and email for both.

- "Form Completed By" – This recipient will complete all required fields with detailed information.
- "Provider" – This recipient provides final review and signature verifying that all information is correct and ready to submit to BCBSLA.

Once the information is entered for both, click the "BEGIN SIGNING" button.

Note: If the "Form Completed By" and "Provider" are the same person, enter the same name and email for each role.

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

- The person completing the form must review the Electronic Record and Signature Disclosure documents and consent to sign electronically.
- Select the checkbox "I agree to use Electronic Records and Signatures."
- Click "CONTINUE" to begin the signing process.

Note: To view and sign documents, the person completing this form must agree to conduct business electronically.

Please Review & Act on These Documents

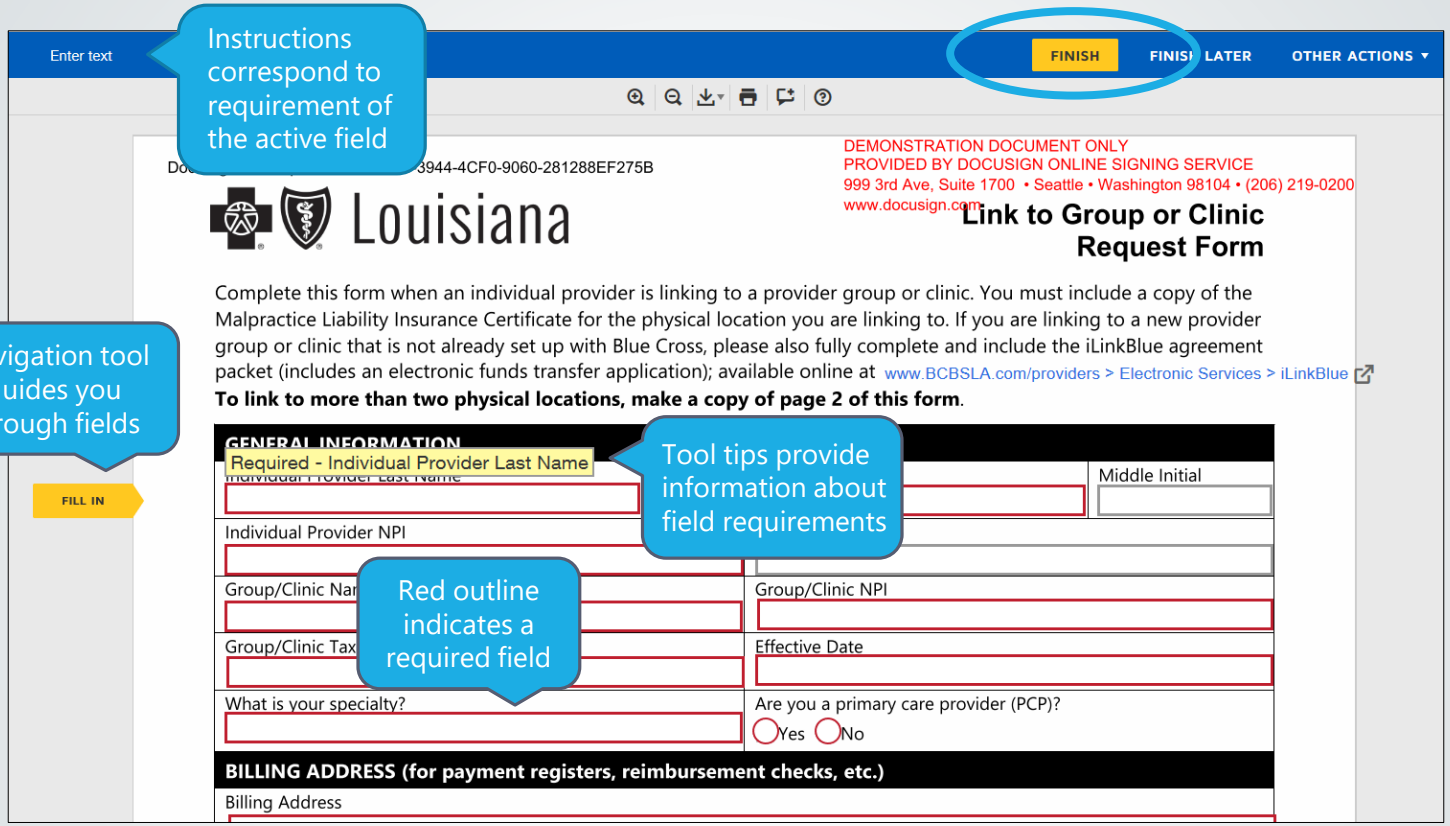
DocuSign

Clark Walley

CONTINUE FINISH LATER OTHER ACTIONS

To help with this transition, we created a DocuSign guide that is available online at **www.BCBSLA.com/providers** **>Join Our Networks**

Easily complete forms with DocuSign®

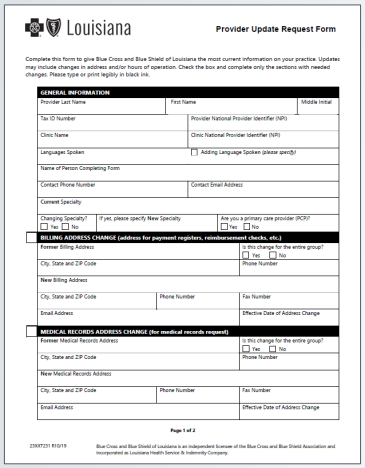


Find our *DocuSign® Guide* at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks

How to Update Your Information

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

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


Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifier (NPI)

Languages Spoken | ☐ Adding Language Spoken (please specify)

Name of Person Completing Form

Contact Phone Number | Contact Email Address

Current Specialty

Changing Specialty? ☐ Yes ☐ No | If yes, please specify New Specialty | Are you a primary care provider (PCP)? ☐ Yes ☐ No

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

Former Billing Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Billing Address

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

Email Address | Effective Date of Address Change

☐ MEDICAL RECORDS ADDRESS CHANGE (for medical records request)

Former Medical Records Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Medical Records Address

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

Email Address | Effective Date of Address Change

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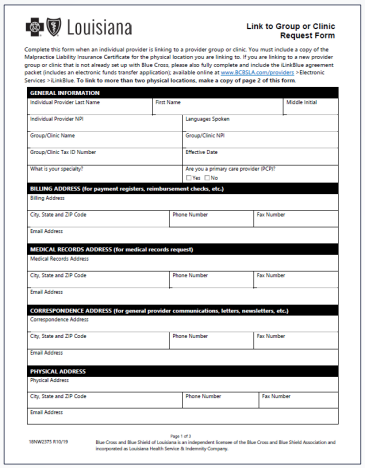
23XX7231 R10/19

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.

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


Louisiana

Link to Group or Clinic Request Form

Complete this form when an individual provider is linking to a provider group or clinic. You must include a copy of the Malpractice Liability Insurance Certificate for the physical location you are linking to. If you are linking to a new provider group or clinic that is not already set up with Blue Cross, please also fully complete and include the Link Blue agreement packet (includes an electronic funds transfer application) available online at www.BCBSLA.com/providers >Electronic Services >LinkBlue. To link to more than two physical locations, make a copy of page 2 of this form.

GENERAL INFORMATION

Individual Provider Last Name | First Name | Middle Initial

Individual Provider NPI | Languages Spoken

Group/Clinic Name | Group/Clinic NPI

Group/Clinic Tax ID Number | Effective Date

What is your specialty? | Are you a primary care provider (PCP)? ☐ Yes ☐ No

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

Billing Address

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

Email Address

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address

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

Email Address

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address

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

Email Address

PHYSICAL ADDRESS

Physical Address

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

Email Address

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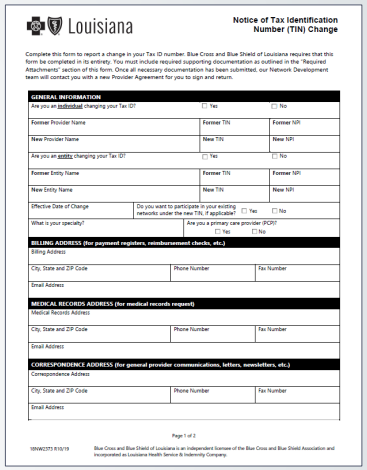
18NW2373 R10/19

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.

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


Louisiana

Notice of Tax Identification Number (TIN) Change

Complete this form to report a change in your Tax ID number. Blue Cross and Blue Shield of Louisiana requires that this form be completed in its entirety. You must include required supporting documentation as outlined in the 'Required Attachments' section of this form. Once all necessary documentation has been submitted, our Network Development team will contact you with a new Provider Agreement for you to sign and return.

GENERAL INFORMATION

Are you an individual changing your Tax ID? ☐ Yes ☐ No

Former Provider Name | Former TIN | Former NPI

New Provider Name | New TIN | New NPI

Are you an entity changing your Tax ID? ☐ Yes ☐ No

Former Entity Name | Former TIN | Former NPI

New Entity Name | New TIN | New NPI

Effective Date of Change | Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No

What is your specialty? | Are you a primary care provider (PCP)? ☐ Yes ☐ No

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

Billing Address

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

Email Address

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address

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

Email Address

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address

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

Email Address

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18NW2373 R10/19

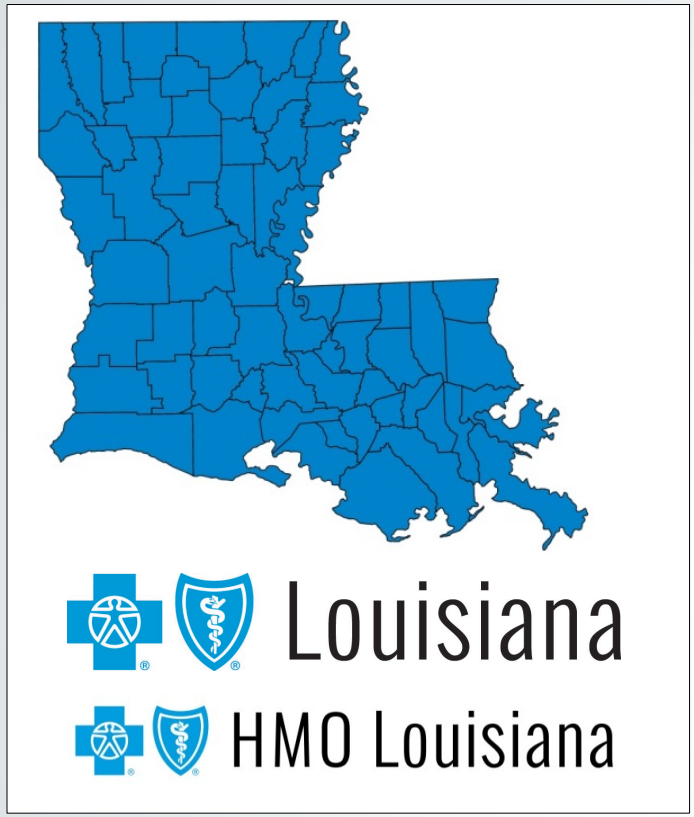
Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross and Blue Shield Association and Incorporated as Louisiana Health Service & Indemnity Company.

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

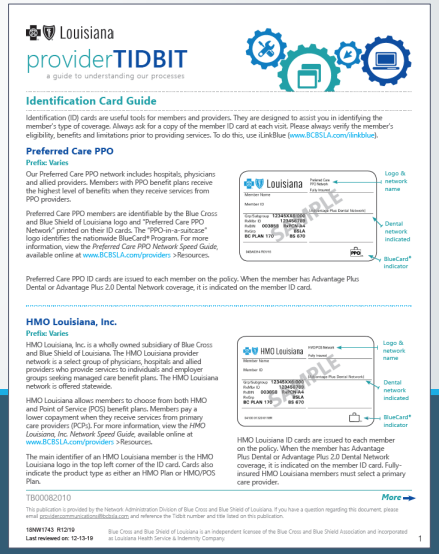
Submit these forms online at **www.BCBSLA.com/providers** >Resources >Forms

Our Networks

Our Provider Networks



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


Louisiana
providerTIDBIT
a guide to understanding our processes

Identification Card Guide

Identification (ID) cards are useful tools for members and providers. They are designed to assist you in identifying the member's type of coverage. Always ask for a copy of the member ID card at each visit. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (www.BCBSLA.com/ilinkblue).

Preferred Care PPO

Prefix: Varies

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

Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and "Preferred Care PPO Network" printed on their ID cards. The "PPO-in-a-suitcase" logo identifies the nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

Logo & network name
Dental network indicated
BlueCard® indicator

Preferred Care PPO ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card.

HMO Louisiana, Inc.

Prefix: Varies

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

HMO Louisiana allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a lower copayment when they receive services from primary care providers (PCPs). For more information, view the *HMO Louisiana, Inc. Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

The main identifier of an HMO Louisiana member is the HMO Louisiana logo in the top left corner of the ID card. Cards also indicate the product type as either an HMO Plan or HMO/POS Plan.

Logo & network name
Dental network indicated
BlueCard® indicator

HMO Louisiana ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card. Fully-insured HMO Louisiana members must select a primary care provider.

TB00082010

More

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this document, please email providercommunications@bcbsla.com and reference the TibbR number and title listed on this publication.

18NW1743 R1219
Last reviewed on: 12-13-19

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.

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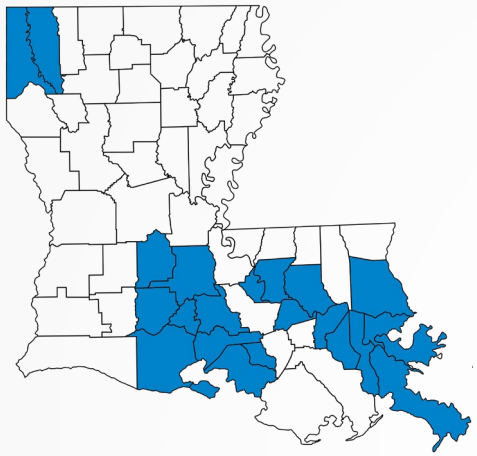
We have a Provider Tidbit to help identify a member's applicable network when looking at the ID card.
The Identification Card Guide is available online at **www.BCBSLA.com/providers**, then click on "Resources." Provider Tidbits can also be accessed through iLinkBlue under the "Resources" menu option.

Our Provider Networks



BLUE CONNECT

New Orleans area

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

Baton Rouge area

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

Lafayette area

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

Shreveport area

Bossier and Caddo parishes

COMMUNITY BLUE

Baton Rouge area

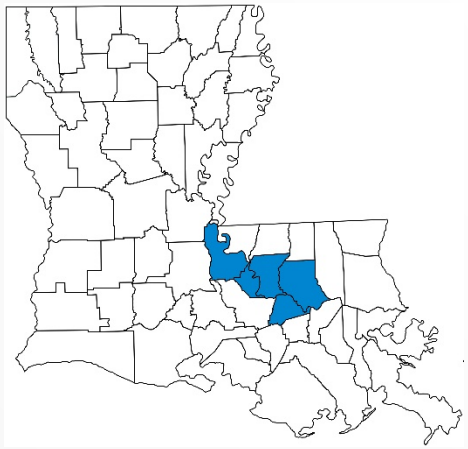
Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Our Provider Networks

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans parishes



PRECISION BLUE

Baton Rouge area

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

Federal Employee Program

The Federal Employee Program (FEP) provides benefits to federal employees, retirees and their dependents. FEP members may have one of three benefit plans: Standard Option, Basic Option or FEP Blue Focus (limited plan).

STANDARD OPTION

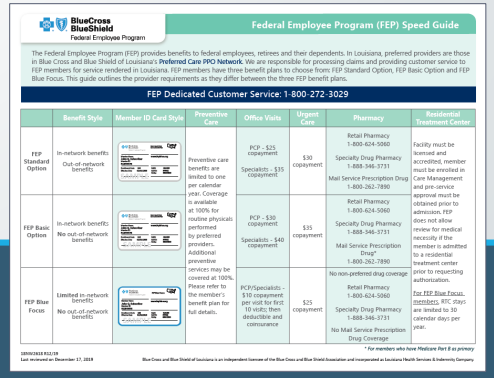
- ✓ In-network
- ✓ Out-of-network

BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

- ✓ **LIMITED** in-network
- X Out-of-network



BlueCross BlueShield Federal Employee Program

Federal Employee Program (FEP) Speed Guide

The Federal Employee Program (FEP) provides benefits to federal employees, retirees and their dependents. In Louisiana, preferred providers are those in Blue Cross and Blue Shield of Louisiana's **Preferred Care PPO Network**. We are responsible for processing claims and providing customer service to FEP members for service rendered in Louisiana. FEP members have three benefit plans to choose from: FEP Standard Option, FEP Basic Option and FEP Blue Focus. This guide outlines the provider requirements as they differ between the three FEP benefit plans.

FEP Dedicated Customer Service: 1-800-272-3029

	Benefit Style	Member ID Card Style	Preventive Care	Office Visits	Urgent Care	Pharmacy	Residential Treatment Center
FEP Standard Option	In-network benefits Out-of-network benefits		Preventive care benefits are limited to one per calendar year. Coverage is available at 100% for routine physicals performed by preferred providers. Additional preventive services may be covered at 100%. Please refer to the member's benefit plan for full details.	PCP - $25 copayment Specialists - $35 copayment	$30 copayment	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug 1-800-262-7890	Facility must be licensed and accredited, member must be enrolled in Care Management and pre-service approval must be obtained prior to admission. FEP does not allow review for medical necessity if the member is admitted to a residential treatment center prior to requesting authorization. For FEP Blue Focus members, RTC days are limited to 30 calendar days per year.
FEP Basic Option	In-network benefits No out-of-network benefits			PCP - $30 copayment Specialists - $40 copayment	$35 copayment	Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 Mail Service Prescription Drug* 1-800-262-7890	
FEP Blue Focus	Limited in-network benefits No out-of-network benefits			PCP/Specialists - $10 copayment per visit for first 10 visits; then deductible and coinsurance	$25 copayment	No non-preferred drug coverage Retail Pharmacy 1-800-624-5060 Specialty Drug Pharmacy 1-888-346-3731 No Mail Service Prescription Drug Coverage	

* For members who have Medicare Part B as primary

GENSG2018 R12/19
Last reviewed on December 17, 2018

Blue Cross and Blue Shield of Louisiana is an Independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Services & Indemnity Company.

New FEP Speed Guide available! Visit
www.BCBSLA.com/providers >Resources>Speed Guides

Our Blue Advantage Networks

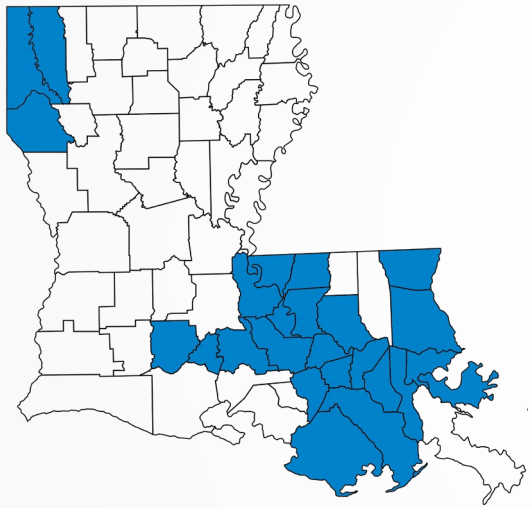
Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Advantage (HMO) and **Blue Advantage (PPO)** networks are available statewide to Medicare eligible members

Healthy Blue Dual Advantage (HMO D-SNP) Network

Healthy Blue Dual Advantage (HMO D-SNP) is our Medicare/Medicaid Dual Advantage special needs product currently available to Medicare/Medicaid-eligible members



HEALTHY BLUE DUAL ADVANTAGE (HMO D-SNP)

New Orleans area

Jefferson, Lafourche, Orleans, St. Bernard, St. Charles, St. Helena, St. John the Baptist, St. Tammany, Terrebonne and Washington parishes

Baton Rouge area

Ascension, Assumption, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, Livingston, St. James, West Baton Rouge and West Feliciana parishes

Lafayette area

Acadia, Lafayette, St. Martin and St. Mary parishes

Shreveport area

Bossier, Caddo and De Soto parishes

Healthy Blue

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

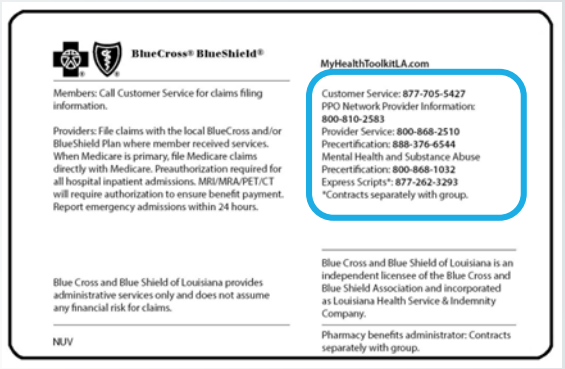
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product

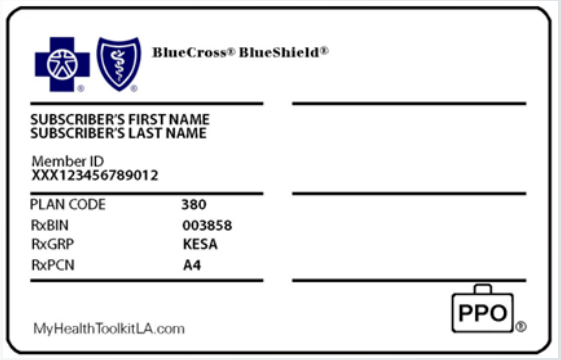
The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product

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





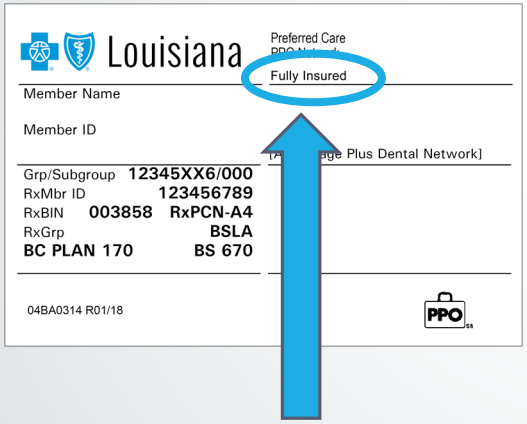
This list of prefixes is available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section

Fully Insured vs. Self-insured

Member ID Card Differences

FULLY INSURED

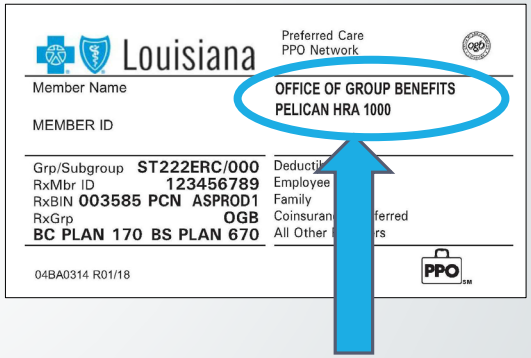
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA



"Fully Insured" notation

SELF FUNDED

Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA



- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

The benefit, limitation, exclusion and authorization **requirements often vary for self-funded groups**. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.BCBSLA.com/ilinkblue**).

Telehealth

IOP & PHP Telehealth

Providers should adhere to the following guidelines for delivering intensive outpatient program (IOP) services via telehealth

- The following criteria apply for IOP services:
  - Provider must operate within the scope of its license to deliver IOP services through telehealth encounters
  - Provider must accept Blue Cross' allowable charges
  - The telehealth visit must be fully documented in the patient's medical record
  - Services must be provided using a non-public-facing platform for telehealth services that is either HIPAA-compliant or approved by the Health and Human Services Office of Civil Rights

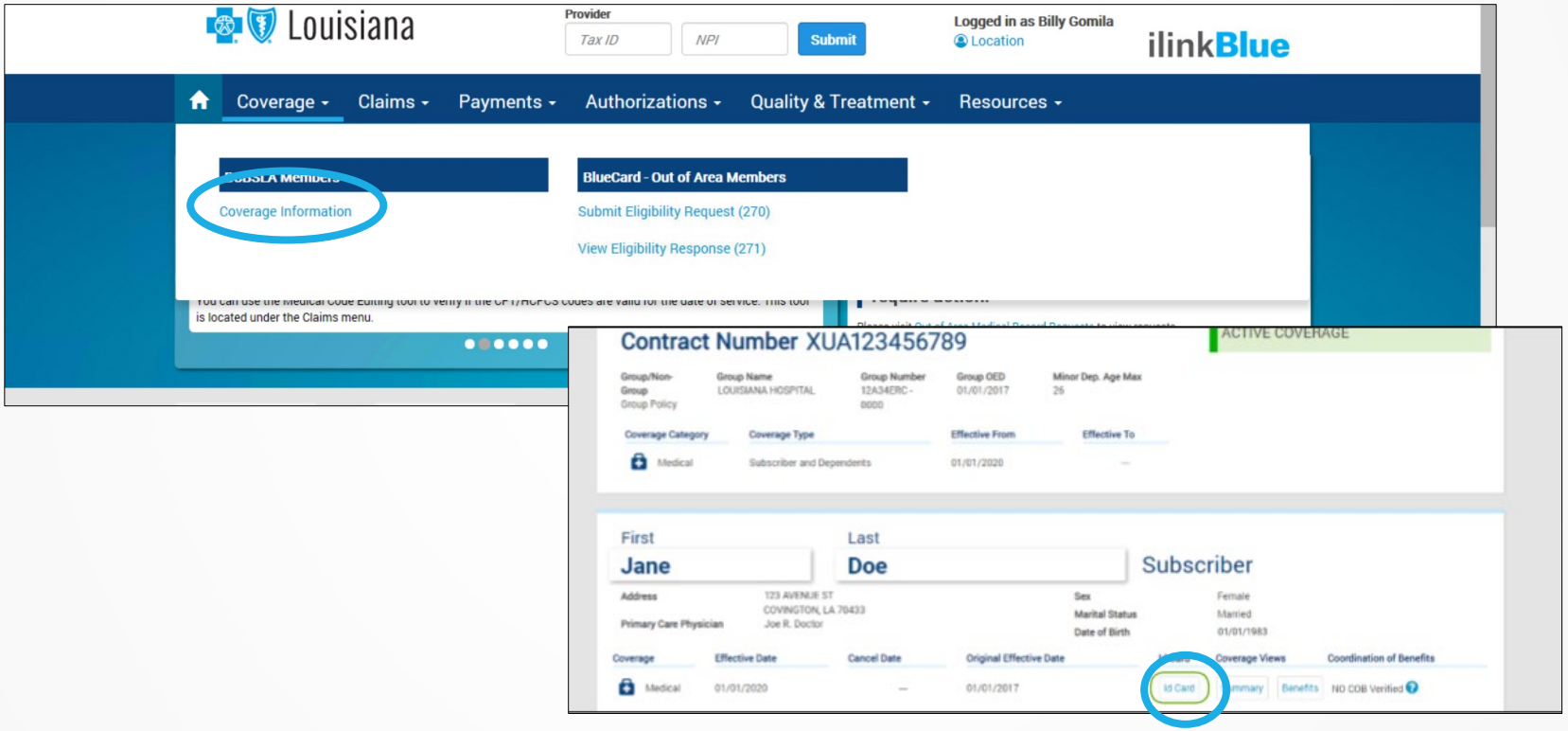
IOP & PHP Telehealth

- Billing guidelines for telehealth IOP services:
  - Blue Cross will allow reimbursement for up to three hours per day; three days per week; for a maximum of nine hours per week
  - Providers filing outpatient hospital claims for IOP telehealth services should bill with the appropriate CPT®/HCPCS code, along with Modifier GT or 95. IOP providers must continue to follow the IOP guidelines outlined in Section 5.6 Behavioral Health of the *Member Provider Policy & Procedure Manual,* available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the Resources section
- PHP Services
  - Blue Cross will not reimburse partial hospitalization program (PHP) telehealth encounters (revenue codes 0912 and 0913) due to the complexity of services. PHP services are typically six hours in length and must essentially be the same nature and intensity (including medical and nursing) as would be provided in a hospital, except that the patient is in the program less than 24 hours per day

iLinkBlue Enhancements

Digital ID Cards in iLinkBlue

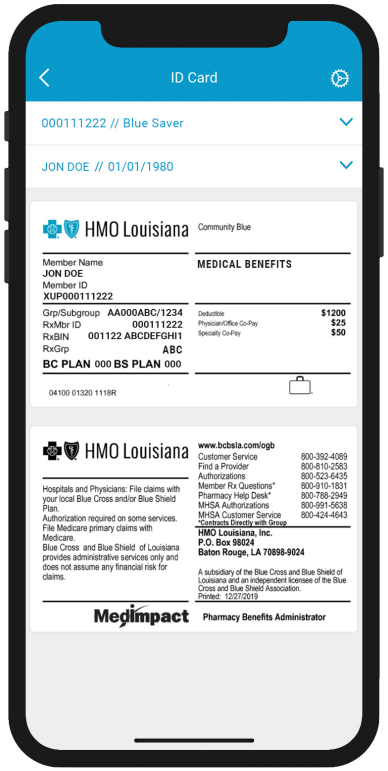
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Coverage Information" menu option, then click “ID Card”



Members Can Access Their Digital ID Cards

Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal:

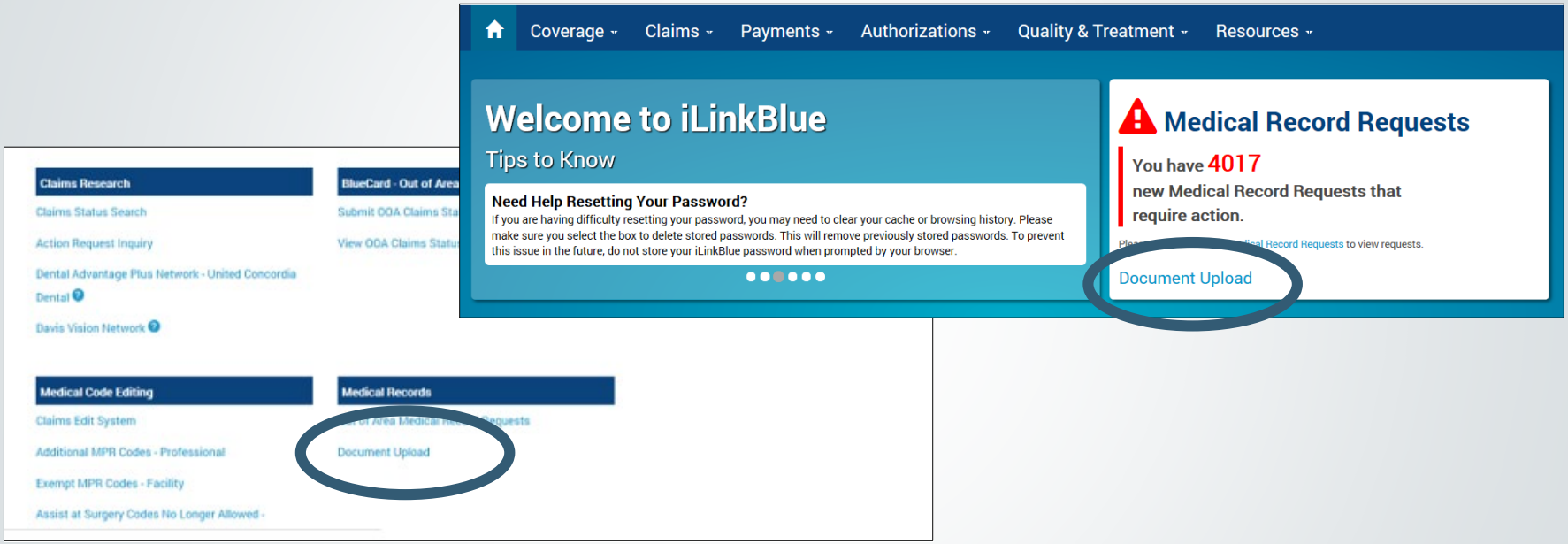
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available
- To access through the Blue Cross member portal, log into the online member account at **www.BCBSLA.com**. There, click on “My ID Card” and use the dropdown menu to choose from ID cards available. These cards can be downloaded as PDFs and saved.



Document Upload Feature

We now offer a feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments

The new feature is quick, secure and available at any time through the iLinkBlue provider portal

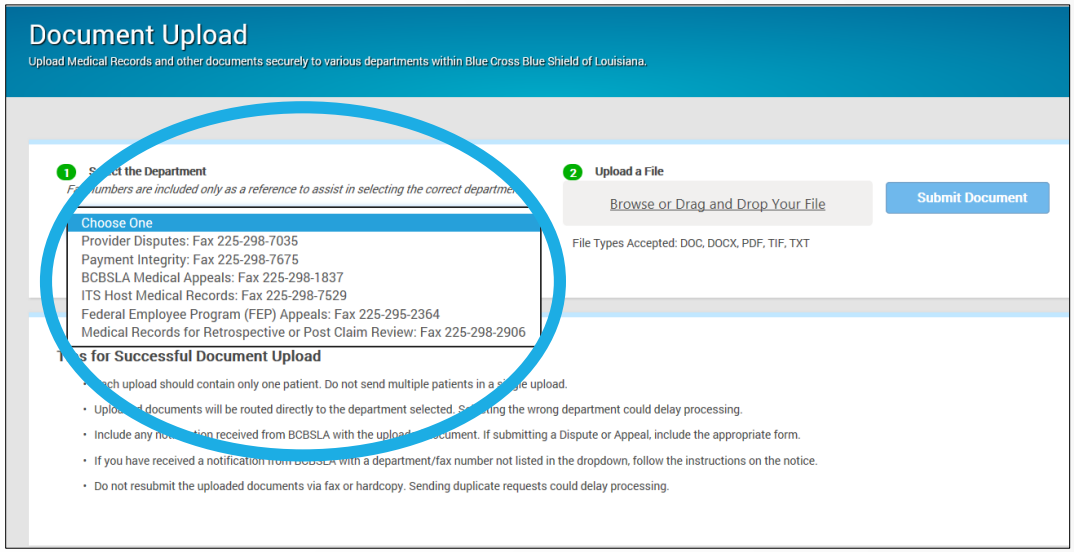


The Document Upload feature can be accessed on iLinkBlue (www.BCBSLA.com/ilinkblue) from the Medical Records Requests alert on the homepage or under Claims >Medical Records >Document Upload

Document Upload Feature

Select the department from the drop-down list you wish to send your document. The fax numbers are included only as a reference to assist in selecting the correct department.

- Provider Disputes
- Payment Integrity
- BCBSLA Medical Appeals
- ITS Host Medical Records
- Federal Employee Program (FEP) Appeals
- Medical Records for Retrospective or Post Claim Review



Document Upload Feature FAQs

What should be included in the uploaded document?

Include any notification, letter or form that is required with the request along with the medical records or other documentation requested. If submitting a Dispute or Appeal, include the appropriate form.

What file types are allowed in the upload process?

DOC, DOCX, PDF, TIF, TXT

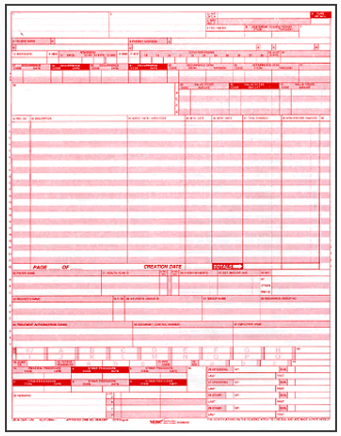
Do I need to send a fax or hard copy request in addition to upload?

No. Sending the uploaded document thru fax, email or hardcopy mail **in addition** to uploading, will result in duplicate requests being received at Blue Cross. This will delay the processing of the request.

Billing & Claims

Filing Claims Hardcopy

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



UB-04

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

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue, Signature Blue, OGB and BlueCard Claims:

Mail hardcopy claims to:

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

For FEP Claims:

BCBSLA
P.O. Box 98028
Baton Rouge, LA 70898

For Blue Advantage Claims:

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

The fastest method of claim submission and payment is electronic submission

Residential Treatment Billing

Services provided by behavioral health facilities—including residential treatment, chemical dependency, intensive outpatient and partial hospitalization services—are paid on a per diem basis. The per diem payment will include all professional and facility services provided to the member when they are enrolled in an outpatient program for the entire duration.

Type of RTC	Billing Guideline
Residential Treatment for Chemical Dependency	Providers are to bill for detoxification services under the Chemical Dependency Unit (CDU) taxonomy code and with the 1002 revenue code. Residential treatment provided after the detoxification services may bill under the Residential Treatment Center (RTC) taxonomy code and the 1001 revenue code.
Residential Treatment for Behavioral Health	All residential treatment must receive prior authorization to provide these services. Providers are to bill these services under their RTC taxonomy code and with the 1001 revenue code.

Taxonomy Codes

If you file multiple specialties under your NPI number, it is very important to also include the appropriate taxonomy code that clearly identifies the specialty

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

Example: A provider who has two specialties with same TAX ID and NPI (e.g., LPC and speech therapist) must use a taxonomy code on **all** claims to identify the specialty

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

Timely Filing

- **Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue & Signature Blue:**
  - Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service
- **FEP:**
  - Claims must be filed by December 31 of the year after the year service was rendered
- **Blue Advantage:**
  - Providers have 12 months from the date of service to file an initial claim
  - Providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim
- **OGB:**
  - Claim must be filed within 12 months of the date of service
  - Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim
- **Self-funded & BlueCard:**
  - Timely filing standards may vary. Always verify the member's benefits, including timely filing standards, through iLinkBlue

The member and Blue Cross are held harmless when claims are denied or received after the timely filing deadline

Resolving Claims Issues

Have an issue with a claim? We are here to help!

Depending on the type of claim issue, there are multiple ways to submit claims reviews that we will outline in this section:

- Action Requests (AR)
- Claims Disputes
- Medical Appeals *(for members)*
- Administrative Appeals & Grievances *(for members)*

Submitting an Action Request is a great option for getting a quick and accurate resolution for your claims issues and:

- Reduce the time it takes for providers to receive a response from Blue Cross
- Allow providers to see responses directly from the adjustments team after review
- Allow providers to submit additional questions once they have reviewed the AR response

Submitting Action Requests

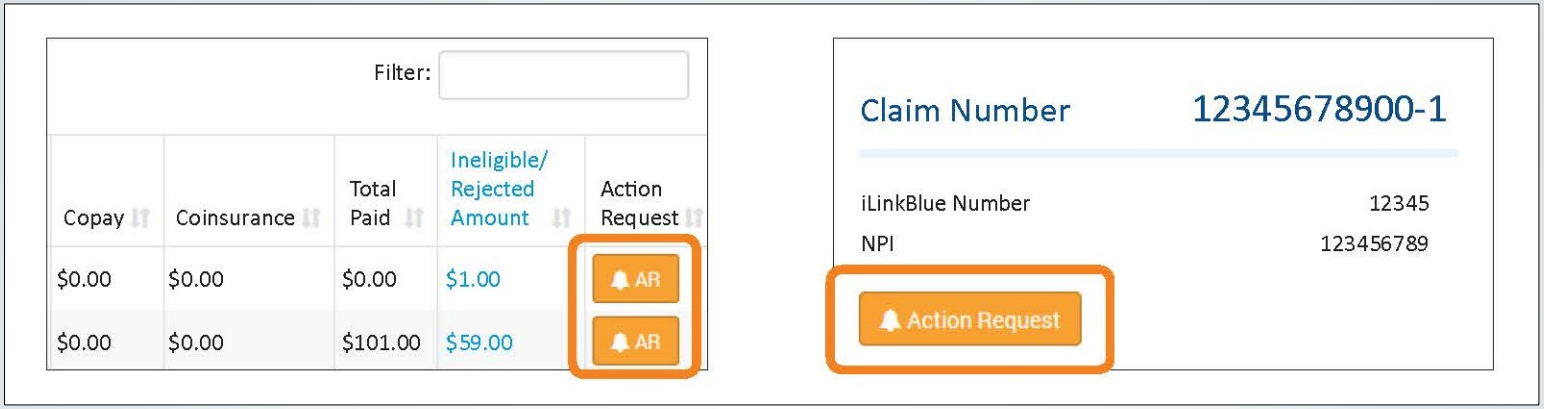
Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim

Common reasons to submit an Action Request

- Code editing inquiries
- Claim status (detailed denials
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No record of membership (effective and term date)
- Medical records receipt
- Recoupment request
- Status of an appeal
- Status of a grievance

NOTE: Action Requests do not allow you to submit documentation regarding your claims review

Submitting Action Requests



Submit an Action Request through iLinkBlue (**www.BCBSLA.com/ilinkblue**)

- On each claim, providers have the option to submit an Action Request review for correct processing
- Click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim
- Please include your contact information
- NOTE: Only complete one AR per claim; not one AR per line item of the claim

As an alternative to filing an Action Request, you may also contact the **Customer Care Center at 1-800-922-8866**

Submitting Action Requests

If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at **provider.relations@bcbsla.com**

Email an overview of the issue along with two action request dates OR two customer service reference numbers if one of the following applies:

- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) and have allowed 10-15 business days after second request, or
- It is a system issue affecting multiple claims

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

Electronic Corrected Claims

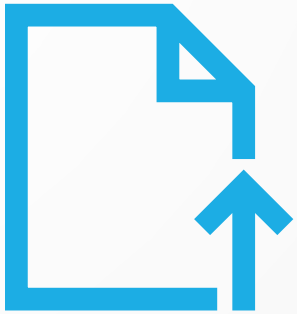
Please follow the steps below to ensure your claims will not deny as duplicates or process incorrectly. You can ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim

- Enter the frequency code "7" in Loop 2300 Segment CLM05-03
- Enter the 10-digit claim number of the original claim (assigned on the processed claim) in Loop 2300 in a REF segment and use F8 as the qualifier
- Note: The adjusted claim should include all charges (not just the difference between the original claim and the adjustment)

Void the Claim

- Use frequency code "8" in Loop 2300 Segment CLM05-03
- Use the 10-digit claim number of the original claim (assigned on the processed claim) in Loop 2300 in a REF segment and use F8 as the qualifier



Part 2 Regulations

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

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

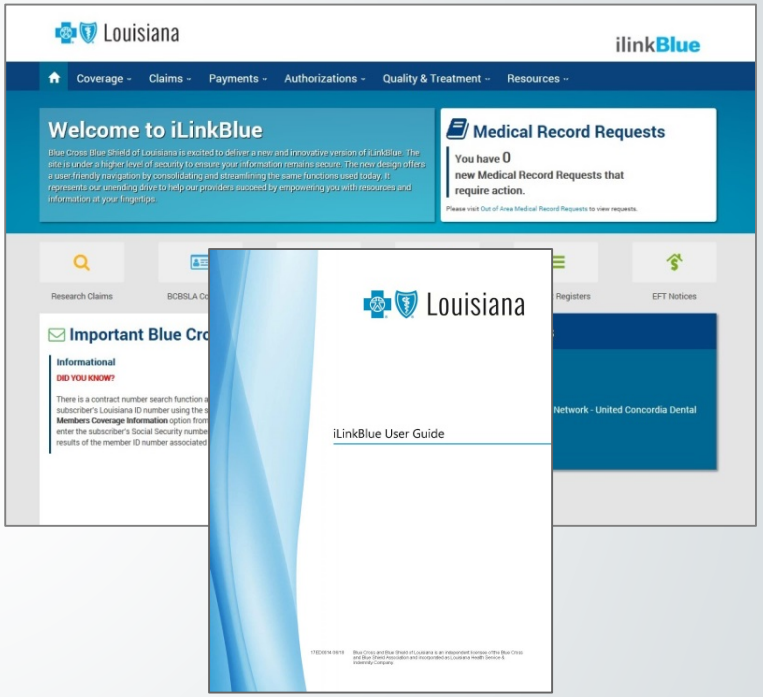
- Providers should consult legal counsel if they have any questions as to whether or not 42 CFR part 2 regulations are applicable

Our Secure Online Services

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
  - Allowables Search
  - Authorizations
  - Medical Policy
  - 1500 Claims Entry

www.BCBSLA.com/ilinkblue

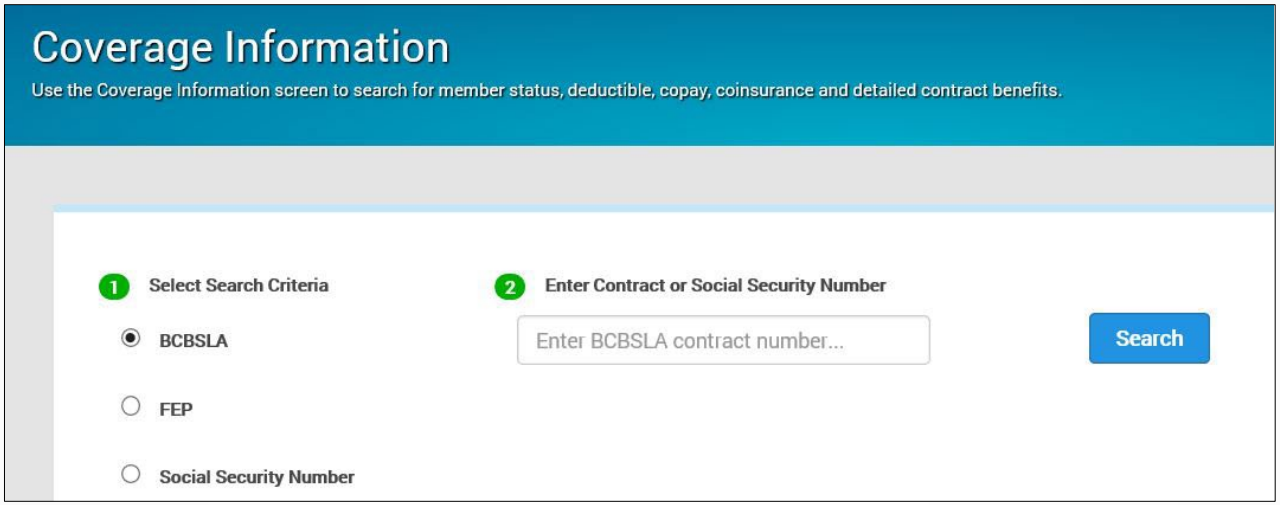


- UB-04 Claims Entry is no longer available
- For iLinkBlue training and education, contact **provider.relations@bcbsla.com**

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

iLinkBlue – Coverage & Eligibility

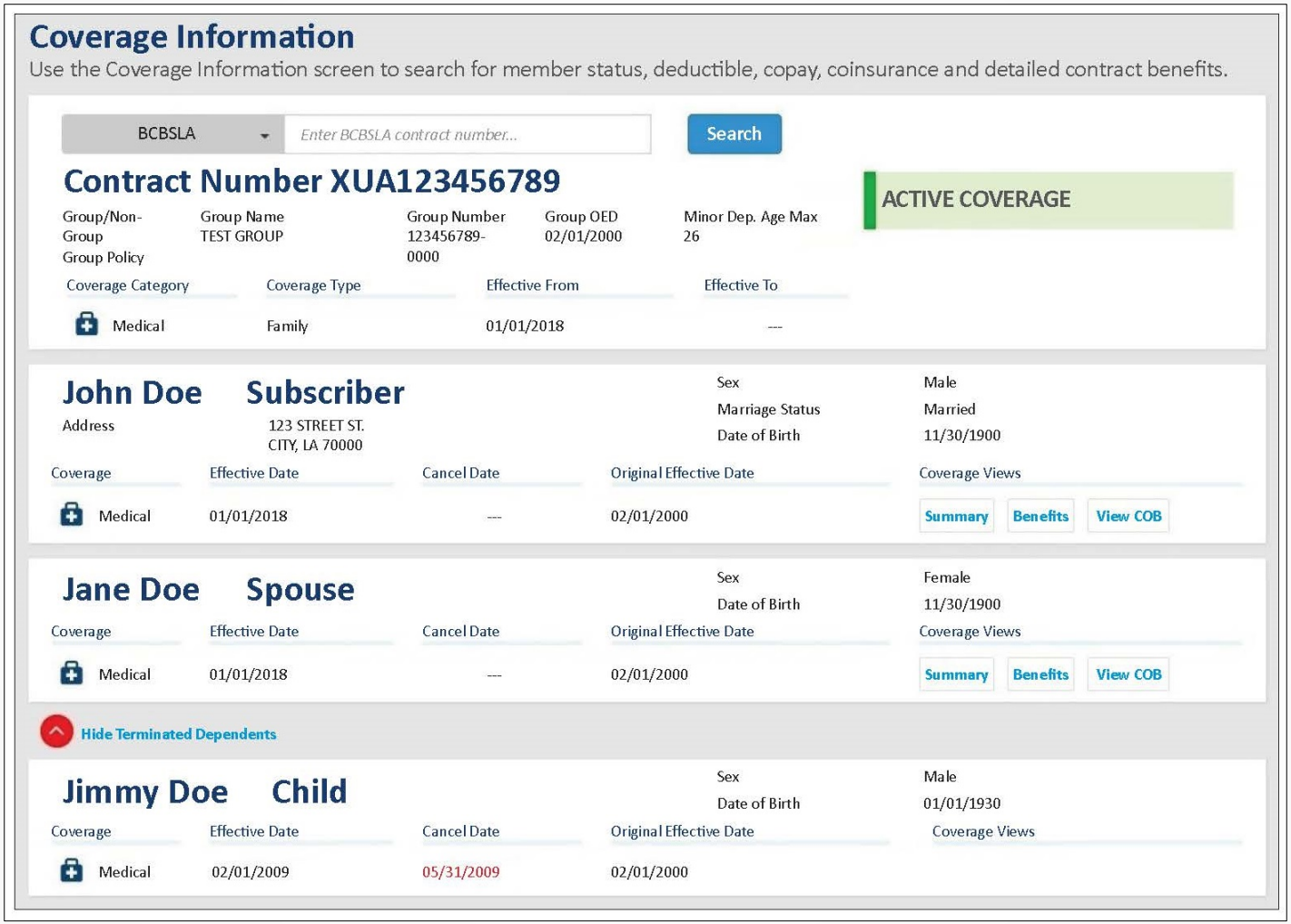
1.



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.



Coverage Information

Use the Coverage Information screen to search for member status, deductible, copay, coinsurance and detailed contract benefits.

BCBSLA | Enter BCBSLA contract number... | Search

Contract Number XUA123456789

ACTIVE COVERAGE

Group/Non-Group Group Policy	Group Name	Group Number	Group OED	Minor Dep. Age Max
	TEST GROUP	123456789-0000	02/01/2000	26

Coverage Category	Coverage Type	Effective From	Effective To
Medical	Family	01/01/2018	---

John Doe Subscriber

Address: 123 STREET ST. CITY, LA 70000

Sex: Male
Marriage Status: Married
Date of Birth: 11/30/1900

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	01/01/2018	---	02/01/2000	Summary Benefits View COB

Jane Doe Spouse

Sex: Female
Date of Birth: 11/30/1900

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	01/01/2018	---	02/01/2000	Summary Benefits View COB

Hide Terminated Dependents

Jimmy Doe Child

Sex: Male
Date of Birth: 01/01/1930

Coverage	Effective Date	Cancel Date	Original Effective Date	Coverage Views
Medical	02/01/2009	05/31/2009	02/01/2000	

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)	$500.00	---	---
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

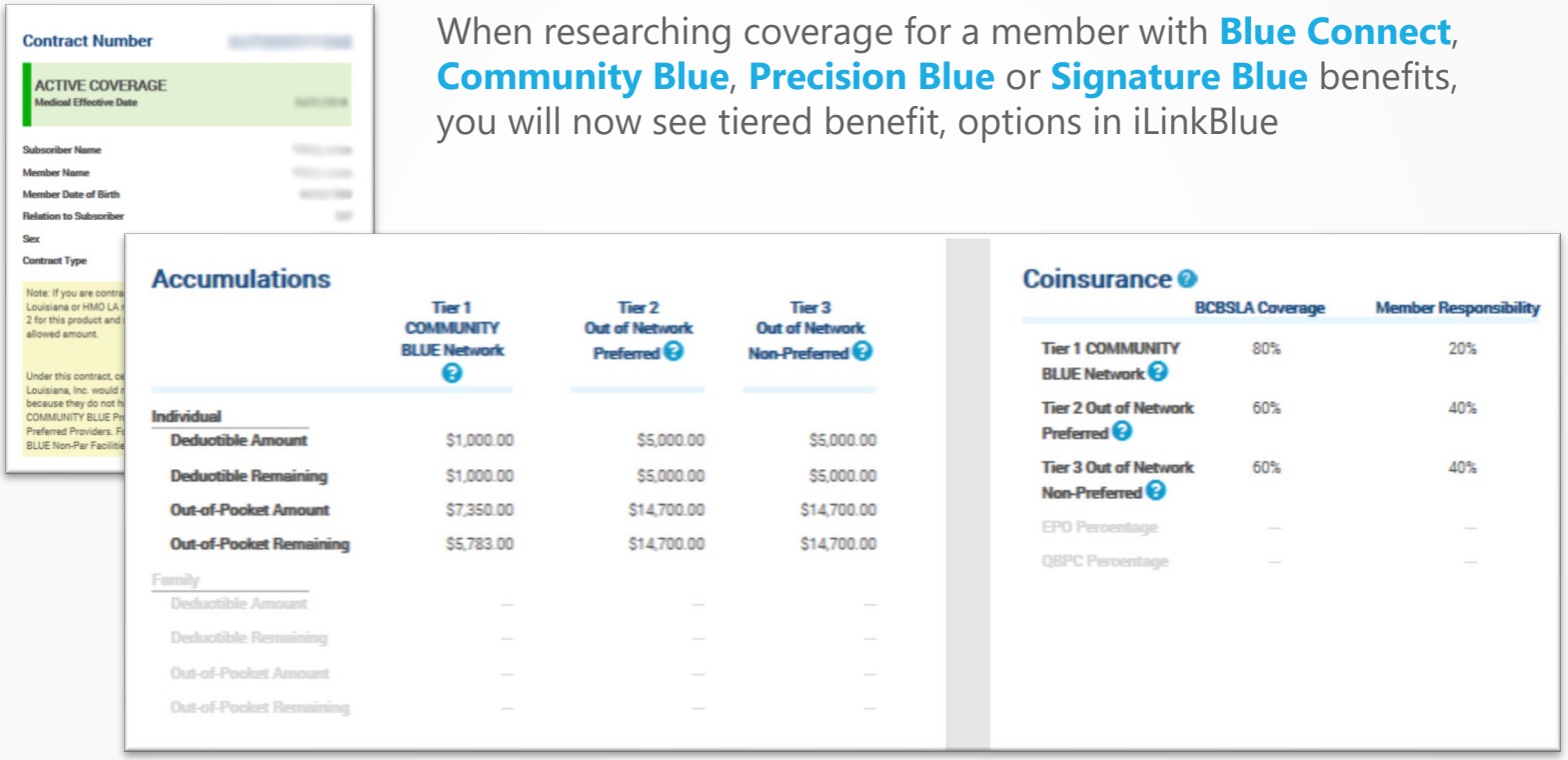
	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	---
Deductible Remaining	$0.00	$1,750.00	---
Out-of-Pocket Amount	$3,000.00	$6,000.00	---
Out-of-Pocket Remaining	$3,000.00	$6,000.00	---

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**, **Precision 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

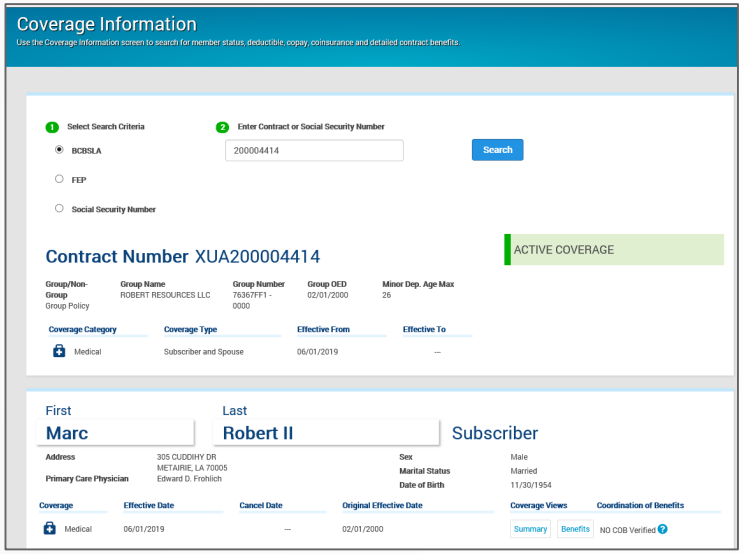
Example Scenario:

- 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

iLinkBlue – Mental Health Benefits Language

When viewing the benefits Summary that is available from the Coverage Information screen, not all details are shown. You must click the "Benefits" button, then expand the "mental health" category (or categories) to ensure you are viewing all of the member's benefits.

1.



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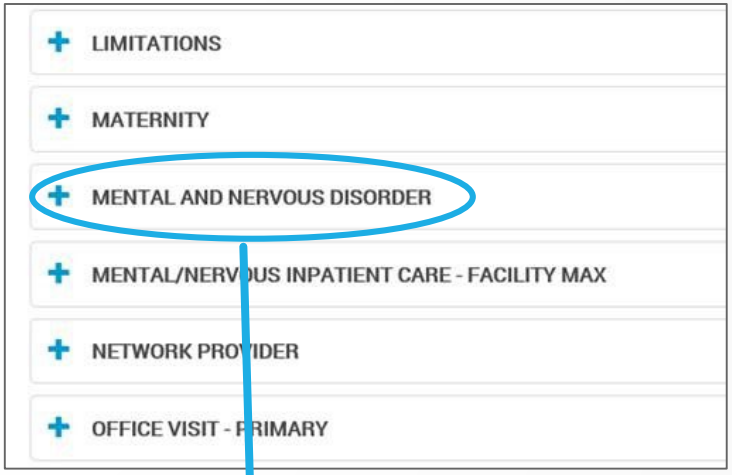
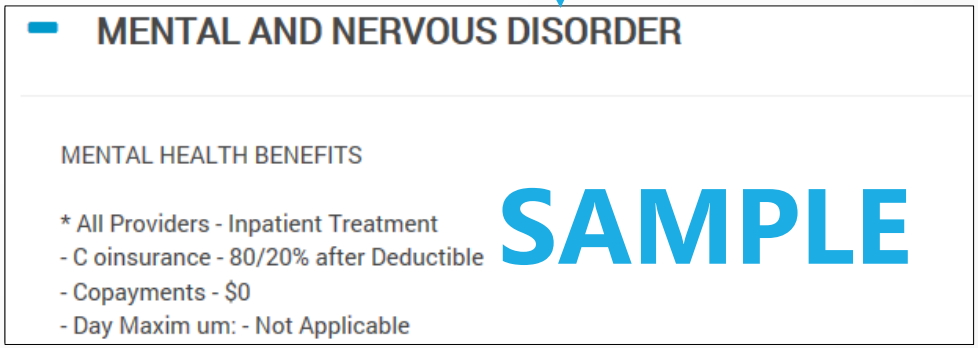
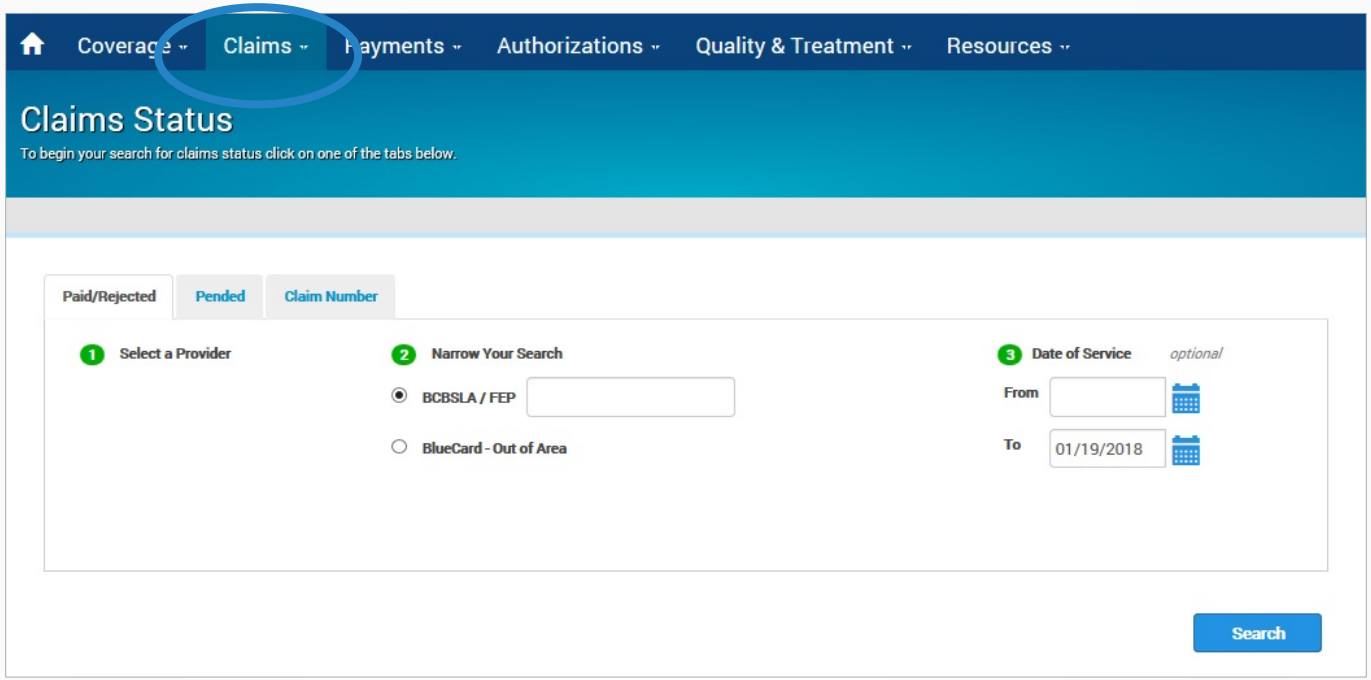




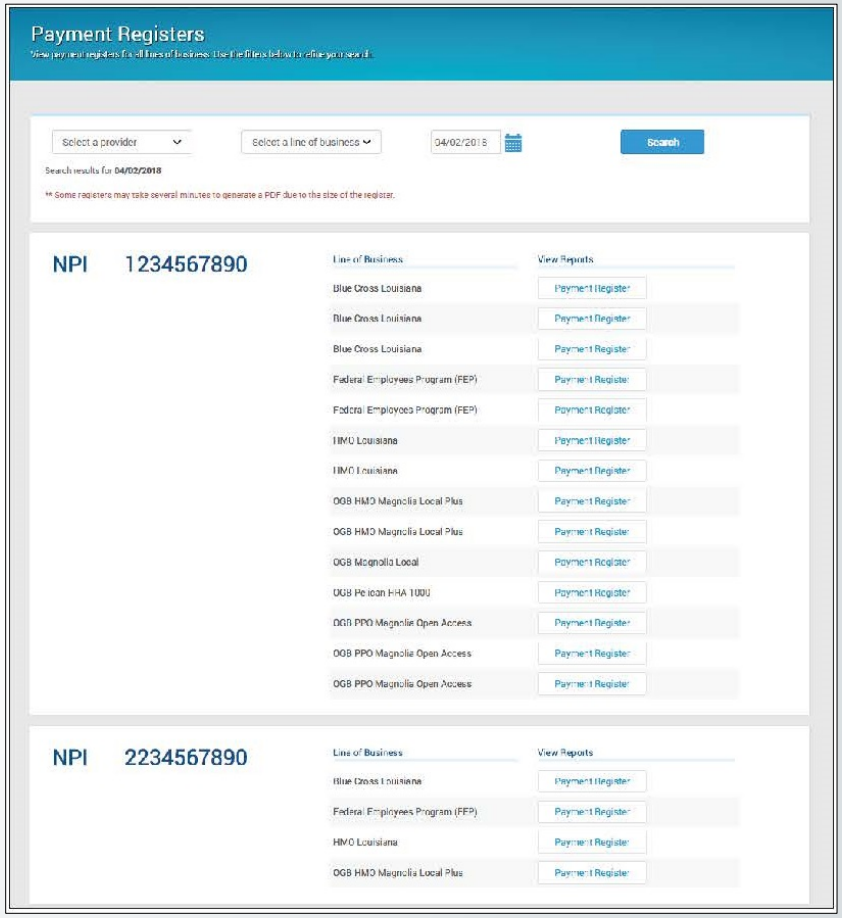
iLinkBlue – Claims Research



- 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 – 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 (**www.BCBSLA.com/ilinkblue**)
- If you have access to multiple NPIs, you will see payment registers for each



NEW DIRECTIONS®

TOGETHER IS THE WAY FORWARD

WHO IS NEW DIRECTIONS?

Blue Cross has partnered with New Directions for their expertise in the provision of behavioral health services

- Manages authorizations for members, performs all utilization and case management activities, as well as ABA case management
- Engages with our providers to improve quality outcomes
- Team of mental health professionals is available 24/7 to assist in obtaining the appropriate level of care for your patients

NEW DIRECTIONS AT A GLANCE

16.5 million members
in fifty states
and internationally

7 partnerships
with Blue Cross and
Blue Shield health plans

2,500+
EAP clients

850+
employees

214,751
Medicare members

738,000
FEP members

ACCREDITATION STATUS

URAC Accreditation for Health Utilization Management

Accredited through September 2021

NCQA Full Accreditation as a Managed Behavioral Healthcare Organization

Accredited through February 2022

URAC Accreditation for Case Management

Accredited through December 2022

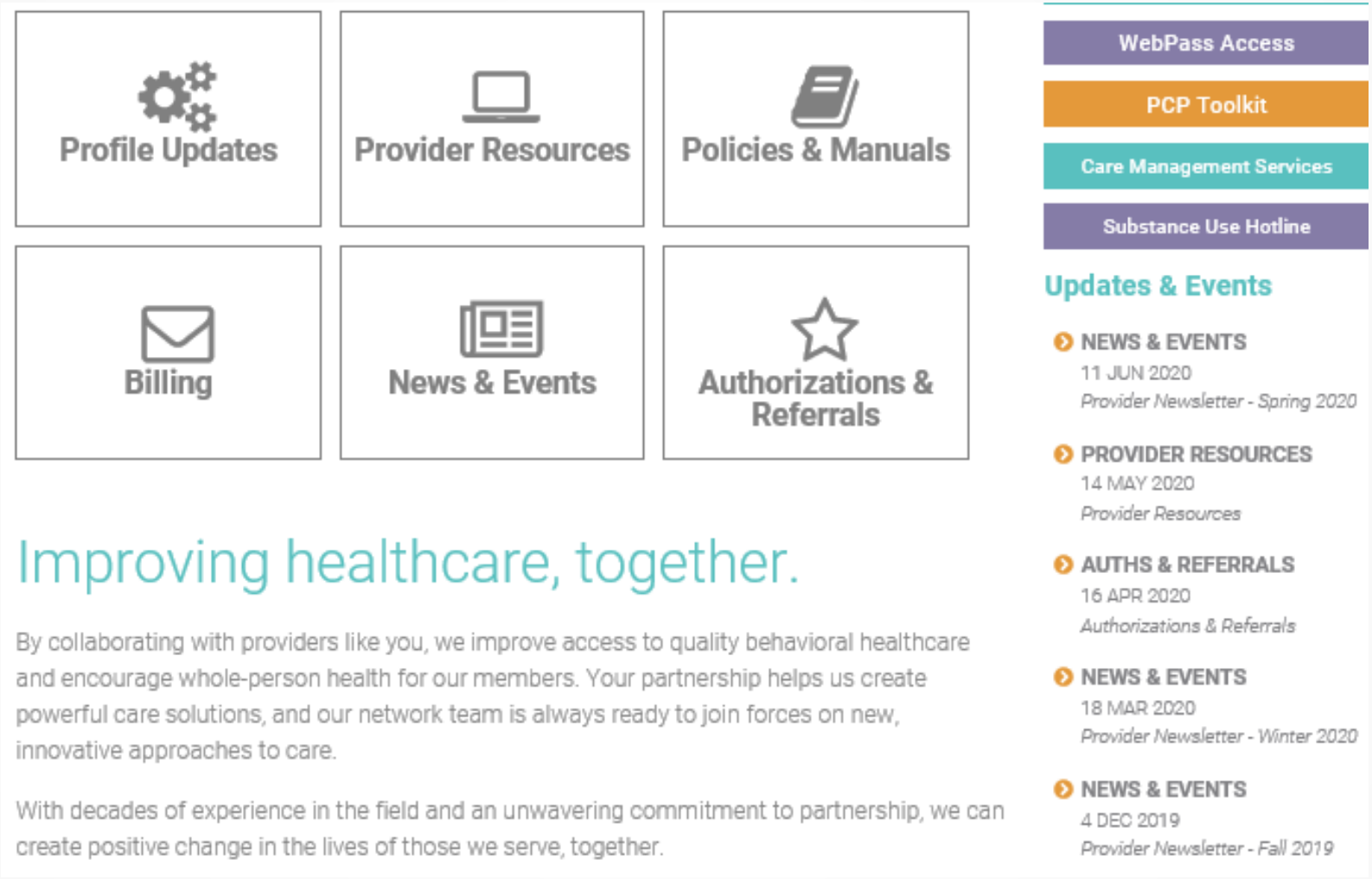
COLLABORATION IS KEY

The member's **mental** health, **physical** health and satisfaction is the goal.

We obtain this through:

RESOURCES	COLLABORATION	SUPPORT
to meet member's needs	with the member, their family, behavioral health and substance use providers, PCP providers and community resources	for the member, significant others, providers and community

HELPING YOU HELP OTHERS



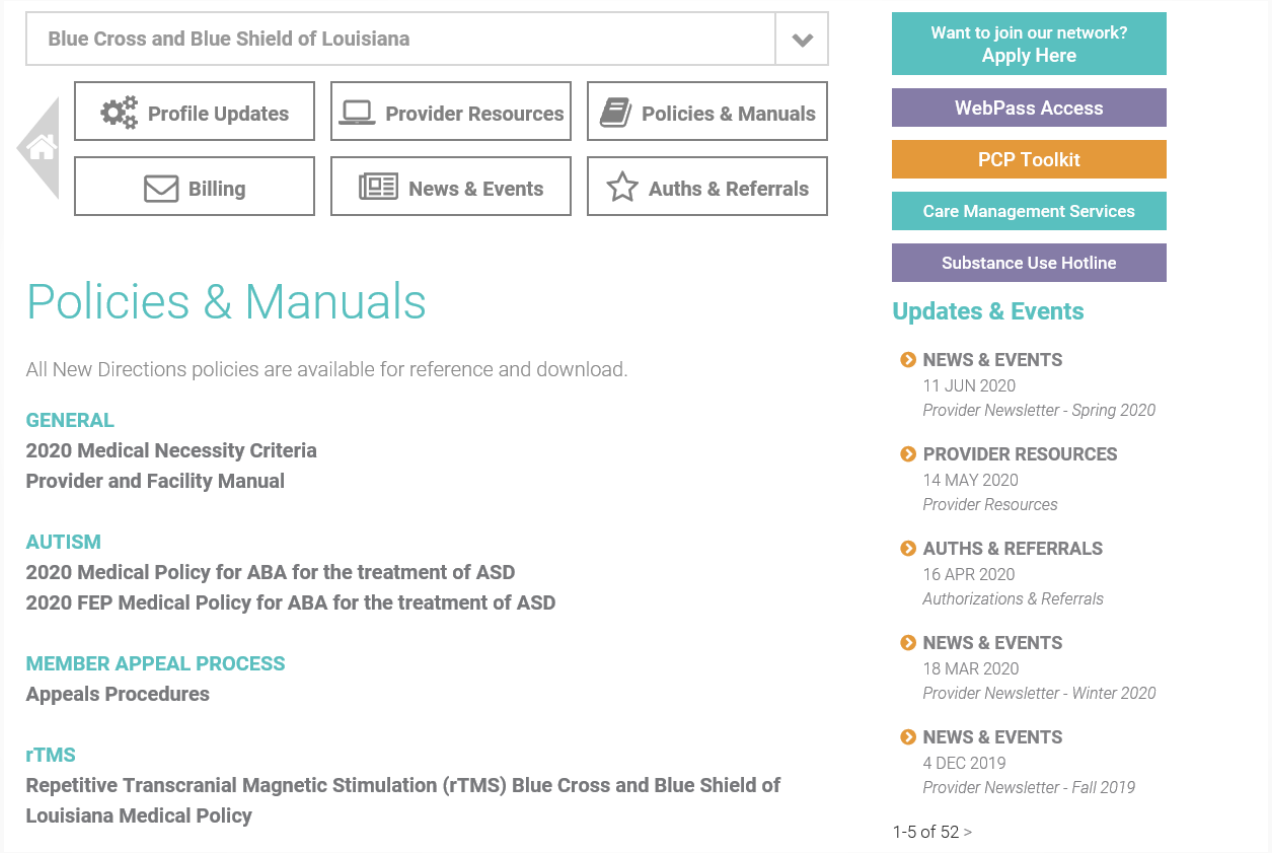
www.ndbh.com/Providers/BCBSLA

NEW DIRECTIONS UTILIZATION MANAGEMENT (UM) TEAM

- UM are clinically licensed staff members
- New Directions Medical Necessity Criteria is the basis for all utilization decisions (found on website)
  - Medicare Advantage is based on Medicare MNC first
  - In denial situations, a board-certified psychiatrist will make the final decision
- New Directions looks at the least restrictive levels of care for each member's treatment focusing on appropriate utilization of BH services to ensure quality and member safety

WHERE TO FIND MNC

www.ndbh.com



MEDICAL NECESSITY CRITERIA TABLE OF CONTENTS

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

USING THE MEDICAL NECESSARY CRITERIA

The Criteria for each level of care are divided into three primary sections:

1. ***Intensity of Services*** means the intensity of services being provided, as well as services that may potentially be needed to provide an appropriate full spectrum of medical treatment, and the qualifications and licensure of the treating provider(s) or facility

2. ***Admission Criteria*** means the symptoms, behaviors or functional impairments exhibited by the member for the initial service request

3. ***Continued Stay Criteria*** means the symptoms, behaviors or functional impairments exhibited by the member for concurrent service requests

MEDICAL NECESSARY CRITERIA

An internal New Directions committee of behavioral health practitioners and psychiatrists developed the **Medical Necessity Criteria (MNC)**

Reviewed annually by:

- A panel of external, practicing behavioral health clinicians and psychiatrists
- Quality Management Committee
- Chief Clinical Officer
- Chief Medical Officer

UTILIZATION MANAGEMENT SPECIFICS

Fax # requirement
Include a fax number for UR department/treating practitioner when submitting requests for authorization.
This allows New Directions to provide timely communication of adverse determinations for requests considered urgent.

Urgent care coverage review schedule
New Directions completes continued stay and step-down reviews for urgent care on the last covered day
Submit continued stay and step-down reviews for Inpatient and Residential on the last authorized day.

Diagnosis
Provide the most accurate diagnosis and update with each update as reflected in the medical record

Progress
Provide CIWA scores, vitals and labs, as indicated. Include the most recent results & scores

Medications
Medications must be updated in each submission

Overdose on Prescribed Medications
Inpatient facilities are required to notify prescribing providers when a patient has attempted to overdose on their prescribed medications. New Directions tracks this info for HEDIS.

UTILIZATION MANAGEMENT SPECIFICS

Depression Screening

- It is expected that a depression screening will be conducted for substance use admissions
- This is a yes/no question on Webpass
- A substance use screening does NOT have to be a formalized tool like the BDI or PHQ-9. It can simply be a licensed clinician or MD assessing their patient for depression via their clinical interview or history and physical.
- New Directions tracks this info for HEDIS

MAT

- When MAT is clinically indicated for someone in substance use treatment, it is imperative that the facility discuss the options and benefits to the patient
- If MAT is not going to be prescribed, it needs to be documented why
- If MAT is prescribed, please provide which MAT the patient is taking
- Also ensure the patient will be able to continue this treatment once discharged. Which prescriber will they see to continue it? Is it covered under their insurance?

UTILIZATION MANAGEMENT SPECIFICS

Timely submissions

For members in Inpatient and Residential, please submit continued stay and step-down review requests prior to 12:30 p.m. EST. Again, reviews should be submitted on the last covered day. Doing so enables New Directions to provide a timely and complete medical necessity determination, allowing for peer reviews if needed.

Continued stay requests

Updated clinical information is required to reflect member's most current status and progress on measurable goals, as listed on the member's individualized treatment plan

Discharge plan

Please ensure that a discharge plan is populated on the initial request and updated with each submission of the individualized plan, including specific providers and appointments

Forms

Please submit all needed forms, including releases of information, member consent for referral to Behavioral Health Homes (BHH) and consent for referral to other providers to coordinate care

EARLY OR PRE-NOTIFICATION REQUIREMENTS

- Early Notification of admissions is **ESSENTIAL** to determination of authorization requests and to ensure the most appropriate and effective care for members
  - For OGB and HMO members, notification is required within 48 hours for inpatient care only

- Prior authorization is **REQUIRED** for:
  - OGB and HMO: prior authorization is required for RTC, PHP and IOP
  - FEP: prior authorization is required for RTC. Members must also be enrolled in CM before authorizations can be issued. PHP and IOP do NOT require authorization.

DETAILS, DETAILS AND MORE DETAILS…

- **Provide as many specifics about the member as possible.**
  - *ex: SI plan, means, intent, access, etc.*
- **Provide as many specifics about the member's substance use as possible**.
  - *ex: drug, use, frequency, last use, duration*
- **Individualized treatment plan and interventions.**
  - *ex: provide safe environment v/s: practice journaling and thought blocking coping skills for cutting*
  - *ex: provide relapse prevention, coping skills and sober supports v/s: Identify one sober support also in construction to be sponsor*
- **What is working? Give details on how interventions are going.**
  - *ex: member was able to tell mom about recent rape*

DETAILS, DETAILS AND MORE DETAILS…

- **If it's not working, what can you change?**
  - *ex: member struggling to complete step because of mother's recent death; will change to writing letter to father*
- **If in readmission, what will be different this time?**
  - *ex: member didn't attend therapy as no transportation- what resources are there*
- **What needs does the member still have?**
  - *ex: stable housing, employment, DBT therapy/groups, trauma therapy, etc.*
- **Symptoms should match the CIWA**
  - *ex: CIWA 4 but the member is having nausea, vomiting etc.; give interventions for nausea such as Zofran; give details such as last episode of vomiting.*
- **If it's not working, what can you change?**
  - *ex: member struggling to complete step because of mother's recent death; will change to writing letter to father*
- **If in readmission, what will be different this time?**
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  - *ex: CIWA 4 but the member is having nausea, vomiting etc.; give interventions for nausea such as Zofran; give details such as last episode of vomiting*

DETAILS CONTINUED…

- **Medical issues addressed**
  - *ex: members have history of seizures but not prescribed anti-seizure medications; why not?*
- **If switching tapers, please indicate why**
  - *ex: switch from Valium to Klonopin taper after several days, why?*
- **Update with new information at every review**
- **Complete details re: if MAT was offered and if it was accepted or not and what was done**
- **Details of family therapy at every review or weekly. If it's not happening, why not?**

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

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

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

DISCHARGE PLANNING AND SCHEDULING SEVEN-DAY APPOINTMENTS

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 seven-day appointments for inpatient BCBSLA Members, please call **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.

Need help with your **discharge planning**? We can assist you, please call **877-300-5909.**

WHY USE QUALITY DISCHARGES

- Improves documentation
- Improves clinical outcomes
- Meets safety standards
- Patient centeredness
- Hospital's community image

KEY STEPS FOR PROVIDERS

1. Ascertain the need for and obtain language assistance
   The initial review form asks about barriers (language preference, etc.)
2. Arrange follow-up care (with providers, for tests)
   Addresses MAT, aftercare appointments, seven-day appointment and medical conditions
3. Plan for follow-up of any test/lab results pending at discharge
4. Organize outpatient services and medical equipment needs
   CM in community, additional referrals or resources
5. Provide a correct medication list, including a plan to access them
   Discharge medication list, name and phone number of pharmacy, educate about meds and possible side effects
6. Reconcile the discharge plans with associated Clinical Practice Guidelines if applicable

KEY STEPS CONTINUED

7. Teach a written plan the member can easily understand
   Aftercare goals reviewed, educate what symptoms to watch for and who to call if any noticed
8. Educate member on diagnosis and medications
   Educate on how to keep health problems from getting worse
9. Provide and review details of what to do if a problem arises
   Crisis/safety plan, number to call for problems after discharge
10. Assess the degree of the member's understanding of the discharge plan
    Questions were addressed, verbalized a clear understanding of discharge plans
11. Expedite transmission of discharge summary to clinicians and New Directions
12. Provide follow-up discharge call within three days to reinforce the discharge plan

FOLLOW-UP AFTER HOSPITALIZATION

HEDIS® (Healthcare Effectiveness Data and Information Set) is an annual performance measurement created by the NCQA (National Committee for Quality Assurance) 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 seven calendar days of discharge.** We track appointments made within seven days, but also want patients to attend those appointments.

Information for the discharge appointment should include:

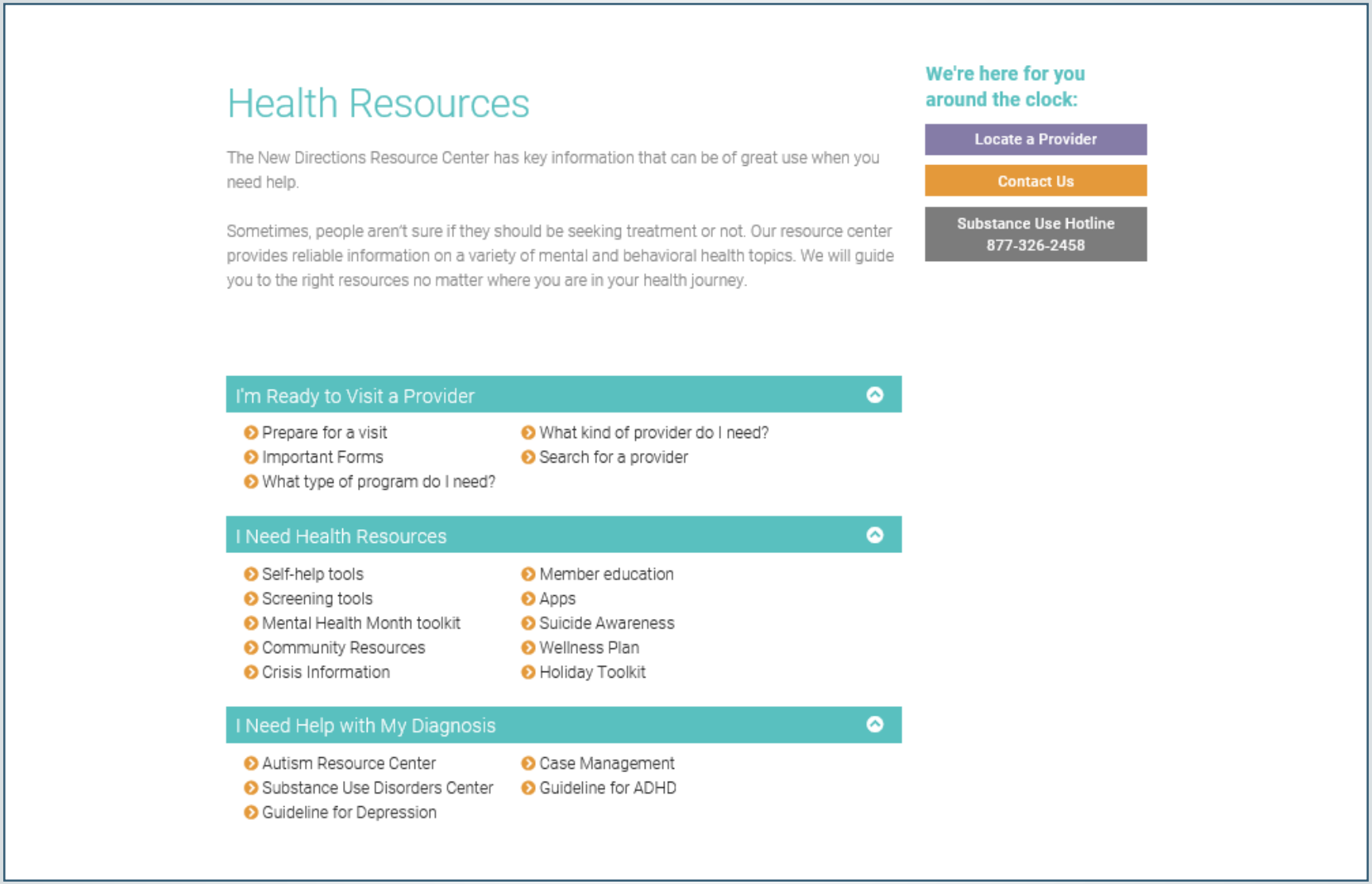
- Name of individual provider
- Credentials
- Appointment date and time
- Contact information for this provider

FOCUSED CARE MANAGEMENT PROGRAMS

	Care Solutions	Member Care Link
Distinctions	**Complex Care Management (CM)** NCQA/ URAC accredited • Opt-in services with high intensity CM outreach • Comprehensive CM assessment • Member centric CM goals, CM survey • Coordination of care with health care providers	**Non-Complex Care Management (CM)** • Condition specific and service related programs • Coordination of care • Healthcare gaps • Members who have not opted in for Care Solutions
	Referral Source: CM Daily Census Report (predictive modeling)	**Referral Sources:** Condition & LOC specific programs, GAP closure, and members who opt out or do not engage in Care Solutions
Both Programs	**Care Transitions Activities** CM services designed to help members transition from higher levels of care to the community with the goal of community tenure	
	Integrated Co-Care Management Activities Collaboration and coordination of CM services between medical and behavior health care managers with the goal to provide comprehensive medical/ behavioral care management expertise	
	Field Based Care Management Activities Any CM activity under Care Solutions or Member Care Link that is face to face with members with the goal to increase engagement and support for members with health care needs	

FOCUSED CARE MANAGEMENT PROGRAM GOALS

- **Improve population management**
  - Percent of priority members targeted
- **Improve member experience and quality of care**
  - 90-day pre/post symptom/functional improvement
  - Professional and community services referred & utilized
  - Gaps closed (seven-day after d/c follow-up appt, MAT education and follow-up, substance use and depression screening follow-up, blood glucose screening, OUD screenings, treatment adherence)
- **Decrease ER/inpatient utilization by priority members**



www.ndbh.com/Resources/

RELEASE OF INFORMATION (ROI)

To have direct communication with family members and support systems, our NDBH clinicians will be requesting your assistance to obtain releases of Information allowing NDBH to discuss members care with their families/supports and provide whatever assistance we can to the families

We believe this communication is vital to support members with their treatment both in the hospital and when they return home. We appreciate your cooperation and support.

FACILITY MEETINGS

Educate Facilities about HEDIS Quality Measures: **Seven Day Scheduled**, **Seven Day Kept**, and **30-Day Recidivism**

Present quality measures to facilities

Provide tools to achieve HEDIS and FUH7 goals such as: Rainmaker List, underlying data, sharing best practices and scheduling line

Facilitate collaboration between ND team, Blue Cross, and facilities to address concerns or issues that arise

SCORECARD

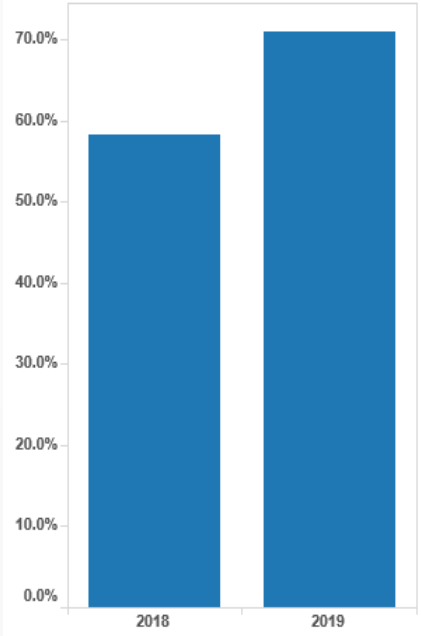
UM - Facility Authorizations for LA; Inpatient Services

Data Source = Authorizations/Optamum; "Approved" Authorizations only

				Admits		% of Total Admits		Days/Units		ALOT		30 Day Readmit %		7 Day FU Sched		Dsch Review %	
Provider ..	Tax ID	Provider Name	Prov ..	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Grand Total				**93.0**	**31.0**	**100.0%**	**100.0%**	**737.0**	**228.0**	**7.9**	**7.4**	**9.7%**	**9.7%**	**58.2%**	**71.0%**	**94.6%**	**100.0%**
				93.0	31.0	100.0%	100.0%	737.0	228.0	7.9	7.4	9.7%	9.7%	58.2%	71.0%	94.6%	100.0%

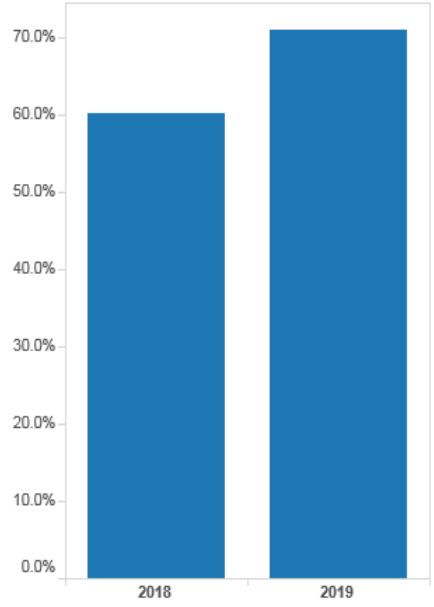
7 Day Follow Ups Scheduled

(After IP Acute Only)



7 Day Follow Up Scheduled After Discharge Review Submitted by Facility

(After IP Acute Only)



Diagnosis Related Group Summary

	Admits		ALOT		30 Day Readmit %	
	2018	2019	2018	2019	2018	2019
Grand Total	**93.00**	**31.00**	**7.9**	**7.4**	**9.7%**	**9.7%**
Major Depression	62.00	16.00	7.3	7.4	4.8%	12.5%
Bipolar	15.00	8.00	10.0	7.9	13.3%	12.5%
NOS-Depressive	5.00	3.00	6.8	6.0	20.0%	0.0%
Schizophrenia & Psycho..	4.00	3.00	9.3	7.3	25.0%	0.0%
SUD	3.00	1.00	7.7	7.0	33.3%	0.0%
Medical/Behavioral	4.00		10.3		25.0%	

WHAT PROVIDERS AND MEMBERS ARE SAYING

Facility Feedback
Longleaf Hospital

“Michelle Sims has made a tremendous difference giving us data quarterly and as needed for BCBS of LA. We’ve identified areas of improvement corrected them thanks to her research and communication. We’ve also identified better ways to get patients to comply with aftercare. She’s an asset to your organization. We are thankful for you and her partnership to take care of our patients.”

-”Claire Hicks, MHA Chief Executive Officer”

Feedback from Members on the Clinical Staff:

"Melissa was fantastic. We have had a lot of case managers and therapists. She listened (sometimes for a long time), she offered help, she offered services, she got him the help he needed. Now he is in a new school and doing great and that has a lot to do with Melissa. She is almost like a member of the family we haven't met.”

“I would love to have my care manager help me in the future if needed, she seem to call just when I needed. She called me every couple of weeks and that made me feel so good! She went above and beyond!”

REMINDERS

Contact LouisianaPR@ndbh.com if you are:

- Submitting your updated Clinical Profile form
- Interested in being a Rainmaker
- Currently or plan on providing MAT

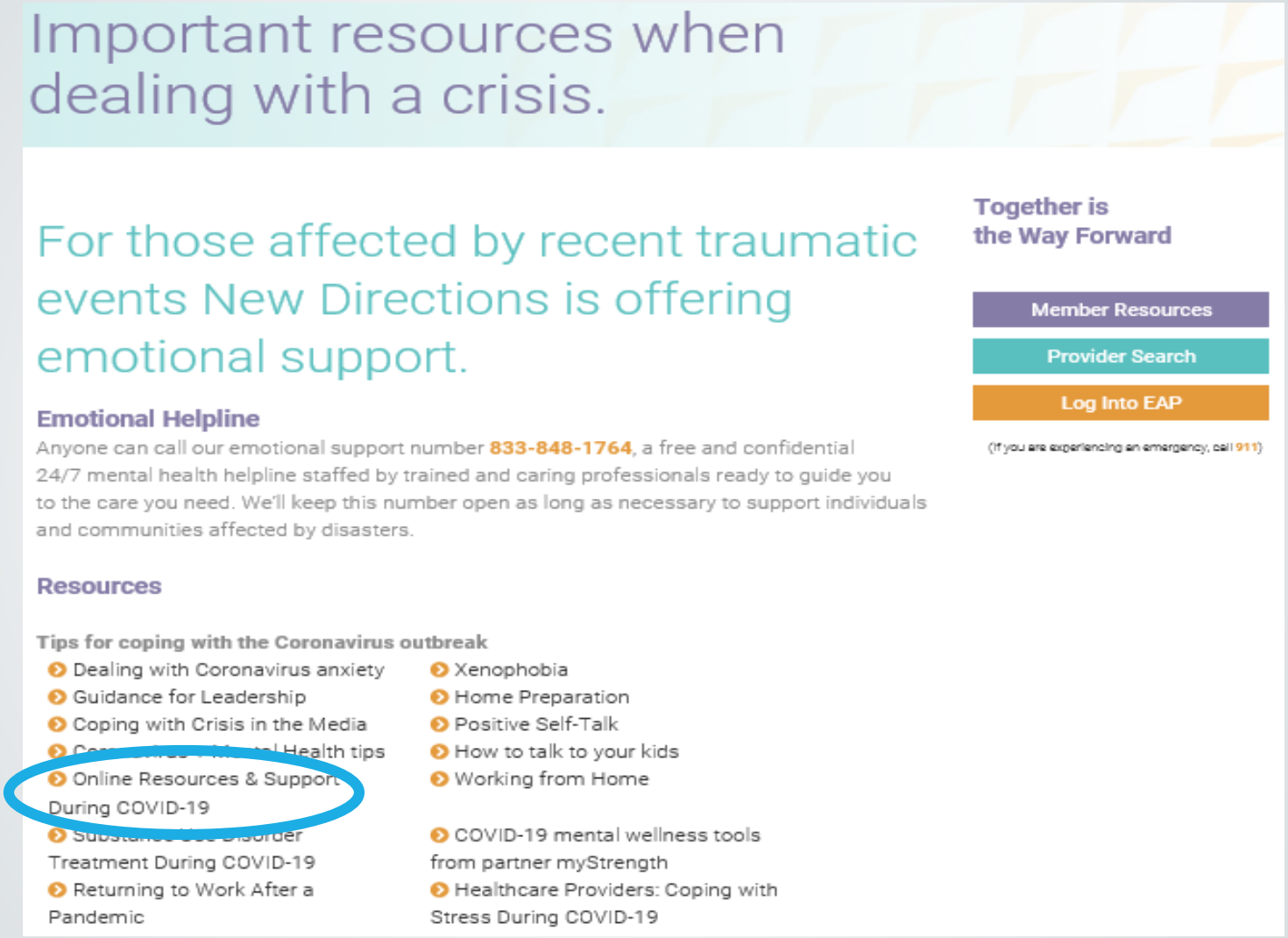
Resources

SEPTEMBER IS SUICIDE AWARENESS MONTH

New Directions Behavioral Health has recently added an online **toolkit** to promote suicide prevention and awareness. The toolkit includes posters, articles and other sharable materials that you can promote during September, and all year round.

This toolkit is available to members and providers. Please share this information and join us in our efforts to **#StopSuicide** and save lives.

CRISIS RESOURCES



Important resources when dealing with a crisis.

For those affected by recent traumatic events New Directions is offering emotional support.

Emotional Helpline

Anyone can call our emotional support number **833-848-1764**, a free and confidential 24/7 mental health helpline staffed by trained and caring professionals ready to guide you to the care you need. We'll keep this number open as long as necessary to support individuals and communities affected by disasters.

Resources

Tips for coping with the Coronavirus outbreak

- Dealing with Coronavirus anxiety
- Guidance for Leadership
- Coping with Crisis in the Media
- [illegible] Health tips
- Online Resources & Support During COVID-19
- [illegible] Disorder Treatment During COVID-19
- Returning to Work After a Pandemic
- Xenophobia
- Home Preparation
- Positive Self-Talk
- How to talk to your kids
- Working from Home
- COVID-19 mental wellness tools from partner myStrength
- Healthcare Providers: Coping with Stress During COVID-19

Together is the Way Forward

Member Resources

Provider Search

Log Into EAP

(If you are experiencing an emergency, call 911)

www.ndbh.com/CrisisResources

Suicide Toolkit

New Directions can help you when you or one of your staff identifies that a patient exhibits warning signs for suicide. The tools below can help you develop and implement a suicide prevention strategy for your organization and support the patient in accessing needed interventions.

Screening Tools

Ask Suicide-Screening Questions (ASQ) Toolkit

Columbia-Suicide Severity Rating Scale (C-SSRS)

Additional screening tools >

Provider Resources

SAMHSA - Suicide Prevention in Primary Care

Suicide Prevention Toolkit for Primary Care Practices

Zero Suicide

New Directions Depression Toolkit

Additional educational articles >

Patient Resources

Health Resource Library

You can help members access the resources they need by calling our Care Management Services or instructing them to call the number on the back of their insurance card.

BEHAVIORAL HEALTH RAINMAKERS

- New Directions actively seeks outpatient behavioral health professionals who can schedule appointments for patients being discharged from an inpatient setting, within seven days
- The Rainmaker list is used as a "**first call**" list for discharge planners at the facilities and the New Directions care managers and care transitions staff
- We are always seeking to add providers to our Rainmaker list. Currently, we are trying to increase participation by prescribing providers. If interested in becoming Rainmaker, please email LouisianaPR@ndbh.com.

RESOURCES

RAP (Resource Access Portal)

Assists New Directions with locating resources to meet the identified needs discussed with the member. For example:

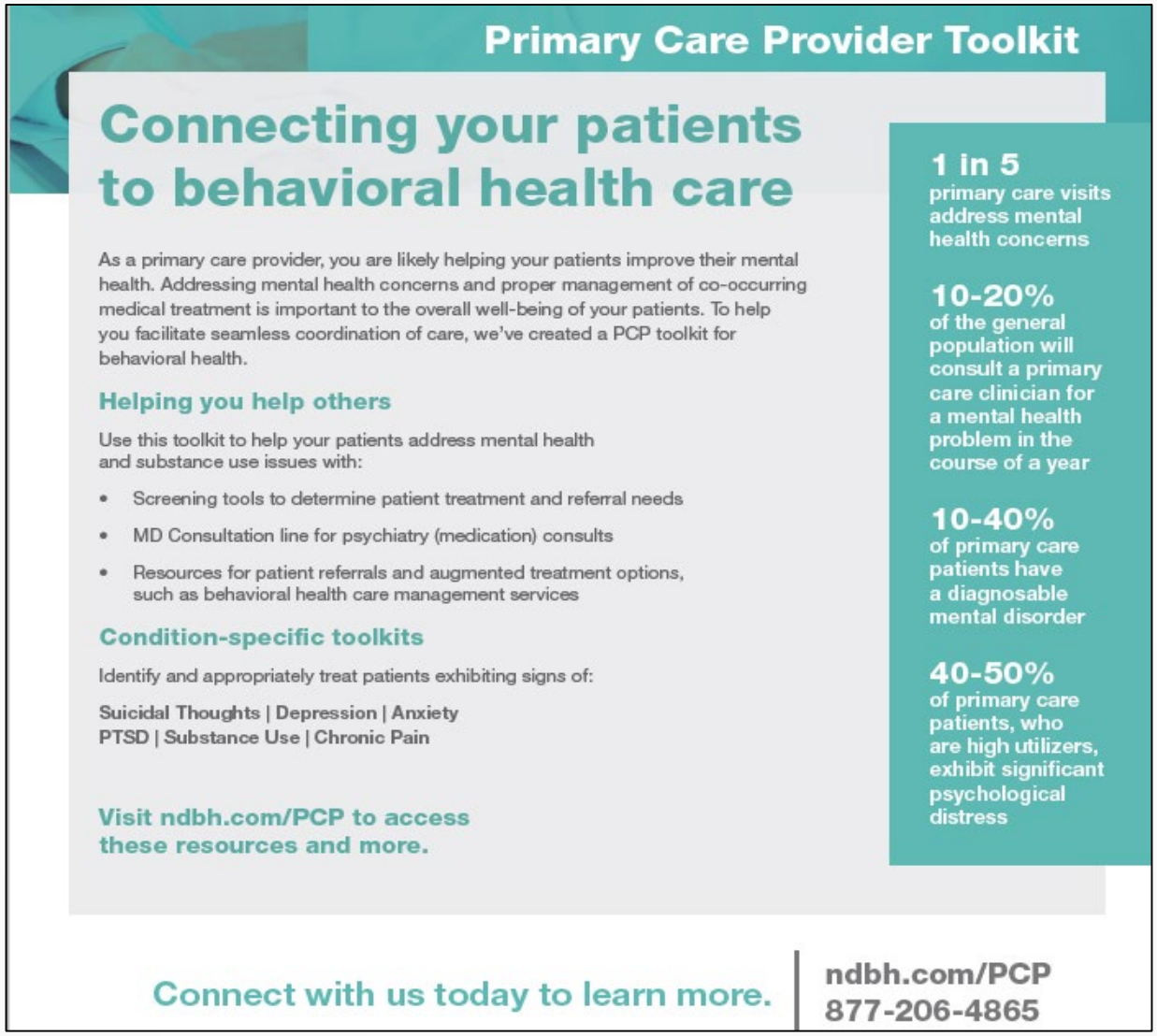
- Financial
- Food Resources
- Transportation Resources
- Vocational Resources
- Educational Services

Provides an increased level of understanding of the member's environment and potential needs related to social determinants of health that should be explored with the member

RESOURCES

- **Transportation pilot**
  - Providing transportation for members residing in the Greater Baton Rouge to aftercare appointments and CVS or Walgreens pharmacies (possibly other areas where Lyft or Uber is available)
- **Baton Rouge Clinic**
  - Partner with BCBSLA, Baton Rouge Clinic (PCP), Capital Area Mental Health, and New Directions to ensure members admitted who are associated with BRC are directed back to BRC to see the social worker who is embedded in the BRC clinic from the Capital Area team

PCP COLLABORATION



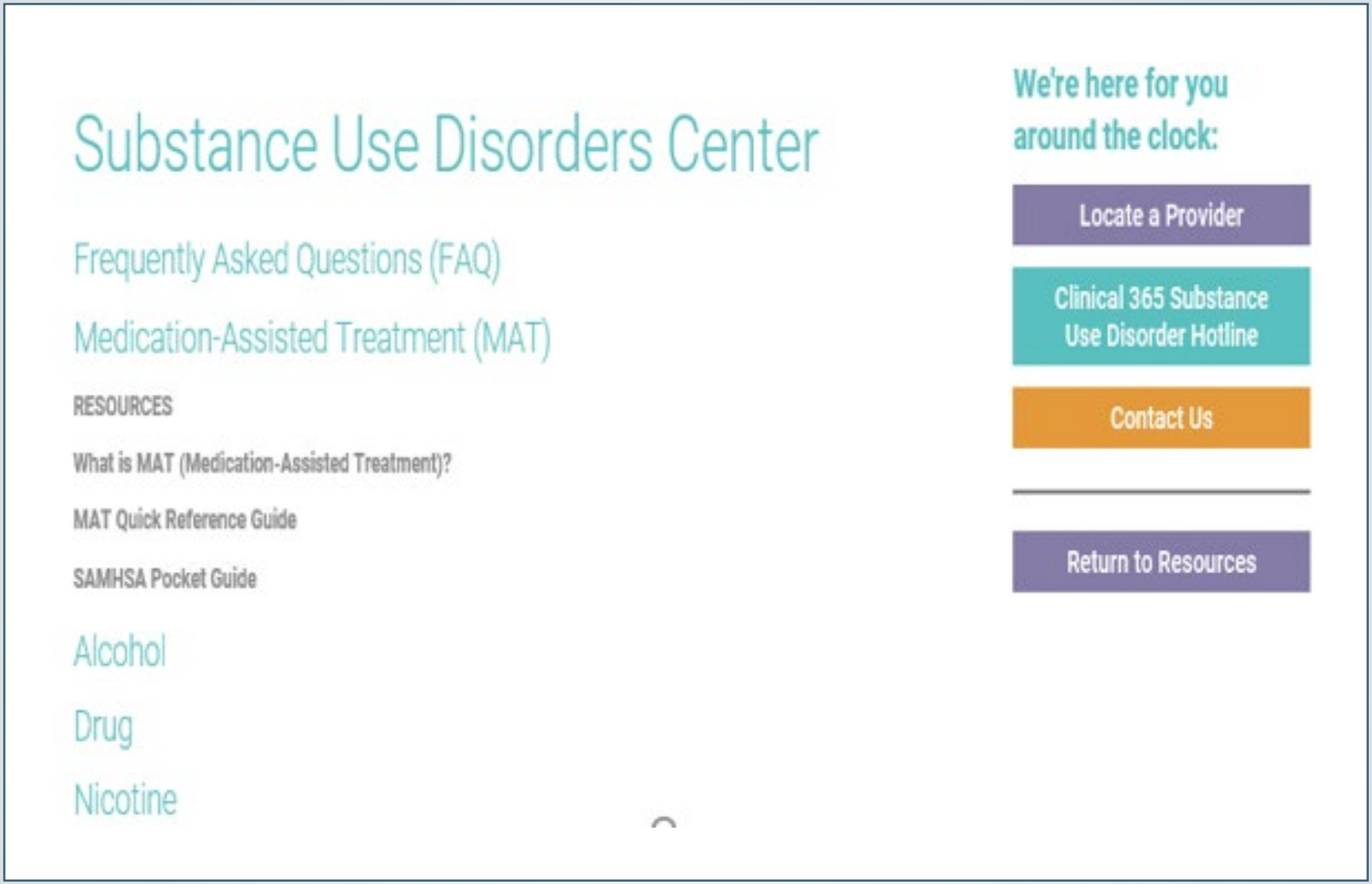
RESOURCES

Best Practices

Practices known to result in successful outcomes for members:

- Effective internal processes that ensure members have an appointment within seven days of discharge
- Raising awareness of how to find and utilize resources in the community

Substance Use



www.ndbh.com/Resources/SubstanceUseCenter

Quick Reference Guide

Medication-Assisted Treatment (MAT) Medications and Pharmacy Benefit Coverage

Medications are available to help people stop using opiates or alcohol. The medications may reduce cravings and withdrawal symptoms. When combined with counseling, medications can increase the chance of successful treatment. Refer to the list below to learn which medications are approved by the FDA to help relieve problems with opiates or alcohol.

Opioid use problems can be helped with the following medications:

BUPRENORPHINE/NALOXONE
Generic Suboxone*
Zubsolv*
Suboxone*
Bunavail*

BUPRENORPHINE
Subutex*
Butrans*
Sublocade*

METHADONE
Methadone+

NALTREXONE
Vivitrol

We're here for you around the clock:

Locate a Provider

Contact Us

Return to Resources

Substance Use Center

Substance Use Disorder Toolkit

www.ndbh.com/PCP/SUDToolkit

- Screening tools
- Provider resources
- Member resources

Provider Resources

Alcohol

Alcohol Screening and Brief Intervention for Youth: Practitioner Guide
Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse Screening and Brief Interventions
Implementing Care for Alcohol and Other Drug Use in Medical Settings, An Extension of SBIRT
SBIRT Training Presentation

Other Drugs

Screening for Drug Use in General Medical Settings
National Institute on Drug Abuse: Medical & Health Professionals
General Guidelines for Substance Use Screening and Early Intervention in Medical Practice

Additional educational articles >

Patient Resources

Health Resource Library

You can help members access the resources they need by calling our Care Management Services or instructing them to call the number on the back of their insurance card.

Screening Tools

Alcohol

Youth Alcohol Screening and Brief Intervention Practitioner's Guide
CRAFFT Screening Tool for Adolescent Substance Abuse
Short Michigan Alcoholism Test Geriatric Version (SMAST-G)
Alcohol Use Disorders Identification Test (AUDIT-C)
The Cage and Cage-Aid Questionnaires

Other Drugs

Screening for Drug Use in General Medical Settings
Tobacco, Alcohol, Prescription Medication, and Other Substance Use Tool (TAPS)
Opioid Risk Tool (ORT)
Drug Abuse Screening Test (DAST)
NIDA Quick Screen

Additional screening tools >

THE OPIOID EPIDEMIC BY THE NUMBERS

130+
People died every day from opioid-related drug overdoses[3] (estimated)

10.3 m
People misused prescription opioids in 2018[1]

47,600
People died from overdosing on opioids[2]

2.0 million
People had an opioid use disorder in 2018[1]

81,000
People used heroin for the first time[1]

808,000
People used heroin in 2018[1]

2 million
People misused prescription opioids for the first time[1]

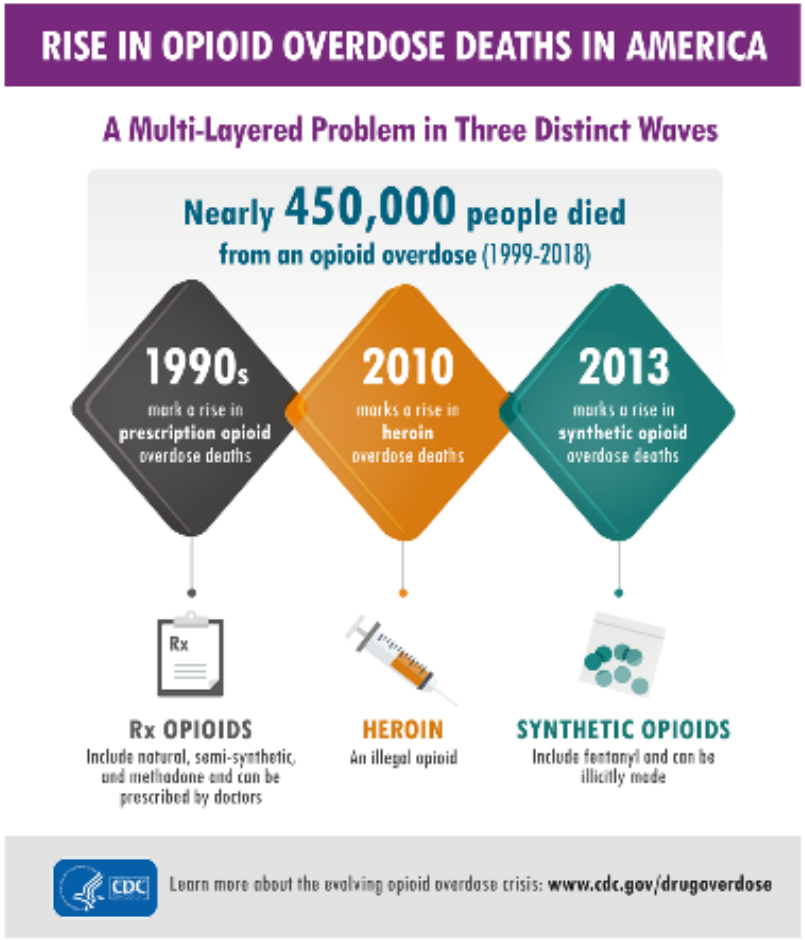
15,349
Deaths attributed to overdosing on heroin (in 12-month period ending February 2019)[2]

32,656
Deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending February 2019)[2]

SOURCES

1. 2019 National Survey on Drug Use and Health. Mortality in the United States, 2018
2. NCHS Data Brief No. 329, November 2018
3. NCHS, National Vital Statistics System. Estimates for 2018 and 2019 are based on provisional data.

Updated October 2019. For more information, visit: http://www.hhs.gov/opioids/


RISE IN OPIOID OVERDOSE DEATHS IN AMERICA
A Multi-Layered Problem in Three Distinct Waves
Nearly 450,000 people died
from an opioid overdose (1999-2018)
1990s
mark a rise in
prescription opioid
overdose deaths
2010
marks a rise in
heroin
overdose deaths
2013
marks a rise in
synthetic opioid
overdose deaths
Rx
Rx OPIOIDS
Include natural, semi-synthetic, and methadone and can be prescribed by doctors
HEROIN
An illegal opioid
SYNTHETIC OPIOIDS
Include fentanyl and can be illicitly made
CDC
Learn more about the evolving opioid overdose crisis: www.cdc.gov/drugoverdose

MAT OVERVIEW

Medication-assisted treatment (MAT) is an effective intervention to treat opioid and alcohol use disorders

MAT is the use of medication to assist with management of cravings and relapse prevention

Optimal outcomes rely on a combination of medication, counseling, group and behavioral therapies, along with peer support

Medications improve patient adherence to treatment and reduce criminal activity and injection use; there is also a decrease in transmission of HIV and Hepatitis C

NIH. (2016). Effective Treatments for Opioid Addiction. Retrieved from www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction

MAT OVERVIEW

- **Alcohol**
  - Disulfiram, Acamprosate, Naltrexone
- **Opioid**
  - Methadone, Buprenorphine, Naltrexone
    - Per federal regulations Methadone must be administered in a licensed opioid treatment program (OTP)
    - Buprenorphine may only be prescribed by providers who have obtained a DEA waiver

*Coverage for medications determined by member's Pharmacy Benefit Manager (PBM)

VALUE OF MAT

MAT is the *most effective* tool for OUD – is considered the gold standard for treatment

- **Increases** treatment retention
- **Decreases** illicit opiate use
- **Increases** ability to gain and maintain employment
- **75% reduced** mortality versus patients with only psychosocial interventions

Detoxification without MAT, to address cravings/relapse, increase the risk of overdose due to lowered tolerance

SAMSHA (2018). Medication Assisted Treatment. Retrieved from www.samhsa.gov/medication-assisted-treatment
Clark, R. E., Samnaliev, M., Baxter, J. D., & Leung, G. Y. (2011). The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine. Health Affairs 30(8), p. 1425-33.

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)

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

SAMSHA (2018). Medication Assisted Treatment. Retrieved from www.samhsa.gov/medication-assisted-treatment
Clark, R. E., Samnaliev, M., Baxter, J. D., & Leung, G. Y. (2011). The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine. Health Affairs 30(8), p. 1425-33.

CHALLENGES IN MAT UTILIZATION

Slow adoption

- As of 2016, only 16% of psychiatrists and 3% of primary care physicians were buprenorphine waivered
- 27% of facilities offered MAT

Stigma

- Belief MAT is trading one drug for another
- The person is not actually sober

MAT ADOPTION DATA

Summary of MAT WebPass Survey Results

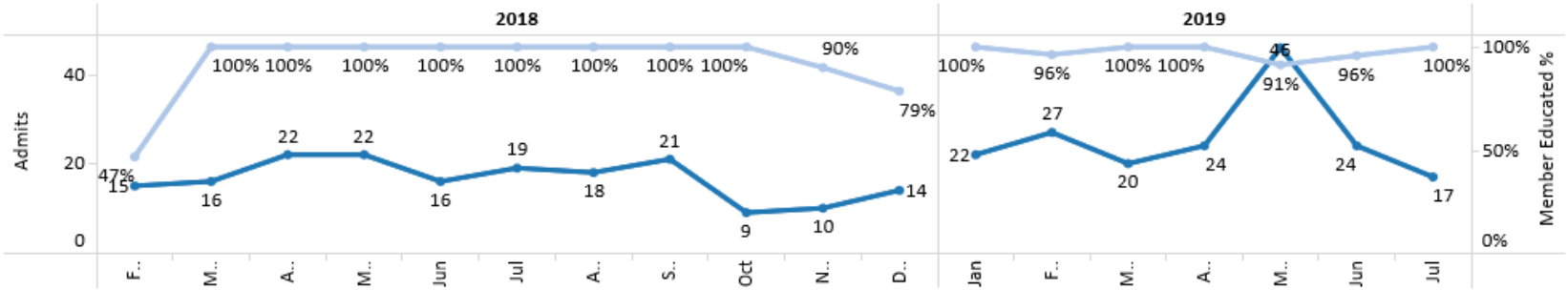
	Admits	% Goal	% Actual
Admits	362	100%	100%
Member Educated on MAT	344	100%	95%
Agreed to MAT	273	35%	75%
Agreed to MAT (AUD)	162	35%	59%
Agreed to MAT (OUD)	111	35%	41%

Agreed to MAT?	Admits	7 Day FU Schd %	30 Day Readmit %
Yes	273		
No	89		

MAT Agent Initiated for Members Agreeing to MAT

	Agreed to MAT	Agreed to MAT (AUD)	Agreed to MAT (OUD)
Naltrexone oral (Revia, Vivitrol, Embeda)	184	118	66
Naltrexone ER (injectable)	79	38	41
Other	9	5	4
Acamprosate (Campral)	1	1	0
Grand Total	273	162	111

Admits & Member Educated % on MAT Trending



TIPS FOR DISCUSSING MAT WITH PATIENTS

- **Discuss why they made the decision to stop using opioid**
  - How did opioids get in the way of their goals?
  - What are their recovery goals?
  - Would MAT allow them to reach their goals?
  - Would work, school or home life improve?
- **MAT is not a crutch**
  - Chronic condition comparison (i.e., is insulin considered a crutch for someone with diabetes)
- **Feeling controlled by medication**
  - Importance of matching the medication to the individual's goals and values
  - Opioids have been interfering with their life; MAT can assist with living life more aligned with their goals/values
- **Be prepared to discuss food/medication interactions and side effects**
- **Be prepared to discuss positive outcomes with medication adherence**

RESOURCES

Myths of MAT

Common questions/concerns about MAT

PCSS – Medications: isn't just replacing one drug for another?

FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency

ALTERNATIVE RESOURCES

SAMHSA provides a treatment locator for prescribers of buprenorphine

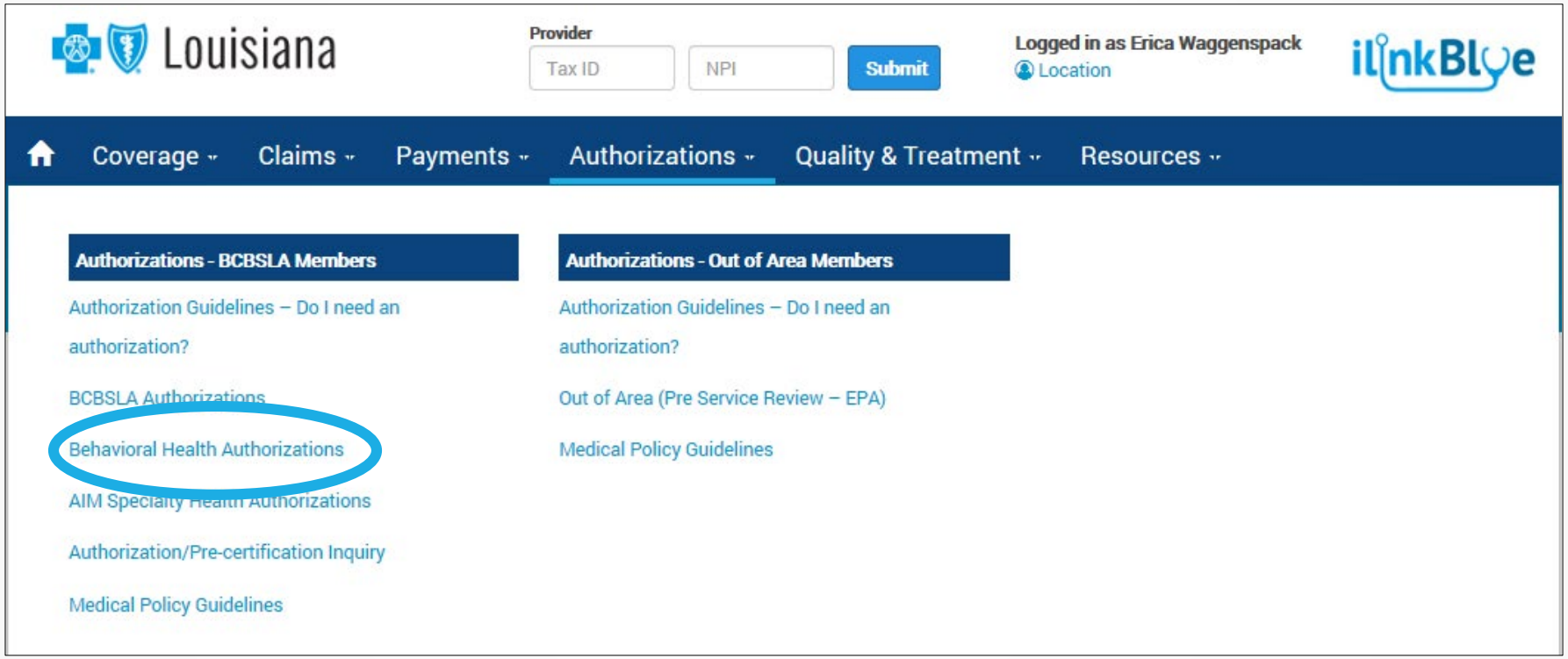
www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

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

WebPass

WEBPASS PORTAL

- Allows for all levels of review to be submitted electronically
  - Initial, Concurrent and Discharge
- After submission of initial request historical information is pulled forward and only requires updating changes and progress
- Log into **iLinkBlue** and select the **BCBSLA Authorizations link**:



WEBPASS ENHANCEMENTS

Retrospective Request Form

Appeals Request Form

Ability to attach documents to Webpass

Behavioral Health New Process
Webpass Retro Review & Appeal Submissions

Requesting retro reviews and appeals has become much easier!

Requests are completed via the ***Webpass*** system; already in use for initial and concurrent reviews

- The medical record can easily be attached via the *Webpass* instead of using faxes or mail

To submit a request

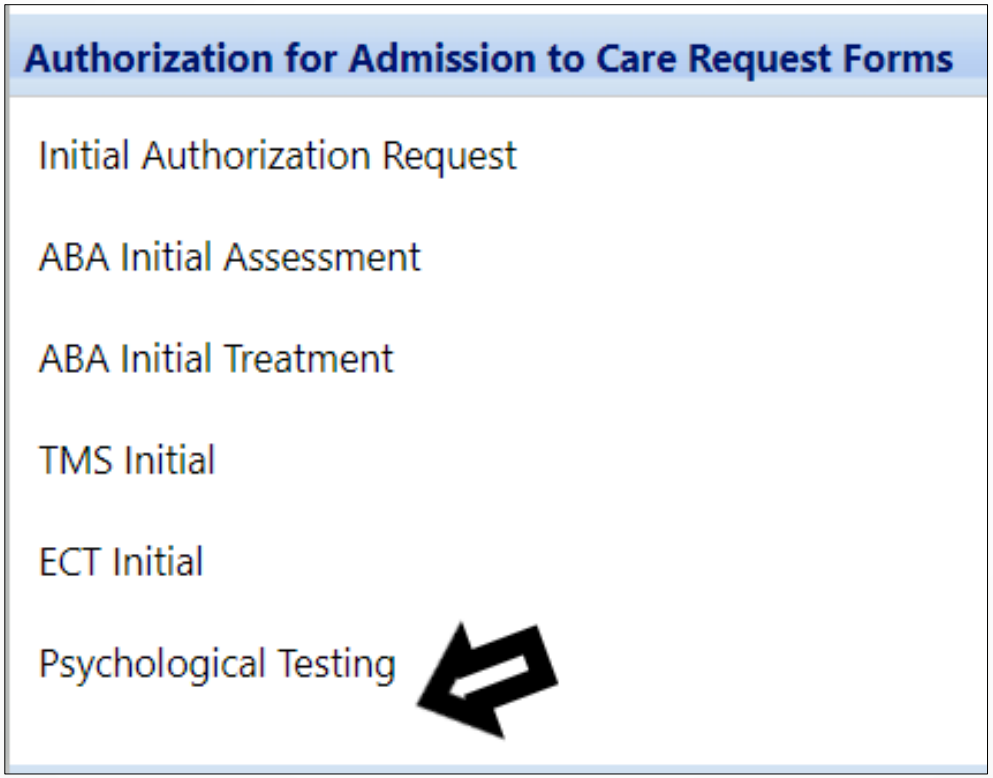
- Accessible via the clinical forms section
- Loads directly into the members record, resulting in timely processing

Tips

- When requesting a retro or an appeal – be sure to have the original authorization number handy!
- Retro requests: It may or may not have a previous authorization number. If so, tie it to the current authorization as you would for a concurrent review.
- Appeals: Make sure and tie it to the current authorization as you would for a concurrent review

ENHANCEMENT: RETROSPECTIVE REQUEST FORM

- The form is visible in the Clinical Forms Page
  - The Retro form will be located at the bottom of the section "Authorization for Admission to Care Request Forms"

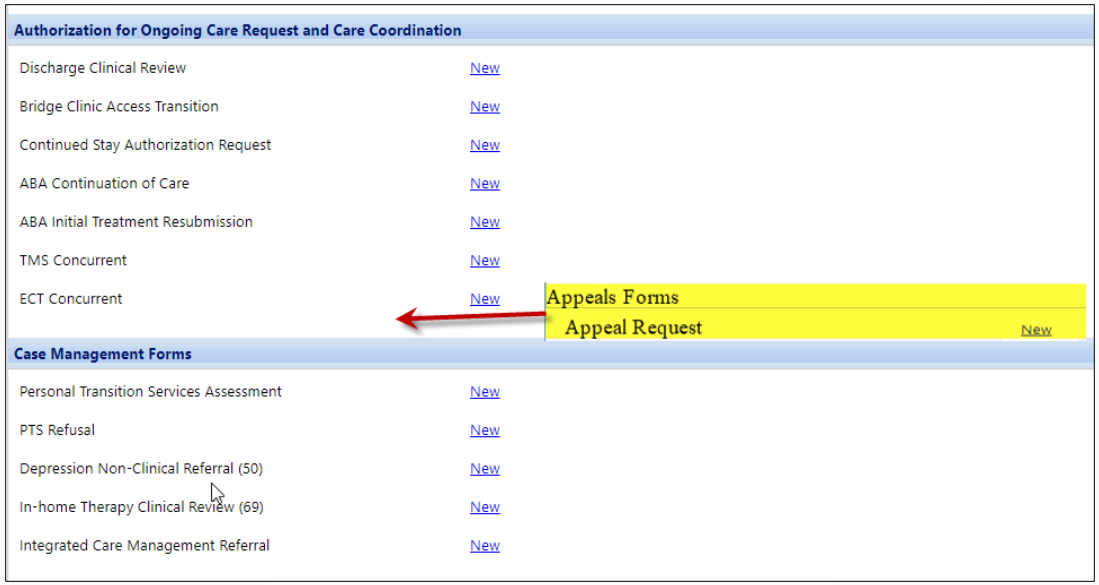


ENHANCEMENT: APPEALS REQUEST FORM

Purpose: Allow providers to complete and submit a survey via WebPass. The survey will allow a file to be uploaded.

Authorization number for the admission being appealed auto-populates from the associated authorization number if an authorization has been selected

File attachment type is a required field
The Appeals form will be located between the “Authorization for Ongoing Care Request and Care Coordination and the Case Management Forms”



Behavioral Health Appeals

Standard Appeal: A verbal or written request to contest an adverse benefit determination that is not an expedited appeal

Expedited Appeal: A written or verbal request by an ordering provider or member to contest an adverse benefit determination, when the member is currently in care; the provider is able to document the member will be in imminent danger or significantly adversely impacted if an urgent decision is not rendered

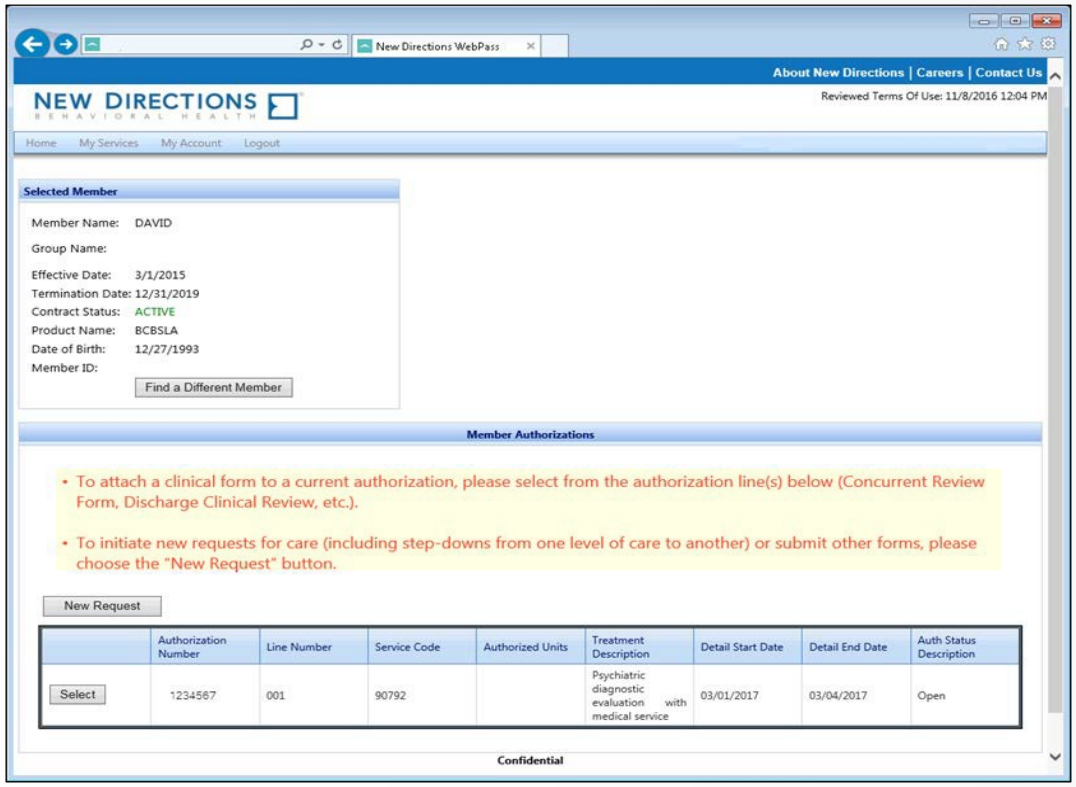
Information on how to request an appeal can be found in many locations:

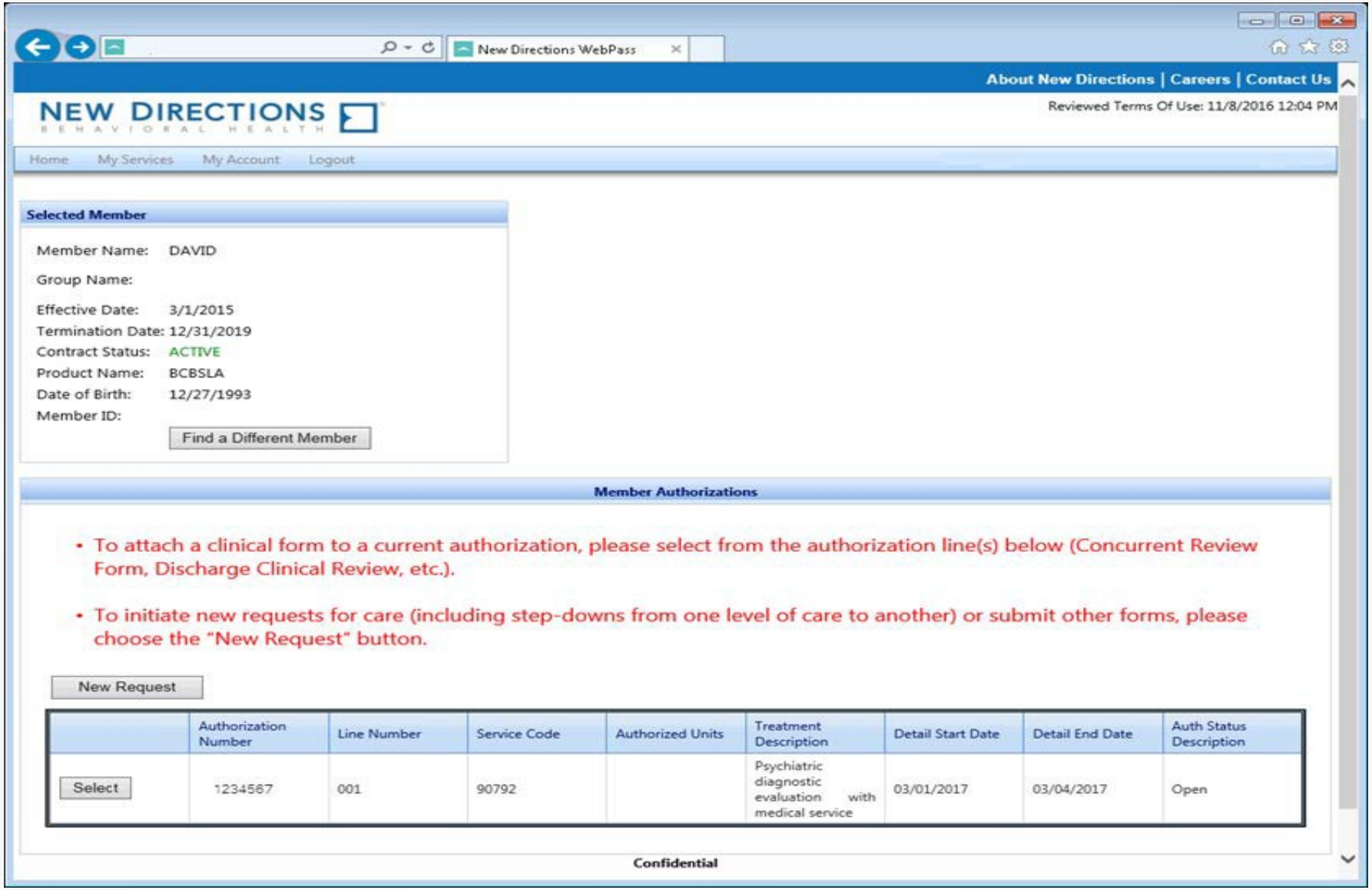
- The initial denial letter after the statement "What can you do if you disagree with our decision?"
- New Directions Louisiana utilization management team members
- New Directions appeals department
- New Directions website
- Blue Cross and Blue Shield of Louisiana (number located on the member's insurance card)

All Louisiana standard and expedited appeals are considered member appeals, regardless who makes the request on behalf of the member in treatment.

LINKING FORMS

- After an Authorization has been created, users can link additional forms to that Authorization
- By linking forms to an existing Authorization, certain information will be automatically carried over to prepopulate the new forms (when the same question appears on both forms)
- To link a form, click Select next to the authorization number
- To start an Initial Review or to submit a form that does not need to be linked, clicking on New Request




New Directions WebPass
About New Directions | Careers | Contact Us
NEW DIRECTIONS
BEHAVIORAL HEALTH
Reviewed Terms Of Use: 11/8/2016 12:04 PM
Home
My Services
My Account
Logout
Selected Member
Member Name: DAVID
Group Name:
Effective Date: 3/1/2015
Termination Date: 12/31/2019
Contract Status: ACTIVE
Product Name: BCBSLA
Date of Birth: 12/27/1993
Member ID:
Find a Different Member
Member Authorizations
• To attach a clinical form to a current authorization, please select from the authorization line(s) below (Concurrent Review Form, Discharge Clinical Review, etc.).
• To initiate new requests for care (including step-downs from one level of care to another) or submit other forms, please choose the "New Request" button.
New Request
Select
1234567
001
90792
Psychiatric diagnostic evaluation with medical service
03/01/2017
03/04/2017
Open
Confidential

Support & Resources

Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary manager

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
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Sue Condon – **sue.condon@bcbsla.com**
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Special Network Development Projects

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

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

Provider Credentialing & Data Management

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Mary Reising manager – **mary.reising@bcbsla.com**

Anne Monroe provider Information Supervisor - **anne.monroe@bcbsla.com**

Rhonda Dyer provider Information Supervisor - **rhonda.dyer@bcbsla.com**

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Provider Credentialing & Data Management Department by emailing **PCDMstatus@bcbsla.com** or by calling 1-800-716-2299

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

For assistance, please contact:

Michelle Sims

Clinical Network Manager

Email: msims@ndbh.com

Phone: 1-816-416-7672

Debbie Crabtree

Provider Relations Coordinator

Email: dcrabtree@nbdh.com

Phone: 1-904-371-6942

We are listening!

Our provider Engagement Survey is open, and we want to hear from you!

If you haven't received an email invitation, please contact **provider.communications@bcbsla.com** and include "Provider Engagement Survey" in the subject line

Thank you!

If you have additional questions after this webinar, please email **provider.relations@bcbsla.com**

Appendix

Credentialing Process

- The credentialing process can take up to 90 days once Blue Cross receives all required information
- After 90 days you may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **PCDMstatus@bcbsla.com** or 1-800-716-2299, option 2
- Required credentialing application packets are available online at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks
- Blue Cross credentials professional, facility and ancillary 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
- Providers will remain non-participating in our networks until their application has been approved by the credentialing subcommittee. The credentialing subcommittee approves credentialing monthly.
- Network providers are recredentialed every three years from their last credentialing acceptance date

Provider Credentialing & Data Management Policy

Below is Blue Cross' policy for credentialing and provider data management requests, which helps ensure requests are processed timely:

- Requests to join our networks or maintain network participation, including the credentialing and recredentialing processes, must be submitted on appropriate forms
- Requests for provider data management 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 Credentialing Applications

Below are the most common reasons credentialing applications are returned:

- Professional provider did not submit the current version of the **Louisiana Standardized Credentialing Application**
- Facility did not submit the **Health Delivery Organization Information Form**
- Not submitting the proper attachments and/or forms
- An alternative application was submitted in place of the credentialing applications identified above *(we do not accept a CAQH application)*

The 90-day processing time begins when we receive all required information. The application processing time starts over once a completed application is returned to Blue Cross. Submitting a completed form is key to timely processing.

Reimbursement During Credentialing

Louisiana has expanded their law allowing additional healthcare provider types to request that Blue Cross reimburse their claims as if they are a network provider during the credentialing process. Claims for network providers are paid directly to the provider.

The following criteria must be met:

- You must be applying for network participation to **join a provider group** that already has an executed group agreement on file with Blue Cross. This provision does not apply for solo practitioners.
- You **must have admitting privileges** to a network hospital. PCPs can have an arrangement with a hospitalist group to admit their patients.
- Your **initial credentialing application** for network participation must include a written letter of request asking Blue Cross to reimburse you at the group contract rate and an agreement to hold our members harmless for payments above the allowable amount

The Reimbursement During Credentialing Instruction Sheet is available online at **www.BCBSLA.com/providers** >Resources >Forms

Claims Disputes & Appeals

Sometimes it may be necessary for a provider to dispute or appeal a claim

CLAIMS DISPUTES

Involves a denial that affects the provider's reimbursement

MEDICAL APPEALS

Involves a denial or partial denial based on:

- Medical necessity, appropriateness, healthcare setting, level of care or effectiveness
- Determined to be experimental or investigational

ADMINISTRATIVE APPEALS & GRIEVANCES

- Claim issue due to the member's contract benefits, limitations, exclusions or cost share
- When there is a grievance

On the next slides, we will detail each of these claims inquiries

Claims Disputes

- Reimbursement reviews:
  - Allowable disputes
  - Bundling issues
- Timely filing
- Authorization penalties
- Failed to obtain an authorization denials
- Refund disputes

Decisions upheld by the Claims Disputes Department are not billable to the member

Administrative Appeals & Grievances

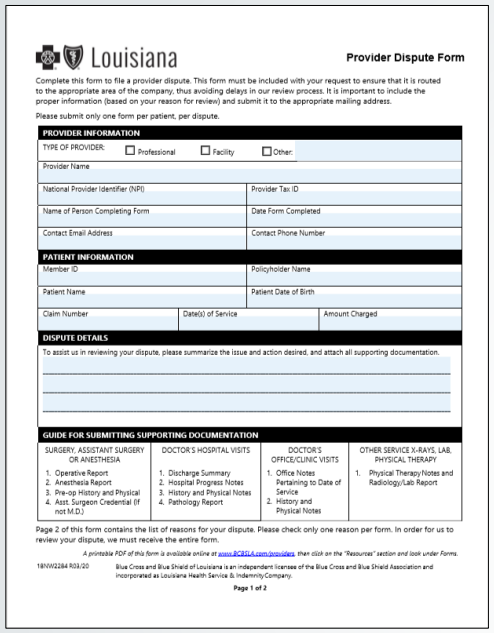
- Administrative appeals involve contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), with the member's authorization

- A grievance is a written expression of dissatisfaction with BCBSLA or a provider's services. Typically, grievances do not involve denied claims.

The top reasons for administrative appeals are:

1. Out-of-Network (OON) providers
2. Contract limitations or exclusions
3. Claims processing (how cost sharing was applied)
   - Deductible
   - Coinsurance
   - Copayment

Provider Dispute Form



Louisiana

Provider Dispute Form

Complete this form to file a provider dispute. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

Contact Email Address | Contact Phone Number

PATIENT INFORMATION

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

Claim Number | Date(s) of Service | Amount Charged

DISPUTE DETAILS

To assist us in reviewing your dispute, please summarize the issue and action desired, and attach all supporting documentation.

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-op History and Physical 4. Asst. Surgeon Credential (if not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

A printable PDF of this form is available online at www.BCBSLA.com/providers then click on the "Resources" section and look under Forms.

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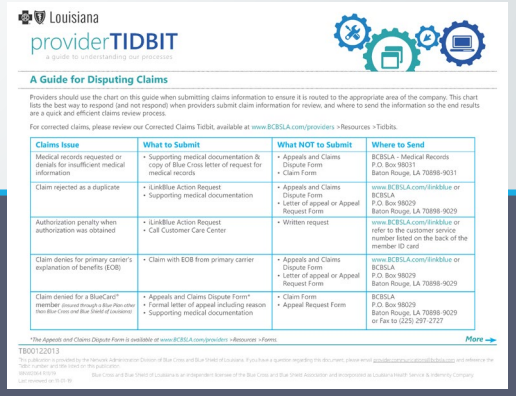
Page 1 of 2

Form is available online at
www.BCBSLA.com/providers
>Resources >Forms

- Use the Provider 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 Provider Dispute Form when claim:
  - Rejected as duplicate
  - Denied for bundling
  - Denied for medical records
  - Denied as investigational or not medically necessary
  - Payment/denial affects the provider's reimbursement
  - Payment affects the member's cost share
  - Denied for a BlueCard member



Louisiana

providerTIDBIT

a guide to understanding our processes

A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denials for insufficient medical information	• Supporting medical documentation & copy of Blue Cross letter of request for medical records	• Appeals and Claims Dispute Form • Claim Form	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	• iLinkBlue Action Request • Supporting medical documentation	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	• iLinkBlue Action Request • Call Customer Care Center	• Written request	www.BCBSLA.com/ilinkblue or refer to the customer service number listed on the back of the member ID card
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denied for a BlueCard® member (Insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Appeals and Claims Dispute Form* • Formal letter of appeal including reason • Supporting medical documentation	• Claim Form • Appeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

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

More →

TB00122013

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this document, please email providernetwork@bcbsla.com and reference the TIDBIT number and title listed on this publication.

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Last reviewed on 01-01-20

For details on where to submit claims issues, refer to the "A Guide For Disputing Claims" tidbit
www.BCBSLA.com/providers >Resources >Tidbits

Submitting Corrected Claims

Louisiana
providerTIDBIT
a guide to understanding our processes

Submitting Corrected Claims

Sometimes providers need to submit corrected claims for services that have already been processed by Blue Cross. To avoid your claims being denied as a duplicate, use the guidelines outlined in this document.

- When a claim is refiled for any reason, **all** services should be reported on the claim. It is inappropriate to refile a claim with only one procedure when more than one procedure was reported on the initial claim. Splitting the claim may cause your claim to be adjusted incorrectly.

Should My Corrected Claim Be an Adjustment or Void?

Submit an adjustment or void to correct any claim that has completed the processing cycle as follows:

- Adjustment Claim - requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim - requests that the entire claim be removed and any payments or rejections be retracted from the member's and provider's records.

General Guidelines

- The claim form should reflect a clear indication as to what information has been changed.
- All procedures performed on a single date of service should be filed on one claim even when submitting corrected claims with changed (i.e. added or deleted) codes or differing units.
- The original claim reference number assigned on your Blue Cross and Blue Shield of Louisiana provider payment register/remittance advice is required when resubmitting the claim.
- A corrected claim submitted to void or adjust a claim should **not** include an Appeal and Claims Dispute Form, letter of appeal, Appeal Request Form or medical records.

Note: Adjustments can be submitted electronically for all changes except those to the member ID or pay-to-provider number. If these fields require change, the provider can void the processed claim and submit a new claim with correct member ID or pay-to-provider information.

Claim Disputes involve separate processes. For more information, please view our Disputing Claims tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

For information on Timely Filing Guidelines, please refer to section 7 in our *Professional Provider Office Manual.*

More →

TB00152017

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this document, please email providercommunications@bcbsla.com and reference the Tidbit number and title listed on this publication.

118NW2407 R11/19
Last reviewed on: 11-15-19

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.

- 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

Workers' Compensation

In most circumstances, services and treatment rendered as a result of any occupational or work-related disease or injury compensable under any federal or state workers' compensation law is a contract exclusion under the terms of a member contract and Blue Cross is not responsible for the claim

Providers should:

- Submit claims to Blue Cross
- Indicate if the services are the result of a work-related injury or illness

If it's determined the service is not covered by workers' compensation or the member's contract does not exclude these services and the claim is not filed to Blue Cross, the provider is at risk of future consideration by failing to meet administrative filing requirements outlined in the member's contract

Subrogation

Subrogation is a contract provision that allows health insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party. As a participating provider, you agree to submit claims for all covered services received by Blue members.

Providers should:

- Indicate if the services are related to an accident or a work-related injury or illness when submitting claim
- Not require the Blue member or the member's attorney to guarantee payment of the entire billed charge
- Not require the Blue member to pay the entire billed charge up front
- Not bill the Blue member for amounts above the reimbursement amount/allowable charge
- Charge the member no more than is ordinarily charged other patients for the same or similar service
- Bill the member only for any applicable cost share (deductible, coinsurance, copayment) and/or non-covered service

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

Provider Self-service Initiative

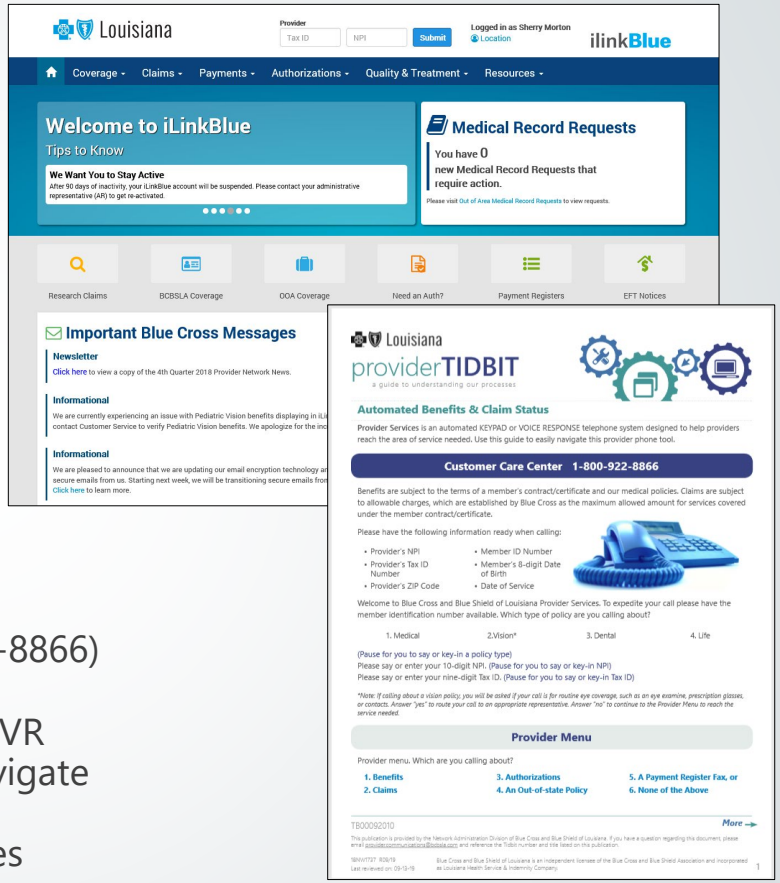
Providers are required to use our self-service tools for:

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

These services are no longer 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



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's Role in Documenting

- Each page of the patient's medical records should include the following:
  - Patient's name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials)
  - Example : John Doe, MD (acceptable)
  - Example: Dr. John Doe (not acceptable)
- 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

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

Coding to the Highest Level of Specificity

- Code all conditions (acute/chronic) being treated to the highest level of specificity
  - Monitored, Evaluated, Assessed or Treated should be noted
- Avoid non-specific and broad statements such as bipolar disorder
- Use terms such as:
  - Type I or II
  - Current or in remission
  - Severity (mild, moderate, severe)
  - Presence of psychotic features

NOTE: Improper documentation could result in audits and/or the request of medical records

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

Medical Record Requests must be returned within seven days of receipt of request

Commercial Diagnostic Accuracy and Completion

Commercial Diagnostic Accuracy and Completion (DAC) is a component of the Affordable Care Act (ACA)

- Encourages health plans to focus on quality improvements, efficiency and stabilization of premiums
- DAC uses diagnosis codes reported on claims to determine the disease state or illness burden (overall health) of a patient, allowing CMS to assign a risk score to each patient
- DAC medical record requests typically begin in January

Blue Cross is currently partnered with Inovalon to conduct out-of-state DAC medical record requests

Commercial Risk Score

- Code all conditions (acute/chronic) being treated to the highest level of specificity
  - Monitored, Evaluated, Assessed or Treated should be noted
- Avoid non-specific and broad statements such as bipolar disorder
- Use terms such as:
  - Type I or II
  - Current or in remission
  - Severity (mild, moderate, severe)
  - Presence of psychotic features

NOTE: Improper documentation could result in audits and/or the request of medical records

Commercial Risk Scores

- Blue Cross identifies those members with potential diagnostic gaps by review of claims data
- Diagnostic gaps are identified through:
  - History: prior year Dx
  - Pharmacy: prescribed medication
  - Diagnostic: lab or diagnostic test
  - Other: diagnosis with potential co-existing condition

What can providers do?

1. Close gaps in care
2. Ensure all documentation reflects what is being billed
3. Ensure chart reflects complete clinical profile for the patient

Risk Adjustment Data Validation Audits

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

Components of the RADV Audits:

- Annual CMS mandate
- Required audit for every insurer who sells a policy on the ACA marketplace
  - Will be used to confirm risk reported
  - To confirm providers' medical records substantiate the reported data and accurately reflect the care rendered and billed
- The Accountable Care Law mandates medical records be provided
- RADV audit requests for medical records begin in June

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

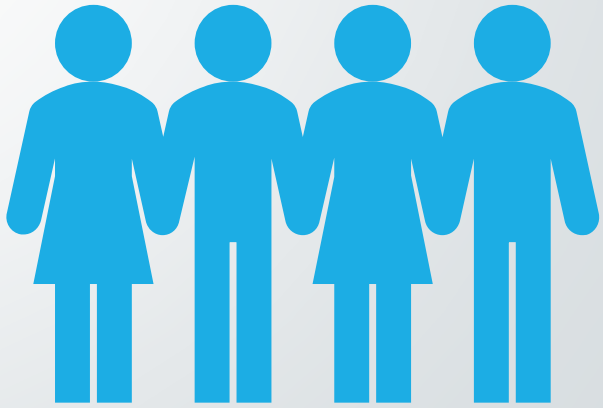
Examples:

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

Out of network referrals

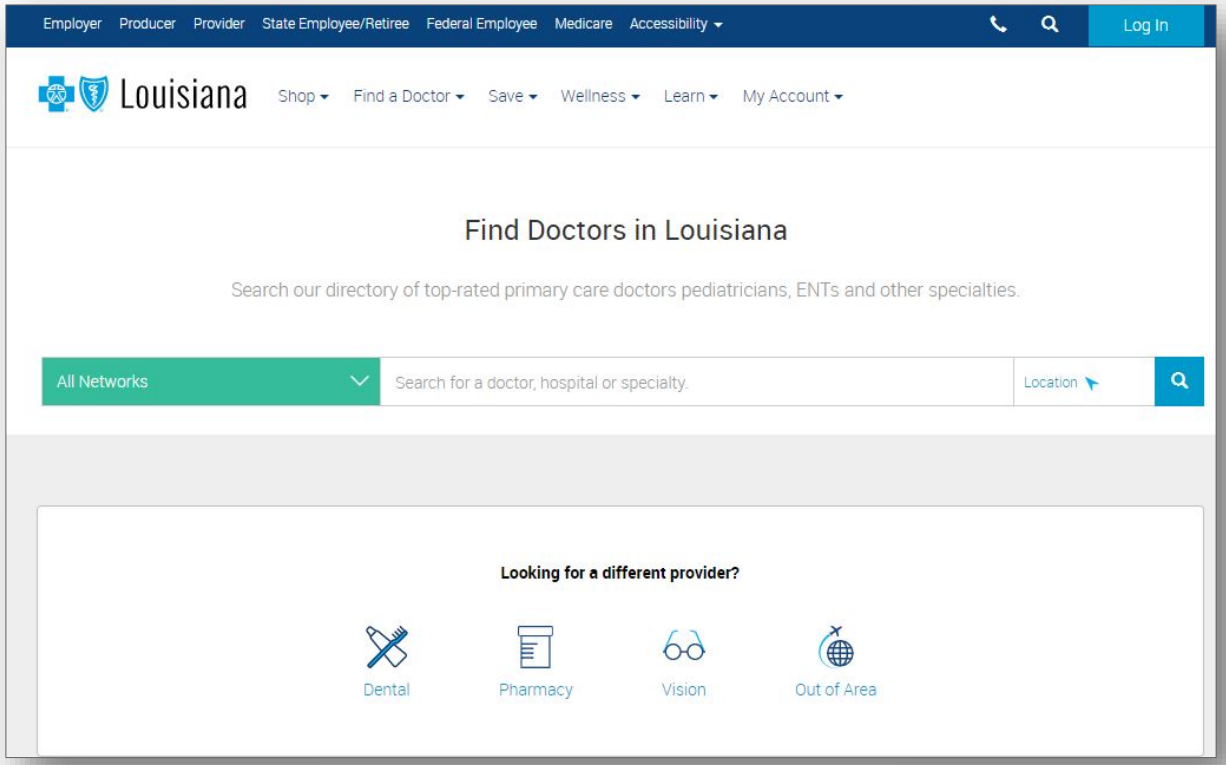
The impact on your patients when you refer Blue Cross members to out-of-network providers:

- 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



Provider Identity Management Team

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

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

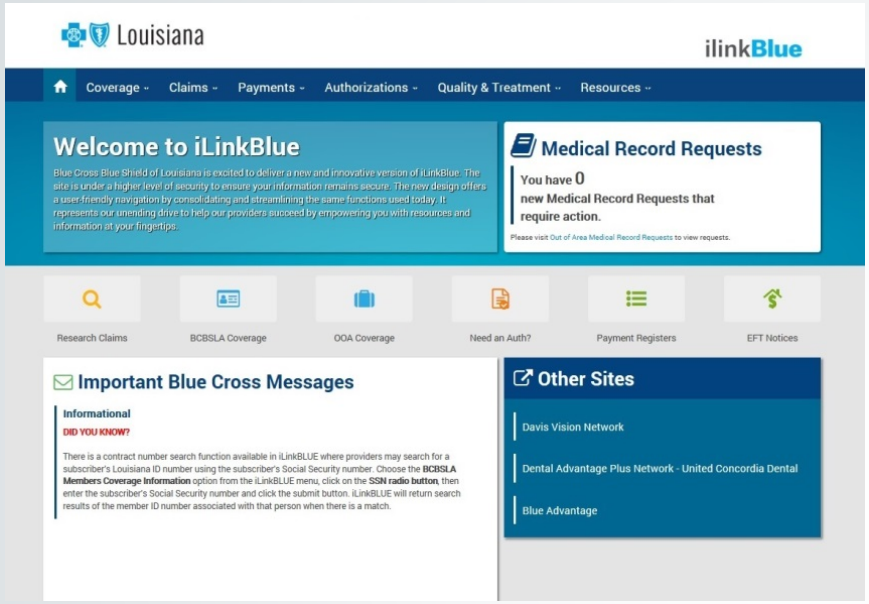
Inactivity Policy

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 Provider Identity Management Team at **PIMTeam@bcbsla.com**

Accessing the Blue Advantage Provider Portal



- The processes for Blue Advantage (HMO)/Blue Advantage (PPO) 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**)
- To gain security access to the Blue Advantage Provider Portal, users must first self-register within the portal; this will start the process of getting the user access to the feature

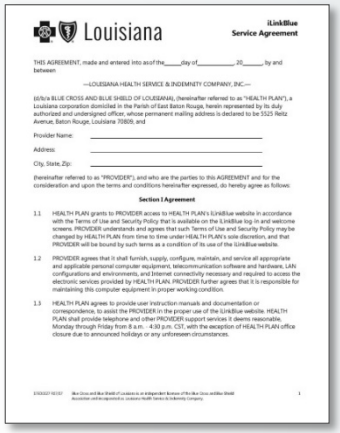
iLinkBlue Application Packet

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The **iLinkBlue Application Packet** is available at **www.BCBSLA.com/providers** >Electronic Services then click on "iLinkBlue"

ALWAYS include NPI/TAX ID on:

- ✓ iLinkBlue Service Agreement
- ✓ Business Associate Addendum to the iLinkBlue Service Agreement
- ✓ Administrative Representative Registration Form
- ✓ Electronic Funds Transfer (EFT) Enrollment Form

These four documents are required to access iLinkBlue:


Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the _____ day of _____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809; and

Provider Name: _____

Address: _____

City, State, Zip: _____

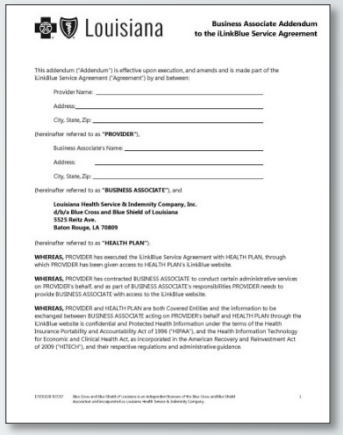
(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.


Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**PROVIDER**"),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "**BUSINESS ASSOCIATE**"), and

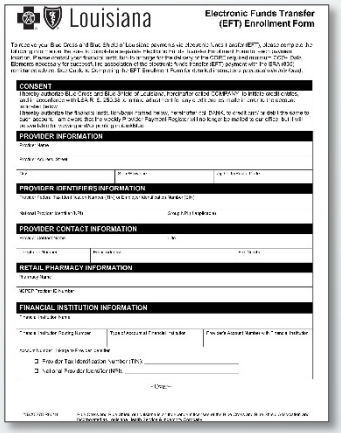
Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

(hereinafter referred to as "**HEALTH PLAN**").

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.


Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

CONSENT

PROVIDER INFORMATION

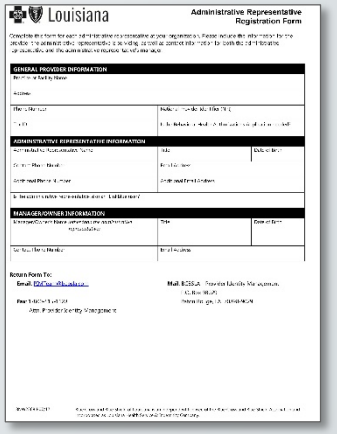
PROVIDER IDENTIFIERS INFORMATION

PROVIDER CONTACT INFORMATION

RETAIL PHARMACY INFORMATION

FINANCIAL INSTITUTION INFORMATION

Electronic Funds Transfer Enrollment Form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Administrative Representative Registration Form

GENERAL PROVIDER INFORMATION

ADMINISTRATIVE REPRESENTATIVE INFORMATION

MANAGER/OWNER INFORMATION

Administrative Representative Registration Form