

# Blue Advantage Behavioral Health Webinar

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 only.

## 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.

November 2023

# BEHAVIORAL HEALTH

An educational presentation from the Provider Relations  
Department of Blue Cross and Blue Shield of Louisiana



Anna Granen,  
Senior Provider Relations  
Representative



Marie Davis,  
Senior Provider Relations  
Representative



Blue adVantage (HMO) | Blue adVantage (PPO)

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).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## Our Mission

To improve the health and lives of Louisianians.

## Our Core Values

- Health
- Sustainability
- Affordability
- Foundations
- Experience

## Our Vision

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

# Agenda

- What's New?
- Reminders & Resources
- Blue Advantage Provider Portal
- Medicare Advantage Members from Other Blue Plans
- Telehealth
- HEDIS®
- Authorizations
- Addendum

# High Quality Score!

**Our HMO plan recently earned 4.5 out of 5 Stars, and our PPO plans recently earned a 4.0 out of 5 Stars for the 2024 Star Ratings from Centers for Medicare & Medicaid Services (CMS).**

- The CMS Star Rating system helps Medicare consumers compare quality of Medicare health and drug plans being offered so they are empowered to make the best healthcare decisions for them.
- The ratings are based on member feedback and data from doctors and hospitals that work with the plan, among other factors.
- Plans that receive a 4.5 out of 5 Stars in the annual ratings have earned CMS' second-highest rating.



# Welcome to the Blue Advantage Network

**Blue Advantage** is our Medicare Advantage product currently available to Medicare-eligible persons statewide.



Louisiana

Blue adVantage (HMO) | Blue adVantage (PPO)

# Who are we?



- Blue Advantage provides HMO and PPO networks to our Blue Advantage members.
- Offers support for population health visits as well as additional quality programs such as the Blue Advantage Coupon program and HEDIS/Star ratings improvement for Blue Advantage members.



# Member ID Cards

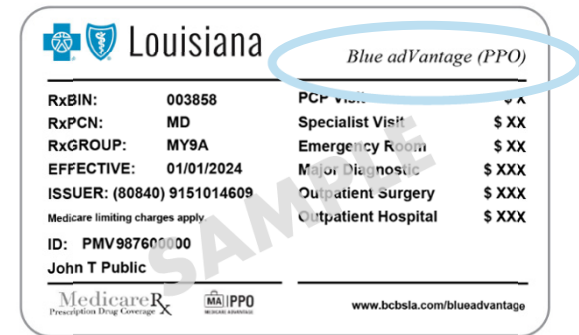


# Member ID Cards

Blue Advantage provides each member with an ID card containing the following:

- Name of the covered member.
- Copayment or coinsurance responsibilities.
- Important phone numbers.

The member ID card is used for all types of coverage such as Medicare Part A, Part B and Part D (pharmacy).



Prefix: PMV



Prefix: MDV



# Reminders & Resources

# Credentialing Information

Blue Cross requires all providers to be credentialed prior to participating in our networks.

- Initial credentialing
  - Louisiana Standardized Credentialing Application (LSCA) through DocuSign®
  - **PCDMstatus@bcbsla.com**, 1-800-716-2299, option 2

Recredentialing is done every three years. Failure to return your recredentialing information will result in network termination.

- Recredentialing
  - CAQH Application or LSCA
  - **recredentialing@vhpla.com**, (318) 807-4755

# Compliance Reminders

As a Blue Advantage provider, you are required to:

- Follow the provider guidelines in your provider manual when discussing Medicare Advantage.
- Routinely check for exclusions by the OIG/GSA (Office of Inspector General/General Services Administration).
- Report any actual or suspected compliance concerns.
- Notify us of any practice information changes.
- Verify that provider training has been completed in:
  - General compliance
  - Fraud, waste and abuse

**CMS offers more information on compliance that you can access through the Blue Advantage Provider Portal. Under the “Resources” section, click on “Compliance.”**

To notify us of any practice changes, use our Provider Update Request Form found online at [www.bcbsla.com/providers](http://www.bcbsla.com/providers) under “Resources” then “Forms.”



# Blue Advantage Manuals and Guides



- Policies
- Procedures
- Reference information required of our Blue Advantage network providers

2024 Provider Quick Reference Guide	
<b>Service</b>	<b>Contact Information</b>
<b>Blue Advantage Customer Service</b>	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at: phone: 1-866-508-7145 fax: 1-877-528-5820 email: <a href="mailto:customerservice@blueadvantage.hdbola.com">customerservice@blueadvantage.hdbola.com</a> mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. 135 DeLard St. Ste 322 Monroe, LA 71201
<b>Blue Advantage Provider Portal</b>	The Blue Advantage Provider Portal is accessible through LinkBlue ( <a href="https://www.hdbola.com/linkblue">www.hdbola.com/linkblue</a> ). Click on "Blue Advantage" under the "Other Sites" section. This portal includes member eligibility and benefits verification, as well as claims status options, prior authorization services and more. <b>Portal Registration:</b> Registration for the Blue Advantage Provider Portal requires two separate security access setups. 1. You must first have access to LinkBlue ( <a href="https://www.hdbola.com/linkblue">www.hdbola.com/linkblue</a> ). Refer to the PM Team section of this guide for more information. 2. Once logged into LinkBlue in the "Other Sites" section to Portal, you can then self-register under an existing Moderator. <b>Technical Support:</b> For technical questions to the Blue Advantage Provider phone: 1-866-508-7145, choose
<b>Blue Advantage Provider Directory</b>	For a list of providers in our Blue Advantage Provider Directory, it is located within

- Key information about the Blue Advantage networks
- Services requiring authorization
- Information on our Blue Advantage electronic tools



- How to access and register for the portal
- Overview of portal features
- Troubleshooting

Available on both the Blue Advantage Resources page and Provider Portal.

# Blue Advantage Customer Service

For inquiries that cannot be addressed through the Blue Advantage Provider Portal, providers may contact customer service at:



1-866-508-7145

Customer Service prompts have been updated, please listen carefully to the new options when calling in.



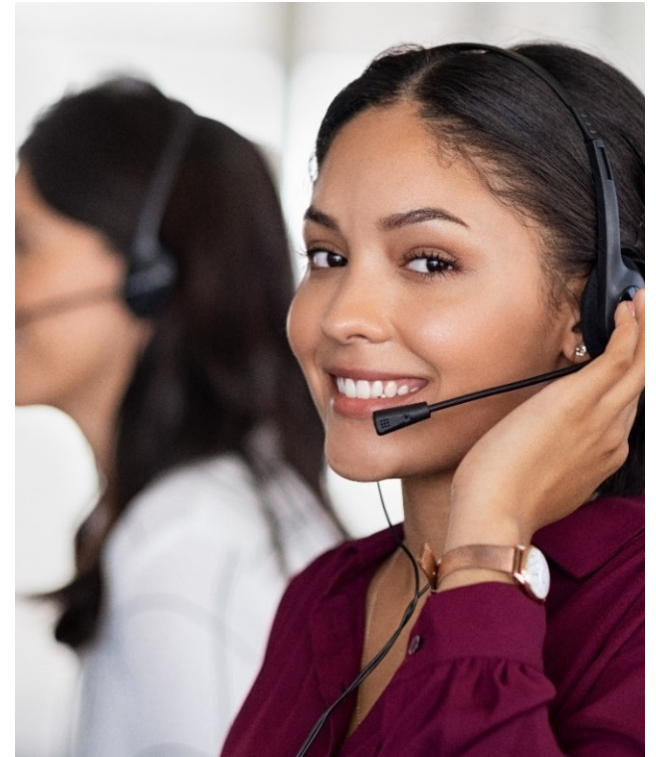
1-877-528-5820



[customerservice@blueadvantagela.com](mailto:customerservice@blueadvantagela.com)



Blue Advantage  
130 DeSiard St, Ste 322  
Monroe, LA 71201



Providers may also contact customer service on the patient's behalf and request a representative call the member to assist with their questions.



# **Blue Advantage Provider Portal**

# Accessing Our Secure Online Services

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

- iLinkBlue
- Blue Advantage Provider Portal

Access to these applications are granted by your organization's Group Moderator (Administrative Rep).

The screenshot displays the iLinkBlue web portal for Louisiana. The header includes the Louisiana state logo and the iLinkBlue logo. A navigation menu is located below the header, containing links for Coverage, Claims, Payments, Authorizations, Quality & Treatment, and Resources. The main content area is divided into several sections: a 'Welcome to iLinkBlue' section with a 'Tips to Know' box, a 'Medical Record Requests' section indicating 10 new requests, and a 'Research Claims' button. A sidebar on the right lists 'Other Sites' including Davis Vision Network, Dental Advantage Plus Network - United Concordia Dental, Blue adVantage (circled in red), and Healthy Blue.



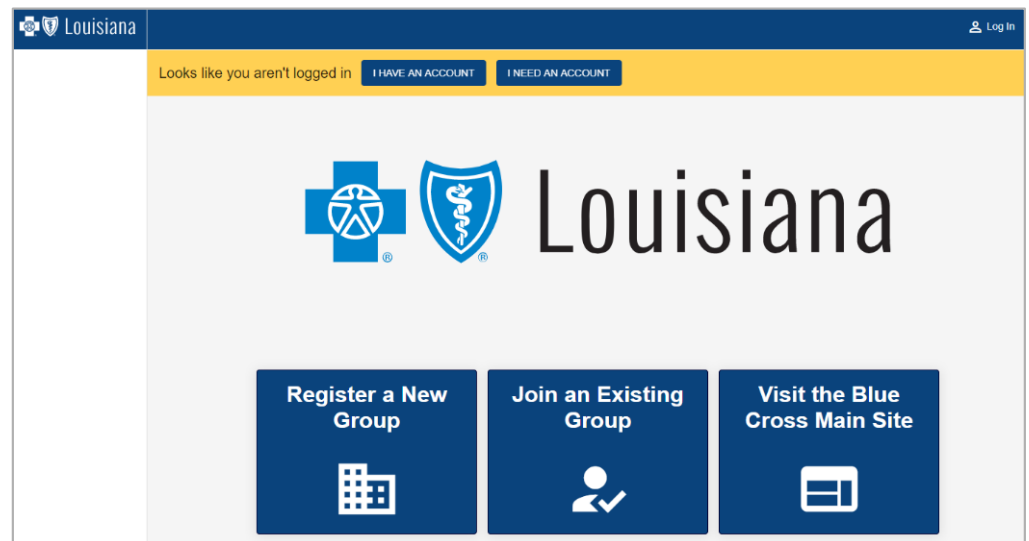
# Helpful Hints

- For additional details on how to register for the Blue Advantage Provider Portal, download the *Blue Advantage Portal User Guide*. Go to [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue), then click “Blue Advantage” under the “Other Sites” section.
- We recommend using Google Chrome to access the Blue Advantage Provider Portal.
- The portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.
- For additional information, please see the “Troubleshooting” section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

# Blue Advantage Provider Portal

Providers need access to the Blue Advantage Provider Portal for the following resources:

- Claims Inquiry
- Member Eligibility
- Provider/Pharmacy Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more




The Blue Advantage Provider Portal is available through iLinkBlue ([www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue)) > **Blue Advantage** (under Other Sites).

# Accessing the Blue Advantage Portal

## Provider Portal Login

The image shows two screenshots of the Louisiana Provider Portal. The top screenshot is the home page, featuring the Louisiana state logo and the text "Louisiana". It includes navigation links for "Register a New Group" and "Join an Existing Group". A "Log In" button is located in the top right corner, indicated by a blue arrow. The bottom screenshot shows a search results page with the heading "No Results" and a search criteria form with fields for Auth ID, Member ID, Member First Name, Member Last Name, Effective Date, and Status.

Looks like you aren't logged in [I HAVE AN ACCOUNT](#) [I NEED AN ACCOUNT](#) [Log In](#)

 **Louisiana**

[Register a New Group](#) [Join an Existing Group](#)

**Provider Portal Home Page**

**No Results**  
Try clicking "Reset Search" and using less filters

**Search Criteria**

Auth ID \_\_\_\_\_  
Member ID \_\_\_\_\_  
Member First Name \_\_\_\_\_  
Member Last Name \_\_\_\_\_  
Effective Date  \_\_\_\_\_  
Status

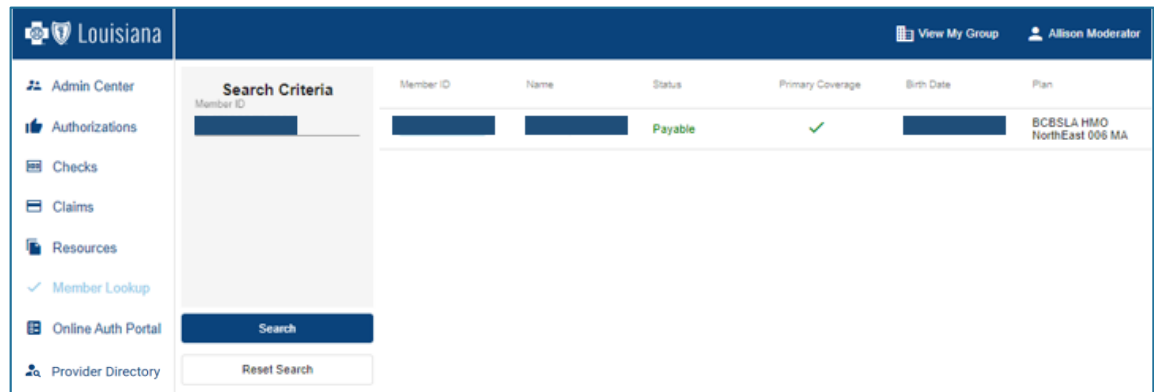
Once registration is complete, providers will be able to log in and access all available portal features.

# Member Lookup

In order to lookup member information users **must** have the member ID. Users will not be able to view more than one member's information at a time.

By clicking on the member ID number, users will have access to the following:

- Member information
- Plan snapshot
- Documents
- Accumulators
- Coinsurance and Copays



The screenshot displays the Louisiana Member Lookup interface. The top navigation bar includes the Louisiana logo, a 'View My Group' button, and the user name 'Allison Moderator'. The left sidebar contains a menu with the following items: Admin Center, Authorizations, Checks, Claims, Resources, Member Lookup (highlighted with a checkmark), Online Auth Portal, and Provider Directory. The main content area is titled 'Search Criteria' and features a 'Member ID' input field with a search button. Below the search criteria, a table displays the search results. The table has columns for Member ID, Name, Status, Primary Coverage, Birth Date, and Plan. A single result is shown with a Member ID, a redacted Name, a Status of 'Payable', a Primary Coverage of a green checkmark, a redacted Birth Date, and a Plan of 'BCBSLA HMO NorthEast 006 MA'.

Member ID	Name	Status	Primary Coverage	Birth Date	Plan
[Redacted]	[Redacted]	Payable	✓	[Redacted]	BCBSLA HMO NorthEast 006 MA

# Member Lookup

Member Information	
Member contact and coverage status	
Name:	[REDACTED]
DOB:	[REDACTED]
Coverage Status:	Active
<a href="#">VIEW CLAIMS</a>	<a href="#">VIEW AUTHS</a>

## Member Information

- In addition to viewing the member’s name and coverage status, users can also view claims and authorizations associated with a member.

## Plan Snapshot

- Includes a summary of the member’s enrollment information such as plan year, program and effective date.

Plan Snapshot	
A quick summary of this enrollment	
Plan:	BCBSLA HMO North Shore 009 Seg 002 MA
Card #:	[REDACTED]
Plan Year:	2020
Program:	BCBS LA HMO INDIVIDUAL
Effective Date:	1/1/2020
Term Date:	12/31/2078

# Member Lookup

## Documents and Accumulators

- Plan-specific documents will appear in the documents section of the member lookup.
- As claims are received and processed, the amount will be updated in the accumulator's section.

### Documents

- [2023 Annual Notice of Changes](#)
- [2023 Summary of Benefits](#)
- [2023 Formulary](#)
- [2023 Evidence of Coverage](#)

Coinsurance and Copays		
Filter		
Description	Day Span	Amount
Inpatient - Acute	Days 1 - 10	\$175
Inpatient - Acute	Days 11 - 90	\$0
Inpatient - Mental Health Care	Days 1 - 8	\$195
Inpatient - Mental Health Care	Days 9 - 90	\$0
Inpatient - Rehab	Days 1 - 10	\$175
Inpatient - Rehab	Days 11 - 90	\$0
Inpatient - Substance Abuse	Days 1 - 8	\$195
Inpatient - Substance Abuse	Days 9 - 90	\$0
Skilled Nursing Facility	Days 1 - 20	\$0
Skilled Nursing Facility	Days 21 - 100	\$165

Items per page: 10 1 - 10 of 14 |< < > >|

## Coinsurance and Copays

- Includes member's coinsurance or copayment amounts by date span and service type.



# Medicare Advantage Members from Other Blue Plans

# Medicare Advantage Members from Other Blue Plans

- Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”
- All MA Blue Plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services.
- MA organizations may also offer a Special Needs Plan (SNP).
- MA Blue Plans may allow in- and out-of-network benefits, depending on the type of product selected.

## How to verify eligibility and/or benefits for MA members from other Blue Plans:

Call the BlueCard Eligibility Line or submit an inquiry through **iLinkBlue**.





# Medicare Advantage PPO Network Sharing

All Blue Plans that offer a MA PPO Plan participate in reciprocal network sharing. This allows Blue MA PPO members to obtain in-network benefits in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

## If you are a participating provider in our MA PPO network...

you should provide the same access to care for Blue MA PPO members as you do for our members. Services will be reimbursed in accordance with your BCBSLA MA PPO allowable charges. The Blue MA PPO member's in-network benefits will apply.

## If you are NOT a participating provider in our MA PPO network...

but do accept Medicare and you see Blue MA PPO members; you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergent care, you will be reimbursed at the member's in-network benefit level.

## If your practice is closed to new members...

you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members.



# MA PPO Network Sharing

- Blue MA PPO members are recognizable by the “MA” suitcase on the member ID card.
- Blue MA PPO members have been asked not to show their standard Medicare ID card when receiving services. Instead, Blue MA PPO members should provide their Blue Cross/Blue Shield member ID card.
- Claims for services rendered in Louisiana should be filed directly to BCBSLA.



Blue MA PPO members are recognizable by the “MA” suitcase on the member ID card.



# Telehealth

# Telehealth Policy

- Blue Advantage outlines existing and expanded direct-to-consumer telehealth encounters.
- Providers must follow CMS telehealth billing guidelines, fully document the telehealth encounter in the patient's medical record adhering to CMS telehealth billing guidelines and agree to Blue Advantage's allowable charges.
- Coverage is subject to the terms, conditions and limitations of each individual member's benefits.

# Place of Service Codes in Telehealth



- Use **POS 10** for all direct to consumer (DTC) telehealth services.
- Bill non-DTC telehealth with the appropriate place of service based on the member's location when services are provided.
- For example, if the member is in the inpatient hospital setting when receiving telehealth services, bill POS 21.
- Do **not** bill POS 02 for telehealth services; Blue Cross does not consider POS 02 valid for claims submission. Claims billed with POS 02 will reject.
- Use **Modifier GT or 95**, whichever is appropriate, to indicate delivery of telemedicine services in real time.



We define DTC telehealth as telehealth services delivered directly between the provider and patient in their home environment (e.g., residence, workplace, personal space, etc.).

# Telemedicine Codes

The following codes can be used for “Direct-to-consumer” telemedicine—when the telemedicine encounter occurs directly between provider and patient.

## Direct-to-consumer Codes

EVALUATION AND MANAGEMENT					
99201	99202	99203	99204	99205	99211
99212	99213	99214	99215	99495	99496
DIETARY AND MEDICAL NUTRITIONAL THERAPY					
97802	97803	97804	G0270	G0271	
BEHAVIORAL HEALTH					
90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845
90846	90847	96156	96158	96160	96161
SMOKING CESSATION					
99406	99407	G0436	G0437		
OBESITY					
G0447					

Providers should use the most current CMS appropriate codes.



**HEDIS®**

# Follow-up after Hospitalization

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

- In conjunction with HEDIS measures, Blue Advantage requires that follow-up outpatient appointments are scheduled to occur within seven days following discharge.
- Patients who attend these scheduled follow up appointments are less likely to **readmit** into inpatient treatment.



# Follow-up Appointment Guidelines

The behavioral health professional can be a:

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

The discharge information provided to Blue Advantage 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

# Follow-up Appointment Guidelines

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

For these step-down level of care programs, the discharge information provided to Blue Advantage needs to include each of the following:

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

Scheduling a seven-day follow-up appointment with an individual outpatient mental health provider, partial hospitalization program (PHP), or intensive outpatient program (IOP) on the same day as discharge does not count as a HEDIS scheduled seven-day follow-up.



# Authorizations

# Services Requiring Authorization

- Inpatient Psychiatric Admission
- Inpatient Chemical Dependency Detoxification Admission
- Intensive Outpatient Program (IOP)
- Partial Hospital Program (PHP)
- Electroconvulsive Therapy (ECT)

# Behavioral Health Authorization Request Form

This form is required with all faxed submissions. If we do not receive this completed form and supporting clinical documentation via fax, processing will be delayed.

Louisiana		Blue Advantage (HMO)   Blue Advantage (PPO)
<small>The purpose of this form is to request a behavioral health prior authorization. Please fax this completed form to (504) 372-5249, Attn: Medical Management. If you have questions about this form, contact Blue Advantage Medical Management at 1-866-502-7145. Please complete all applicable areas below.</small>		<b>Behavioral Health Authorization Request Form</b>
Request Date: / /	Date of Admission/Service Start: / /	Time of Admission
<b>TYPE OF REVIEW</b>		
<input type="checkbox"/> Presentation		
<input type="checkbox"/> Concurrent Review		
<input type="checkbox"/> Discharge (Please complete DC planning on pg.2)		
Estimated Length of Care: _____		
<b>INPATIENT SERVICES</b>		
<input type="checkbox"/> Inpatient Medical Health	Examination within 20 days <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Inpatient Denial		
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)	
Was the member admitted through the ER?		If yes, please provide location, date and time of ER visit.
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>OUTPATIENT SERVICES</b>		
<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Psychological Testing	How often do these services occur?
<input type="checkbox"/> IOP	<input type="checkbox"/> Medication Management	
<input type="checkbox"/> PHP	<input type="checkbox"/> ABA Therapy	
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)	
<b>PATIENT INFORMATION</b>		
Patient Name	Member ID Number	
Address	Date of Birth	
Emergency Contact	Phone	
Parent/Guardian/Legal Representative	Alternate Phone	
<small>The information on this form is protected health information and subject to all privacy and security regulations under HIPAA. © 2016 BCBSLA, LLC MEMBER SERVICES Blue Cross and Blue Shield of Louisiana (BCBSLA) offers Blue Advantage (HMO), Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross and Blue Shield Association, offers Blue Advantage (PPO). Blue Advantage from Blue Cross and Blue Shield of Louisiana (BCBSLA) is a 100% plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a 100% plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.</small>		

To download the authorization form, go to [www.bcbsla.com/providers](http://www.bcbsla.com/providers), then click on “Blue Advantage” under the Other Sites section. Click “Resources” then “Forms.”

The *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Resources page, [www.bcbsla.com/providers](http://www.bcbsla.com/providers), then click “Go to BA Resources” at the bottom of the page.

# Behavioral Health Authorization Request Process

You may begin a Behavioral Health Authorization request via fax, phone or by using the Blue Advantage Provider Portal.

- Fax: (318) 812-6249
- Phone: 1-866-508-7145, choose option 3, then option 3

Authorizations can be requested through the Blue Advantage Provider Portal for Outpatient Behavioral Health services **only**.

**Please include all pertinent clinical information with your request.**

# Behavioral Health Authorization Request Process

- Outpatient authorization requests should be submitted prior to services being rendered, if possible.
- Inpatient authorization requests should be submitted within 24-hours of admission or the next business day with complete clinical information.
- Blue Advantage will notify the requesting provider/facility of the authorization decision within 72 hours from the date and time request is received. Notification of decision will be provided via phone and fax.
- Requests received without a completed authorization request form and clinical documentation will be returned to the provider, delaying the review process.
- Concurrent reviews must be submitted via fax with the Behavioral Health Authorization form.

# Documentation Requirements for Behavioral Health Authorization Requests

- Date and time service begins
- Type of service:
  - Select the most appropriate level of care, inpatient or outpatient. **Please do not select both options on one form.**
  - If the option is not available on the form, please write in the service you are requesting and all applicable CPT® or HCPCS codes.
  - For outpatient services, please provide the following information on the form:
    - Frequency of service – How often do these services occur?
    - CPT or HCPCS codes – Include number of units for each code.



# Documentation Requirements for Behavioral Health Authorization Requests

- ICD-10 diagnosis code(s).
- Member Information: Name, date of birth and ID number.
- Provider Information: Full name and NPI number for the attending/treating provider and facility where services are to be rendered.
- Person to contact regarding authorization request. Include the appropriate phone and fax number.

# Documentation Requirements for Behavioral Health Authorization Requests

Complete clinical documentation to support request for services. This includes, but is not limited to:

- Please include CPT/HCPCS and Rev codes for requested services.
- All evaluations related to the member's current symptoms and diagnosis.
- Evidence that the focus of treatment is consistent with the member's symptoms and diagnosis.
- A clearly defined treatment plan.
- Evidence that interventions are consistent with the member's level of need and are related to treatment of the member's symptoms and diagnosis.
- Evidence that co-occurring conditions are being addressed by the provider either directly or by referral.

# Documentation Requirements for Behavioral Health Authorization Requests

- Concurrent Reviews, both Inpatient and Outpatient:
  - Documentation establishing the need for and expected benefit of continued services.
  - All available evaluations, group notes, provider progress notes, clinical progress notes, medication changes conducted since last review period.
  - Requests for additional authorized units of service should be submitted timely to ensure no gaps in coverage.

**Documentation should be legible.**

# Medical Necessity

- Authorization requests are reviewed for medical necessity.
- InterQual (IQ) is utilized to support medical necessity.
- If documentation is thorough and clearly supports medical necessity of the request, decisions are expedited and approved by a clinical reviewer.
- Clinical reviews are routed to a medical director in the following circumstances:
  - Documentation does not support medical necessity.
  - Any request that involves a non-covered benefit.
  - Requests involving medically complex patients with extenuating circumstances.

# Retroactive Authorization

Retro authorization requests will only be considered when notification is 30 days or less from service start **and** there are no denied/pending claims on file.

- Fax: (318) 812-6249
- Phone: 1-866-508-7145, choose option 3, then option 3

# Online Auth Portal

A Behavioral Health authorization request can be submitted online for the following outpatient services:

- **OPFAC** - a procedure performed in an outpatient facility setting
  - Intensive Outpatient Program (IOP)
  - Partial Hospitalization Program (PHP)
  - Electroconvulsive Therapy (ECT)

# Creating An Outpatient Authorization

## For Behavioral Health Requests:

- Once the authorization request has been submitted, **it will be sent to the Blue Advantage Medical Management team for review**. If medical necessity criteria is met, the request will be approved.
- Providers will be contacted via phone or fax with the decision. If additional information is needed, specific instructions will be given. Providers may return to the **Authorization** browse screen to check on the status of the request.

# Online Auth Portal

Providers can submit online authorization requests for select outpatient services through the “Online Auth Portal” feature.

The screenshot displays the Louisiana provider portal interface. The top navigation bar includes the Louisiana state logo and name on the left, and a "View My Group" button with a user profile icon on the right. A left-hand sidebar menu lists several navigation options: Admin Center, Authorizations, Checks, Claims, Resources, Member Lookup, Online Auth Portal (highlighted with a red box), and Provider Directory. The main content area features a white box titled "Online Auth Portal" with the following text: "Click the button below to access the online auth portal. The online auth portal will open in a new tab. If you are having trouble connecting, please ensure that you are not blocking any pop-ups from this site. IMPORTANT NOTE: The online auth portal is a separate site and does not allow you to log in using your portal account. Portal users may only access the online auth portal from this site and must do so by clicking the button below. Attempting to log in directly to the online auth portal may result in your account being locked." Below this text is a blue button labeled "Visit the Online Auth Portal".



# Creating An Outpatient Authorization

Locate the member record by entering the Member ID and one of the following:

- First Name and Last Name or Date of Birth

Click on the desired member record to display the Member Summary screen.

The screenshot shows a web application interface for member lookup. At the top left, there is a 'Home' button. Below it, a sidebar menu contains 'Member Lookup' (highlighted with a red box), 'Messages', and 'Authorizations'. The main area features a search bar with a 'Clear Fields' button and input fields for 'Member ID', 'First Name', 'Last Name', and 'Date of Birth'. A search icon is located to the right of the 'Date of Birth' field. Below the search bar is a table with the following columns: 'Member ID', 'Member Name', 'Date of Birth', 'PCP', 'Benefit Product', and 'Insura'. The table is currently empty.

# Creating An Outpatient Authorization

- Click on the “Authorizations” tab.
- Then select “New Authorization” and choose “Outpatient” from the menu.

The screenshot displays a web-based interface for managing patient authorizations. At the top, there are navigation tabs: 'Home', 'Authorizations', 'Care Enrollments', and 'Summary'. The 'Authorizations' tab is selected and highlighted with a red box. Below the tabs, there is a patient information section with fields for Member ID, DOB, Benefit Name, Language, Gender, PCP Info, Address, Phone, and Email. A table of authorization records is shown below, with columns for Auth ID, Request Date, POS, Service Type, Expected Admit Date, Admit Date, Admit Status, Status, and Start Date. A dropdown menu is open over the table, showing a '+ New Authorization' button and a list of options: 'Inpatient' and 'Outpatient'. The 'Outpatient' option is highlighted with a red box. Below the table, there is a 'Notes' section with tabs for 'Assessments' and 'Messages', and a search bar. At the bottom of the page, there is a footer with the text 'CPT © copyright 2018 American Medical Association. All rights reserved.'

Auth ID	Request Date	POS	Service Type	Expected Admit Date	Admit Date	Admit Status	Status	Start Date
667419	04/16/2020 08:36	IP	Medical		04/15/2020		Approved	
661801	03/09/2020 14:27	OP	Outpatient Services in MD Office			INITIATED	Approved	03/09/2020
653792	02/05/2020 08:47	IP	Medical		02/04/2020		Approved	02/06/2020
645831	01/02/2020 08:37	IP	Observation		01/01/2020		Approved	01/03/2020
641367	12/09/2019 07:56	OP	Durable Medical Equipment				Approved	12/09/2019
611132	07/19/2019 09:52	OP	Therapy				Approved	07/19/2019
610527	07/17/2019 10:10	OP	Outpatient Service in Facility				Approved	07/17/2019
576760	02/11/2019 13:43	OP	Reimbursement				Approved	02/18/2019
553252	11/05/2018 13:53	OP	Drugs				Approved	11/05/2018

# Creating An Outpatient Authorization

Complete the authorization form and provide all needed information. Mandatory field names are identified by red titles.

The screenshot shows a web-based form titled "New Outpatient Authorization". The form is divided into several sections. The "Primary Coverage" field is highlighted with a green border. The "Service Status" and "Request Type" fields have red titles. The "Request Date/Time" field is set to "06/03/2020 13:50". The "Service" section contains a "Requested Service" sub-section with "Service Type" and "Requested Start Date" highlighted with a black border. The "# of Services" field is set to "1". The "Procedure" field is empty. The "Requestor Contact Info" section has "Entered By" set to "Mindy" and "Phone" set to "(###) ###-#### ~x:#####". The "Providers" section is partially visible at the bottom. The form has "Submit" and "Cancel" buttons at the bottom right.

Primary Coverage:			
Service Status:		Request Type:	
Request Date/Time:		06/03/2020 13:50	
<b>Service</b>			
Requested Service			
Service Type:		# of Services:	1
Requested Start Date:	06/03/2020		
Procedure:			
<b>Requestor Contact Info</b>			
Entered By:	Mindy	Phone:	(###) ###-#### ~x:#####
<b>Providers</b>			
Requesting Provider:		Rel:	OFFERFROM - Referral Req
		Submit	Cancel

# Creating An Outpatient Authorization

Comments are not required but providers may enter specific information about the request. All available attachments should be included.

The screenshot shows a web form titled "New Outpatient Authorization". At the top, there are fields for "Requesting Member" and "Referring Provider". Below these are "Servicing Provider" (a dropdown menu) and "Role" (a dropdown menu currently set to "REFERTO - Refer To Provider"). A plus sign button is located to the right of the "Role" field. The "Diagnosis" section contains an "ICD-10 Diagnosis Code" field with a dropdown arrow, a plus sign button, and a close button (X). The "Comments" section is a text area with a blue border and a dropdown arrow, containing the text "Please enter specific information as to the service you are requesting:". The "Attachments" section features a "Select files..." button and a text area with the placeholder "drop files here to upload". At the bottom right, there are "Submit" and "Cancel" buttons.

# Creating An Outpatient Authorization

Once your **Authorization** has been submitted, a decision will be rendered for the services requested. Your request will be sent to Blue Advantage's Medical Management team for review. You may return to **Authorization** browse screen to check on the status of the request.

New Outpatient Authorization

Requesting Member: [Field] Referring Provider: [Field]

Servicing Provider: [Field] Role: REFERTO - Refer To Provider

+

**Diagnosis**

ICD-10 Diagnosis Code: [Field]

+

**Comments**

Please enter specific information as to the service you are requesting:

[Text Area]

**Attachments**

Select files... drop files here to upload

Submit Cancel



# Questions



# Addendum

# ABNs Not Used for Blue Advantage

**CMS does not allow use of Advanced Beneficiary Notices (ABNs) for MA plans.**

**To hold members financially liable for non-covered services not clearly excluded in the member's Evidence of Coverage (EOC), contracted providers must do the following:**

- Request a pre-service organization determination from Blue Advantage if they know or have reason to know that a service may not be covered by Medicare.
- If Blue Advantage denies the coverage request, it will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.
- After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN, should the member desire to receive them.



# Billing Requirements

Providers should bill according to Medicare guidelines. **CMS guidelines are followed for all claims, both electronic and paper:**

- Faxed claims are not accepted.

## **Timely Filing**

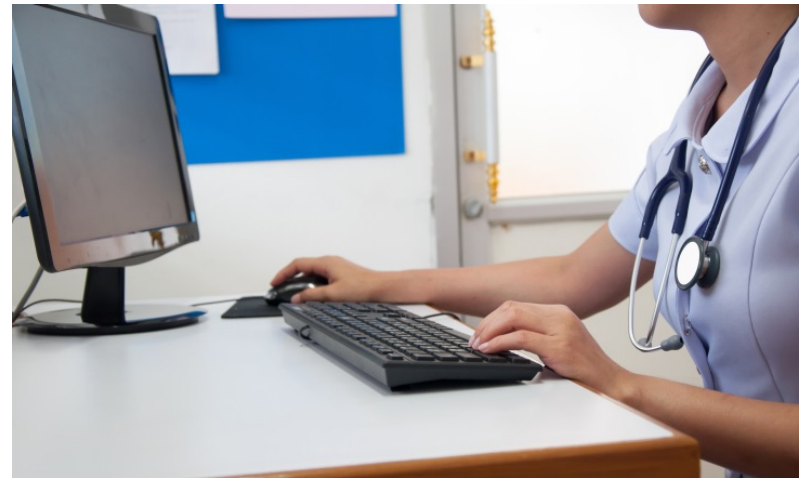
- Providers should check the language in their Blue Advantage agreement.

Refer to [www.CMS.hhs.gov](http://www.CMS.hhs.gov) for specific details.

# Checking Claim Status

Use the Claim Inquiry tool (available on the Blue Advantage Provider Portal) for standard claims status checks.

- Below are multiple ways to inquire about a claim:
  - Claim number
  - Date(s) of service
  - Provider name
  - Member name
  - Claim status
  - Date of claim status
  - Payment amount



If the status of the claim is “**In Process**,” you will not be able to review the summary.

# Claims

## Resubmission

- No payment was issued on the claim line in question.
- The incorrect or missing information on the original claim resulted in the claim denial. This would be corrected/added and resubmitted (i.e., invalid procedure code modifier combination).
- The claim can be resubmitted on paper or electronically, **not faxed**.
- The claim will be treated as an initial claim for processing purposes with no provider explanation necessary.

## Corrected

- A **previously paid claim** in which the provider needs to add, remove or change a previously paid claim line.
- Providers must submit a corrected claim if all lines of the claim were previously paid, and they are wanting to add or remove a claim line or change something on a claim line.
  - Examples:
    - Adding or removing a previously paid claim line where charges were billed for a service that was not rendered, or provider did not bill for a service that was rendered.
    - Changing a previously paid claim line where an incorrect date of service or an incorrect procedure code was billed.
- The corrected claim will be denied as a duplicate if the original claim number is not included.

# CMS-1500 Corrected Claims

**EDI/1500/Professional claims** can be submitted electronically as “Corrected Claims.”

- In Loop 2300 ~ CLM05-03 must contain a “7,” REFO1 must contain an “F8” and REFO2 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

**1500 paper claim forms** can be submitted as “corrected claims.”

- The paper 1500 claim submitted must indicate a frequency of 7 in Block 22 (Resubmission Code Box) and the original reference claim number in Block 22 (Original Ref. No. Box).

The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.

The corrected claim will be denied as a duplicate if the original claim number is not included.

# UB-04 Corrected Claims

**EDI/UB/Facility corrected claims** can be submitted electronically as "Corrected Claims".

- The type of bill must indicate a frequency of 7.
- "F8" must indicate in Loop 2300 REF01.
- REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

**UB-04 corrected claims** can also be submitted on paper as "corrected claims."

- The paper UB-04 corrected claim submitted must indicate a frequency of 7 in Block 4.
- The original reference claim number in Block 64.
- Reason for the correction in Block 80.

The corrected claim will be denied as a duplicate if the original claim number is not included.

# Resolving Claims Issues

Contact Blue Advantage Customer Service at **1-866-508-7145**.

- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 working days for first request.
- Check the Blue Advantage Provider Portal for a claims resolution.
- Request a second review for correct processing.
- Allow 10-15 working days for second request.

## When to Contact Provider Relations for Claims Help

If unresolved after second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations, [provider.relations@bcbsla.com](mailto:provider.relations@bcbsla.com).

It is required to document the customer service representative's name and date for each call.

# Adjustments, Additional Payments, Overpayments & Voluntary Refunds

Blue Advantage will perform adjustments upon discovery of an incorrectly processed claim.

Adjustment claims can be identified on provider remits as ending in:

- **"A1"** **"A2"** **"A3"** etc.

If an adjustment results in additional payment, it will appear on the provider's remittance.

If a refund is not received timely, the overpayment will be withheld from the provider's next remittance.

If you discover an overpayment you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund.

# Timely Filing Disputes

If disputing a timely filing denial of a claim, and the claim is filed:

## Electronically

The only acceptable proof of timely filing is the second level acceptance report from the clearinghouse that indicates the claim was accepted by Blue Advantage.

## Paper

The provider must submit supporting documentation from their practice management system including the applicable field descriptions since the documentation is specific to your system.

## OR

A UB-04/CMS-1500 with the original date billed **AND** documentation supporting the claim was submitted within the timeframe specified in your contract agreement from the date of service, **AND** follow-up was done at a minimum of every 60 days.

- If there is no documentation supporting the follow-up activity, (i.e., filed second submission MM/DD/YYYY or contacted plan and spoke with \_\_\_\_\_, on MM/DD/YYYY), the timely filing denial will stand. This documentation is required for any CMS audits.



# Subrogation

- Blue Advantage subrogates with other liability carrier to recoup CMS funds.
- Conditional payments are made, which allows recoupment when a settlement is reached.
- Blue Advantage allowable charges apply.
- Claims that contain potential third-party liability (TPL) will be paid by Blue Advantage on a conditional basis, which permits us to recoup any payments if/when a settlement is reached.



# Provider Pay Disputes

**When a participating provider disagrees** with the amount that has been paid on a claim or line item:

- Disputes over the payment amount must be filed within the timeframe specified in your contract, which is based on the date the claim was processed.
- The dispute notice should be submitted in writing and include the basis for the dispute and documents supporting your position.
- Regardless of the existence or outcome of the dispute, participating providers are not allowed to seek additional compensation from members other than copayments, coinsurance and payment for non-covered services.

**Once a decision has been made:**

- Blue Advantage will communicate the decision in writing if it is determined the correct amount was previously paid.
- If payment is corrected, it will appear on a remittance advice to the requesting provider.
- If you still disagree with Blue Advantage's decision, you have opportunities for additional levels of administrative review. Please follow the instructions in your contract.



## **Provider Pay Dispute Address:**

Blue Advantage  
Attn: Provider Disputes  
130 DeSiard St, Ste 322  
Monroe, LA 71201

# Member Appeals

## When a member disagrees with a denial of services, an appeal:

1. Must be filed within **60 days** from the date of the organizational determination (e.g., EOB or provider remit is issued, whichever is applicable).
2. Must be submitted in writing and **does not apply to participating providers unless it involves a pre-service request.**
3. Claim appeals can be filed by either a member or a non-contracted provider.
4. Pre-service appeals can be filed by both participating and non-participating providers, the member or the member's authorized representative, and can be submitted in writing or requested by calling Blue Advantage Customer Service at 1-866-504-7145.

# Call Centers

## Authorizations (including Medical Management)

1-866-508-7145, choose option 3, then option 3

## Behavioral Health

1-866-508-7145, choose option 3, then option 3

## Blue Advantage Customer Service

1-866-508-7145  
[customerservice@blueadvantagela.com](mailto:customerservice@blueadvantagela.com)

## Blue Advantage Provider Portal

1-866-508-7145, choose option 3, then option 2

## Provider Disputes

1-866-508-7456, choose option 3, then option 2

## Pharmacy

1-800-935-6103/TTY:711

# Provider Relations

**Kim Gassie** Director

**Jami Zachary** Manager

**Marie Davis - Senior Provider Relations Rep.**

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

**Anna Granen - Senior Provider Relations Rep.**

Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

**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

**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

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

**Paden Mouton, Supervisor**

# Provider Contracting

**Jason Heck, Director – [jason.heck@bcbsla.com](mailto:jason.heck@bcbsla.com)**

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Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangipahoa and Washington parishes

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**[provider.contracting@bcbsla.com](mailto:provider.contracting@bcbsla.com) | 1-800-716-2299, option 1**

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# PCDM Department

Provider Network Setup, Credentialing, Contracting &  
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**Kristin Ross**, Manager, Provider Contract Administration  
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To check the status on your credentialing application or provider data update, please email [PCDMstatus@bcbsla.com](mailto:PCDMstatus@bcbsla.com) or call 1-800-716-2299, option 2.