Behavioral Health Webinar for Facility 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 FACILITY PROVIDERS

2021

Louisiana

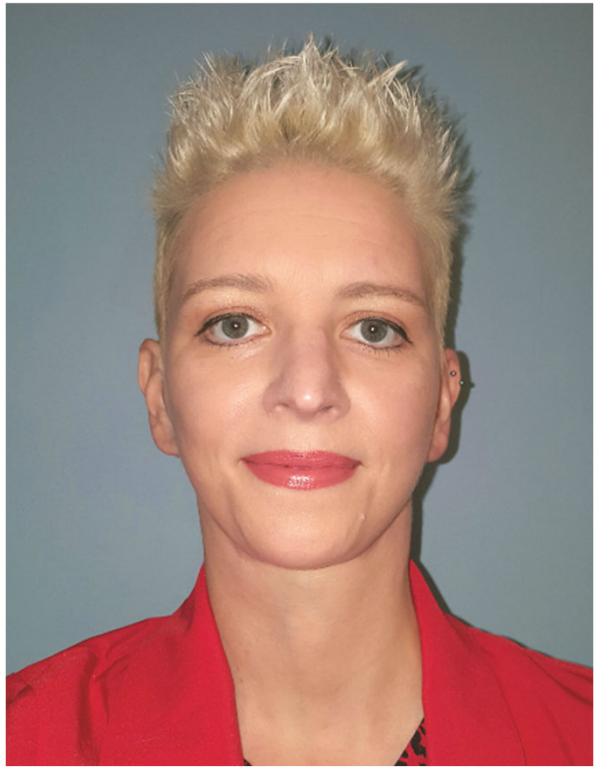
PROVIDER RELATIONS DEPARTMENT

PROVIDER.RELATIONS@BCBSLA.COM

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 RELATIONS TEAM

Jami Zachary

Anna Granen

Patricia O' Gwynn

Mary Guy

Lisa Roth

Marie Davis

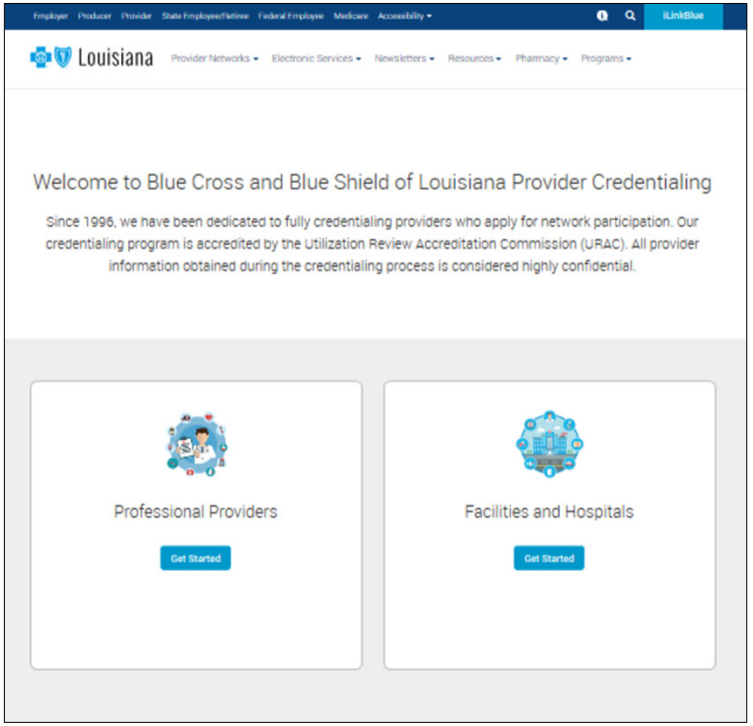
Melonie Martin

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.

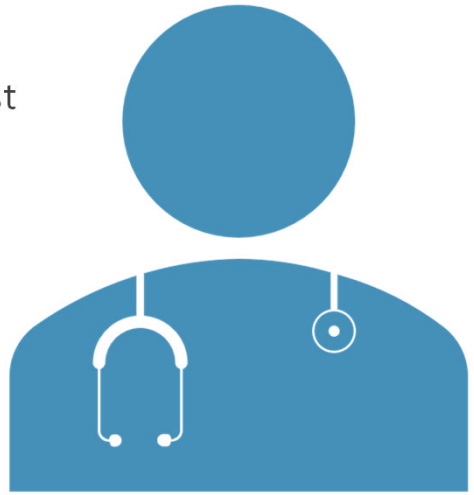
- Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:
  - Credentialing packets
  - Quick links to the Provider Update Request Form
  - Credentialing criteria for professional, facility and hospital-based providers
  - Frequently asked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



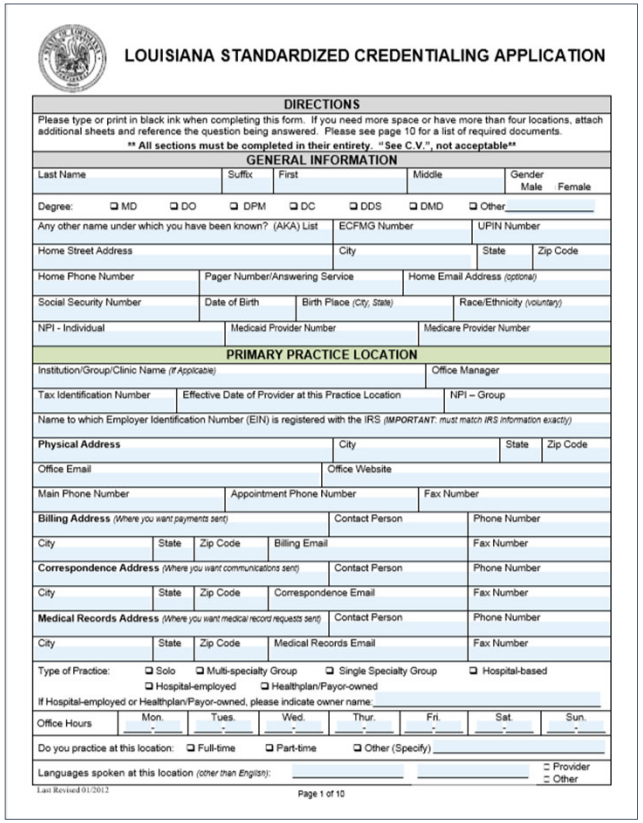
After 90 days, you may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **pcdmstatus@bcbsla.com**.

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**.

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

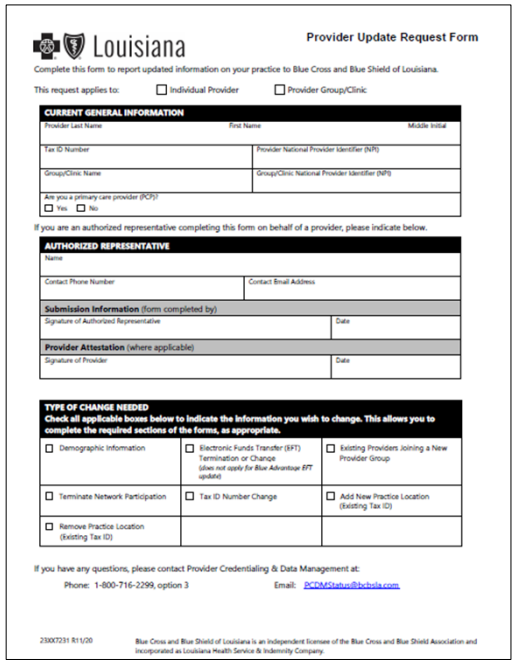
Page 1 of 10

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

2330X7231 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.

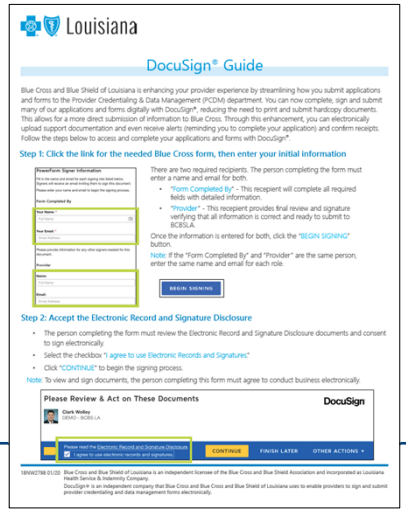
Digitally Submitting Applications & Forms to Blue Cross with DocuSign®

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)

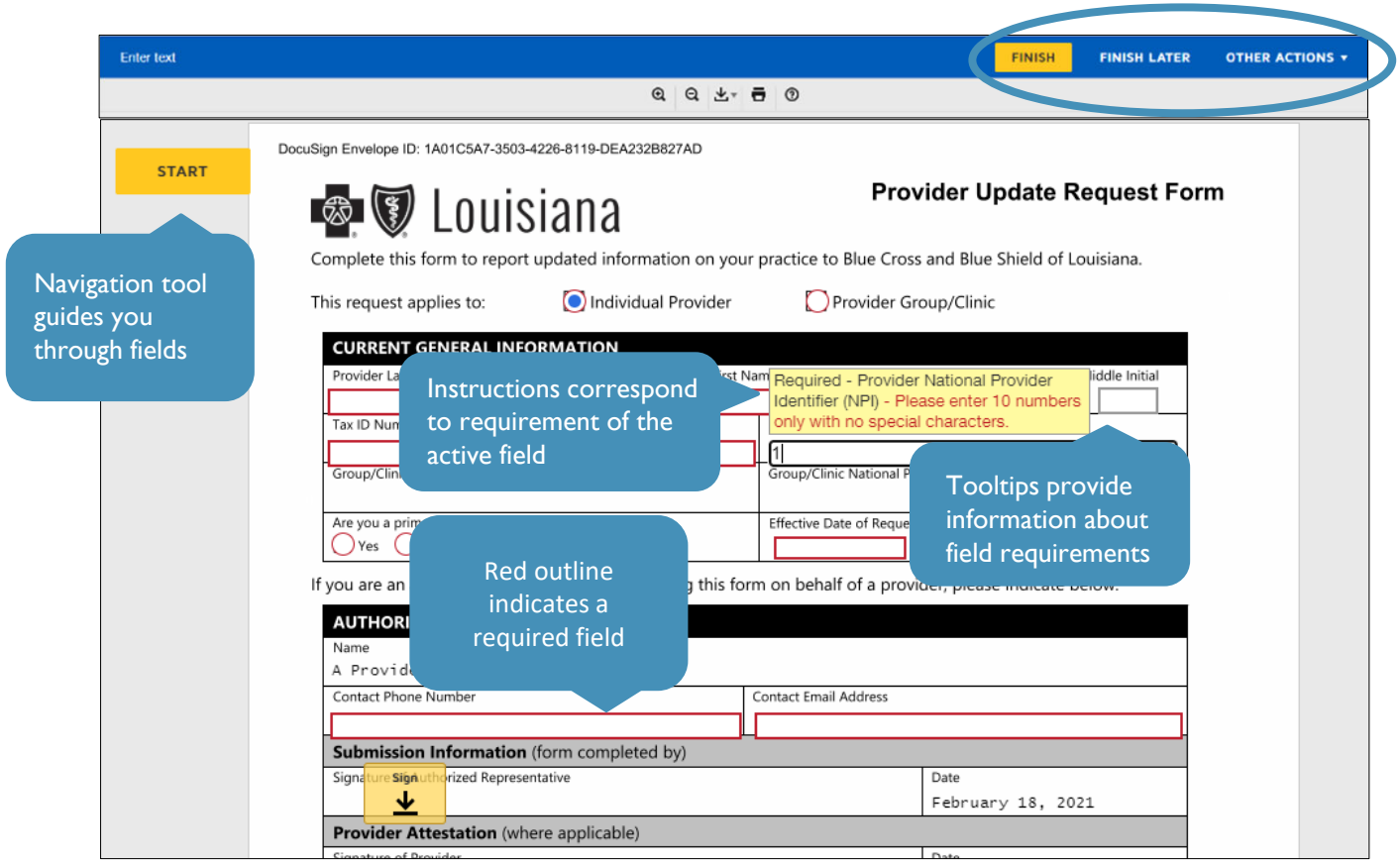
Forms:

- **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.

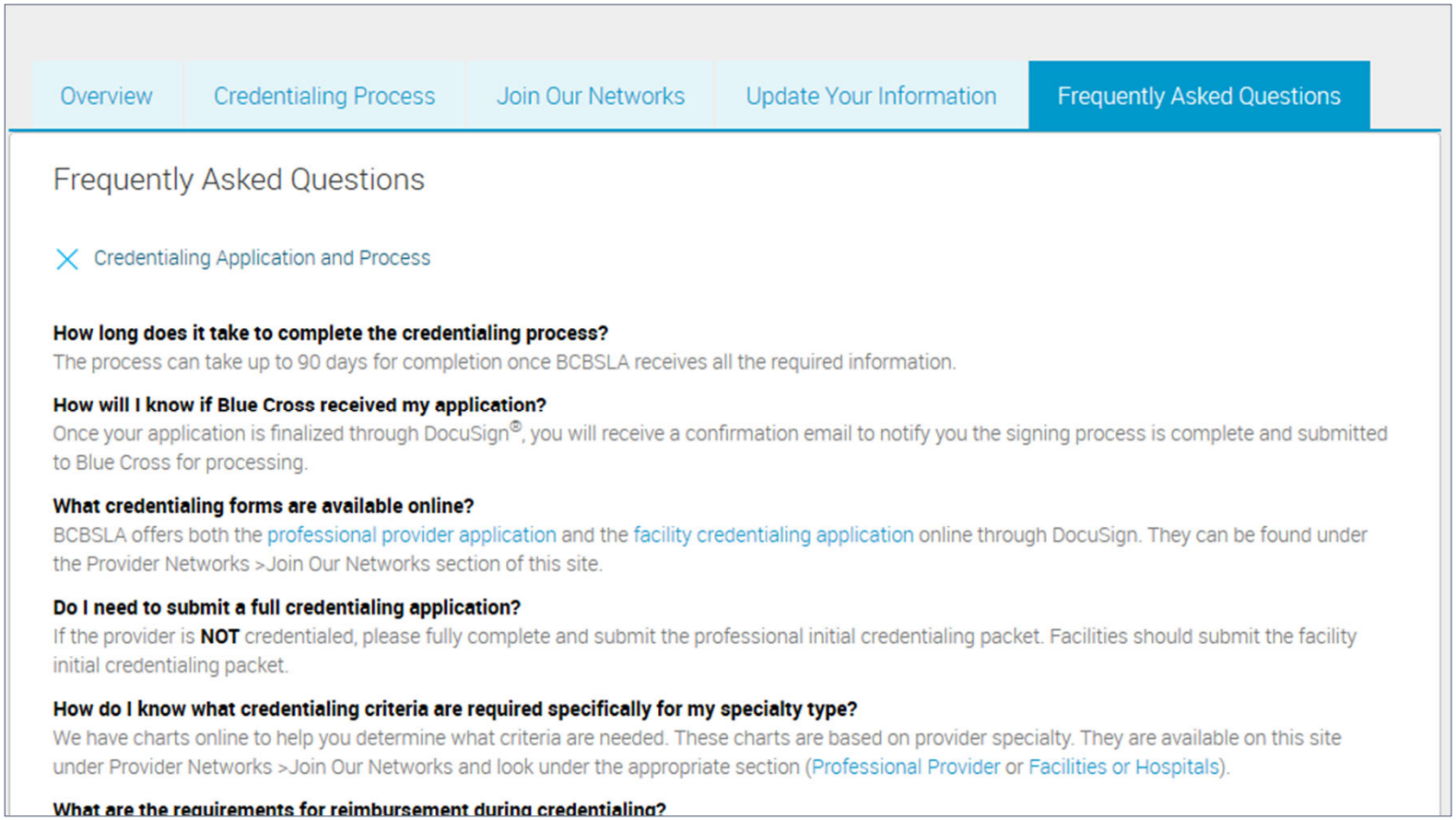
www.BCBSLA.com/providers >Provider Networks >Join Our Networks >Professional Providers

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.

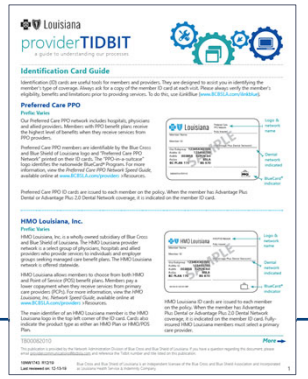
OUR NETWORKS

Our Provider Networks

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

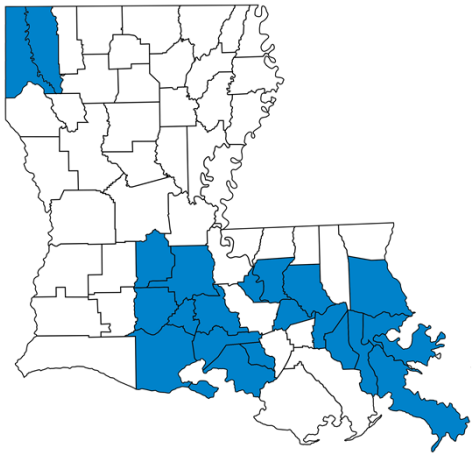
Louisiana

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

Lafayette area

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

Shreveport area

Bossier and Caddo parishes

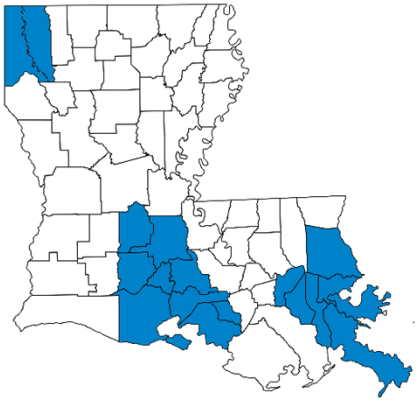
COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks

NEW NETWORK 2021



BlueHPN

Lafayette area

Acadia, Evangeline, Iberia, Jefferson and Lafayette parishes

Shreveport area

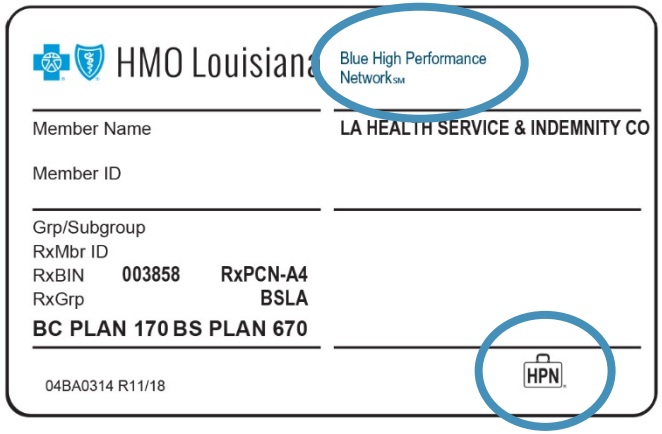
Bossier and Caddo parishes

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

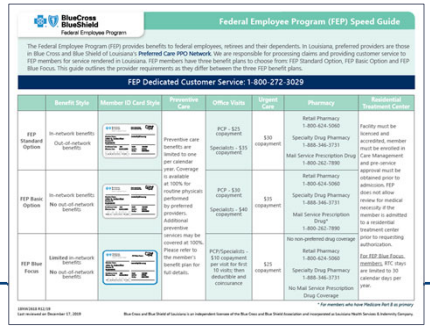
BASIC OPTION

- ✓ 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.

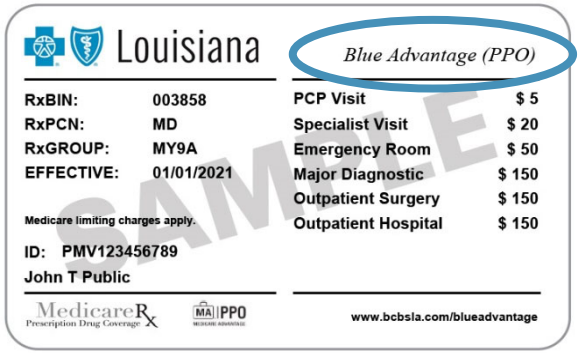


An FEP Speed Guide is available at **www.BCBSLA.com/providers** >Resources >Speed Guides.

Our Blue Advantage Networks

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

NEW PREFIXES FOR 2021

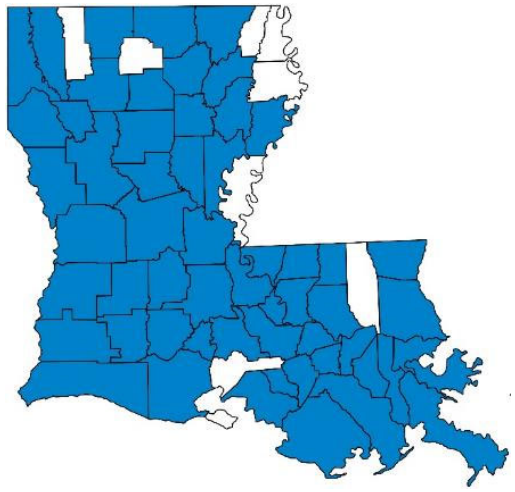


Prefix: PMV

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.

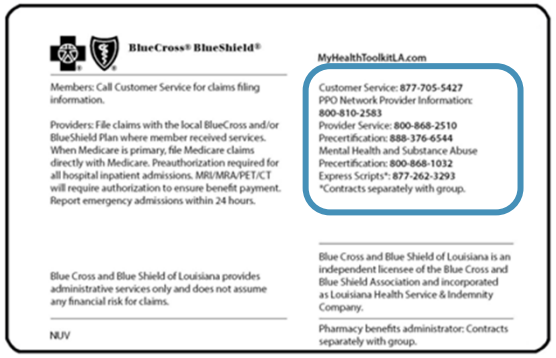
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

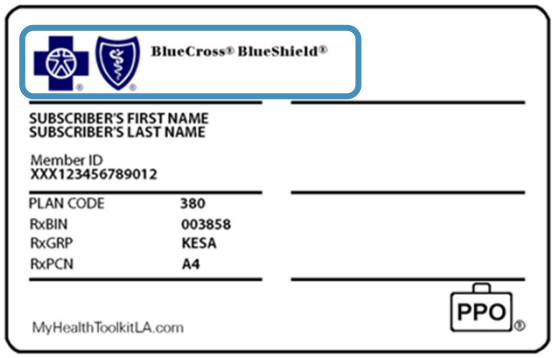
The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

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.





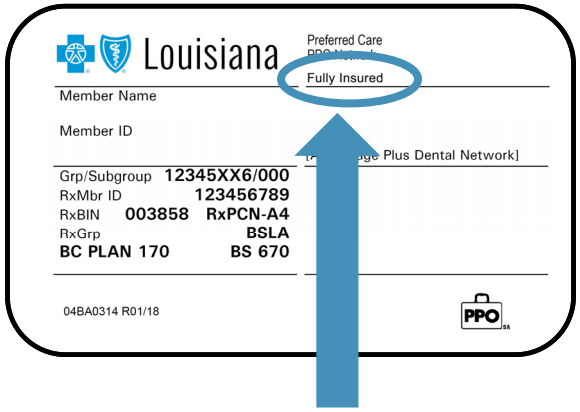
This list of prefixes is available on iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Resources" section.

Fully Insured vs. Self-insured

Member ID Card Differences

FULLY INSURED

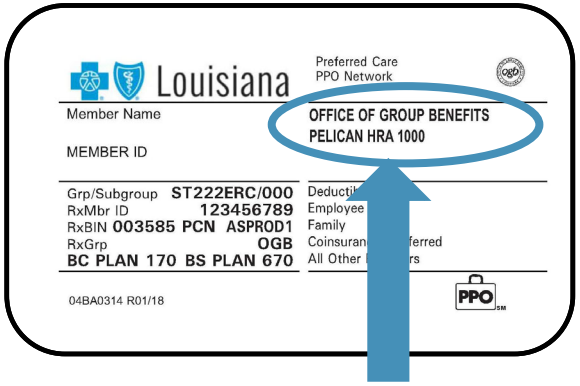
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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

Telehealth Policy

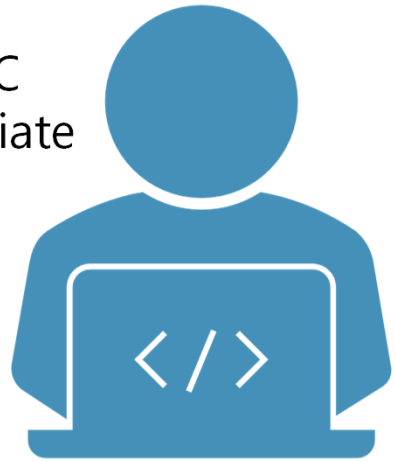
- BCBSLA outlines existing and expanded allowed direct-to-consumer telehealth encounters.
- Providers must follow the telehealth billing guidelines in the provider manual, fully document the telehealth encounter in the patient's medical record adhering to the criteria listed in the expanded telehealth guidelines and agree to Blue Cross' allowable charges.
- Coverage is subject to the terms, conditions and limitations of each individual member contract and policy.
- Telehealth Guidelines can be found on the COVID-19 Provider Resource page (**www.BCBSLA.com/providers**, then click the link at the top of the page) for expanded COVID-19 provisions, as they will not display in iLinkBlue.

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.

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

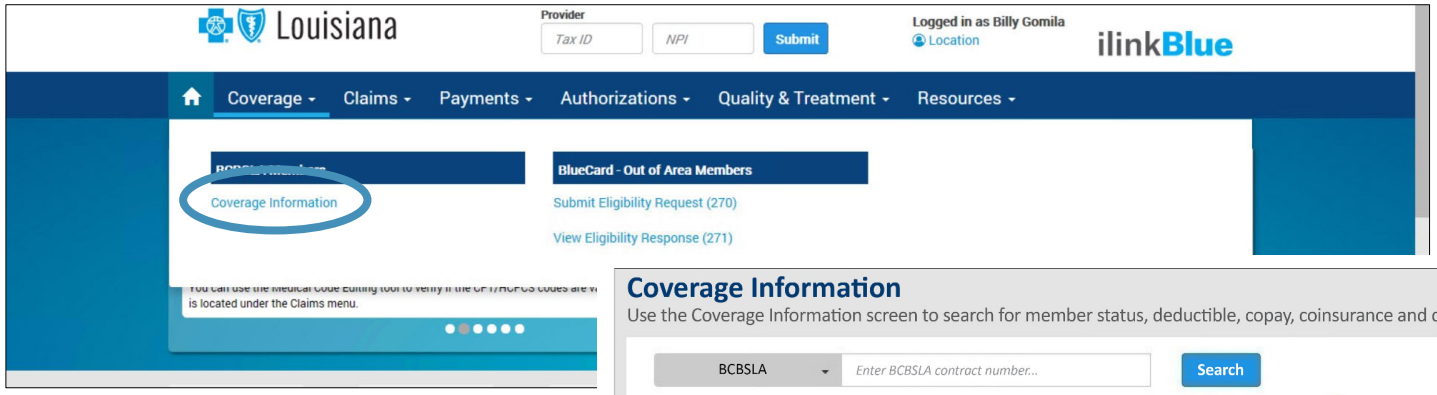
- Billing guidelines for telehealth IOP services:
  - Blue Cross will allow reimbursement for up to three hours per day; three days per week; for a maximum of nine hours per week.
  - Providers filing outpatient hospital claims for IOP telehealth services should bill with the appropriate CPT®/HCPCS code, 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.

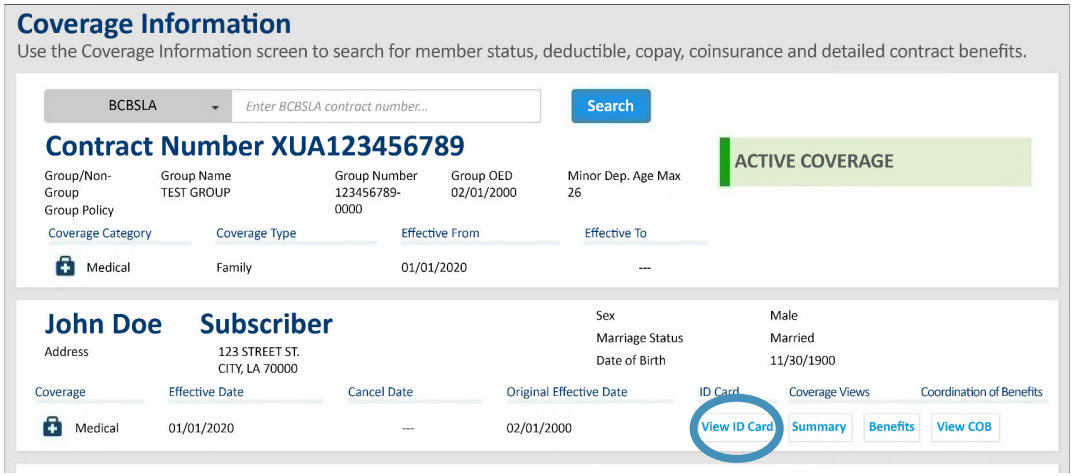
- PHP Services
  - Blue Cross will not reimburse partial hospitalization program (PHP) telehealth encounters (revenue codes 0912 and 0913) due to the complexity of services. PHP services are typically six hours in length and must essentially be the same nature and intensity (including medical and nursing) 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

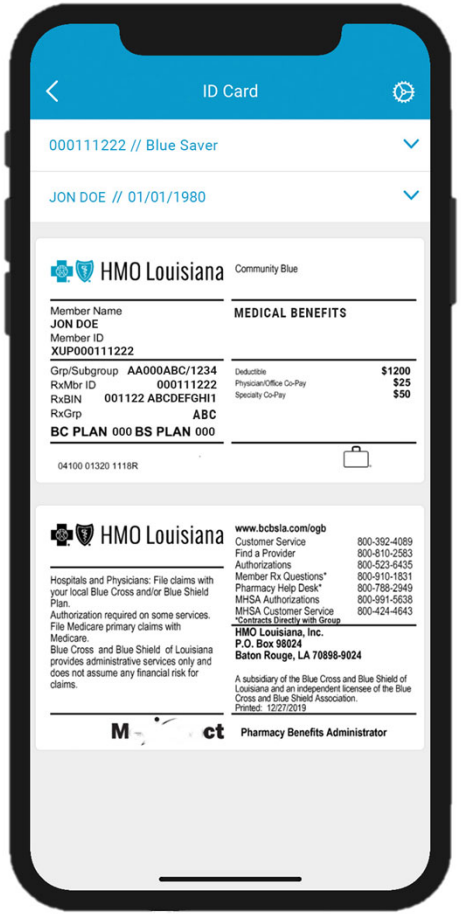
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.BCBSLA.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”





Digital ID Cards

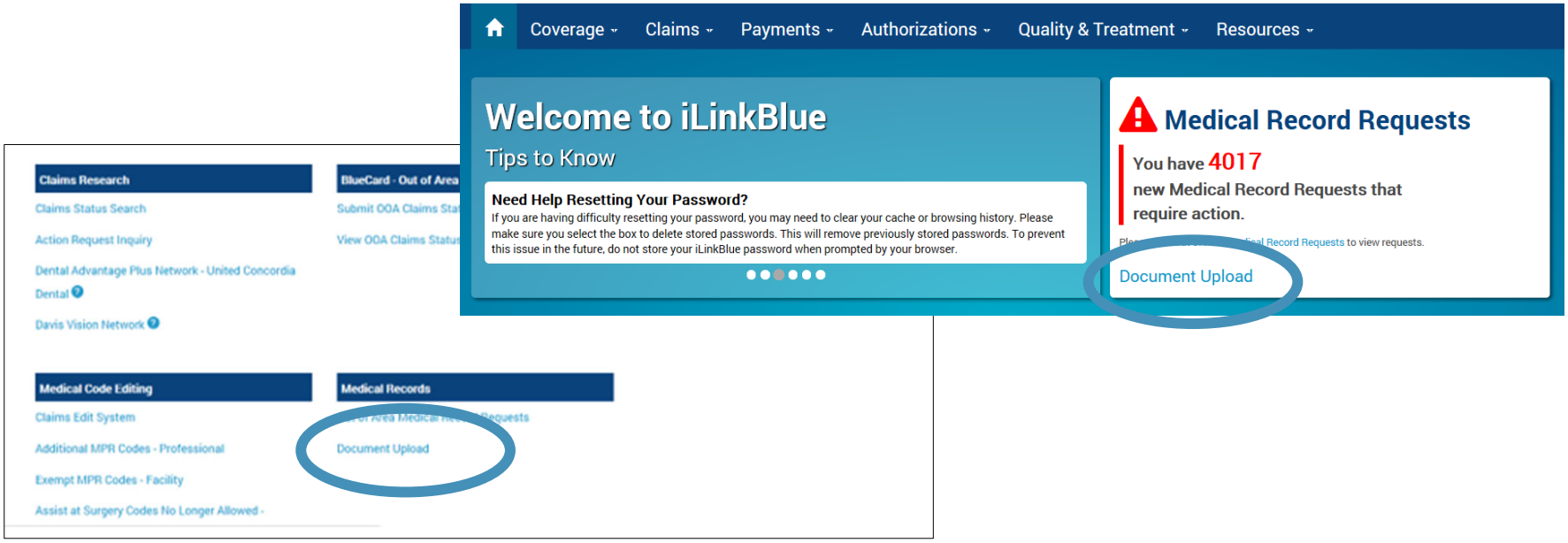
- Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal:
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.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

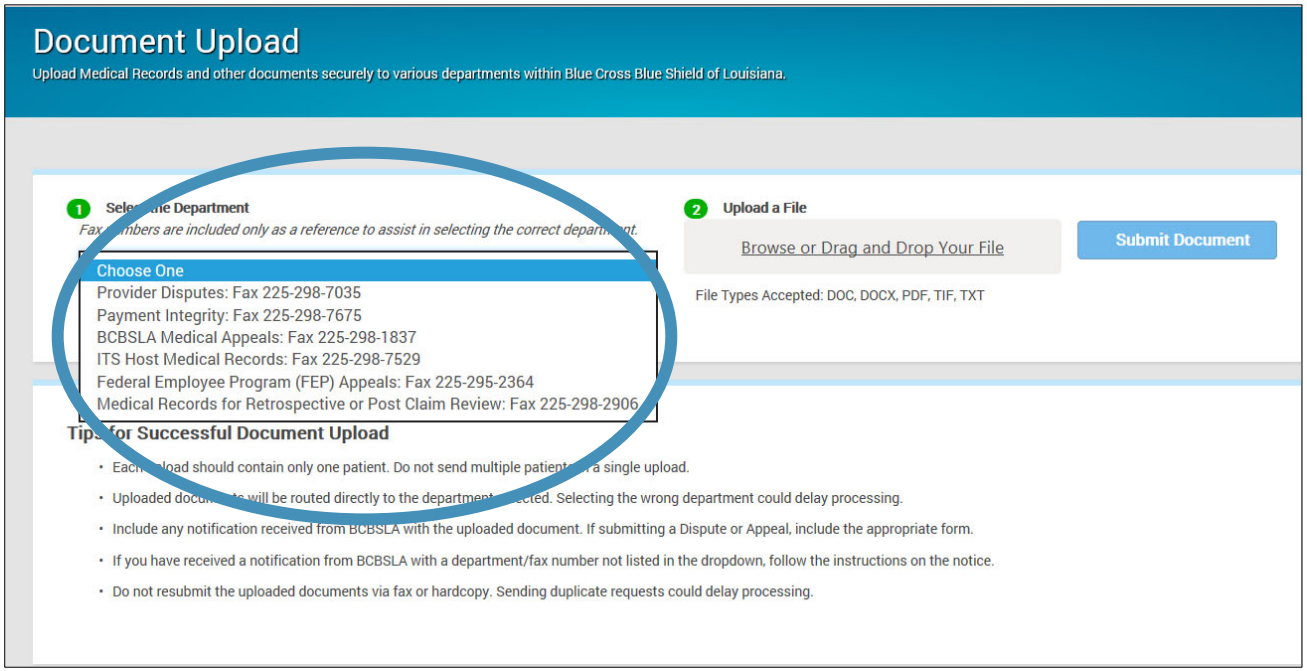
The new feature is quick, secure and available at any time through the iLinkBlue provider portal.



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?

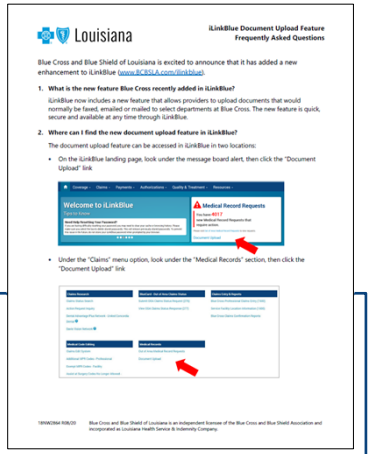
- DOC, DOCX, PDF, TIF, TXT

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

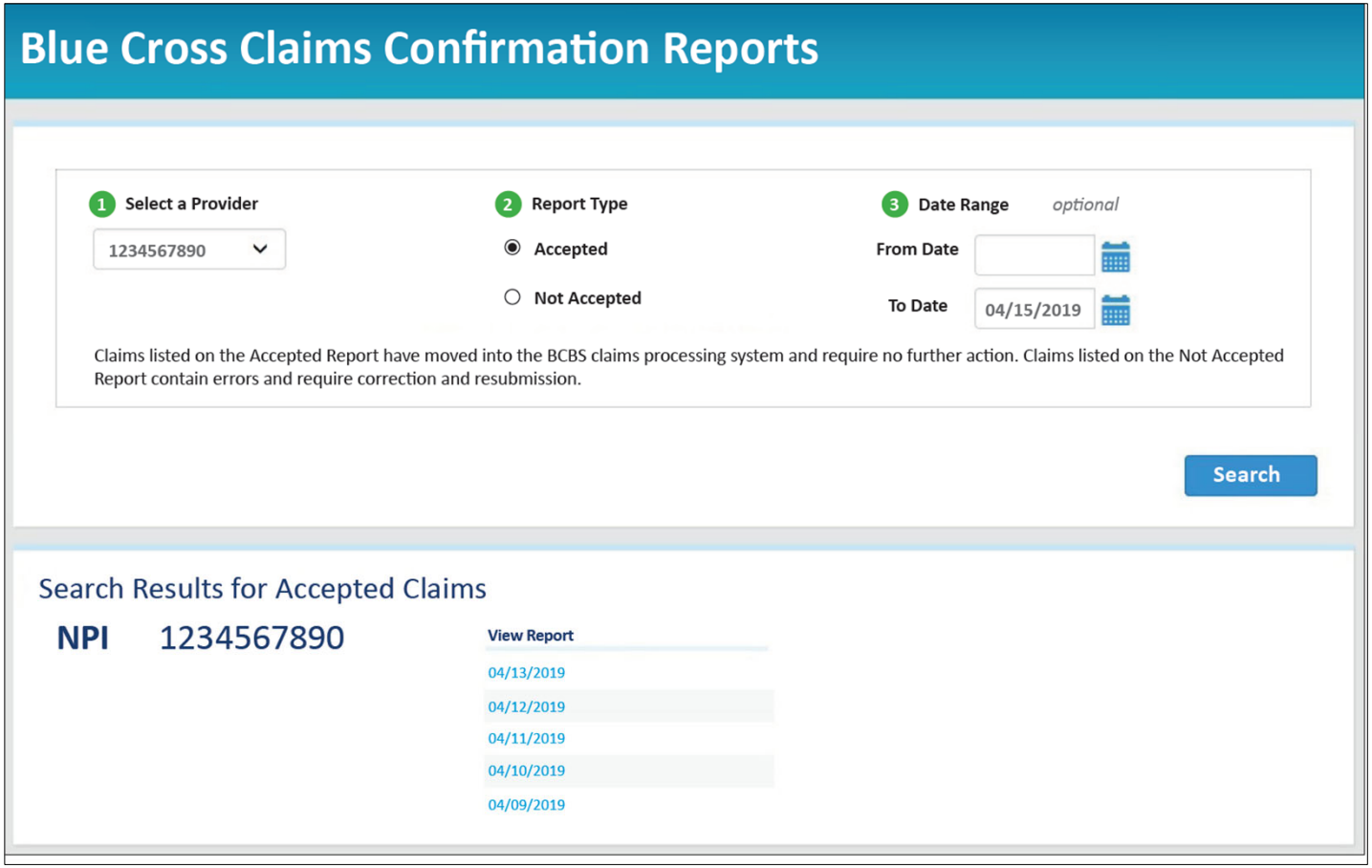
   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

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

Blue Cross Claims Confirmation Reports

- Provide detailed claim information on transactions that were accepted or not accepted by Blue Cross for processing.
- You may access these reports via iLinkBlue (Claims >Blue Cross Claims Confirmation Reports).
- Reports are available up to 120 days.
- The reports include claims that are submitted iLinkBlue as well as through a clearinghouse or billing agency.

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

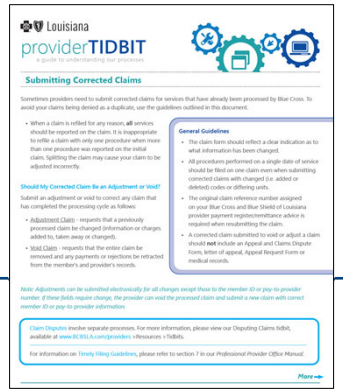
PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION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

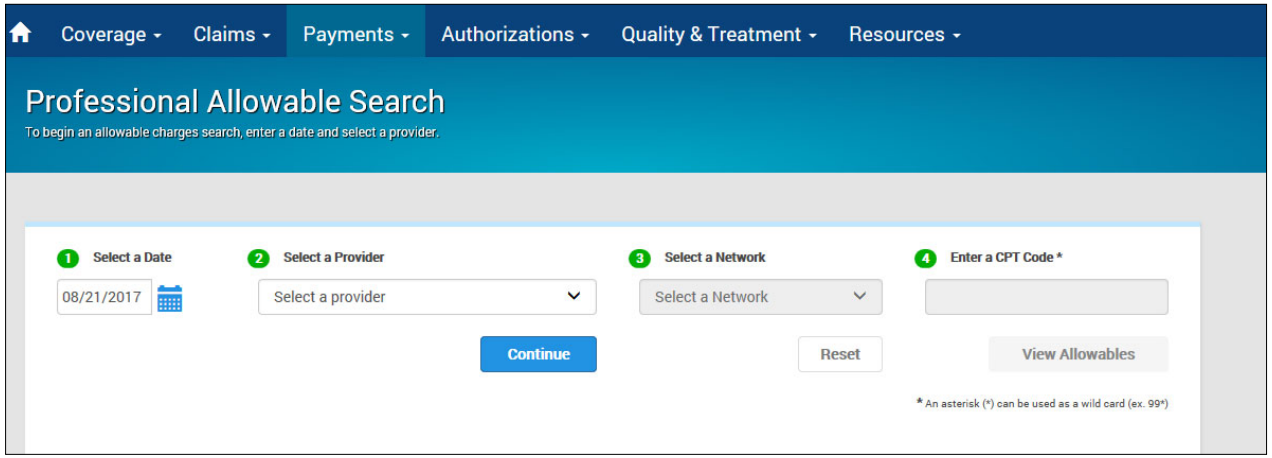
BILLING & CLAIMS

Allowable Charges

You can use iLinkBlue to look up allowables for a single code or a range of codes (**www.bcbsla.com/ilinkblue** >Payments >Professional Provider Allowable Charges Search)

single code example: 90833 (allowable results for 90833 only)

code range examples: 908* (allowable results include all codes beginning with 908)
90* (allowable results include all codes beginning with 90)
9* (allowable results include all codes beginning with 9)



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

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, 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

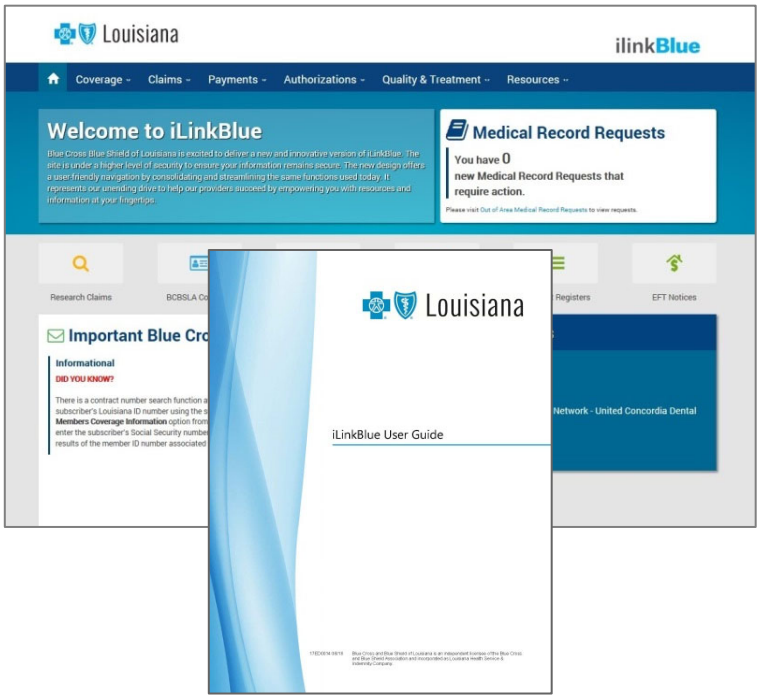
- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 business days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 business days for second request

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

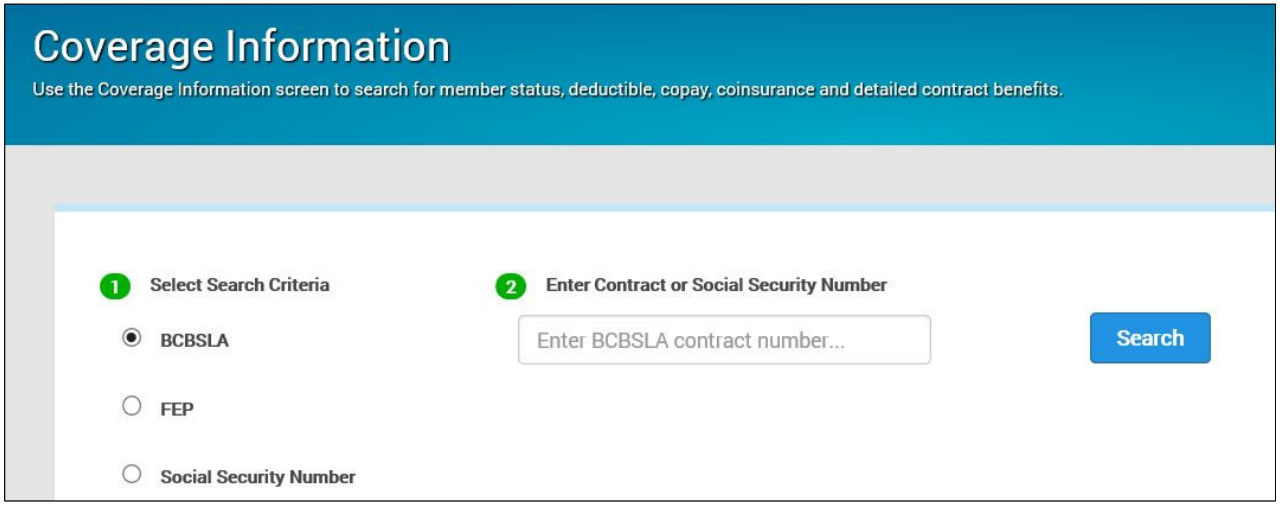


- For iLinkBlue training and education, contact **provider.relations@bcbsla.com.**

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

iLinkBlue – Coverage & Eligibility

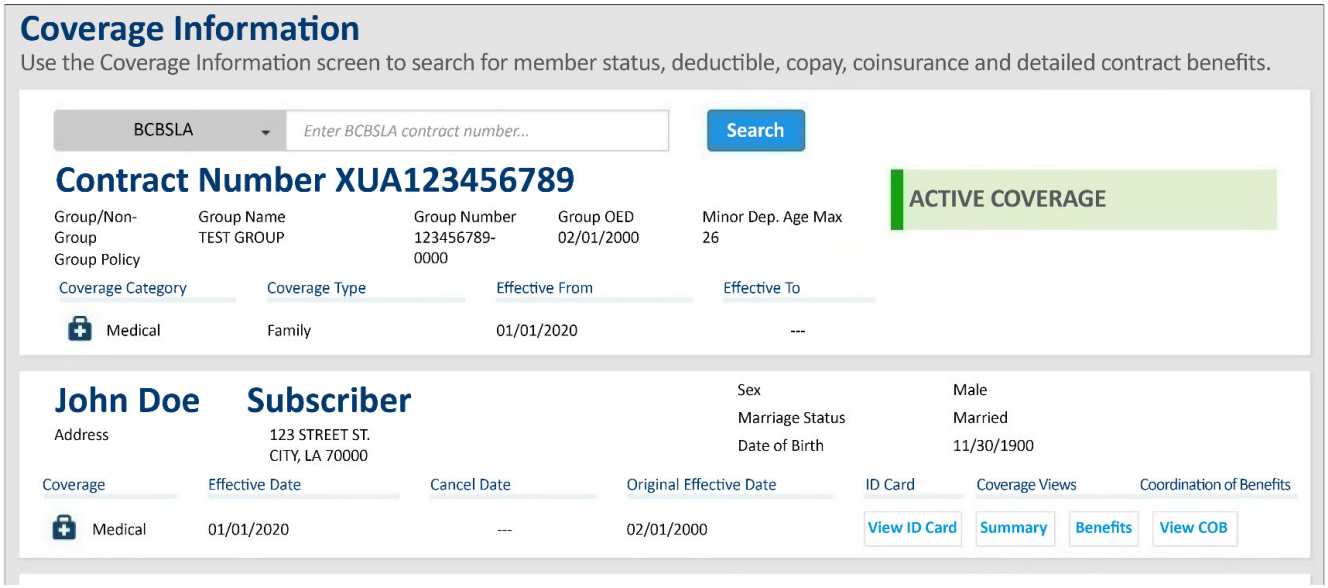
1.



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

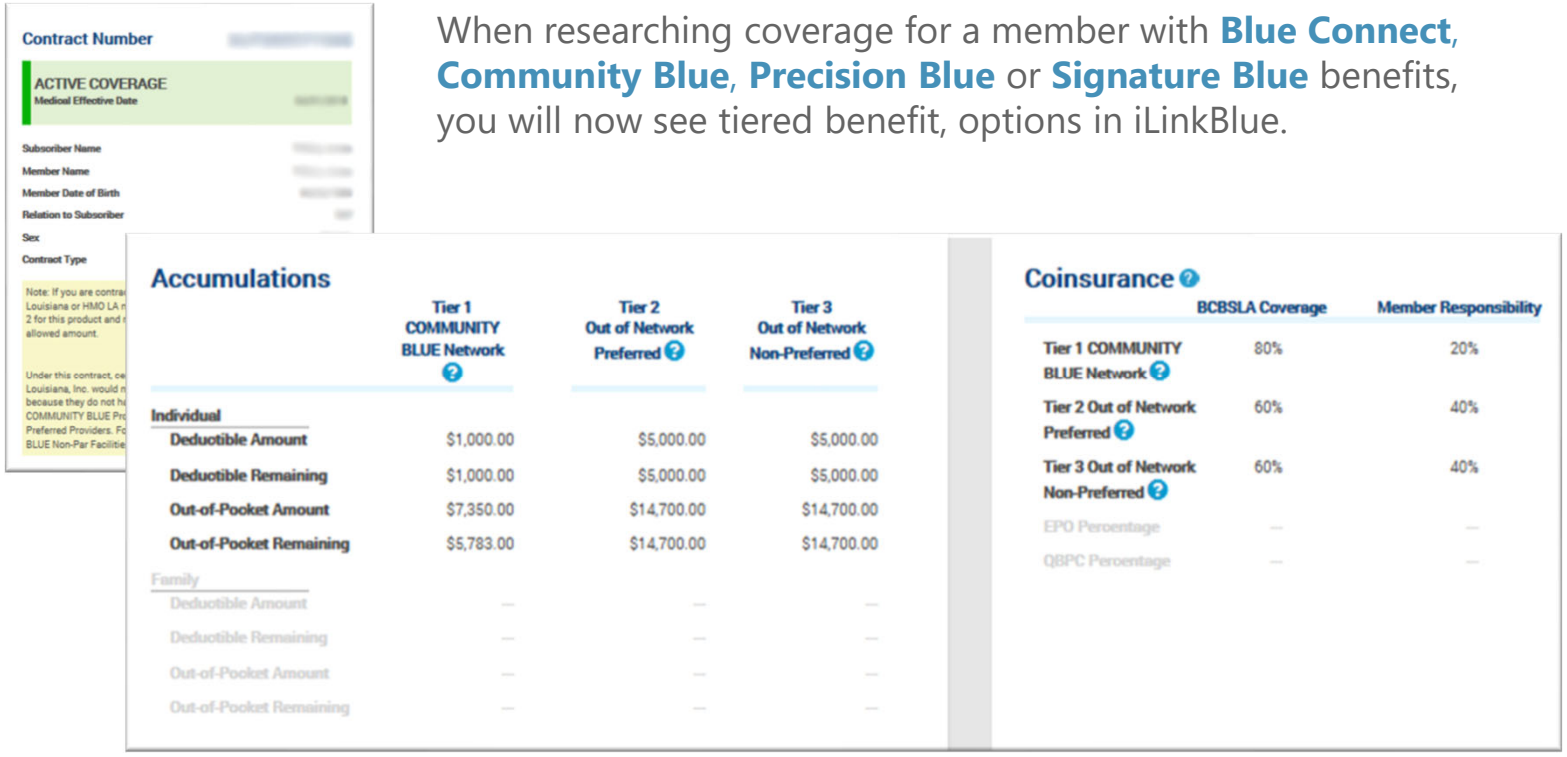
	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	---
Deductible Remaining	$0.00	$1,750.00	---
Out-of-Pocket Amount	$3,000.00	$6,000.00	---
Out-of-Pocket Remaining	$3,000.00	$6,000.00	---

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

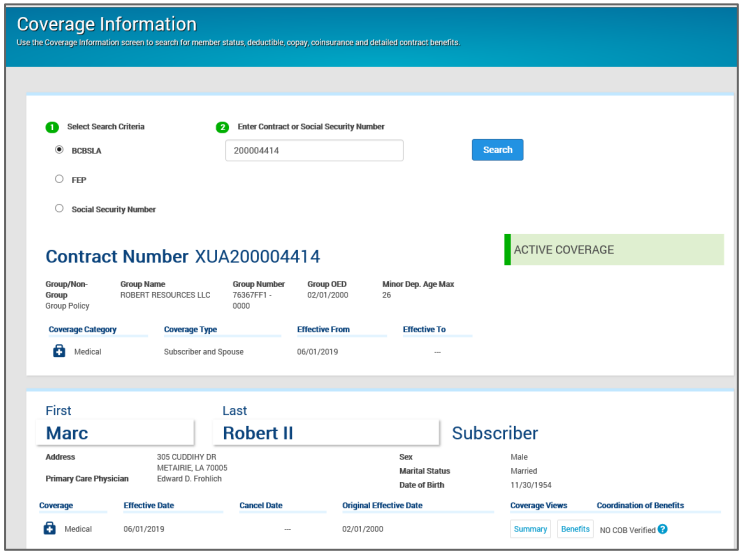
Applies to providers who do not participate in any Blue Cross network.

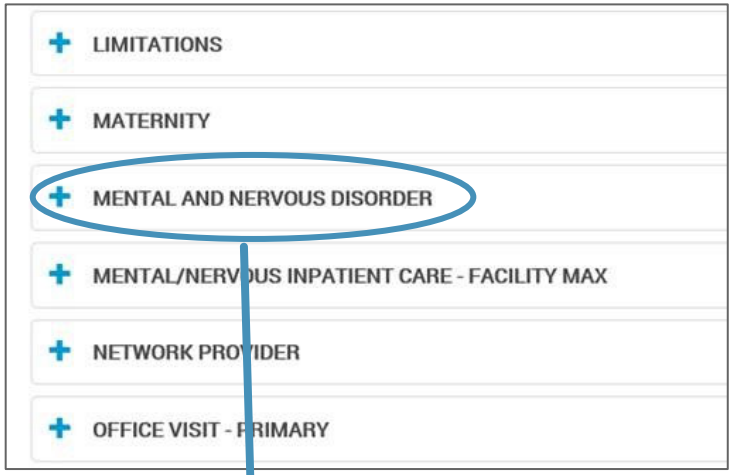
Example Scenario:

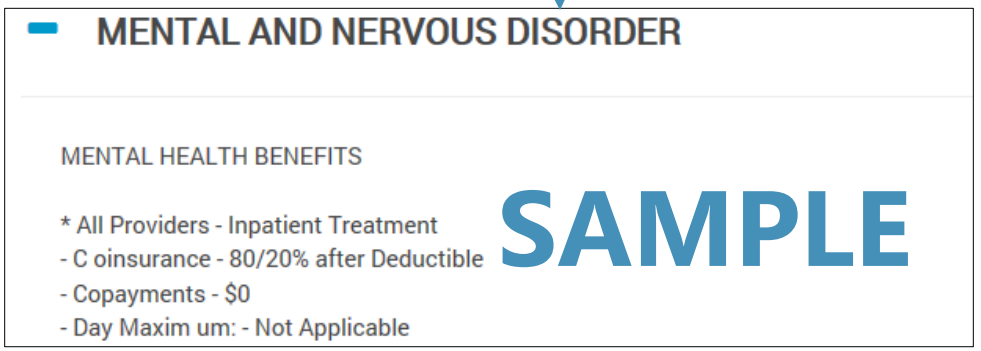
- A Community Blue member sees a non-participating provider.
- The member copay and accumulators identified under Tier 3 should be applied.
- Provider can bill the member for all amounts over the allowed amount.

iLinkBlue – Mental Health Benefits Language

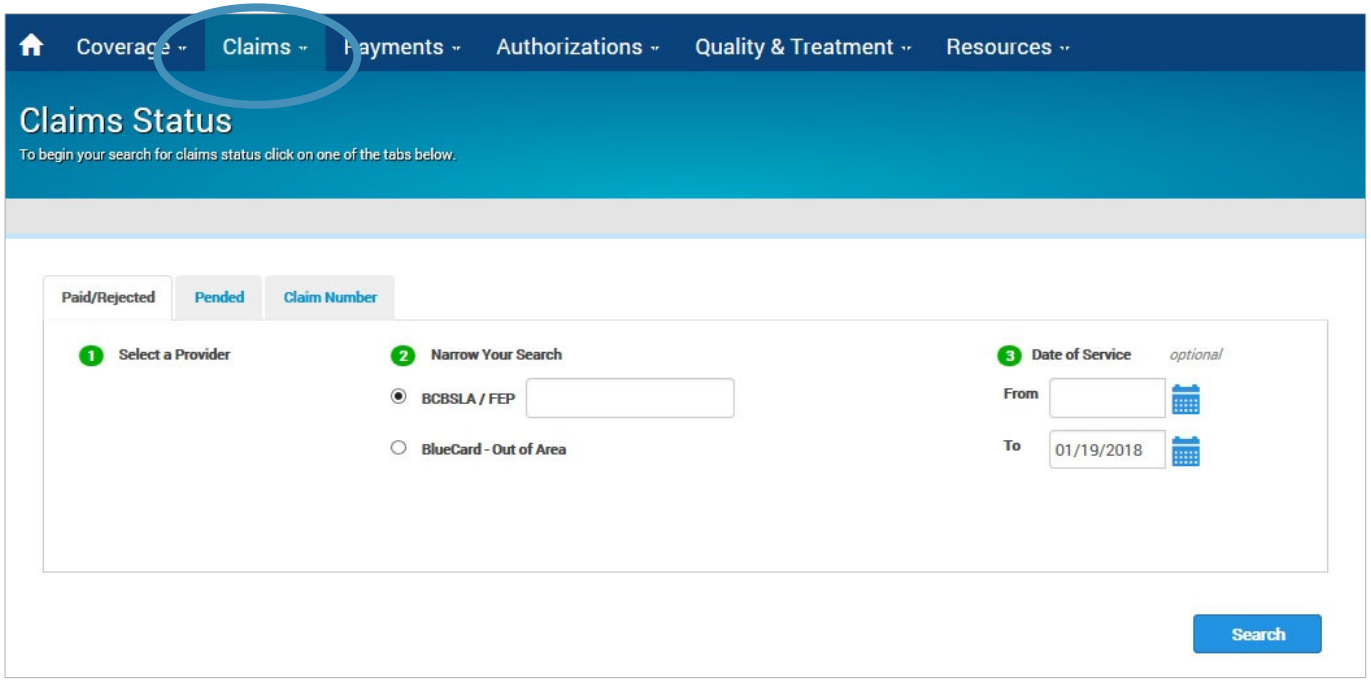
1.







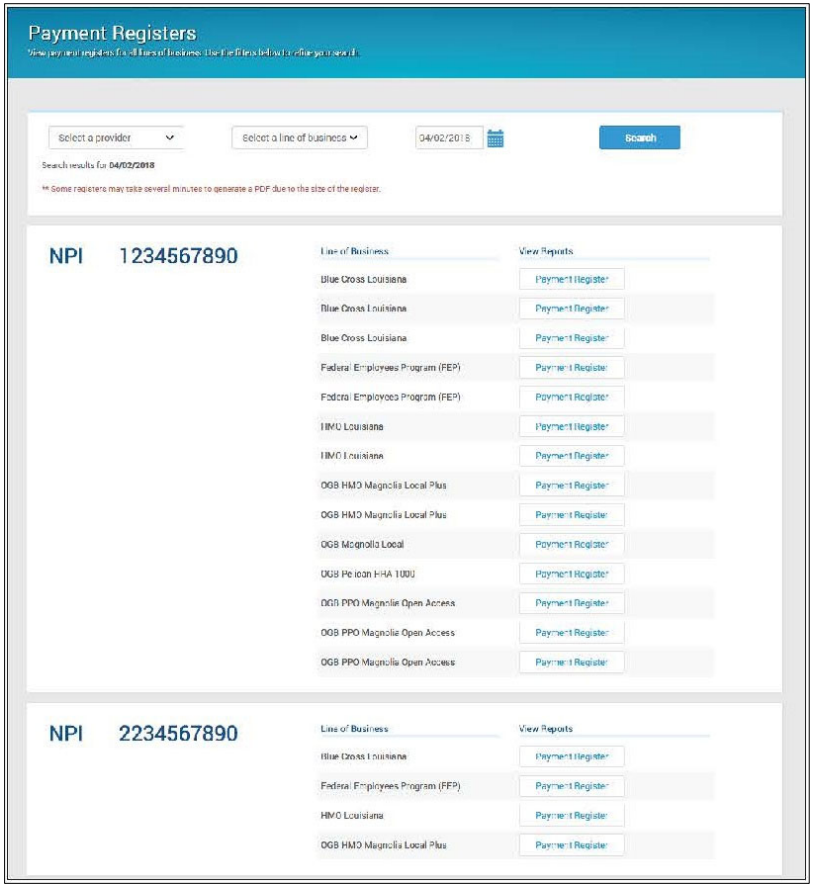
iLinkBlue – Claims Research



- 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

WHO IS NEW DIRECTIONS?

BCBSLA 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

15 million
members
in fifty states
and internationally

7 partnerships
with Blue Cross and
Blue Shield health plans

2.25 million
EAP Members

780+
employees

26 years
of behavioral
health experience

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

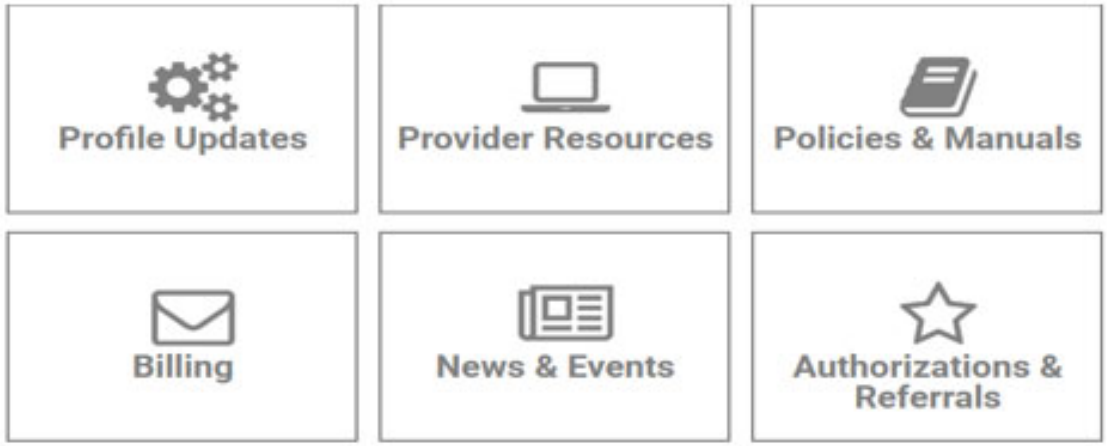
COLLABORATION IS KEY

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



Want to join our network?
Apply Here

WebPass Access

PCP Toolkit

HEDIS® Toolkit

Care Management Services

Substance Use Hotline

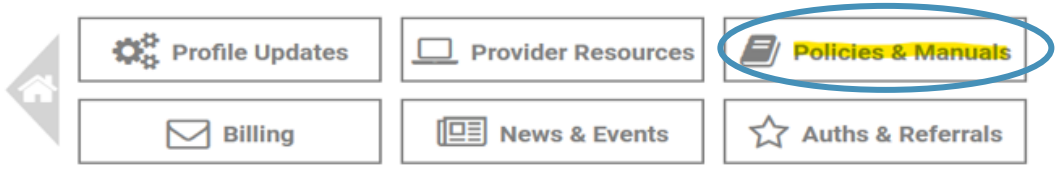
Improving healthcare, together.

By collaborating with providers like you, we improve access to quality behavioral healthcare and encourage whole-person health for our members. Your partnership helps us create powerful care solutions, and our network team is always ready to join forces on new, innovative approaches to care.

With decades of experience in the field and an unwavering commitment to partnership, we can create positive change in the lives of those we serve, together.

Where to Find New Direction's Medical Necessity Criteria

www.ndbh.com/providers/bcbsla/policiesmanuals



Policies & Manuals

All New Directions policies are available for reference and download.

GENERAL
2021 Medical Necessity Criteria
Provider and Facility Manual

AUTISM
2021 Medical Policy for ABA for the treatment of ASD
2021 FEP Medical Policy for ABA for the treatment of ASD

MEMBER APPEAL PROCESS
Appeals Procedures

rTMS
Repetitive Transcranial Magnetic Stimulation (rTMS) Blue Cross and Blue Shield of Louisiana Medical Policy

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.

MNC Program Guidelines-Programming Requirements

Each level of care in the MNC will outline the criteria the provider must meet to provide this level of care to members. This section will include assessment requirements, timeframes for completion of items, clinical components of the program and hourly requirements of the level of care.

Psychiatric Intensive Outpatient Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.
3. There is documentation of evaluation within one week of admission by a psychiatrist who remains available as medically indicated for face-to-face evaluations.
4. After a multidisciplinary assessment, an individualized treatment plan using evidence - based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care, and other issues that affect the likelihood of successful community tenure.
5. Treatment programming includes documentation of at least one individual counseling session weekly or more as clinically indicated.
6. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
7. Licensed behavioral health practitioners supervise all treatment.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. A Multidisciplinary treatment program that occurs three days per week and provides a minimum of 9 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms/problems, New Directions does not count these activities in the total hours of treatment delivered.
10. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
11. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.

MNC Program Guidelines- Initial Authorization

Each level of care in the MNC will outline the criteria the member must meet to be eligible for this level of care. It provides examples of areas of concern that may be addressed in this level of care.

Initial Authorization Request

PIO

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of nine hours of treatment each week is required to safely and effectively treat the member's current condition.
5. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 1 area, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
6. The member is cognitively capable to actively engage in the recommended treatment plan.
7. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including, but not limited to: medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources , or any other factors that would impact the overall treatment outcome and community tenure.
    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.
    c. The member is at high risk for admission to acute inpatient care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

MNC Program Guidelines-Concurrent Review

Each level of care in the MNC will outline the criteria the member must meet to be eligible for continued treatment in this level of care.

Continued Authorization Request(s)
PIO

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her behavioral health treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively developing discharge plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
9. The member continues to need intensive outpatient care because of at least two of the following:
    a. The members condition or stage of recovery requires the need for multiple treatment interventions per week in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care.
    b. Marked variability in day-to-day capacity to cope with life situations.
    c. A crisis situation is present in family, work and/or interpersonal relationships which may require resources such as frequent observation, crisis intervention services, safety planning, problem solving, social services, care coordination, client instruction, support, additional family interventions and other services that may be provided as clinically indicated.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity frequency and duration of current behaviors and symptoms.

USING THE MEDICAL NECESSITY CRITERIA

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

- **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.

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

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

MEDICAL NECESSITY 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

NEW DIRECTIONS UTILIZATION MANAGEMENT (UM) TEAM

- The UM team are clinically licensed staff members.
- New Directions Medical Necessity Criteria is the basis for all utilization decisions (found on website).
    - 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.

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 and 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 information 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 information 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.

WEBPASS

Logging Into WebPass

We strongly encourage the use of WebPass via iLinkBlue.

Your responses will be timelier if using WebPass.

Access to WebPass via iLinkBlue:

First, you will need to determine if your facility has an established Administrative Representative

The Administrative Representative is responsible for adding new users and modifying existing users' access.

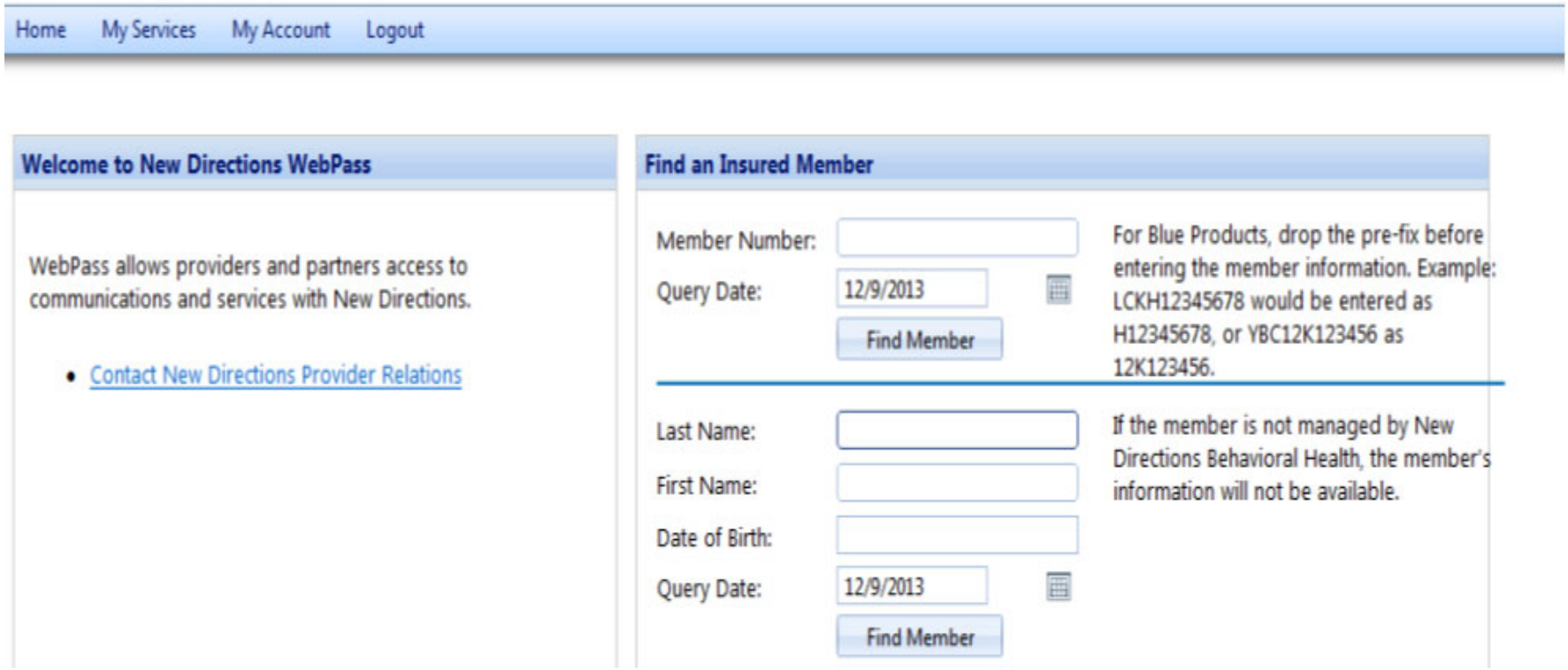
Below are the instructions from Blue Cross:

1. Establish an Administrative Representative within your organization
a) If unknown, contact Blue Cross' PIM Team at 1-800-716-2299, option 5
b) If an Administrative Rep needs to be set up: visit www.BCBSLA.com/providers >Electronic Services >Admin Reps

2. Administrative Representative will set up iLinkBlue users and must allow users access to WebPass (authorizations) instructions to use iLinkBlue: visit www.BCBSLA.com/providers >Resources >Manuals >iLinkBlue User Guide

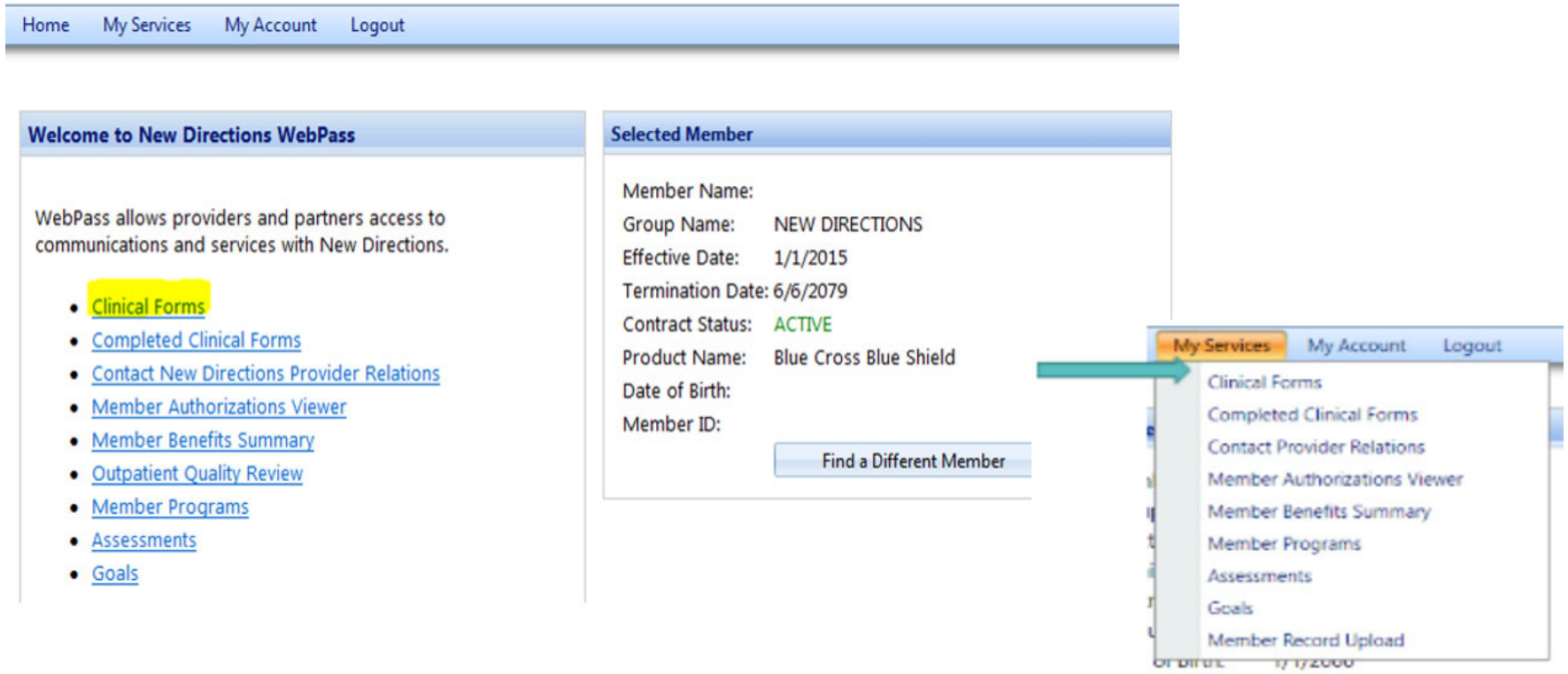
GETTING STARTED

Before you select a form, you will first look up a member. To do so, enter the member ID number (minus the prefix). You also have the option to enter the member's last name (first 3 letters only), first name (first 3 letters only), and date of birth.

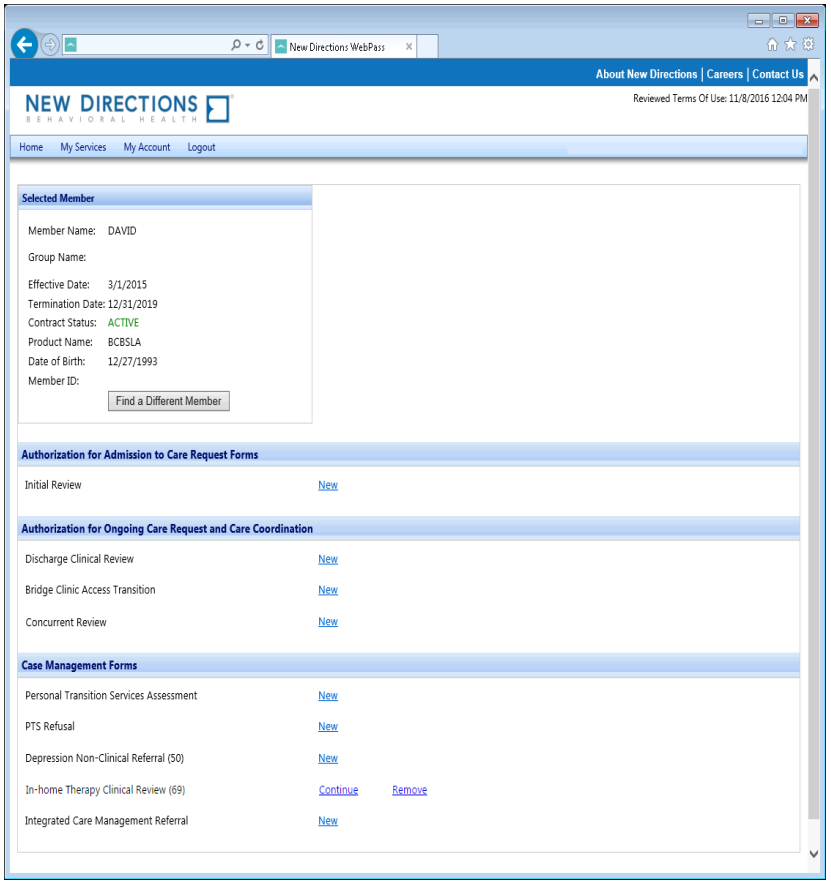


FILLING OUT CLINICAL FORMS

To choose the appropriate form, click on “Clinical Forms” either in the list or under the drop down in “My Services.”



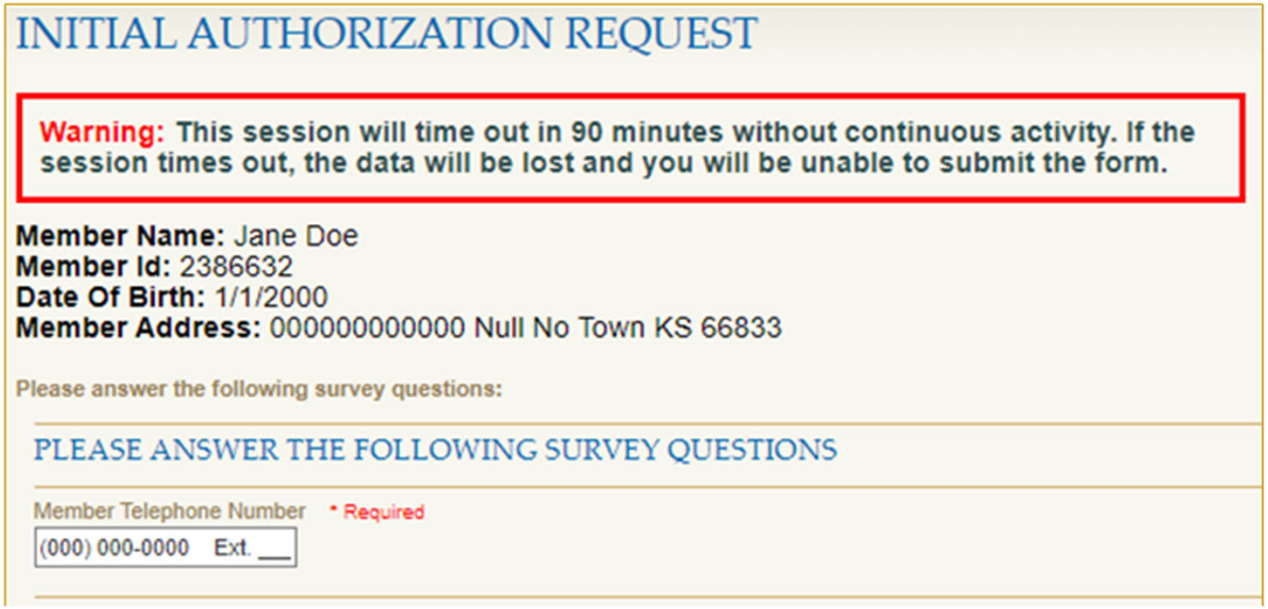
CLINICAL FORMS



- The Forms page is divided into three sections: Admission, Ongoing and Case Management.
- If there are no forms to select under a specific category, the word “None” will appear.
- If there are no authorizations available to link to, the Clinical Forms page will be all that is shown. If there are available authorizations to link, you will first see another page.

FILLING OUT CLINICAL FORMS

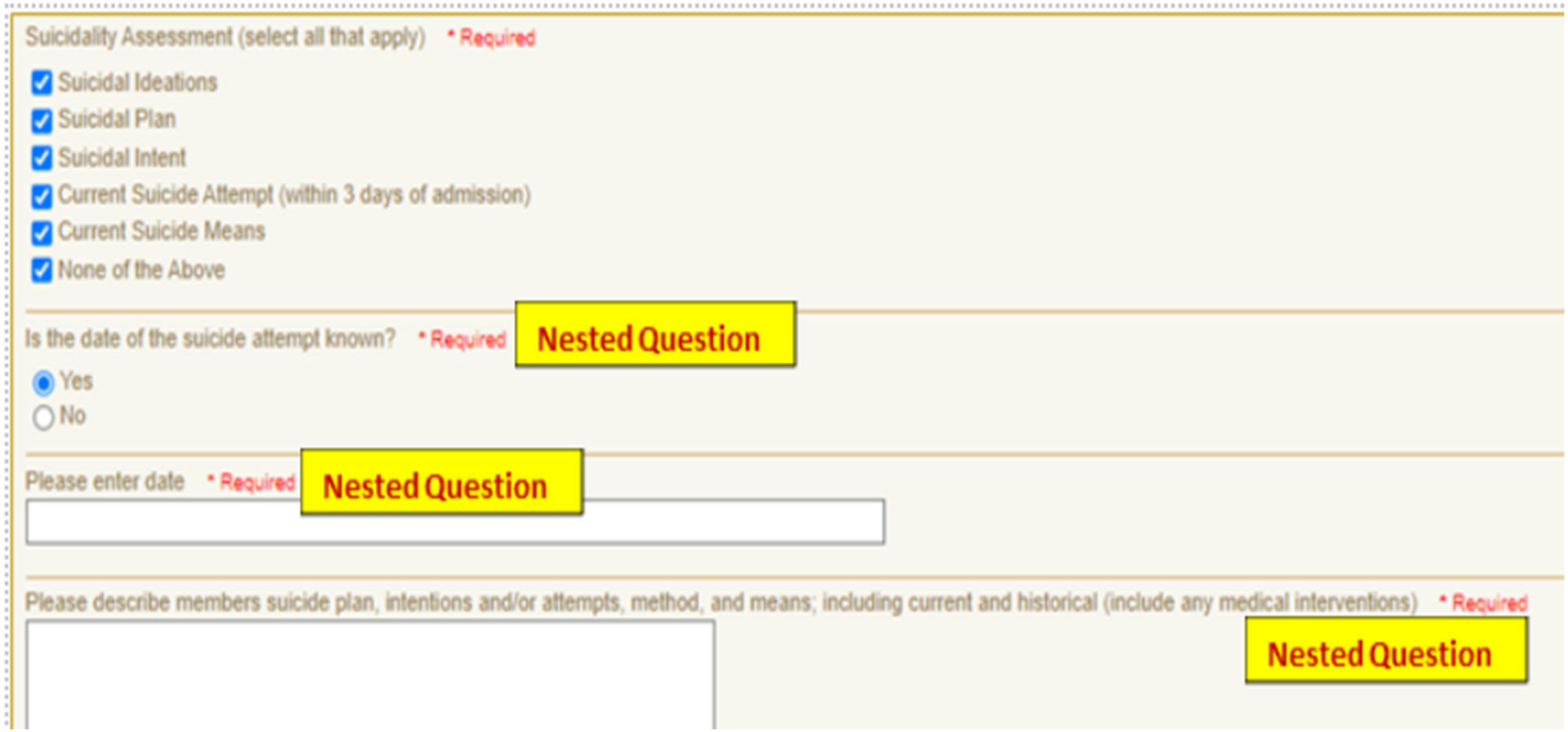
After users select a form, they will enter the clinical information needed for New Directions to conduct a higher level of care review.



As each section is completed, the Question Jumplist will display a green checkmark. Clicking on an item listed in the Question Jumplist will link users to that section.
This helps with navigation on the form.

INTERACTIVE QUESTIONS

Some questions only appear based on the previous answer given.
Example shown below.

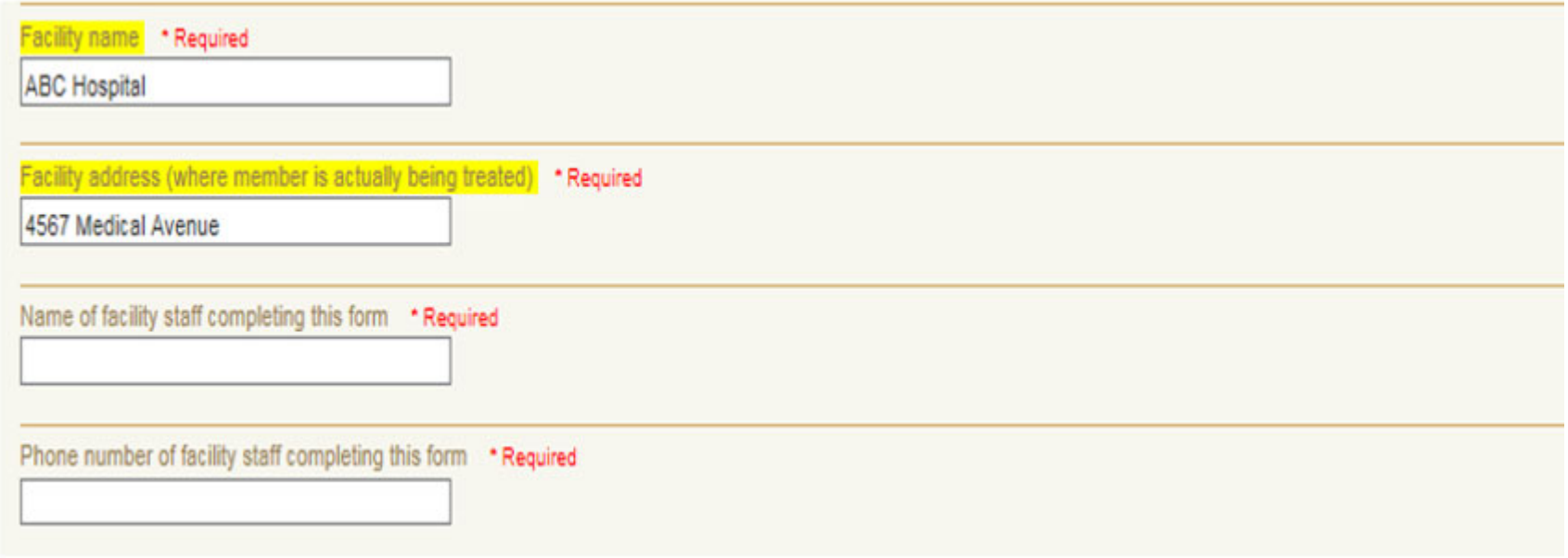


TEXT BOX

Some questions will enable a text box if “other” is selected. See below.

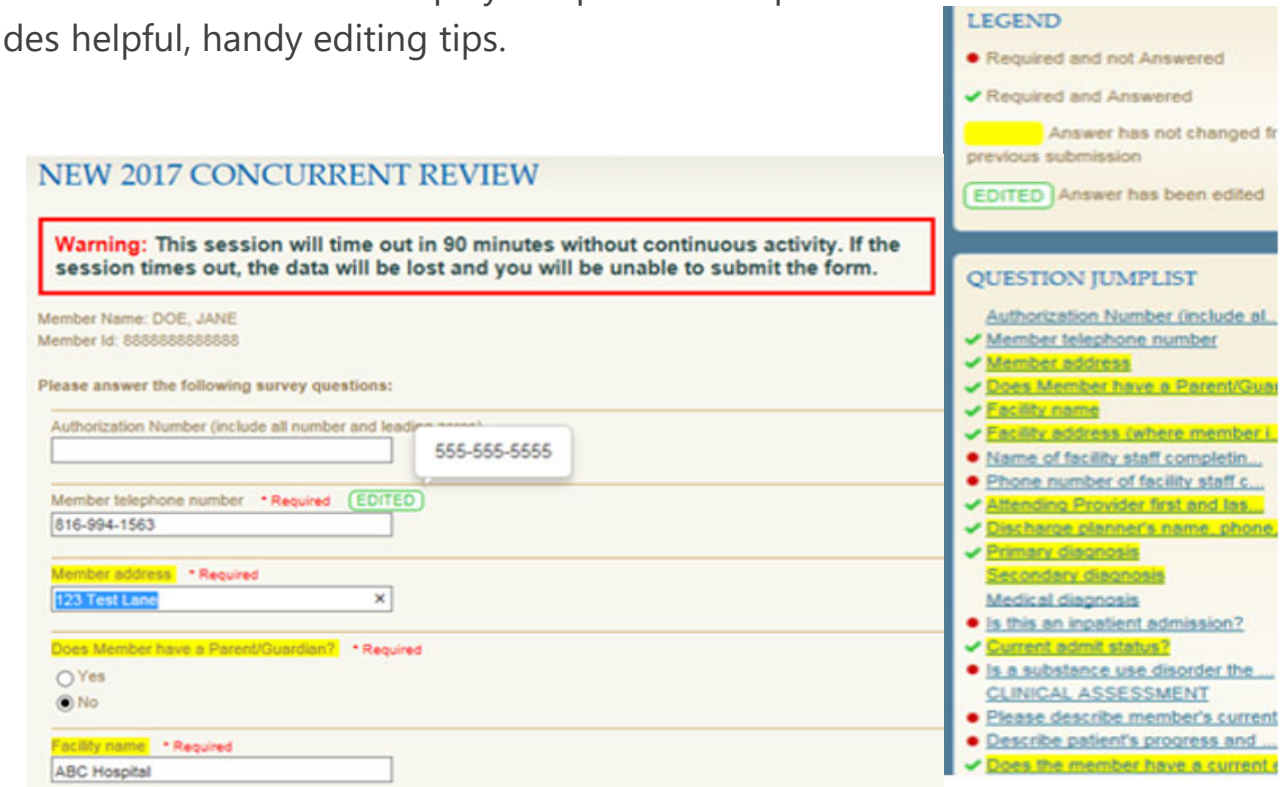
PREPOPULATED INFORMATION

Questions that have prepopulated answers will be highlighted to ensure they are visible by the user. **All highlighted answers need to be reviewed and updated as applicable. Not all questions will be prepopulated**. Some questions are not present on both initial and concurrent forms and some questions are set not to prepopulate.

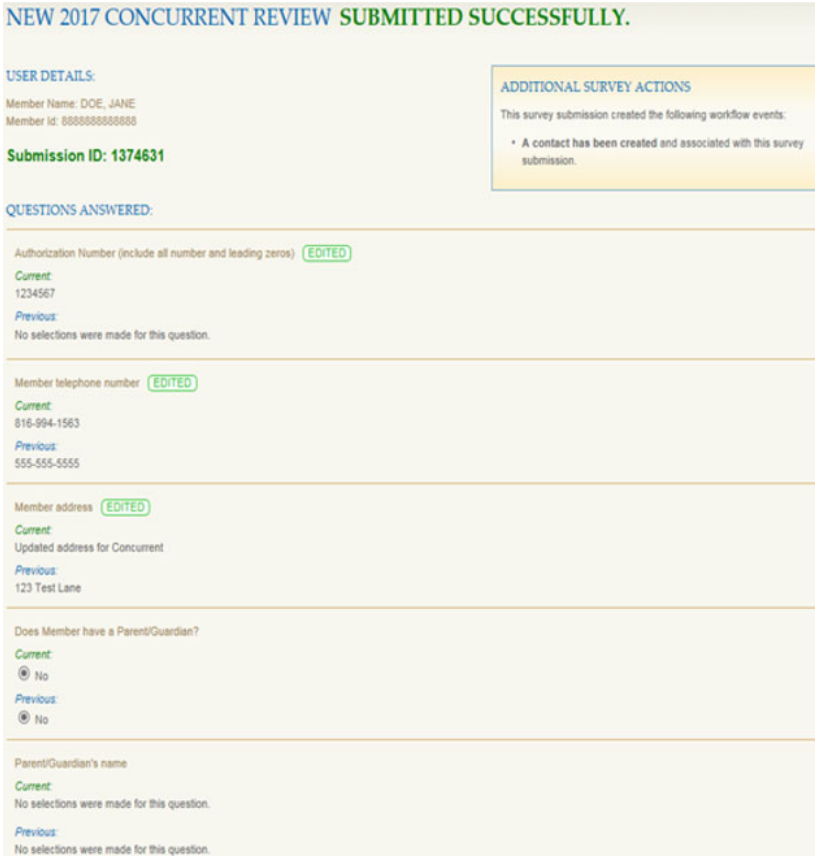


REVIEW OF PREPOPULATED INFORMATION

- After a user changes the highlighted information, the highlight will be removed, and an Edited indicator will appear.
- Only alpha-numeric characters count as edits. Spaces, returns, punctuation, special characters will not be counted as an edit.
- Hovering over the "Edited" indicator will display the previous response.
- The Legend provides helpful, handy editing tips.



EDITED INFORMATION


NEW 2017 CONCURRENT REVIEW SUBMITTED SUCCESSFULLY.

USER DETAILS:

Member Name: DOE, JANE
Member Id: 8888888888888

Submission ID: 1374631

ADDITIONAL SURVEY ACTIONS

This survey submission created the following workflow events:

- A contact has been created and associated with this survey submission.

QUESTIONS ANSWERED:

Authorization Number (include all number and leading zeros) EDITED
Current:
1234567
Previous:
No selections were made for this question.

Member telephone number EDITED
Current:
816-994-1563
Previous:
555-555-5555

Member address EDITED
Current:
Updated address for Concurrent
Previous:
123 Test Lane

Does Member have a Parent/Guardian?
Current:
No
Previous:
No

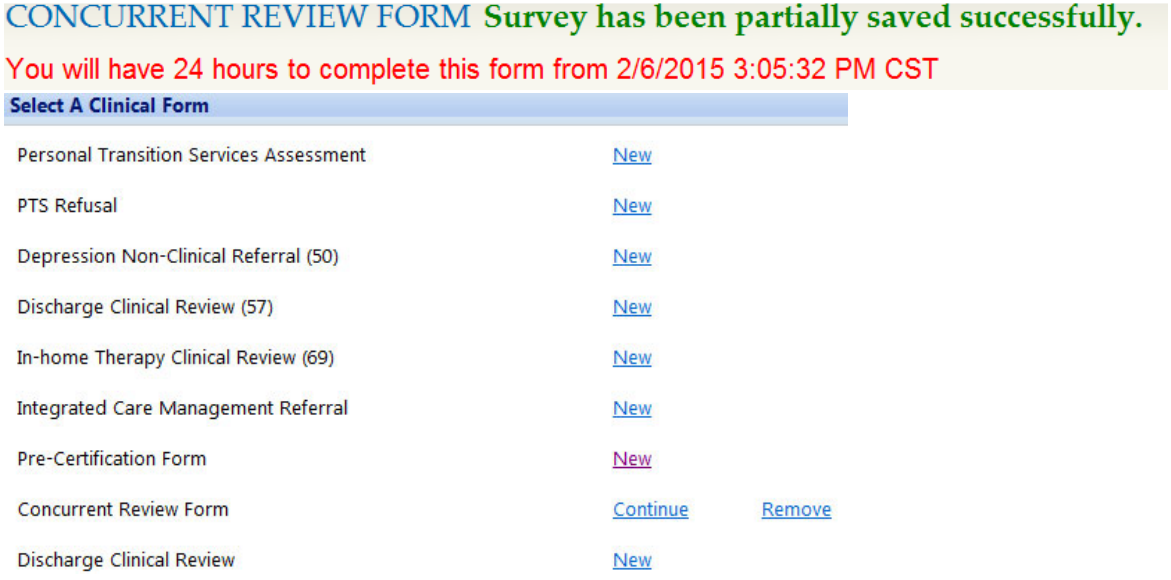
Parent/Guardian's name
Current:
No selections were made for this question.
Previous:
No selections were made for this question.

If information is prepopulated, a page will appear that shows the Current/Previous answers, as well as the EDITED indicator where applicable. If no information is prepopulated, the standard results page will appear.

SAVING PARTIALLY COMPLETED FORMS

At the bottom of each form, the following options will be available:

Note: Forms must be competed and submitted within 24 hours after they are initially saved. If not, they will be deleted. Anyone who has a WebPass account and shares the same Tax ID can complete the form. Users will have the option to continue or remove forms.



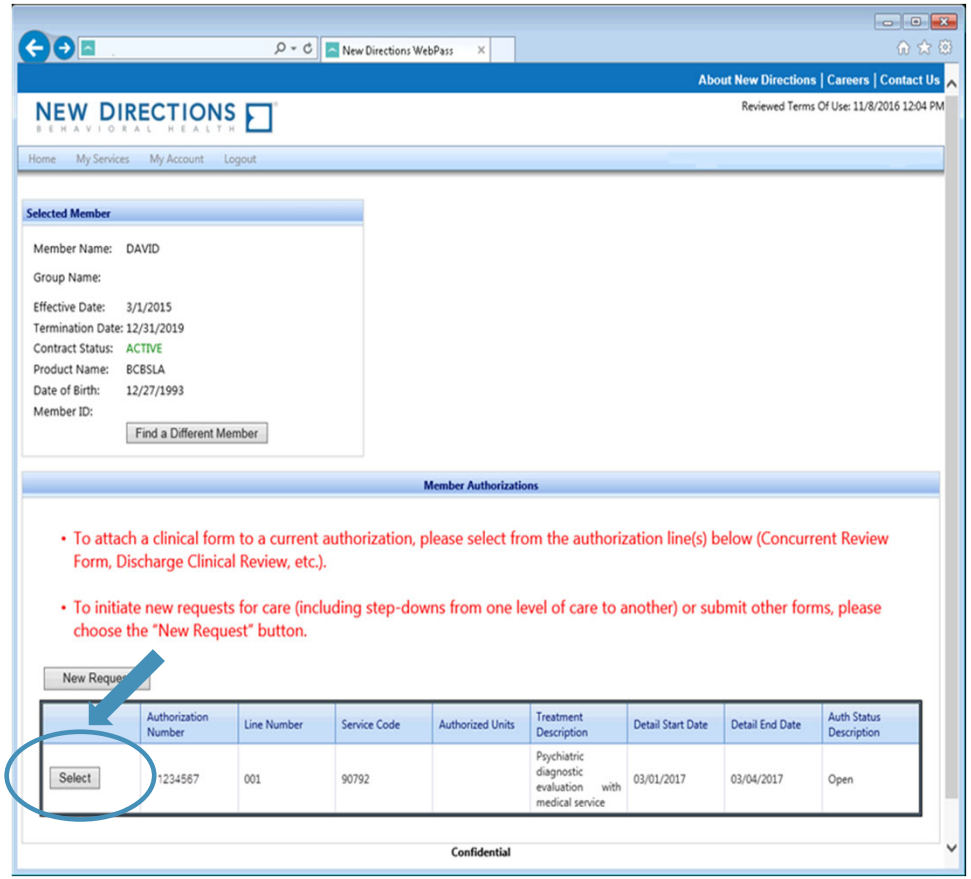
REVIEWING PREVIOUS REQUEST FORMS

- To view forms submitted by any user who shares the same Tax ID, click on "Completed Clinical Forms."
- Users will be able to view all forms that have been submitted by Tax ID for the member.

Reviewing Status of Request Form

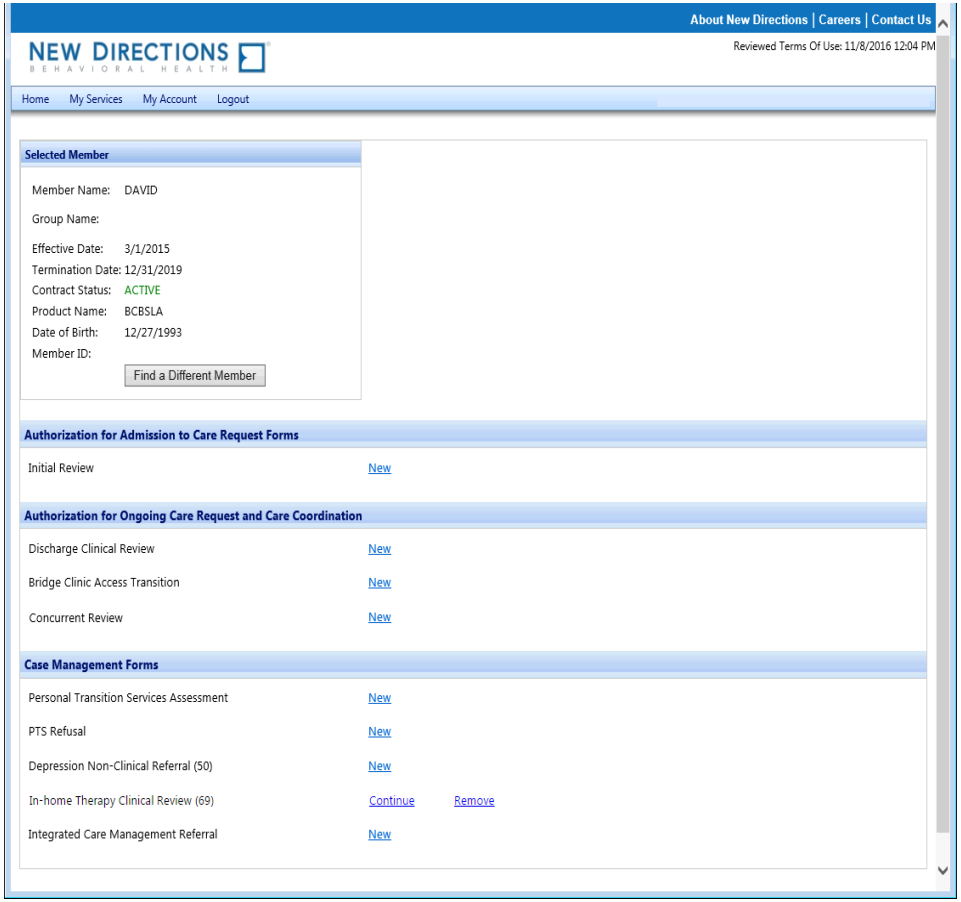
- To view the status of a request, click on "Member Authorization Viewer"
- Users will be able to view all authorization requests and statuses on the selected member. Click on "Details" or "History" to view more information about the authorization.

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, click on New Request.

FORMS LIST



- After users select an Authorization or "New Request," the Forms list will be displayed.
- Note: Even if an Authorization is selected, an Initial Review will never be linked to an existing Authorization in WebPass.
- Note: Partially saved surveys will remain tied to the original selection unless removed/expired.

VALUABLE INFORMATION TO INCLUDE IN YOUR CLINICAL FORMS

- **Provide as many specifics about the member's behavioral health symptoms and substance use as possible.**
  - *ex: SI plan, means, intent, access, etc.*
- **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 or is not working?**
  - *give details on progress of interventions or changes being made*
  - *ex: member was able to tell mom about recent rape*
- **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.*
- **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 Blue Shield of Louisiana
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.

BEST PRACTICES FOR DISCHARGE PLANNING

Discharge Planning Overview

Discharge planning is a critical component of quality member ocare that begins on the day of admission. Likewise, treatment and recovery does not end at the time of discharge. Quality discharge plans are needed for all levels of care within **forty-eight hours of discharge** or change in service level.

This information is needed from providers to coordinate care and provide support to members post discharge from the level of care they are receiving at your facility.

The Discharge Clinical Form was updated to increase accuracy, reduce redundancy and improve workflow.

Discharge Planning Best Practices

Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.

- Assist member with coordination of care to follow-up visit with appropriate referrals, scheduling and communication.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Make sure that the member has follow-up appointment scheduled; preferably within 7 days but no later than 30 days of the inpatient discharge.
- Engage members and parents/guardian/family/support system and/or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments. This is critically important for a child or adolescent.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.

Discharge Planning Best Practices Continued…

- Follow-up providers maintain appointment availability for members with recent inpatient discharge.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Encourage communication between the behavioral health specialist and PCP. Ensure that the member has a PCP and that care transition plans with the PCP are shared.
- Provide timely submission of claims.

Discharge Planning Best Practices Continued…

- **Begin discharge planning on day of admission**
  - Identify appropriate outpatient providers and coordinate care for the member's aftercare plan.
  - Scheduling follow up appointments based on your facility's average length of stay instead of waiting for a discharge date, can significantly increase the likelihood of obtaining an appointment within 7 days of discharge.
    - For example: Member admits 3/1. Average length of stay is 6 days. The discharge planners can schedule the follow up appointment for 3/8 or 3/9 and be within 7 days of discharge, if the member is inpatient for 2-7 days.

Discharge Planning Best Practices Continued…

- **Ascertain the need for and obtain language assistance.**
  - The initial review form asks about barriers (language preference, etc.).

- **Educate members regarding their diagnosis, medications and how to keep health problems from getting worse.**

- **Ensure members understand their discharge plan.**
  - Address any questions.
  - Teach a written plan the member can easily understand.

- **Provide a follow-up discharge call within 3 days to reinforce the discharge plan.**

Discharge Planning Best Practices Continued…

Provide and review details of what to do if a problem arises

- Review aftercare goals, educate what symptoms to watch for and who to call if any noticed.
- Crisis/safety plan, number to call for problems after discharge.

Engage the member's support system

- Involve the member's support system during treatment and discharge planning.

- During members' inpatient stay, obtain a signed release of information allowing NDBH to discuss members' care with their support system. This can be accomplished by using your facility ROI, and we ask that you please send it to our staff so that it is on file. This form can be uploaded in WebPass.

Discharge Planning Best Practices Continued…

Coordination of care

- Upon admission, identify appropriate outpatient providers and begin coordinating care.
  - Notify member's primary care physician (PCP) and behavioral health providers of the recent hospitalization.
  - If a member has an established BH provider, get a signed release of information and consult with their outpatient provider.
  - Please be sure to document the provider's name and phone number in both your initial review and concurrent reviews. Our clinical team will reach out to the provider to let them know their patient has been admitted as well.

- Perform medication reconciliation and provide to member's outpatient providers and include in the discharge information submitted to NDBH.

Discharge Planning Best Practices Continued…

- Expedite transmission of discharge summary to clinicians and NDBH
  - Submit discharge information via WebPass to NDBH as soon as possible, preferably within 48 hours, so our care transitions team can also reach out to the member to reinforce the discharge plan and assist with any barriers.

- If the member does not have an established provider, coordinate a “meet and greet” between the member and the 7 day follow up outpatient provider while the member is still inpatient. This can be via phone.

HEDIS CRITERIA

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 patients who have had inpatient treatment for mental illness have a follow-up visit with a **behavioral health professional within 7 calendar days of discharge**.
- NDBH tracks appointments made within 7 days, but also wants patients to **attend those appointments**.
- Patients who attend these scheduled follow up appointments are less likely to **readmit** into inpatient treatment.

FOLLOW UP APPOINTMENT GUIDELINES

The behavioral health professional can be a:

- Psychiatrist
- Psychiatric Nurse Practitioner
- Licensed Psychologist
- Licensed Clinical Social Worker

The discharge information provided to NDBH for the outpatient appointment needs to include each of the following:

- Name of individual provider
- His or her credentials
- Appointment date and time
- Contact information for this provider

For Example:

Jane Smith, LCSW

2/1/2021 at 1:30 p.m.

FOLLOW UP APPOINTMENT GUIDELINES

An intensive outpatient (IOP) or partial hospitalization (PHP) does count towards a follow up visit.

Residential Treatment Centers (RTC) admissions are excluded from the scheduled 7 day follow up appointment percentage.

For these step-down level of care programs, the discharge Information provided to NDBH needs to include each of the following:

- Name of the treatment program
- Appointment date and time
- Contact information for this provider

For Example:
Willow Haven Residential Treatment Center
1/15/2021 at 12 p.m.

FOLLOW UP APPOINTMENT GUIDELINES

Scheduled 7 day follow-up appointments with an individual outpatient provider on the same day as discharge do not count as a HEDIS scheduled 7 day follow-up.

For Example:

Discharge Date: 2/1/2021

Jane Smith, LCSW

2/1/2021 at 1:30 p.m.

This does not include the following:

- Residential Treatment Centers (RTC)
- Partial Hospitalization Programs (PHP)
- Intensive Outpatient Programs (IOP)

RESOURCES

DISCHARGE PLANNING AND SCHEDULING 7-DAY APPOINTMENTS

Scheduling

New Directions realizes that scheduling member appointments within 7 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 assist with 7-day appointments for inpatient BCBSLA Members, please call **877-300-5909** or send an email to **DL_Louisiana_UM@ndbh.com**.
Include facility name, contact name of the facility staff member and phone number.

To 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.**

Resources

NDBH Clinical Team: 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.

Behavioral Health Rainmakers

A rainmaker is a provider that has made a verbal commitment to see BCBSLA members within 7 days of discharge from an acute psychiatric IP stay.

The Rainmaker list is used as a "**first call**" list for discharge planners at facilities and the New Directions case managers and care transitions staff.
Please ask to speak with the contact person listed on the rainmaker list and always state you are calling from the rainmaker list.

We send out the rainmaker list once a month, to the NDBH clinical staff and the contacts at your facility that we have on file.

If you are not currently receiving the list, please reach out to us at the below email address.

Your feedback regarding the rainmaker list is much appreciated. Please email feedback to **LouisianaPR@ndbh.com**.

NEW DIRECTIONS BEHAVIORAL HEALTH WEBSITE

Resources for members**:** www.ndbh.com/Resources/

The New Directions Resource Center has key information that can be of great use by members when help is needed.

Our resource center provides reliable information on a variety of mental and behavioral health topics and will guide the member to the right resources. Below are a few examples of resources available on the NDBH website:

- Substance use hotline
- Depression
- Crisis
- Suicide awareness/hotline
- Community resources
- NDBH Care Management services

NDBH FOCUSED CARE MANAGEMENT PROGRAMS

	Care Solutions	Member Care Link
Distinctions	**Complex Care Management (CM)** NCQA/ URAC accredited	**Non-Complex Care Management (CM)**
	• Opt-in services with high intensity CM outreach • Comprehensive CM assessment • Member centric CM goals, CM survey • Coordination of care with health care providers	• 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 Goals

Improve member experience and quality of care

- 90-day pre/post symptom/functional improvement
- Professional and community services referred and utilized
- Gaps closed (7-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 ED utilization and inpatient admissions

FACILITY MEETINGS

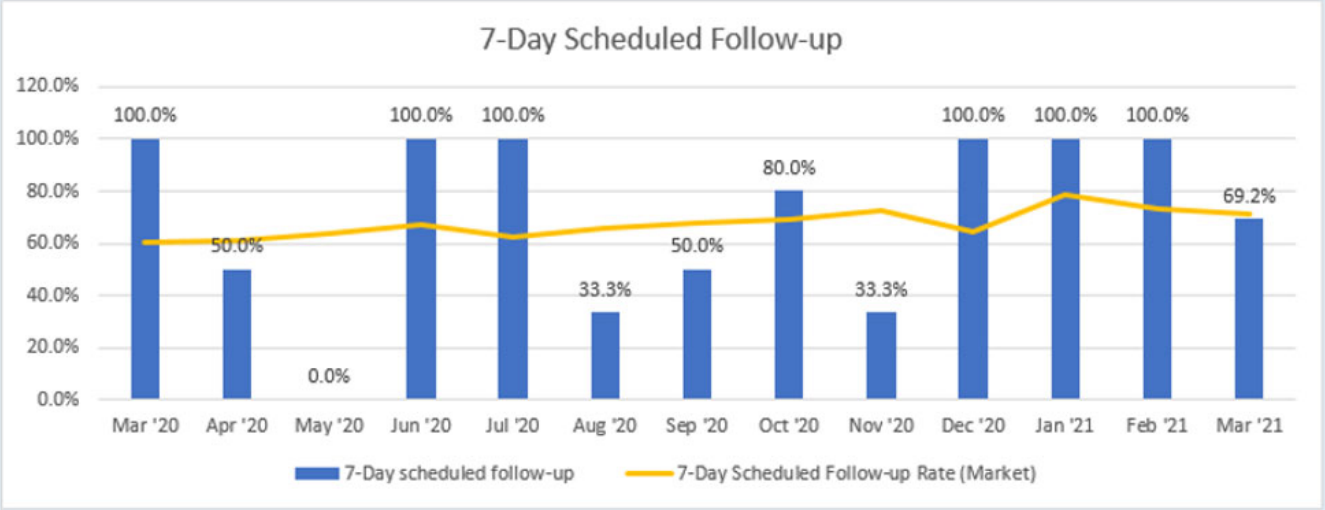
FACILITY MEETINGS

- Educate Facilities about HEDIS Quality Measures: **Seven Day Scheduled**, **Seven Day Kept**, MAT utilization, Discharge planning and **30-Day Recidivism**.
- Present quality measures to facilities - develop a plan to improve metrics.
- Identify facility best practices and share ideas from other providers.
- 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 MARKET COMPARISONS

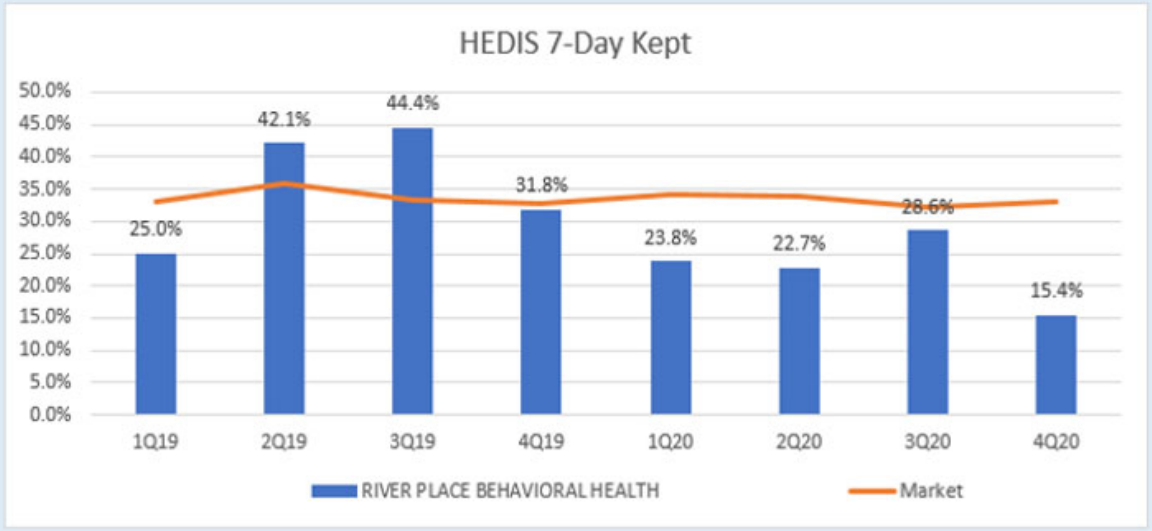
Example of Comparison Data
Scheduled 7 Day Follow-Up

Facility Name		7-Day Scheduled Follow-up Rate				
TIN		Market	2019	57.5%		
NPI						
Reporting Period		Facility	2019	60.0%		
Period to Date Admits		Facility	2020	64.6%		
Current Month Admits		Facility	2021	84.6%		
		Facility	Current month	69.2%		
Authorization Threshold		**Populations:**		Child/Adol	Adult	Geri
Excluded Product:	Medicare	Status:				



Example of Comparison Data
7 Day Kept Follow-up Appointment

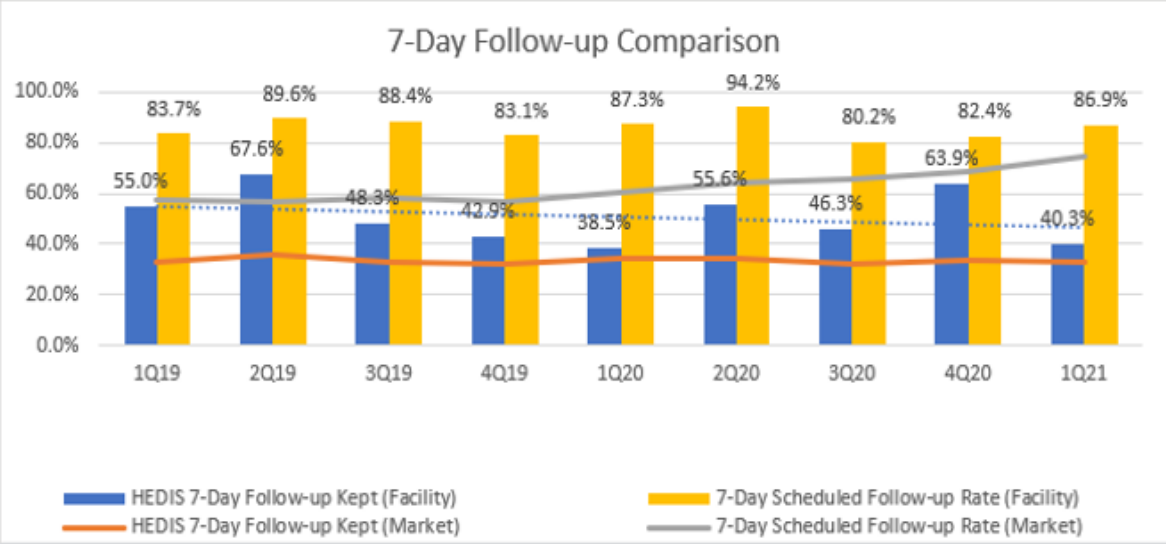
Facility Name	HEDIS 7-Day Follow-up Kept (Facility)				
TIN	BCBS LA	2019	33.8%	Eligible	2317
NPI	BCBS LA	2020	33.3%	Eligible	2081
Reporting Period	Facility	2019	35.4%	Eligible	96
2019 Admits	Facility	2020	23.8%	Eligible	84
2020 YTD Admits	Facility	Current Quarter	15.4%	Eligible	13
Current Quarter Admits	**Populations:**	Child/Adol	Adult	Geriatric	



Example of Comparison Data

Scheduled 7 FUH and Kept 7 FUH Comparison

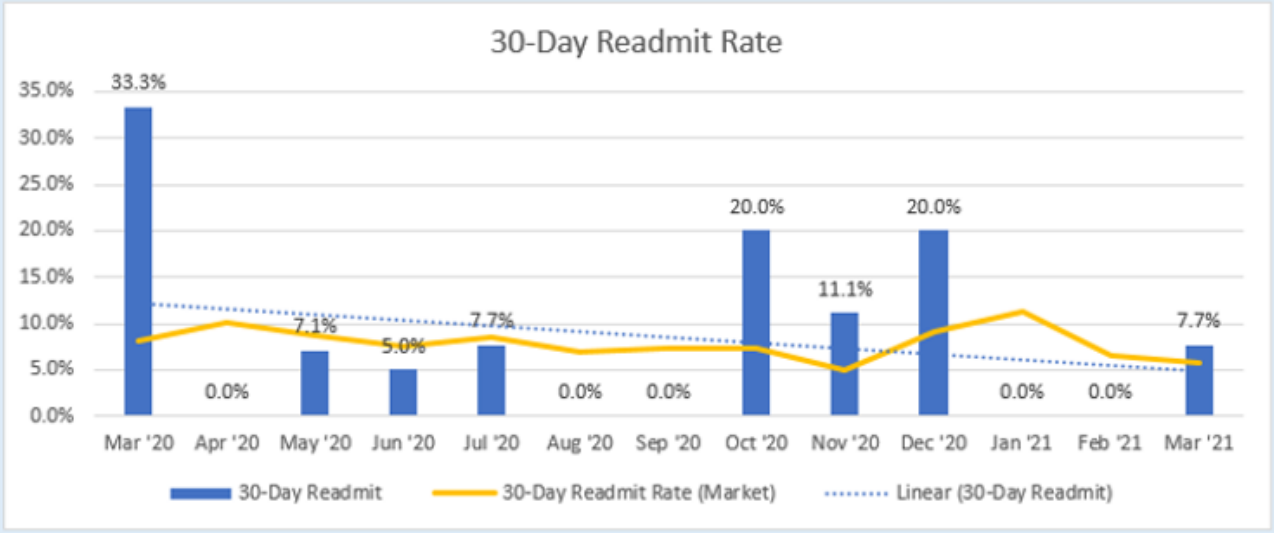
Facility Name				HEDIS 7-Day Follow-up Kept (Facility)				
TIN				BCBS LA	2019	33.8%	Eligible	2320
NPI				BCBS LA	2020	33.4%	Eligible	2086
Reporting Period	1Q19	thru	1Q21	Facility	2019	52.5%	Eligible	179
2019 Admits	292			Facility	2020	49.5%	Eligible	200
2020 YTD Admits	321			Facility	Current Quarter	40.3%	Eligible	72
Current Quarter Admits	97			Populations:	Child/Adol	Adult	Geriatric	



Example of Comparison Data

30 Day Readmission

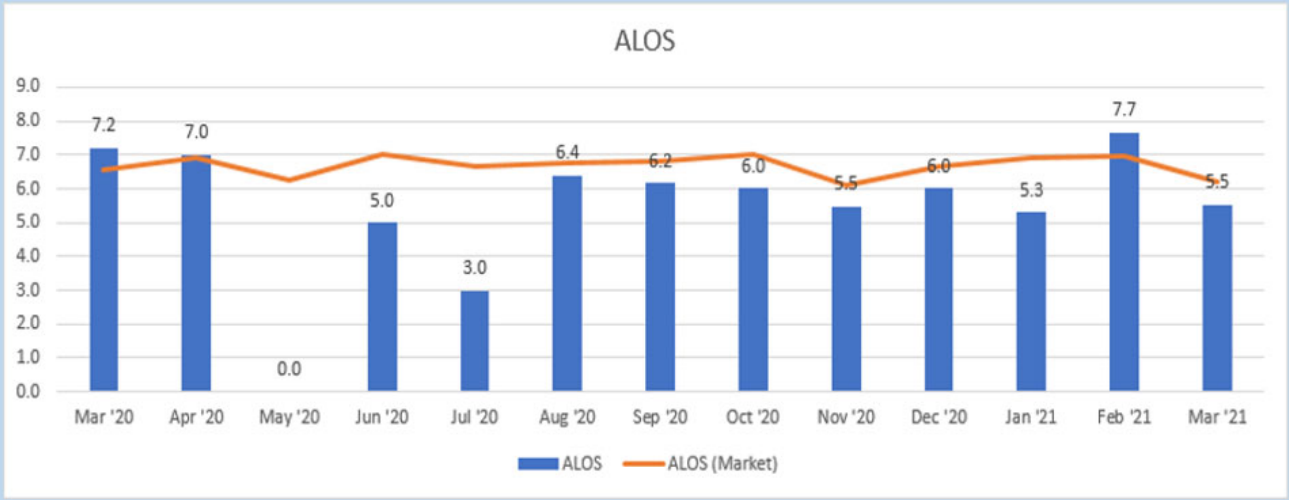
Facility Name		30-Day Readmit Rate			
TIN		Market	2019	7.2%	
NPI		Market	2020	7.6%	
Reporting Period		Facility	2019	8.3%	
Period to Date Admits		Facility	2020	8.5%	
Current Month Admits		Facility	Current month	7.7%	
		Populations:	Child/Adol	Adult	Geri
Excluded Product:	Medicare	Status:			



Example of Comparison Data

Average length of Stay

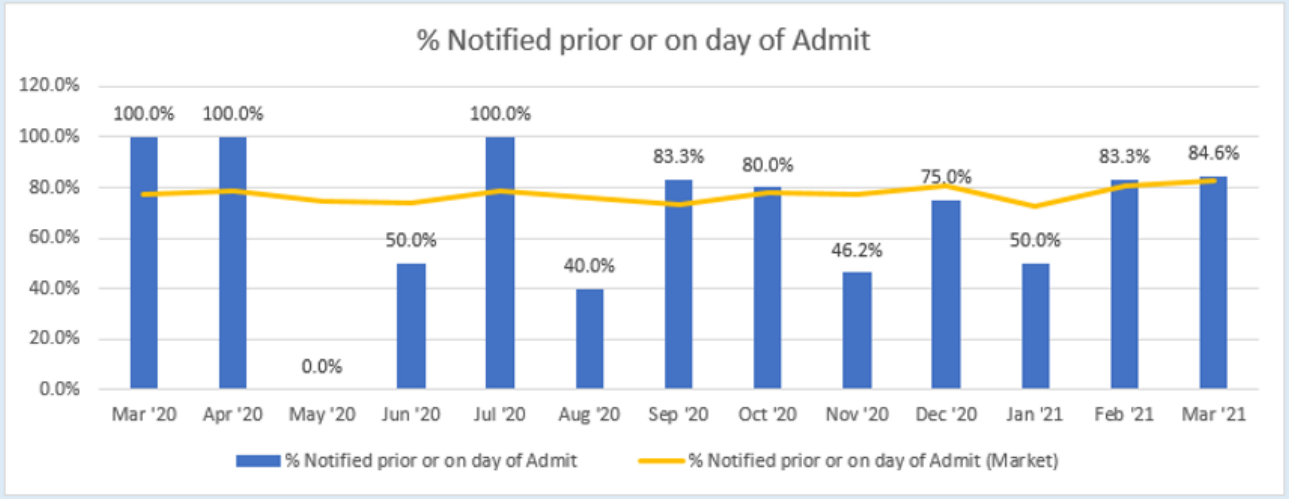
Facility Name		ALOS			
TIN		Market	2019	6.1	
NPI		Market	2020	6.6	
Reporting Period		Facility	2019	5.4	
Period to Date Admits		Facility	2020	5.9	
Current Month Admits		Facility	2021	5.9	
		Facility	Current month	5.5	
Authorization Threshold		**Populations:**	Child/Adol	Adult	Geri
Excluded Product:	Medicare	Status:			



Example of Comparison Data

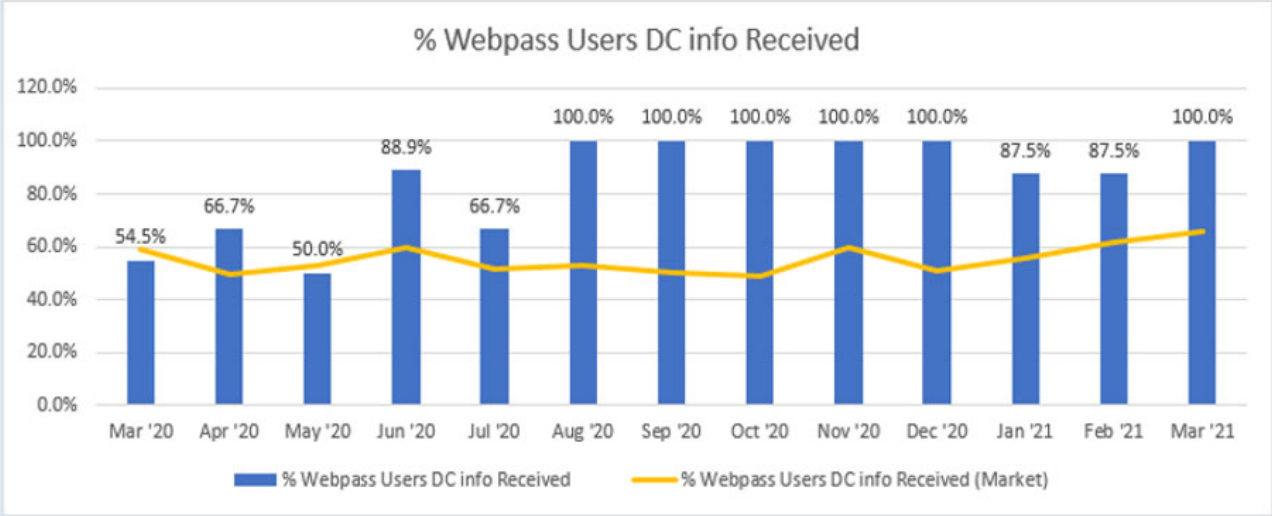
Percent Notified Prior or on Day of Admission

Facility Name		% Notified prior or on day of Admit				
TIN		Market	2019	74.9%		
NPI		BCBS LA Gold Card	2020	76.4%		
Reporting Period		Facility	2019	70.0%		
Period to Date Admits		Facility	2020	68.6%		
Current Month Admits		Facility	2021	72.4%		
		Facility	Current month	84.6%		
Authorization Threshold		Populations:		Child/Adol	Adult	Geri
Excluded Product:	NONE	Status:				



Example of Comparison Data
Discharge Info Submitted via WebPass

Facility Name		% Webpass Users DC info Received			
TIN		Market	2019	47.2%	
NPI					
Reporting Period		Facility	2019	63.9%	
Period to Date Admits		Facility	2020	84.1%	
Current Month Admits		Facility	2021	90.0%	
		Facility	Current month	100.0%	
Authorization Threshold		Populations:	Child/Adol	Adult	Geri
Excluded Product:	Medicare	Status:			



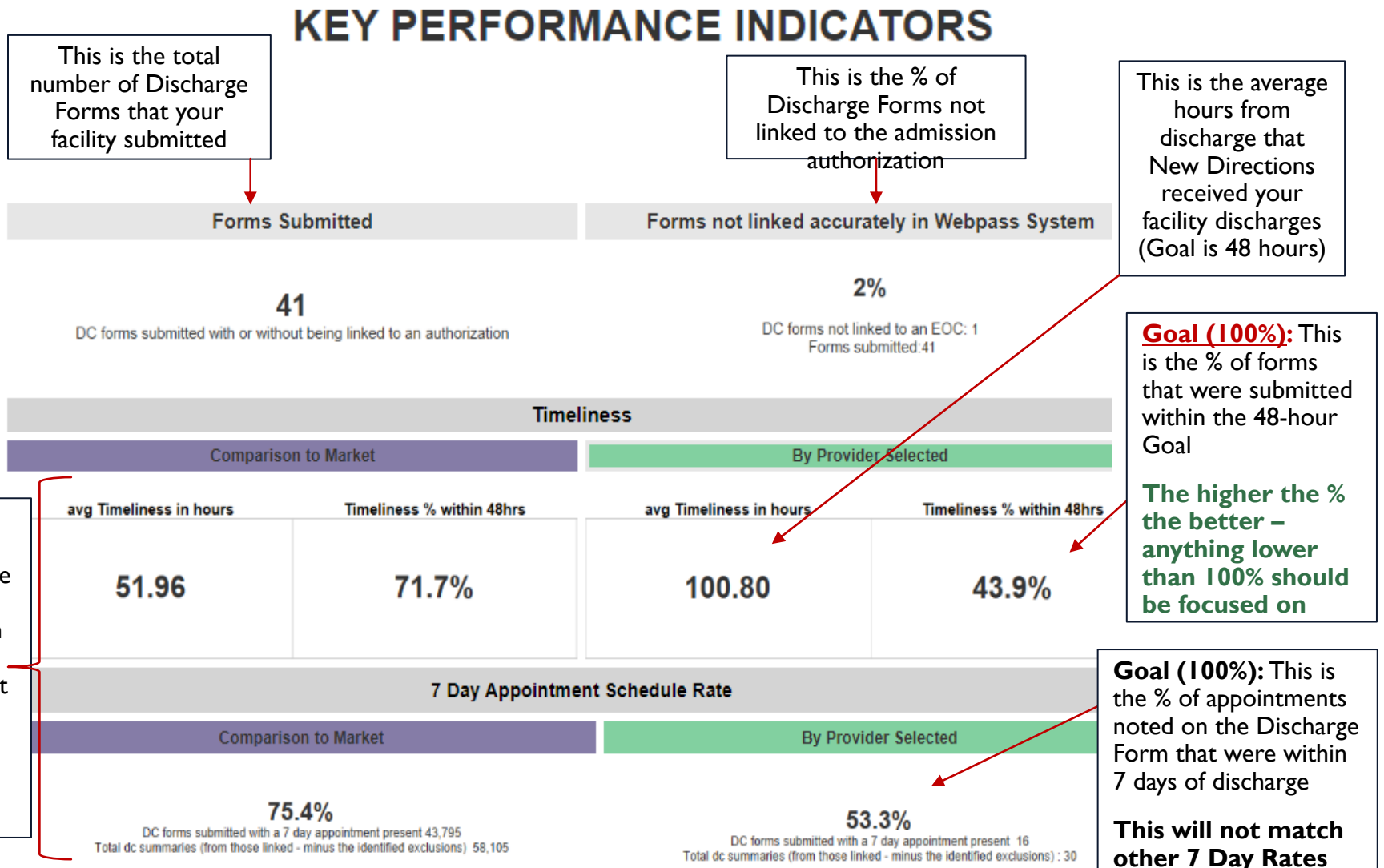
WEBPASS DISCHARGE CLINICAL REVIEW FORM DASHBOARD

Discharge Clinical Review Form Dashboard

Discharge Dashboard provider Key Performance Indicator related to the Discharge Clinical Form (WebPass and telephonic).

- Submission of Discharge Clinical Forms
- Submission of Discharge Clinical Forms within 48-hours of each member discharge
- Seven-Day Follow-Up Appointment scheduling rates, HEDIS qualified appointments for mental health
- Presence of a Crisis, Safety or Relapse Prevention Plan
- Documentation of member involvement in the discharge planning process
- Documentation of member understanding of their discharge plans and goals
- Presence of an applicable signed Authorized Delegate Form (ROI)

Example


KEY PERFORMANCE INDICATORS
This is the total number of Discharge Forms that your facility submitted
This is the % of Discharge Forms not linked to the admission authorization
This is the average hours from discharge that New Directions received your facility discharges (Goal is 48 hours)
Forms Submitted
Forms not linked accurately in Webpass System
41
DC forms submitted with or without being linked to an authorization
2%
DC forms not linked to an EOC: 1
Forms submitted:41
Goal (100%): This is the % of forms that were submitted within the 48-hour Goal
The higher the % the better – anything lower than 100% should be focused on
Timeliness
Comparison to Market
By Provider Selected
This shows the performance of all providers in the Market Regions that you served members from
avg Timeliness in hours
Timeliness % within 48hrs
avg Timeliness in hours
Timeliness % within 48hrs
51.96
71.7%
100.80
43.9%
7 Day Appointment Schedule Rate
Comparison to Market
By Provider Selected
75.4%
DC forms submitted with a 7 day appointment present 43,795
Total dc summaries (from those linked - minus the identified exclusions) 58,105
53.3%
DC forms submitted with a 7 day appointment present 16
Total dc summaries (from those linked - minus the identified exclusions) : 30
Goal (100%): This is the % of appointments noted on the Discharge Form that were within 7 days of discharge
This will not match other 7 Day Rates due to various reasons, including data source, filters, etc.

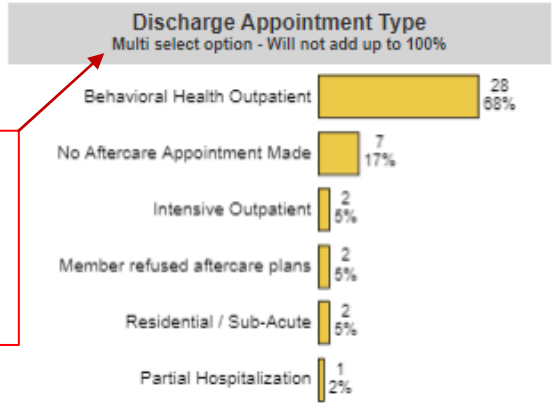
Example

DISCHARGE APPOINTMENT DATA

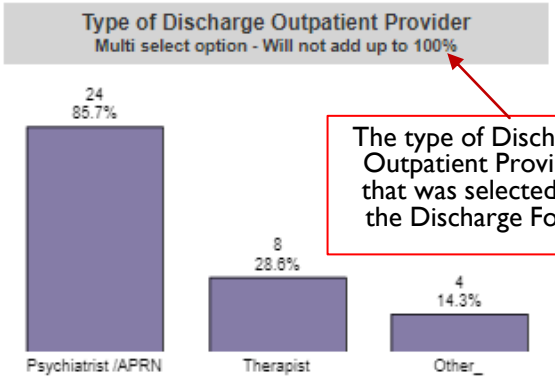
The percentage of 'Outpatient' Appointments that were secured that were virtual/telehealth appointments. This is for informational purposes only. This question was implemented 2/18/21; the numbers will not be present before this time

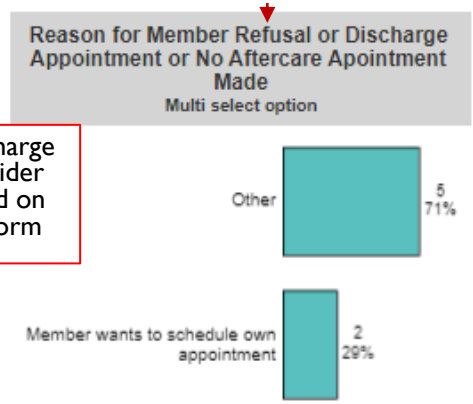
The reason selected on the form for why the member refused or no appointment was made

The breakdown of responses given for Discharge Appt Type

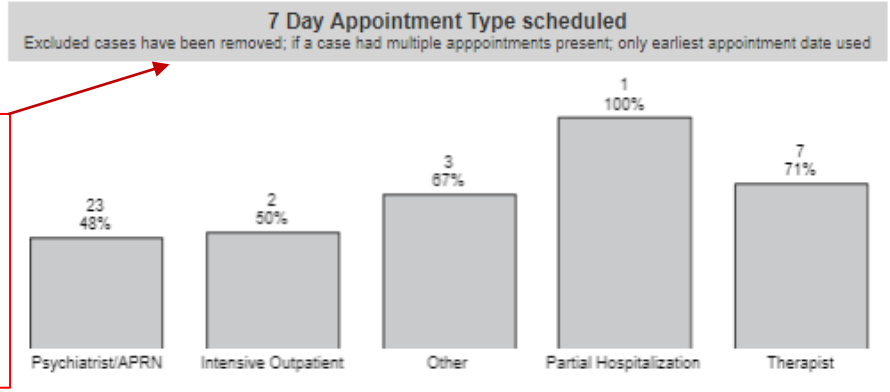


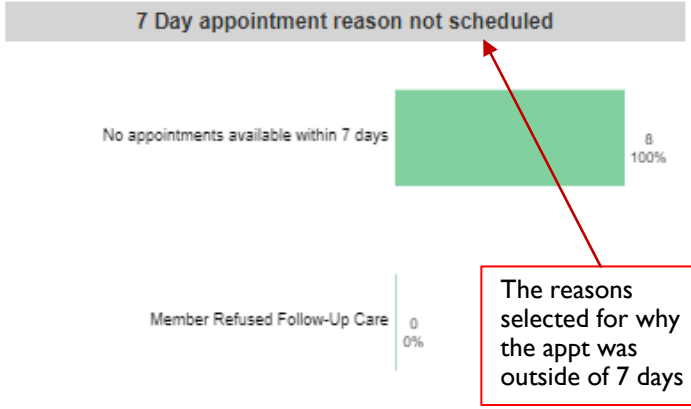
The type of Discharge Outpatient Provider that was selected on the Discharge Form





The percentage of each appointment type that was scheduled within 7 days of Discharge





The reasons selected for why the appt was outside of 7 days

The performance of all providers in the Market Regions that you served members from

Example

Goal: 100% Yes

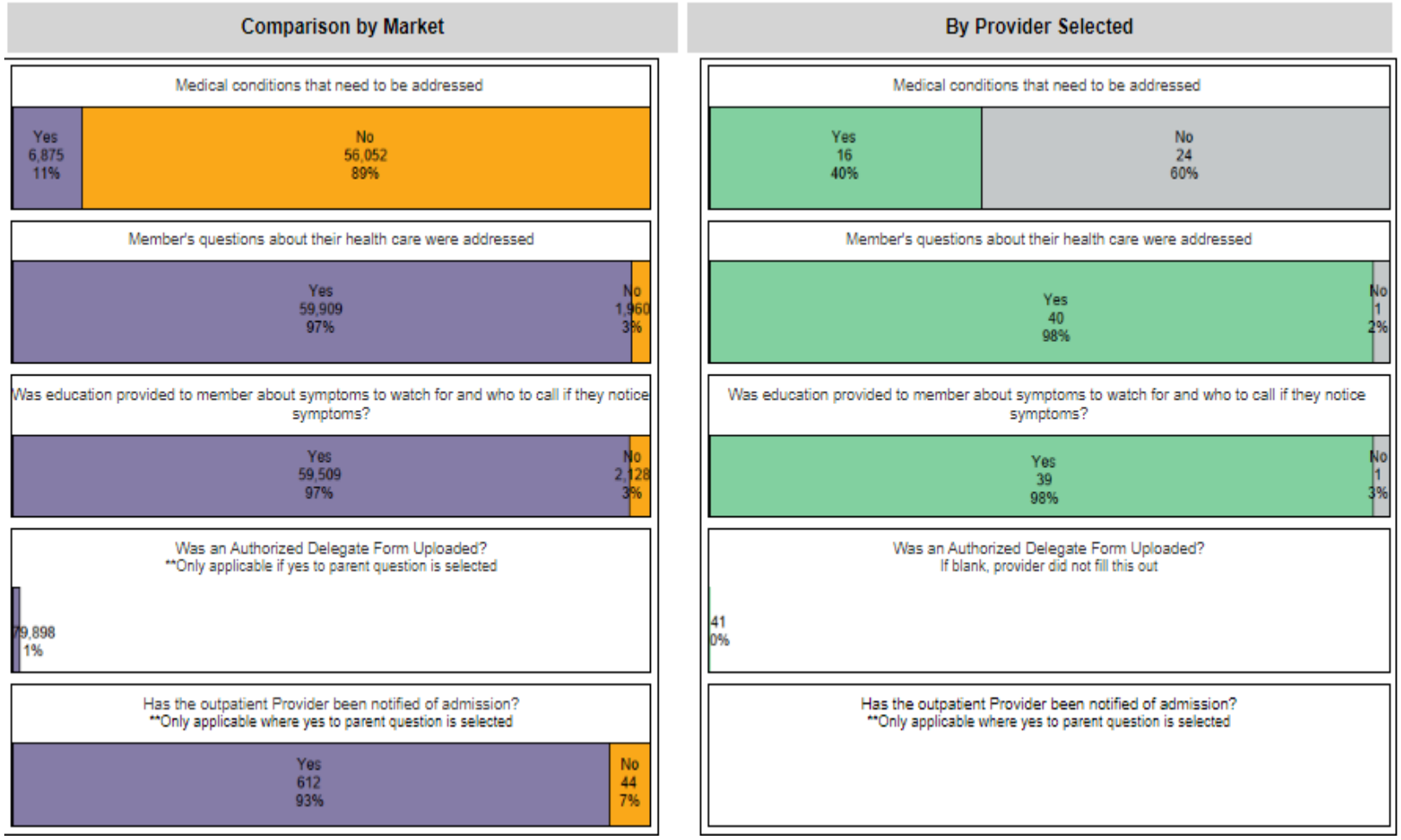
QUALITY DISCHARGE PLANNING ELEMENTS

The performance of all providers in the Market Regions that you served members from

Example

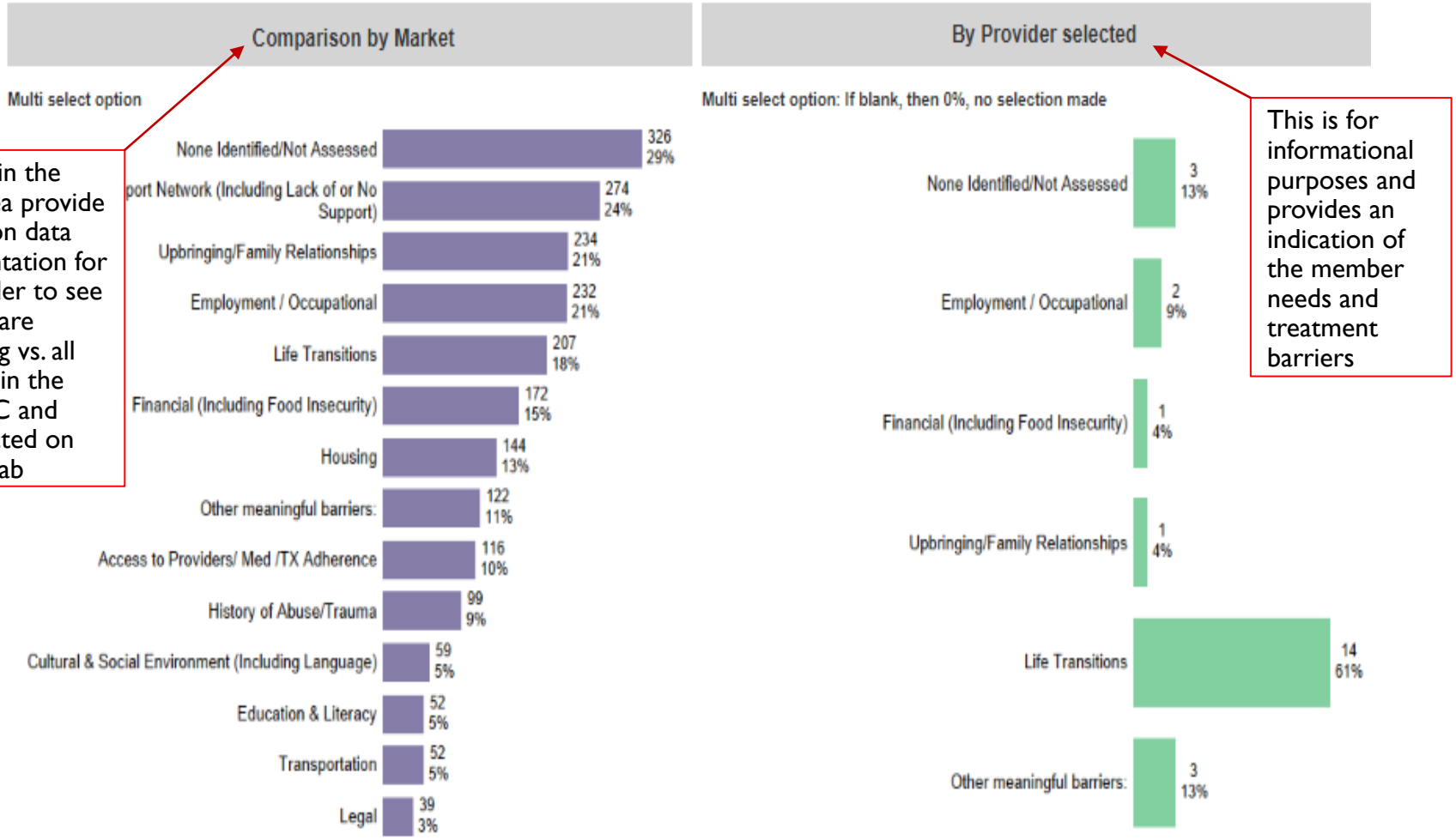
Your facility's specific data

QUALITY DISCHARGE PLANNING ELEMENTS



Example

SOCIAL DETERMINANTS OF HEALTH- SDOH



The stats in the purple area provide comparison data for presentation for the provider to see how they are performing vs. all providers in the payer, LOC and LOB selected on previous tab

This is for informational purposes and provides an indication of the member needs and treatment barriers

EXAMPLE:
2020

ANTI PSYCHOTIC DATA TAB

Explanation for why the member is being discharged on two or more antipsychotic medications

SUBSTANCE USE

Resources to Share with Members

www.ndbh.com/Resources/SubstanceUseCenter

Resources to Share with Members

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

Resources

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 >

Member 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 >

GUIDING PRINCIPLES DOCUMENT: KEY CONCEPTS IN STANDARD OF CARE FOR SUD (WHAT WORKS IN TREATING SUDS)

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

GUIDING PRINCIPLES DOCUMENT: DISEASE AND CHRONIC CARE MODEL

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

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

WHAT IS MAT?

Medication-assisted treatment (MAT) is the use of medications and counseling to treat substance use disorders. Many people with opioid use disorder (OUD) or alcohol use disorder (AUD) can benefit from MAT. In fact, it is the most effective way for some individuals to recover long term.

- There are several medications currently approved by the FDA for alcohol and opioid dependence.
    - AUD - Disulfiram, acamprosate, naltrexone.
    - OUD - 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.
- These medications work by normalizing brain chemistry without any euphonric effects.
- They cease physiological cravings and withdrawal symptoms.

SAMSHA (2018). Medication Assisted Treatment. Retrieved from https://www.samhsa.gov/medication-assisted-treatment

VALUE OF MAT

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

- ***Increases:***
  - treatment retention and ability to recover.
  - ability to gain and maintain employment.
  - the risk of overdose (due to loss of tolerance) and other adverse consequences (SAMSHA)
- ***Decreases:***
  - criminal activity/illicit opiate use.
  - injection use which leads to reduced transmission of HIV and Hepatitis C.

SAMSHA (2018). Medication Assisted Treatment. Retrieved from https://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), pp. 1425-33.

Discussing MAT Adoption with Facilities

- NDBH is committed to supporting all providers of SUD services to improve the quality of these treatment services and ensure that members have access to timely, appropriate treatment.

- NDBH developed a set of guiding principles and evidence-based practices to share with providers treating SUD. https://www.ndbh.com/docs/ContentManaged/Providers/Resources/Guiding_principles_in_the_treatment_of_SUD_Final2.pdf

- NDBH seeks to promote:
  - Application of a chronic condition approach to SUD.
  - Use of evidence-based best practices, including MAT.
  - Efforts to help members move towards self-management in their recovery.
  - Addressing unmet needs of substance users through innovation.
  - Collaborating to improve systems of care for members with SUD.

Summary of MAT Benefits

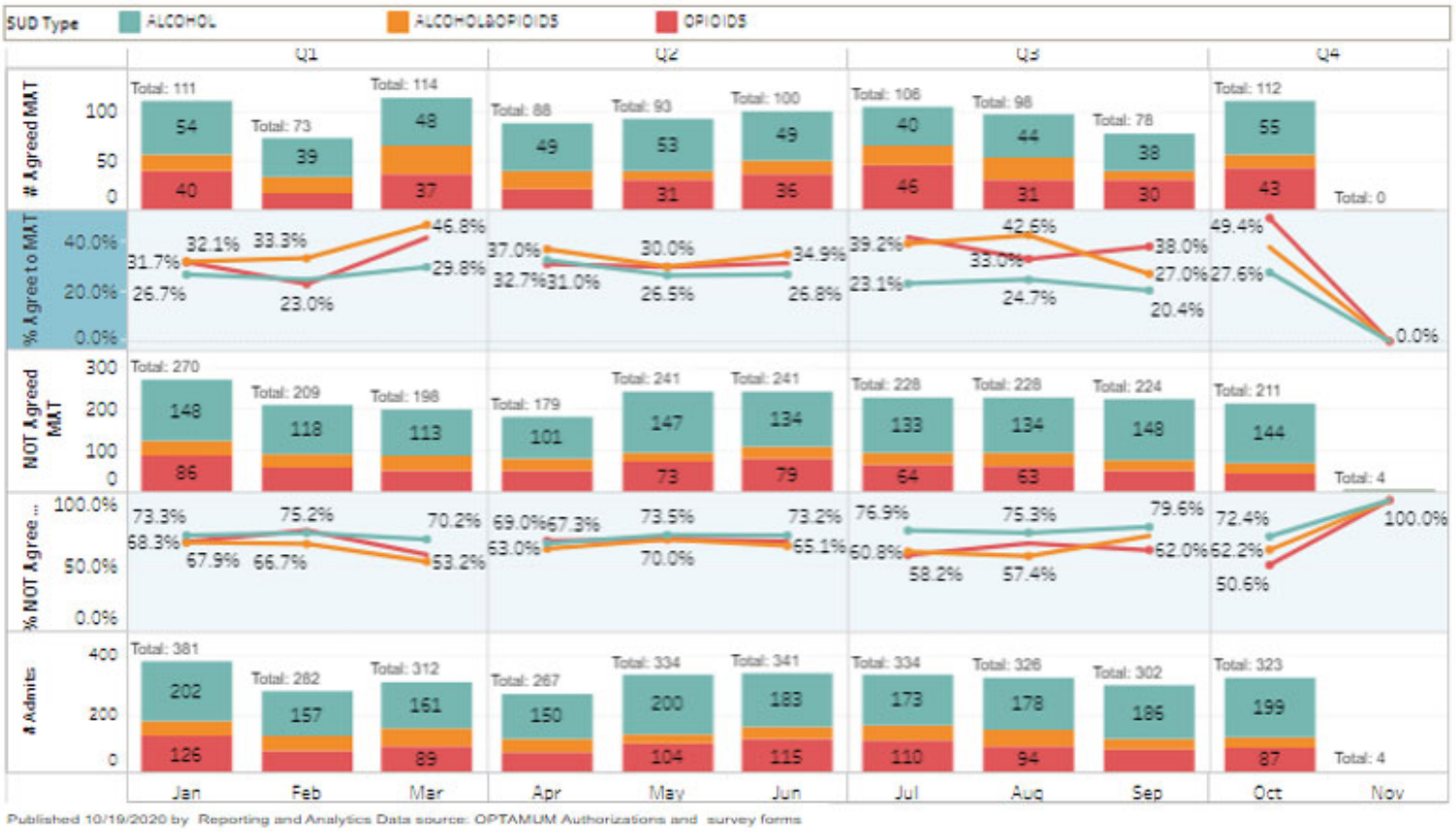
- MAT is considered gold standard for treatment.
- Using MAT Medications for opioid withdrawal management is recommended over abrupt cessation of opioids. (American Society of Addiction Medicine).
- Opioid recovery rates without MAT were 7% successful (SAMSHA).
- Opioid recovery rates improve to 60% with MAT (SAMSHA).
- Without MAT, opioid relapse decreases motivation due to cravings/relapse (SAMSHA).
- 75% reduced mortality versus patients with only psychosocial interventions (SAMSHA).
- Successful recovery requires individualized, coordinated network of community-based system of care (ROSC), including Recovery Support Services (RSS).

Benchmarks and Expectations for Facilities

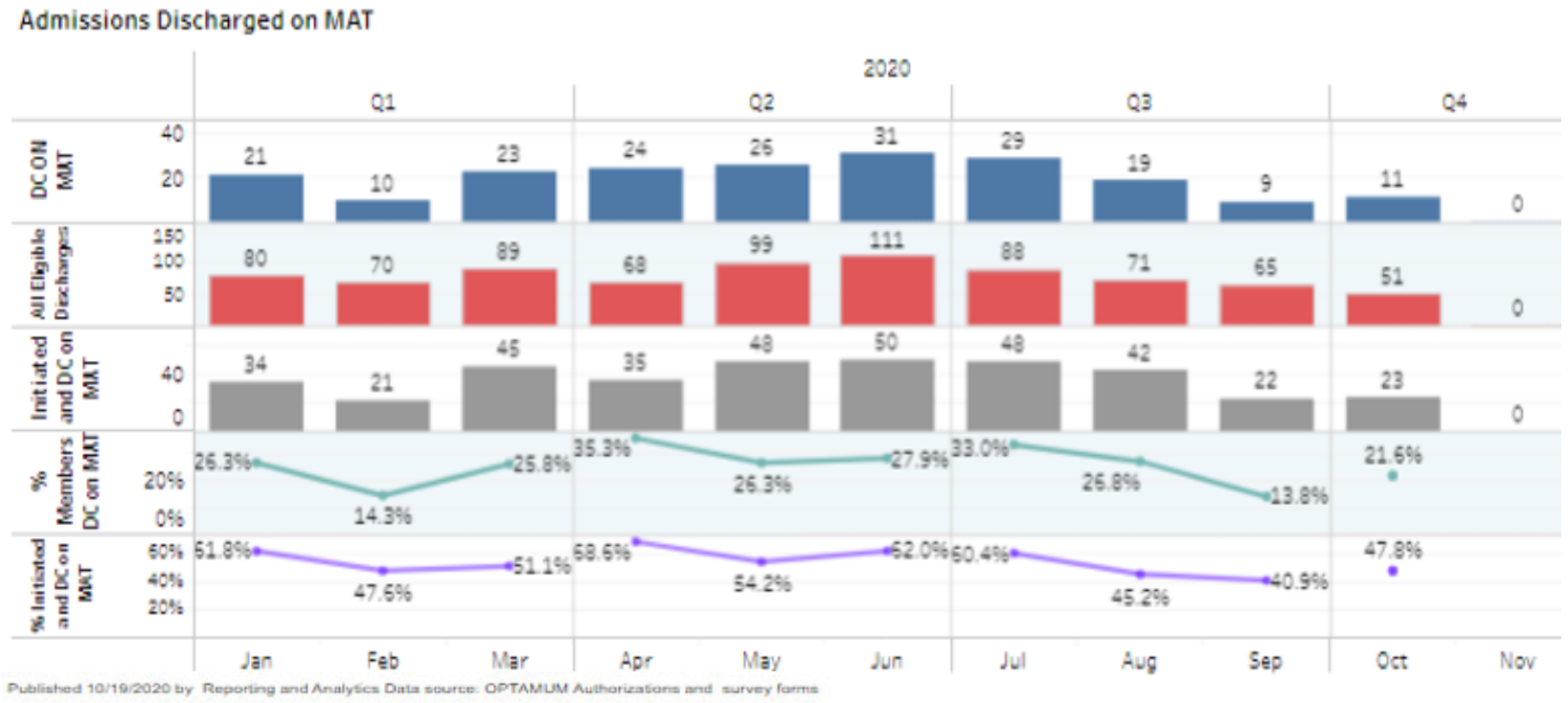
- MAT Education: 100% of SUD DX members will receive MAT education.
- MAT (AUD) Acceptance: 50% of members educated on MAT for alcohol use disorder will accept MAT.
- MAT (OUD) Acceptance: 40% of members educated on MAT for opioid use disorder will accept MAT.
- MAT Acceptance and Initiation: 50% of members accepting MAT will initiate while in the facility.
- MAT Acceptance with Referral to appropriate MAT provider: 35% of members will be referred to MAT provider if not initiated in the facility.

Admission Educated on MAT

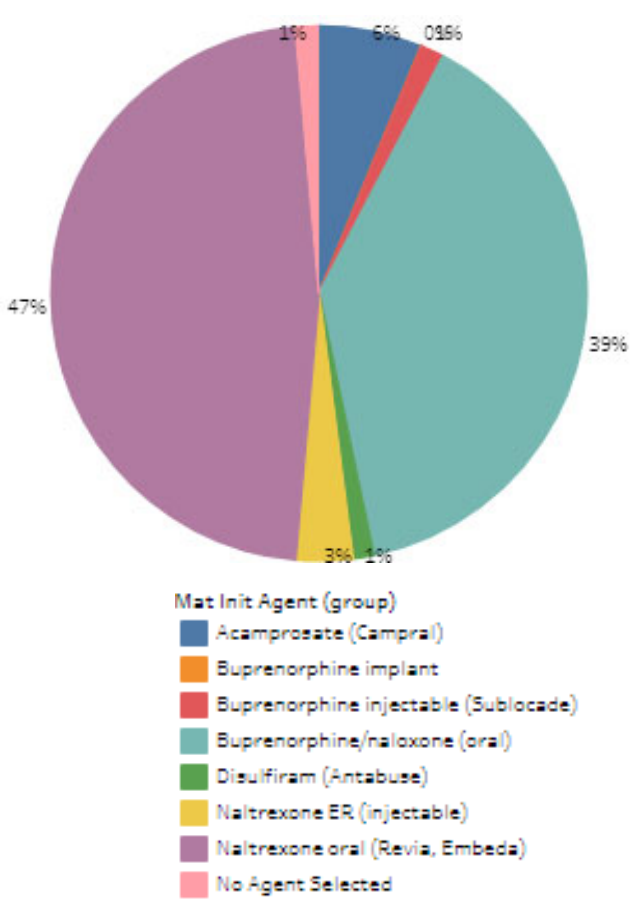
Admission Agreed to MAT



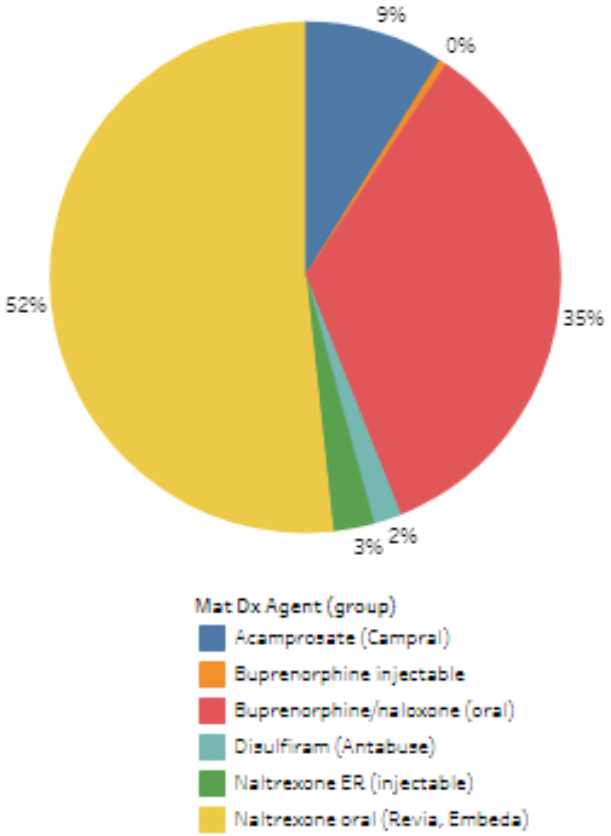
Admission Discharged on MAT



% MAT Initial Agents-Admits Agreed



% MAT Agents upon Discharge



Published10/19/2020 by Reporting and Analytics Data source: OPTAMUM Authorizations and survey forms

SUICIDE

SEPTEMBER IS SUICIDE AWARENESS MONTH

New Directions Behavioral Health has 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.

https://www.ndbh.com/suicide

Crisis Resources to Share with Members

I'm Ready to Visit a Provider

- Prepare for a visit
- Important Forms
- What type of program do I need?
- What kind of provider do I need?
- Search for a provider

I Need Health Resources

- Self-help tools
- Screening tools
- Mental Health Month toolkit
- Community Resources
- Crisis Information
- Advance Directives
- Member education
- Apps
- Suicide Awareness
- Wellness Plan
- Holiday Toolkit

I Need Help with My Diagnosis

- Autism Resource Center
- Substance Use Disorders Center
- Guideline for Depression
- Case Management
- Guideline for ADHD

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.

REMINDERS

Contact LouisianaPR@ndbh.com

- If you would like to schedule a virtual meeting with our Network Operations staff to learn more about your facility's HEDIS outcome measures scorecard
- For available resources
- To receive the monthly rainmaker list

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 Sims

Clinical Network Manager

Email: msims@ndbh.com

Phone: 1-816-416-7672

Debbie Crabtree

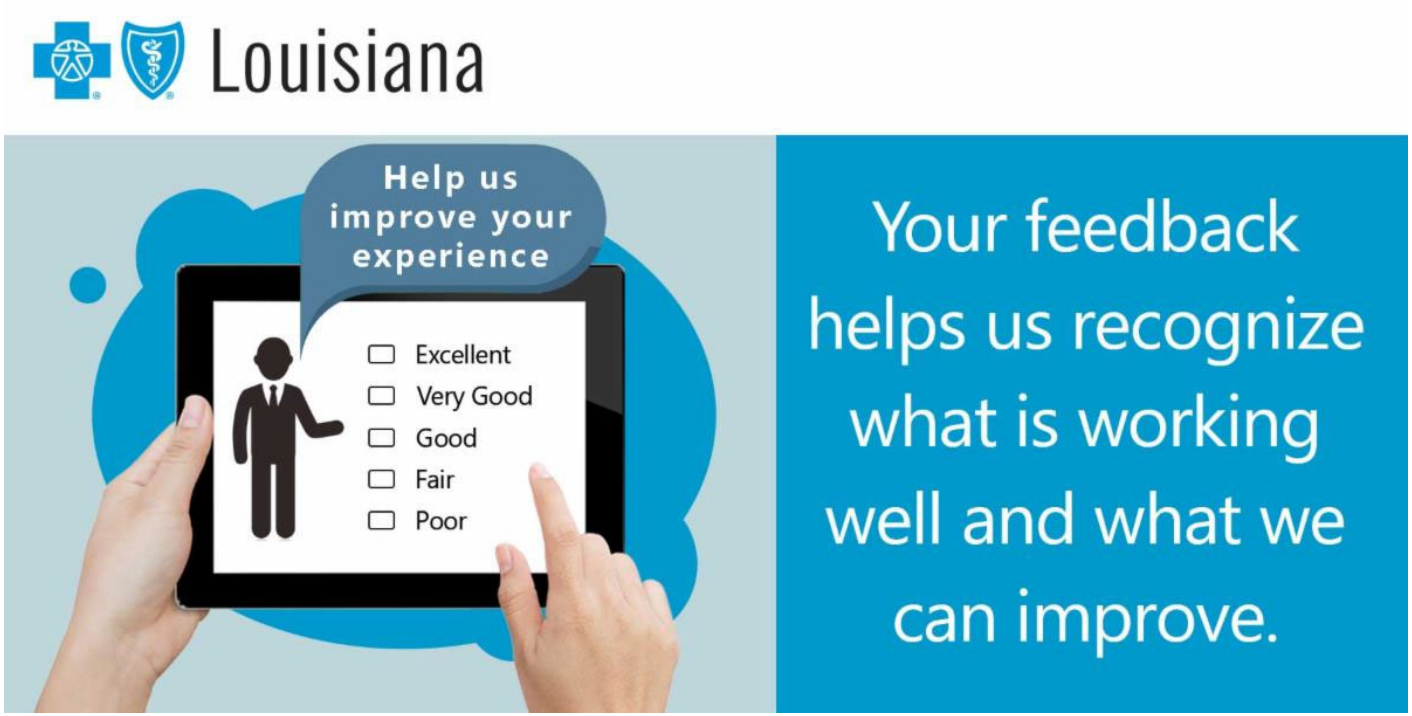
Provider Relations Coordinator

Email: dcrabtree@nbdh.com

Phone: 1-904-371-6942

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.

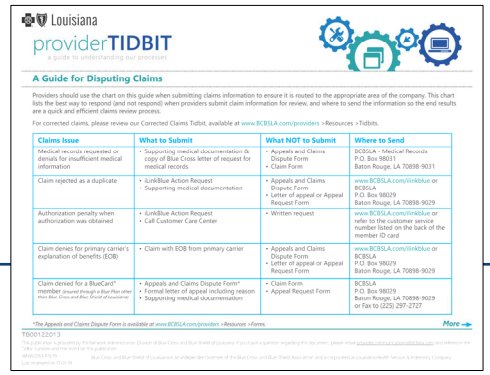
The top reasons for administrative appeals are:

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.

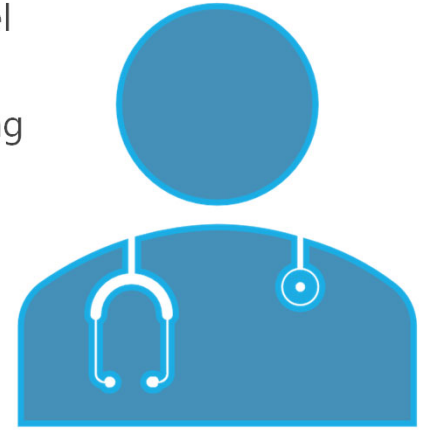
Allows opportunities to engage patients in care management programs and care prevention initiatives.

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

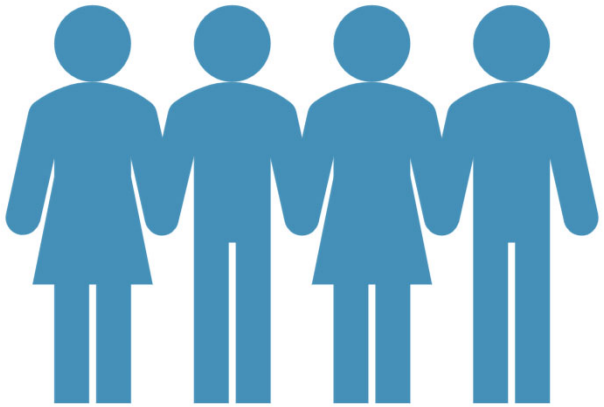
Examples:

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

OUT OF NETWORK REFERRALS

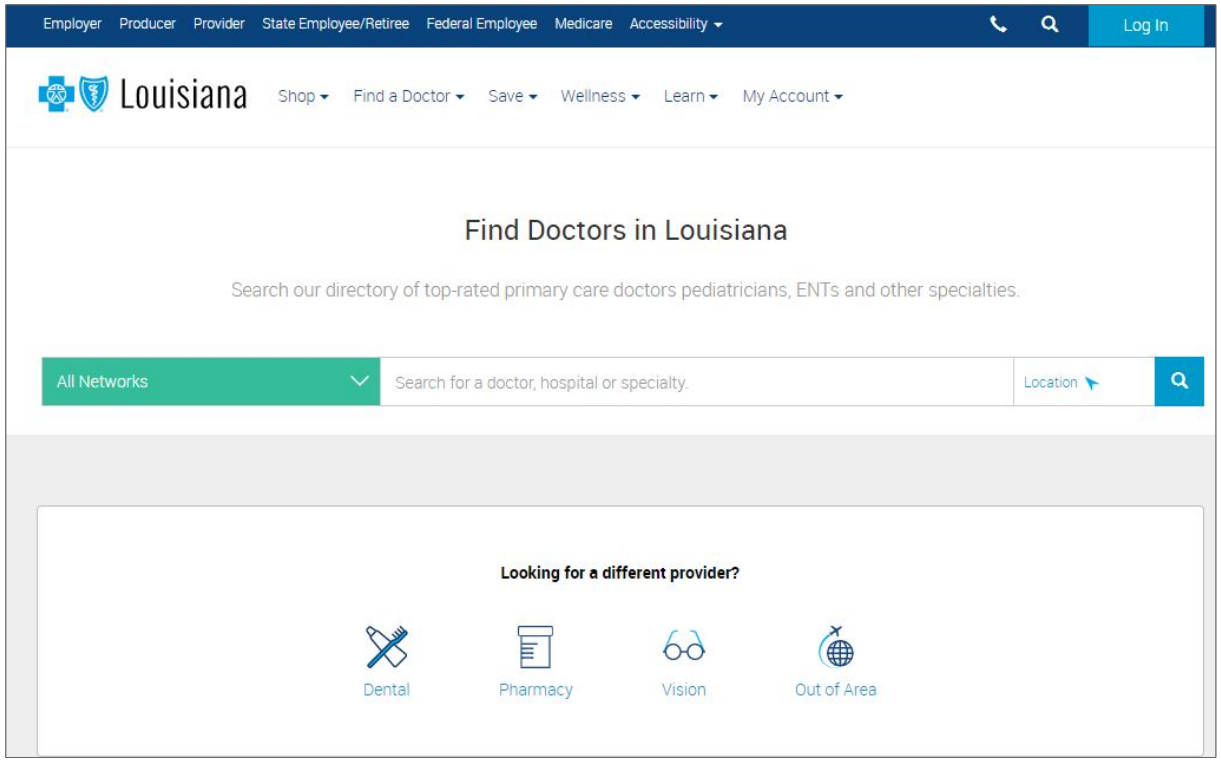
The impact on your patients when you refer Blue Cross members to out-of-network providers:

- 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

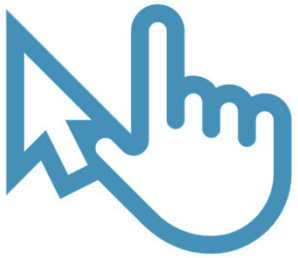
What they will do for you:

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

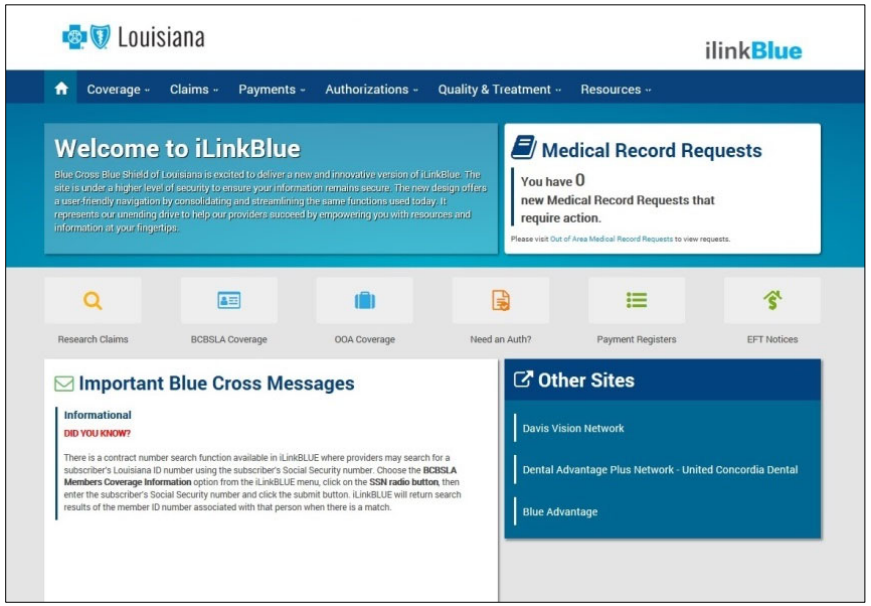
INACTIVITY POLICY

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.

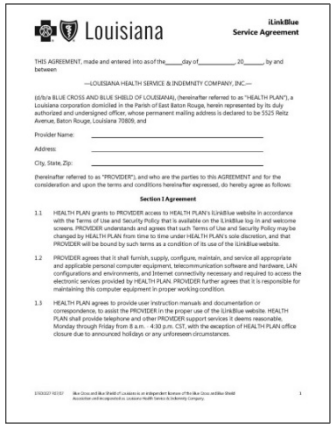
iLinkBlue Application Packet

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”.

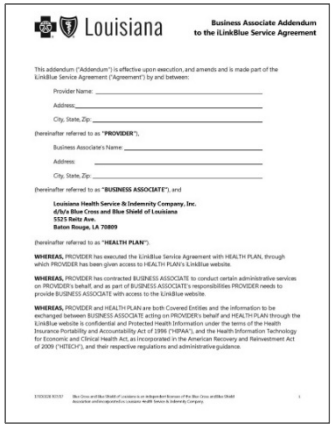
ALWAYS include NPI/TAX ID on:

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

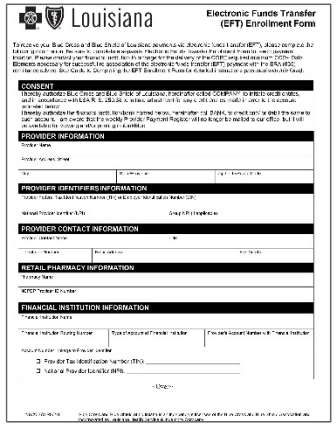
These four documents are required to access iLinkBlue:



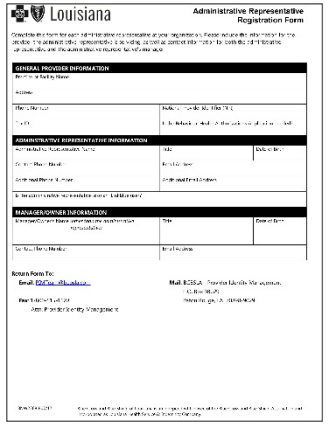
iLinkBlue Service Agreement



Business Associate Addendum



Electronic Funds Transfer Enrollment Form



Administrative Representative Registration Form