Behavioral Health Webinar for ABA Providers

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

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

How to submit questions:

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

Louisiana

Behavioral Health Webinar

Applied Behavioral Analysis

August 2023

Provider Relations Department | provider.relations@bcbsla.com

PRESENTED BY:

Marie Davis
Senior Provider Relations Representative
Blue Cross

Kelly Winkleman, LCSW, BCBA, CCM
Autism Resource Program, Interim Manager
Lucet

WELCOME!

Today's presentation will take you on a journey through:

- ✓ network participation as a behavioral health provider
- ✓ using iLinkBlue
- ✓ researching member benefits
- ✓ authorization requirements
- ✓ filing claims in iLinkBlue
- ✓ resolving claim issues
- ✓ telehealth
- ✓ billing guidelines
- ✓ provider support

Blue Cross and Blue Shield of Louisiana partners with:

Lucet™

The Behavioral Health Optimization Company

- ✓ Lucet is an independent company that manages, on Blue Cross' behalf, behavioral health services for our members for authorizations, utilization management, case management and applied behavioral analysis case management. Lucet engages with our providers to improve quality outcomes.
- ✓ Lucet's team of mental health professionals are available 24/7 to assist in obtaining the appropriate level of care for your patients.

New Directions & Tridiuum united to transform the behavioral health system for the better.

Now called Lucet

Lucet at a glance

15 million members
in 50 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

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 2025

NETWORK PARTICIPATION

Network Participation

Credentialing is Required for Network Participation

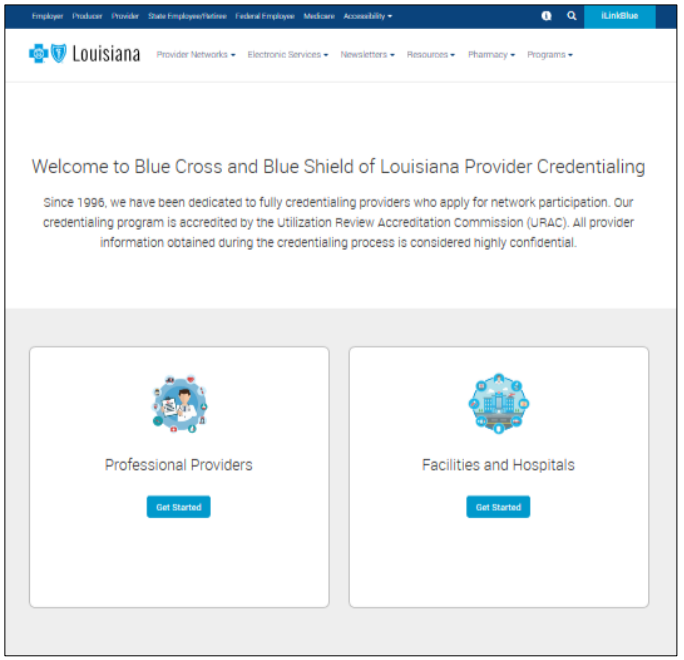
Blue Cross and Blue Shield of Louisiana credentials all practitioners and facilities that participate in our networks.

We partner with **Vantage Health Plan** and **symplrCVO** to conduct credentialing verification processes for our commercial networks.

Network Participation

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)

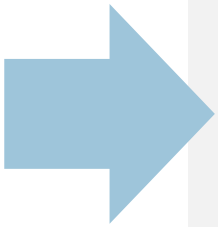


www.bcbsla.com/providers >Network Enrollment >Join Our Networks

Credentialing Criteria

These professional provider types must meet certain criteria to participate in our networks.

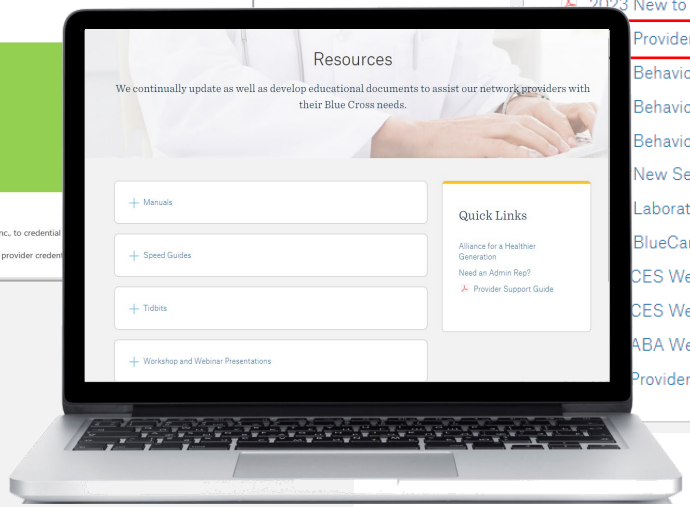
View the *Credentialing Criteria* for these professional provider types at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Professional Providers >Credentialing Process.

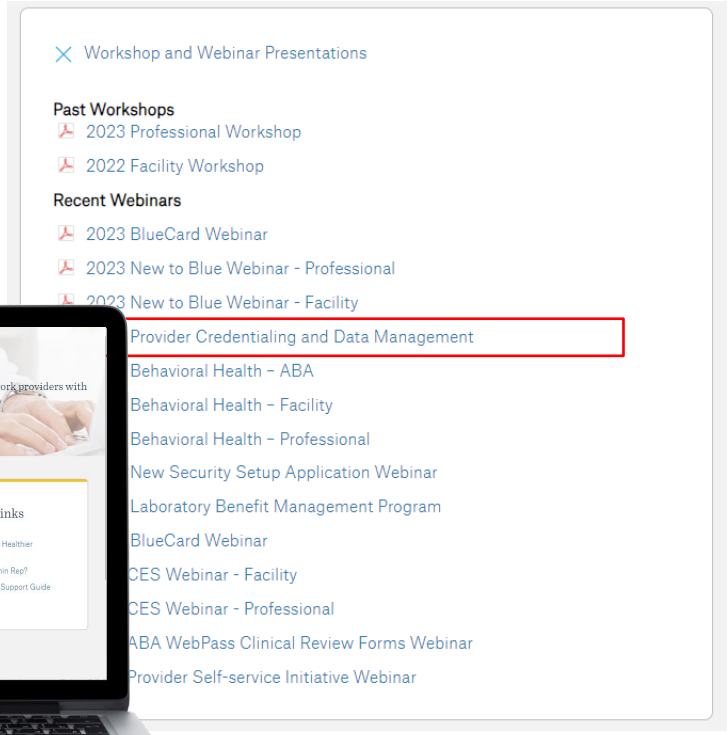


- Applied Behavioral Analyst (ABA)
- Licensed Professional Counselor (LPC)
- Licensed Addiction Counselor (LAC)
- Licensed Clinical Social Worker (LCSW)
- Psychologist (Ph.D)
- Doctor of Medicine (MD)
- Doctor of Osteopathic (DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

Learn More About Credentialing

For full information on how to complete the credentialing/recredentialing processes, view our **Provider Credentialing & Data Management Webinar** presentation. It is available online at **www.bcbsla.com/providers** >Resources >Workshops & Webinars.



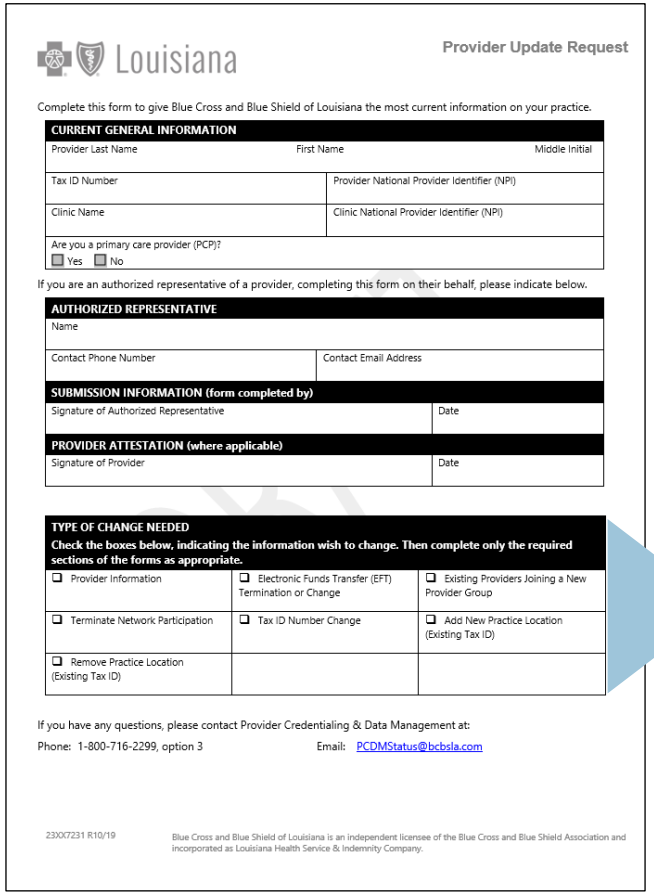


To attend this webinar, registration links are in our upcoming Provider Weekly Digests.

Updating Your Information

It is important that we always have your most current information!

Our **Provider Update Request Form** accommodates all your change requests, which are handled directly by our Provider Data Management Team.



Louisiana

Provider Update Request

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice.

CURRENT GENERAL INFORMATION

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

If you are an authorized representative of a provider, completing this form on their behalf, 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 the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.

❑ Provider Information	❑ Electronic Funds Transfer (EFT) Termination or Change	❑ 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 R10/19

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

This form allows you to make any of the following changes. Simply check the appropriate box(es) to indicate the type of change needed. You may select more than one option.

TYPE OF CHANGE

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	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

The form is available online at **www.bcbsla.com/providers** >Resources >Forms.

Updating Your Information

It is important that we always have your most current information!

- Indicate on the Provider Request Form the type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Completing the entire form is not required.

TYPE OF CHANGE **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	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

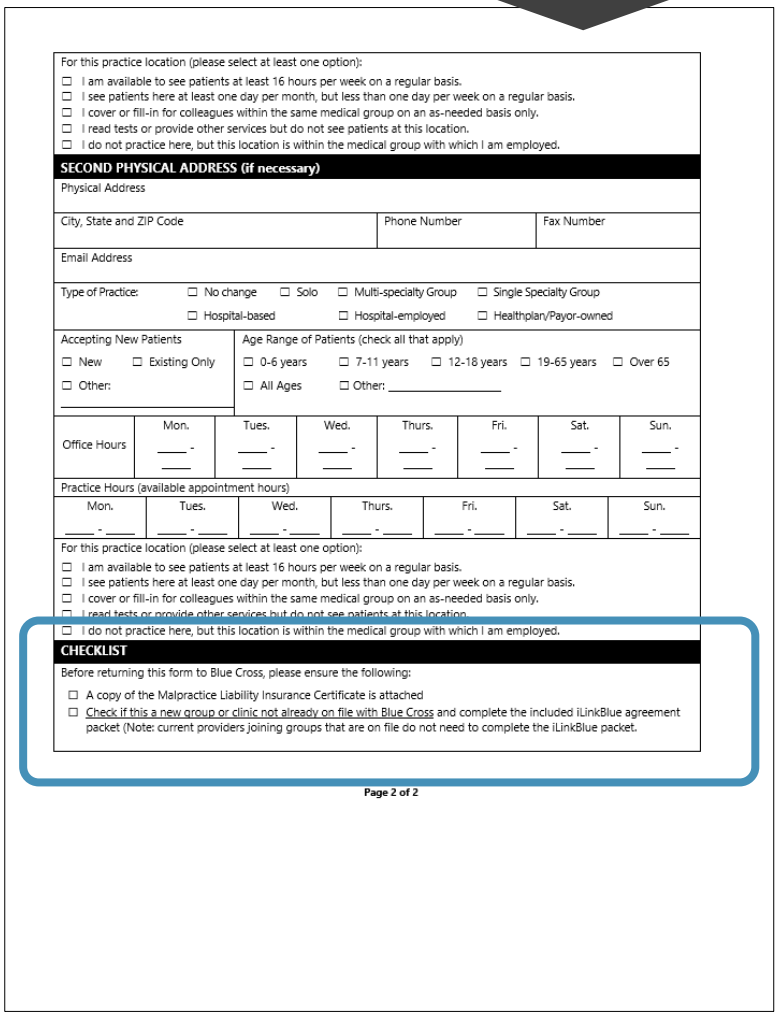
Updating Your Information

It is important that we always have your most current information!

Some change selections on the **Provider Update Request Form** include a checklist of required supporting documentation needed to complete your request.

- Complete the checklist
- Ensure all requested items on the checklist are included or completed before submitting.

Submissions that are missing checklist items will be returned.



For this practice location (please select at least one option):
☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

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

Email Address

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Accepting New Patients: ☐ New ☐ Existing Only ☐ Other:

Age Range of Patients (check all that apply): ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

For this practice location (please select at least one option):
☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

☐ A copy of the Malpractice Liability Insurance Certificate is attached
☐ Check if this a new group or clinic not already on file with Blue Cross and complete the included iLinkBlue agreement packet (Note: current providers joining groups that are on file do not need to complete the iLinkBlue packet.

Page 2 of 2

Online Provider Directories

Keeping your information updated is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at **www.bcbsla.com**.

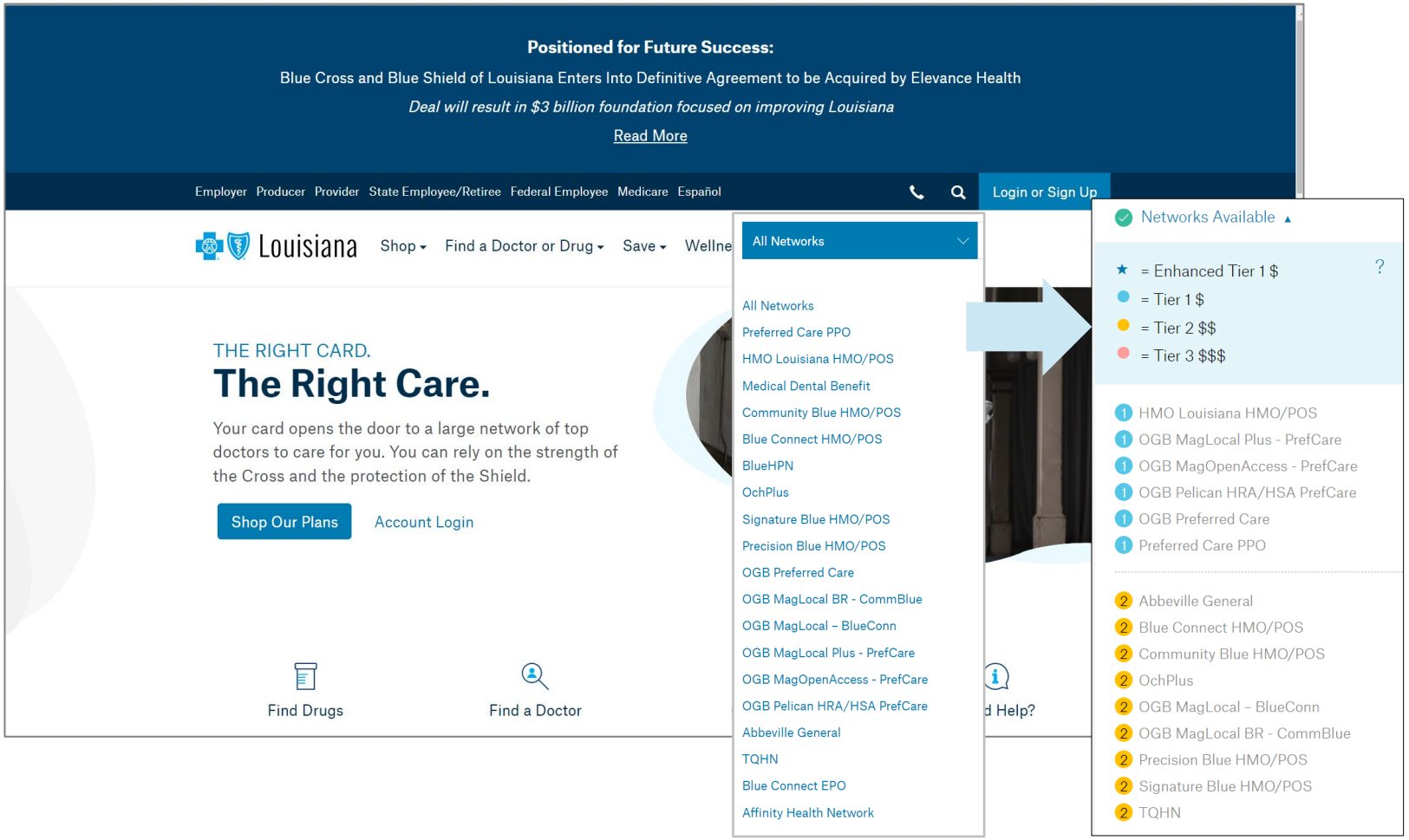
- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.

It is the contractual responsibility that all participating providers keep their information current with Blue Cross. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

Online Provider Directories

www.bcbsla.com >Find a Doctor or Drug >Local Provider Directory



USING ILINKBLUE

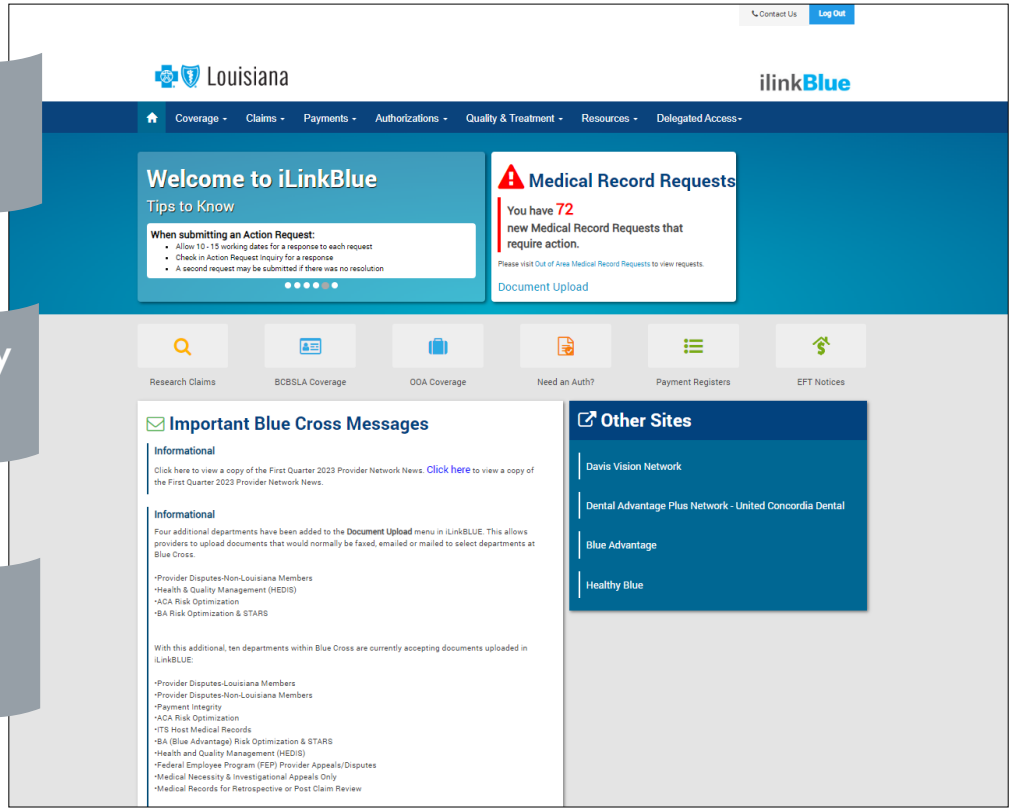
What is iLinkBlue?

iLinkBlue is Blue Cross and Blue Shield of Louisiana's secure online provider portal.

no cost to providers

user-friendly navigation

secure auth applications



www.bcbsla.com/ilinkblue

- Allowable Charges
- Authorizations
- Eligibility
- Benefits
- Coordination of Benefits (COB)
- Claims Research
- Electronic Funds Transfer
- Estimated Treatment Cost
- Grace Period Notices
- Manuals
- Medical Code Editing
- Medical Policies
- Payment Information
- Electronic Funds Transfer (EFT) Notifications
- BlueCard® Medical Record Requests
- Professional Claims Submission

Accessing iLinkBlue

Blue Cross requires that provider organizations have at least one **administrative representative** to manage our secure online services.

Louisiana

Instructions for Accessing Our Secure Online Services

Blue Cross offers many online services that require secure access. Blue Cross requires that each provider organization must designate at least one administrative representative to self-manage user access to our secure online services. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (for BlueCard® members)
- and more (as we develop new services)

To Report Your Administrative Representative to Blue Cross:

1. Determine who at your organization should be an administrative representative.
2. Complete the Administrative Representative Registration Form that includes the Acknowledgment Form (on the following pages). Send completed documents to our Provider Identity Management (PIM) Team.

   Email: PIMTeam@bcbsla.com **Fax**: 1-800-515-1128 Attn. Provider Identity Management
3. Once your administrative representative is set up, they will receive a welcome email.

Need Help?

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 is an Administrative Representative?

- A person designated to serve as the key person for delegating access to our secure online services to appropriate users for the provider.
- A person who agrees to adhere to Blue Cross' guidelines.
- A person who will only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.
- A person who promptly terminates employee access when an employee changes roles or terminates employment.

18NW2367 R06/22

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Administrative representative duties include:

- ✓ Identify users at your organization who will need access to our secure online services.
- ✓ Assign users appropriate access to applications – You will assign individual user access to the appropriate users.
- ✓ Manage users and terminate user access when it is no longer needed.

Detailed instructions and the Administrative Representative Registration Packet can be found on our Provider Page at **www.bcbsla.com/providers** >Electronic Services >Admin Reps.

Accessing iLinkBlue

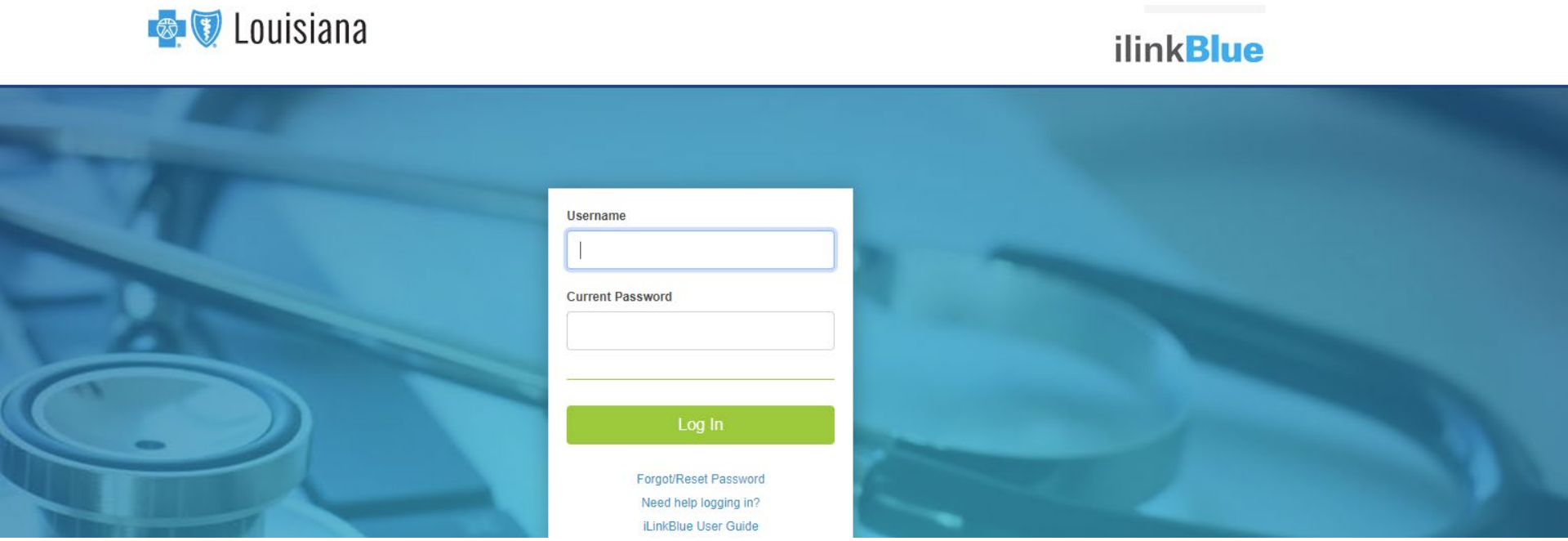
Need access to iLinkBlue?

Does your organization have an administrative representative?

- Reach out to your organization's administrative representative to request access.
- The administrative representative will use the Delegated Access application in iLinkBlue to set up your appropriate level of security access.
- Deeper levels of security may include member eligibility and coverage research, submitting claims, and/or access to secure authorization applications.

- Self designate at least one administrative representative at your organization.
- Complete the Administrative Representative Registration Packet available online at **www.bcbsla.com/providers** >Electronic Services >Admin Reps.
- Contact our Provider Identity Management (PIM) Team at **PIMteam@bcbsla.com** or 1-800-716-2299, option 5 with questions.

Accessing iLinkBlue



Logging in for the first time:

- Password must be reset.
- Click on the "Forgot/Reset Password" button.
- Follow the prompts, enter your username and click the "Request Password" button.
- The system will send you an email to reset your password. Click on the link in the email. Follow the prompts.

Passwords

Passwords must be eight positions and contain a number, an uppercase letter, a lowercase letter and one special character (~! @#$%^&). Do not use your browser's password manager function to save or store your password. This can prevent you from changing your password when it expires.

iLinkBlue accounts that are not accessed for 180 days are locked due to inactivity. **Reach out to your administrative representative to have your account reset.**

If you are the administrative representative and need your password reset, reach out to the Provider Identity Management (PIM) Team.

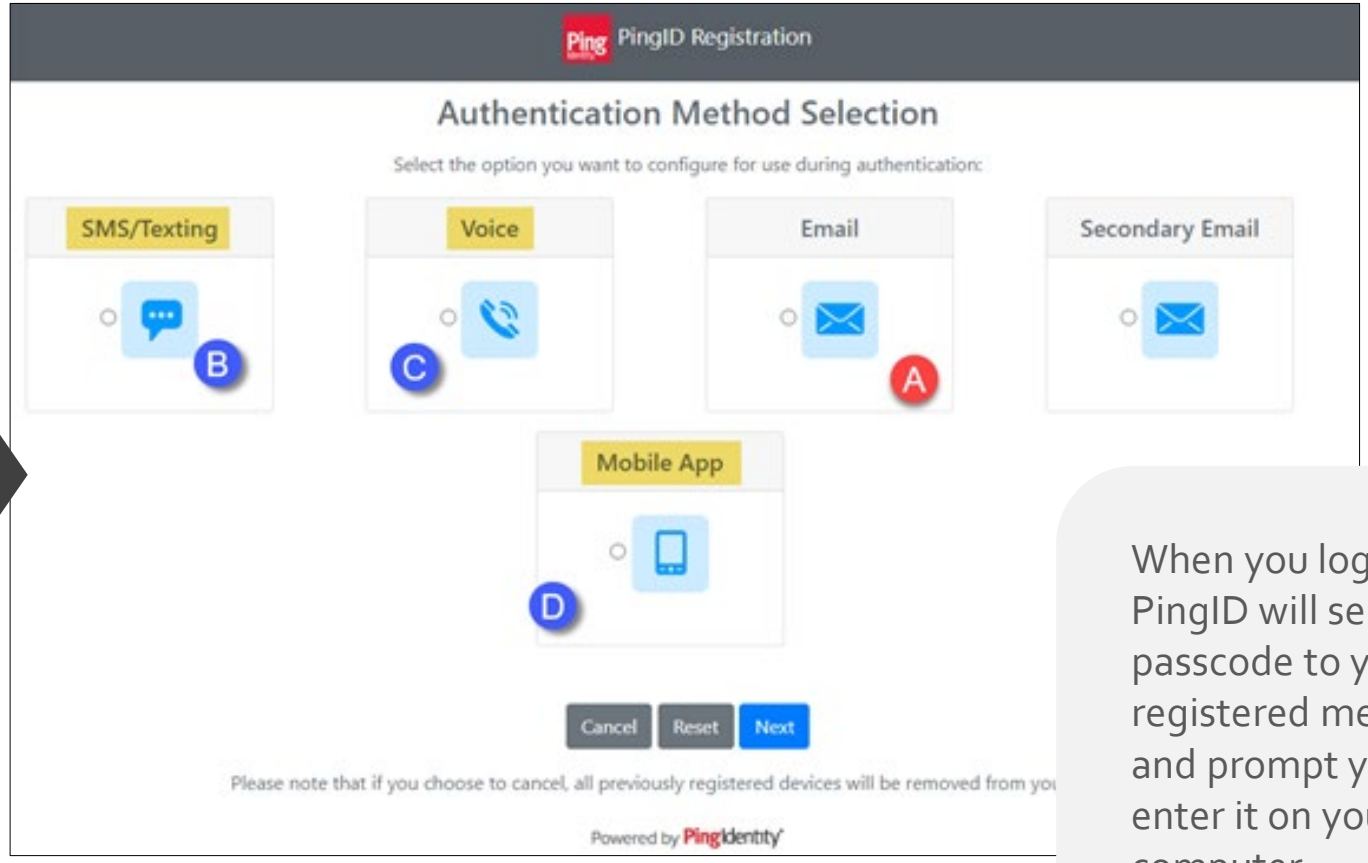
Phone: 1-800-716-2299, option 5
Monday – Friday 7:30 a.m. to 4 p.m.

Email: **PIMteam@bcbsla.com**

Multi-factor Authentication

Multi-factor authentication (MFA) is required to securely access iLinkBlue. MFA is a security feature that delivers a unique identifier passcode via email, text and other formats. To set up MFA, you must register an authentication method with PingID.

We recommend registering **two or more** options for account recovery.

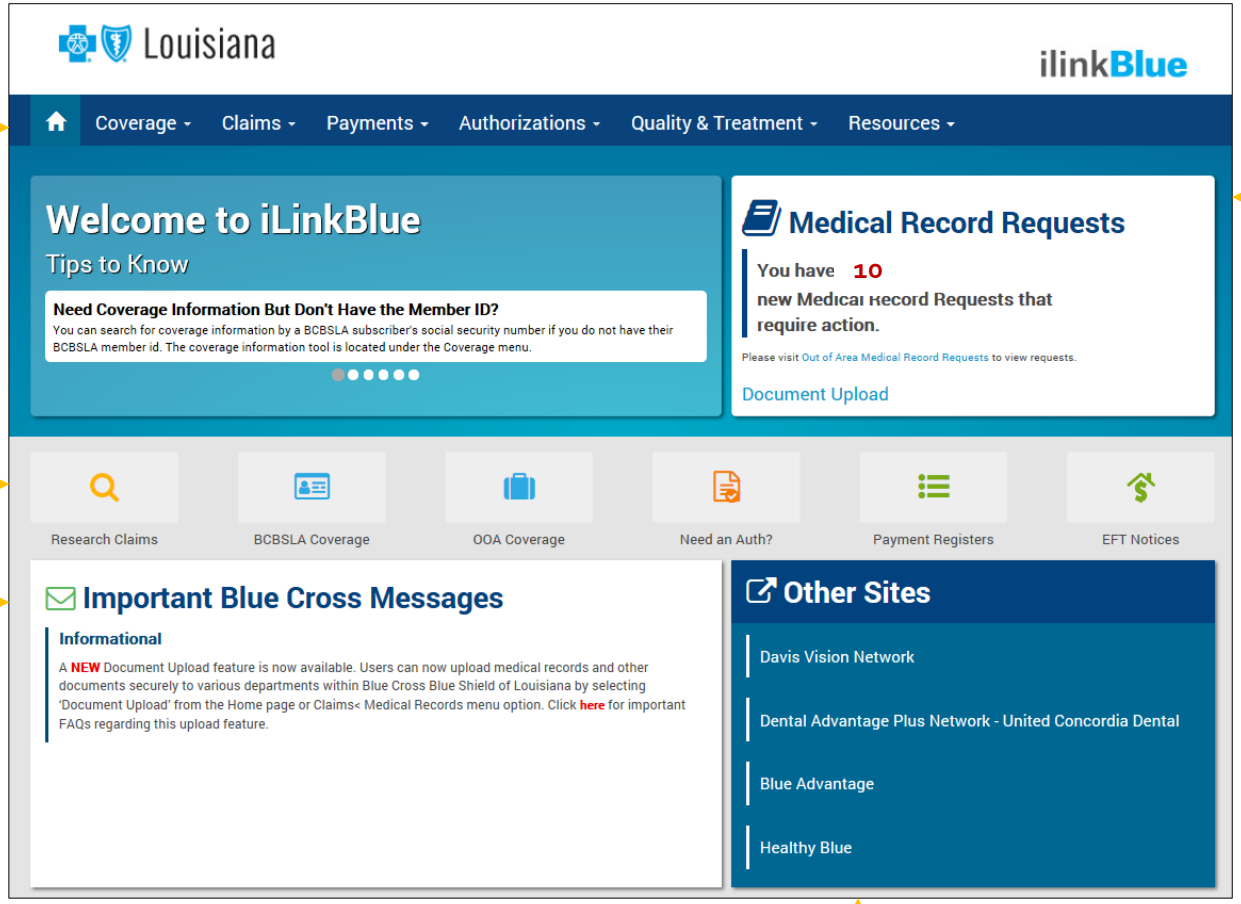


When you log in, PingID will send a passcode to your registered method and prompt you to enter it on your computer.

Navigating iLinkBlue

Top Navigation

The top navigation streamlines the iLinkBlue functions under six menus. When you click a menu option, a sub-menu appears that includes relevant features.



Quick Links

This area contains shortcuts to the six most-used iLinkBlue functions.

Message Board

Contains up-to-the minute posts for upcoming events, new features, system outages, holiday notices and other important bulletins.

Medical Record Requests

You receive an alert when you have Out of Area Medical Record Requests for BlueCard members. To view these requests, click the "Out of Area Medical Record Requests" link on the alert. This does not include medical record requests for BCBSLA members. To upload medical records and other documents, click the "Document Upload" link.

Other Sites

We provide quick access to other sites a provider might need to access.

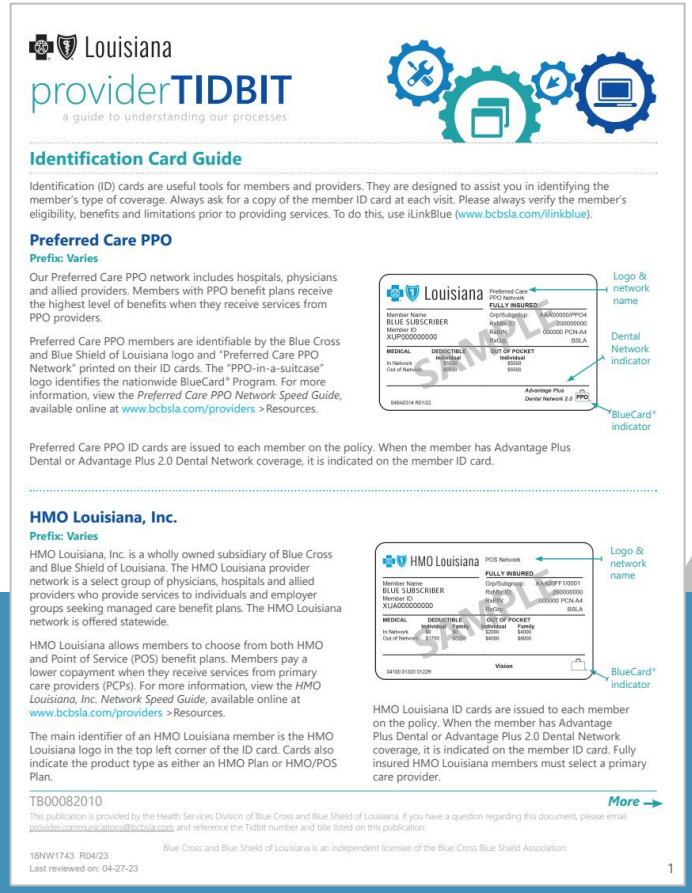
MEMBER BENEFITS

Blue Cross' Provider Networks

Blue Cross offers several provider networks that are tied to our members' benefit plans. These networks include:

- Preferred Care PPO
- HMO Louisiana, Inc.
- Blue Connect
- BlueHPN
- Community Blue
- Precision Blue
- Signature Blue

Our Identification Card Guide Provider Tidbit is a guide to identify members' applicable networks when looking at the ID card. Go to www.bcbsla.com/providers, click "Resources," then "Provider Tidbits."



Louisiana

providerTIDBIT

a guide to understanding our processes

Identification Card Guide

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

Preferred Care PPO

Prefix: Varies

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

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

Louisiana Preferred Care PPO Network FULLY INSURED Member Name BLUE SUBSCRIBER Member ID XUP000000000 Group/Subgroup XUA00000/PPO4 RxBIN 000000 RxPCN A4 RxGrp BSLA MEDICAL DEDUCTIBLE Individual $5000 Family $10000 In Network Out of Network OUT OF POCKET Individual $5000 $5000 Advantage Plus Dental Network 2.0 PPO SAMPLE

Logo & network name

Dental Network indicator

BlueCard® indicator

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

HMO Louisiana, Inc.

Prefix: Varies

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

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

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

HMO Louisiana POS Network FULLY INSURED Member Name BLUE SUBSCRIBER Member ID XUA000000000 Group/Subgroup XUA00FF10001 RxBIN 000000 RxPCN A4 RxGrp BSLA MEDICAL DEDUCTIBLE Individual $2000 Family $4000 In Network Out of Network $1750 $3500 OUT OF POCKET Individual $4000 Family $8000 Vision SAMPLE

Logo & network name

BlueCard® indicator

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

TB00082010 More →

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

18NW1743 R04/23

Last reviewed on: 04-27-23

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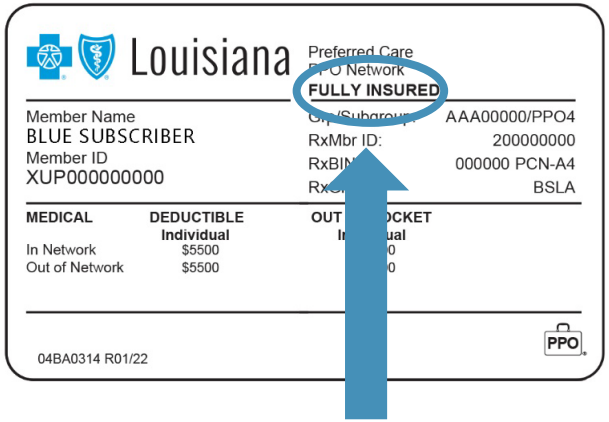
Fully Insured & Self Funded

FULLY INSURED

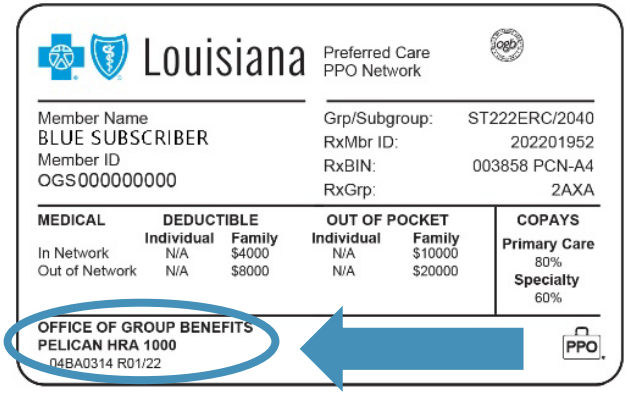
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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**).

FEP Members

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

STANDARD OPTION

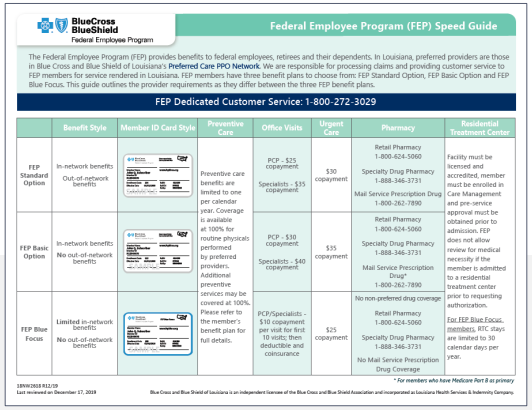
- ✓ In-network
- ✓ Out-of-network

BASIC OPTION

- ✓ In-network
- X Out-of-network

FEP BLUE FOCUS

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



BlueCross BlueShield Federal Employee Program

Federal Employee Program (FEP) Speed Guide

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

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

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

** For members who have Medicare Part B as primary*

18NW2810 R12/19
Last reviewed on December 17, 2019

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

The FEP Speed Guide is available at **www.bcbsla.com/providers** >Resources >Speed Guides.

BlueCard® Program (out-of-area) Members

BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan service area. The main identifiers 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 PPO or EPO product.

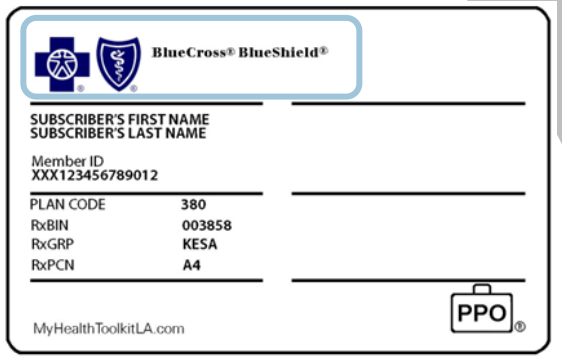
The empty suitcase indicates the member is enrolled in a Blue Plan traditional, HMO, POS or limited benefits product.

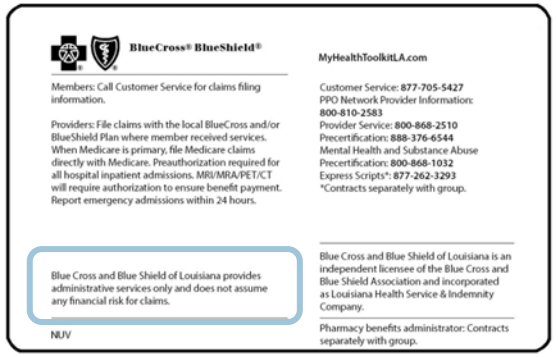
The HPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) product.

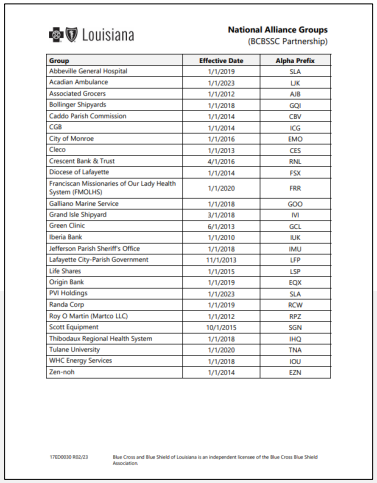
National Alliance Members

(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.







Louisiana

National Alliance Groups
(BCBSSC Partnership)

Group	Effective Date	Alpha Prefix
Abbeville General Hospital	1/1/2019	SLA
Acadian Ambulance	1/1/2023	LJK
Associated Grocers	1/1/2012	AJB
Bollinger Shipyards	1/1/2018	GQJ
Caddo Parish Commission	1/1/2014	CBV
CGB	1/1/2014	ICG
City of Monroe	1/1/2016	EMO
Cleco	1/1/2013	CES
Crescent Bank & Trust	4/1/2016	RNL
Diocese of Lafayette	1/1/2014	FSX
Franciscan Missionaries of Our Lady Health System (FMOLHS)	1/1/2020	FRR
Galliano Marine Service	1/1/2018	GOO
Grand Isle Shipyard	3/1/2018	IVI
Green Clinic	6/1/2013	GCL
Iberia Bank	1/1/2010	IUK
Jefferson Parish Sheriff's Office	1/1/2018	IMU
Lafayette City-Parish Government	11/1/2013	LFP
Life Shares	1/1/2015	LSP
Origin Bank	1/1/2019	EQX
PVI Holdings	1/1/2023	SLA
Randa Corp	1/1/2019	RCW
Roy O Martin (Martco LLC)	1/1/2012	RPZ
Scott Equipment	10/1/2015	SGN
Thibodaux Regional Health System	1/1/2018	IHQ
Tulane University	1/1/2020	TNA
WHC Energy Services	1/1/2018	IOU
Zen-noh	1/1/2014	EZN

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Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

We publish a list of these groups (with prefixes) in iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Referring Members Out-of-network

You can find network providers to refer members to in our online provider directories at www.bcbsla.com >Find a Doctor.

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

- higher cost shares (deductibles, coinsurances, copayments)
- no benefits for some members
- balance billing to member for all amounts not paid by Blue Cross if the provider is non-participating

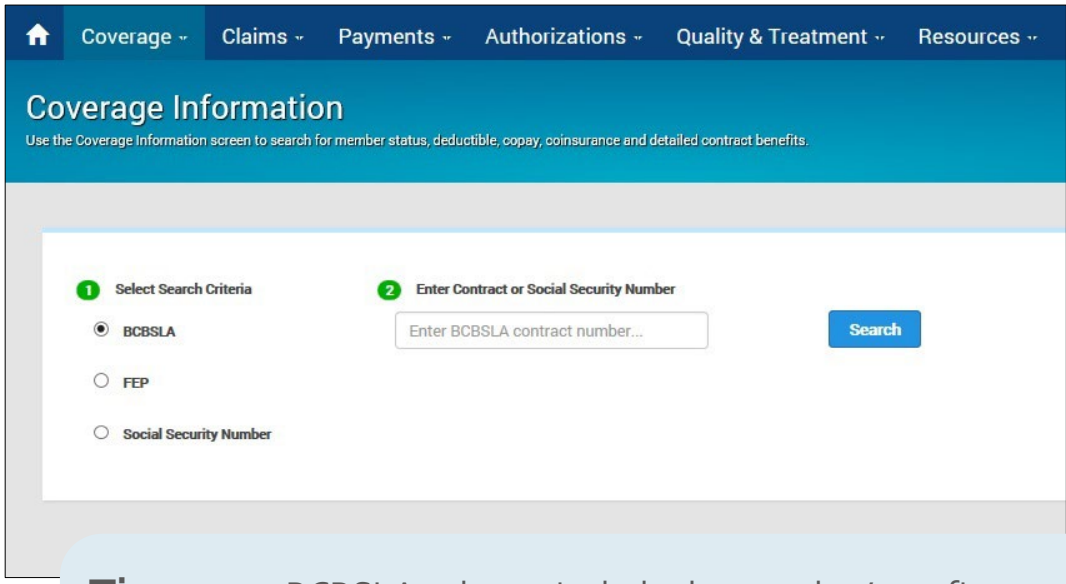
If a provider continues to refer patients to out-of-network providers, their entire fee schedule could be reduced.

Verifying Member Benefits in iLinkBlue

Use iLinkBlue (**www.bcbsla.com/ilinkblue**) to lookup a member's coverage information.

Choose the "Coverage" menu option. Enter the member ID number to view coverage information for:

- BCBSLA (including HMO Louisiana, Inc.) members
- FEP members. This section is not used for out-of-area members.



Tips

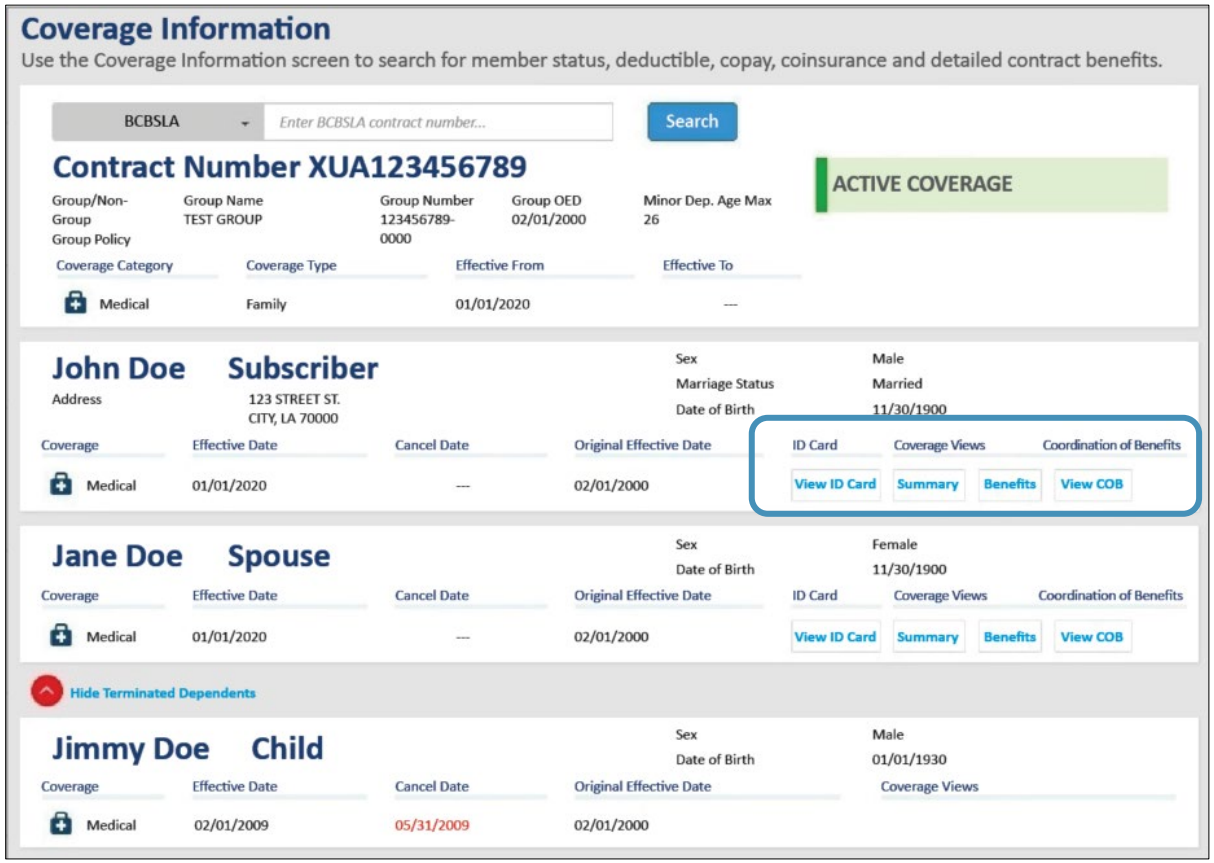
- BCBSLA – do not include the member's prefix.
- FEP – must include the letter "R".
- A different application is used for BlueCard (out-of-area) members.

If you do not have the member ID number, you can search using the subscriber's Social Security Number (SSN), when available. iLinkBlue will return search results with the member ID number. An error message will display if searching by a dependent's SSN. It must be the SSN of the policy holder.

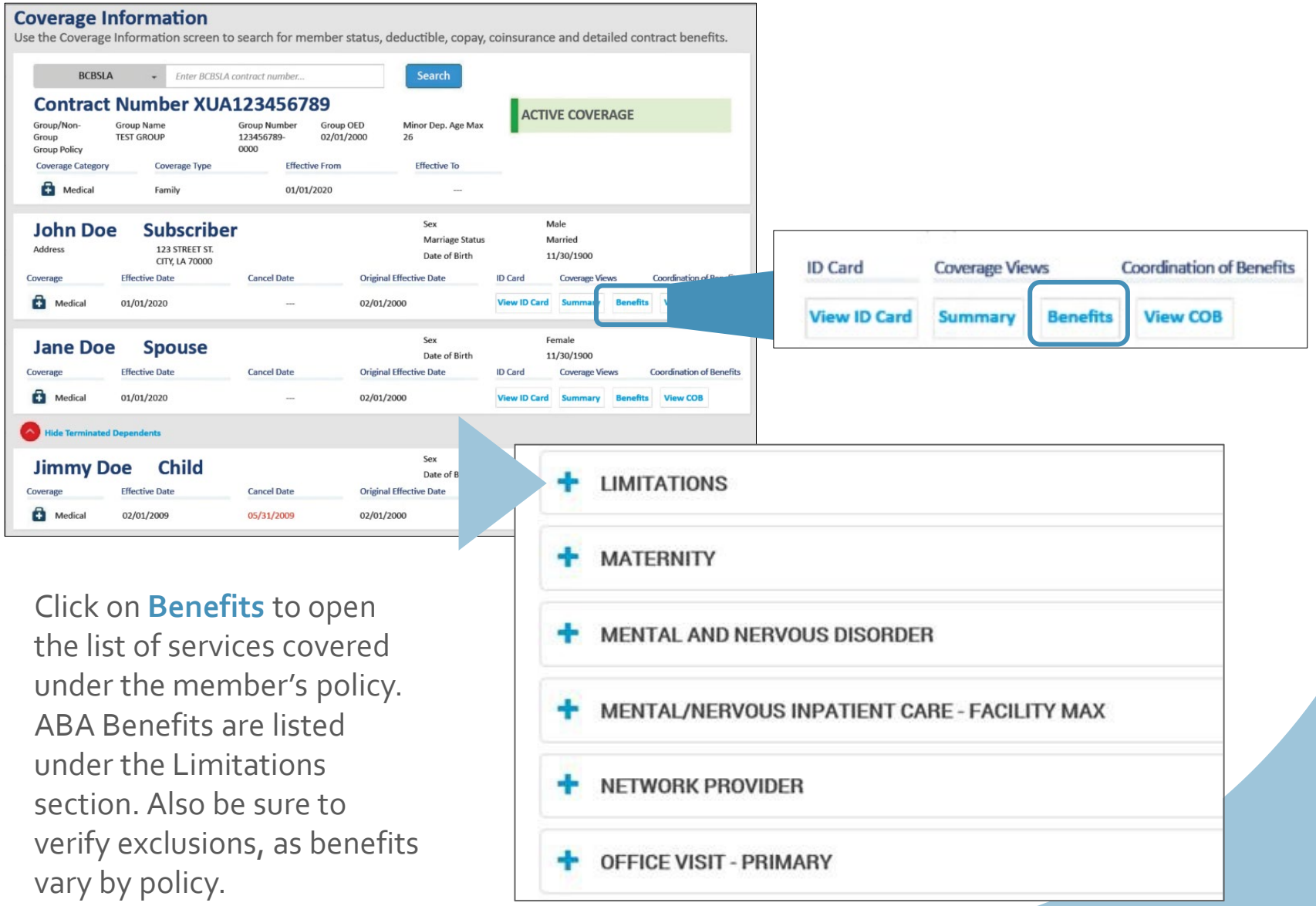
Coverage Information

This screen identifies members covered on a policy, effective date and the status of the contract (active, pended, cancelled).

- The **View ID Card** button allows you to download a PDF of the member ID card.
- The **Summary** button allows you to view a benefit summary. It includes the member's cost share (deductible, copay and coinsurance) and remaining out-of-pocket amounts.
- The **Benefits** button allows you to view the coverage details of the member's benefits plan.
- The **View COB** button allows you to view coordination of benefits information.



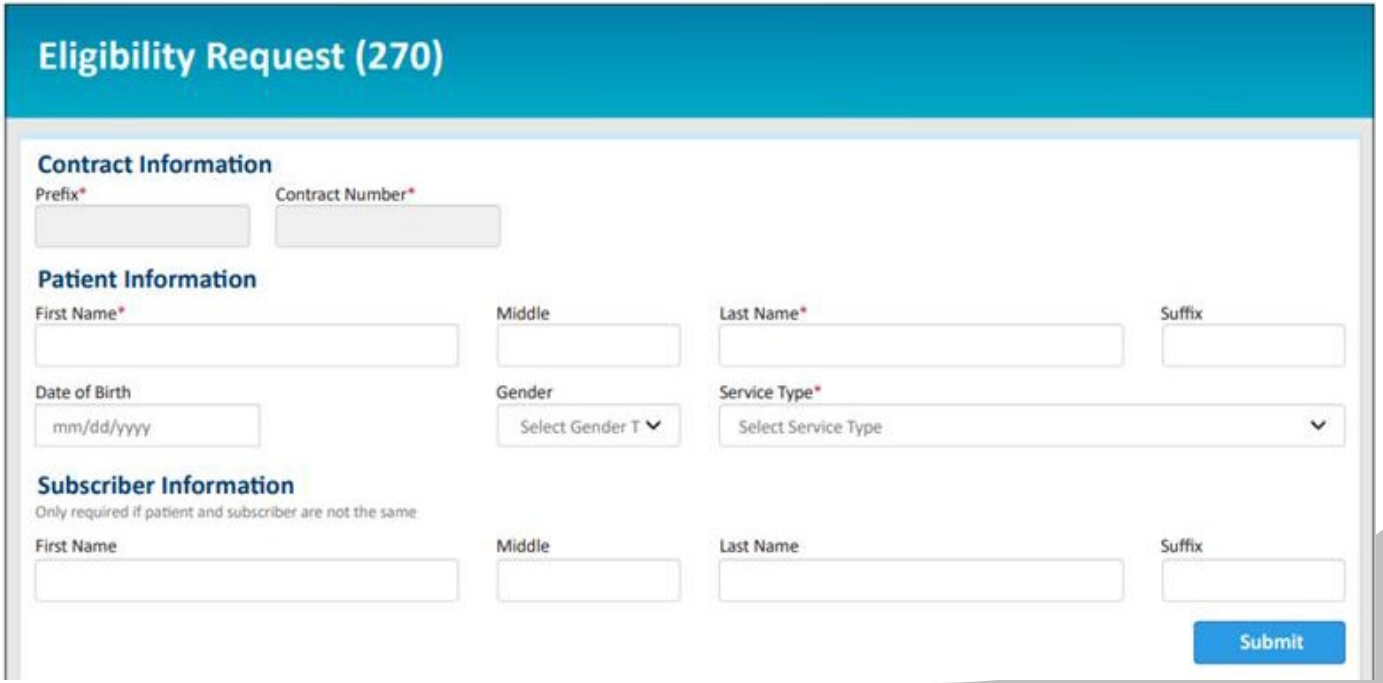
ABA Benefits



Click on **Benefits** to open the list of services covered under the member's policy. ABA Benefits are listed under the Limitations section. Also be sure to verify exclusions, as benefits vary by policy.

Verifying Benefits for BlueCard 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).



ABA Services Enhancement

Blue Cross covers ABA services for members of all ages diagnosed with Autism Spectrum Disorder (ASD) when prior authorization is obtained. ASD benefits include, but are not limited to:

- Medically necessary assessment
- Evaluations or tests performed for diagnosis
- Habilitative and rehabilitative care
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care

Effective January 1, 2023, for new and existing policies.

Note: It is optional for self-funded policies. Please always verify benefits.

Applied Behavior Analysis may be available for coverage for treatment of ASD when determined to be medically necessary.

ASD benefits are subject to the copayments, deductible amount and coinsurance percentage that are applicable to the benefits obtained.

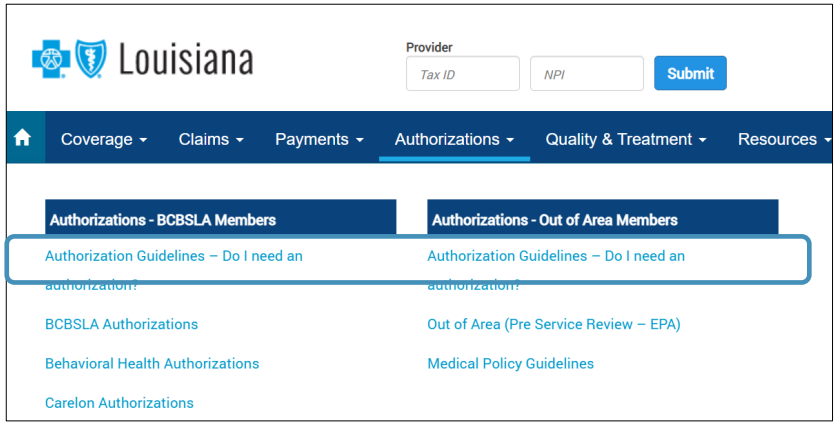
DO I NEED AN AUTH?

Behavioral Health Auth Requirements

Do I need an authorization?

There are **two** resources that can be used to research authorization requirements.

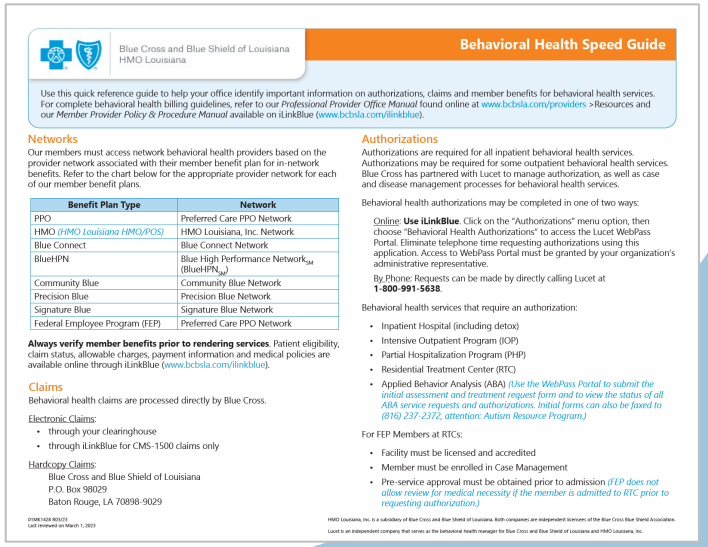
1 iLinkBlue's Authorization's Guidelines application



The same application is used for **both** BCBSLA and BlueCard (out-of-area) members. Enter the member's prefix (the first three characters of the member ID number) to access general pre-authorization/pre-certification information.

2 Behavioral Health Speed Guide

This guide provides details about our behavioral health policies, including the list of services that require prior authorization. It is available at **www.bcbsla.com/providers** >Resources >Speed Guides.



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℠ (BlueHPN℠)
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 Lucet to manage authorization, as well as case and disease management processes for behavioral health services.

Behavioral health authorizations may be completed in one of two ways:

Online: **Use iLinkBlue**. Click on the "Authorizations" menu option, then choose "Behavioral Health Authorizations" to access the Lucet WebPass Portal. Eliminate telephone time requesting authorizations using this application. Access to WebPass Portal must be granted by your organization's administrative representative.

By Phone: Requests can be made by directly calling Lucet at **1-800-991-5638**.

Behavioral health services that require an authorization:
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA) *(Use the WebPass Portal to submit the initial assessment and treatment request form and to view the status of all ABA service requests and authorizations. Initial forms can also be faxed to (816) 237-2372, attention: Autism Resource Program.)*

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.)*

DSMEI428 R01/23
Last reviewed on March 1, 2023

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.

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

Behavioral Health Auth Requirements

Requirements vary based on the member's policy. Please always verify benefits prior to rendering services.

Below is the list of authorization requirements. Authorizations are required for all inpatient behavioral health services and may be required for some outpatient behavioral health services:

- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA)

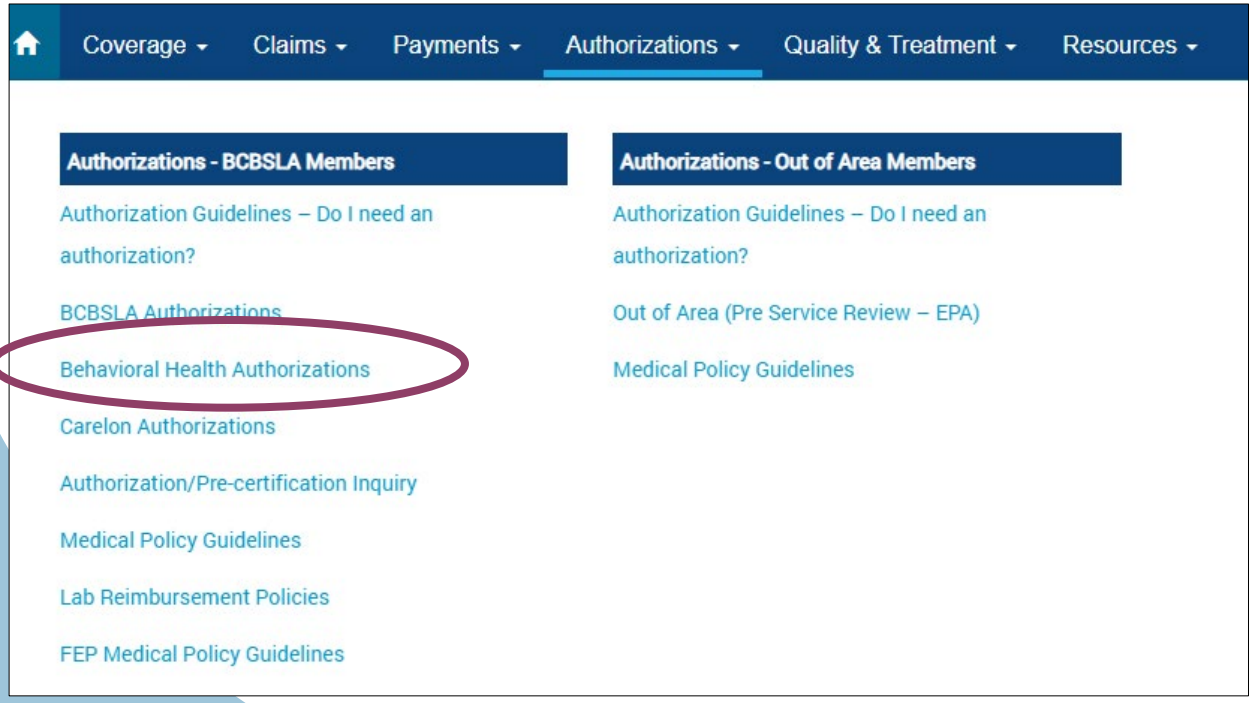
For FEP Members at RTCs:

- 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.

Requesting Authorizations

Please use **WebPass Portal** to electronically request authorizations for behavioral health services and submit clinical information. It is a web-based application in iLinkBlue (**www.bcbsla.com/ilinkblue**) and is facilitated by **Lucet**.



By Phone:

In the event you are unable to use **WebPass Portal**, you can call Lucet for assistance at 1-877-563-9347.

Use WebPass Portal

You can use WebPass Portal to submit treatment requests for:

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

www.bcbsla.com/ilinkblue >Authorizations >Behavioral Health Authorizations

Medical Necessity Appeals

First-level appeals

Send directly to Lucet:

Lucet Health
ATTN: Appeals Coordinator
P.O. Box 6729
Leawood, KS 66206
Fax: 1-816-237-2382

Decision to Overturn Denial

A 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

A letter is sent to member and provider directing them on how and where to file a second-level appeal request.

Second-level appeals

Are handled one of two ways:

1. By BCBSLA
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.

Medical Necessity Appeals

WebPass Retro Review & Appeal Submissions

Requesting retro reviews and appeals has become much easier.

Requests are completed via the WebPass system; already in use for initial and concurrent reviews.

- The medical record can easily be attached via the WebPass instead of using fax or mail.

To submit a request

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

Tips

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

Diagnostic Review

Purpose

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

Comprehensive Evaluation

- ASD specific
- Cognitive and developmental
- Adaptive assessment
- Neurological information

Some records are missing, what do we do?

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

Treatment Review

15-day review period

Post-Service Reviews

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

Ending Services

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

BCBA Name Changes

- Extended vacations, maternity/medical leave of absence, caseload reassignment

Types of Denials

Administrative Denial

- Denial given due to a benefit structure limitation.
  - Examples: The place of service is excluded; member does not have an Autism diagnosis; ABA is excluded under the plan.
- Notification given to family and provider; family offered behavioral health case management.

Peer Review

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

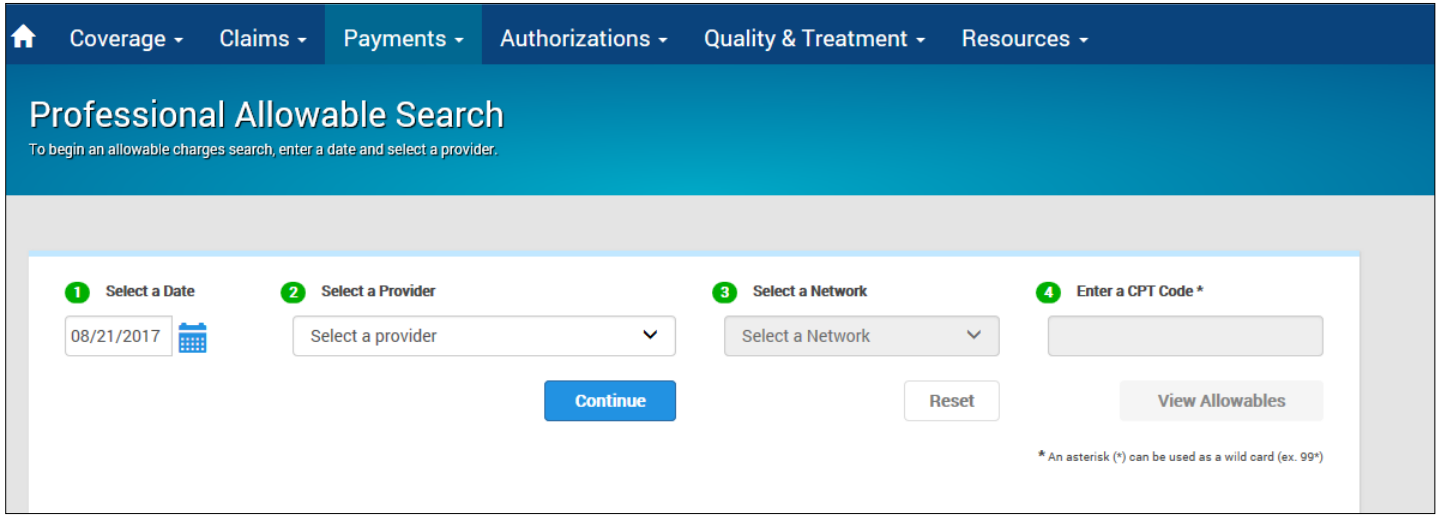
FILING CLAIMS

Timely Filing

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

Policy Type	Filing Requirements
• Preferred Care PPO • HMOLA (including Blue Connect, Community Blue, Precision Blue, Signature Blue) • BlueHPN	Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.
• Federal Employee Program (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.
• Office of Group Benefits (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 Groups • BlueCard (out-of-area)	Timely filing standards may vary. Always verify the member's benefits (including timely filing standards) through iLinkBlue.

Researching Allowables



Use iLinkBlue to view allowables for a single code or a range of codes.

Look up a single code:

Enter: 90833

Results: allowable for 90833 only

Look up a range of codes:

Enter:	Results:
908*	allowables for all codes beginning with 908
90*	allowables for all codes beginning with 90
9*	allowables for all codes beginning with 9

Submitting Claims

Electronic Transmission

Blue Cross accepts electronic claims transmitted via HIPAA 837P and 837I submitted electronically through your clearinghouse.

We do not charge a fee for electronic transactions.

Providers can submit transactions directly to us or indirectly through a third-party clearinghouse.

For more information on how to submit electronic claims to Blue Cross, visit **www.bcbsla.com/providers** >Electronic Services >Clearinghouse Services.

or

Hardcopy

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

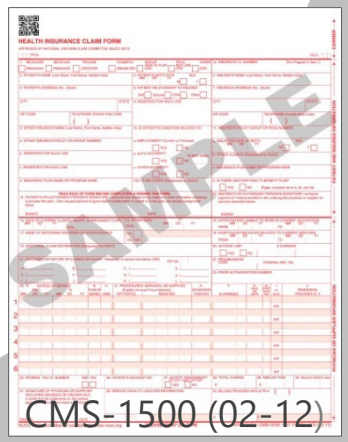
For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue, BlueHPN, Signature Blue, OGB and BlueCard Claims:

Mail hardcopy claims to:

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

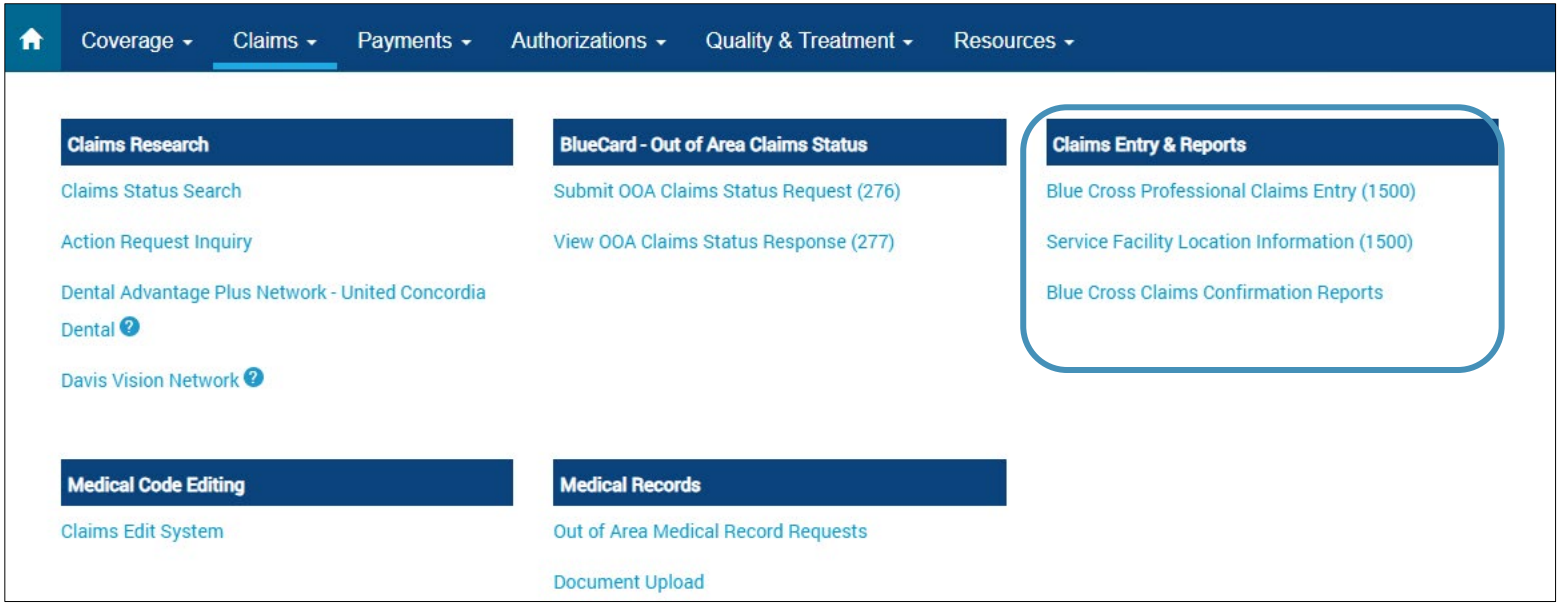
For FEP Claims:

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



CMS-1500 (02-12)

Submitting Claims in iLinkBlue

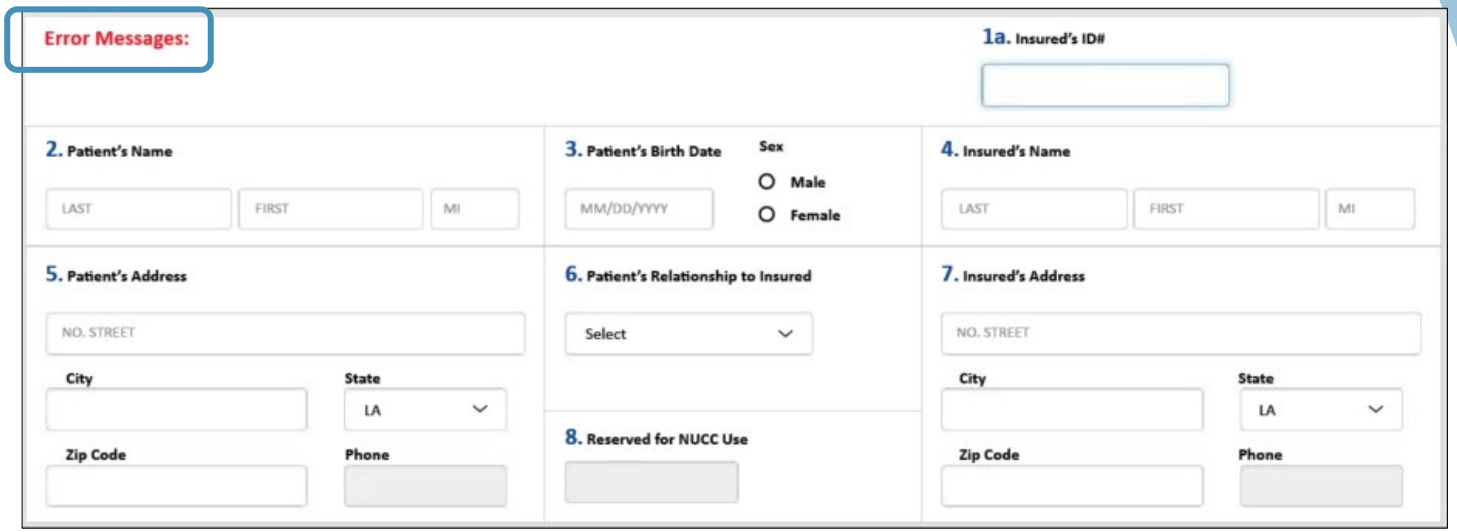


- Only providers who bill on a **HCFA 1500 form** can submit claims through iLinkBlue. There is no fee attached for this service.
- On the electronic iLinkBlue claim form, required fields are highlighted. If the claim entry contains errors, an error message advises that corrections can be made prior to submission.

Submitting Claims in iLinkBlue

Blue Cross Professional Claims Entry (1500) – follows the format of the HCFA 1500 form R (02-12).

If the claim entry contains errors, the edits will be listed under the "Error Messages" section at the top of the screen.



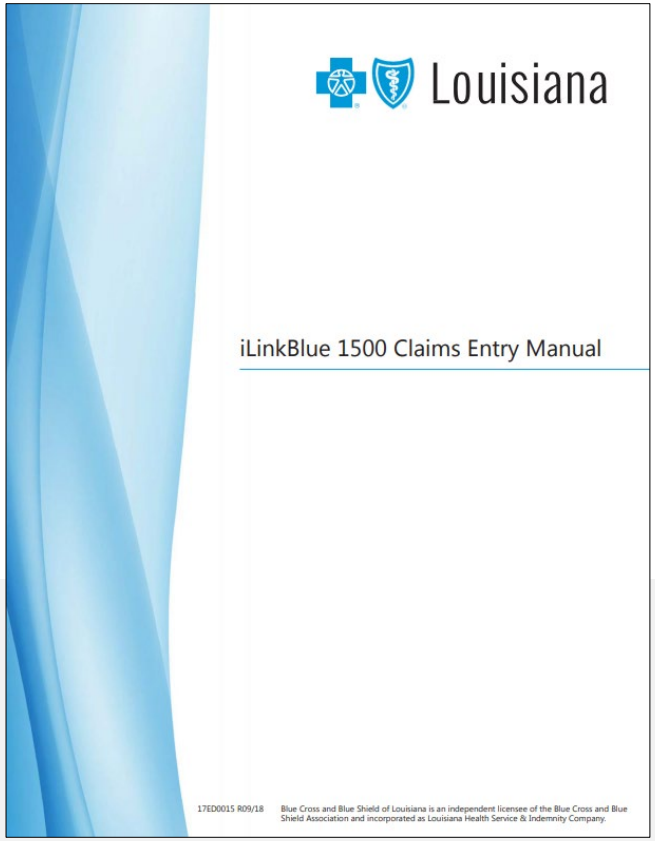
When the claim is submitted and accepted, the provider will receive a confirmation message.

Claim for 12345678901; DOE, JANE has been submitted

Submitting Claims in iLinkBlue

When you click the **Submit Claim** button and are sent to the iLinkBlue login screen, you were logged out because of inactivity.

During claim entry, if you stop to research information like a diagnosis or procedure code, be aware that the security features in **iLinkBlue will log out after 15 minutes of inactivity**.

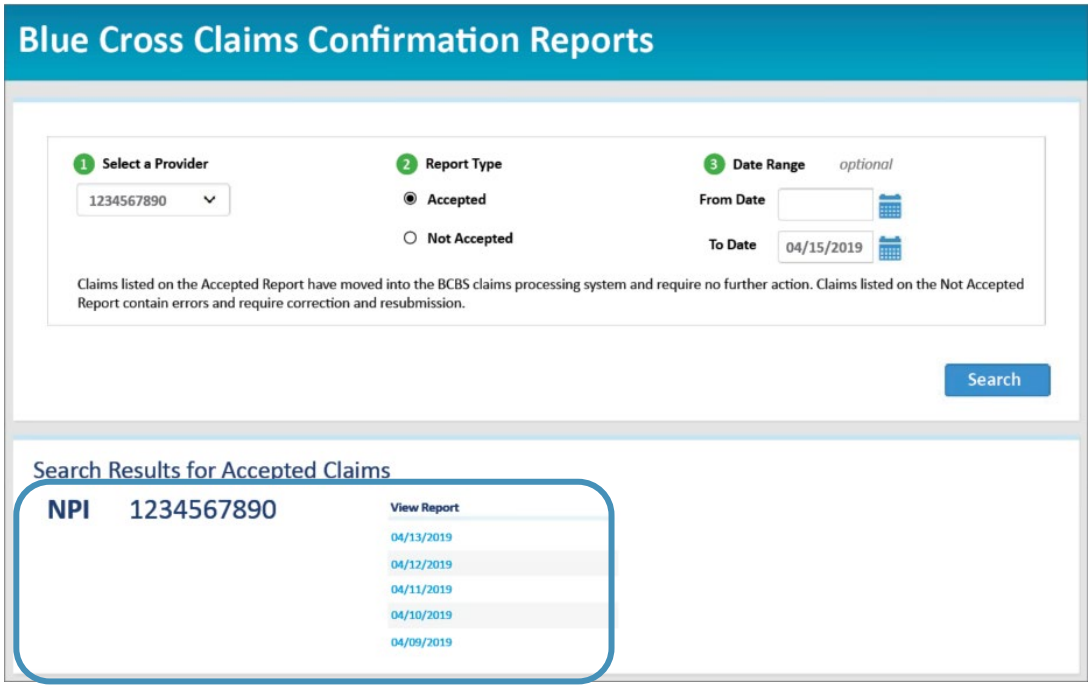


For complete instruction on using the 1500 Form claim entry application, view our *iLinkBlue 1500 Claims Entry Manual*, available under the Resources menu option.

Verifying Receipt of Claims

Confirmation Reports are generated in iLinkBlue and allow providers to electronically research submitted claims. Daily reports confirm acceptance of claims submitted directly through iLinkBlue, billing agency or clearinghouse.

- ✓ Reports are available within 24 hours of submitting claims (prior to 3 p.m.).
- ✓ Reports are available up to 120 days.
- ✓ Reports are displayed by date.



Sample 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 on the Not Accepted report.

Accepted Report Example

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

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z NPI# 1234567891
BC ID # T5678
SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 4-14-23
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 Example

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

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z NPI# 1234567891
BC ID # T5678
SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 4-14-23
PAGE 1

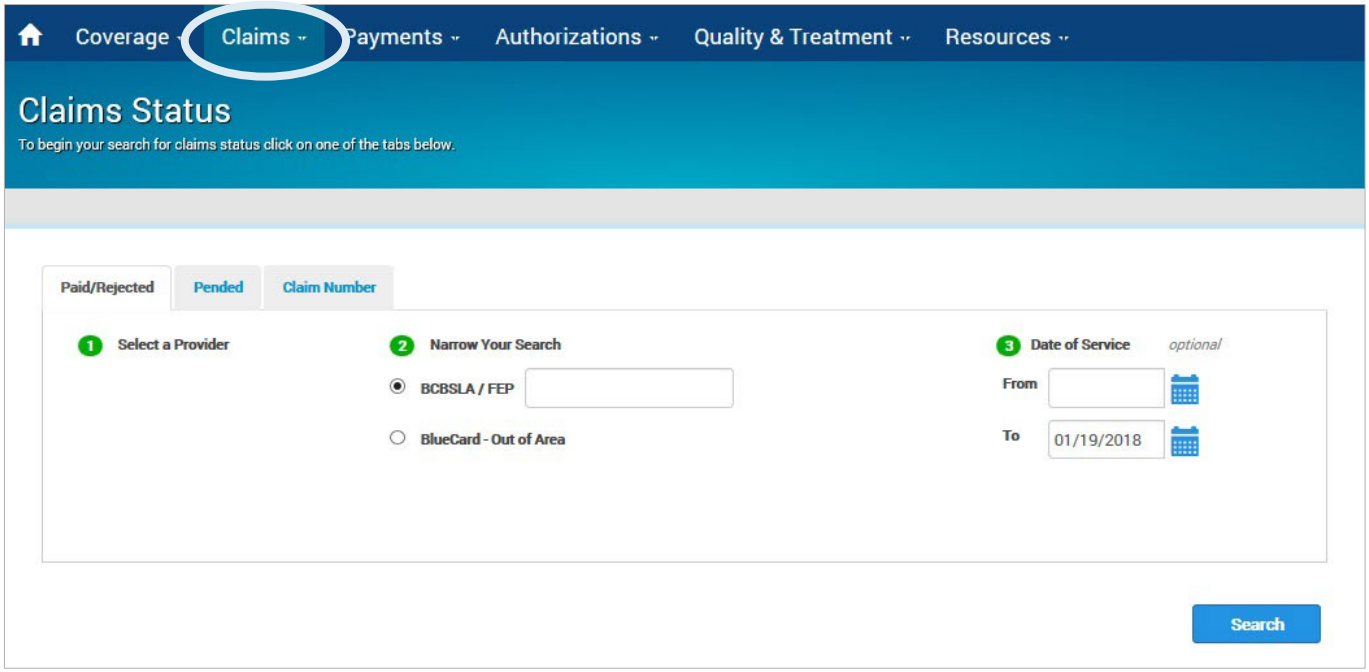
837P NOT ACCEPTED REPORT

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

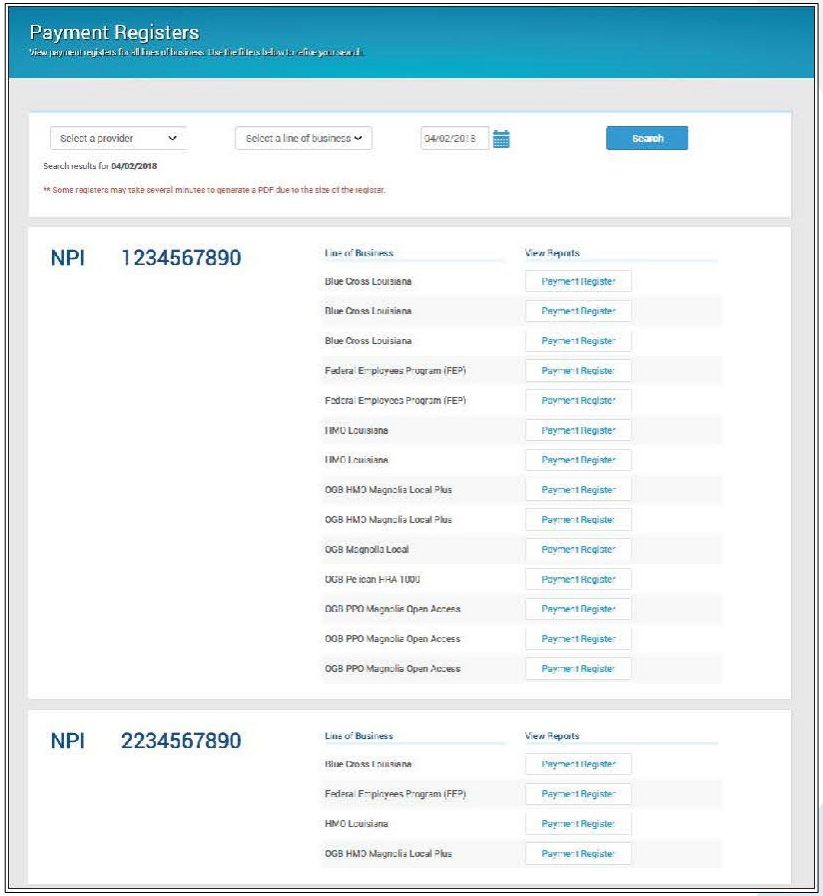
Claims Research



- 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.

Payment Registers

- Use the **Payments** menu option in iLinkBlue 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.
- If you have access to multiple NPIs, you will see payment registers for each.



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 for member treatment.
- 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.

Medical Records Requests

From time to time, you may receive a medical record request from us, or one of our vendors, to perform medical record chart audits on our behalf.

- Per your Blue Cross network agreement, providers are not to charge a fee for providing medical records to Blue Cross or agencies acting on our behalf.
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge.
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee.

Medical record requests must be returned within seven days of receipt of request.

Commercial 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.

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.

RESOLVING CLAIM ISSUES

Have an Issue with a Claim?

Sometimes a provider may need find an issue with a claim. It is best to **first inquire about the claim,** then if necessary submit a formal request.

Blue Cross classifies formal requests into three different categories:

CLAIMS DISPUTES

Involves a denial that affects the provider's:

- Reimbursement, including bundling issues
- Timely filing
- Authorization penalties
- Refund disputes

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

Inquiring About Claim Issues

Use the iLinkBlue Action Requests application!

It allows you to electronically communicate with Blue Cross when you have questions or concerns about a claim.

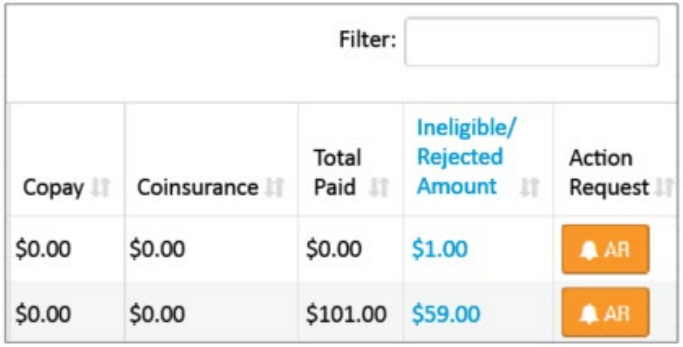
Common reasons to submit an Action Request

- Code editing inquiries
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No record of membership (effective and term date)
- Recoupment request
- Status of dispute

The **Action Requests** application does not allow you to upload documentation. For this reason, it is important to include full details when submitting the inquiry.

Submitting an Action Request

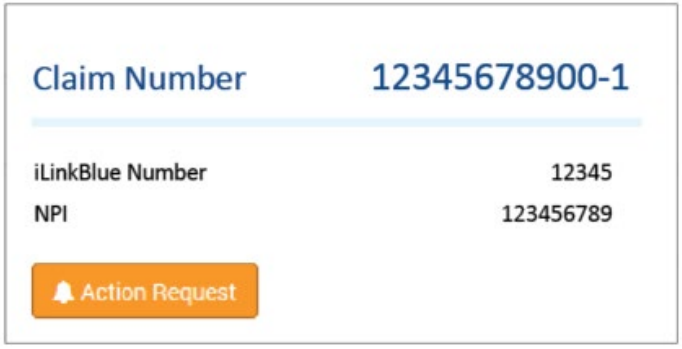
In iLinkBlue there is an **Action Request** button on each claim. It opens an electronic form that prepopulates with information on the specific claim. There are multiple places within iLinkBlue that include the action request buttons.



on the **Paid/Rejected Claims Results** screen

and

on the **Pended Claims Results** screen

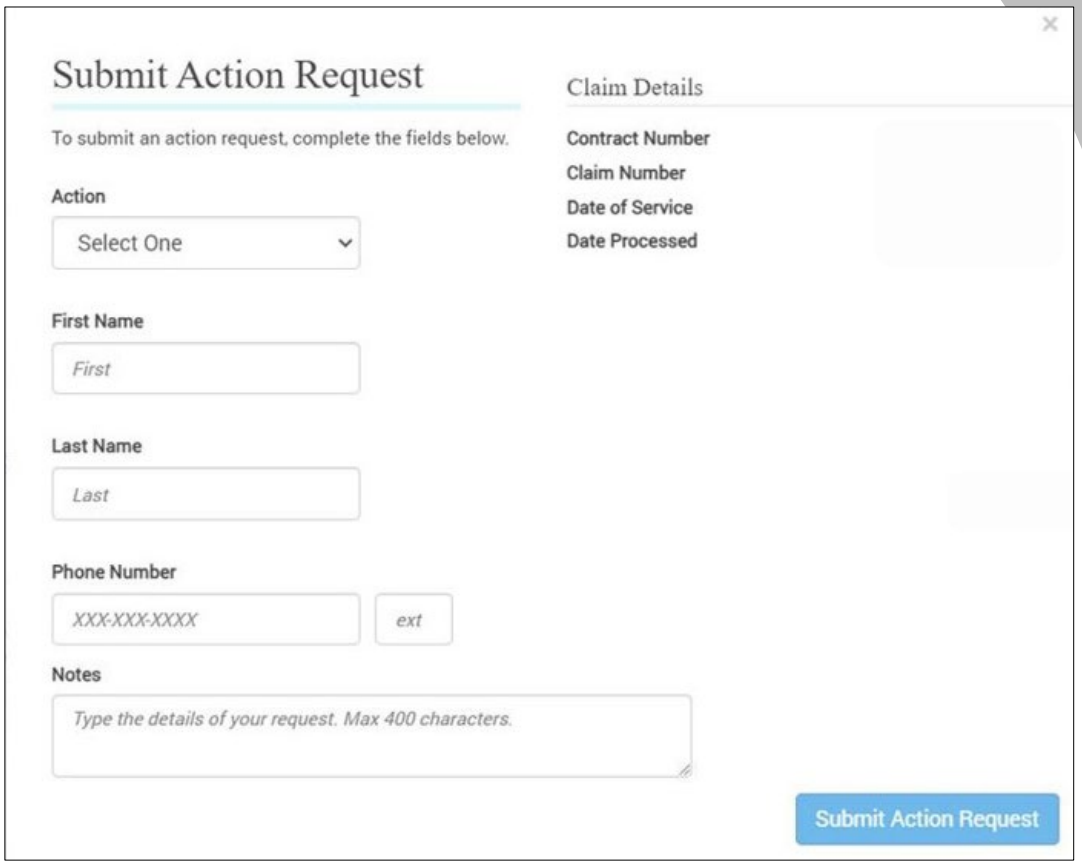


on the **Claims Detail** screen

Submitting an Action Request

When submitting an Action Request:

- Include your contact information
- Be specific and detailed
- Allow 10-15 working days for a response to each request
- Check in Action Request Inquiry for a response
- Submit a second request if there was no resolution

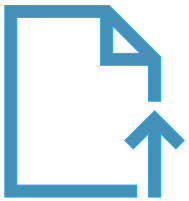


As a second step to **submitting an Action Request,** if you did not get a resolution, you may also contact the **Customer Care Center** using the number on the back of the patient's member ID card.

How Do I Correct or Void a Claim?

For professional claims submitted electronically through a clearinghouse:

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:



Claim Adjustment

- 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.

How Do I Correct or Void a Claim?

For professional claims submitted hardcopy or through iLinkBlue:

When a claim is refiled for any reason, all services should be reported on the claim.

Hardcopy Claim

Claims that were previously processed on a CMS-1500 can be changed:

- Adjust Claim – In Block 22, enter "7" for a claim adjustment (information or charges added to, taken away or changed).
- Void Claim – In Block 22, enter "8" to request that the entire claim be removed, and any payments or rejections be retracted from the member's and provider's records.
- In Block 22, enter the original claim reference number.

iLinkBlue Claim

If submitting a corrected professional claim through iLinkBlue:

- In Field 19A, enter the applicable Professional Claim Adjustment/Void Indicator: A (Adjustment Claim) or V (Void Claim).
- In Field 19B, enter the Internal Control Number (ICN Number that is the original claim number).

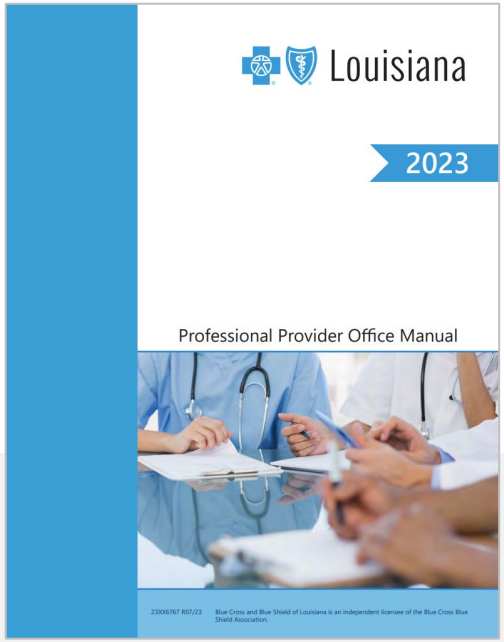

Louisiana
providerTIDBIT
Submitting Corrected Claims
General Guidelines

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

TELEHEALTH

Telehealth Policy

- 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.
- Coverage is subject to the terms, conditions and limitations of each individual member contract and policy.
- Blue Cross adheres to the rules and regulations outlined by the Louisiana Board of Medical Examiners regarding telehealth prohibitions.



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

Appropriate Place of Service (POS)

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.).

- 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 may reject.
- Blue Cross will not reimburse telehealth services for HCPCS codes 0362T or 0373T due to their complexity requiring a face-to-face encounter.

Telemedicine

Reimbursement for telemedicine services is available when provided utilizing your own telemedicine platform.

Provider types performing telehealth services must ensure the delivery of telehealth is within their respective scope and guidance of their relevant licensing and/or certifying boards.

Encounters must be performed in real time using audio-only or audiovisual telecommunication systems.

Audio-only telehealth visits must meet the criteria outlined in Section 5.37 of our Professional Provider Office Manual.

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

- Non-direct patient services (e.g., coordination of care before/after patient interaction).
- Services rendered by text-only telephone communication, facsimile, email, mobile applications or any other non-secure electronic communication.
- In many cases, telehealth is not separately billable during the same episode of care that an in-person service is provided.
- Triage to assess the appropriate place of service and/or appropriate provider type.
- Services not eligible for separate reimbursement when rendered to patient in-person.
- Patient communications incidental to E&M, counseling or medical services covered by the member's policy.
- Presentation/origination site facility fee.
- Services/codes that are not specifically listed in the provider manual.

Telemedicine Codes

Codes listed below with an asterisk (*) may be billed as audiovisual telehealth services only. All other listed codes can be billed as audiovisual or audio-only telehealth services.

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

Category	Code
Office & Outpatient Visits (E&M)	99201-99205, 99211-99215
Wellness & Preventive E&M	99381-99387, 99391-99397
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 96156, 96158, 96160-96161
Applied Behavioral Analysis (ABA)	97151*, 97152*, 97153*, 97154*, 97155*, 97156*, 97157*, 97158*
Physical Therapy, Occupational Therapy and Speech Therapy	92507, 92521, 92522, 92523-92524, 92526, 92610, 96105, 97110*, 97112*, 97116*, 97161*, 97162*, 97164*, 97165*, 97166*, 97168*, 97530*, 97535*
Preventive Medicine Counseling	99401-99404
Transitional Care Management	99495, 99496
Diabetes Management	G0108-G0109
Dietary & Nutritional Therapy	97802-97804, G0270-G0271
Obesity Counseling	G0447
Alcohol & Substance Abuse Screening	99408, 99409, G0442, G0443
Smoking Cessation & Tobacco Counseling	99406-99407
Sexually Transmitted Infections & High-intensity Behavioral Counseling	G0445

Use **Modifier GT or 95,** whichever is appropriate**,** to indicate delivery of telemedicine services in real time. Use **Modifier 93** for audio-only telehealth services.

ABA BILLING GUIDELINES

ABA Billing Guidelines

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

Claim payments are based on:

- Licensure
- Certification
- Registration

(as designated by the state Behavior Analyst Board)

Licensed Behavior Analyst (LBA)

- Can bill directly.
- Services must be billed with Modifier TG.

State-certified Assistant Behavioral Analysts (SCABA)

- Cannot bill directly.
- Services must be billed through the supervising LBA with the appropriate codes and modifier.
- Services must be billed with Modifier TF.

Registered Line Technician (RLT)

- Cannot bill directly.
- Services must be billed through the supervising licensed behavior analyst (LBA).
- RLTs with a Bachelor's degree: Use Modifier HN.
- RLTs without a Bachelor's degree: Do not use a modifier.

ABA Billing Guidelines

Use one of the following CPT® codes with appropriate, required modifiers for ABA services:

Code	Units	Clinician Type	Modifier
97151	15 min	SCABA	TF
		LBA	TG
97152	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97153	15 min	RLT with Bachelor's	HN
		SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97154	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97155	15 min	SCABA	TF
		LBA	TG
97156	15 min	SCABA	TF
		LBA	TG
97157	15 min	SCABA	TF
		LBA	TG
97158	15 min	SCABA	TF
		LBA	TG
0362T	15 min	SCABA	TF
		LBA	TG
0373T	15 min	SCABA	TF
		LBA	TG

Billing ABA Codes

Assessment and Re-Assessment Codes

97151

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

97152

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

Billing ABA Codes

Treatment Codes

97153

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

97154

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

Billing ABA Codes

Treatment Codes

97155

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

Adaptive treatment protocol modification may include:

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

Billing ABA Codes

Concurrent Billing

97153 & 97154 with 97155

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

Caregiver Training

97156

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

97157

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

Billing ABA Codes

Group Treatment

97158

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

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

Billing ABA Codes

Exposure Codes

0362T

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

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

Billing ABA Codes

Exposure Codes

0373T

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

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

OTHER BILLING GUIDELINES

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.

Lucet™

RESOURCES

Autism Resource Program

Credentials

- Three Care Managers – Board Certified Behavioral Analyst (BCBA) and/or Licensed Behavioral Analyst (LBA)
- One Team Lead – BCBA
- One Manager – BCBA
- One Clinical Consultant – BCBA, LBA, LPC

Role

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

Autism Resource Program

Provider contact

- Treatment requests
- Diagnostic information

Parent contact

- Diagnostic information
- Additional resources

Coordinated Calls

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

Autism Resource Program

Family Support Coordinator

- Providers resources and referrals for families
- Assists with family calls to assess ongoing needs

Behavioral Health Referral and Collaboration

- Referrals for other behavioral health needs such as referrals and resources for outpatient therapy, psychiatry, family therapy and medication management

Written Correspondence

Emails

- Not secure
- Limit the use of Protected Health Information (PHI)

Fax for information

- Can occur during a review
- After authorization approval

Extension letter

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

Provider letter

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

Transition and Aftercare Planning

- Begin during the early phases of treatment and will change over time based upon response to treatment and presented needs.
- Focus on the skills and supports required for the member for transitioning toward their natural environment.
- Identify appropriate services and supports for the time period following ABA treatment.
- Include a planning process and documentation with active involvement and collaboration with a multidisciplinary team to include caregivers.
- Long term outcomes must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.
- Long-term Objective – An objective and measurable goal that details the overall terminal mastery criteria of a skill being taught.
- Realistic expectations should be set with current treatment plan goals connecting to long term outcomes.

Care Manager (CM)

- Serves as an additional resource for family.
- Welcome packet sent to family with FAQs, medical necessity criteria and contact information of assigned CM.
- Answer questions regarding diagnostic requirements and connect with in-network providers to complete as needed.
- Contact family periodically to ensure parents are satisfied with services and have needed resources.
- Can address clinical questions family may have regarding ABA services.
- Help connect recently diagnosed individuals with ABA providers.

Lucet™ is hosting **FREE** continuing education series for ABA providers.

If you would like to attend, or would like more information, please call **1-877-563-9347**.

WE ARE HERE FOR YOU!

Provider Relations

Kim Gassie Director

Jami Zachary Manager

Anna Granen Senior Provider Relations Representative

Marie Davis Senior Provider Relations Representative

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

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

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

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

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

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

Lucet Contact Information

For assistance, please contact:

Autism Resource Program: 1-877-563-9347

Kelly Winkelman, LCSW, BCBA, CCM

Autism Resource Program, Interim Manager

Email: kwinkelman@lucethealth.com

Phone: 1-816-416-7418

Jenna Gallegos, M.Ed, BCBA

Autism Resource Program, Team Lead

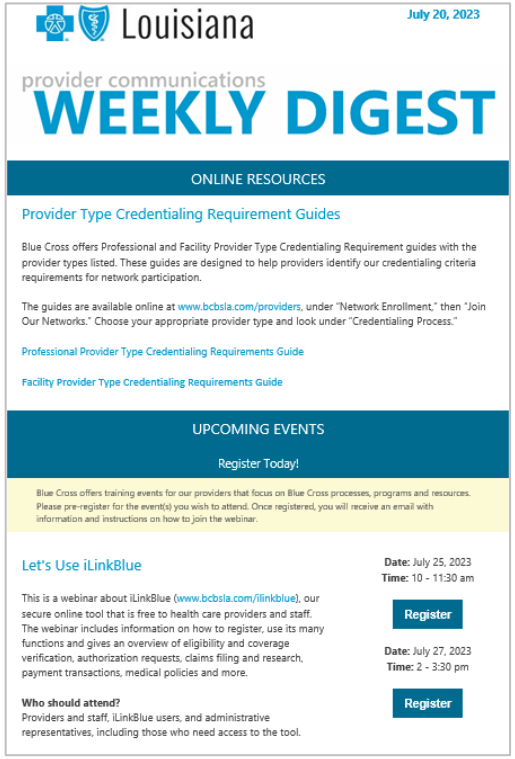
Email: jgallegos@lucethealth.com

Phone: 1-816-416-7213

Blue Advantage Behavioral Health Webinars

Blue Advantage (HMO) and **Blue Advantage (PPO)** will be conducting a webinar on **November 15** about behavioral health requirements for these members.

Look for the webinar registration link in our Weekly Digest, sent every Thursday.



Louisiana

July 20, 2023

provider communications

WEEKLY DIGEST

ONLINE RESOURCES

Provider Type Credentialing Requirement Guides

Blue Cross offers Professional and Facility Provider Type Credentialing Requirement guides with the provider types listed. These guides are designed to help providers identify our credentialing criteria requirements for network participation.

The guides are available online at www.bcbsla.com/providers, under "Network Enrollment," then "Join Our Networks." Choose your appropriate provider type and look under "Credentialing Process."

Professional Provider Type Credentialing Requirements Guide

Facility Provider Type Credentialing Requirements Guide

UPCOMING EVENTS

Register Today!

Blue Cross offers training events for our providers that focus on Blue Cross processes, programs and resources. Please pre-register for the event(s) you wish to attend. Once registered, you will receive an email with information and instructions on how to join the webinar.

Let's Use iLinkBlue

This is a webinar about iLinkBlue (www.bcbsla.com/ilinkblue), our secure online tool that is free to health care providers and staff. The webinar includes information on how to register, use its many functions and gives an overview of eligibility and coverage verification, authorization requests, claims filing and research, payment transactions, medical policies and more.

Who should attend?
Providers and staff, iLinkBlue users, and administrative representatives, including those who need access to the tool.

Date: July 25, 2023
Time: 10 - 11:30 am

Register

Date: July 27, 2023
Time: 2 - 3:30 pm

Register

Provider Engagement Survey

Your feedback is important!

THANK YOU to everyone who took our 2022 survey. Based on your feedback, we made changes including:

- Less Blue Cross emails to your inbox – we created the Provider Weekly Digest as a way to consolidated provider communications into one email digest that goes out every Thursday. It includes notifications, general announcements and provider training event information and registration options.
- iLinkBlue training webinars – we now offer iLinkBlue training webinars for new users.
- Improvement to our credentialing process – we have focused on improving our customer service and resolving provider issues timely.

We would ❤ for you to complete our 2023 survey. **It ends on:**

Participants could win 1 of 26 gift cards with top prize of $500.

If you have not received a survey link, send us an email to **provider.communications@bcbsla.com** and put "Provider Engagement Survey" in the subject line.

Thank you!

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