Behavioral Health Webinar for ABA Providers

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform.

How to submit questions:

- Open the chat feature at the top of your screen to type your question related to today's training webinar
- In the "Send to" field, select "All Panelists."
- Once your question is typed in, hit the "Send" button to send it to the presenter.
- We will address submitted questions at the end of the webinar.

BEHAVIORAL HEALTH WEBINAR FOR ABA PROVIDERS

2021

Louisiana

PROVIDER RELATIONS DEPARTMENT

PROVIDER.RELATIONS@BCBSLA.COM

PRESENTED BY:

Marie Davis
Provider Relations
BCBSLA

New Directions Team:

Michelle Kim, MS, BCBA
Autism Resource Program

Katherine Wooten
Clinical Director – Corporate Programs

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 RELATIONS TEAM

Jami Zachary

Anna Granen

Patricia O' Gwynn

Mary Guy

Lisa Roth

Marie Davis

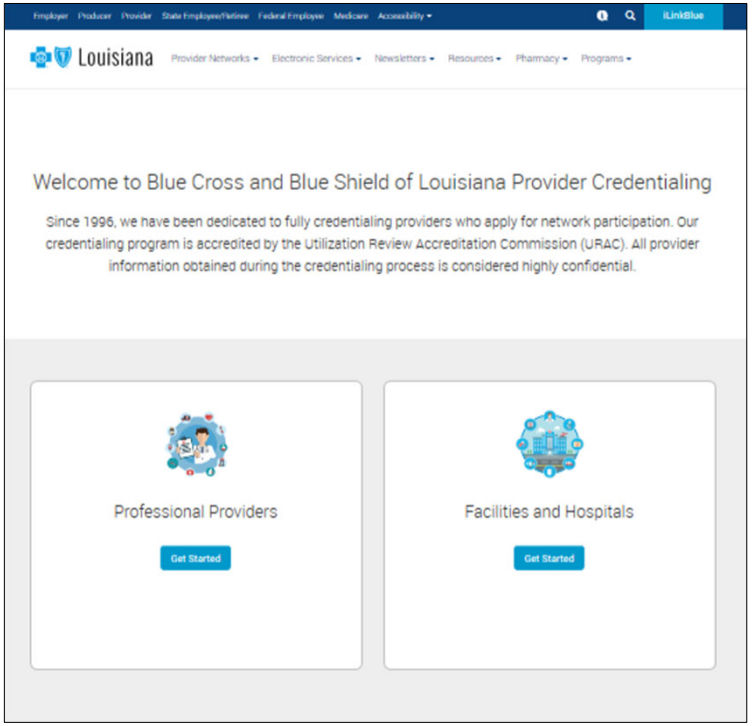
Melonie Martin

PROVIDER CREDENTIALING & DATA MANAGEMENT

Join Our Networks

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.

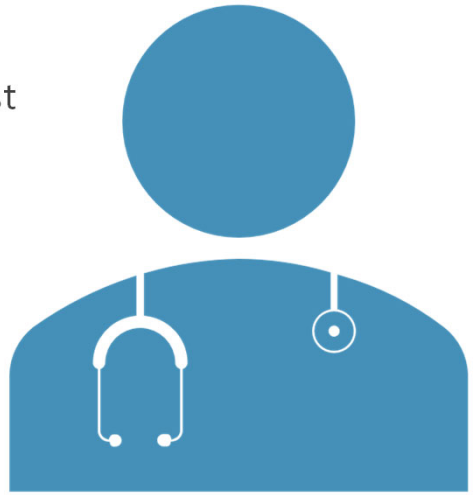
- Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:
  - Credentialing packets
  - Quick links to the Provider Update Request Form
  - Credentialing criteria for professional, facility and hospital-based providers
  - Frequently asked questions (FAQs)



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

Credentialing Process

- The credentialing process can take up to 90 days after all required information is received.
- Providers will remain non-participating in our networks until a signed and executed agreement is received by our contracting department.
- The committee approves credentialing twice per month.
- Network providers are recredentialed every three years from their last credentialing acceptance date.



After 90 days, you may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **pcdmstatus@bcbsla.com**.

Credentialing Update

- Blue Cross and Blue Shield of Louisiana has partnered with **Symplr: Healthcare Governance**, Risk and Compliance (GRC) Solutions, to assist with the verification of our recredentialing applications.
- Providers may be directly contacted by **Symplr** to verify application details and supporting documentation and direct you how to submit needed documentation.
- If you have additional questions, you may email our Provider Credentialing & Data Management Department at **pcdmstatus@bcbsla.com**.

Credentialing Criteria - Professional

The following professional provider types must meet certain criteria to participate in our networks:

- Applied Behavioral Analyst (ABA)
- Doctor of Osteopathic (DO)
- Doctor of Medicine (MD)
- Louisiana Addictive Counselor(LAC)
- Licensed Clinical Social Worker (LCSW)
- Psychologist (Ph.D.)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Licensed Professional Counselor (LPC)

View the *Credentialing Criteria* for these professional provider types at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks >Professional Providers >Credentialing Process.

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:

1. 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.

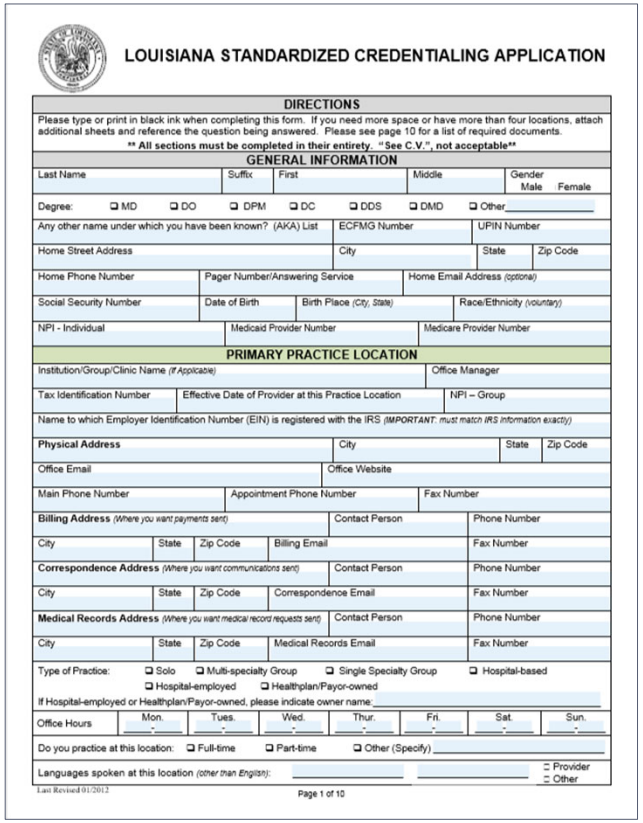
2. You **must have admitting privileges** to a network hospital. PCPs can have an admitting arrangement with a hospitalist group to admit patients on their behalf. This letter must be on letterhead and signed by the physician or the hospitalist group that will admit on behalf of the provider. This letter must be attached to the Reimbursement During Credentialing Request.

3. Your **initial credentialing application** for network participation must include a written letter on letterhead and signed by the provider or authorized representative for the provider, requesting 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.

Required Recredentialing Documents

- Network providers who are due for recredentialing will receive a notification letter six months in advance of their due date.
- The notification will be emailed by DocuSign® to the correspondence email address on file with Blue Cross.
- DocuSign will send reminder emails every seven days until the application has been submitted.
- Current providers seeking recredentialing should use the Louisiana Standardized Credentialing Application that is included in the link that is sent via DocuSign.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

** All sections must be completed in their entirety. "See C.V.", not acceptable**

GENERAL INFORMATION

Last Name | Suffix | First | Middle | Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number

Home Street Address | City | State | Zip Code

Home Phone Number | Pager Number/Answering Service | Home Email Address (optional)

Social Security Number | Date of Birth | Birth Place (City, State) | Race/Ethnicity (voluntary)

NPI - Individual | Medicaid Provider Number | Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (If Applicable) | Office Manager

Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)

Physical Address | City | State | Zip Code

Office Email | Office Website

Main Phone Number | Appointment Phone Number | Fax Number

Billing Address (Where you want payments sent) | Contact Person | Phone Number

City | State | Zip Code | Billing Email | Fax Number

Correspondence Address (Where you want communications sent) | Contact Person | Phone Number

City | State | Zip Code | Correspondence Email | Fax Number

Medical Records Address (Where you want medical record requests sent) | Contact Person | Phone Number

City | State | Zip Code | Medical Records Email | Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

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

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location (other than English): _____ _____ ☐ Provider ☐ Other

Last Revised 01/2013

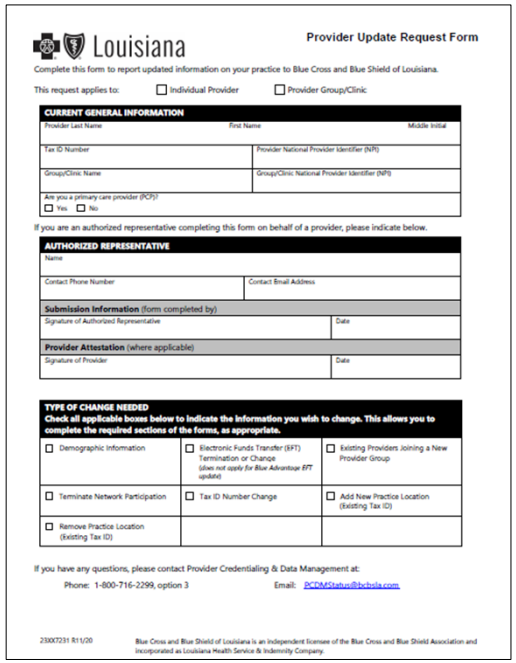
Page 1 of 10

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

How to Update Your Information

Now on DocuSign

Maintaining information within your provider record is a key piece to participating in Blue Cross and Blue Shield of Louisiana provider networks or obtaining a provider record. It is important that you keep us abreast of any changes to the information in your record. This allows us to keep our directories current, contact you when needed as well as disperse payments. These forms are in DocuSign® format, allowing you to easily submit them to Blue Cross electronically.



Louisiana

Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana.

This request applies to: ☐ Individual Provider ☐ Provider Group/Clinic

CURRENT GENERAL INFORMATION

Provider Last Name | First Name | Middle Initial

Tax ID Number | Provider National Provider Identifier (NPI)

Group/Clinic Name | Group/Clinic National Provider Identifier (NPI)

Are you a primary care provider (PCP)? ☐ Yes ☐ No

If you are an authorized representative completing this form on behalf of a provider, please indicate below.

AUTHORIZED REPRESENTATIVE

Name

Contact Phone Number | Contact Email Address

Submission Information (form completed by)

Signature of Authorized Representative | Date

Provider Attestation (where applicable)

Signature of Provider | Date

TYPE OF CHANGE NEEDED

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information | ☐ Electronic Funds Transfer (EFT) Termination or Change (does not apply for Blue Advantage EFT update) | ☐ Existing Providers Joining a New Provider Group

☐ Terminate Network Participation | ☐ Tax ID Number Change | ☐ Add New Practice Location (Existing Tax ID)

☐ Remove Practice Location (Existing Tax ID)

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

23XX7231 R11/20

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.

What changes do you need to make?

Provider Update Request Form – to update information such as:

- Demographic Information – for updating contact information
- Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group
- Add Practice Location – to add a practice location(s)
- Remove Practice Location – to remove a practice location(s)
- Tax Identification Number (TIN) Change – to change your Tax ID number
- Terminate Network Participation – to terminate existing network participation or an entire provider record
- EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method

Submit these forms online at **www.BCBSLA.com/providers** >Provider Networks >Professional Provider >Update Your Information.

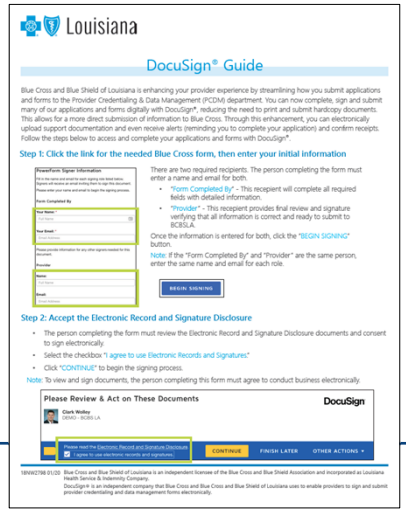
Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

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?

As 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 recepient will complete all required fields with detailed information.
- "Provider" - This recepient 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 Wolley
DEMO - BCBS LA

Please read the Electronic Record and Signature Disclosure
I agree to use electronic records and signatures.

CONTINUE FINISH LATER OTHER ACTIONS

18NW2798 01/20 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.

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

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

Easily complete packets & forms with DocuSign

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

Credentialing packets:

- Professional (initial)
- Facility (initial)

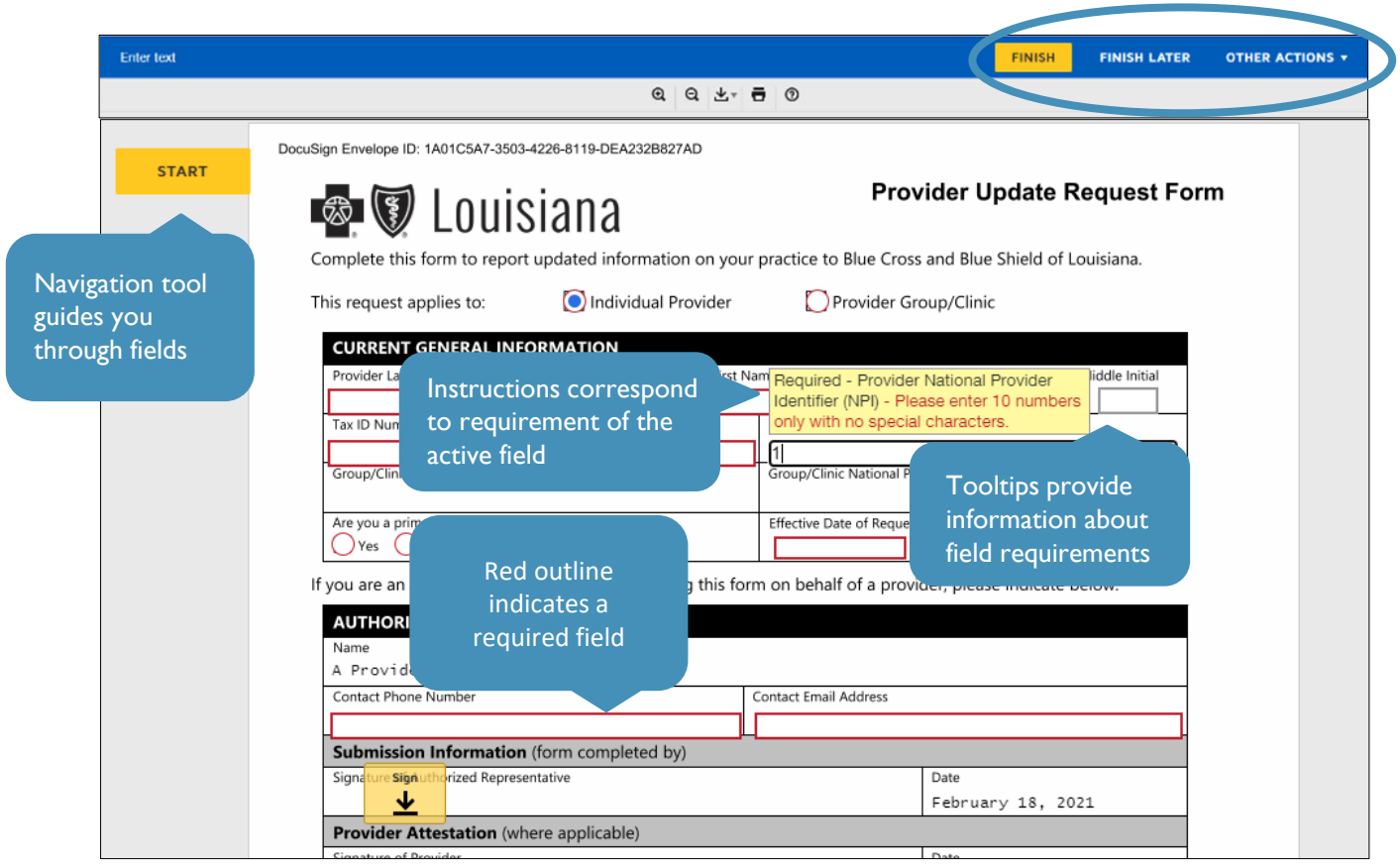
Forms:

- **Provider Update Request Form** – to update information such as:
  - Demographic Information – for updating contact information
  - Existing Providers Joining a New Provider Group – if you are joining an existing provider group or clinic or adding new providers to your group
  - Add Practice Location – to add a practice location(s)
  - Remove Practice Location – to remove a practice location(s)
  - Tax Identification Number (TIN) Change – to change your Tax ID number
  - Terminate Network Participation – to terminate existing network participation or an entire provider record
  - EFT Term/Change Request – to change your electronic funds transfer (EFT) information or to cancel receiving payments via this method
- **EFT Enrollment Form** – to begin receiving payments via electronic funds transfer (EFT)

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

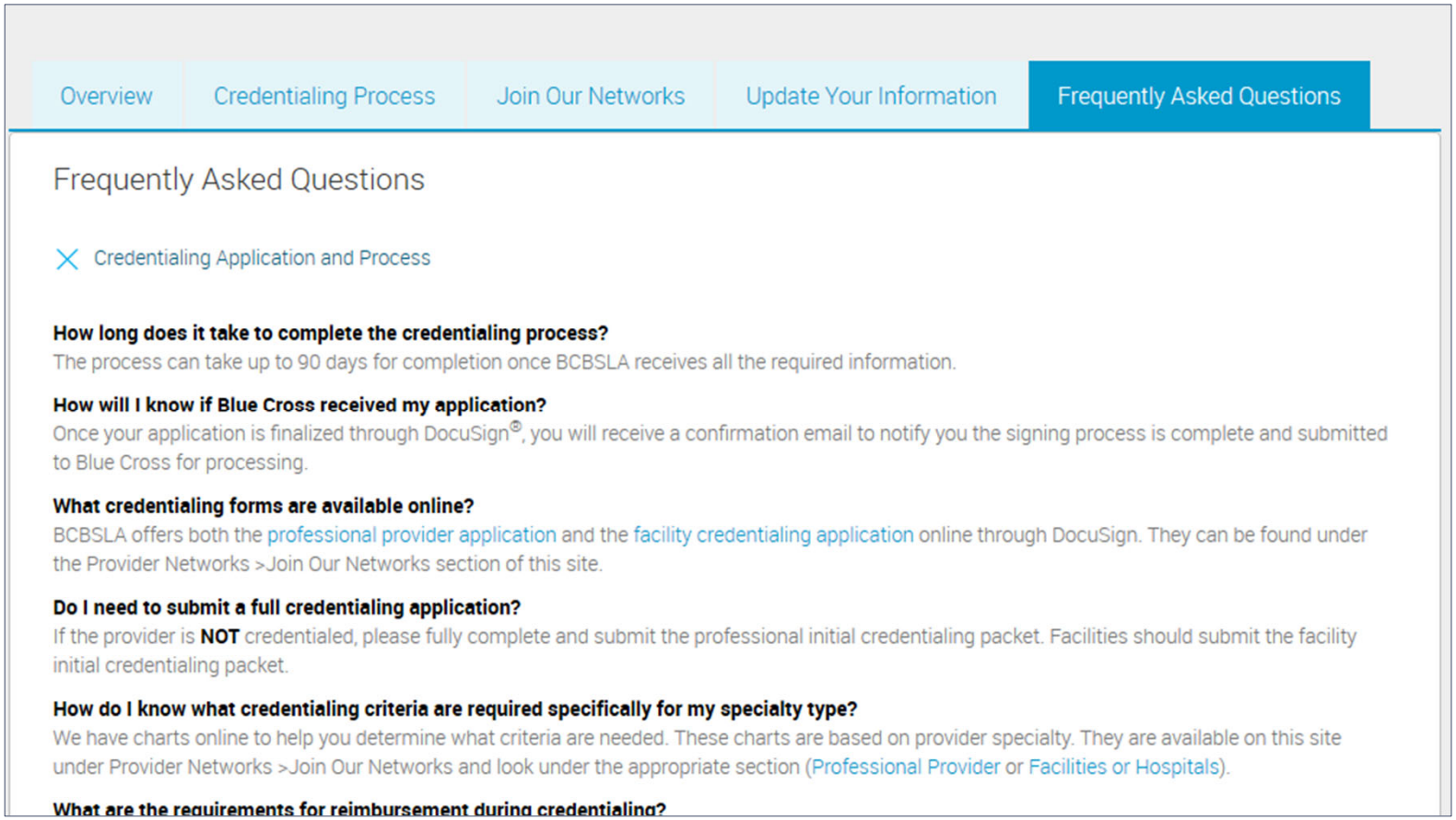
www.BCBSLA.com/providers >Provider Networks >Join Our Networks >Professional Providers

Easily Complete Forms with DocuSign



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

Frequently Asked Questions



A list of FAQs are available at **www.BCBSLA.com/providers** >Provider Networks >Join Our Networks >Professional Providers >Frequently Asked Questions.

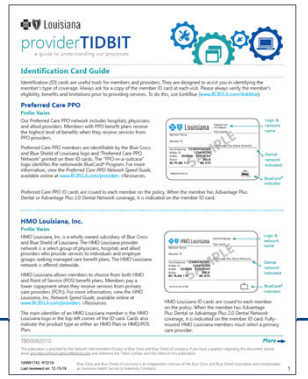
OUR NETWORKS

Our Provider Networks

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

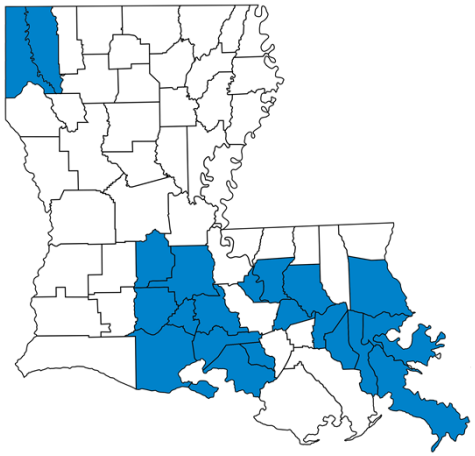
Louisiana

HMO Louisiana


Louisiana
providerTIDBIT
a guide to understanding our processes
Identification Card Guide
Preferred Care PPO
HMO Louisiana, Inc.

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

Shreveport area

Bossier and Caddo parishes

Lafayette area

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

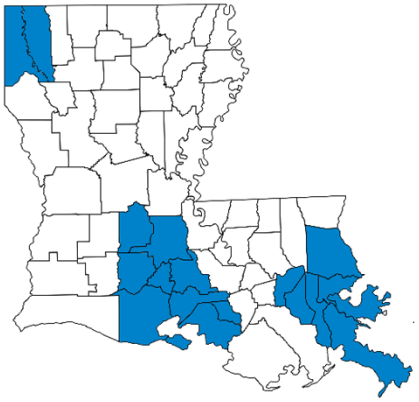
COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks

NEW NETWORK 2021



BlueHPN

Lafayette area

Acadia, Evangeline, Iberia, Jefferson and Lafayette parishes

Shreveport area

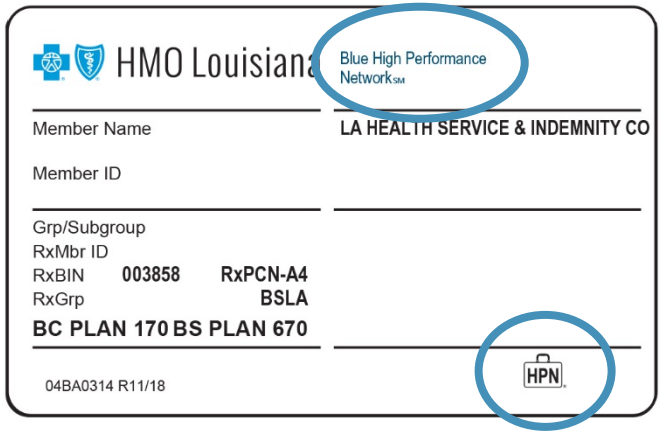
Bossier and Caddo parishes

New Orleans area

Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany and Vermilion parishes

BlueHPN members are identifiable by the HPN in a **suitcase logo** in the bottom right-hand corner of the card.

HPN®



Our Provider Networks

PRECISION BLUE

Baton Rouge area

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

SIGNATURE BLUE

New Orleans area

Jefferson and Orleans 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

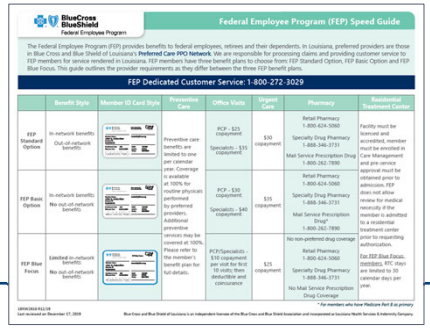
BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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

New Timely Filing guidelines:
In-network PPO providers must file claims within 15 months of the date of service.

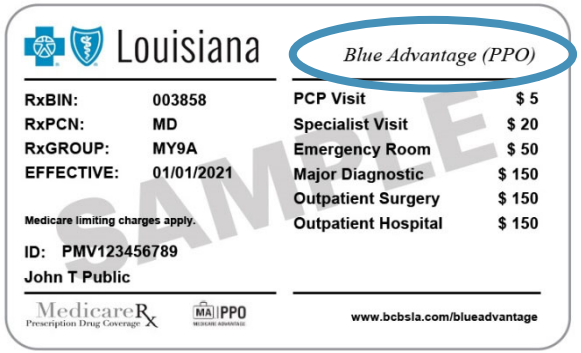


An FEP Speed Guide is available at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Our Blue Advantage Networks

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

NEW PREFIXES FOR 2021

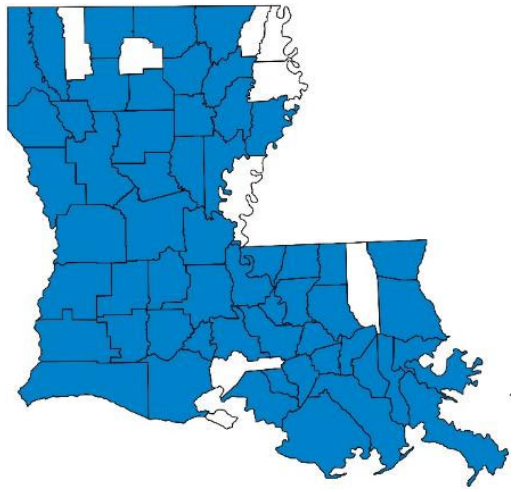


Prefix: PMV

Prefix: MDV

Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

Our Provider Networks



Healthy Blue

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)

Statewide with the exception of the following parishes:

- Concordia
- East Carroll
- Iberia
- Lincoln
- Madison
- Tangipahoa
- Webster
- West Carroll

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.

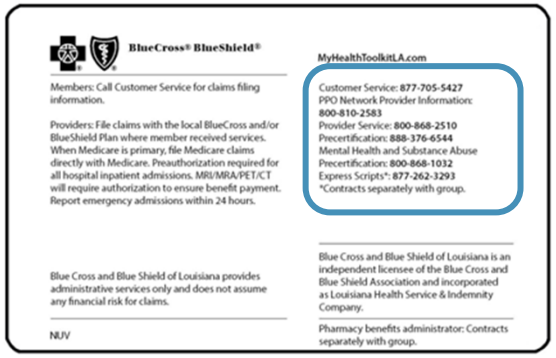
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

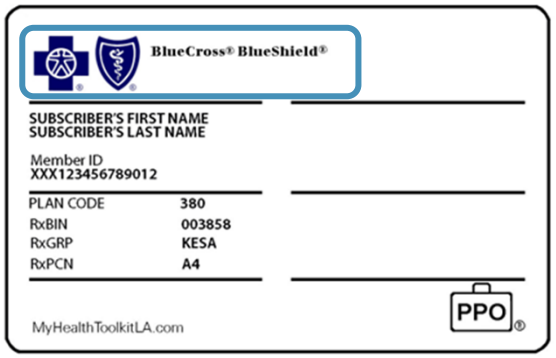
The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

The HPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) 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.





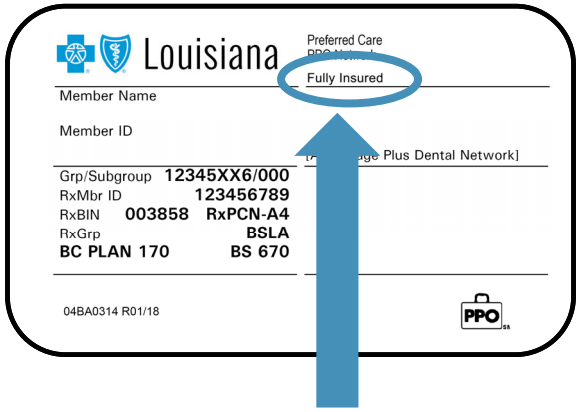
This list of prefixes is available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-insured

Member ID Card Differences

FULLY INSURED

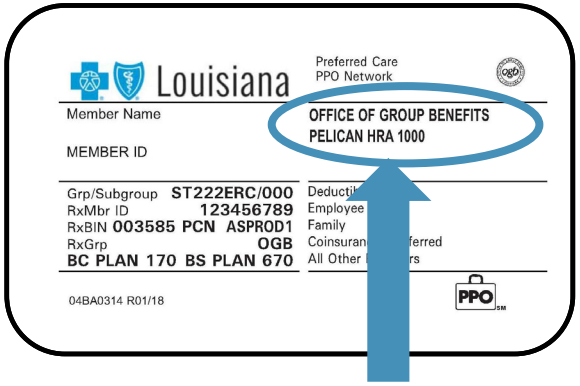
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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**).

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 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.

If a provider continues to refer patients to out-of-network providers, their entire fee schedule could be reduced.

TELEHEALTH

ABA Telehealth Policy

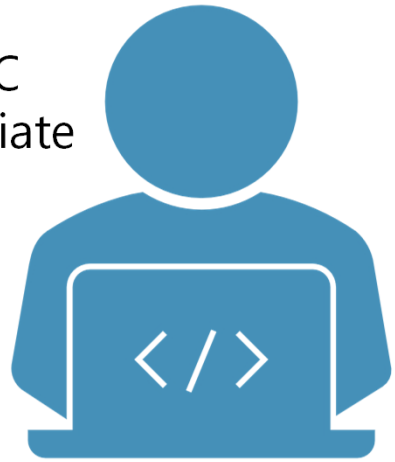
- BCBSLA has continued to monitor the spread of COVID-19, as to the emergency, we have **temporarily** expanded our telehealth policy.
- This expansion includes applied behavioral analysis (ABA) telehealth services to help with the temporary cessation of in-person services during this time of public health crisis.
- ABA providers must follow the telehealth billing guidelines in the provider manual and agree to Blue Cross' allowable charges.
- Credentialed network ABA providers can deliver limited telehealth (audio and visual) services to replace office visits, effective for dates of service on and after March 16, 2020.

For more information about our telemedicine requirements, billing and coding guidelines, see our *Professional Provider Office Manual* at **www.BCBSLA.com/providers** >Resources >Manuals.

Billing Guidelines

Telemedicine/Telehealth – Blue Cross updated the telehealth section (5.37) of its *Professional Provider Office Manual*, effective for dates of service on and after July 1, 2021:

- Changed telehealth service exclusions from services not medically appropriate for the setting to services not suitable for the setting.
- Changed not listed direct to consumer (DTC) telehealth codes being denied as not medically necessary to being not eligible for reimbursement as telehealth services.
- Removed notation that Blue Cross determined unlisted DTC telehealth services are not clinically and medically appropriate to deliver via a telehealth encounter.



Telemedicine

Reimbursement for **direct-to-consumer (DTC)** telemedicine services is available when provided within the scope of your license and utilizing your own telemedicine platform

- The appropriate **place of service** for when performing **DTC telemedicine** this way is typically **POS 11** (office).
- The reimbursable **CPT® codes/services for DTC telemedicine** can be found in the *Professional Provider Office Manual* (section 5-2).
- Encounters must be performed in real time using audio **and** video technology.

The following are examples of services that are not eligible for reimbursement as telemedicine services:

- Non-direct patient services (e.g., coordination of care before/after patient interaction).
- Services rendered by audio-only telephone communication, facsimile, email, text or any other non-secure electronic communication.
- Services not eligible for separate reimbursement when rendered to patient in person.
- Presentation/origination site facility fee.
- Services/codes that are not specifically listed in the provider manual.

Telemedicine claims are paid the same as an in-office visit.

ABA Telehealth Services

Credentialed network ABA providers can deliver limited telehealth (audio and visual) services to replace office visits, effective for dates of service on and after March 16, 2020. The expanded telehealth policies will continue to be effective until we are past this national emergency.

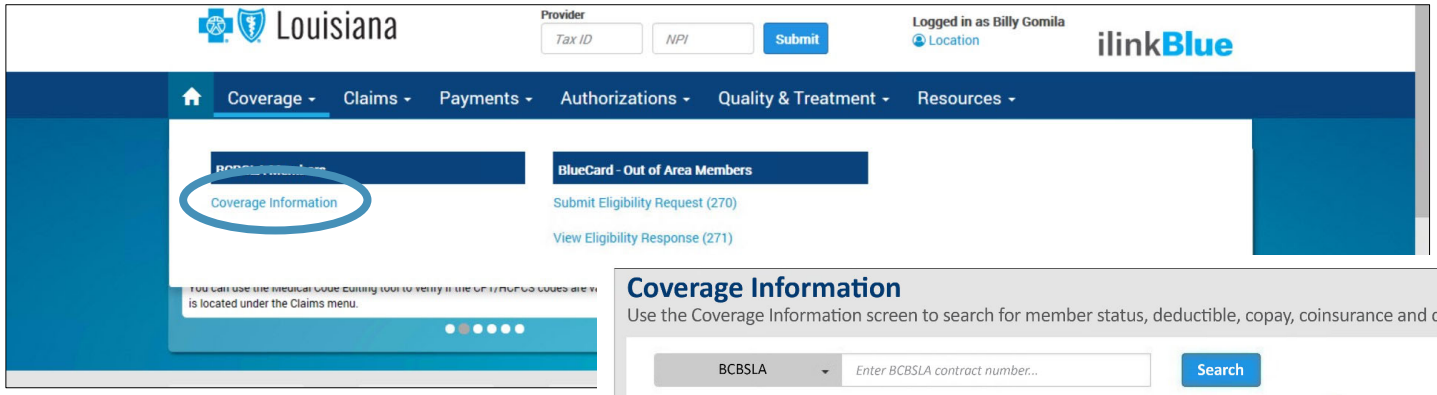
- ABA providers must adhere to the telehealth billing guidelines in the provider manual and agree to Blue Cross' allowable charges.
- ABA providers filing claims for telehealth should continue to use the appropriate place of service code they have been using, along with Modifier GT or 95.
- ABA providers billing telehealth services must continue to follow the guidelines outlined in Section 5.6 Autism and Section 5.7 Behavioral Health of our Professional Provider Office Manual available online at **www.BCBSLA.com/providers** >Resources >Manuals.
- Telehealth ABA services are limited to the following CPT® codes: 97151, 97152, 97153, 97154, 97155, 97156, 97157 and 97158.
- Blue Cross will not reimburse telehealth services for HCPCS codes 0362T or 0373T due to their complexity requiring a face-to-face encounter.
- ABA providers must fully document the telehealth encounter in the patient's medical record.
- Telehealth claims will be paid using standard member cost shares.

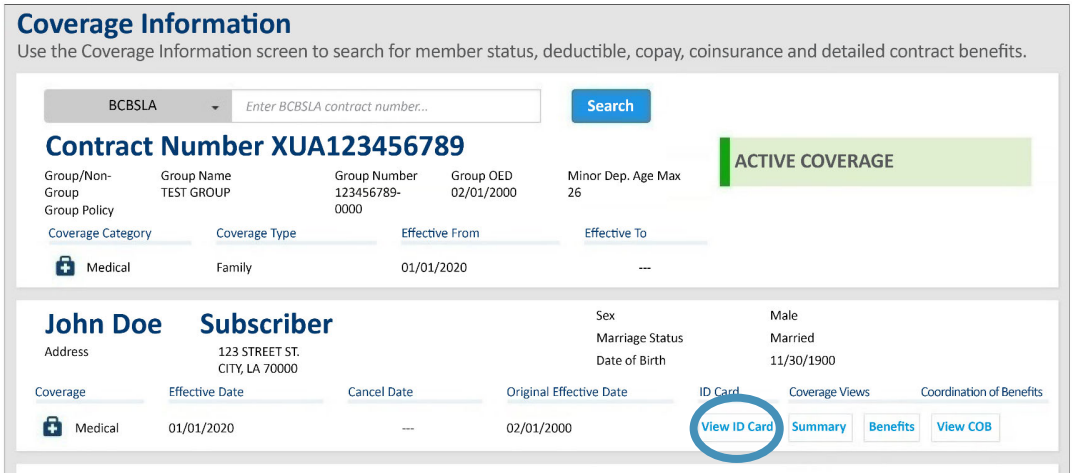
Blue Cross will notify providers when the expanded telehealth policies are no longer effective. We will continue to review our telehealth guidelines and update as new developments occur.

ILINKBLUE ENHANCEMENTS

Digital ID Cards in iLinkBlue

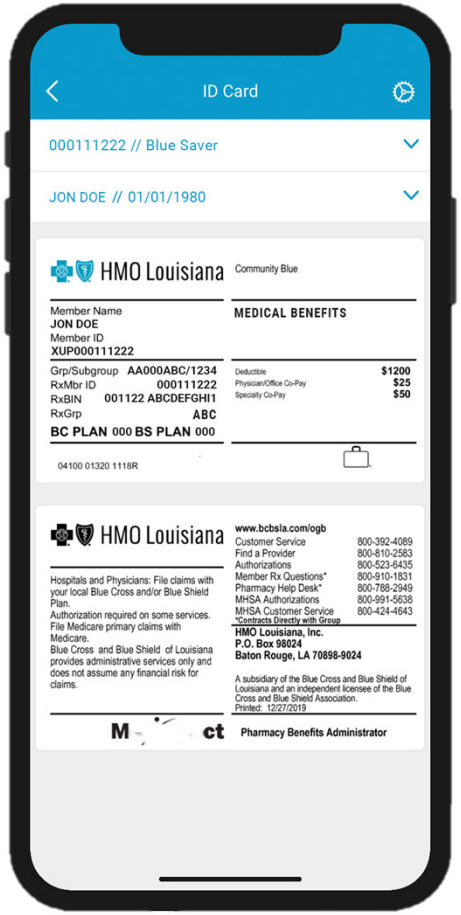
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”





Digital ID Cards

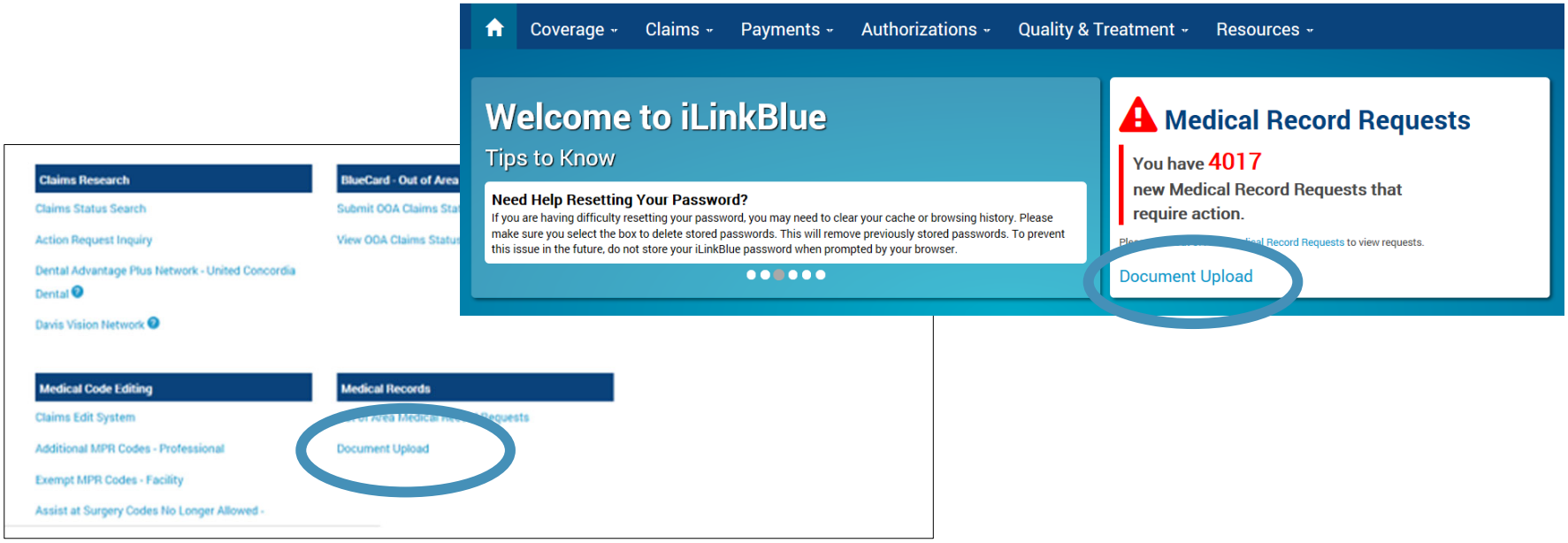
- Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal:
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.
- 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.

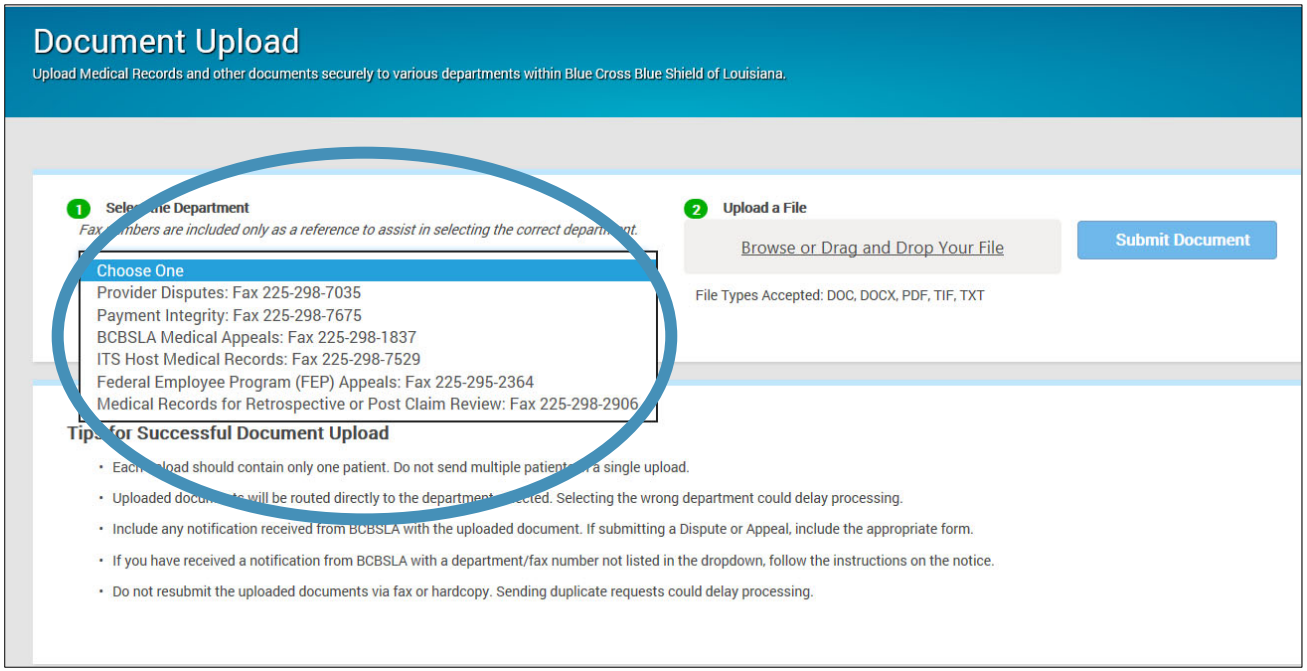
The new feature is quick, secure and available at any time through the iLinkBlue provider portal.



The Document Upload feature can be accessed on iLinkBlue (**www.BCBSLA.com/ilinkblue**) 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.



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?

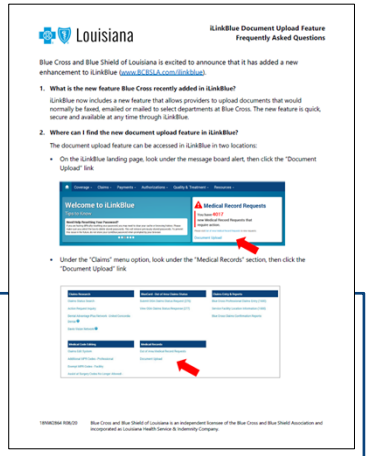
- DOC, DOCX, PDF, TIF, TXT

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.

Is there a file size limitation?

- Flies that are over 10MB in size will not be accepted for upload.
  Documents that exceed this limit will need to be faxed or mailed to Blue Cross.


Louisiana

iLinkBlue Document Upload Feature
Frequently Asked Questions

Blue Cross and Blue Shield of Louisiana is excited to announce that it has added a new enhancement to iLinkBlue (www.BCBSLA.com/ilinkblue).

1. **What is the new feature Blue Cross recently added in iLinkBlue?**

   iLinkBlue now includes a new feature that allows providers to upload documents that would normally be faxed, emailed or mailed to select departments at Blue Cross. The new feature is quick, secure and available at any time through iLinkBlue.

2. **Where can I find the new document upload feature in iLinkBlue?**

   The document upload feature can be accessed in iLinkBlue in two locations:

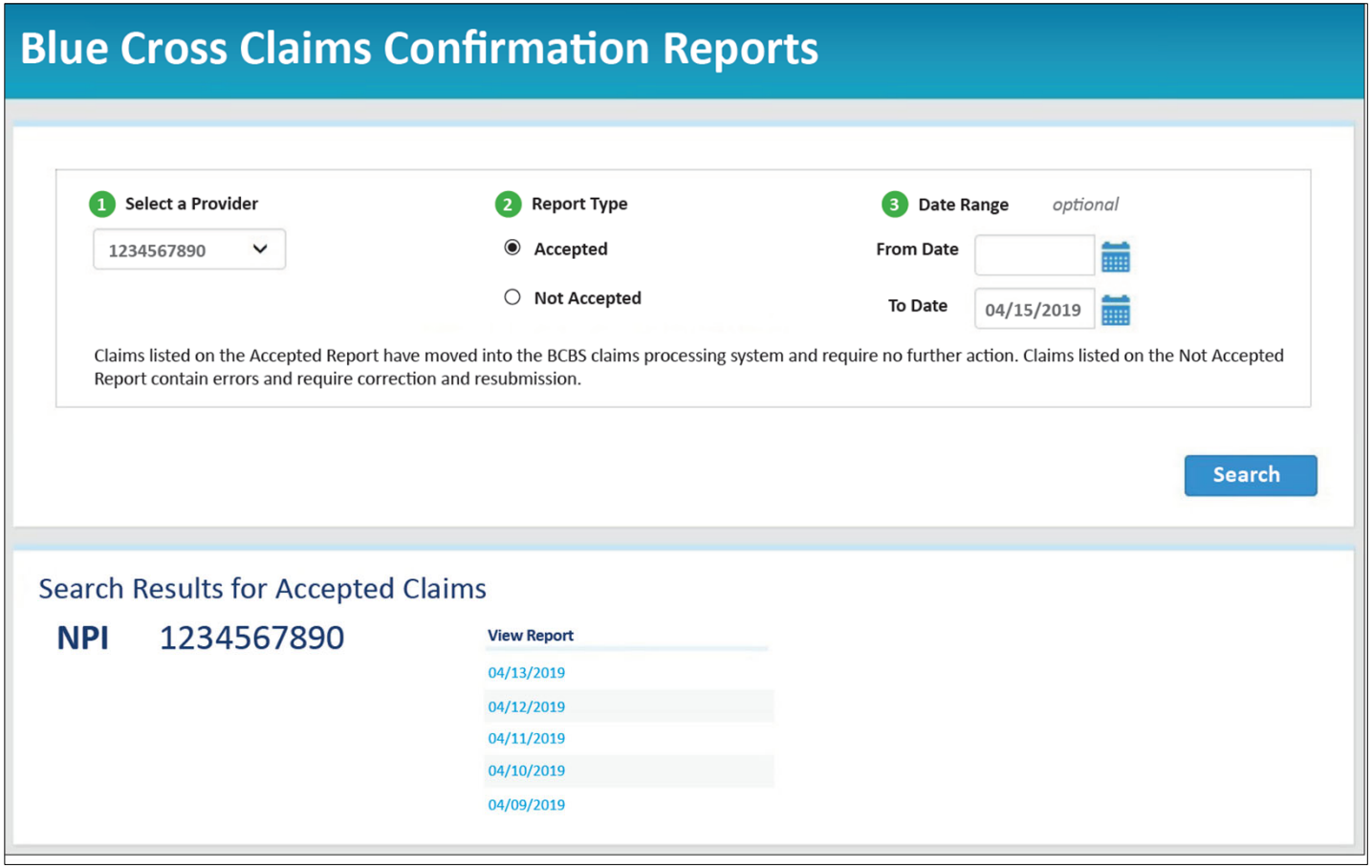
   - On the iLinkBlue landing page, look under the message board alert, then click the "Document Upload" link

   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

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.

For a copy of the Document Upload Feature FAQs send an email to **provider.relations@bcbsla.com**.

Blue Cross Claims Confirmation Reports



Blue Cross Claims Confirmation Reports

Confirmation Reports indicate detailed claim information on transactions that were accepted or not accepted for processing. Providers are responsible for reviewing these reports and correcting claims appearing on the “Not Accepted” report.

Accepted Report

Blue Cross and Blue Shield of Louisiana
837 Accepted / Not Accepted / Warning Report
Professional Claims Report

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z NPI# 1234567891
BC ID # T5678
RECEIVE DATE: 04-12-19

SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 04-12-19

PAGE 1

837P ACCEPTED REPORT

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	CH TRACKING NUMBER
L12345678	DOE	JOHN	XUA123458789	040819	040819	125.00	123459876123

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
837P TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS: 1 CLAIMS FOR $125.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
GRAND TOTAL CLAIMS: 1 CLAIMS FOR $125.00

Not Accepted Report

Blue Cross and Blue Shield of Louisiana
837 Accepted / Not Accepted / Warning Report
Professional Claims Report

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z NPI# 1234567891
BC ID # T5678
RECEIVE DATE: 04-12-19

SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 04-12-19

PAGE 1

837P NOT ACCEPTED REPORT

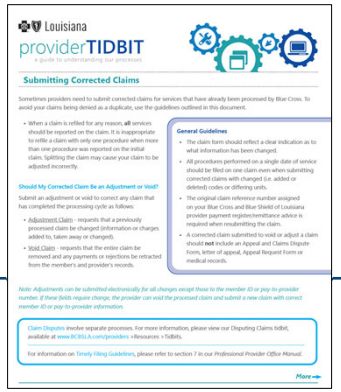
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION IRS CONFLICT	987654321

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
837P TOTAL CLAIMS: 2 CLAIMS FOR $412.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
GRAND TOTAL CLAIMS: 2 CLAIMS FOR $412.00

Submitting a Corrected Claim

- When a claim is refiled for any reason, all services should be reported on the claim.
- 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.
- If submitting a corrected claim through iLinkBlue:
  - In Field 19A, enter the applicable Professional Claim Adjustment/Void Indicator: A (Adjustment Claim) or V (Void Claim)
  - In Field 19B, enter the Internal Control Number (ICN Number that is the original claim number)


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.

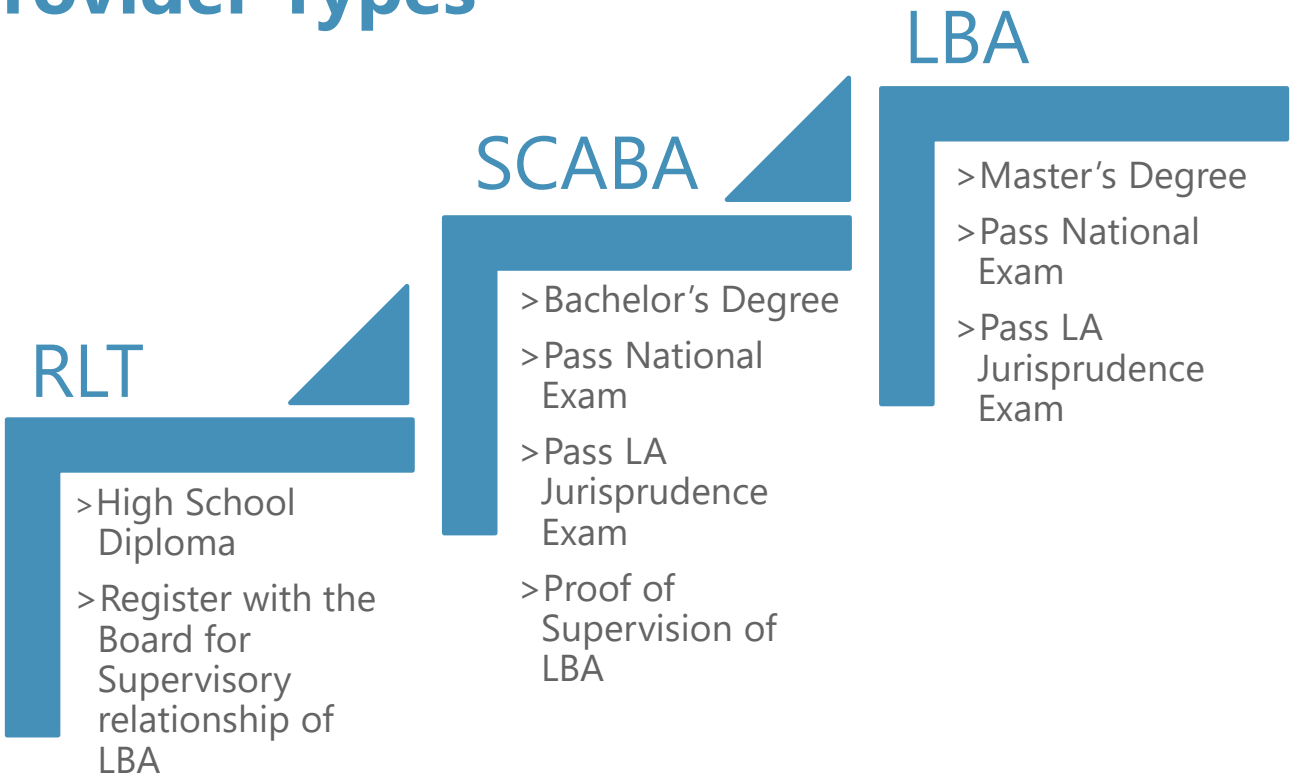
For information on Timely Filing Guidelines, please refer to section 7 in our *Professional Provider Office Manual*.

More

For more information find our Submitting a Corrected Claim Tidbit at **www.BCBSLA.com/Providers** >Resources, then >Tidbits.

BILLING & CLAIMS

ABA Provider Types



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

ABA Billing Guidelines

- **Licensed Behavior Analyst (LBA)**
  - Can bill directly.
  - Services must be billed with Modifier TG.
- **State-certified Assistant Behavioral Analysts (SCABA)**
  - Cannot bill directly.
  - Services must be billed through the supervising LBA with the appropriate codes and modifier.
  - Services must be billed with Modifier TF.
- **Registered Line Therapists (RLT)**
  - Cannot bill directly.
  - Services must be billed through the supervising licensed behavior analyst (LBA).
  - RLTs with a Bachelor's degree: Use Modifier HN.
  - RLTs without a Bachelor's degree: Do not use a modifier.

Claim payments will be based on your:
- Licensure
- Certification
- Registration

(as designated by the state Behavior Analyst Board)

Provider	Billable Modifier
LBA	TG
SCABA	TF
RLTs with a Bachelor's degree	HN
RLTs without a Bachelor's degree	none

ABA Coding

Code	Time	Clinician Type	Modifier
97151	15 minutes	SCABA	TF
		LBA	TG
97152	15 minutes	SCABA	TF
		LBA	TG
		RLT w/o Bachelor's	none
97153	15 minutes	RLT with Bachelor's	HN
		SCABA	TF
		LBA	TG
		RLT w/o Bachelor's	none
97154	15 minutes	SCABA	TF
		LBA	TG
		RLT w/o Bachelor's	none
97155	15 minutes	SCABA	TF
		LBA	TG
97156	15 minutes	SCABA	TF
		LBA	TG
97157	15 minutes	SCABA	TF
		LBA	TG
97158	15 minutes	SCABA	TF
		LBA	TG
0362T	15 minutes	SCABA	TF
		LBA	TG
0373T	15 minutes	SCABA	TF
		LBA	TG

Filing Claims Hardcopy

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

CMS-1500 (02-12)

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

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, 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.
130 DeSiard St. Ste. 322
Monroe, LA 71201

For Healthy Blue Dual Advantage (D-SNP):

Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

For BlueHPN Claims:

HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898

Timely Filing

- **Blue Cross, HMO Louisiana, Blue Connect, Community Blue, BlueHPN, 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:**
  - Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the service were provided

- **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

- **HMO D-SNP:**
  - Claim must be filed within 12 months of the date of service

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

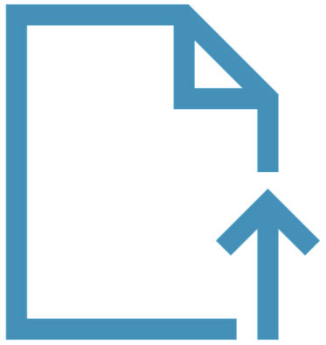
Please follow the steps below to ensure your claims will not deny as duplicates or process incorrectly. You can ensure the accurate electronic (837I or 837P) submission by following the instructions below:

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

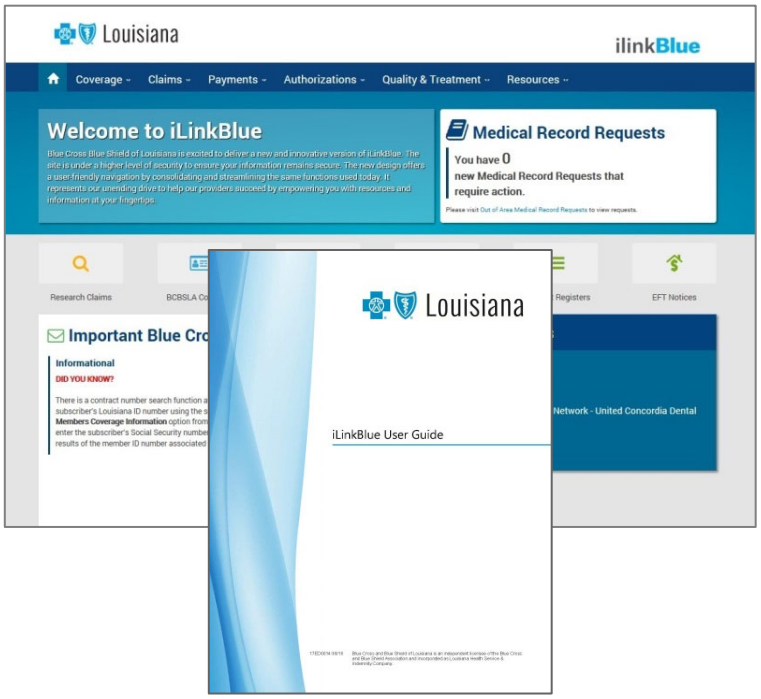


OUR SECURE ONLINE SERVICES

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

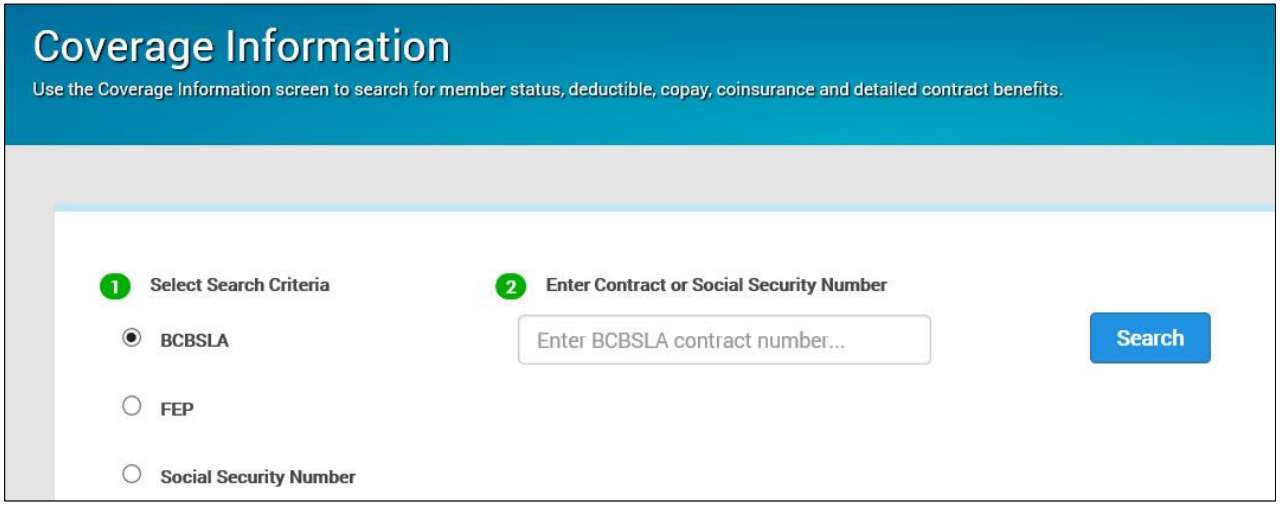


- For iLinkBlue training and education, contact **provider.relations@bcbsla.com**.

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

iLinkBlue – Coverage & Eligibility

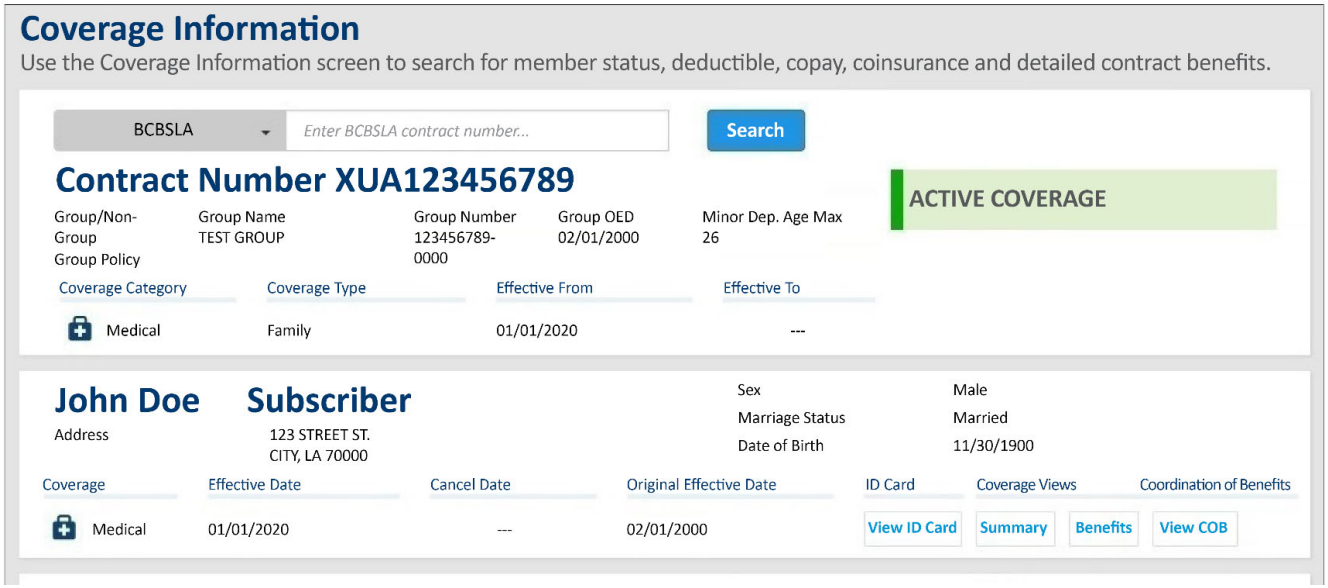
1.



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.



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

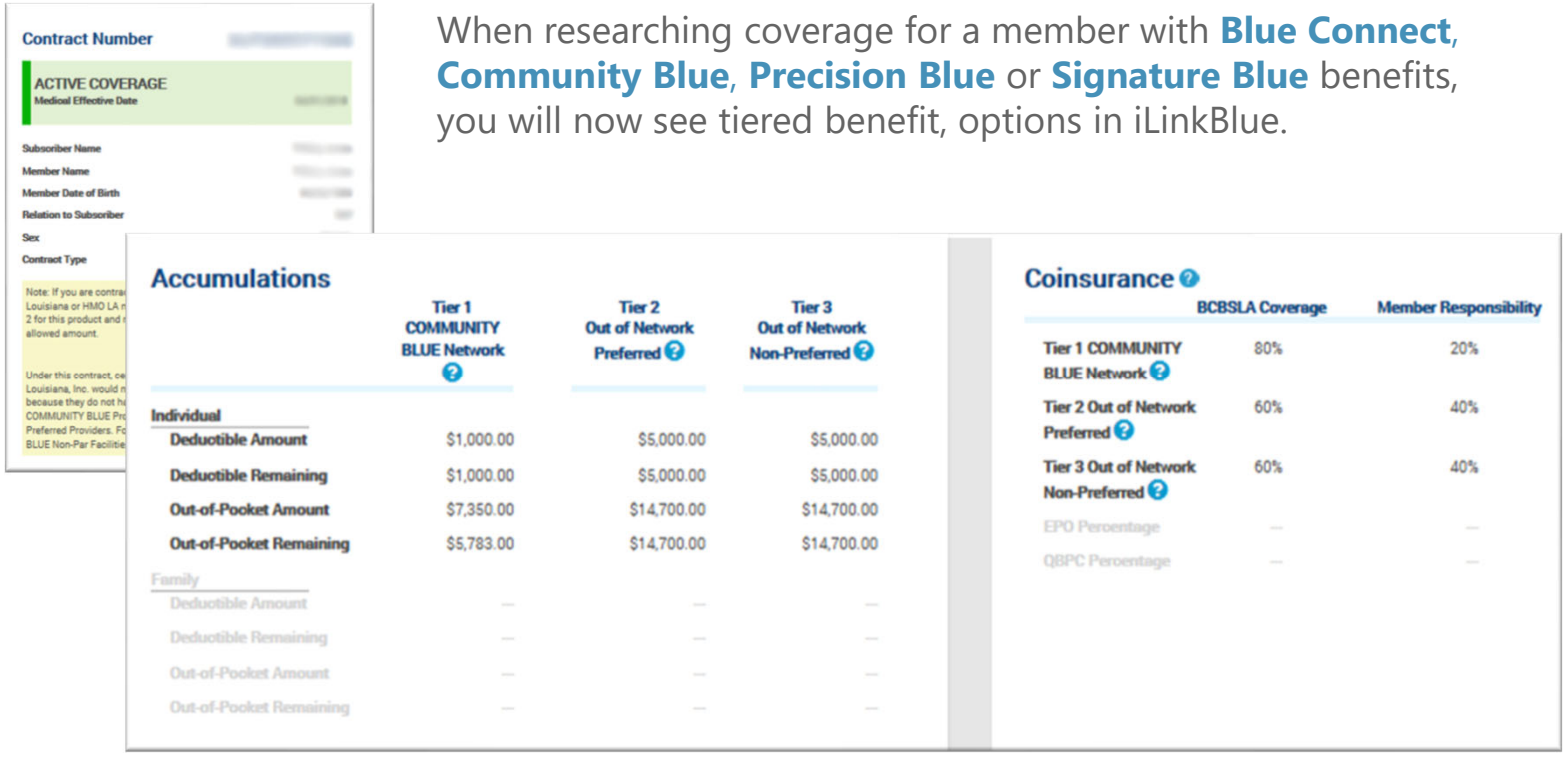
	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	---
Deductible Remaining	$0.00	$1,750.00	---
Out-of-Pocket Amount	$3,000.00	$6,000.00	---
Out-of-Pocket Remaining	$3,000.00	$6,000.00	---

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.

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

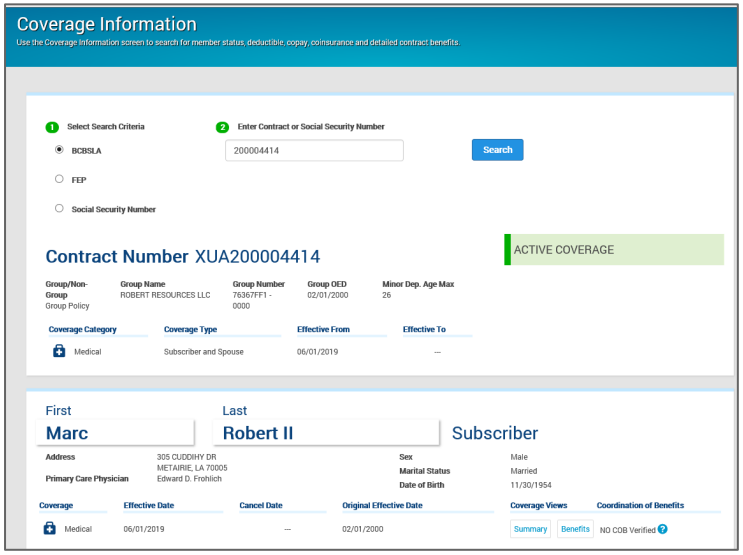
Applies to providers who do not participate in any Blue Cross network.

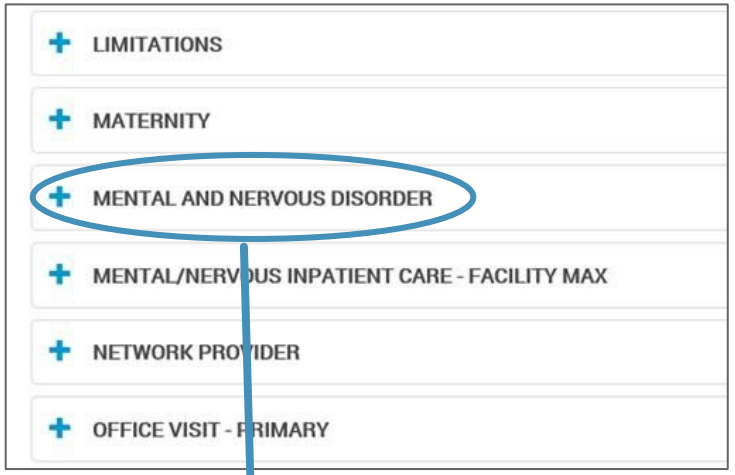
Example Scenario:

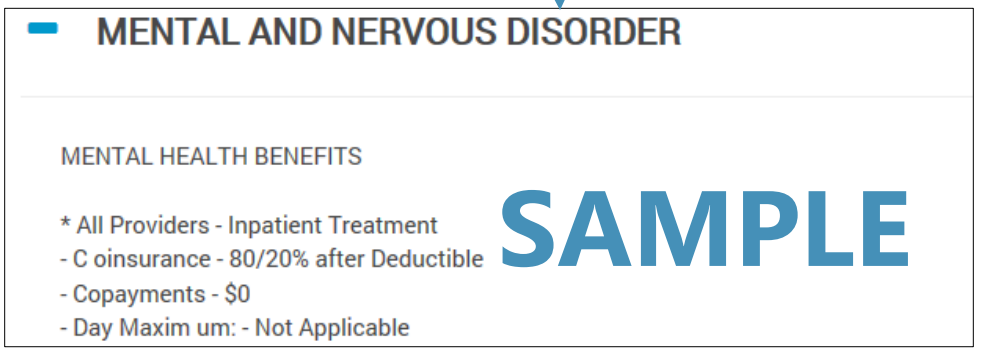
- A Community Blue member sees a non-participating provider.
- The member copay and accumulators identified under Tier 3 should be applied.
- Provider can bill the member for all amounts over the allowed amount.

iLinkBlue – Mental Health Benefits Language

1.





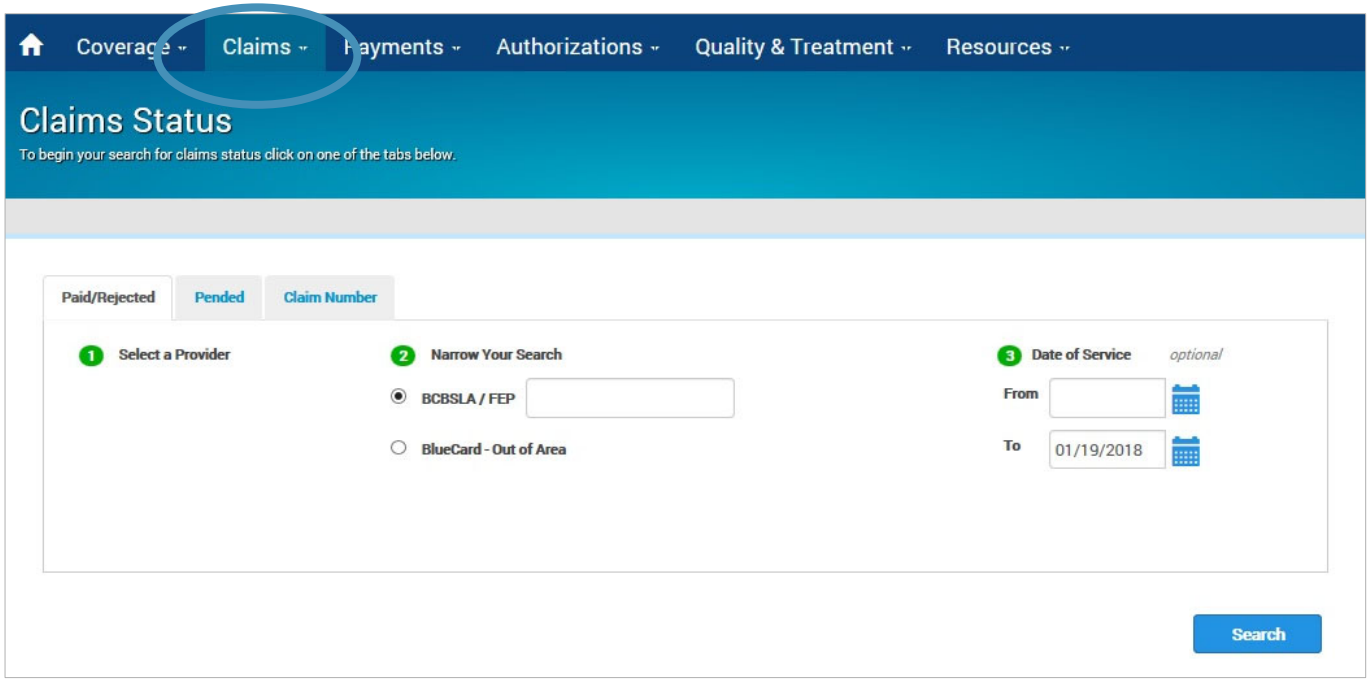


FILING CLAIMS IN ILINKBLUE

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

A detailed manual on how to submit claims through iLinkBlue is under the "Resources" section of iLinkBlue. The *Blue Cross Professional 1500 Manual* is under the "Manuals" tab.

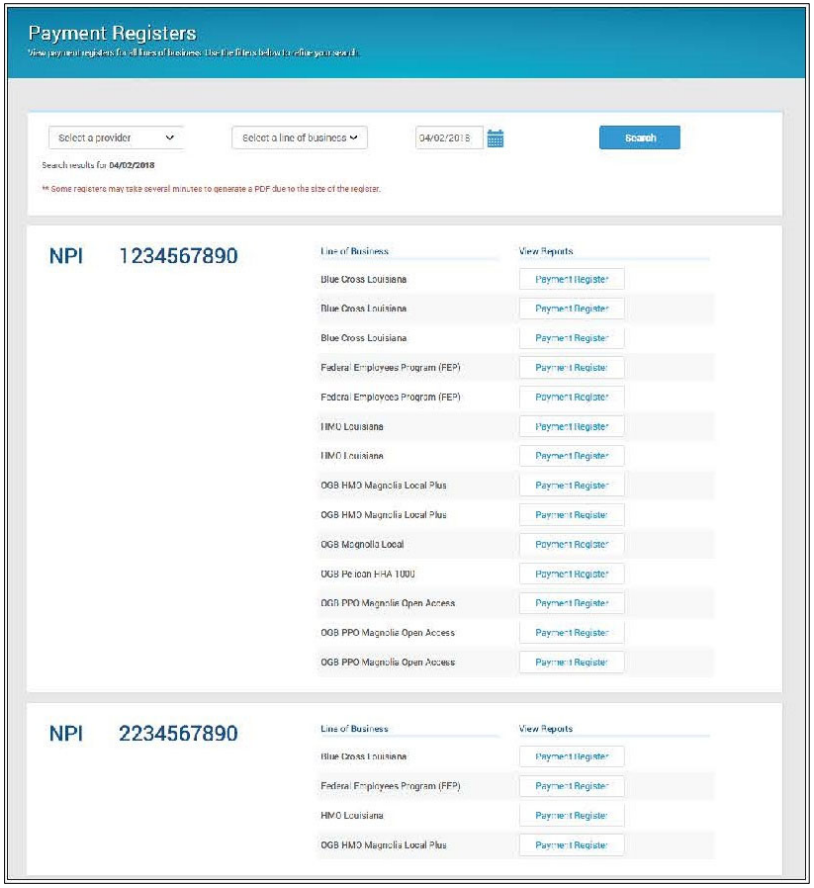
iLinkBlue – Claims Research



- Use the "Claims" menu option to research paid, rejected and pended claims.
- You can research BCBSLA, FEP and BlueCard-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

Autism Resource Program

COVID-19 TELEHEALTH UPDATES

Codes

97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158

When

Indefinitely

Who

INN providers and in-state members

AUTISM RESOURCE PROGRAM

Credentials

- 3 Care Managers – BCBAs and/or LBA
- 1 Team Lead – LBA

Role

- Review treatment requests
- Educate on medical policy
- Assist families (referrals, etc.)

Autism Resource Program (cont'd)

Provider contact

- Treatment requests
- Diagnostic information

Parent contact

- Diagnostic information
- Additional resources

Coordinated Calls

- Collaborative call with parent and provider
- Discussions include coordinating care, reviewing letters/correspondence sent out during or after a review.

WEBPASS

Online portal to submit treatment requests

Types of Forms

- Initial Assessment
- Initial Treatment
- Continuation of Care
- Discharge Form
- Amended Requests:
  - BCBA name changes
  - Amending CPT hours

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.

Diagnostic Review

Purpose

A comprehensive medical records establishing a medical diagnosis of Autism provides baseline information regarding the member's current severity level.

Comprehensive Evaluation

- ASD Specific
- Cognitive and Developmental
- Adaptive Assessment
- Neurological Information

Some records are missing, what do we do?

- Extension for request
- Approval of short authorization while records are obtained

TREATMENT REVIEW

15-day review period

Post-Service Reviews

- Requests submitted more than 30 days after requested start dates
- Medical Records
- Automatic extension

Ending Services

- Please provide notification: last date of services, transition or additional services recommended, etc.

BCBA Name Changes

- Extended vacations, Maternity/Medical Leave of Absence, Caseload reassignment.

WRITTEN CORRESPONDENCE

Emails

- Not secure
- Limit the use of PHI

Fax for information

- Can occur during a review
- After authorization approval

WRITTEN CORRESPONDENCE (CONT'D)

Extension letter

- Extends review time.
- Additional 45 days + final 15 days to determine medical necessity.
- Mailed to provider and family.
- Can be faxed by CM upon request.
- Entering final 15 days (what to expect).

Provider letter

- Details concerns with request and expectation for specific information to be included during next review.
- Mailed to provider and family.
- Follow-up call with family and provider to explain letter (coordinated or individual calls).

TYPES OF DENIALS

Administrative Denial

- Denial given due to a benefit structure limitation.
- Examples: Benefit exhausts at age 17 and member is 18 yo; ABA may be an exclusion; Place of Service setting may be excluded.
- Notification given to family and provider; family offered Behavioral Health Case Management.

Peer Review

- Denial due to medical necessity not being met.
- Clinical information is presented for a Medical Director to review and provide final outcome.
- Examples: lack of progress; goals duplicating other services.
- Partial Denial: portion of request is being approved.
- Taper to Denial: gradual reduction in hours over the course of several weeks are approved with a final cap to full denial of hours.
- Notification to family and provider with denial letter noting appeal rights; family offered Behavioral Health Case Management.

CPT CODES

Assessment and Re-Assessment Codes

97151

- Conducted by BCBA, face-to-face with member.
- Review of current and past behavioral functioning, previous assessments and health records.
- Interview with parents/caregivers for history.
- Administer and interpret the results of standardized and non-standardized assessments.
- Report preparation.
- Review findings and recommendations with parents.
- Develop treatment plan.

CPT CODES

97152

- Conducted by Registered Behavior Technician (RBT), Board Certified Assistant Behavior Analyst (BCaBA), face-to-face with member.
- Data collection for functional behavior assessments, functional analysis or other structured procedures.
    - Evaluate deficient adaptive behaviors, maladaptive behaviors or other impaired functioning related to:
        - Communication
        - Social behavior
        - Ritualistic and repetitive behaviors, self injurious or other aberrant behaviors
- Line therapist may complete under direction of BCBA, qualified professional off-site.
- Requires clinical rationale for need.

CPT CODES

97153

- Face-to-face with member, administered by registered line technician (RLT), BCaBA.
- BCBA-designs treatment goals/objectives, analyzes data and determines progress.

97154

- Face-to-face with two or more members, administered by RLT, BCaBA.
- Board Certified Behavioral Analyst (BCBA) - designs treatment goals/objectives, analyzes data, observes treatment implementation for program revision, and determines progress.
- Maximum group members is eight.

CPT CODES

97155

- Administered by BCBA or qualified health care professional.
- Face-to-face with a single member or member and line technician.
- Resolves one or more problems with the protocol and may simultaneously direct a line technician in administering the modified protocol while member is present.

Adaptive treatment protocol modification may include:

- Design, analysis and edits to antecedent or consequence strategies.
- Individualized behavior plan based on functions maintaining aberrant behavior.
- Inclusion of additional acquisition/replacement skills to current treatment plan.
- Analysis and editing of prompt fading, chaining, differential reinforcement or generalization procedures, which require the expertise of the BCBA.

CPT CODES

97155

- The code valuations of 97153 and 97154 include activities occurring before or after the session (definitions of treatment targets, written protocols, reviewing data, completing session notes summarizing behavioral definitions or protocols that may need to be scrutinized by Qualified Healthcare Provider (QHP).
- The code valuations of 97153 and 97154 include direction of the line technician by the QHP by analyzing data, observation of treatment implementation for potential program revision and determining whether use of treatment goals and objectives is producing adequate progress. This includes direction of the line technician with established protocols and retraining from the RLT task list.
- Direction of the line technician without the member is considered a bundled service and is part of the valuation of the ABA face to face CPT codes.
- Clinical rationale must be provided for requests that exceed two hours of adaptive behavior treatment protocol modification per 10 hours of adaptive behavior treatment by protocol.
- Concurrent Billing with 97153.

CONCURRENT BILLING

97153 & 97154 with 97155

- Concurrent billing is allowed for adaptive behavior treatment with protocol modification (97155) and adaptive behavior treatment by protocol, administered by technician (97153), simultaneously.
- Concurrent billing is allowed for adaptive behavior treatment with protocol modification (97155) and group adaptive treatment (97154) simultaneously.
- Documentation of the services should reflect that they were administered at the same time.

CPT CODES

97156

- Administered by BCBA.
- Face-to-face with parents/caregivers with/without the member present.
- Used to implement treatment protocols to address deficient adaptive or maladaptive behaviors.

97157

- Administered by BCBA.
- Face-to-face with parents/caregivers without the member present.
- Used to implement treatment protocols to address deficient adaptive or maladaptive behaviors.
- Maximum of eight group members.

CPT CODES

97158

- Administered by BCBA.
- Face-to-face with two or more members.
- Member must have direct participation in treatment protocol/interactions to meet their own treatment goals.
- Protocol adjustments are made in real time dynamically during the session.
- Maximum of eight members per group.

This code entails differentiating prompting methods, instruction, antecedent/consequence strategies, varying goals/skills and reinforcement schedules in real time with multiple members simultaneously

CPT CODES

Exposure codes

0362T

- On-site direction by BCBA, qualified healthcare professional.
- With the assistance of two or more line therapists/assistants to assist in treatment protocol with supervision of BCBA, qualified healthcare professional.
- For member who exhibits destructive behavior (e.g., elopement, pica or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/windows).
- Requires safe, structured customized environment with possible use of protective gear and padded room.
- Requires clinical rationale for need based on frequency, severity and intensity of the destructive behaviors.

BCBA/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors

CPT CODES

Exposure codes

0373T

- On-site direction by BCBA, qualified healthcare professional.
- With the assistance of two or more line therapists/assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional.
- For member who exhibits destructive behavior (e.g., elopement, pica or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/windows).
- Requires safe, structured customized environment with possible use of protective gear and padded room.
- Requires clinical rationale for need based on frequency, severity and intensity of the destructive behaviors.

Staged environment to teach members appropriate alternative response to severe destructive behaviors. Typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior.

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.

SUPPORT RESOURCES

Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary manager

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn, Jefferson Davis, St. Landry, Vermilion

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

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana, Livingston, Pointe Coupee, St. Martin

Melonie Martin
East Baton Rouge, Ascension, West 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. Acadia

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

Jennifer Aucoin **Angela Jackson** **Paden Mouton** **Brittany Thompson**

Provider Contracting

Shelton Evans director – **shelton.evans@bcbsla.com**

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

Danielle Jackson manager – **danielle.jackson@bcbsla.com**

Ashley Wilson – **ashley.wilson@bcbsla.com**
Northshore

Cora LeBlanc – **cora.leblanc@bcbsla.com**
Houma, Thibodeaux

Dayna Roy – **dayna.roy@bcbsla.com**
Alexandria, Lake Charles

Jason Heck – **jason.heck@bcbsla.com**
Shreveport

Jill Taylor – **jill.taylor@bcbsla.com**
New Orleans

Mica Toups – **mica.toups@bcbsla.com**
Lafayette

Sue Condon – **sue.condon@bcbsla.com**
Baton Rouge

Shannon Taylor – **shannon.taylor@bcbsla.com**
Monroe

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

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

Call Centers

Customer Care Center	**1-800-922-8866**
FEP Dedicated Unit	**1-800-272-3029**
OGB Dedicated Unit	**1-800-392-4089**
Blue Advantage	**1-866-508-7145**

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

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, options 2 and 3.

New Directions Contact Information

For assistance, please contact:

Michelle Kim

Autism Resource Program, Manager

Email: mkim@ndbh.com

Phone: 1-816-416-7672

Katherine Wooten

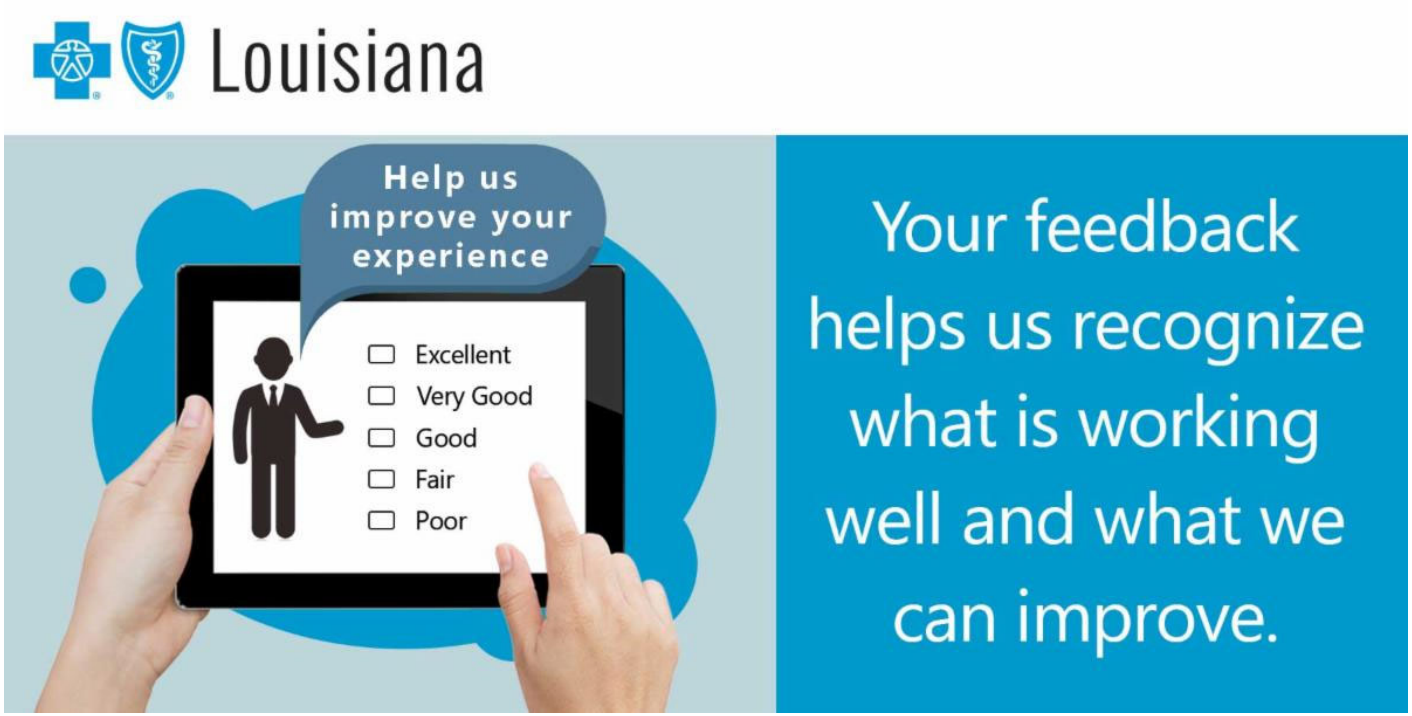
Clinical Director – Corporate Programs

Email: kwooten@ndbh.com

Phone: 1-816-994-1424

Your opinion is important to us. Will you please help us out by completing the New Directions Survey and let us know how we are doing?

http://survey.constantcontact.com/survey/a07ehtsflzxknaf3vgt/start



We are listening!

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

If you have not 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

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.

INCOMPLETE CREDENTIALING APPLICATIONS

- 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.

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.

MEDICAL APPEALS

Claim denied as investigational or not medically necessary

STANDARD

COMPLETED WITHIN 30 DAYS OF RECEIPT

- Complete ALL information on the appeals form (including contact information in case additional records are needed). Incomplete information may delay the review.
- Clearly identify service being appealed (ex: drug name, specific procedure, DME item, etc.)
- Include supporting rationale AND supporting clinical records
- Please read the "What can you do if you still disagree with our decision?" section of the initial denial letter and appeal denial letter for the appropriate appeal timeframes and instructions for the member's policy
- We require network providers to disclose ineligible services to members prior to performing or ordering services. Our medical policies are available on iLinkBlue (www.BCBSLA.com/ilinkblue).
- Benefit determinations are made based on the medical policy in effect at the time of service

Send claims to:

Behavioral Health Medical Necessity Appeal (send first-level appeals directly to New Directions)
New Directions Behavioral Health
Attn: Appeals Coordinator
P.O. Box 6729
Leawood, KS 66206
Fax 1-816-237-2382

MEDICAL APPEALS

Claim denied as investigational or not medically necessary

APPEAL

COMPLETED WITHIN 72 HOURS OF RECEIPT

- Could seriously jeopardize the life or health of your patient or their ability to regain maximum function, **OR**
- Would, in the opinion of the treating physician with the knowledge of the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
- If submitting with the appeal form included in the initial denial letter, the physician must clearly mark the form as "**Expedited"** (urgent) and sign the attestation that requested service meets the above expedited criteria.
- Fax the appeal request along with supporting documentation to the number listed on the "A Guide For Disputing Claims" tidbit, available at www.BCBSLA.com/providers.

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 Blue Cross or a provider's services. Typically, grievances do not involve denied claims.

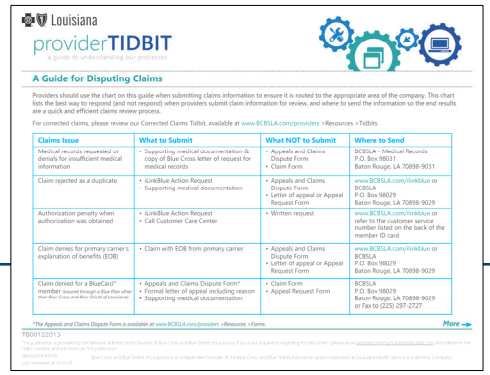
The top reasons for administrative appeals are:

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

- 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

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


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

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

Benefits of Proper Documentation

Allows identification of high-risk patients.

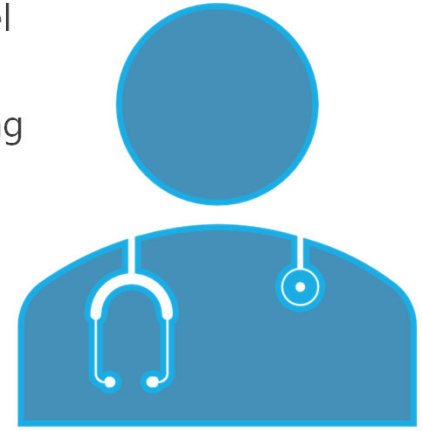
Allows opportunities to engage patients in care management programs and care prevention initiatives.

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.

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

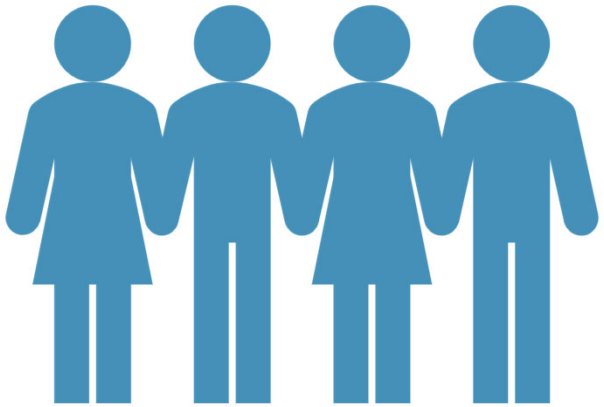
Examples:

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

OUT OF NETWORK REFERRALS

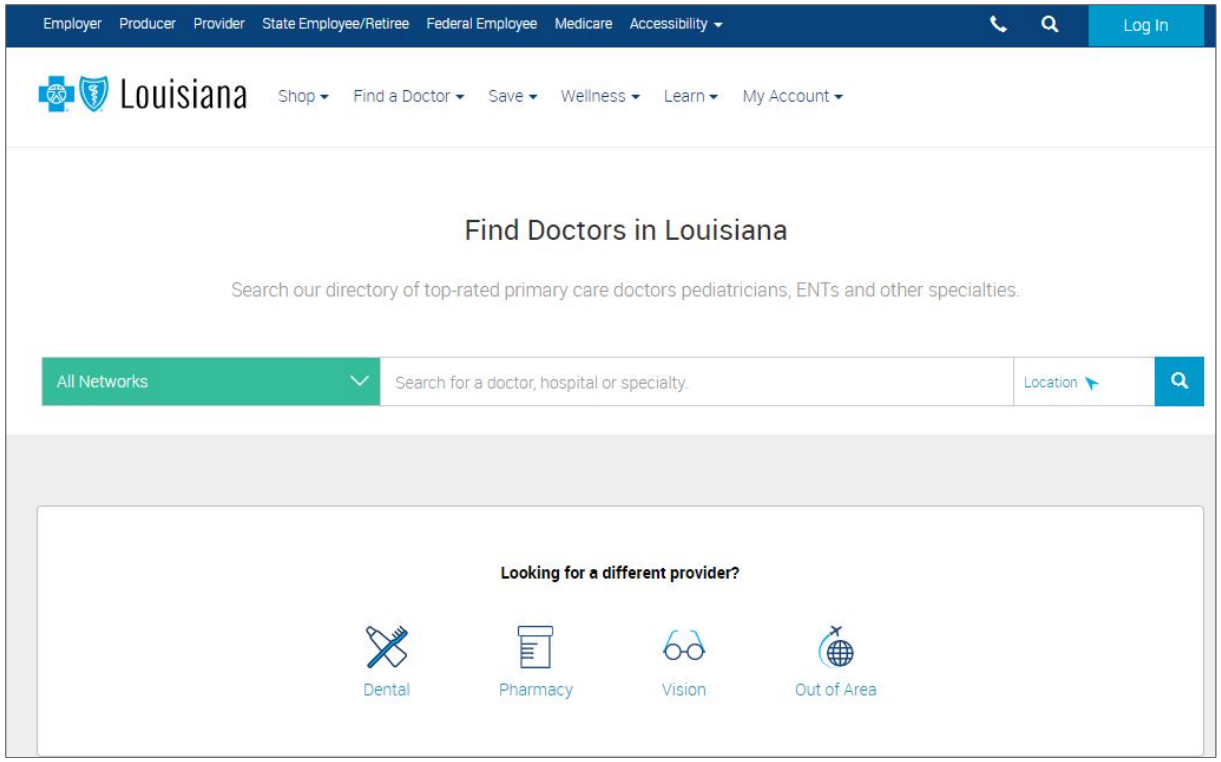
The impact on your patients when you refer Blue Cross members to out-of-network providers:

- 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

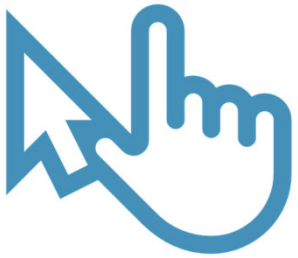
What they will do for you:

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

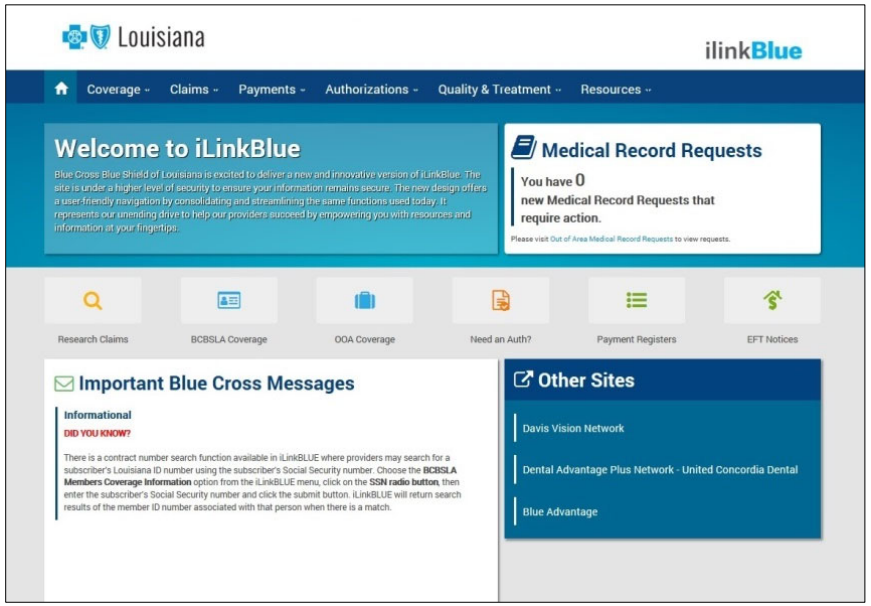
INACTIVITY POLICY

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 VANTAGE 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.

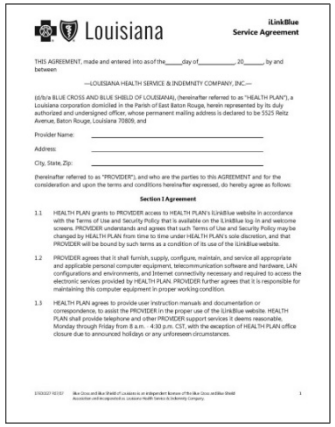
iLinkBlue Application Packet

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:

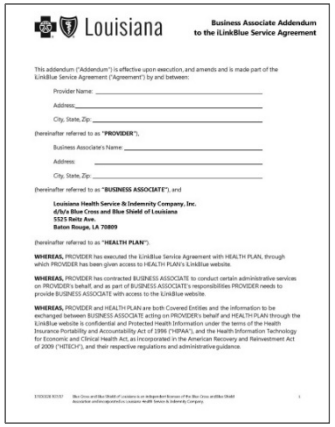
- iLinkBlue Service Agreement
- Business Associate Addendum to the iLinkBlue Service Agreement
- Administrative Representative Registration Form
- Electronic Funds Transfer (EFT) Enrollment Form

These four documents are required to access iLinkBlue:


Louisiana

iLinkBlue Service Agreement

iLinkBlue Service Agreement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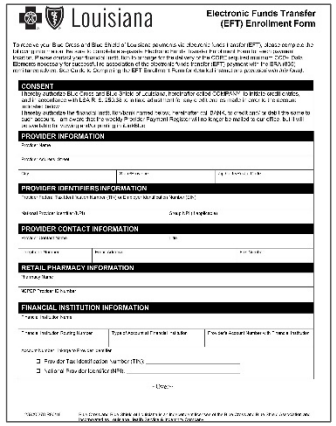
Business Associate Addendum to the iLinkBlue Service Agreement

Business Associate Addendum


Louisiana

Electronic Funds Transfer (EFT) Enrollment Form

CONSENT

PROVIDER INFORMATION

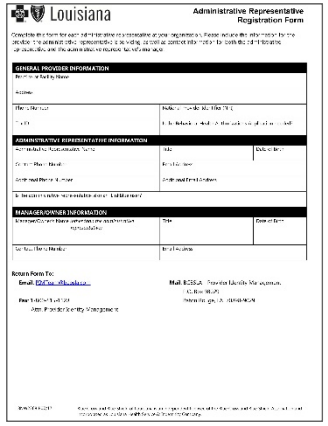
PROVIDER IDENTIFIERS INFORMATION

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