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 Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

BEHAVIORAL HEALTH WEBINAR FOR FACILITY PROVIDERS

AUGUST 2022

Provider Relations Department, provider.relations@bcbsla.com

HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO). Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

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

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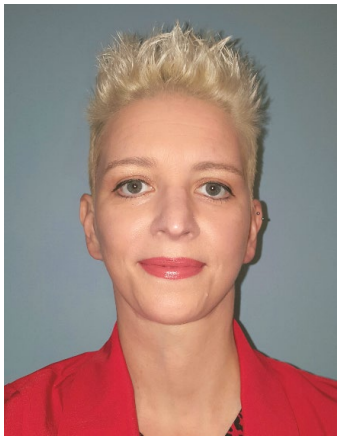
Marie Davis

Provider Relations
BCBSLA



Michelle Sims, LPC, LMFT
Clinical Network Manager
New Directions

Debbie Crabtree
Provider Relations Specialist
New Directions

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

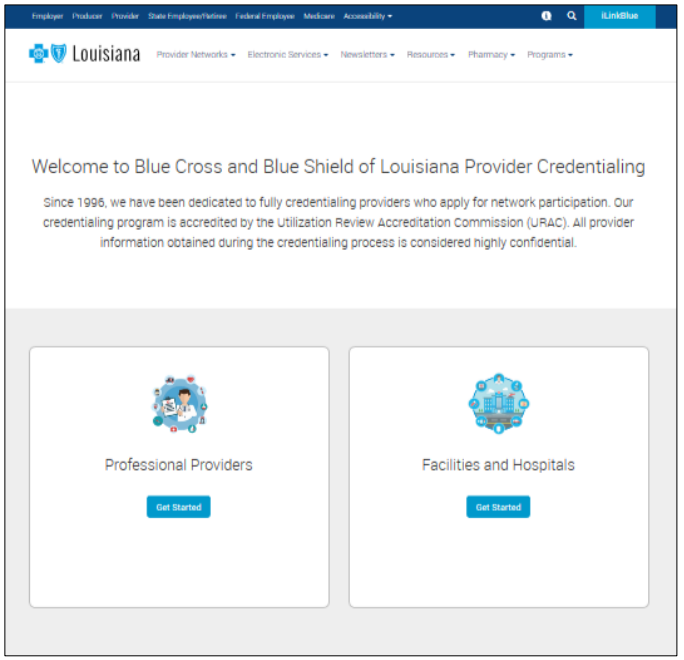
To serve Louisianians as the statewide leader in offering access to affordable healthcare by improving quality, value and customer experience.

PROVIDER CREDENTIALING & DATA MANAGEMENT

JOIN OUR NETWORK

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

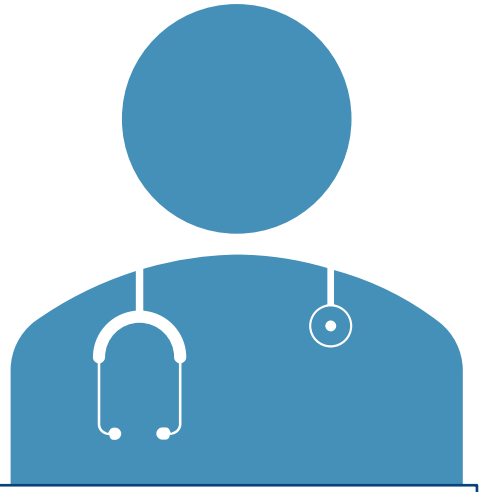
- Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:
  - Credentialing packets
  - Quick links to the Provider Update Request Form
  - Credentialing criteria for professional, facility and hospital-based providers
  - Frequently asked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



You may inquire about your credentialing status by contacting our Provider Credentialing & Data Management Department at **PCDMStatus@bcbsla.com**.

VANTAGE HEALTH MANAGING BLUE CROSS CREDENTIALING/RECREDENTIALING

Blue Cross is pleased to announce its partnership with Vantage Health Plan, Inc. to recredential our network providers. This move will simplify the recredentialing experience for many of our providers.

Aug. 2021

Recredentialing for professional providers participating in both the Blue Cross and Vantage networks.

Nov. 2021

Expanded to include the recredentialing of all Blue Cross professional providers.

Feb. 2022

Expanded to include initial credentialing for professional providers and initial and recredentialing for Blue Cross facility providers.

VANTAGE HEALTH MANAGING BLUE CROSS RECREDENTIALING

Use the chart below for the new recredentialing process:

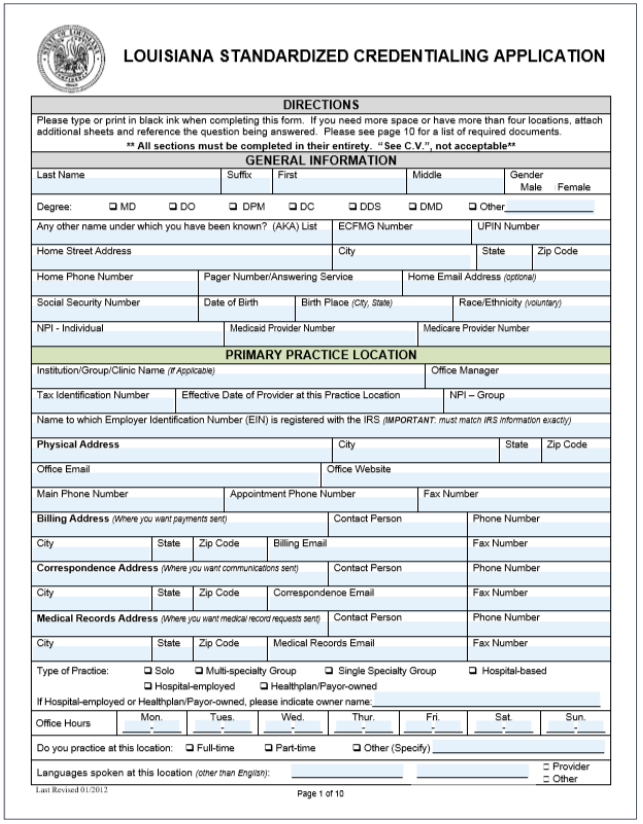
Process initiated by:	Vantage
Form(s) to complete for professional provider recredentialing:	CAQH Application or Louisiana Standardized Credentialing Application (LSCA).
Form(s) to complete for facility reverification:	Facility Credentialing Application, Facility Credentialing Application Checklist and any applicable Facility Information Form Attachments.
Where to submit forms:	To Vantage based on instructions included with recredentialing form.
Verification Process:	Vantage
Who to contact:	Vantage: recredentialing@vhpla.com or (318) 807-4755

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).

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

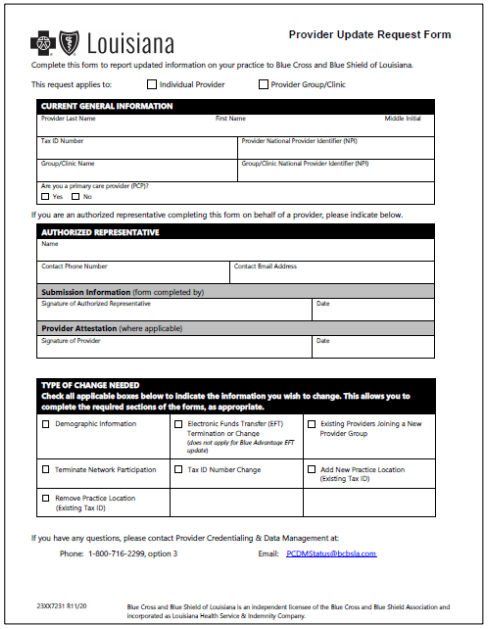
Last Revised 01/2012

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

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



Louisiana

Provider Update Request Form

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

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

CURRENT GENERAL INFORMATION

Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Group/Clinic Name	Group/Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? ☐ Yes ☐ No		

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

AUTHORIZED REPRESENTATIVE

Name	
Contact Phone Number	Contact Email Address
Submission Information (form completed by)	
Signature of Authorized Representative	Date
Provider Attestation (where applicable)	
Signature of Provider	Date

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

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change *(does not apply for Blue Advantage EFT update)*	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

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

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

23XX7231 R1 1/20

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** >Resources >Forms.

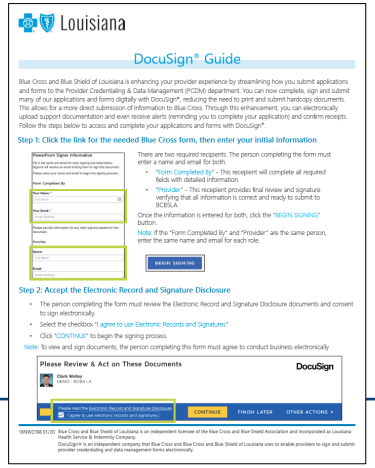
DIGITALLY SUBMITTING FORMS WITH DOCUSIGN

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

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

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

BEGIN SIGNING

Step 2: Accept the Electronic Record and Signature Disclosure

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

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

Please Review & Act on These Documents

DocuSign

CONTINUE FINISH LATER OTHER ACTIONS

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

EASILY COMPLETE FORMS WITH DOCUSIGN

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

Credentialing packets:

- Professional (initial)
- Facility (initial)

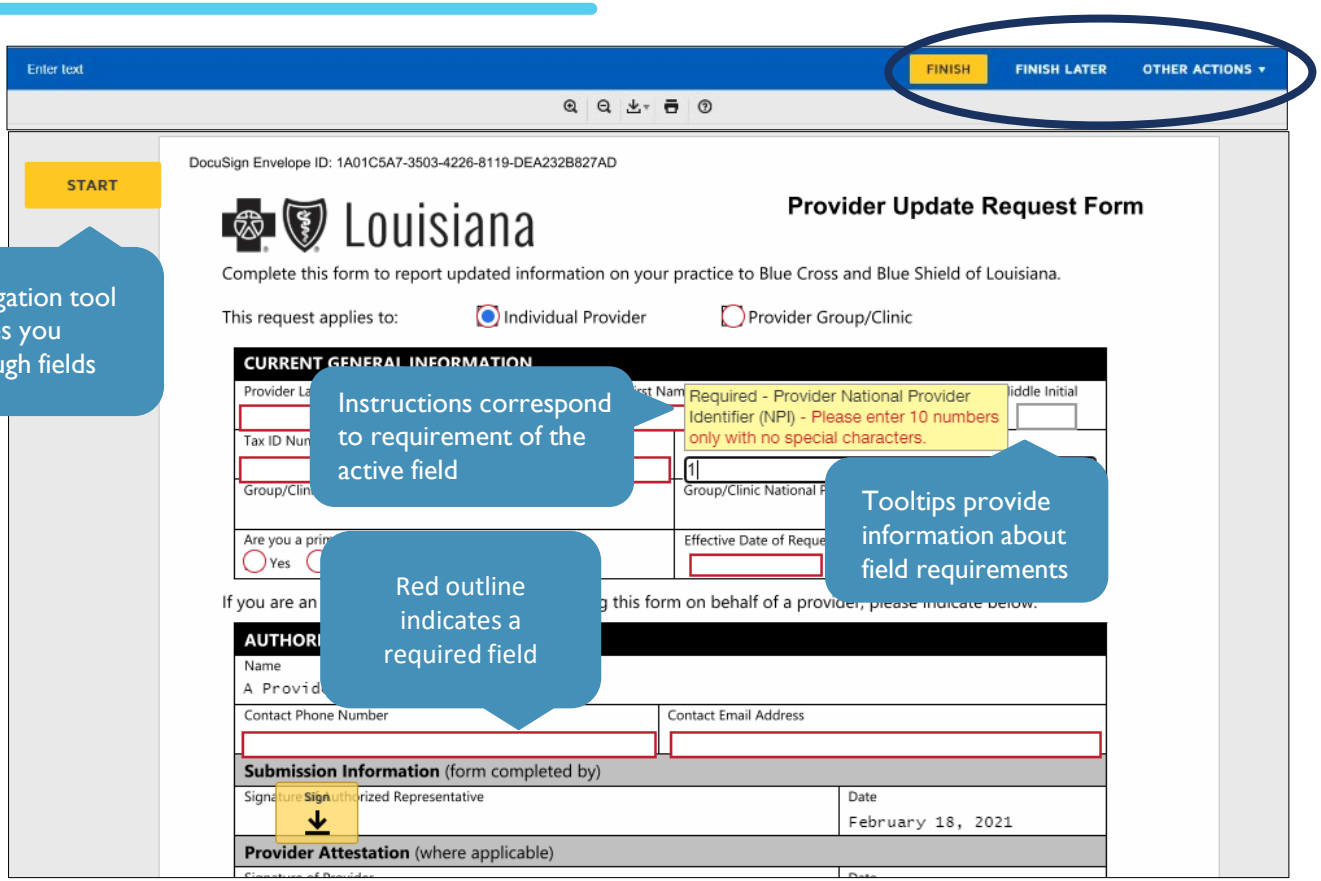
Forms:

- **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.

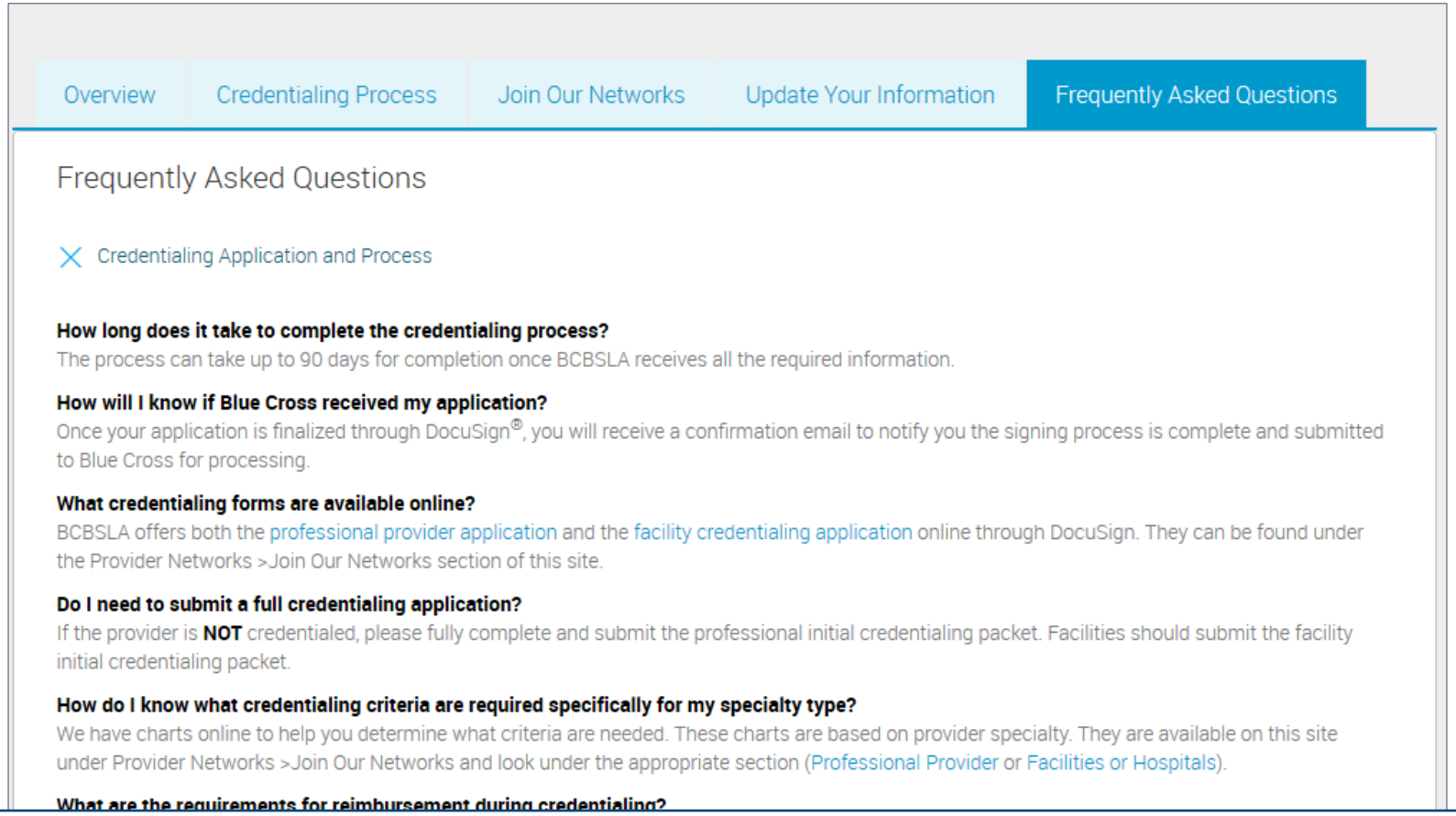
www.bcbsla.com/providers >Provider Networks >Join Our Networks >Facilities and Hospitals.

EASILY COMPLETE FORMS WITH DOCUSIGN



Find our *DocuSign Guide* at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks >Facilities and Hospitals >Join Our Networks.

FREQUENTLY ASKED QUESTIONS



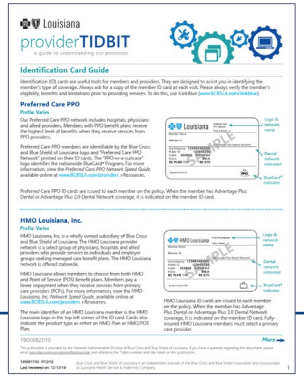
A list of FAQs are available at **www.bcbsla.com/providers** >Provider Networks >Join Our Networks >Facilities and Hospitals >Frequently Asked Questions.

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

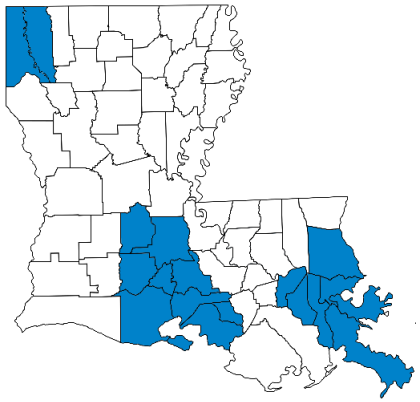
Identification Card Guide

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

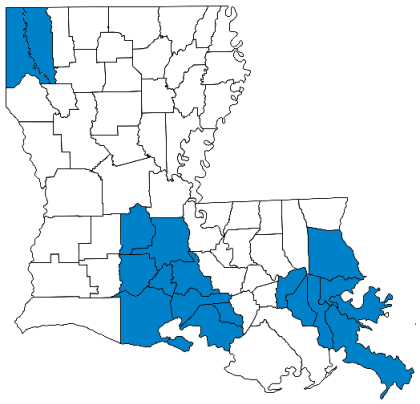
Bossier and Caddo parishes

COMMUNITY BLUE

Baton Rouge area

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

Our Provider Networks



BlueHPN

Lafayette area

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

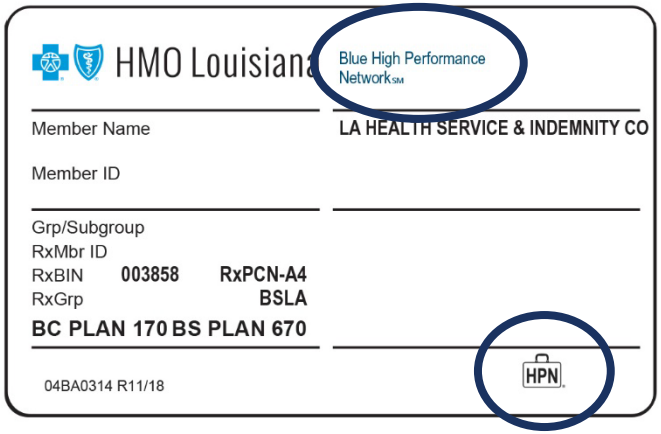
New Orleans area

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

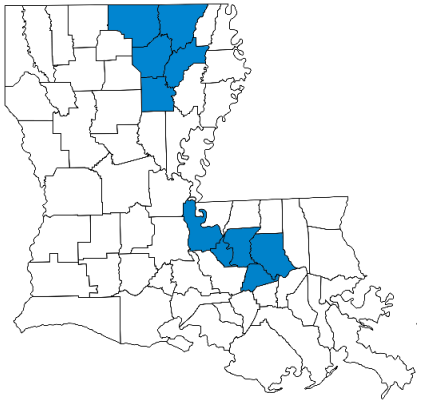
Shreveport area

Bossier and Caddo parishes

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



Our Provider Networks



PRECISION BLUE

Baton Rouge area

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

Greater Monroe/ West Monroe area

Caldwell, Morehouse, Ouachita, Richland and Union parishes

SIGNATURE BLUE

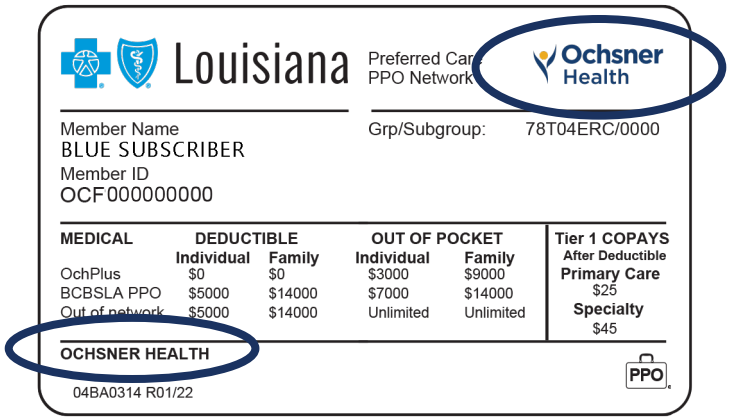
New Orleans area

Jefferson and Orleans parishes

Our Provider Networks

Effective January 1, 2022, for BCBSLA members.

Ochsner Health Network (OHN) is available statewide to eligible members. This is a select network in which BCBSLA partners with Ochsner Health Plan to manage.



Prefix: OCF

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

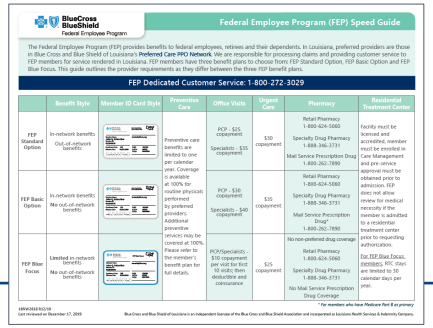
BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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

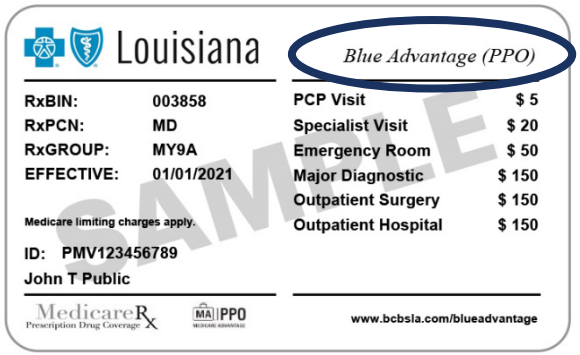
New Timely Filing guidelines:
In-network PPO providers must file claims within 15 months of the date of service.



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.



Prefix: PMV

Prefix: MDV

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

BLUECARD® PROGRAM

- BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area.
- The main identifiers for BlueCard members are the prefix and the "suitcase" logo on the member ID card. The suitcase logo provides the following information about the member:

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

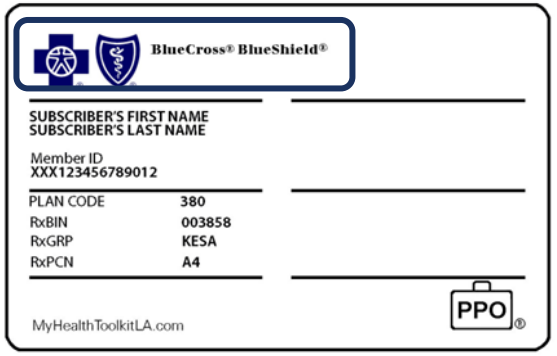
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

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

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.



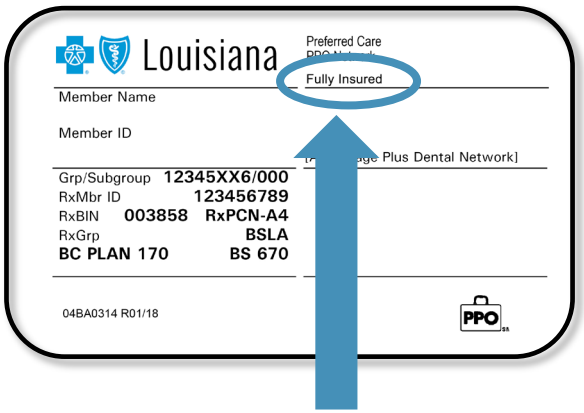
This list of prefixes is available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

FULLY INSURED VS. SELF-INSURED

Member ID Card Differences

FULLY INSURED

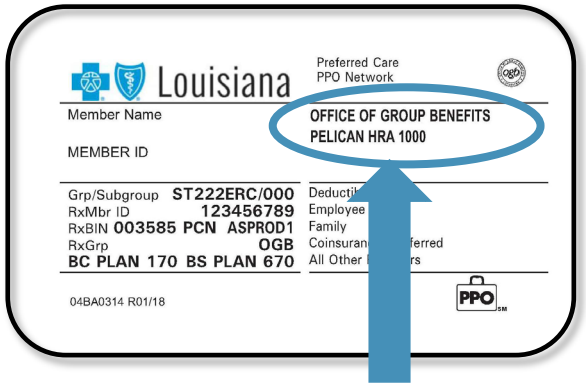
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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.

For more information about our telemedicine requirements, billing and coding guidelines, see our *Member Provider Policy & Procedure Manual* (our facility manual) located only in iLinkBlue at **www.bcbsla.com/ilinkblue** > Resources.

TELEHEALTH PLACE OF SERVICE CODE

- The appropriate place of service is based on where the member is located when the service is performed except when performing DTC telehealth services (place of service 10 should be used for DTC).
- For example, if the member is in the inpatient hospital setting when the telehealth service is performed, place of service 21 should be billed.
- To ensure the appropriate benefits and reimbursement apply, do not bill place of service 02 to Blue Cross for telehealth services.
- Blue Cross does not consider place of service 02 valid for claims submission. Claims billed with place of service 02 may reject.

For more information about our telemedicine requirements, billing and coding guidelines, see Section 5.37 Telehealth/telemedicine our *Professional Provider Office Manual* at **www.bcbsla.com/providers** >Resources >Manuals.

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

MULTI-FACTOR AUTHENTICATION SOON TO BE REQUIRED FOR ILINKBLUE ACCESS

Beginning September 2022, multi-factor authentication (MFA) verification will be required for iLinkBlue users to securely access iLinkBlue.

MFA is a security feature that authenticates who you are when logging in. You must preregister **at least two methods** of verification.

- email
- text
- voice call
- smartphone app

Our step-by-step instruction guide for MFA registration is available at **www.bcbsla.com/providers** >Resources >Speed Guides.

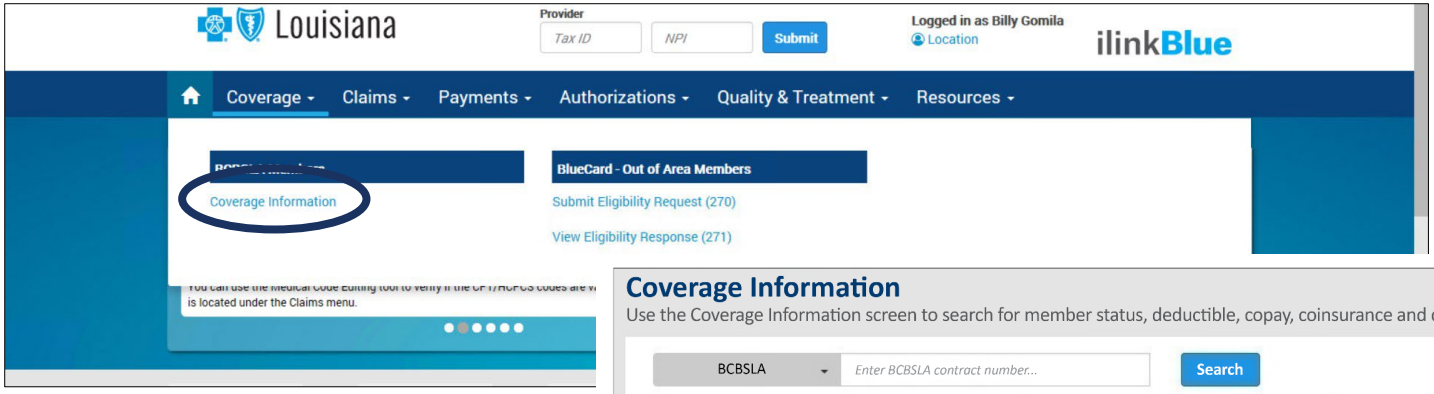
SECURITY SETUP TOOL UPDATE

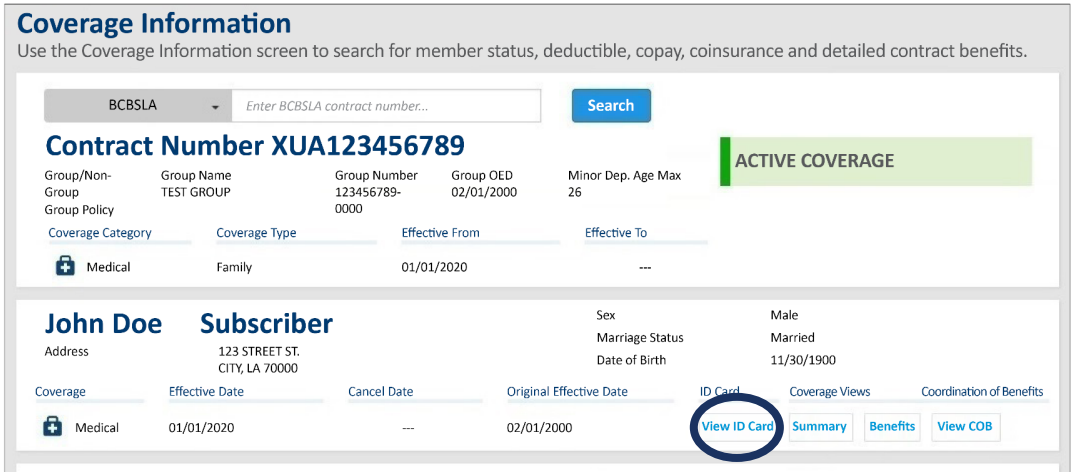
- **September 2022**, we are introducing a new Security Setup Application for administrative representatives called Delegated Access. It will be available through iLinkBlue only.
  - Replaces the existing Sigma Security Setup Tool used today.
  - Gives administrative representatives a better user experience with simpler navigation while maximizing functionality.
- We will migrate the data housed in the current tool for your provider organization to the new application.
- You will not need to reload information into the new application. The goal is to create a seamless transition.

We will provide more details soon. At that time, if you have questions about these changes, please contact our Provider Relations Department at **provider.relations@bcbsla.com**.

DIGITAL ID CARDS IN ILINKBLUE

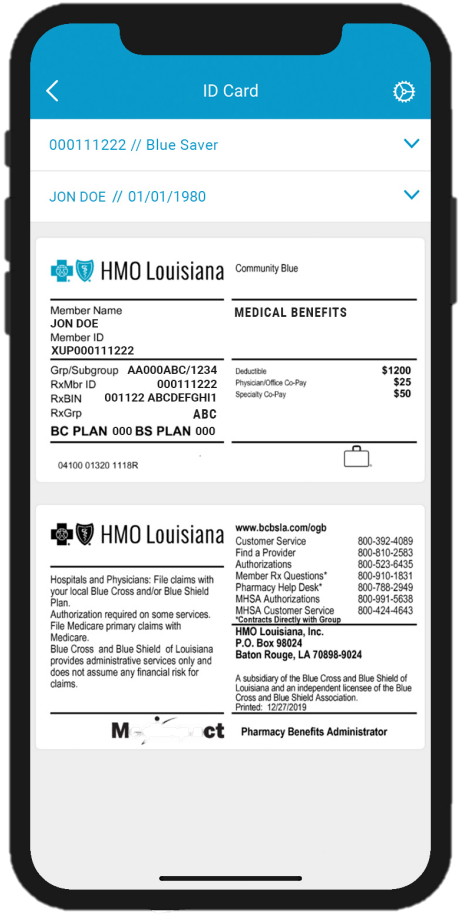
Digital ID cards are downloadable PDFs that can be accessed through iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Coverage Information" menu option, then click “View ID Card.”





DIGITAL ID CARDS

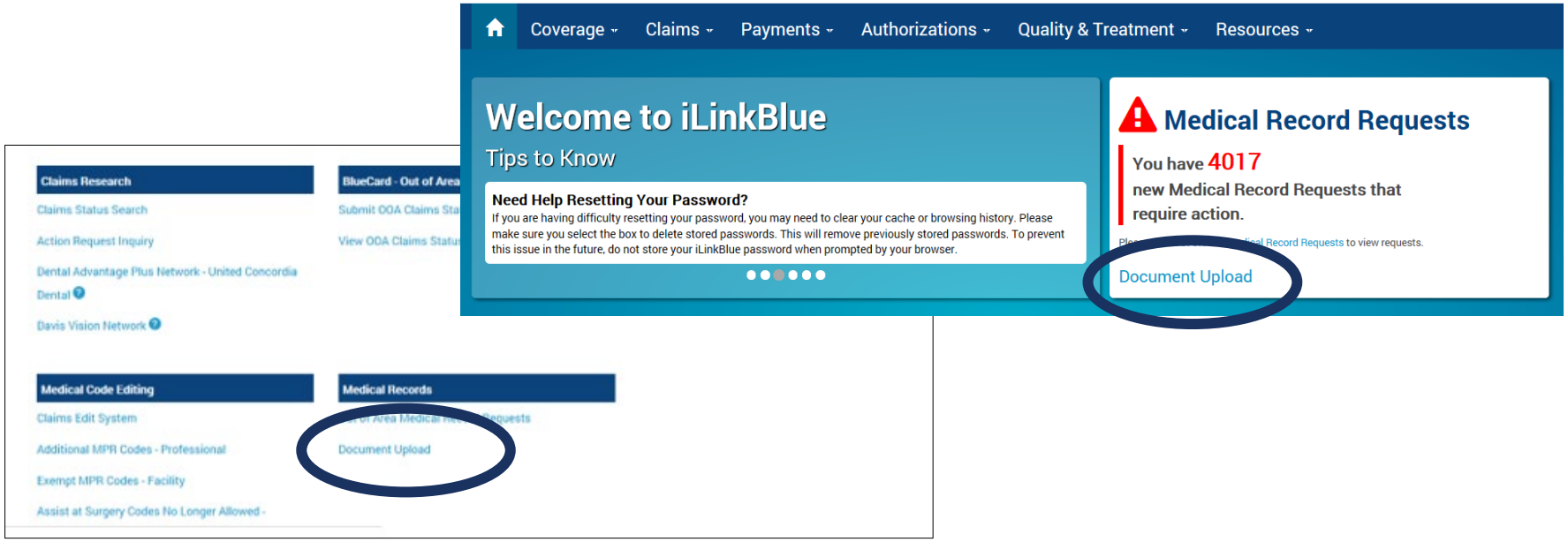
- Our members may also access their cards through their smartphone, via the Blue Cross mobile app or through our online member portal.
- To access through the Blue Cross mobile app, log on and choose the “My ID Card” option on the front page and use the dropdown menu to choose from the ID cards available.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

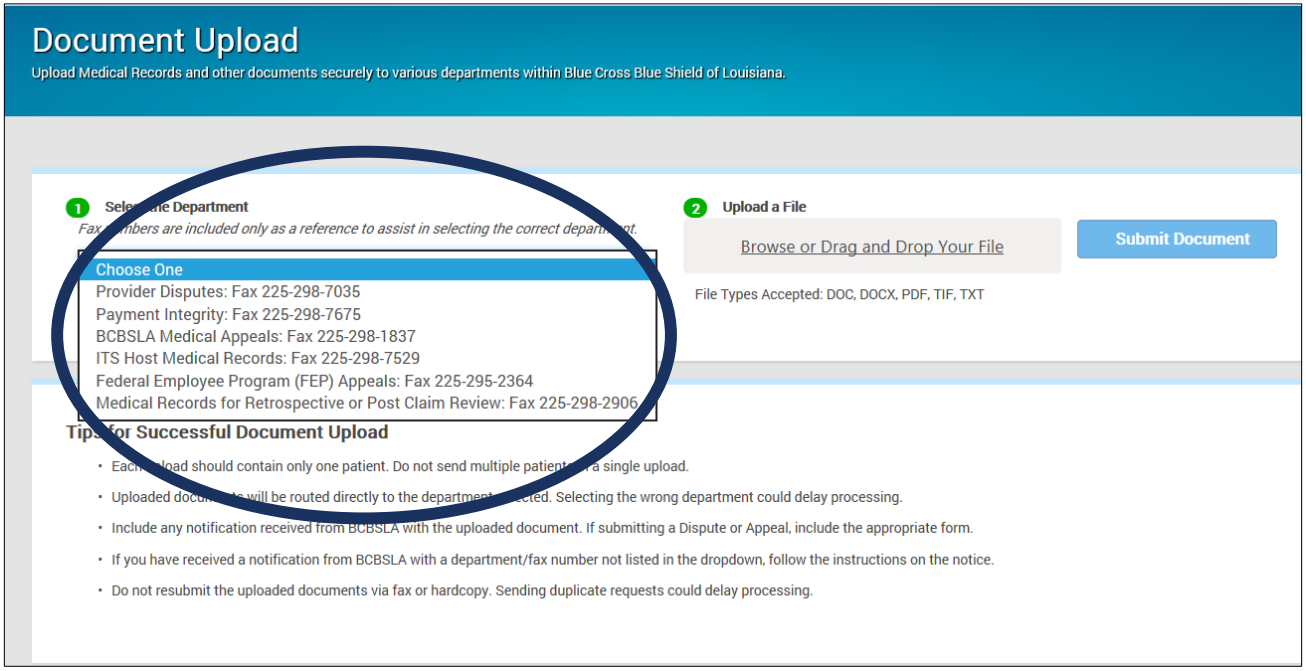
The new feature is quick, secure and available at any time through the iLinkBlue provider portal.



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?

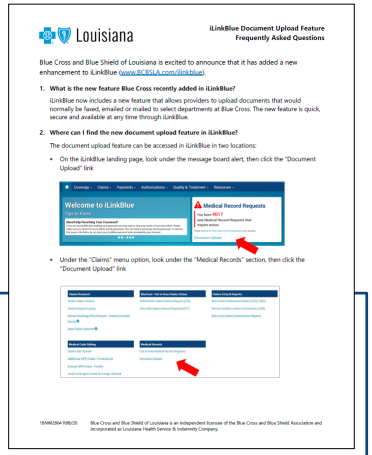
- DOC, DOCX, PDF, TIF, TXT

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

- No. Sending the uploaded document through 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?

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


Louisiana

iLinkBlue Document Upload Feature Frequently Asked Questions

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

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

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

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

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

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

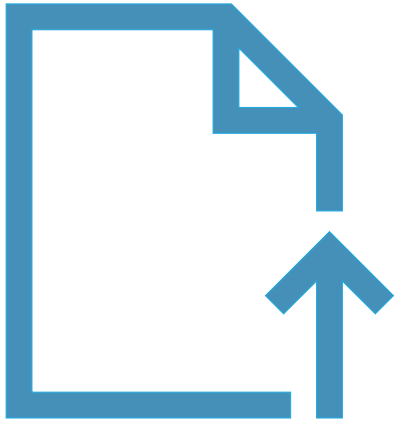
   - Under the "Claims" menu option, look under the "Medical Records" section, then click the "Document Upload" link

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

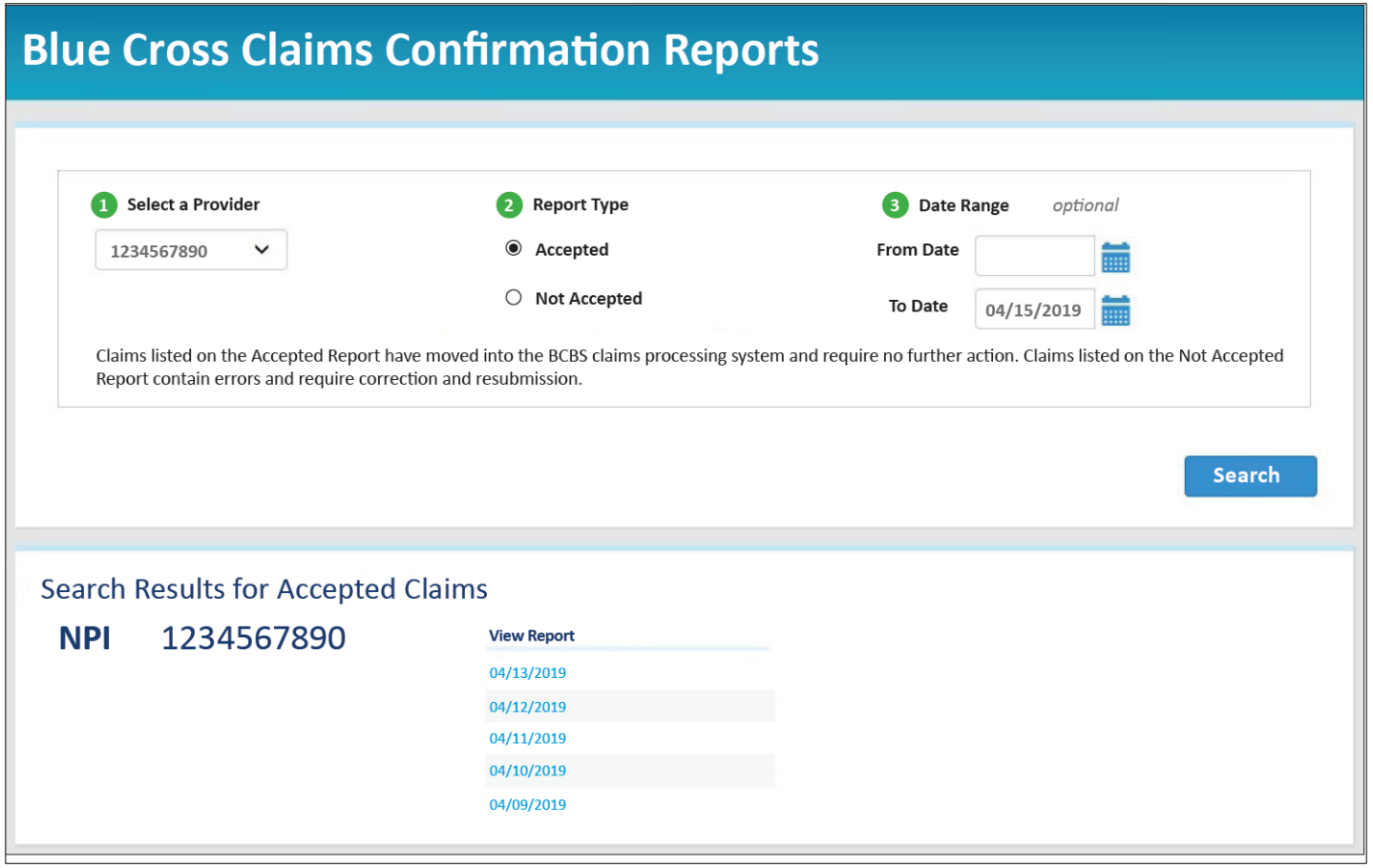
For a copy of the Document Upload Feature FAQs send an email to **provider.relations@bcbsla.com**.

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.



CLAIMS CONFIRMATION REPORTS



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

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

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

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

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.

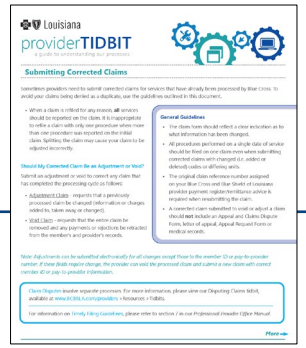
- Adjustment Claim – requests that a previously processed claim be changed (information or charges added to, taken away or changed).
- Void Claim – requests that the entire claim be removed, and any payments or rejections be retracted from the member's and provider's records.

Corrected claims submitted in the 837 format should include the following:

- In Loop 2300 Segment CLM05-03, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Loop 2300 in the REF segment, use "F8" as the qualifier and enter the original claim reference number.

Corrected claims submitted on a UB-04:

- In Block 4, Type of Bill, enter the applicable frequency code:
  - 7 - Adjustment Claim
  - 8 - Void Claim
- In Block 64, Document Control Number, enter the original claim reference number

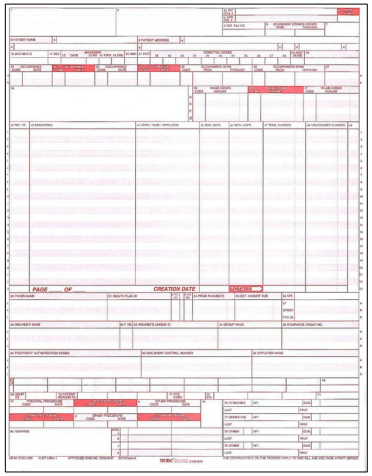

Louisiana
providerTIDBIT
Submitting Corrected Claims
General Guidelines

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

BILLING & CLAIMS

FILING CLAIMS HARDCOPY

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



UB-04 (CMS 1450)

- 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 BlueHPN Claims:

HMO Louisiana
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

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.

AUTHORIZATIONS

Authorizations are required for all inpatient behavioral health services. Authorizations may be required for some outpatient behavioral health services. Blue Cross has partnered with New Directions to manage the authorization, case and disease management processes for behavioral health services.

New Directions: 1-800-991-5638

Behavioral health services that require an authorization:

- Applied Behavior Analysis (ABA) (Providers must submit an initial assessment request and treatment request form on the New Directions WebPass Portal. It can also be used to view the status of all ABA service requests and authorizations.)
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)

For FEP Members at RTCs:

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

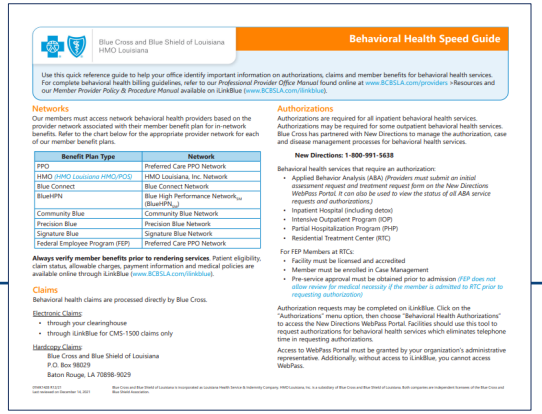
AUTHORIZATIONS

Authorization requests may be completed on iLinkBlue (**www.bcbsla.com/ilinkblue**).

Click on the "Authorizations" menu option, then choose "Behavioral Health Authorizations" to access the New Directions WebPass Portal.

Facilities should use this tool to request authorizations for behavioral health services which eliminates telephone time in requesting authorizations.

Access to WebPass Portal must be granted by your organization's administrative representative. Additionally, without access to iLinkBlue, you cannot access WebPass.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Behavioral Health Speed Guide

Use this quick reference guide to help your office identify important information on authorizations, claims and member benefits for behavioral health services. For complete behavioral health billing guidelines, refer to our *Professional Provider Office Manual* found online at www.BCBSLA.com/providers >Resources and our *Member Provider Policy & Procedure Manual* available on iLinkBlue (www.BCBSLA.com/ilinkblue).

Networks

Our members must access network behavioral health providers based on the provider network associated with their member benefit plan for in-network benefits. Refer to the chart below for the appropriate provider network for each of our member benefit plans.

Benefit Plan Type	Network
PPO	Preferred Care PPO Network
HMO *(HMO Louisiana HMO/POS)*	HMO Louisiana, Inc. Network
Blue Connect	Blue Connect Network
BlueHPN	Blue High Performance Network$_{SM}$ (BlueHPN$_{SM}$)
Community Blue	Community Blue Network
Precision Blue	Precision Blue Network
Signature Blue	Signature Blue Network
Federal Employee Program (FEP)	Preferred Care PPO Network

Always verify member benefits prior to rendering services. Patient eligibility, claim status, allowable charges, payment information and medical policies are available online through iLinkBlue (www.BCBSLA.com/ilinkblue).

Claims

Behavioral health claims are processed directly by Blue Cross.

Electronic Claims:

- through your clearinghouse
- through iLinkBlue for CMS-1500 claims only

Hardcopy Claims:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Authorizations

Authorizations are required for all inpatient behavioral health services. Authorizations may be required for some outpatient behavioral health services. Blue Cross has partnered with New Directions to manage the authorization, case and disease management processes for behavioral health services.

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- Applied Behavior Analysis (ABA) *(Providers must submit an initial assessment request and treatment request form on the New Directions WebPass Portal. It can also be used to view the status of all ABA service requests and authorizations.)*
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)

For FEP Members at RTCs:

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

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

Access to WebPass Portal must be granted by your organization's administrative representative. Additionally, without access to iLinkBlue, you cannot access WebPass.

For more information find Behavioral Health Speed Guide at **www.bcbsla.com/Providers** >Resources >Speed Guides.

TAXONOMY CODES

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

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

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

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

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.

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:

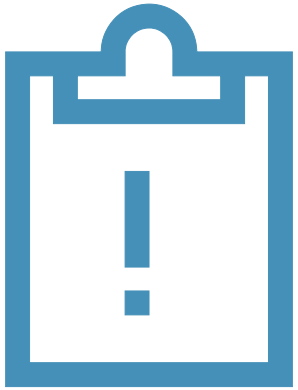
- Reduce the time it takes for providers to receive a response from Blue Cross.
- Allow providers to see responses directly from the adjustments team after review.
- Allow providers to submit additional questions once they have reviewed the AR response.

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
- Status of dispute

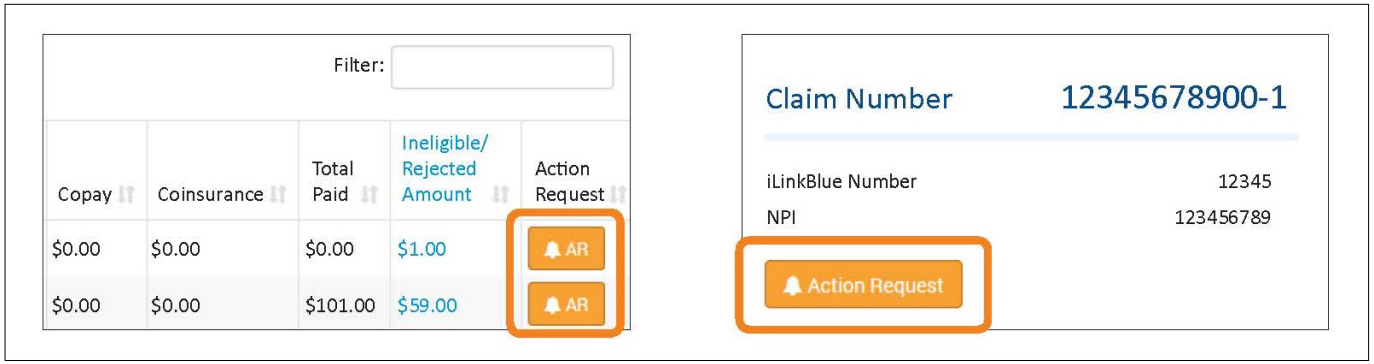


NOTE: Action Requests do not allow you to submit documentation regarding your claims review.

SUBMITTING ACTION REQUESTS

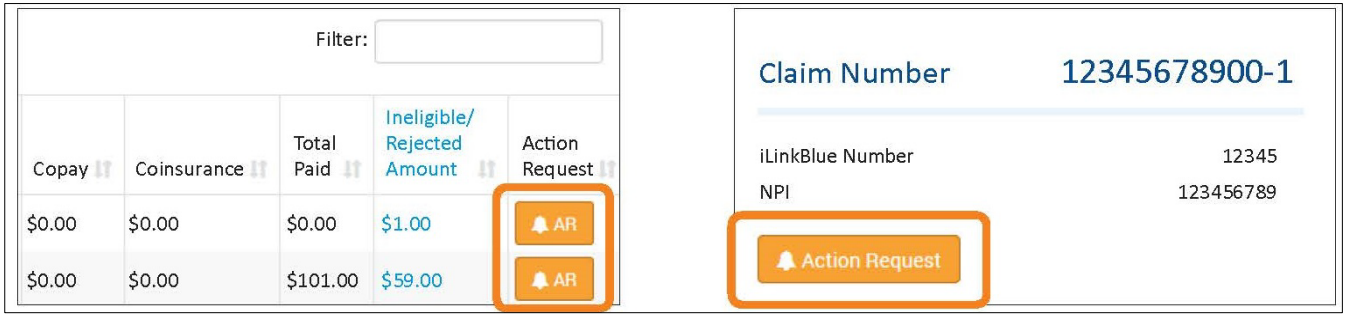
Submit an Action Request through iLinkBlue (**www.bcbsla.com/ilinkblue**).

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



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

SUBMITTING ACTION REQUESTS



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

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

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

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

ELECTRONIC CORRECTED CLAIMS

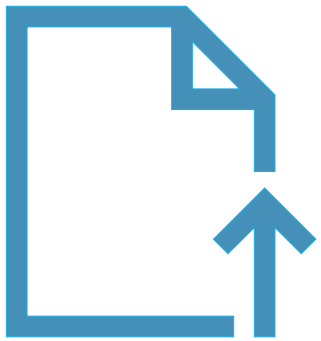
Please follow the steps below to ensure your claims will not deny as duplicates or process incorrectly. You can ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim

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

Void the Claim

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



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 polic.y
- 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 appeals 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.

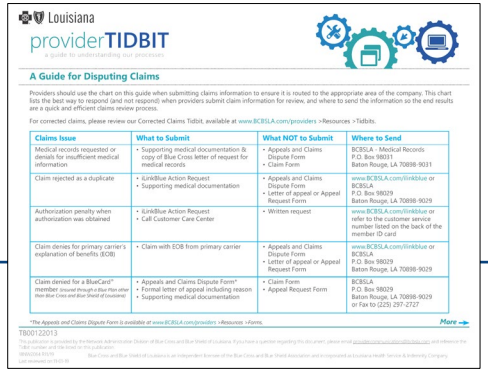
The top reasons for administrative appeals are:

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	• iLink®Blue 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	• iLink®Blue 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.

MEDICAL NECESSITY APPEALS

First-level appeals

Send directly to New Directions:

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

Fax: 1-816-237-2382

New Directions Conducts medical necessity reviews:

- **Decision to Overturn Denial** – Letter is sent to member and provider letting them know denial was overturned and processing instructions are communicated to Blue Cross to pay claim

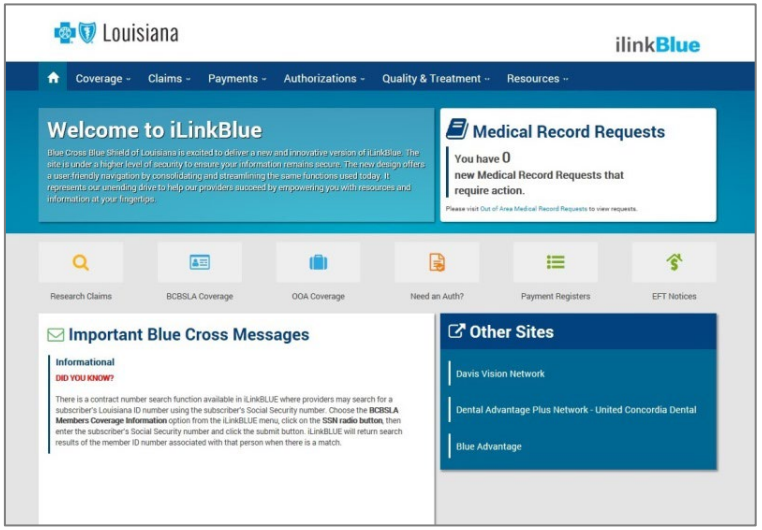
- **Decision to Uphold Denial** – Letter is sent to member and provider directing them on how and where to file a second-level appeal request.

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

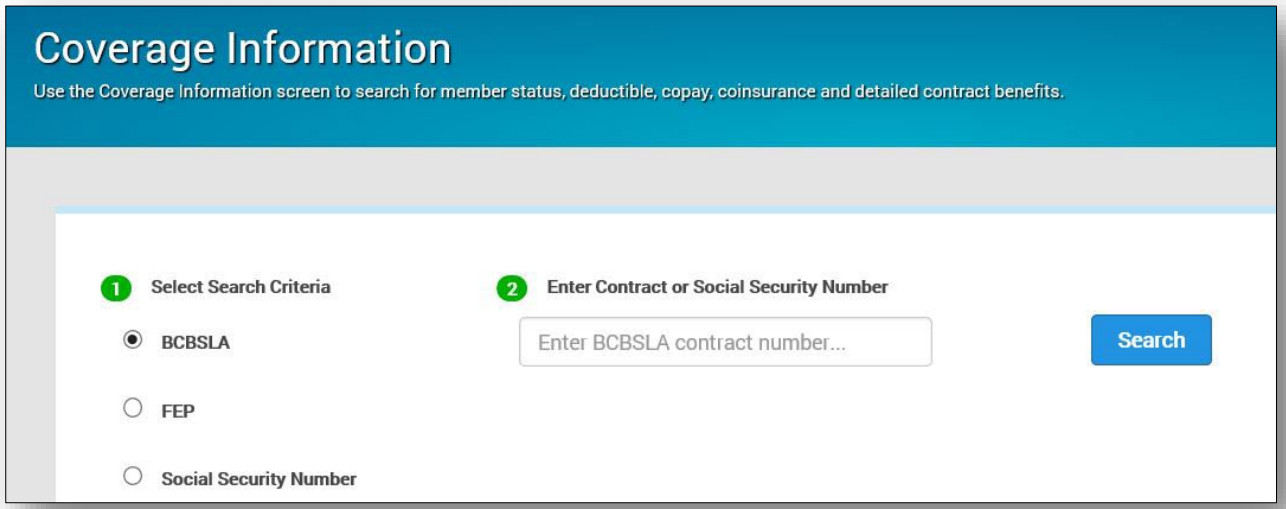


- iLinkBlue user account suspends upon 90 days of inactivity.
- iLinkBlue user account that remains inactive for 120 days will be terminated.
- For iLinkBlue training and education, contact **provider.relations@bcbsla.com**.

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

ILINKBLUE – COVERAGE & ELIGIBILITY

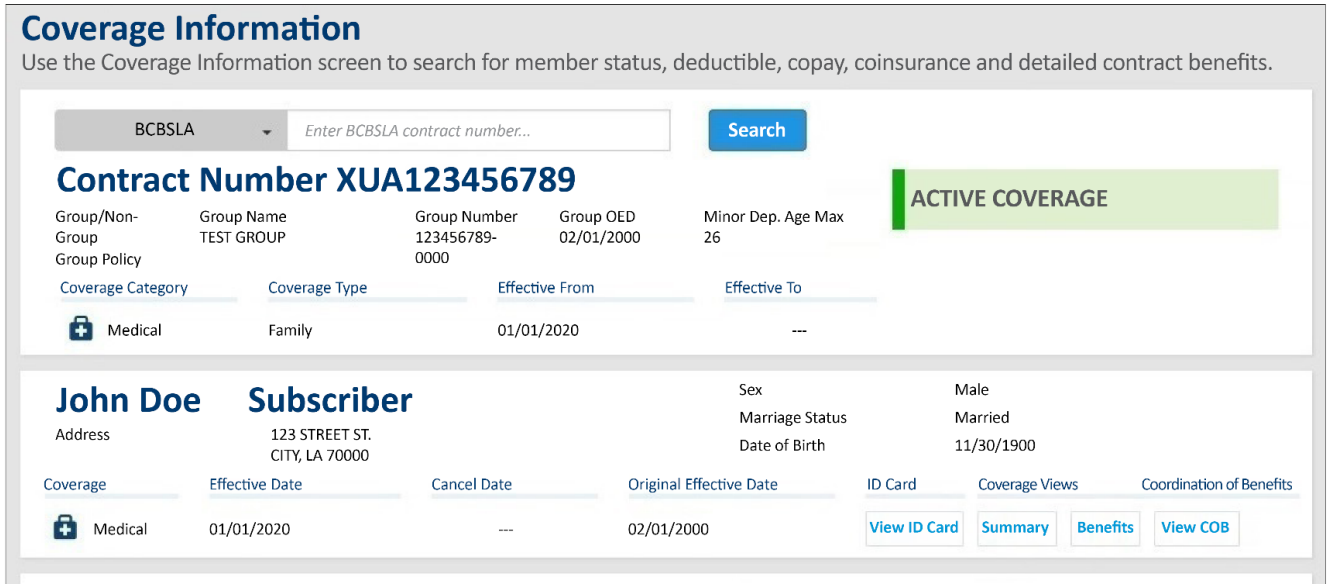
1.



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

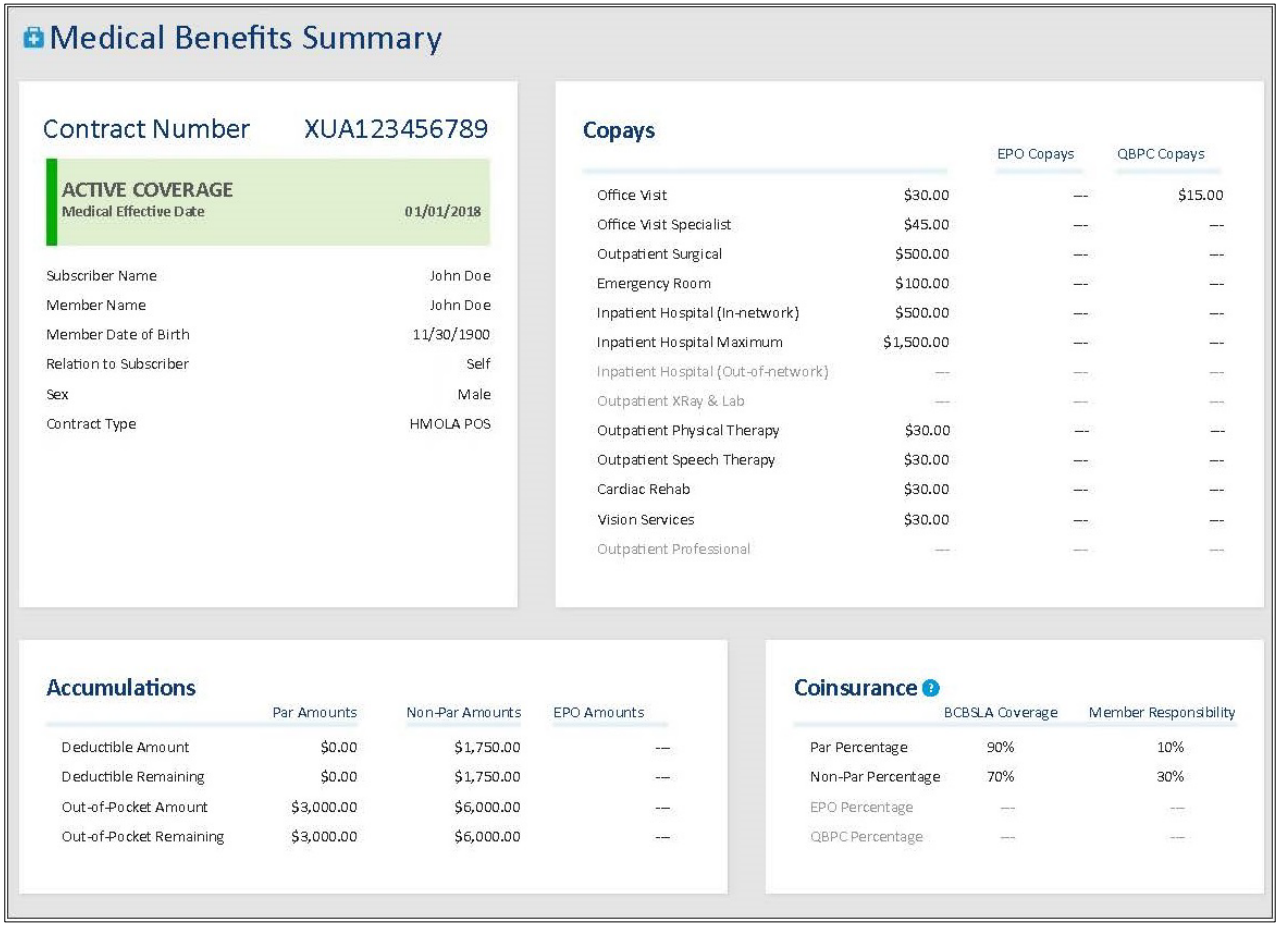
ILINKBLUE – COVERAGE & ELIGIBILITY

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

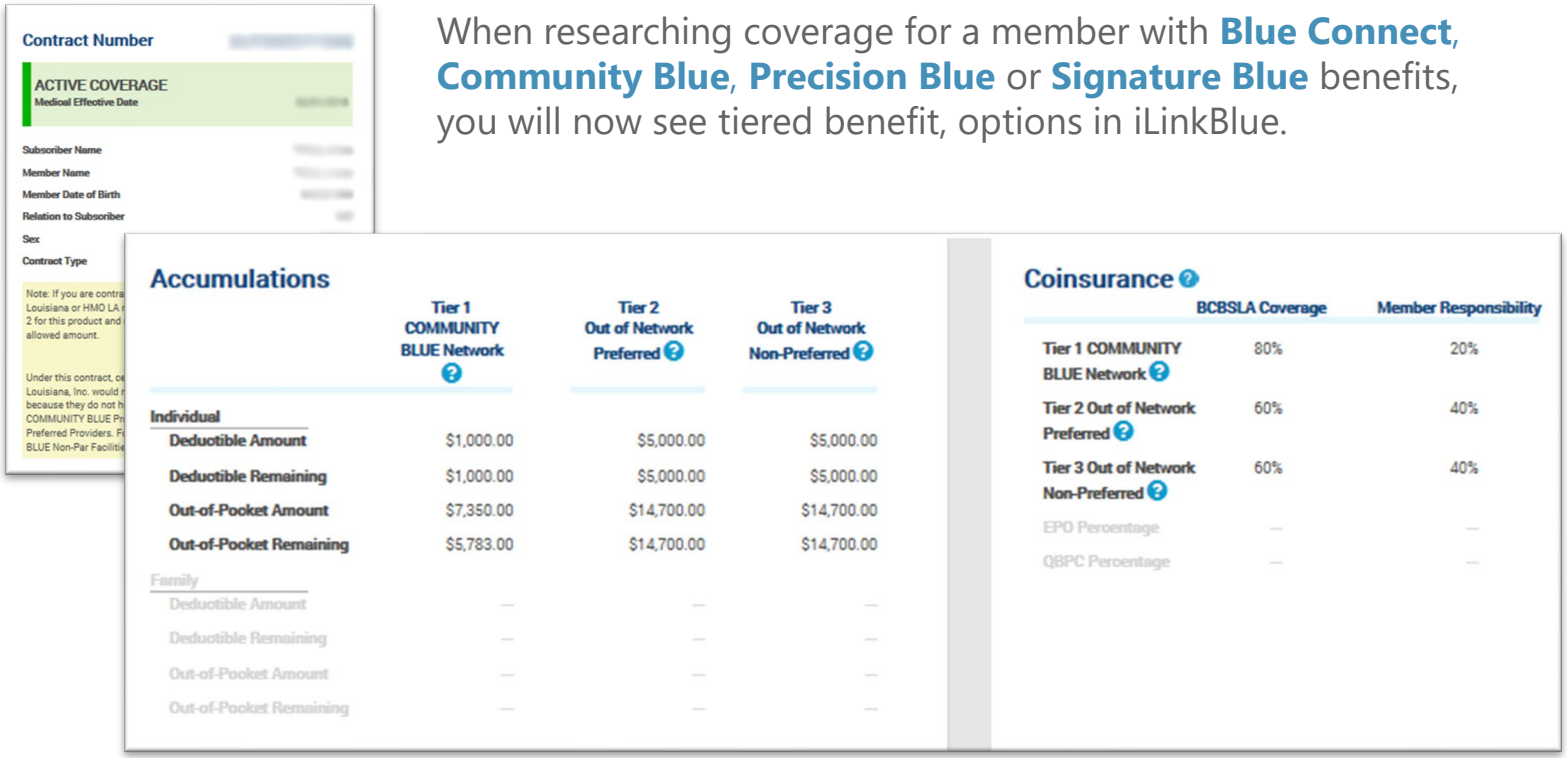
	Par Amounts	Non-Par Amounts	EPO Amounts
Deductible Amount	$0.00	$1,750.00	---
Deductible Remaining	$0.00	$1,750.00	---
Out-of-Pocket Amount	$3,000.00	$6,000.00	---
Out-of-Pocket Remaining	$3,000.00	$6,000.00	---

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

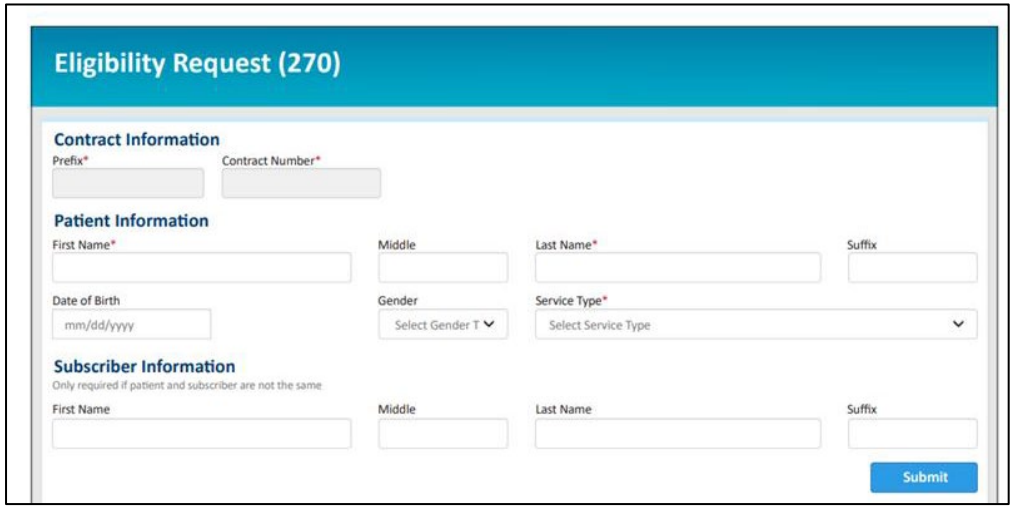
Applies to providers who do not participate in any Blue Cross network.

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.

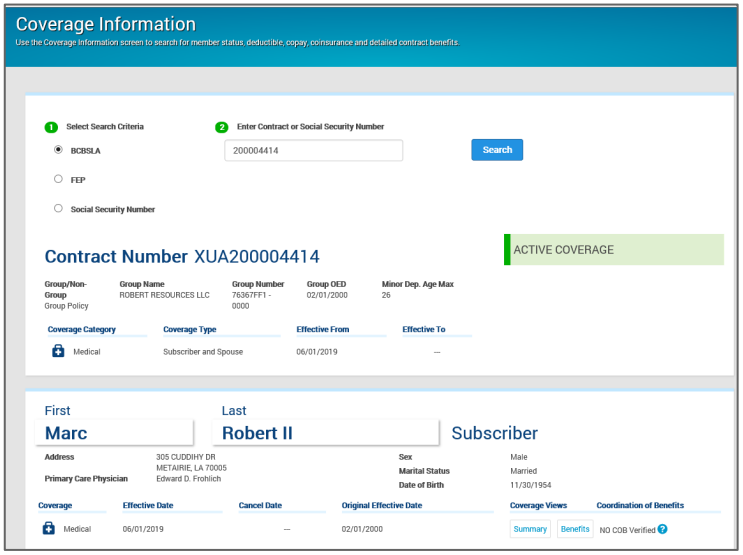
ILINKBLUE – OUT-OF-AREA MEMBERS

Use the "Coverage" menu option to research BlueCard (out-of-area) member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana).

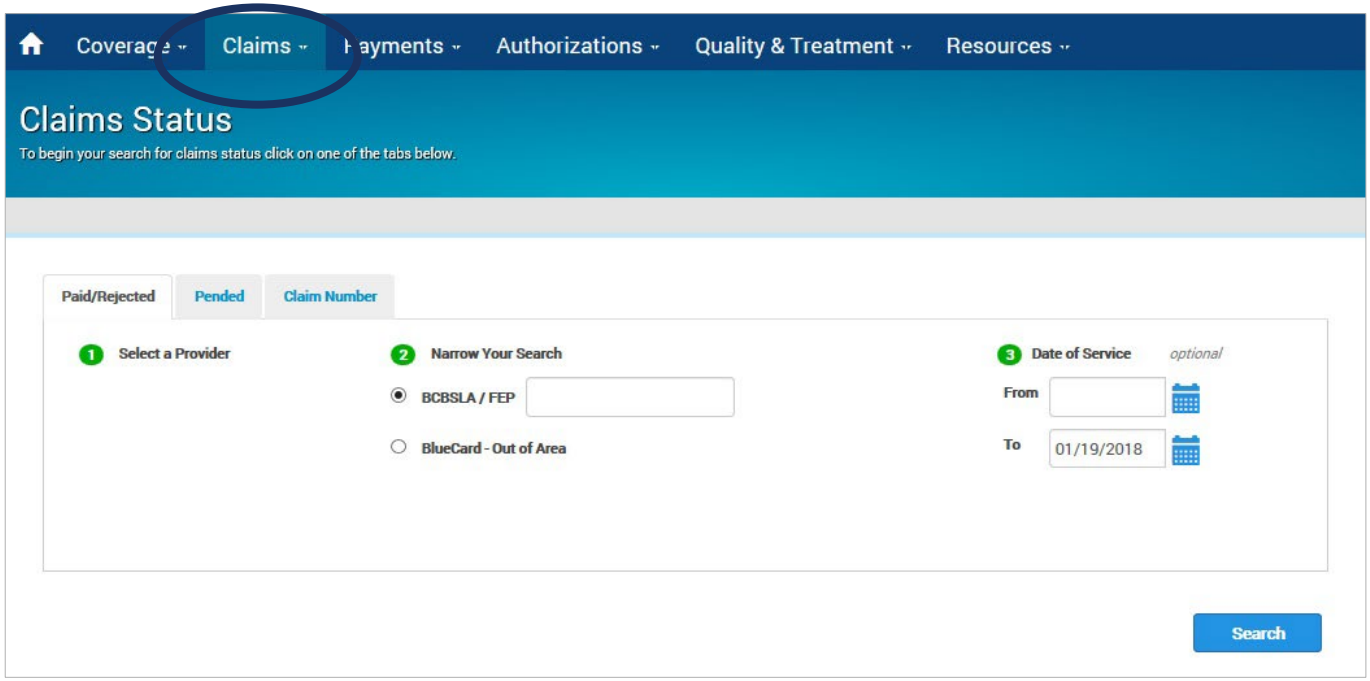


ILINKBLUE
MENTAL HEALTH BENEFITS LANGUAGE

1.



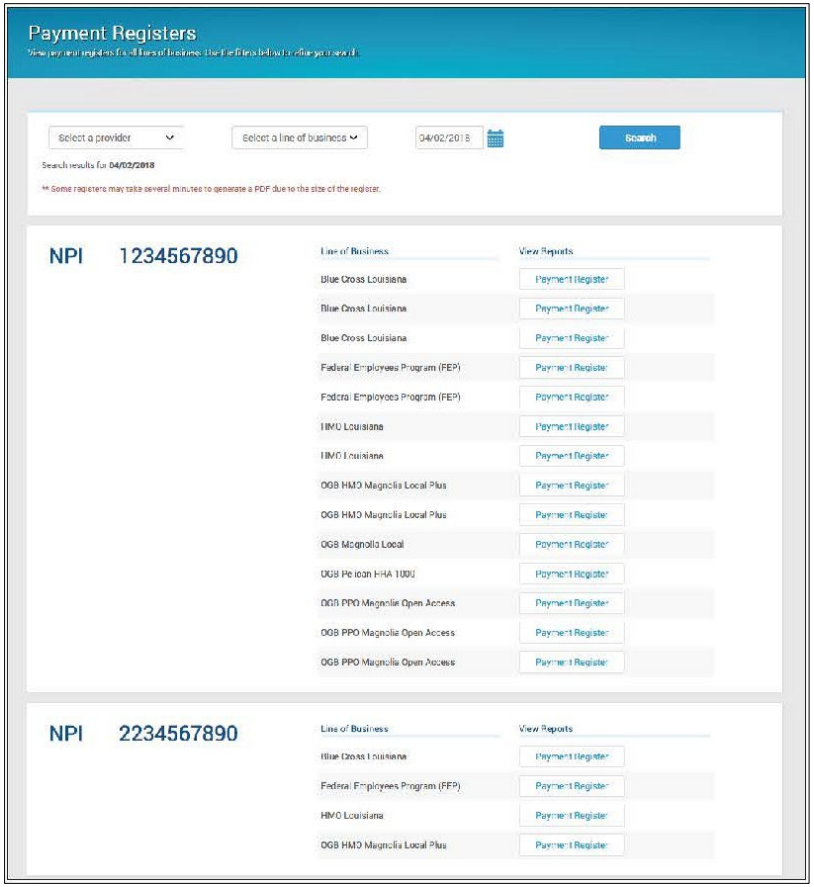
ILINKBLUE – CLAIMS RESEARCH



- 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 our expertise in the provision of behavioral health services.

- Manages authorizations for members, performs all utilization and care management activities, as well as ABA care 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

2.25 million
EAP Members

27 years
of behavioral
health experience

7 partnerships
with Blue Cross and
Blue Shield health plans

780+
employees

Tridiuum
New Directions
acquired Tridiuum
in January

ACCREDITATION STATUS

URAC Accreditation for Health Utilization Management

Accredited through September 2024

NCQA Full Accreditation as a Managed Behavioral Healthcare Organization

Accredited through February 2025

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

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 at **www.ndbh.com/providers/BCBSLA/PoliciesManuals**. **Changes to MNC will be implemented for 2023. We will utilize LOCUS (Level of Care Utilization System) and ASAM for SUD.**
  - 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 behavioral health services to ensure quality and member safety.

UTILIZATION MANAGEMENT SPECIFICS

Fax # requirement
Include a fax number for Utilization Review (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 Clinical Institute Withdrawal Assessment (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 depression screening does NOT have to be a formalized tool like the Beck Depression Inventory (BDI) or the Patient Health Questionnaire (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.

Medication Assisted Treatment (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. 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, 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: RTC, PHP and IOP
  - FEP: prior authorization is required for RTC. Members must also be enrolled in Care Management (CM) before authorizations will be issued. **Failure to obtain prior authorization and/or enroll member in CM, will result in a denial**. CM can be emailed at **dl_louisiana_cm@ndbh.com**.
  - FEP does not require authorization for PHP and IOP.

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 LA
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.

WEBPASS

LOGGING INTO WEBPASS

We strongly encourage the use of WebPass as your responses will be timely.

You may access WebPass on the NDBH website or iLinkBlue (**www.bcbsla.com/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.

Instructions:

1. Establish an administrative rep within your organization.
   - If unknown, contact BCBSLA Provider Identity Management (PIM) Team at 1-800-716-2299, option 5.
   - To set up an administrative rep visit **www.bcbsla.com/provider** >Electronic Services >Admin Reps.

2. Administrative Representative will set up iLinkBlue users and must allow users access to WebPass (authorizations) instructions to use iLinkBlue. Instructions can be found in the iLinkBlue User Guide found at **www.bcbsla.com/provider** >Electronic Services >iLinkBlue, under "User Guides."

HEDIS CRITERIA

FOLLOW-UP AFTER HOSPITALIZATION

H**EDIS (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 seven calendar days of discharge**.

- NDBH tracks appointments made within seven 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
- Licensed Professional Counselor
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist

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 CONTINUED…

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 seven 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 CONTINUED…

Scheduled seven day follow up appointments with an individual outpatient provider on the same day as discharge do not count as a HEDIS scheduled seven-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 (RTCs)
- PHPs
- IOPs

DISCHARGE CLINICAL REVIEW QUESTIONS

In order to receive credit for a qualified scheduled seven-day appointment, it is imperative to answer the below question and select the most appropriate type.

Behavioral Health Discharge appointments, select all that apply (not Medical - asked below):

- Residential/Sub-Acute (RTC)
- Partial Hospitalization (PHP)
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient (i.e., LCSW, LPC, Psychiatrist, Psychologist)
- Member refused behavioral health discharge plans
- No Behavioral Health Discharge Appointment Made
- Other Support (Support Groups AA, etc.)
    - This selection **does not** meet HEDIS criteria. Therefore, it will not count as a scheduled 7 FUH.

DISCHARGE CLINICAL REVIEW QUESTIONS

If the follow up appointment is not with a RTC, PHP or IOP and you selected "Behavioral Health Outpatient," the question below needs to be answered.

Behavioral Health Discharge appointments, select all that apply (not Medical - asked below):

- Electroconvulsive Therapy
- Visiting Nurse
- In-Home
- Psychiatrist/APRN
- Therapist
- Other
  - This selection **does not** meet HEDIS criteria. Therefore, it will not count as a scheduled 7 FUH.

DISCHARGE CLINICAL REVIEW QUESTIONS

Was there a behavioral health appointment scheduled within seven calendar days of discharge?

- Yes
- No

If no, please select reason why appointment was not scheduled.

- AMA
- State custody
- Death of patient
- Jail
- Juvenile detention
- Member preference
- Member refused follow-up care
- Provider preference
- Transfer to group home
- Transfer to Nursing home
- Transfer to another BH IP
- Transfer to Residential
- Walk-in Clinic
- No appointments available within seven calendar days

BEST PRACTICES

DISCHARGE PLANNING OVERVIEW

Discharge planning is a critical component of quality member of care 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 **48 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.

Our preferred method to receive the discharge information is via WebPass by completing the **Discharge Clinical Review Form**.

BEST PRACTICES TO IMPROVE "KEPT" SEVEN DAY FOLLOW-UP APPOINTMENT

- Engage members and parents/guardian/family/support system and/or significant others in the treatment plan. Advise them about the importance of treatment, attending appointments and potential side effects of medications as well as what to do if side effects appear after discharge.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Ensure the member has a follow-up appointment scheduled within seven calendar days of discharge through coordination of care with appropriate behavioral health specialists.
    - Begin discharge planning on day of admission
        - Scheduling follow up appointments based on your facility's average length of stay, rather than waiting for a discharge date, can significantly increase the likelihood of obtaining an appointment within seven calendar days of discharge. For example: Member admits March 1. Average length of stay is six days. The discharge planners can schedule the follow up appointment for March 8 or March 9, and be within seven days of discharge, if the member is inpatient for two-seven days.
- Before scheduling an appointment, verify with the member that it is a good fit by discussing barriers such as transportation, location and time of the appointment.

BEST PRACTICES TO IMPROVE "KEPT" SEVEN DAY FOLLOW-UP APPOINTMENT

- 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.

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

- 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.

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

FACILITY MEETINGS

FACILITY MEETINGS

- Educate Facilities about HEDIS Quality Measures: **Seven-day scheduled**, **seven-day kept**, MAT utilization, discharge planning and **30-day readmissions.**
- 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.

Example Scorecard

KEY PERFORMANCE INDICATORS

NEW DIRECTIONS®

Select Filters Here ▼

Reset Filters

HEDIS FUH 7-DAY RATE - QUARTERLY

Provider Name

Reporting Period: 1/1/2021 - 5/4/2022

Provider Tax ID:

Provider NPI: All

Plan Name: LA

LOB: All

Facility

DX Type: MH

YTD | 2022
FUH 7-Day Rate: 31.6%
Eligible: 19

Current Quarter | Q3 2022
FUH 7-Day Rate: 21.3%
Eligible: 183

2021
FUH 7-Day Rate: 15.4%
Eligible: 78

2020
FUH 7-Day Rate: 24.4%
Eligible: 86

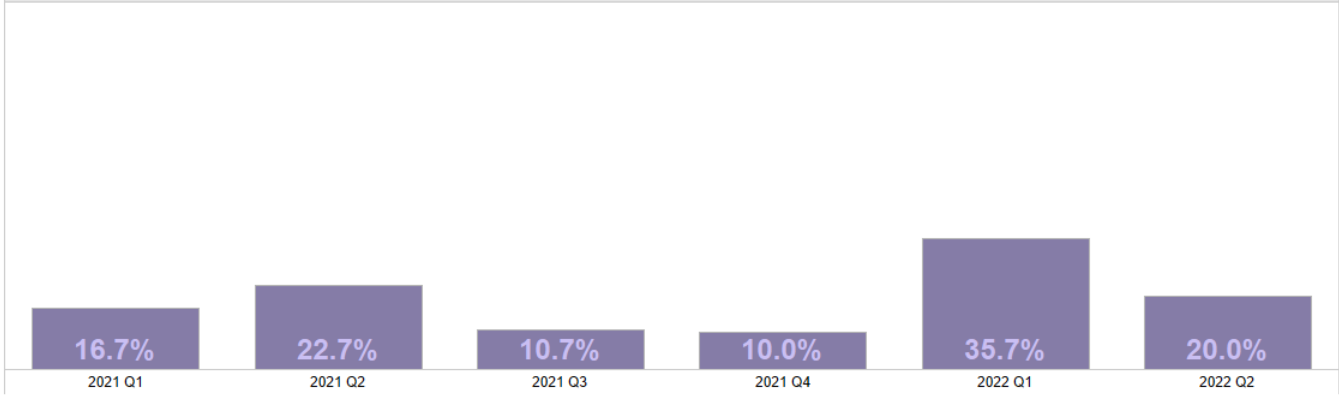
Market

YTD 2022 | 31.2%
Eligible | 5,086

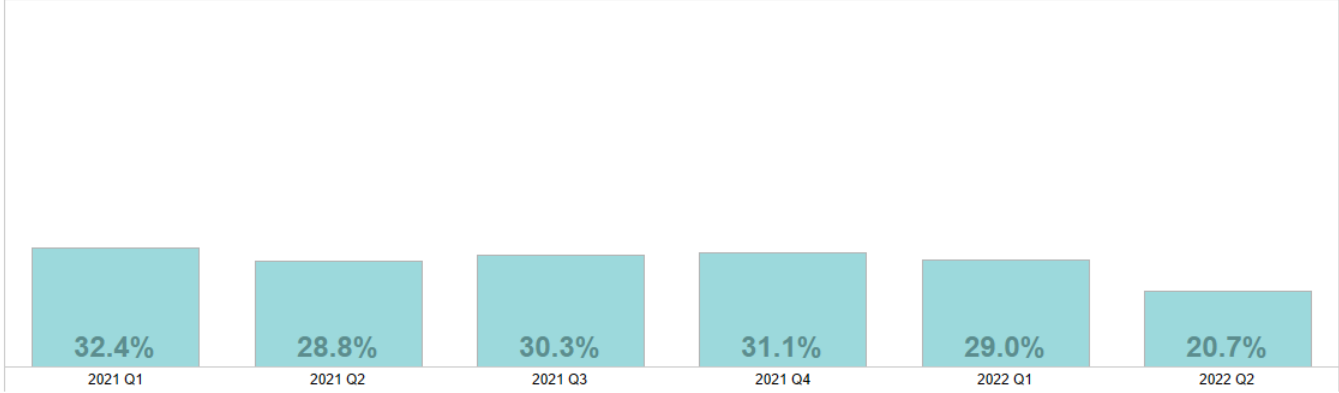
2021 | 30.7%
Eligible | 2,187

2020 | 33.1%
Eligible | 2,158

FACILITY HEDIS FUH 7-DAY RATE



MARKET HEDIS FUH 7-DAY RATE



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

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

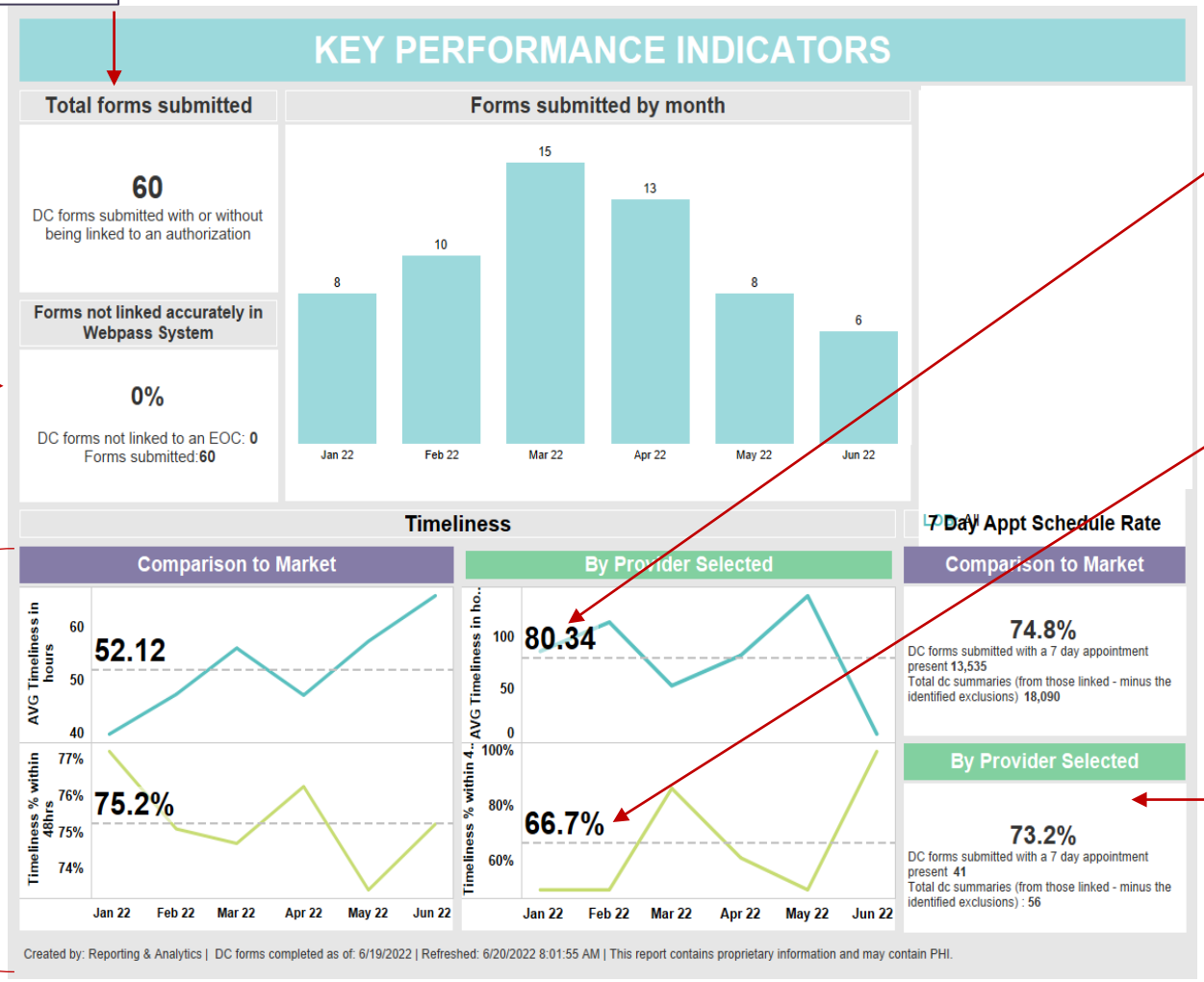
This is the average hours from discharge that New Directions received your facility discharges (Goal is 48 hours)

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

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

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

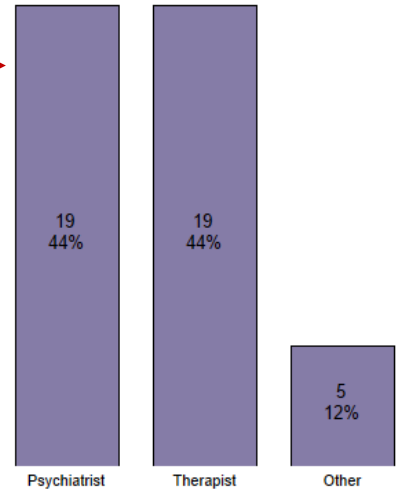
The reason selected on the form for why the member refused or no appointment was made

DISCHARGE APPOINTMENT DATA

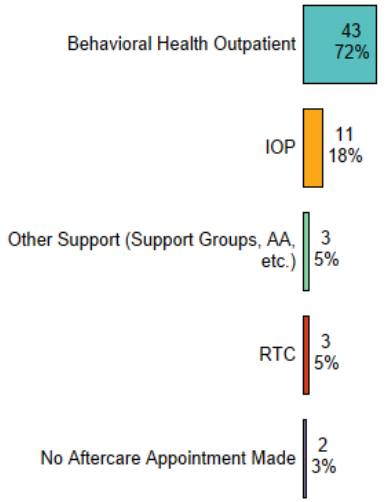
SELECTIONS MADE

The breakdown of responses given for Discharge Appt Type

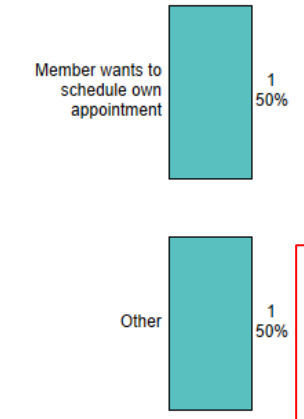
Type of Discharge Outpatient Provider
Multi select option - Will not add up to 100%



Discharge Appointment Type
Multi select option - Will not add up to 100%



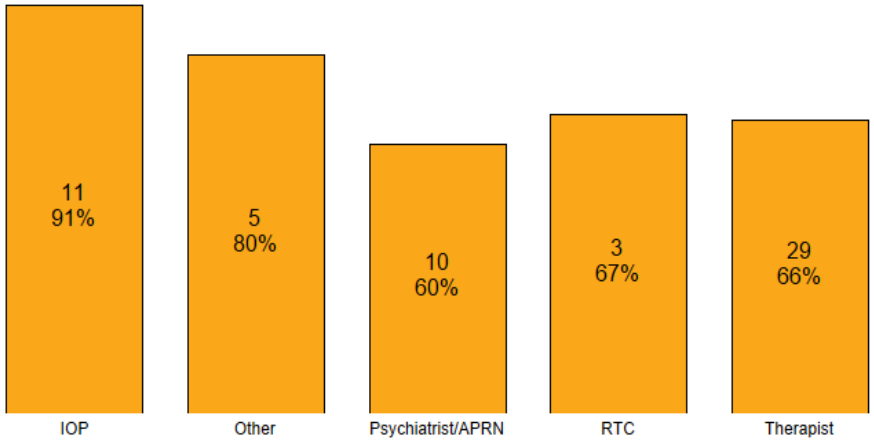
Reason for Member Refusal or Discharge Appointment or No Aftercare Apointment Made
Multi select option



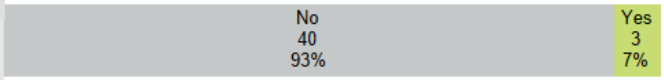
The percentage of each appointment type that was scheduled within 7 days of Discharge

The percentage of 'Outpatient' Appointments that were secured that were virtual/telehealth appointments.

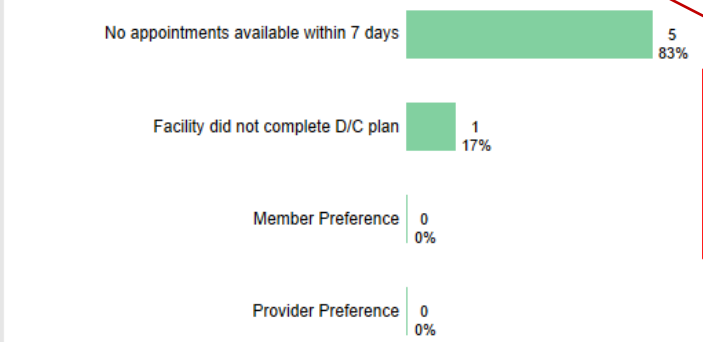
7 Day Appointment Type Scheduled



Discharge Appointment Virtual/Telehealth



7 Day appointment reason not scheduled



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

RESOURCES

RESOURCES

Follow-up Appointments

If your facility needs assistance with seven-day appointments for BCBSLA members, you can reach our clinical team at **877-317-4847**

NDBH Clinical Team: Find Help Now (findhelp.org)

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 seven calendar 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**.

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 (seven-day after discharge 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.

NEW DIRECTIONS BEHAVIORAL HEALTH WEBSITE

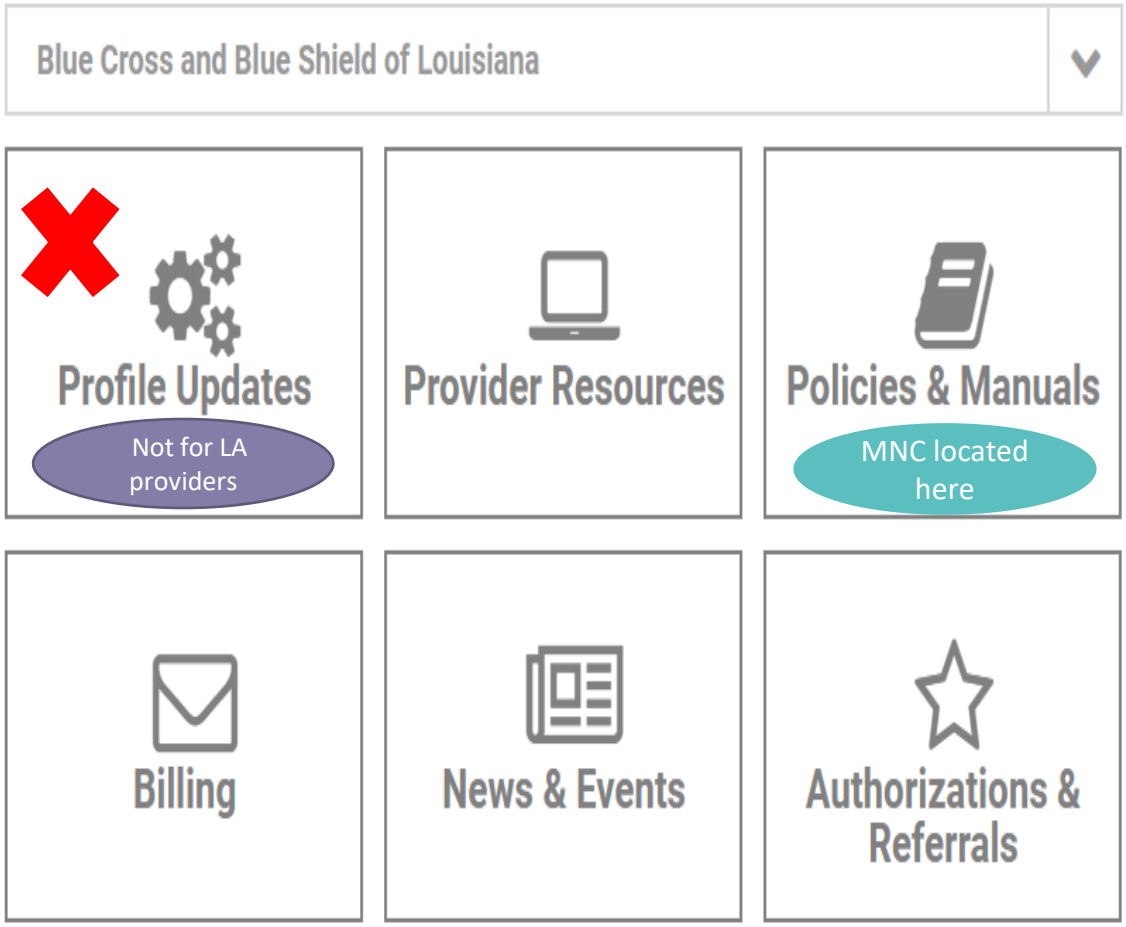
Resources for members**:** **www.ndbh.com/Resources/**

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

HELPING YOU HELP OTHERS



Want to join our network? Apply Here

WebPass Access

PCP Toolkit

HEDIS® Toolkit

Emergency Department Toolkit — NEW

Clinical Practice Guidelines — NEW

Care Management Services

Substance Use Hotline

PCP Toolkit

Addressing mental health concerns and proper management of co-occurring medical treatment is important to the overall well being of patients. We offer this toolkit to PCPs and encourage collaboration with all providers.

HEDIS TOOLKIT

The purpose of this toolkit is to offer better understanding of the 2022 Measurement Year HEDIS behavioral health performance measures and to provide guidance to healthcare providers on how they can help improve the quality of care and performance on the HEDIS measures.

Emergency Department Toolkit

The purpose of this toolkit is to offer guidance and a better understanding of the HEDIS behavioral health performance measures related to follow-up care for members after being seen in the emergency department for mental illness, substance use or drug overdose.

Clinical Practice Guidelines

New Directions Behavioral Health (New Directions) adopts clinical practice guidelines (CPGs) that are meant to assist providers with screening, assessing, and treating common behavioral health and substance use disorders. New Directions may adopt newly published guidelines throughout the year. We encourage you to periodically return to this webpage for updates.

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

*Indicates Buprenorphine-based medication that requires a prescriber have a DEA waiver, 8 hours of training, and a limited number of patients.
^Methadone is only offered in federally licensed programs that are required to offer counseling services and urine drug screens

Alcohol Use Disorder (AUD) has three FDA–approved medications:

NALTREXONE
Revia
Vivitrol
Embeda

ACAMPROSATE
Campral

DISULFIRAM
Antabuse

Prescribers can help you decide which will work best for you. Since not all prescribers offer the same treatment, New Directions is here to help connect you with the right one. Contact New Directions by calling the phone number on the back of your insurance card.

We're here for you around the clock:

Locate a Provider

Contact Us

Return to Resources

Substance Use Center

RESOURCES

Substance Abuse 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 >

VALUE OF MAT

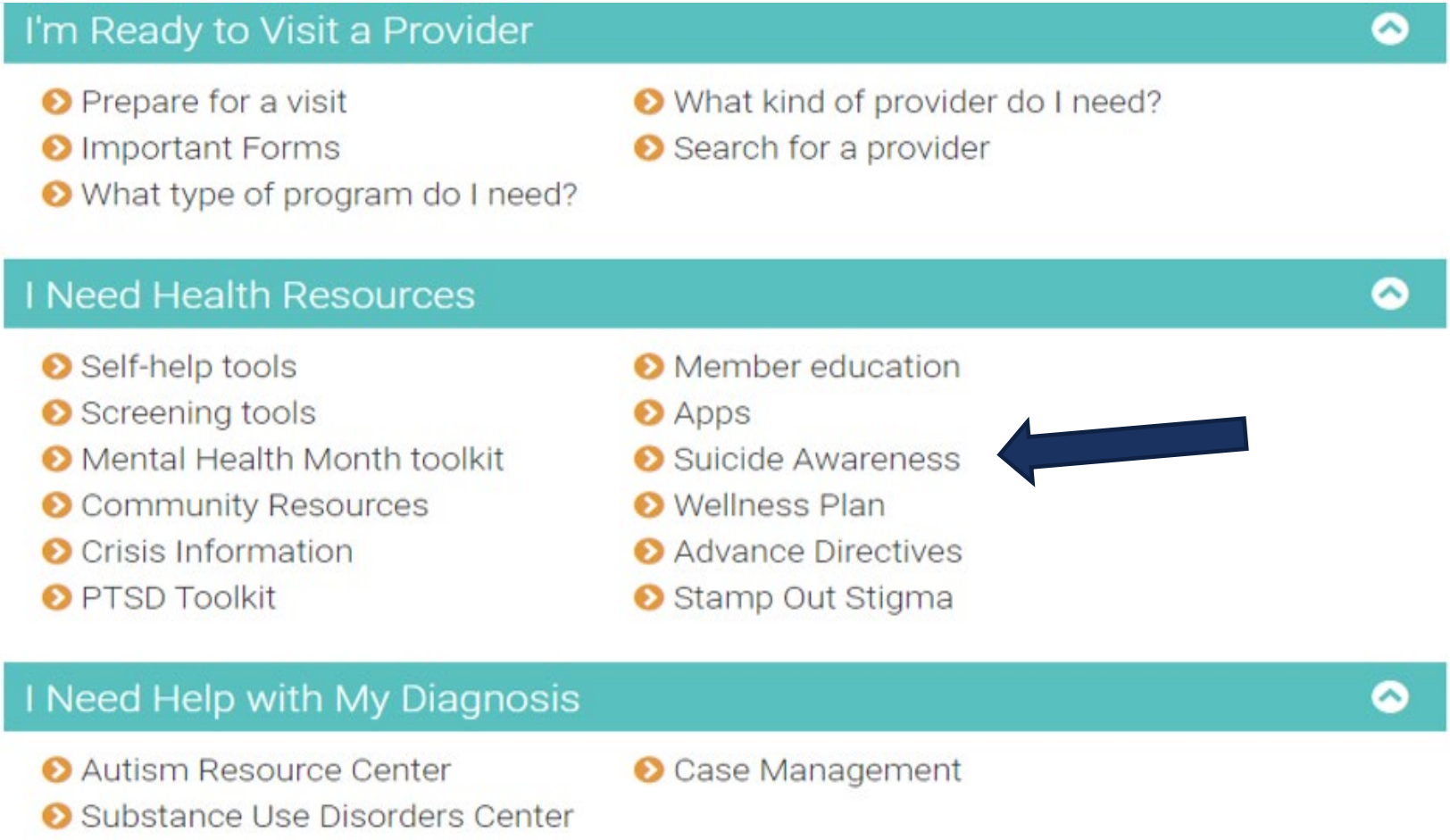
MAT is the most effective tool for Opioid Use Disorder (OUD) – is considered the gold standard for treatment.

- 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), p. 1425-33.

SUICIDE

CRISIS RESOURCES TO SHARE WITH MEMBERS



www.ndbh.com/Resources/

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.

www.ndbh.com/Suicide

Suicide Toolkit

www.ndbh.com/PCP/SuicideToolkit

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.

TRAUMA

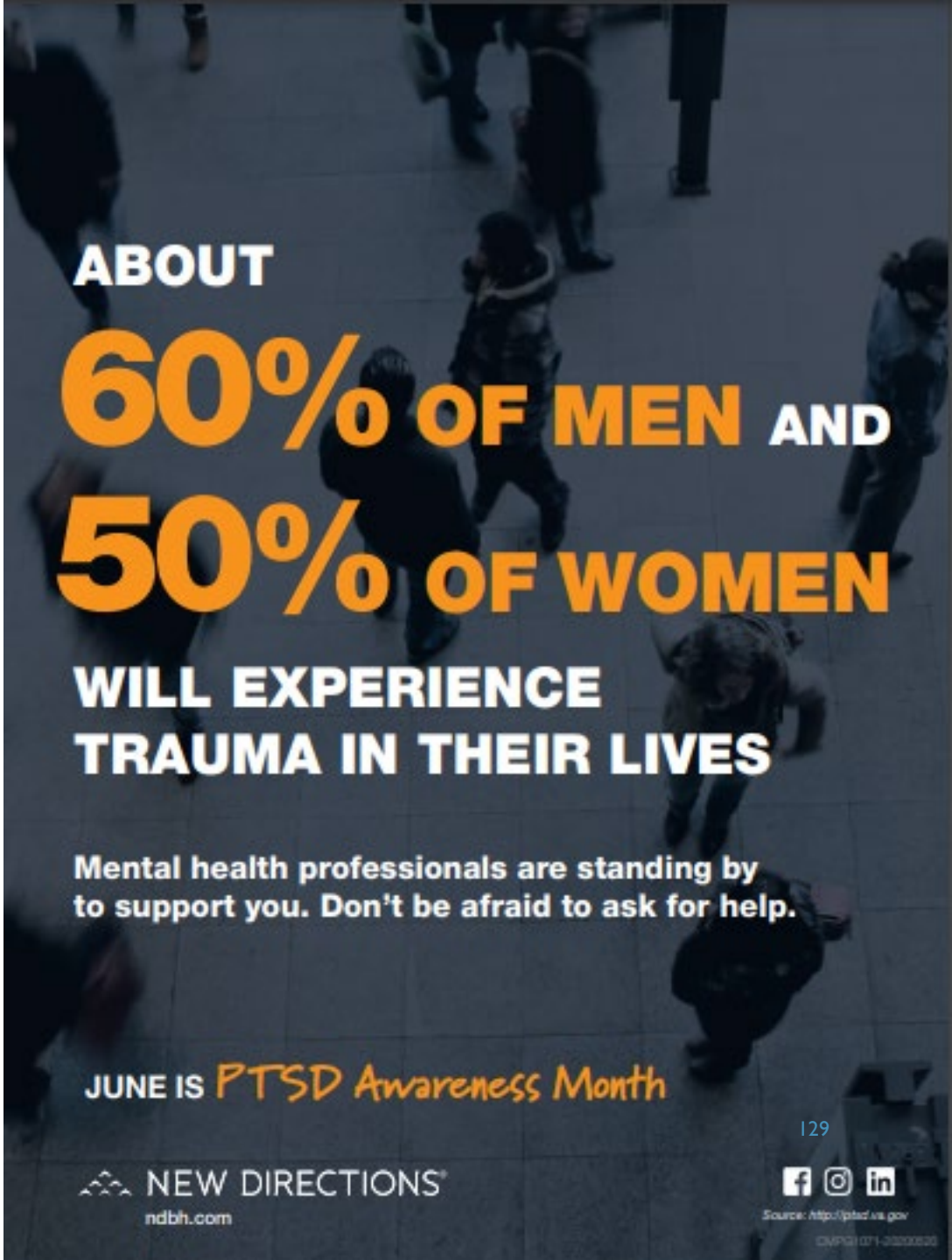
CRISIS RESOURCES TO SHARE WITH MEMBERS

www.ndbh.com/Resources/

HELPING TO HEAL TRAUMA

A majority of adults in the United States have experienced a traumatic event. New Directions Behavioral Health has an online **toolkit** to promote PTSD awareness. The toolkit includes posters, articles and other sharable materials that you can share.

www.ndbh.com/PTSD-Toolkit



Post-Traumatic Stress Disorder Toolkit

Because treatment of PTSD requires specialized training and intensive, often prolonged, treatment, it is not typically treated in primary care settings. However, PCPs can play a vital role by detecting the presence of PTSD, helping patients understand that they may have PTSD, educating patients about their treatment options and prescribing recommended medication when needed. PCPs can use the PC-PTSD-5 to screen for PTSD. The test is simple, easy to administer and score, and was developed specifically for use in primary care settings.

The following tools are being provided to assist in the identification of PTSD in your patients.

Screening Tools

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Additional screening tools >

Provider Resources

U.S. Department of Veteran Affairs: PTSD

Posttraumatic Stress Disorder (PTSD)

American Academy of Pediatrics: Trauma Toolbox for Primary Care

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.

www.ndbh.com/PTSD-Toolkit

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

Emotional Helpline

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

For up-to-date resources on the hurricane, click here.

- Dealing with a traumatic event
- Managing Your Distress with Events in the Community
- Prolonged Stress
- Coping with grief and loss
- Common Responses to Traumatic Events

Resources

Tips for coping with the Coronavirus outbreak

- Dealing with Coronavirus anxiety
- Guidance for Leadership
- Coping with Crisis in the Media
- Coronavirus + Mental Health tips
- Online Resources & Support During COVID-19
- Substance Use Disorder Treatment During COVID-19
- Healthcare Providers: Coping with Stress During COVID-19
- Xenophobia
- Home Preparation
- Positive Self-Talk
- How to talk to your kids
- Working from Home
- Returning to Work After a Pandemic

Tips for coping with a traumatic event

- Dealing with a traumatic event
- Anticipatory Anxiety
- Managing a Team During a Crisis
- Coping Strategies During Times of High Stress
- Take care of yourself
- Empathetic Rounding
- Managing Your Distress with Events in the Community
- Common Responses to Traumatic Events

Tips for handling grief and loss

- Coping with grief and loss

Tips for supporting others after a traumatic event

- Supporting recovery

Tips for parents and teachers after a school shooting

- Talking to Children about School Violence

Tips for handling Natural Disasters

- Caring for Animals Before, During and After a Disaster
- Managing Flood Distress
- Coping with Traumatic Natural Disasters
- What to do and take when evacuating your home
- Anniversaries and Trigger Events
- Coping with Anxiety about Hurricanes
- Preparing for hurricane
- Recovering from disaster
- What to Do Before, During and After a Tornado
- Prolonged Stress

REMINDERS

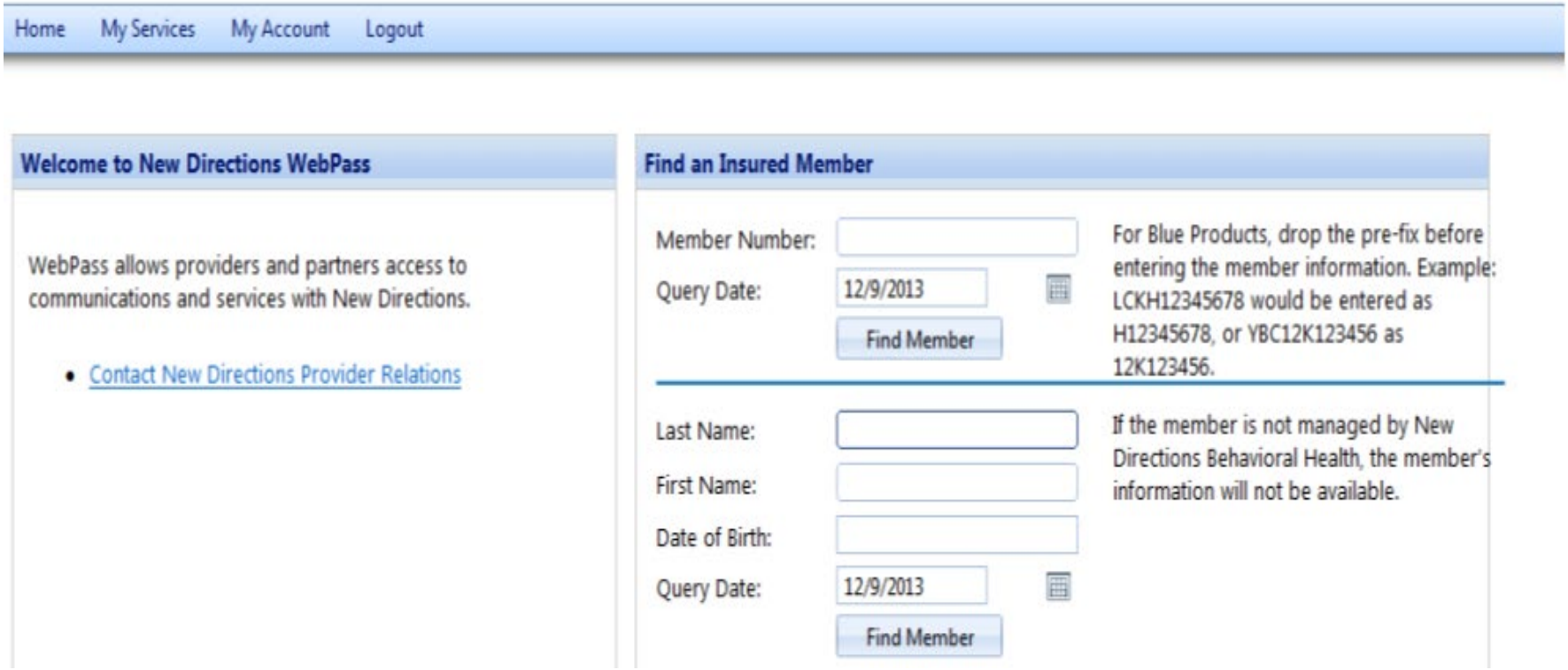
Contact LouisianaPR@ndbh.com

- 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.

APPENDIX

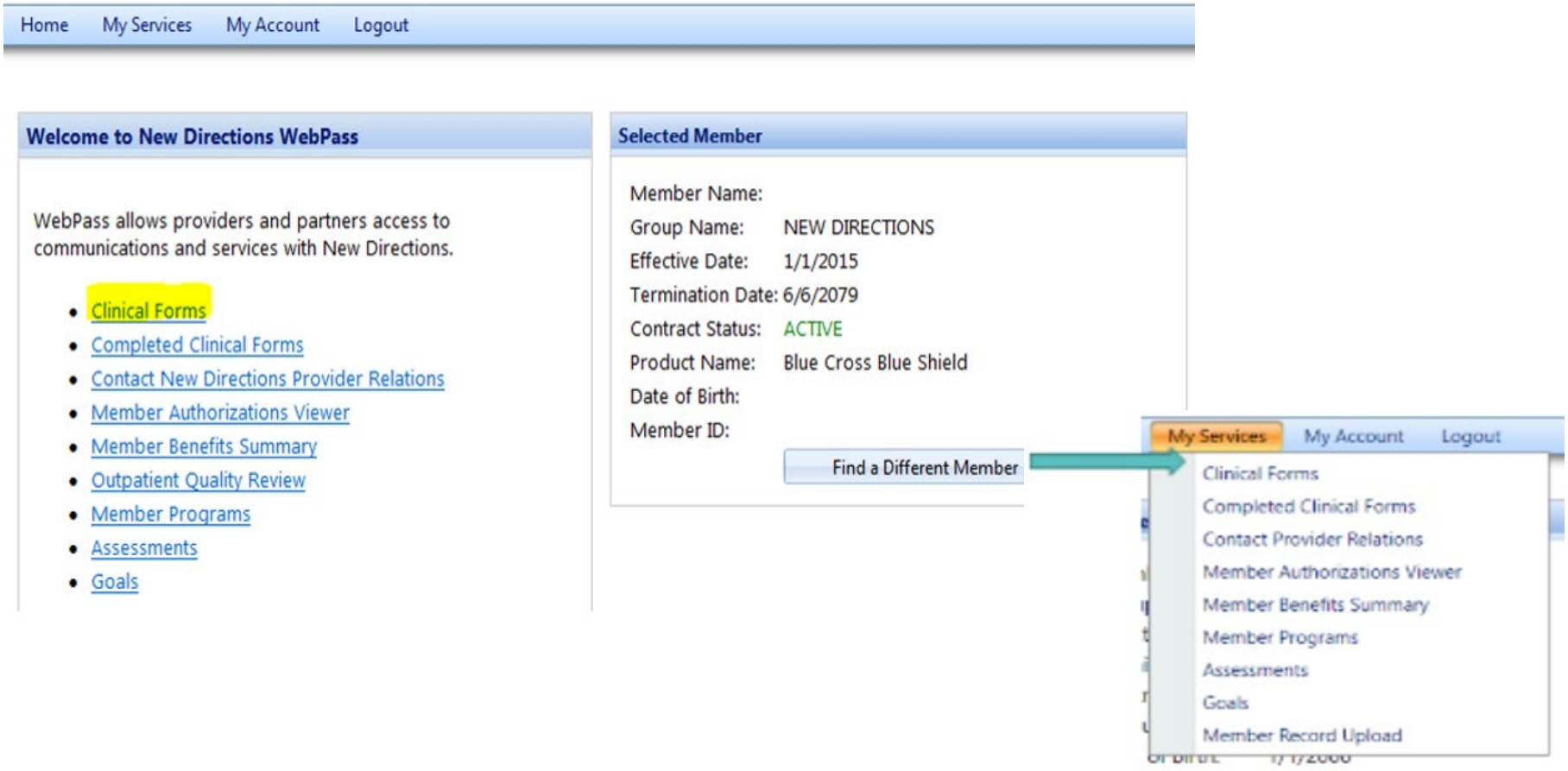
GETTING STARTED

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.

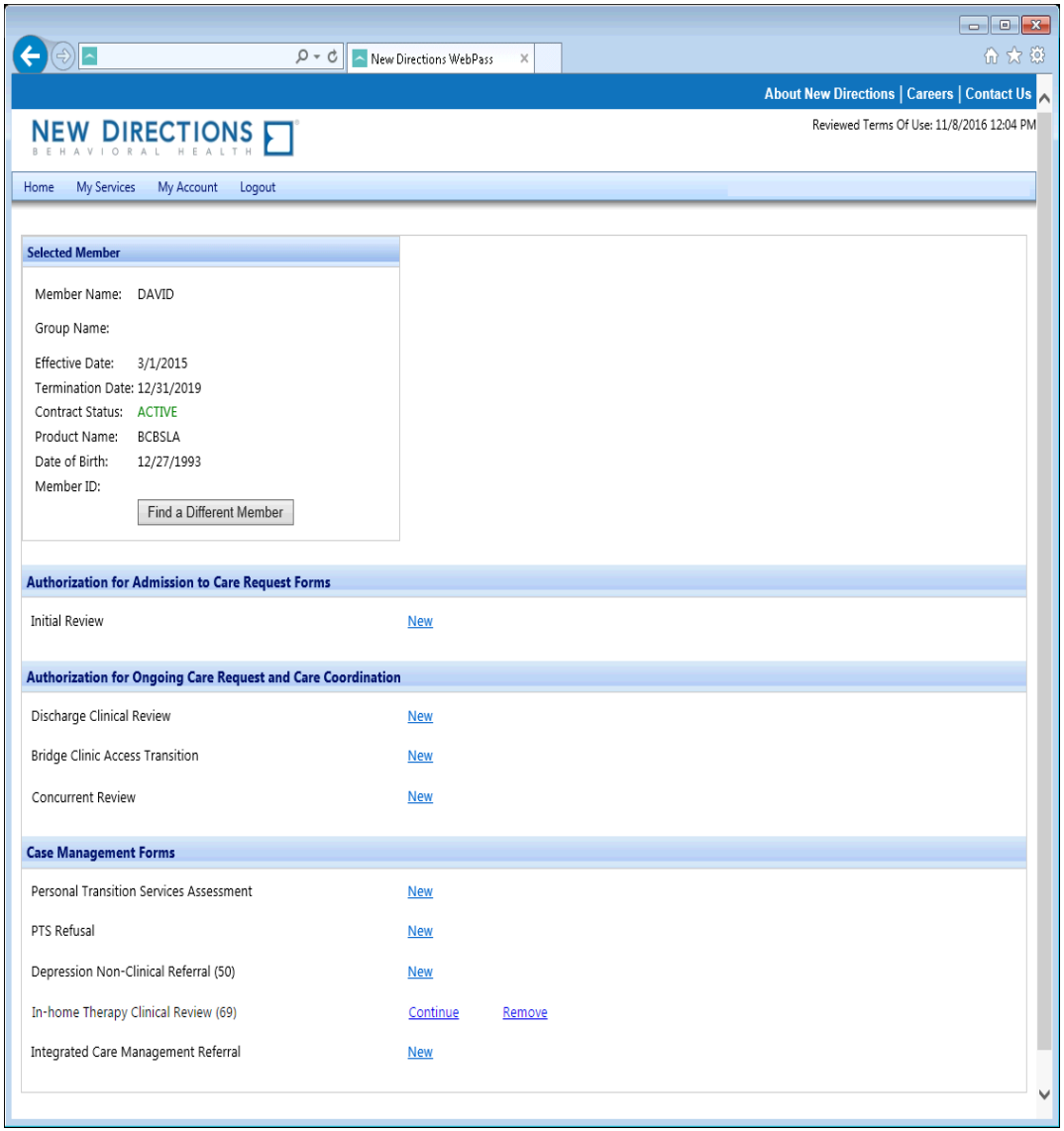


FILLING OUT CLINICAL FORMS

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

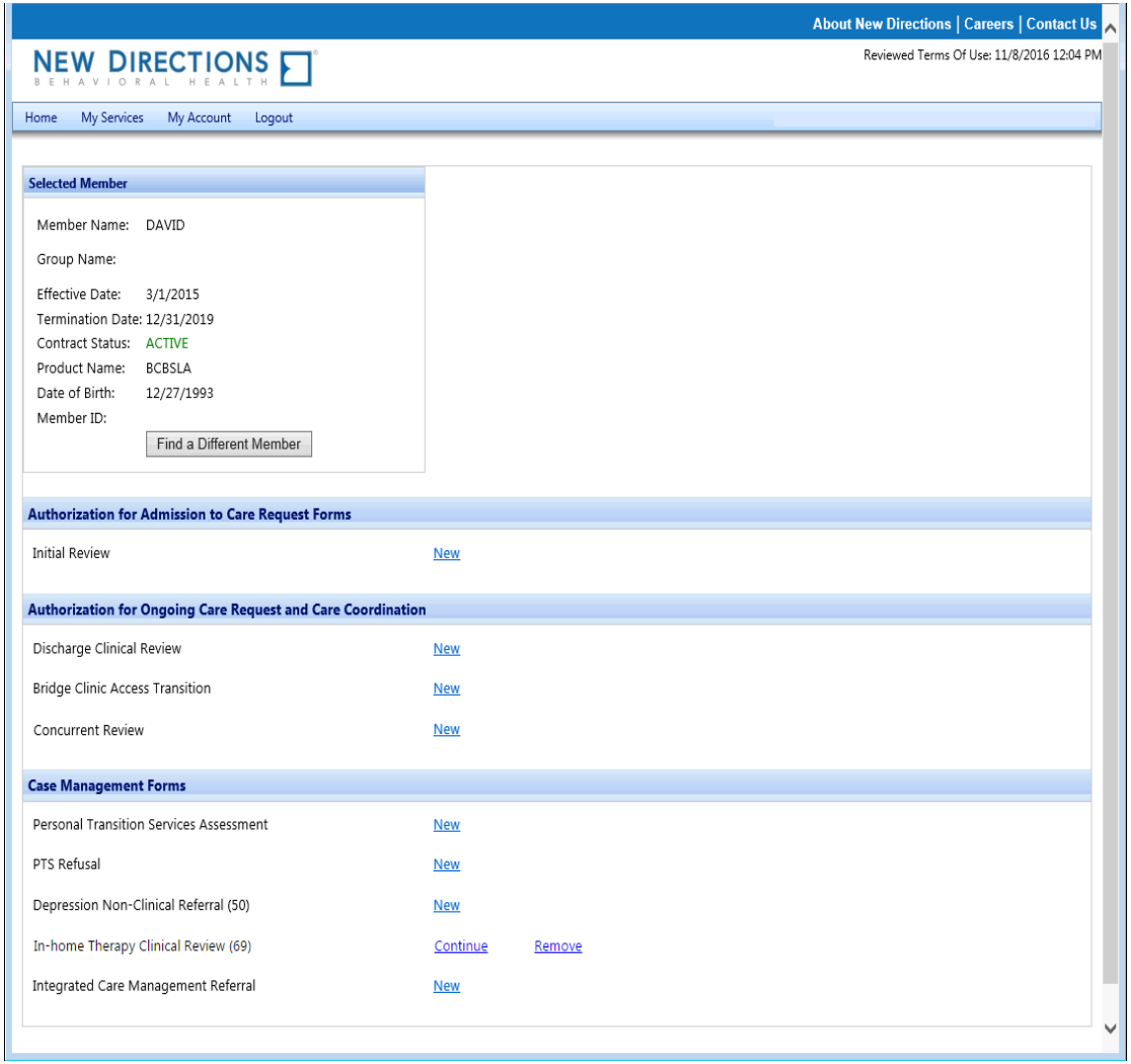


CLINICAL FORMS



- 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.

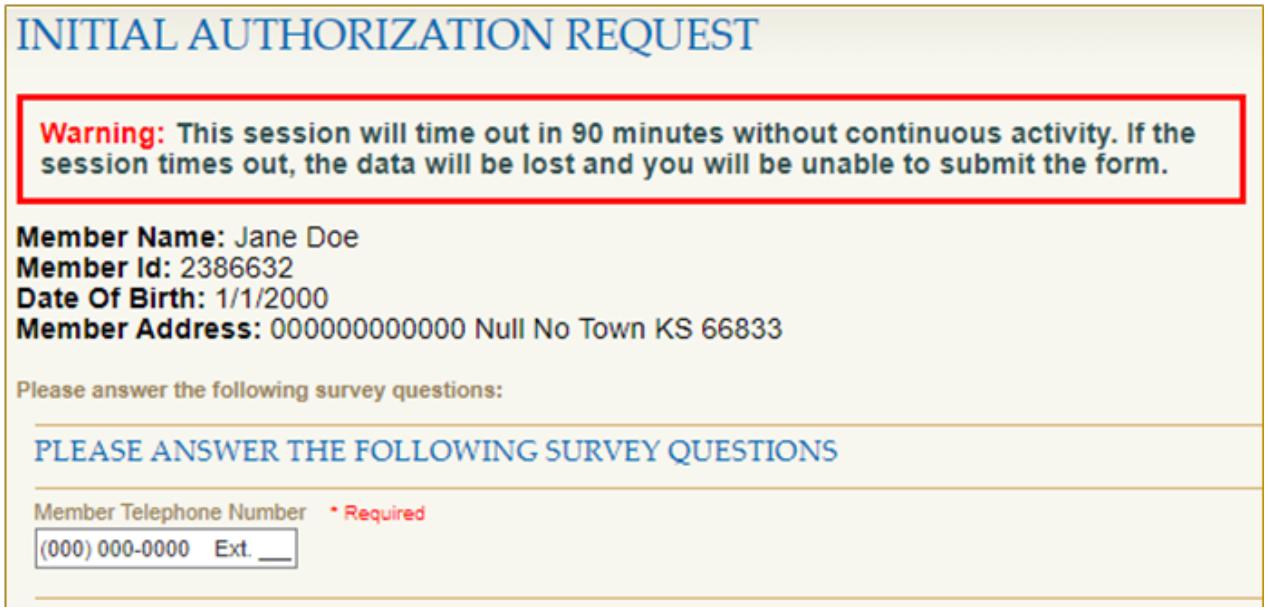
FORMS LIST



- 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.

FILLING OUT CLINICAL FORMS

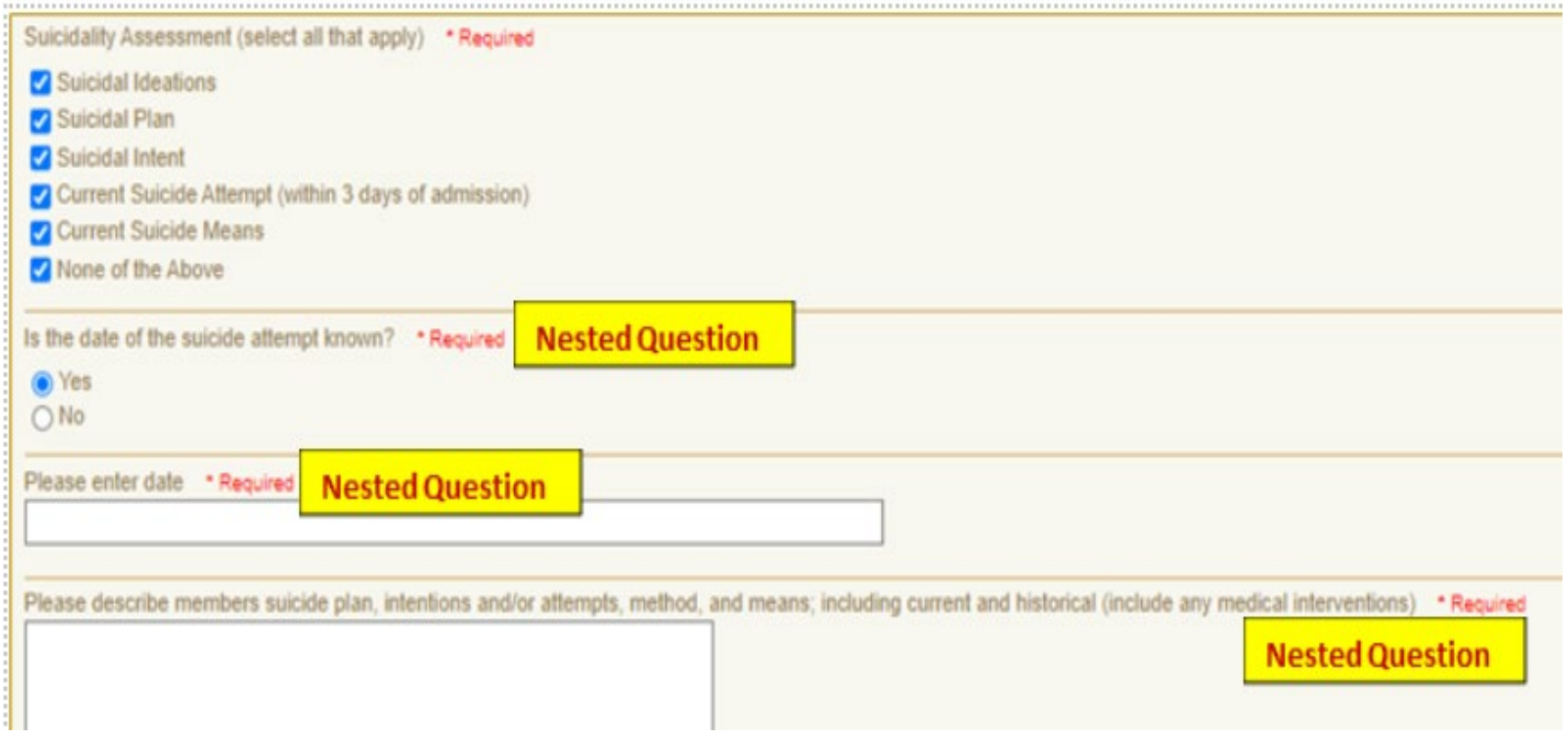
After users select a form, they will enter the clinical information needed for New Directions to conduct a higher level of care review.



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.

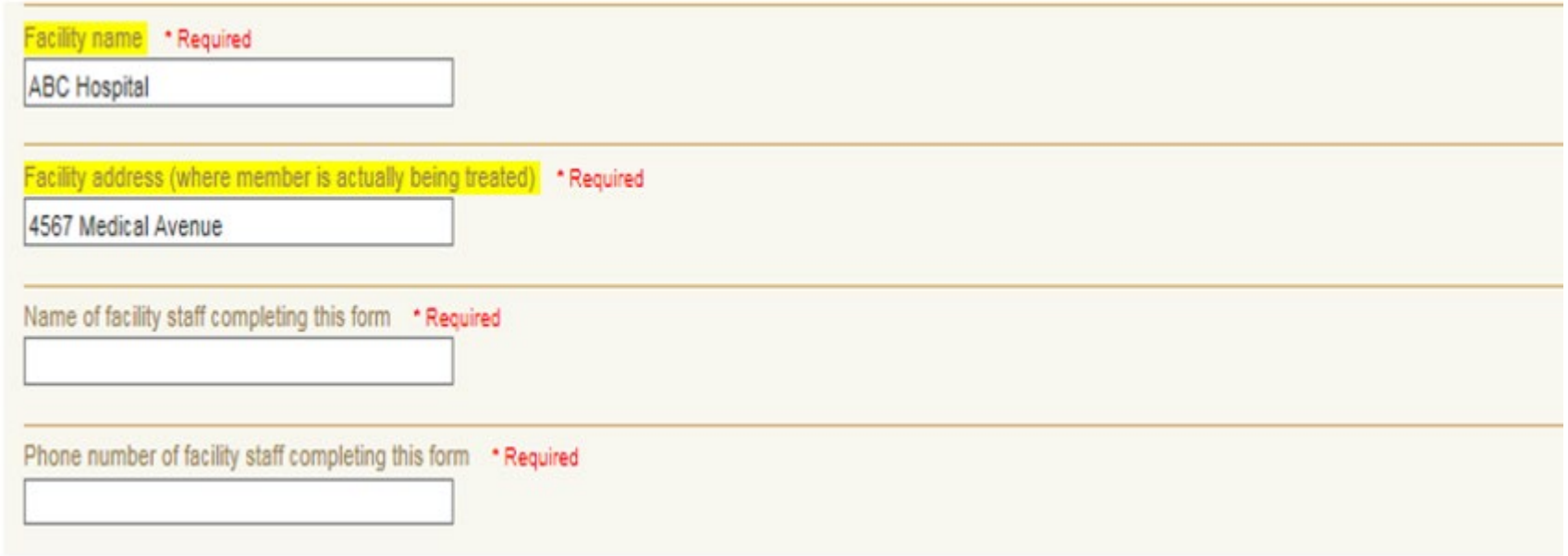


TEXT BOX

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

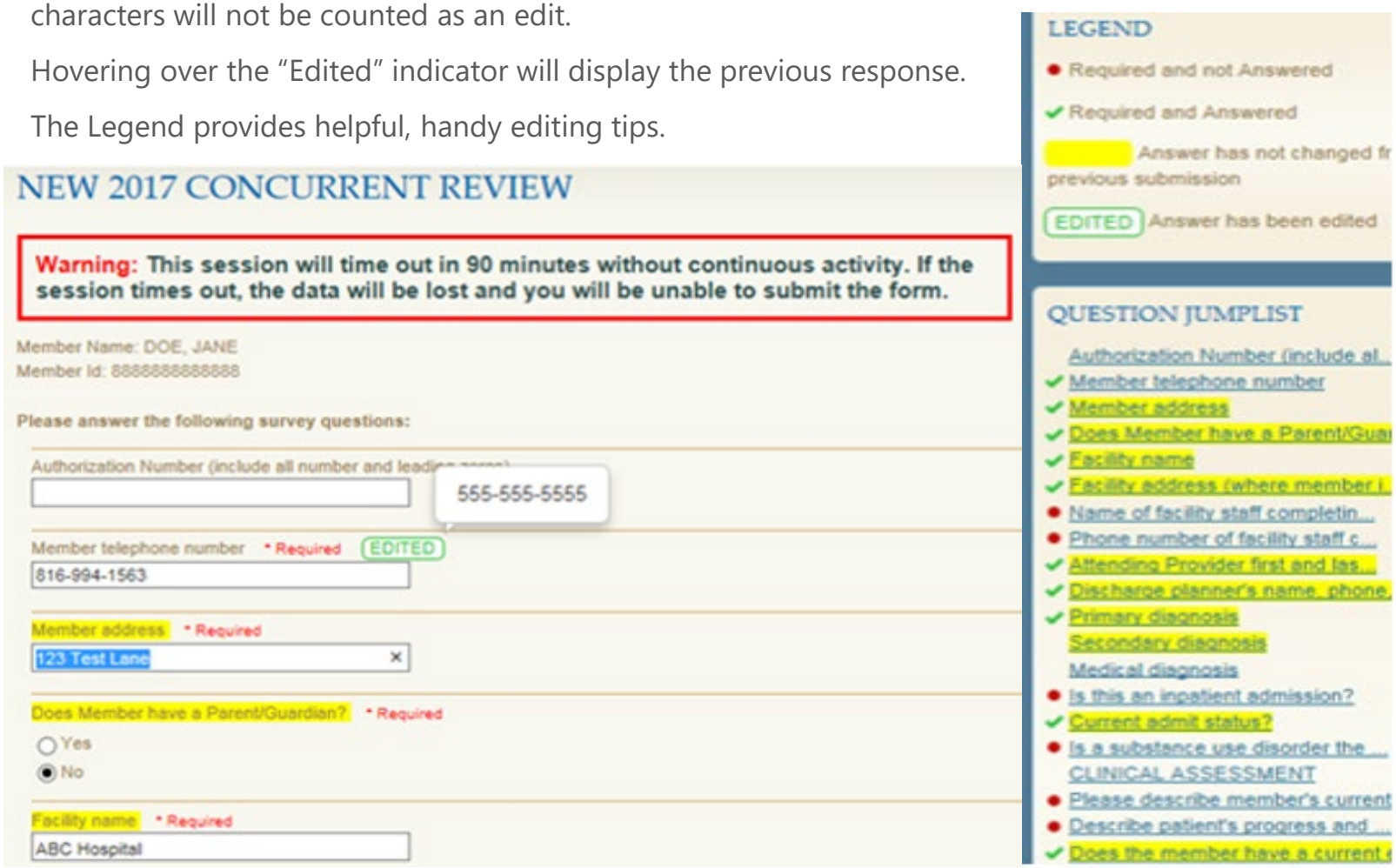
PREPOPULATED INFORMATION

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.

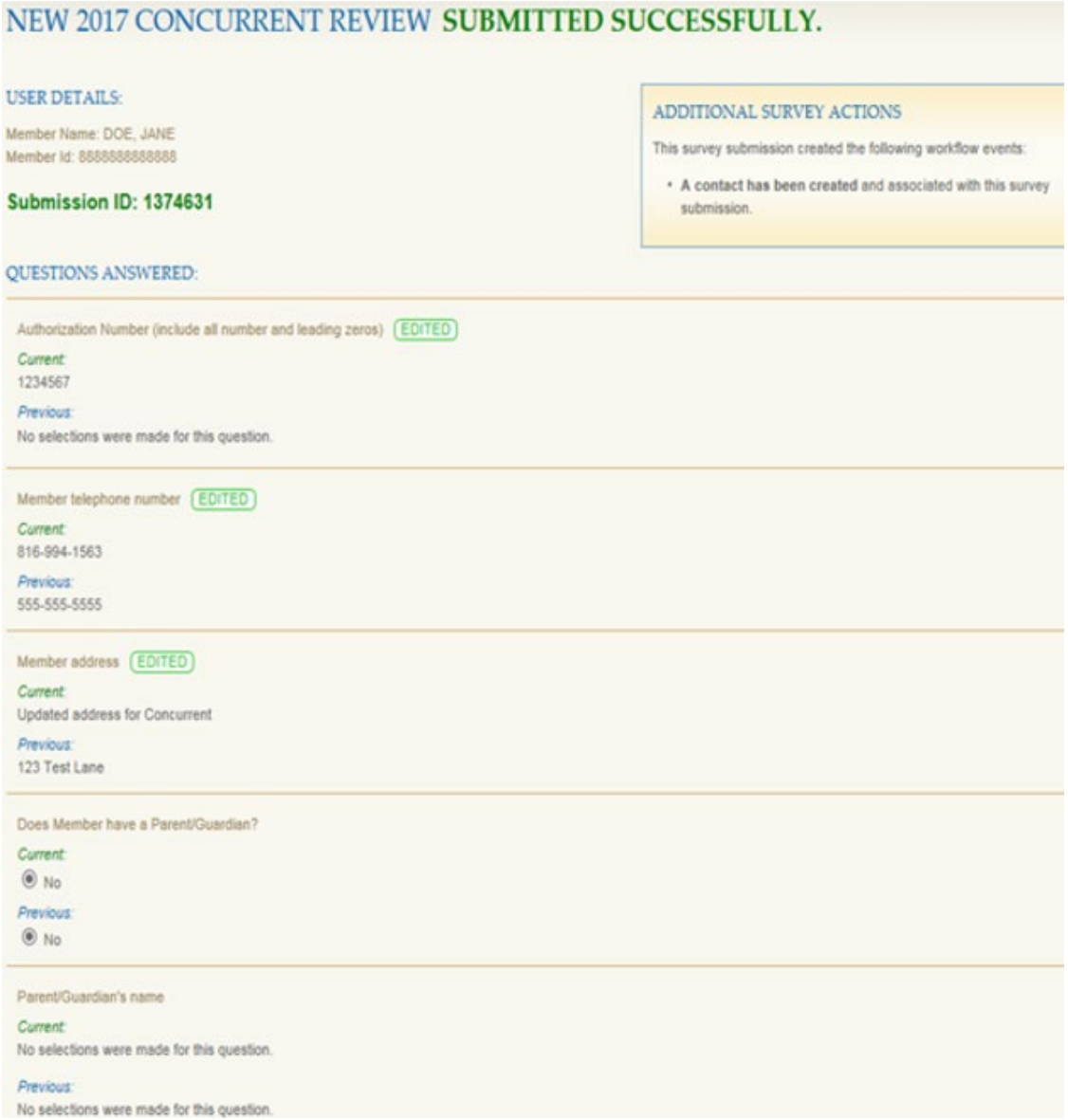


REVIEW OF PREPOPULATED INFORMATION

- 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

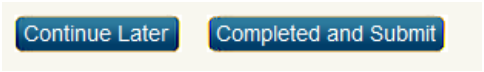
Current:
No selections were made for this question.

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.

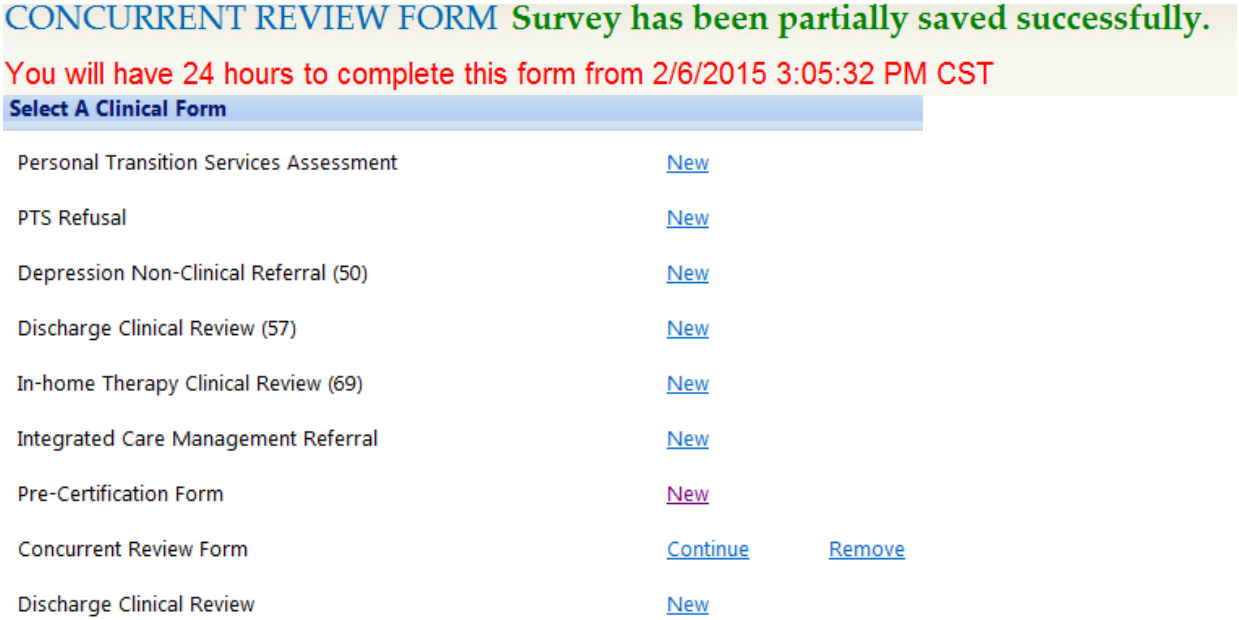
SAVING PARTIALLY COMPLETED FORMS

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.



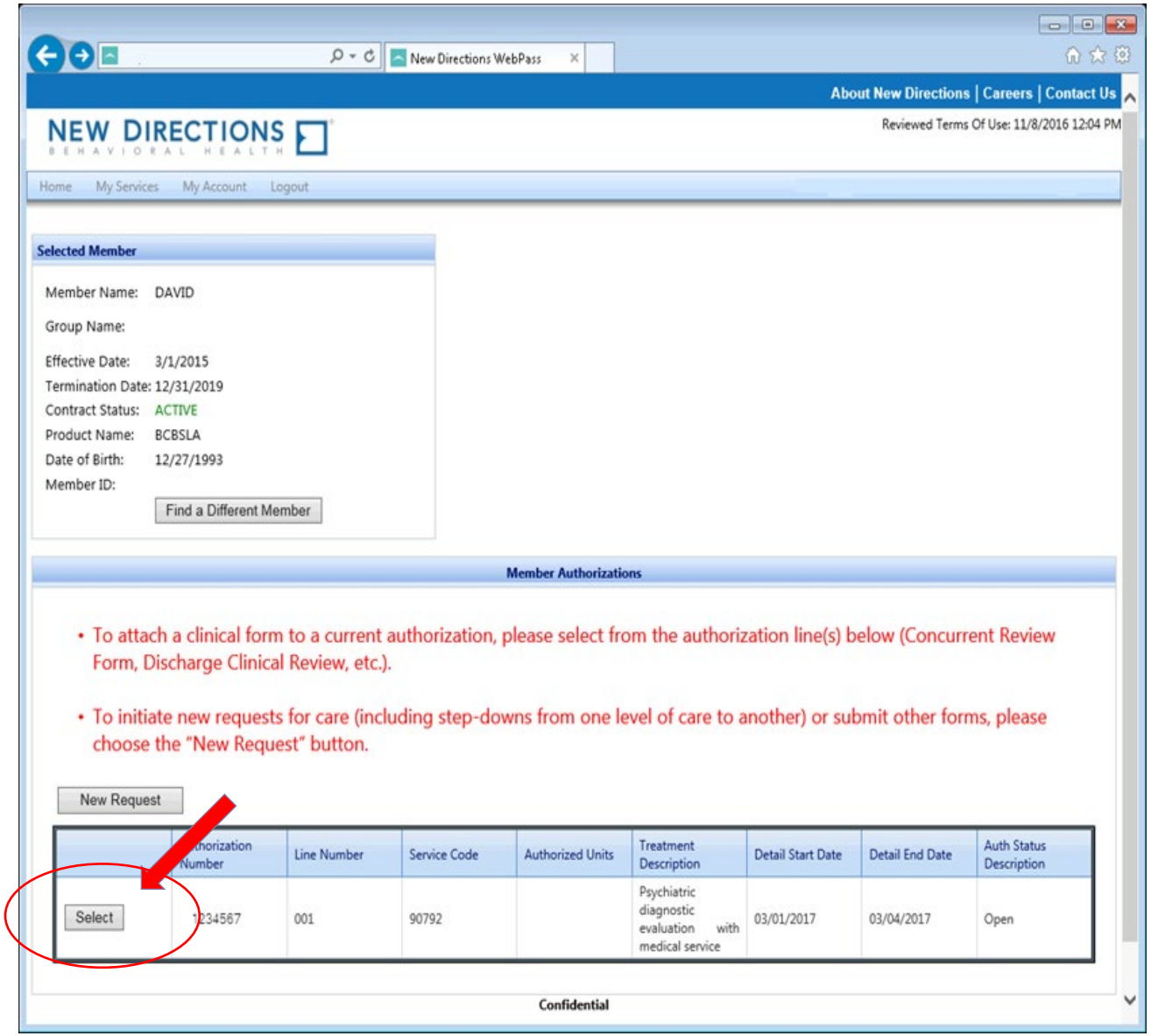
REVIEWING PREVIOUS REQUEST FORMS

- 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.

SUPPORT RESOURCES

PROVIDER RELATIONS

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

Michelle Hunt
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

Yolanda Trahan
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Marie Davis
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

Paden Mouton, Supervisor

PROVIDER CONTRACTING

Jason Heck*, Director – jason.heck@bcbsla.com

Cora LeBlanc, Sr. Provider Network Development Representative – cora.leblanc@bcbsla.com
St. John The Baptist, Terrebonne, Lafourche, St. Charles, St. James, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula, Lasalle parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@bcbsla.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension, Assumption, Iberville, Caddo, Bossier, Webster, Claiborne parishes

Dayna Roy, Sr. Provider Network Development Representative – dayna.roy@bcbsla.com
Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Rapides, St. Landry, St. Martin, Vermilion, Vernon parishes

Jill Taylor, Provider Network Analyst – jill.taylor@bcbsla.com
Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangipahoa, Washington parishes

*Jason Heck works with providers in the following parishes: Desoto, Red River, Bienville, Sabine, Natchitoches, Winn, Jackson and Lincoln

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

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

PROVIDER CREDENTIALING & DATA MANAGEMENT

Venessa Williams, Manager Provider Information
vennessa.williams@bcbsla.com

Anne Monroe, Provider Information Supervisor
anne.monroe@bcbsla.com

Mallory Trant, Provider Information Supervisor (Credentialing)
mallory.trant@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.

1-800-716-2299, option 2 | **PCDMStatus@bcbsla.com**

QUICK CONTACTS

Joining the Network

Getting Credentialed – PCDMStatus@bcbsla.com, 1-800-716-2299, option 2
Getting Contracted – provider.contracting@bcbsla.com, 1-800-716-2299, option 1

Updating your Information

Data Management – PCDMStatus@bcbsla.com, 1-800-716-2299, option 2

Education, iLinkBlue Training & Outreach

Provider Relations – provider.relations@bcbsla.com, 1-800-716-2299, option 4

Electronic Services

iLinkBlue – www.bcbsla.com/ilinkblue
EDI Services (clearinghouse) – EDIServices@bcsla.com, 1-800-716-2299, option 3
Security Access to Online Services – PIMteam@bcbsla.com, 1-800-176-2299, option 5

Ongoing Support

Customer Care & IVR Phone Services – 1-800-922-8866

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 Specialist

Email: **dcrabtree@nbdh.com**

Phone: 1-904-371-6942

We are listening!

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

If you 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**

BCBSLA 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.

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
- 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?

- Close gaps in care.
- Ensure all documentation reflects what is being billed.
- 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

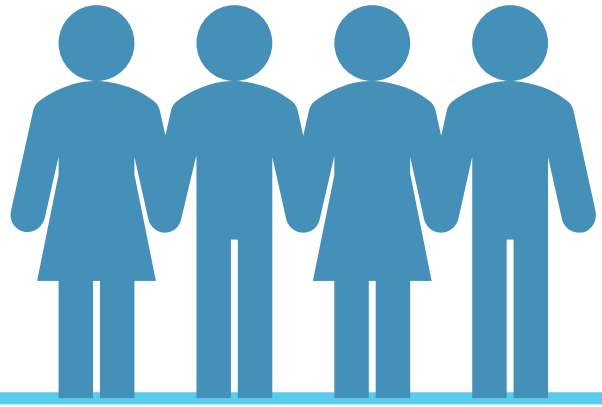
Examples:

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

OUT-OF-NETWORK REFERRALS

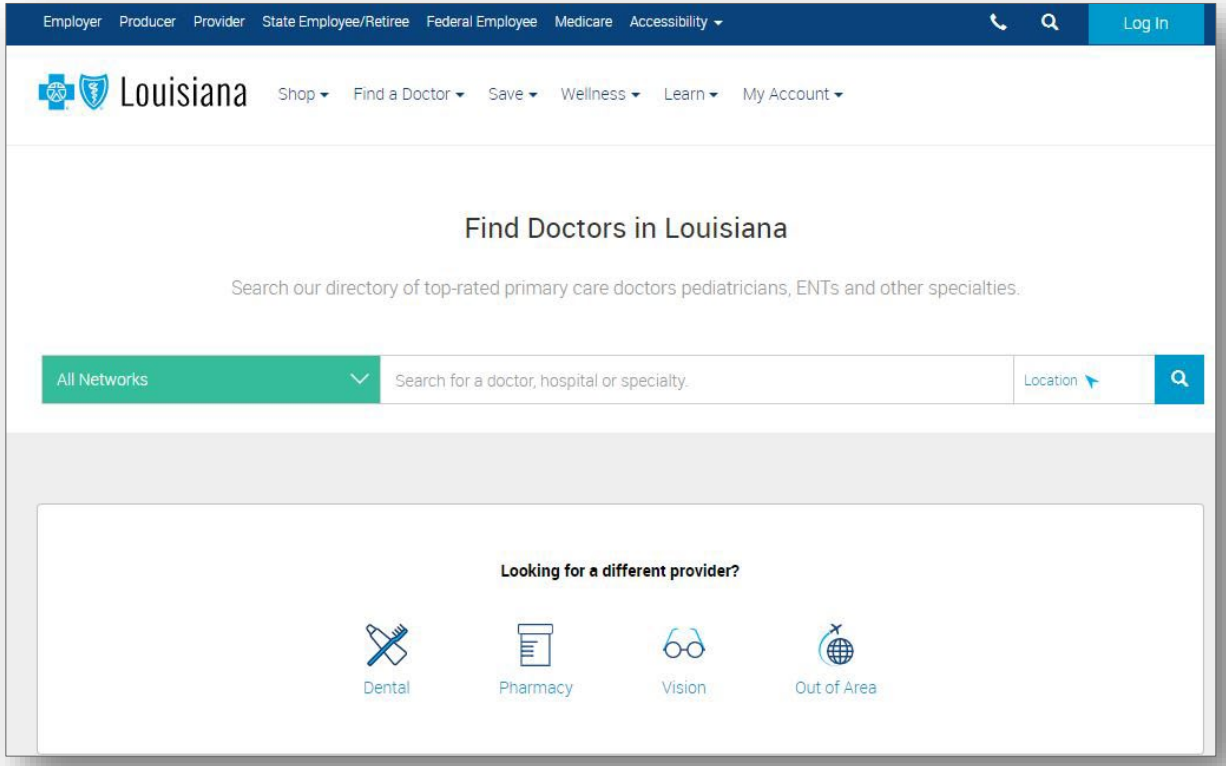
The impact on your patients when you refer Blue Cross members to out-of-network providers:

- 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:

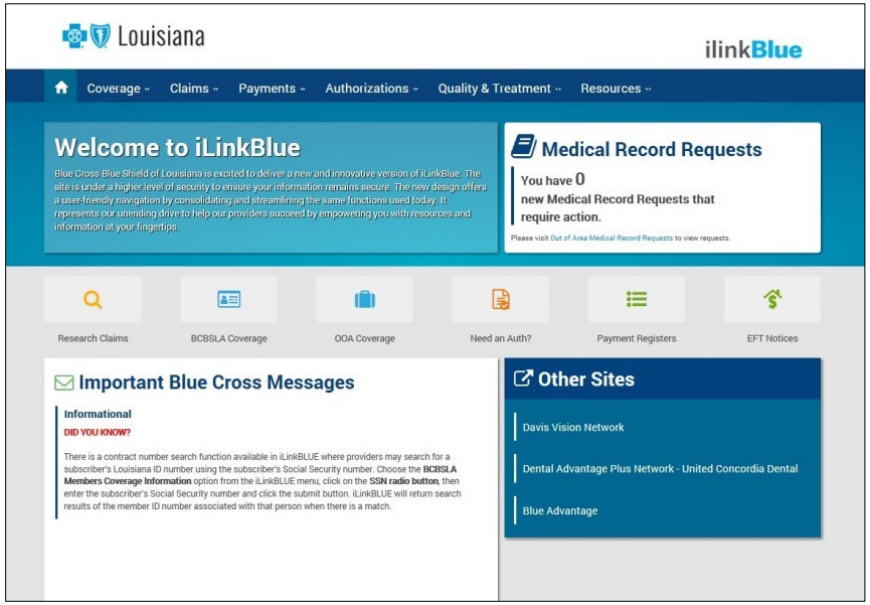
Email: **PIMTeam@bcbsla.com**

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.

ACCESSING THE VANTAGE PROVIDER PORTAL



- The processes for Blue Advantage (HMO) | Blue Advantage (PPO) differ from our other provider network processes.
- We have created a separate portal for these contracted providers to access those processes.
- You must access the Blue Advantage Provider Portal through iLinkBlue (**www.bcbsla.com/ilinkblue**).
- To gain security access to the Blue Advantage Provider Portal, users must first self-register within the portal; this will start the process of getting the user access to the feature.

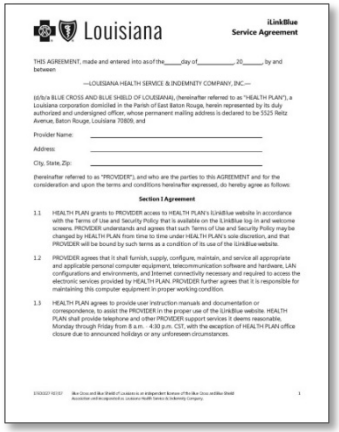
iLINKBLUE APPLICATION PACKET

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

ALWAYS include NPI/TAX ID on:

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

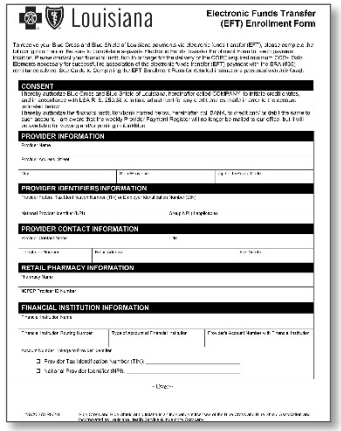
These four documents are required to access iLinkBlue:


Louisiana
iLinkBlue Service Agreement

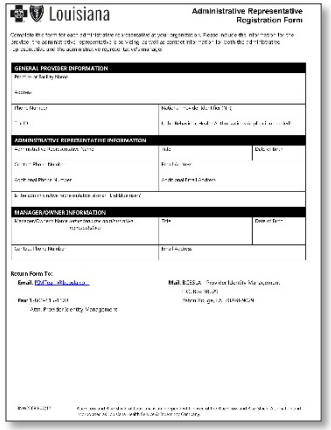
iLinkBlue Service Agreement


Louisiana
Business Associate Addendum to the iLinkBlue Service Agreement

Business Associate Addendum


Louisiana
Electronic Funds Transfer (EFT) Enrollment Form

Electronic Funds Transfer Enrollment Form

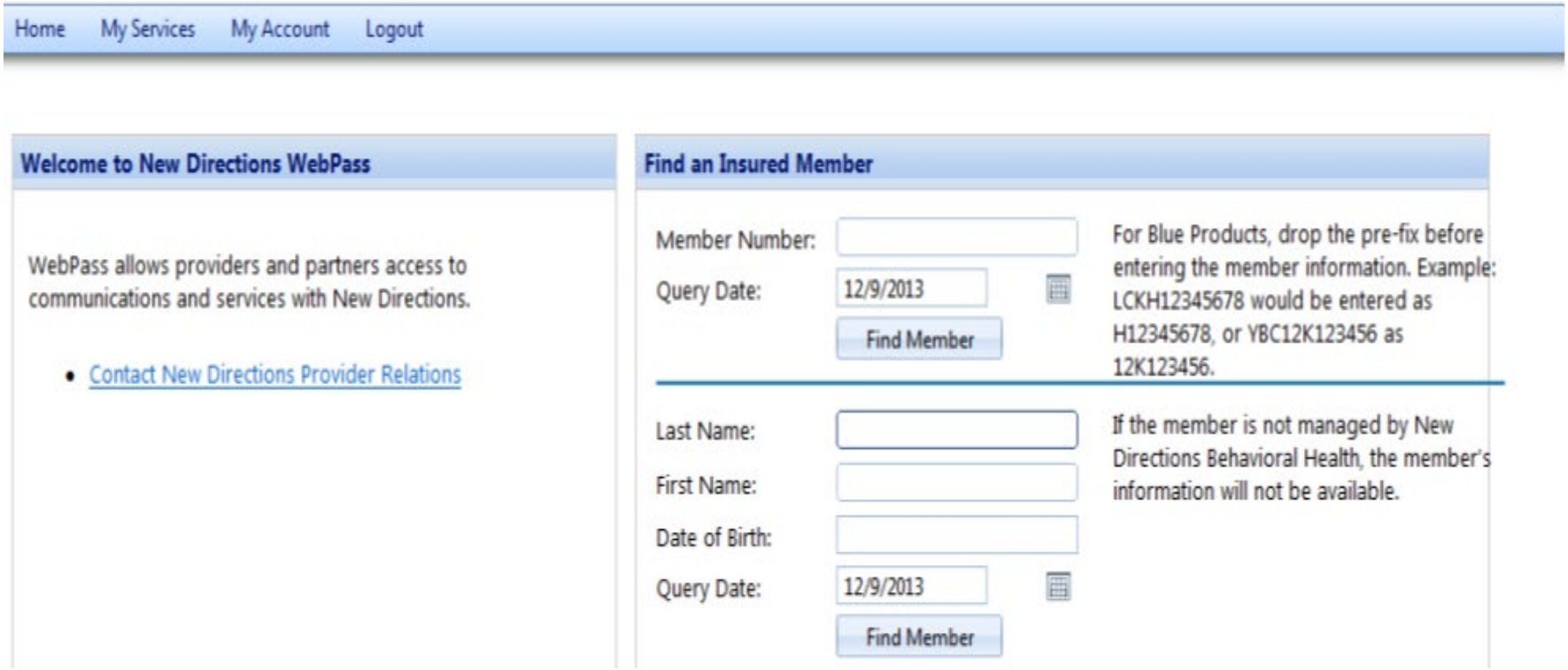

Louisiana
Administrative Representative Registration Form

Administrative Representative Registration Form

NEW DIRECTIONS APPENDIX

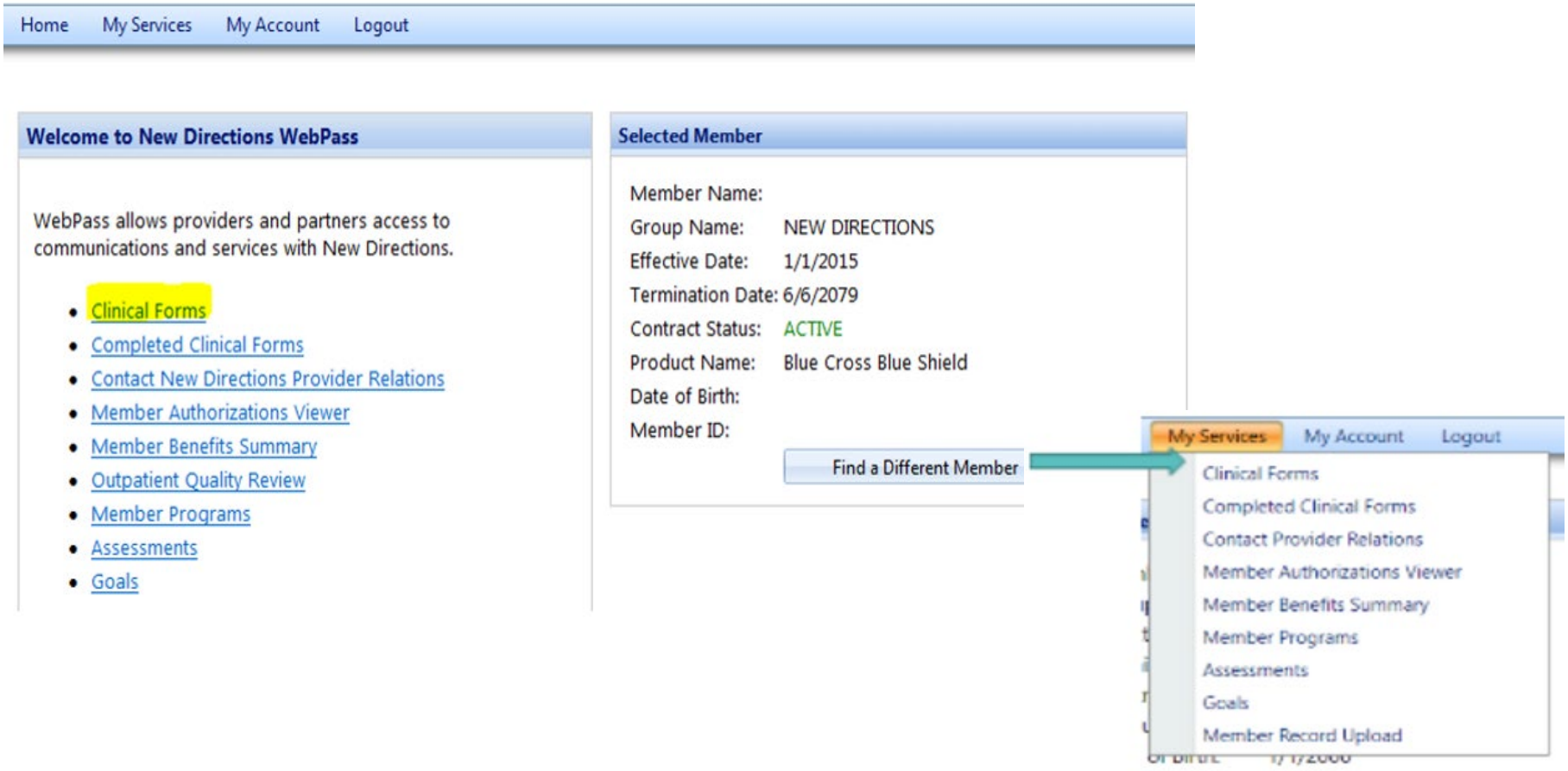
GETTING STARTED

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.

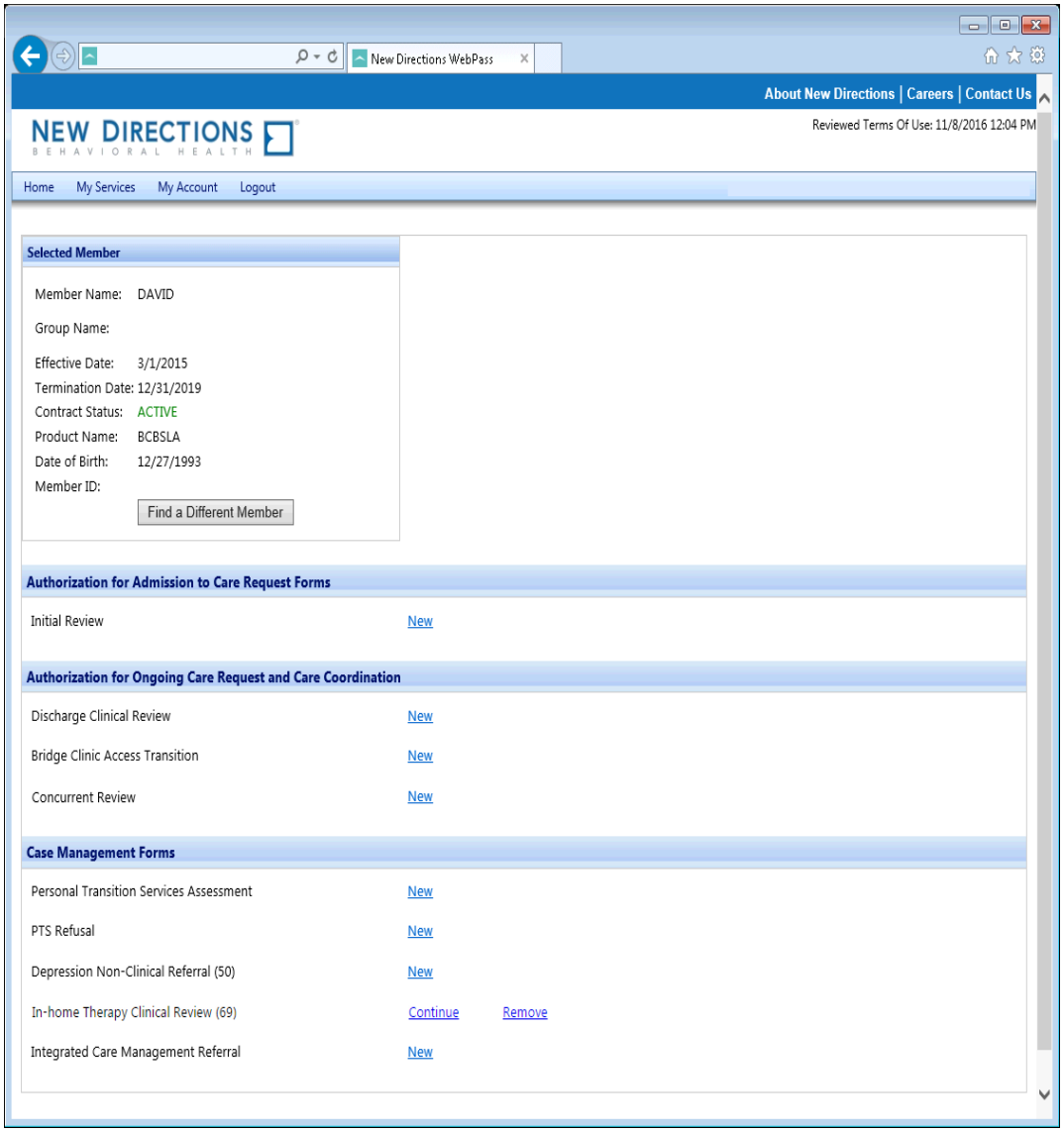


FILLING OUT CLINICAL FORMS

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

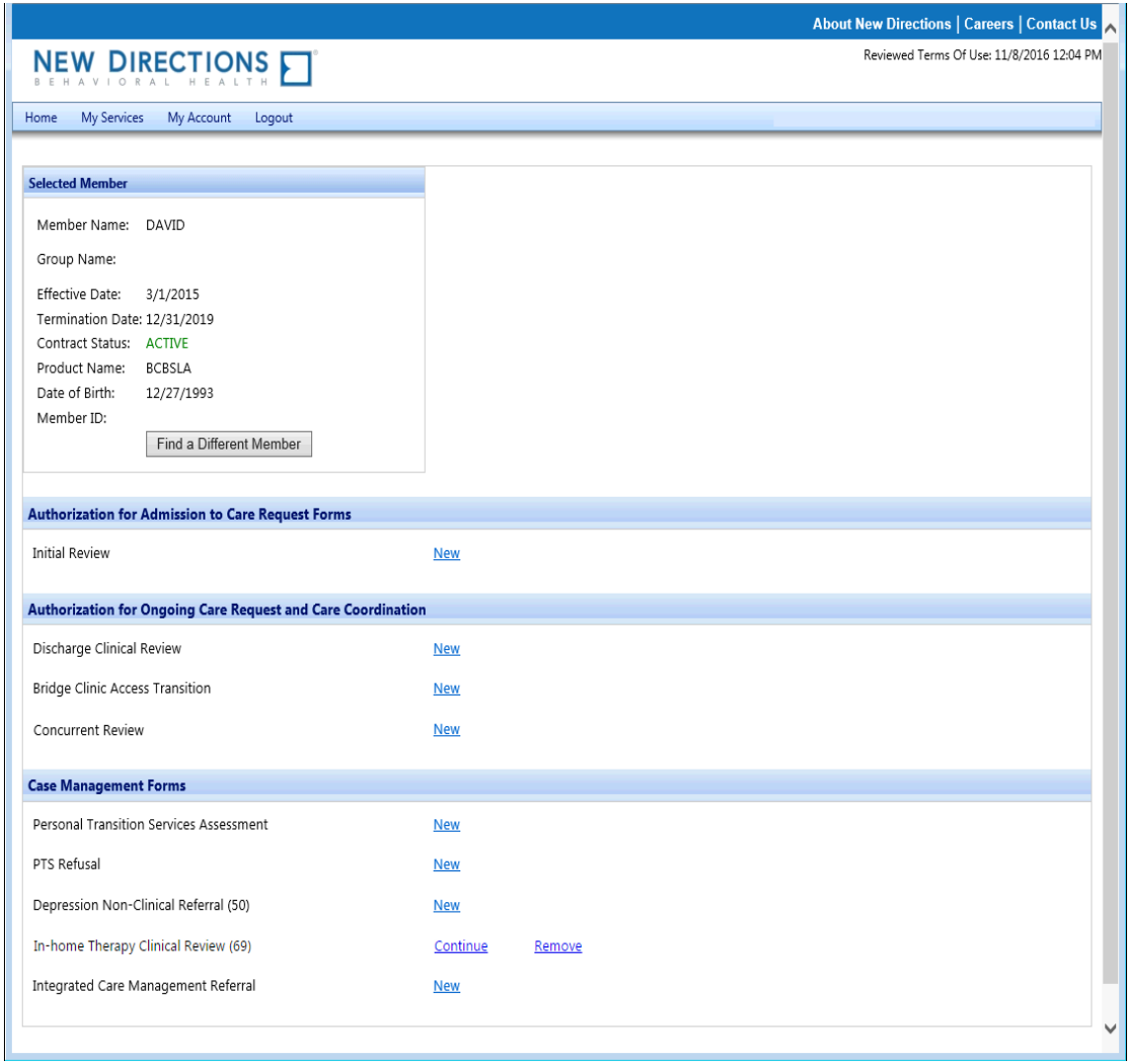


CLINICAL FORMS



- 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.

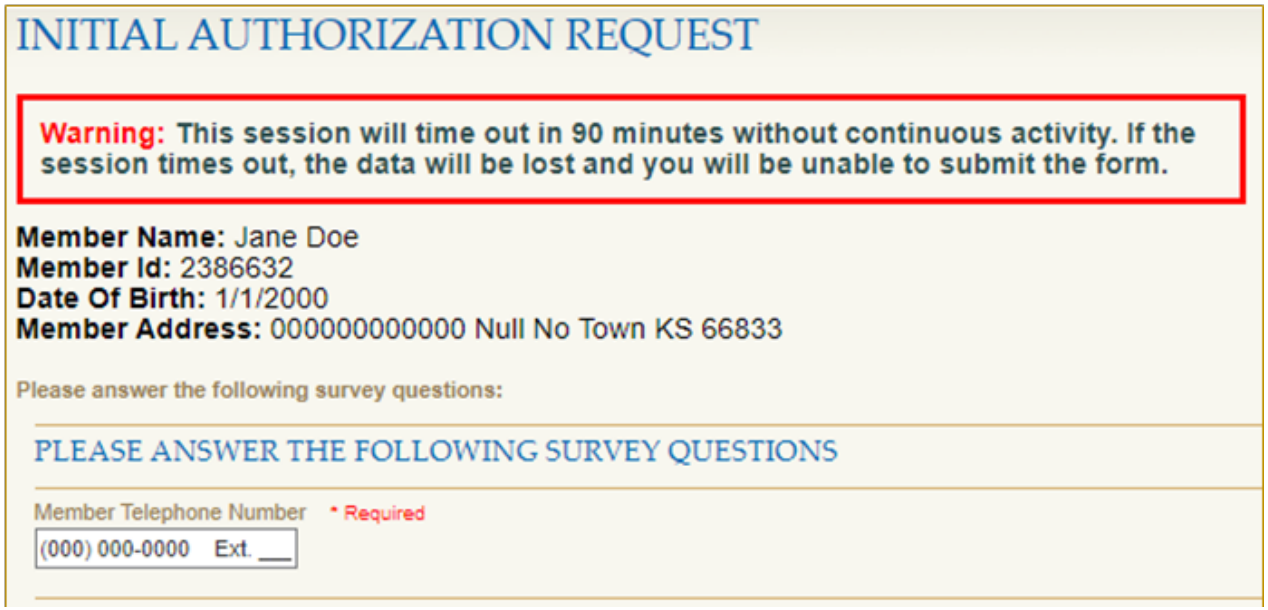
FORMS LIST



- 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.

FILLING OUT CLINICAL FORMS

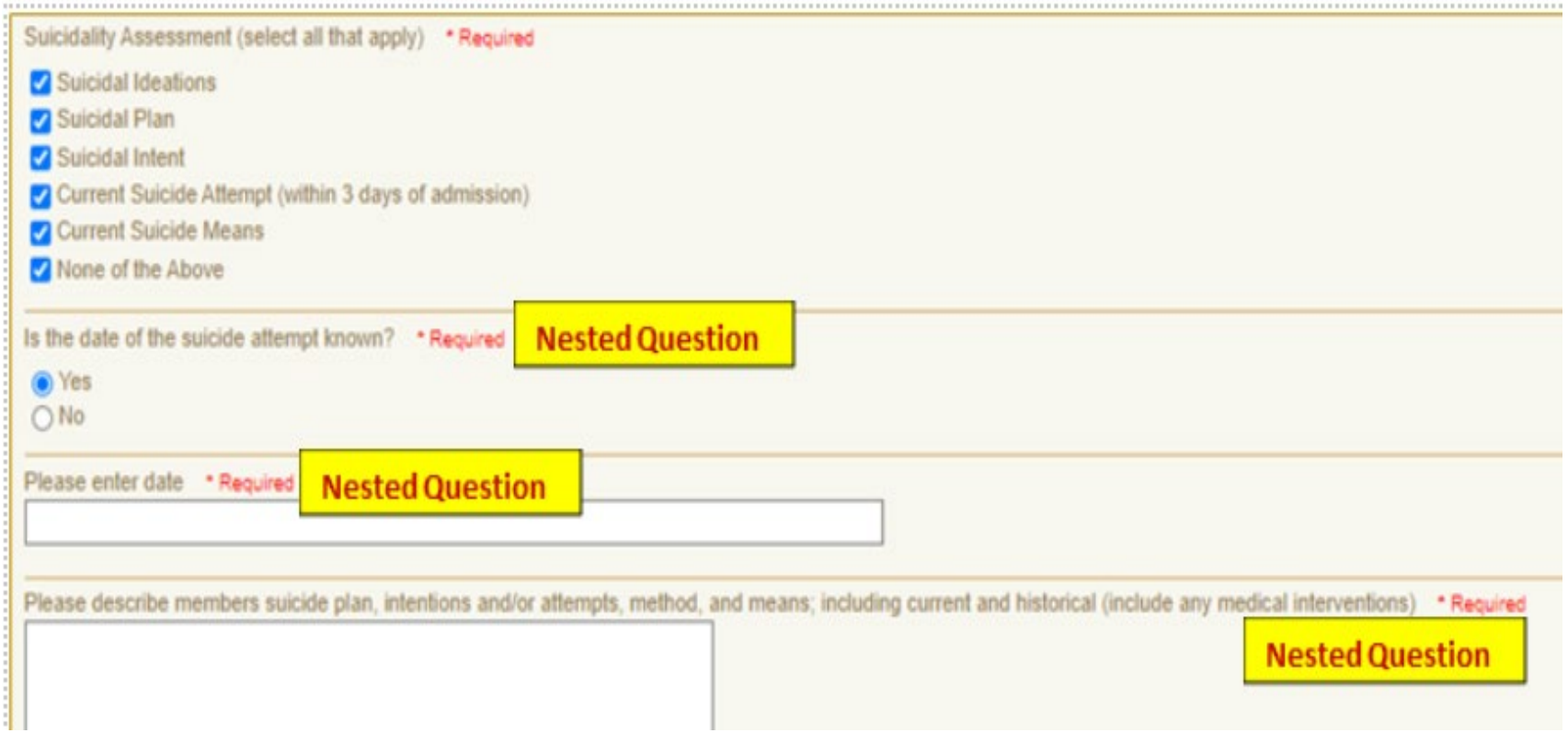
After users select a form, they will enter the clinical information needed for New Directions to conduct a higher level of care review.



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.

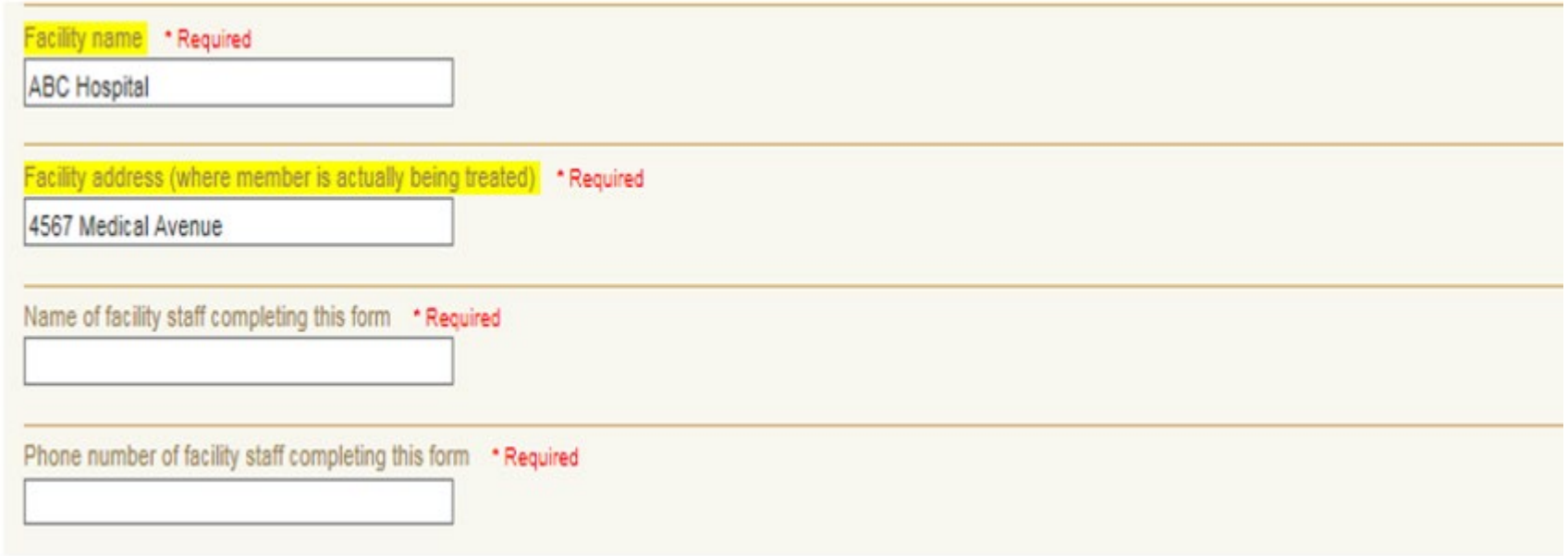


TEXT BOX

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

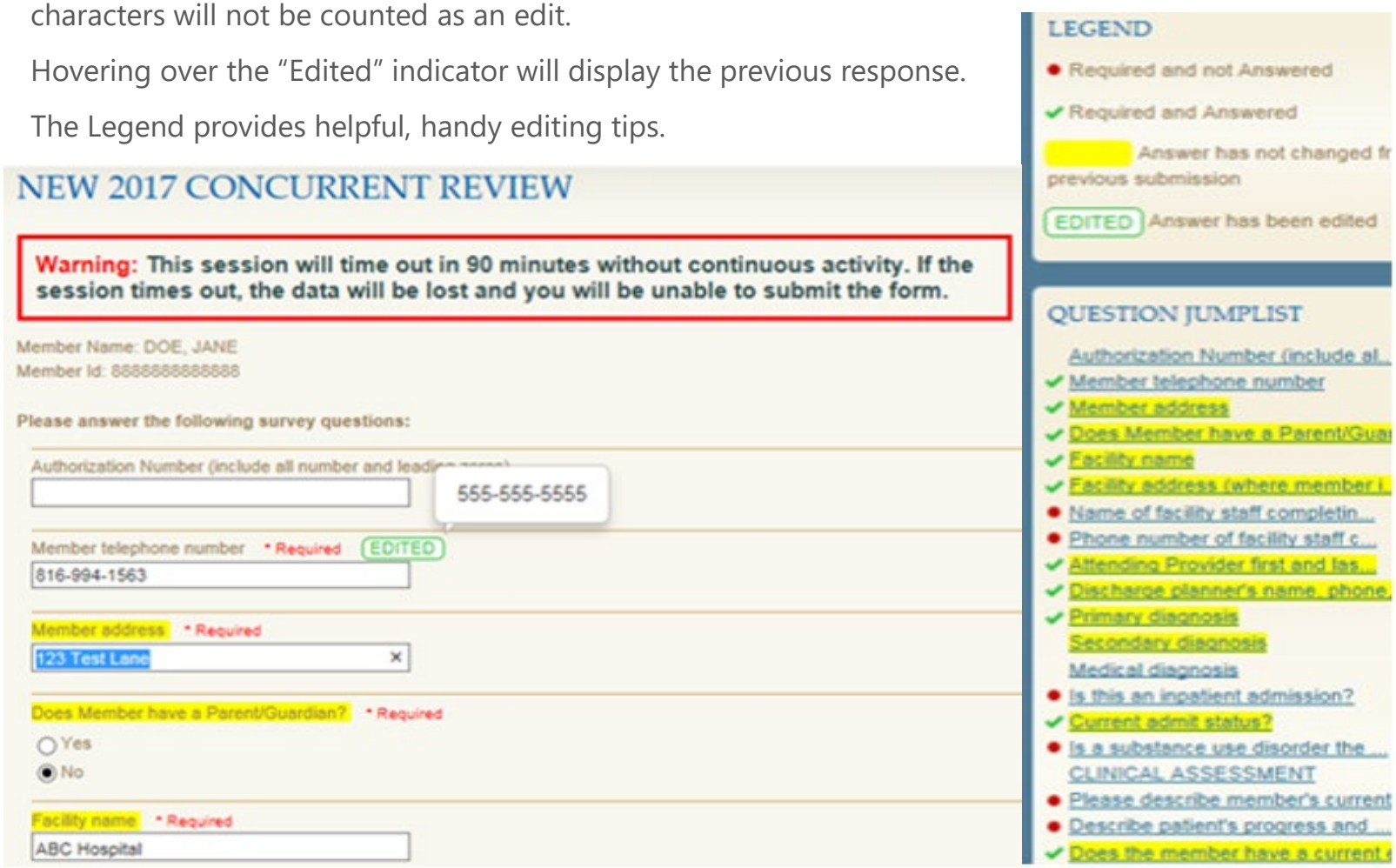
PREPOPULATED INFORMATION

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.

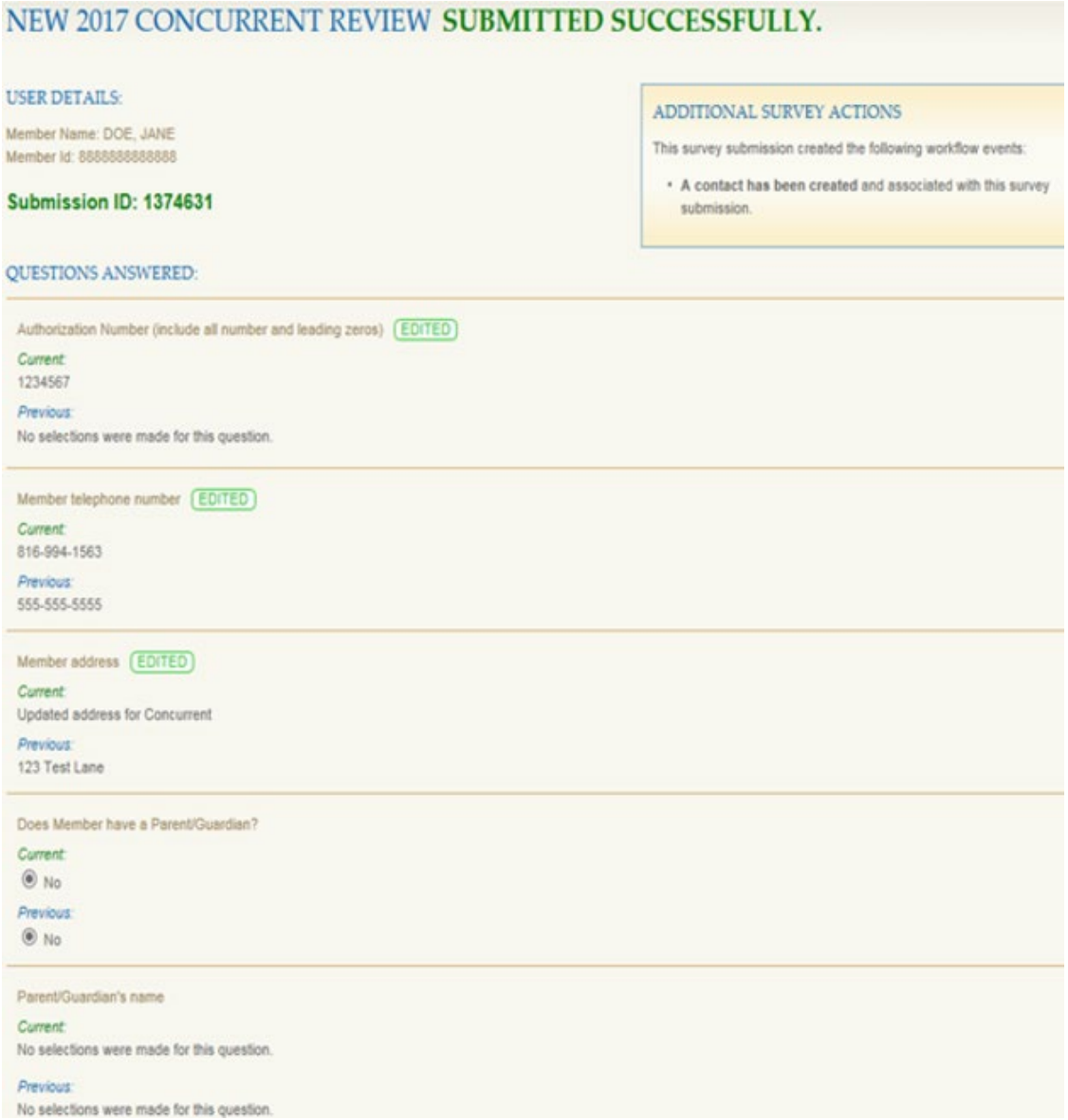


REVIEW OF PREPOPULATED INFORMATION

- 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

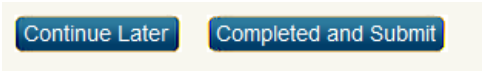
Current:
No selections were made for this question.

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.

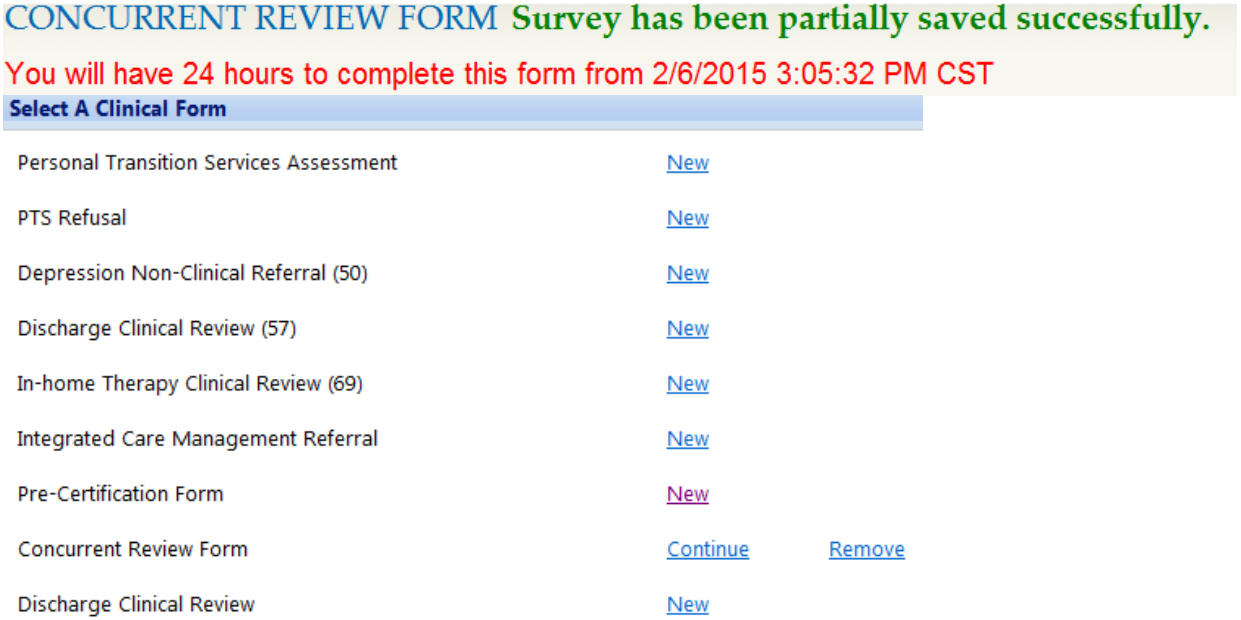
SAVING PARTIALLY COMPLETED FORMS

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.



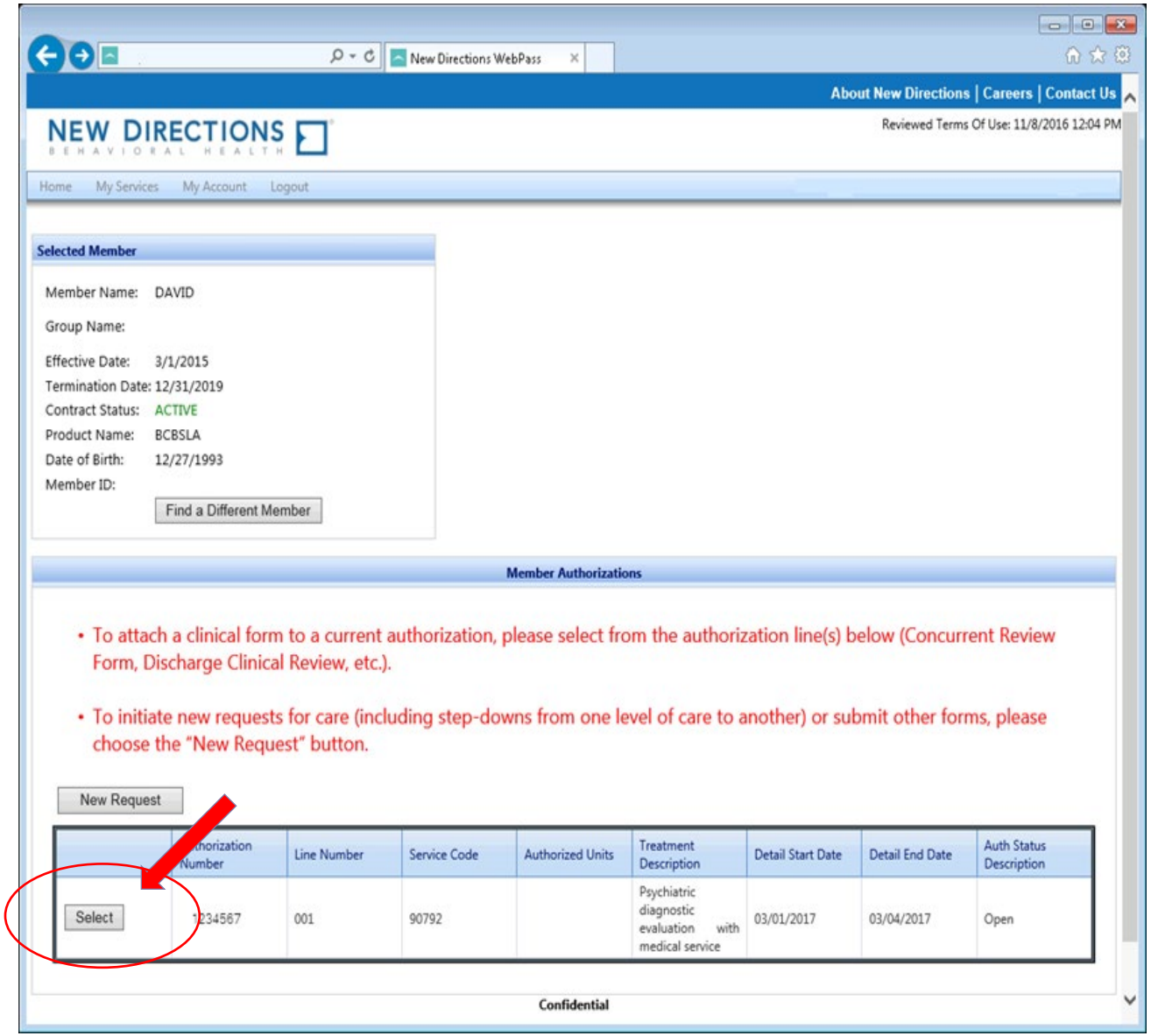
REVIEWING PREVIOUS REQUEST FORMS

- 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.