Behavioral Health Webinar for Facility Providers

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

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

How to submit questions:

- Open the Q&A feature at the 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

Facility Providers

August 2023

Provider Relations Department | provider.relations@bcbsla.com

PRESENTED BY:

Marie Davis
Senior Provider Relations Representative
Blue Cross

Debbie Crabtree
Provider Relations Specialist
Lucet

Michelle Sims, LPC, LMFT
Clinical Network 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

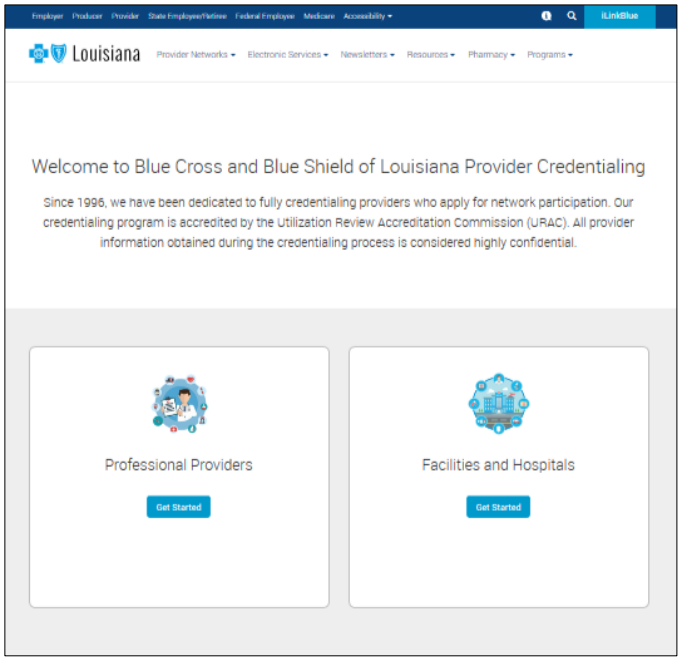
Blue Cross and Blue Shield of Louisiana credentials all practitioners and facilities that participate in our networks.

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.

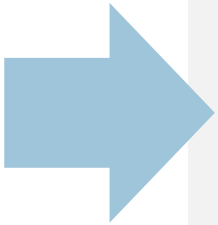
- Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:
  - Credentialing packets
  - Quick links to the Provider Update Request Form
  - Credentialing criteria for professional, facility and hospital-based providers
  - Frequently asked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



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

Credentialing Criteria

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

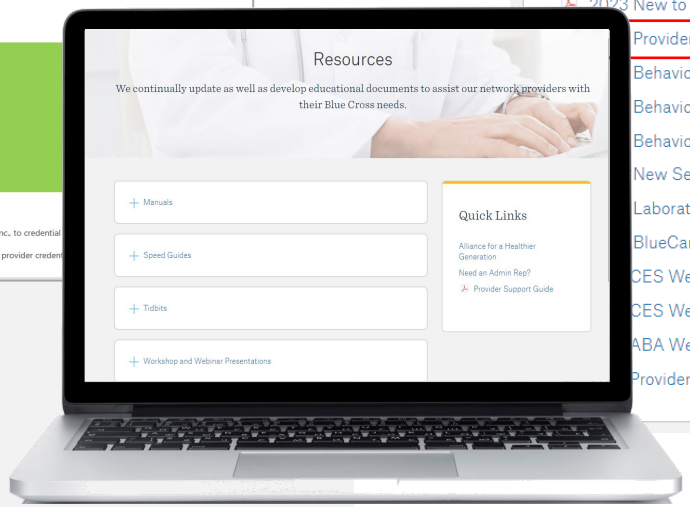


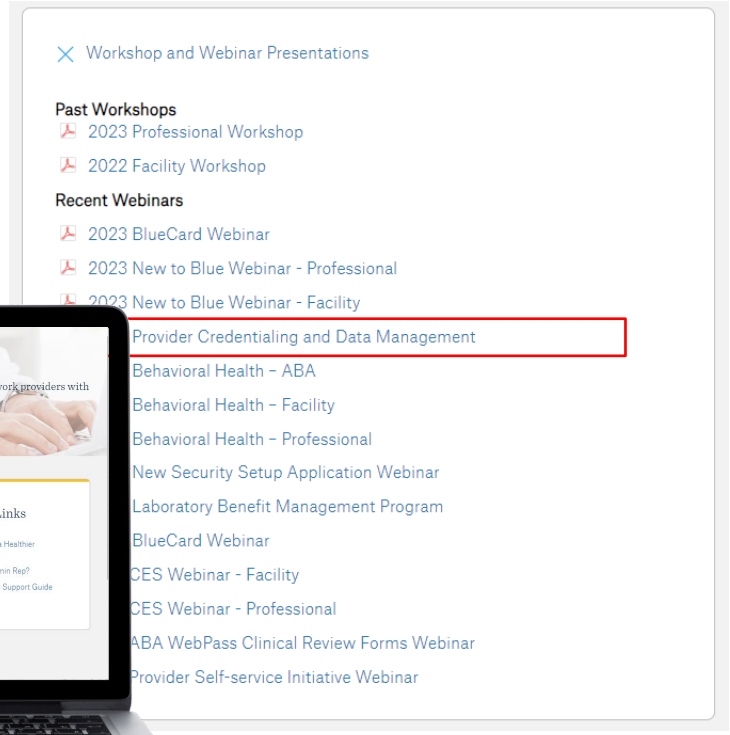
- Hospitals/Acute Care
- IOP / PHP Facilities
- Psych / CDU Facilities
- Residential Treatment Centers

View the *Credentialing Criteria* for these facilities at **www.bcbsla.com/providers** >Network Enrollment >Join Our Networks >Facilities and Hospitals >Credentialing Process.

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.



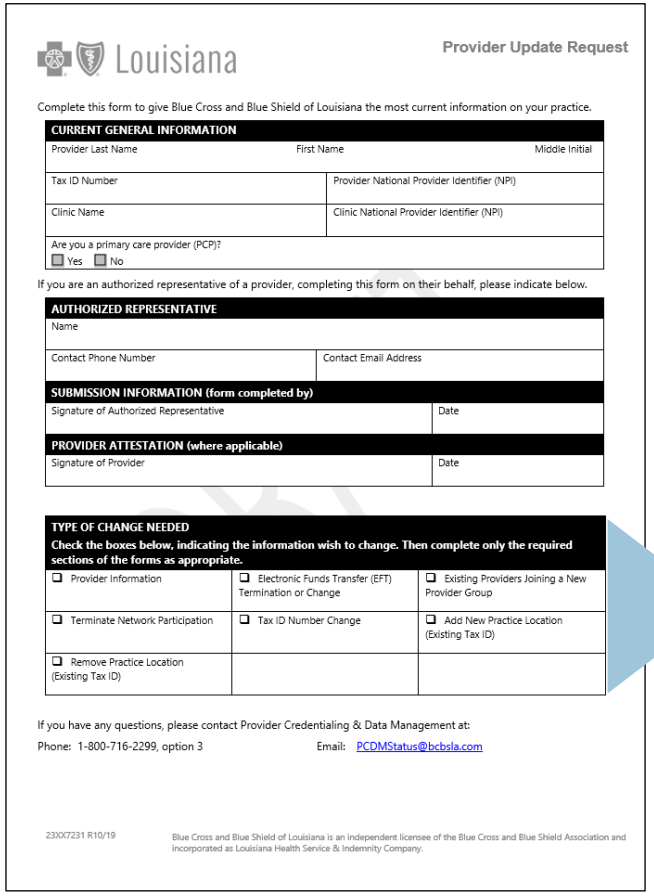


To attend this webinar, registration links are in our upcoming Provider Weekly Digests.

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 they 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)		

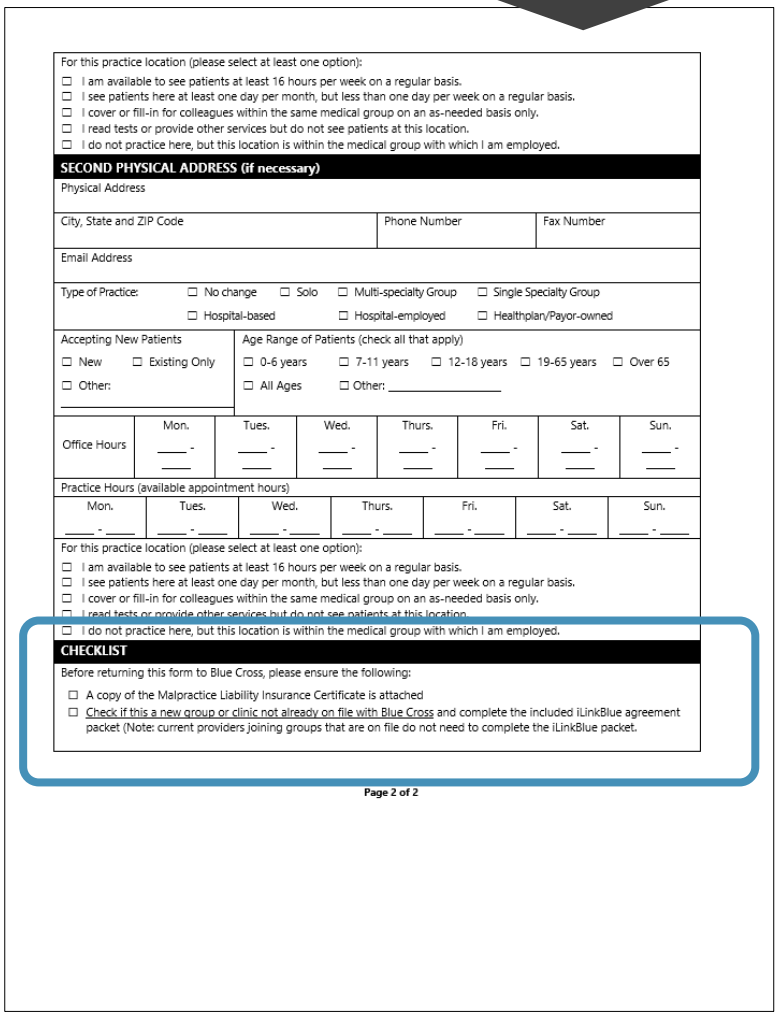
Updating Your Information

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

USING ILINKBLUE

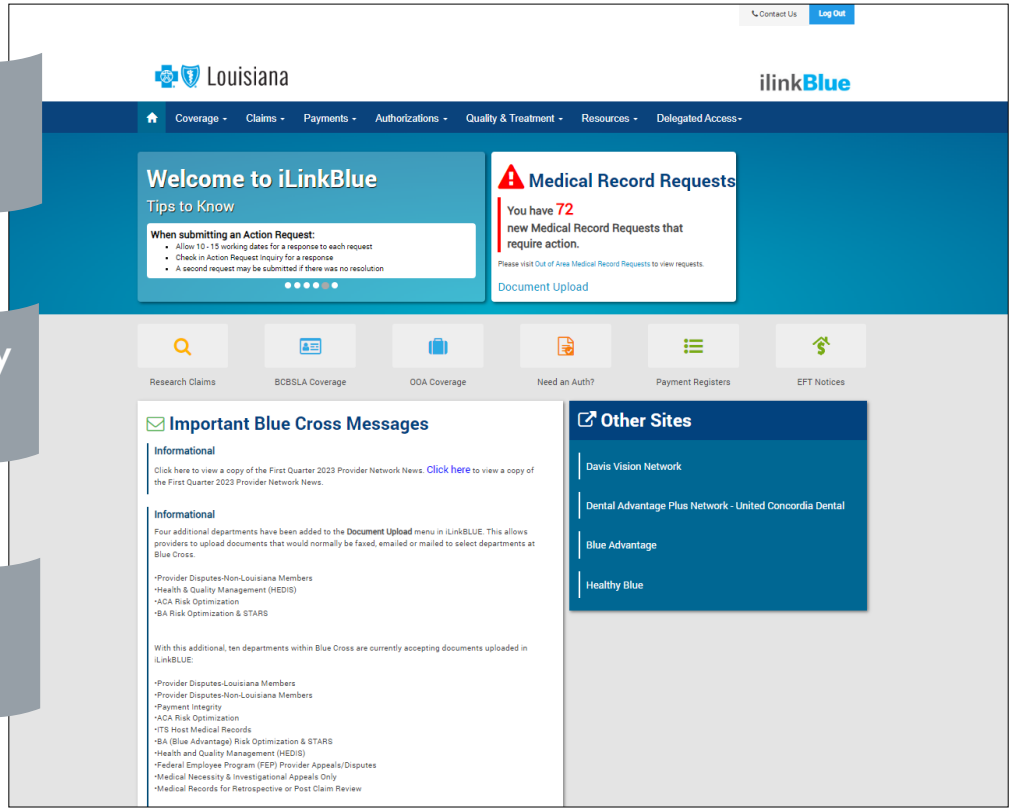
What is iLinkBlue?

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.

<u>Administrative representative duties include</u>:

- ✓ 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

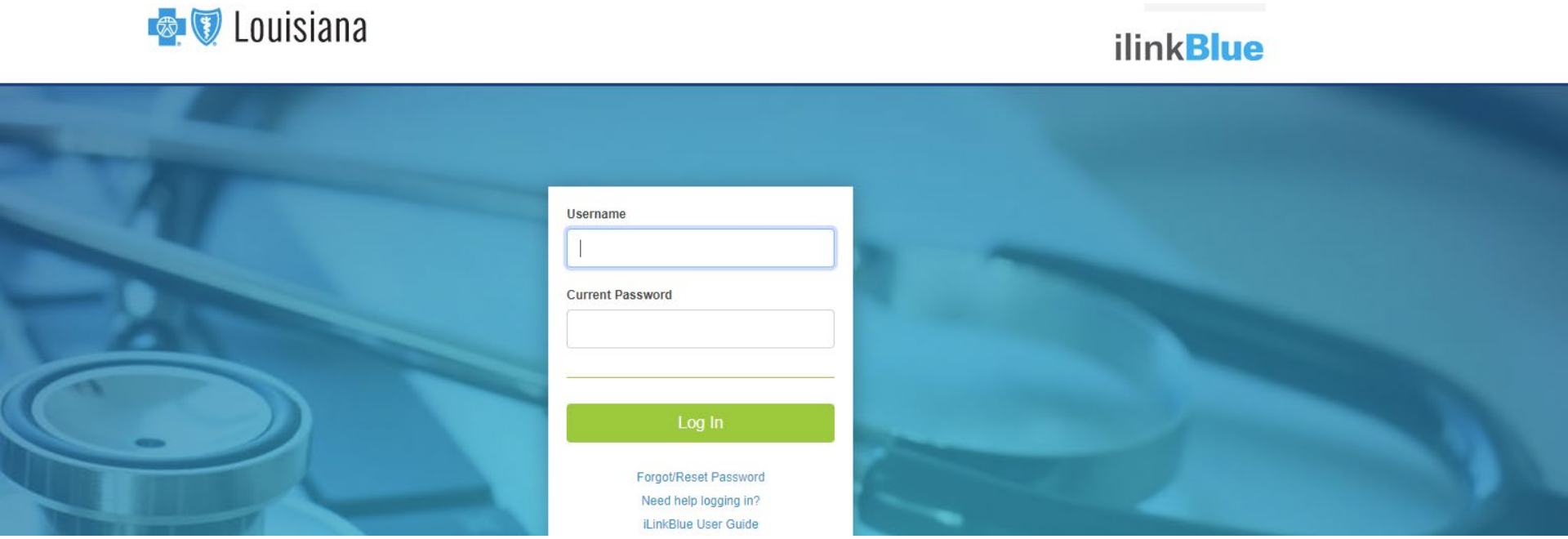
Need access to iLinkBlue?

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 to iLinkBlue.
- 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. It is 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.

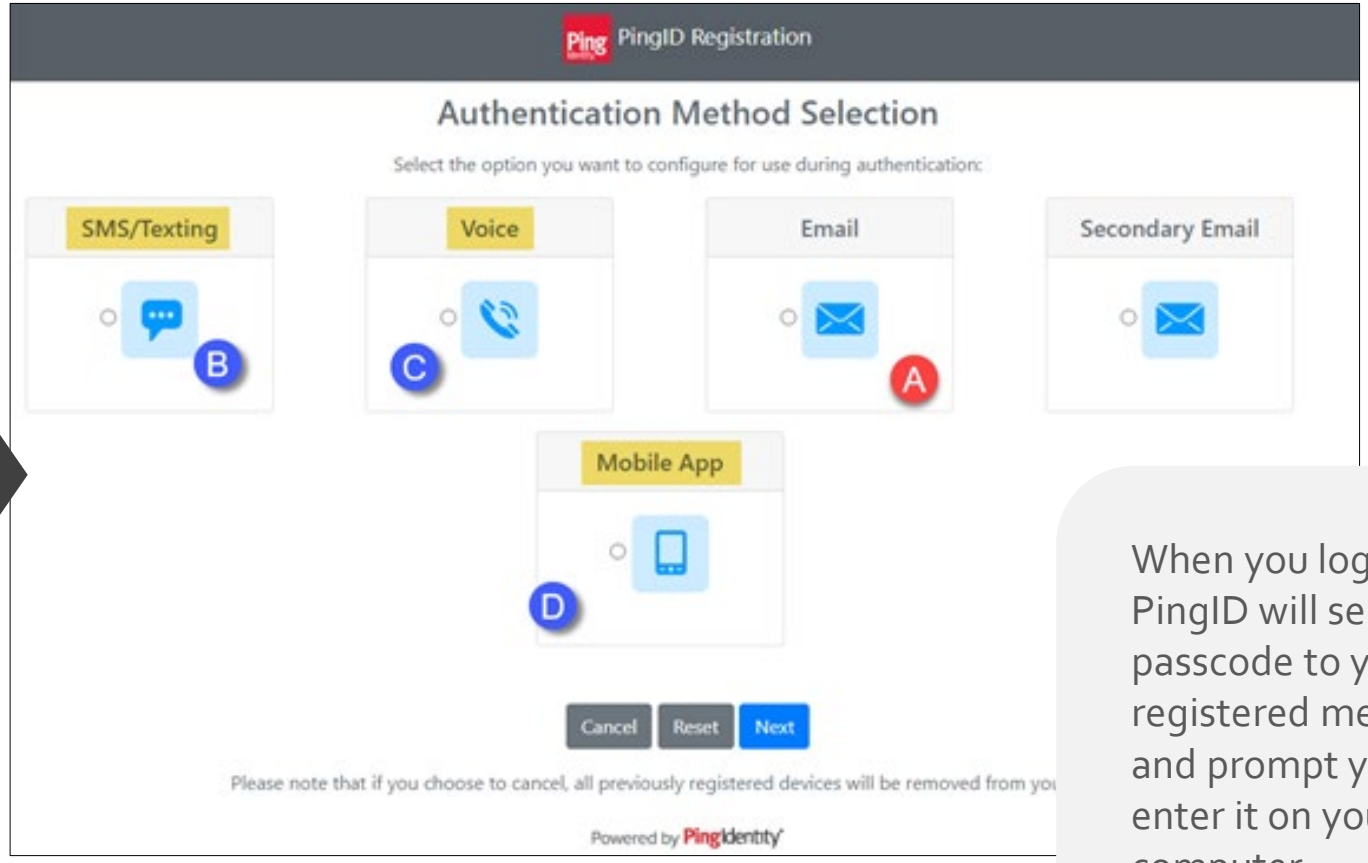
Phone: 1-800-716-2299, option 5
Monday – Friday 7:30 a.m. to 4 p.m.

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.

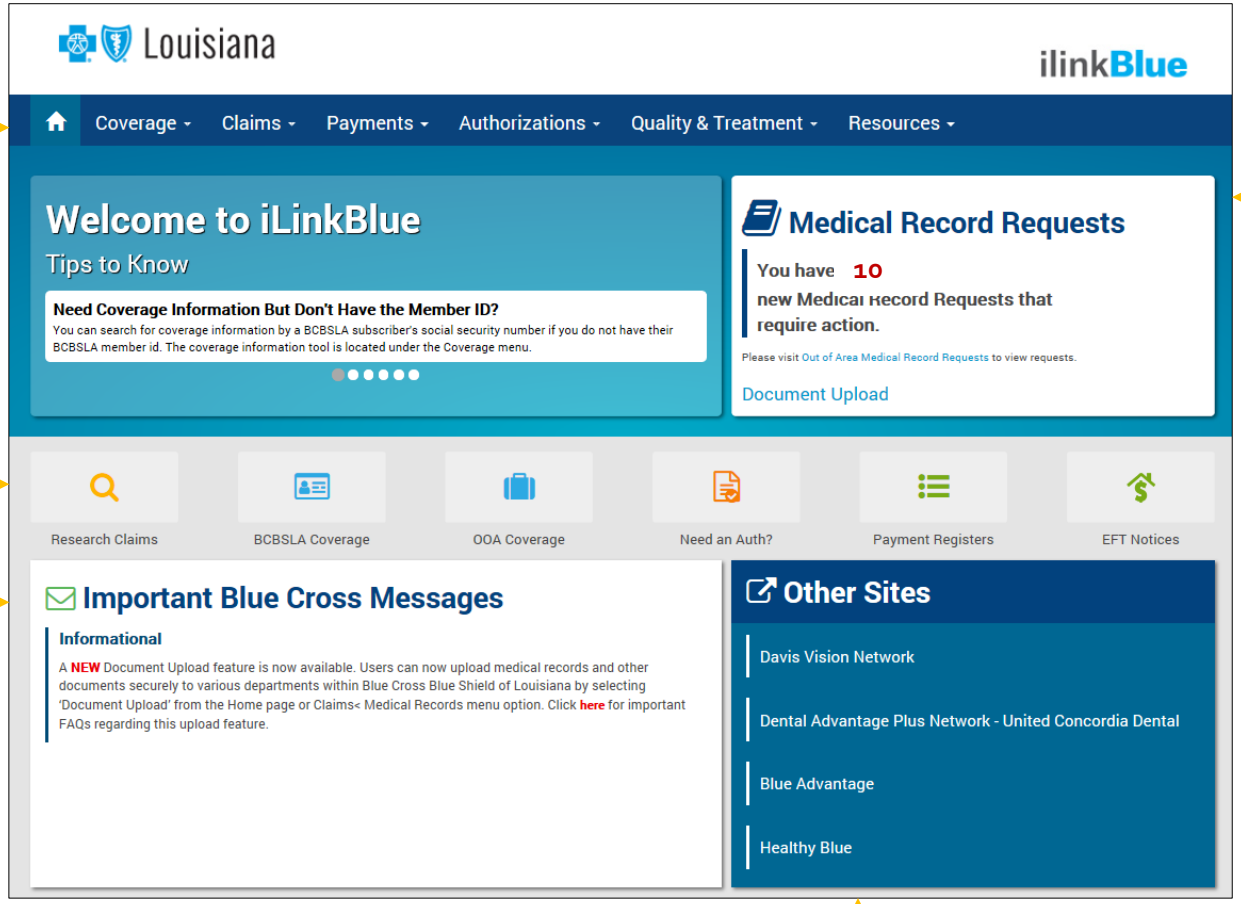


When you log in, PingID will send a passcode to your registered method and prompt you to enter it on your computer.

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.

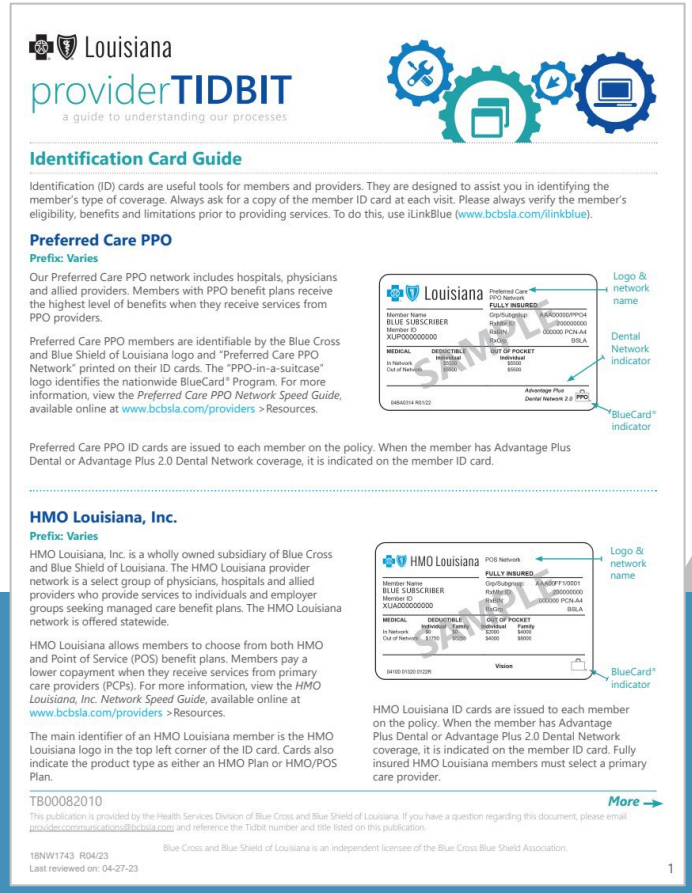
MEMBER BENEFITS

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 SAMPLE MEDICAL DEDUCTIBLE Individual $5000 Family $10000 In Network Out of Network OUT OF POCKET Individual $5000 $5000 Advantage Plus Dental Network 2.0 PPO

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 SAMPLE MEDICAL DEDUCTIBLE Individual $1750 Family $3500 In Network Out of Network OUT OF POCKET Individual $4000 Family $8000 Vision

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

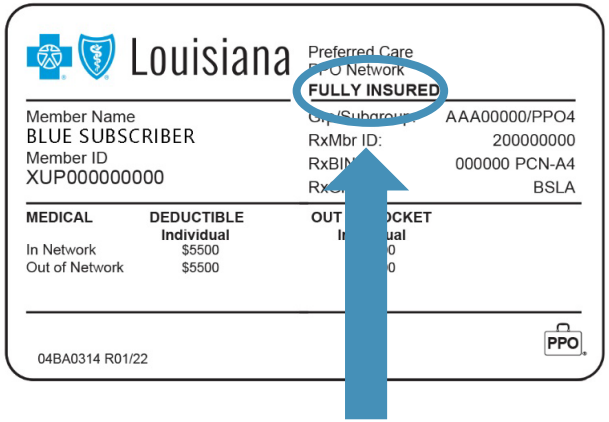
Last reviewed on: 04-27-23

1

Fully Insured & Self Funded

FULLY INSURED

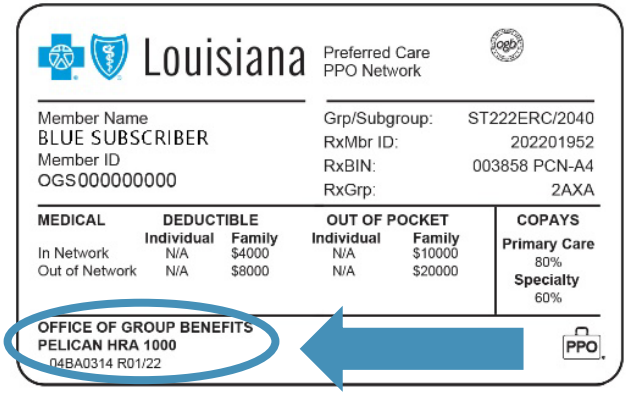
Group and individual policies issued by Blue Cross/HMOLA and claims are funded by Blue Cross/HMOLA.



"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

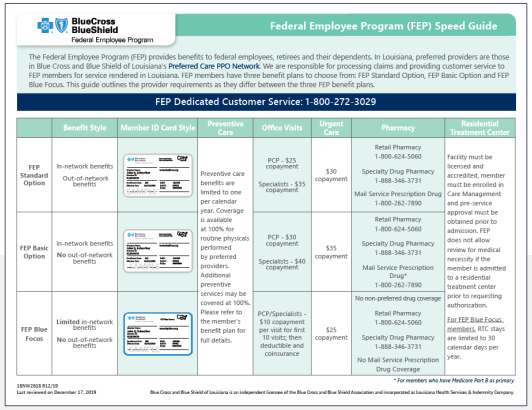
- ✓ In-network
- ✓ Out-of-network

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.

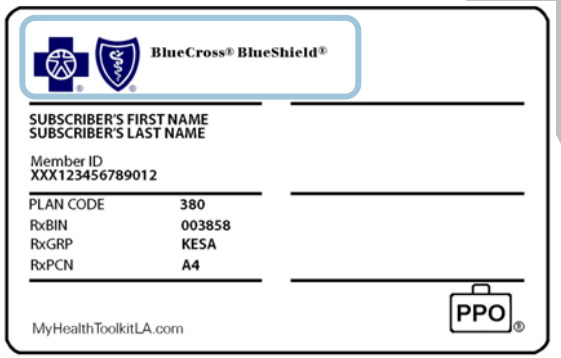
The empty suitcase indicates the member is enrolled in a Blue Plan traditional, HMO, POS or limited benefits product.

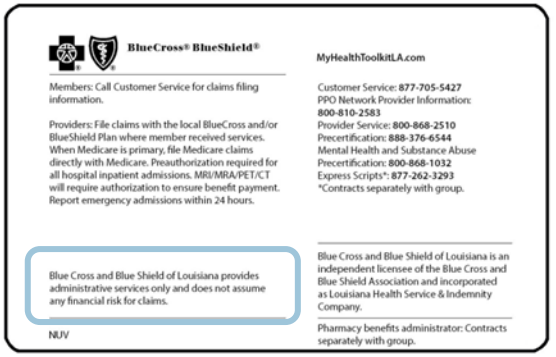
The HPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) product.

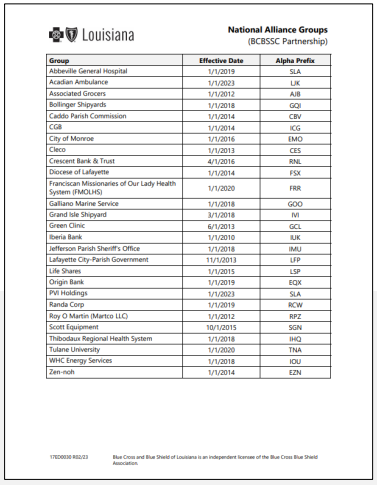
National Alliance Members

(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

17ED0030 R02/23

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

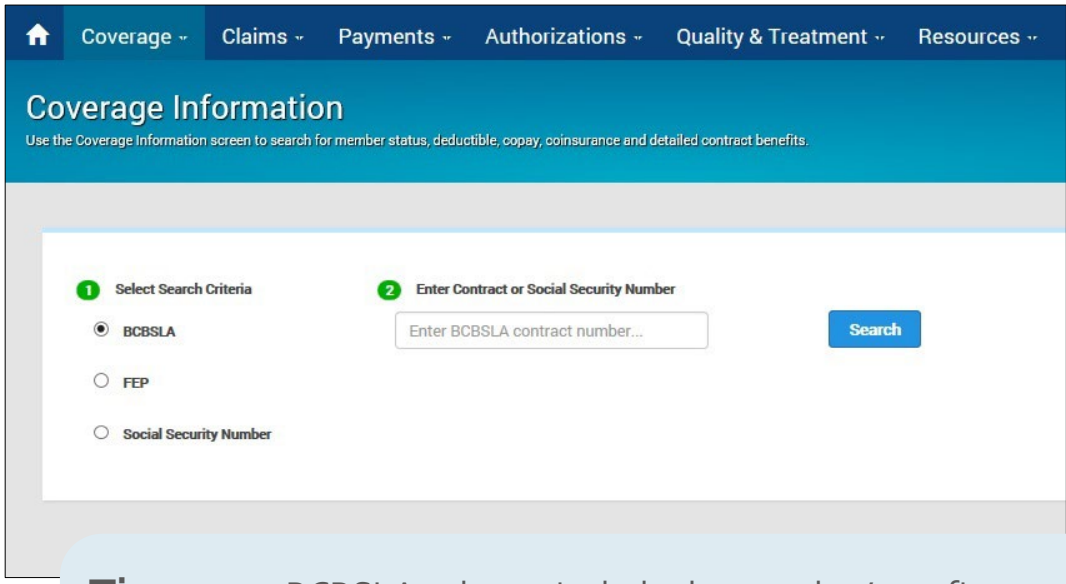
If a provider continues to refer patients to out-of-network providers, their entire fee schedule could be reduced.

Verifying Member Benefits in iLinkBlue

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

Choose the "Coverage" menu option. Enter them 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

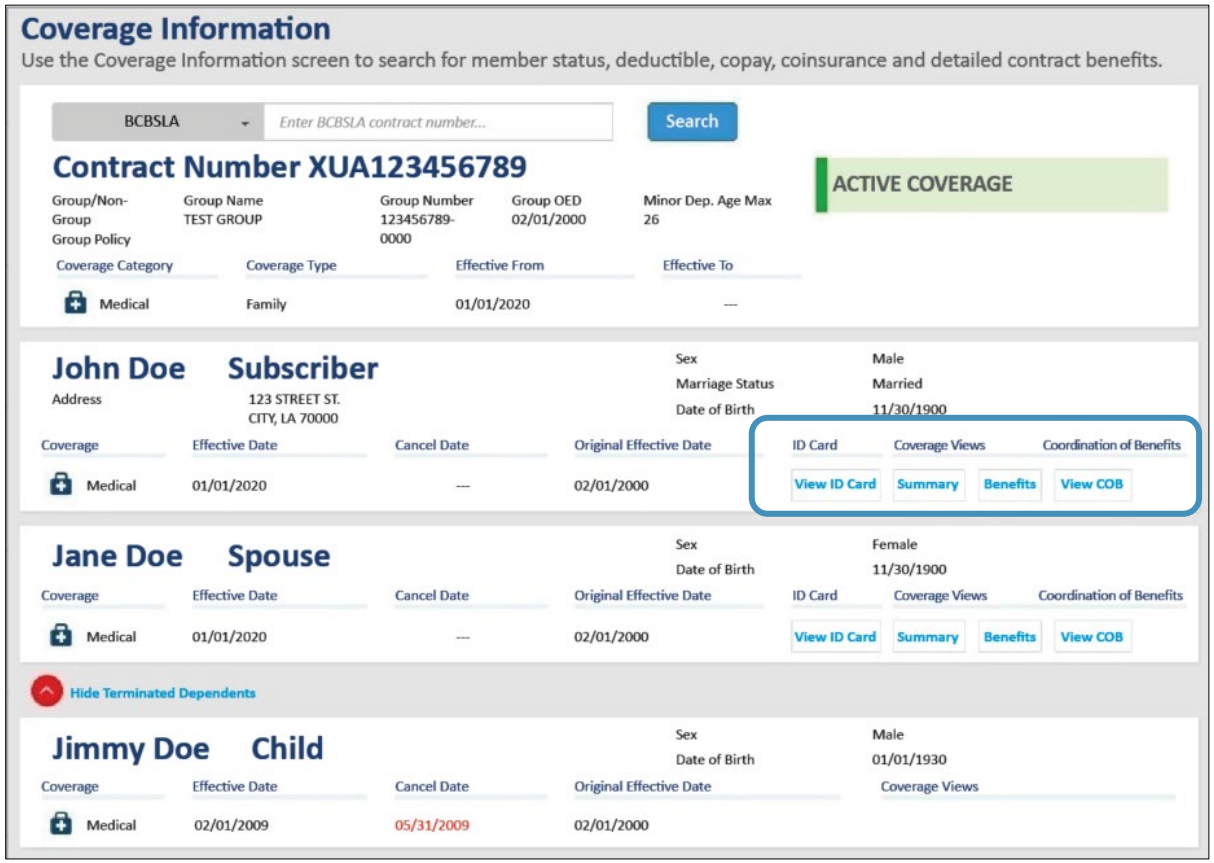
- BCBSLA – do not include the member's prefix.
- FEP – must include the letter "R"
- A different application is used for BlueCard (out-of-area) members

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.

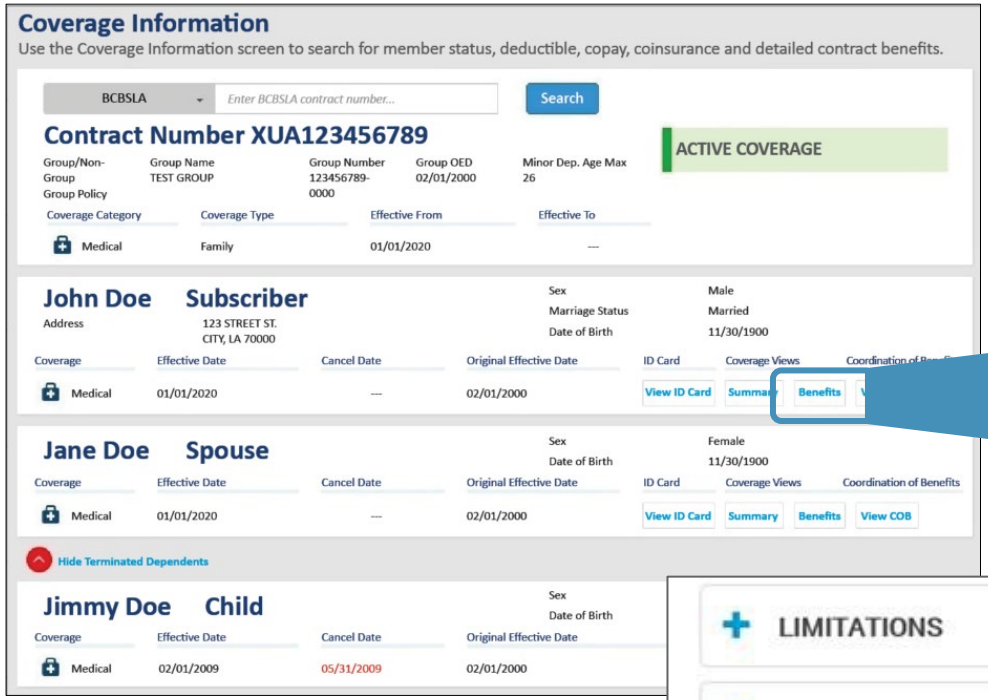
Coverage Information

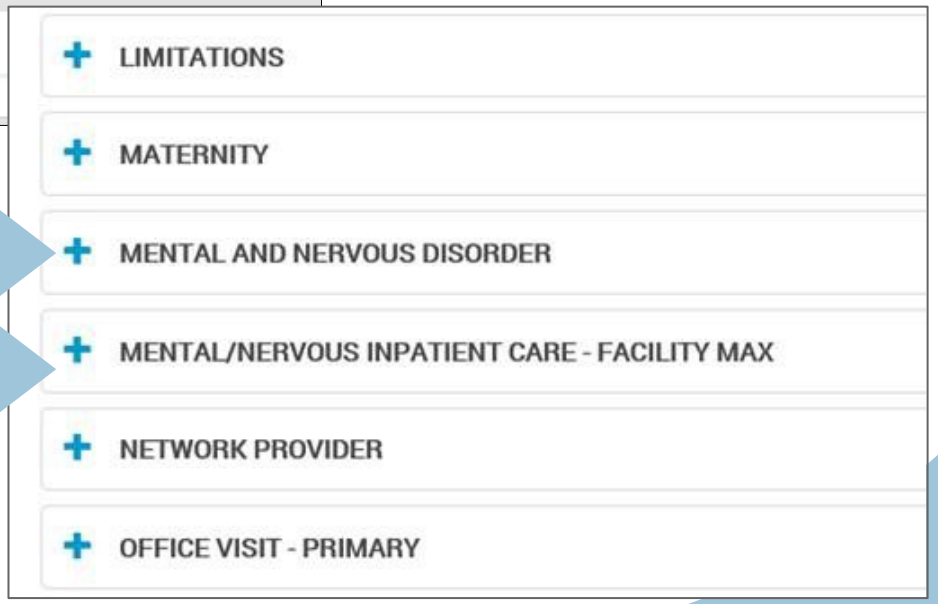
This screen identifies members covered on a policy, effective date and the status of the contract (active, pended, cancelled).

- 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.



Behavioral Health Benefits





Click on **Benefits** to open the list of services covered under the member's policy. Also be sure to verify limitations and exclusions, as benefits vary by policy.

Behavioral Health Benefits

Benefits for treatment of Mental Health are available. **Sample** benefits are below:

Network Providers:

- Physician Office Visits: $40 per visit
- Non-Physician Office Visits: $40 per visit
- Outpatient Services (includes OP facility and OP therapies not performed in office): 80%-20%
- Inpatient Hospital Admission: 80%-20%
- All other services are payable the same as medical benefits

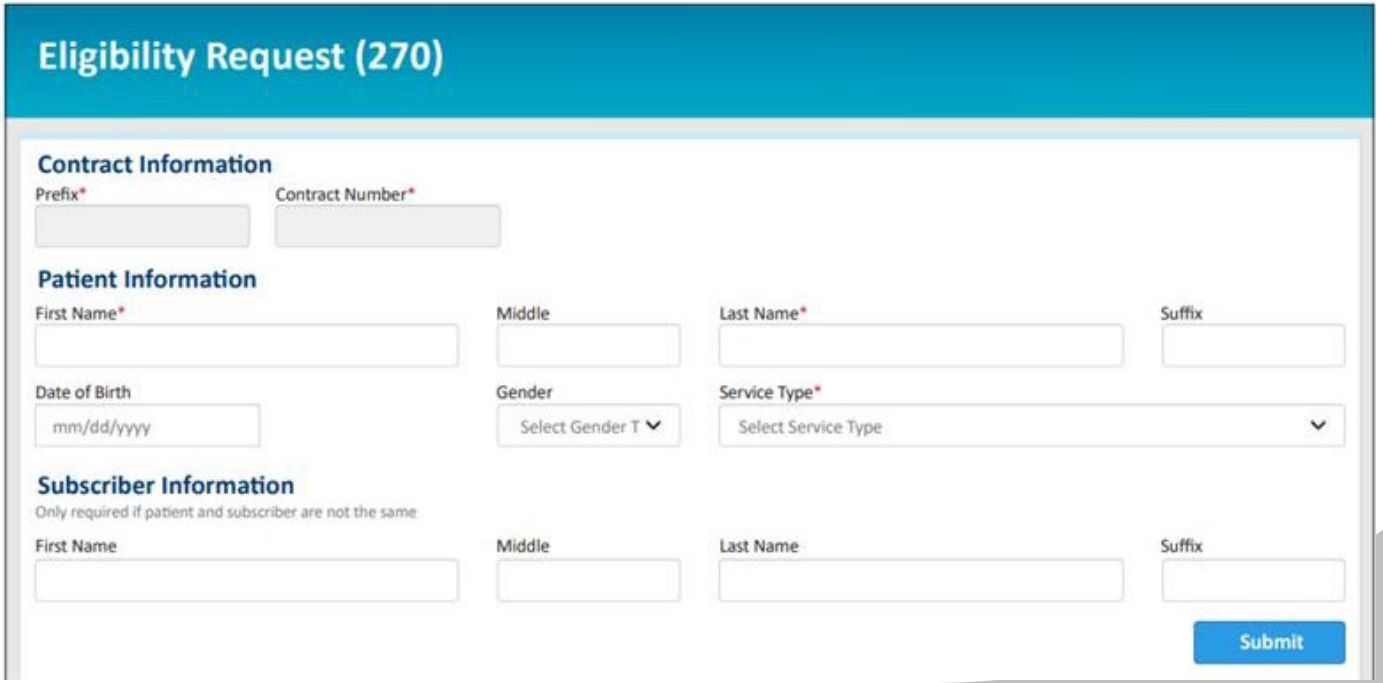
Non-Network Providers:

- Physician Office Visits: 60%-40%
- Non-Physician Office Visits: 60%-40%
- Outpatient Services (includes OP facility and OP therapies not performed in office): 60%-40%
- Inpatient Hospital Admission: 60%-40%
- All other services are payable the same as medical benefits

The first follow-up visit after discharge from inpatient facility for the treatment of a mental disorder is available at no cost when performed within 7 days of discharge by a network provider.

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).



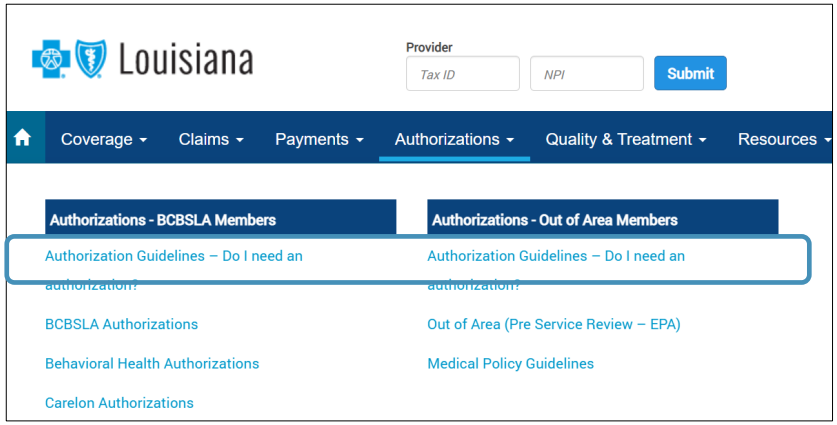
DO I NEED AN AUTH?

Behavioral Health Auth Requirements

Do I need an authorization?

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

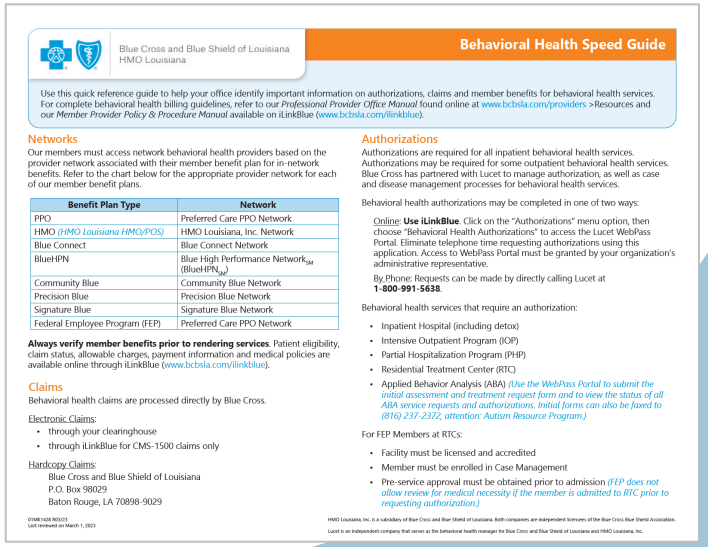
1 iLinkBlue's Authorization's Guidelines application



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 key 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.

FEP Requirements

The Federal Employee Program (FEP) Network requires prior authorization for admission to residential treatment centers (RTCs). FEP will not allow for a medical necessity review if a member is admitted to an RTC prior to an authorization request.

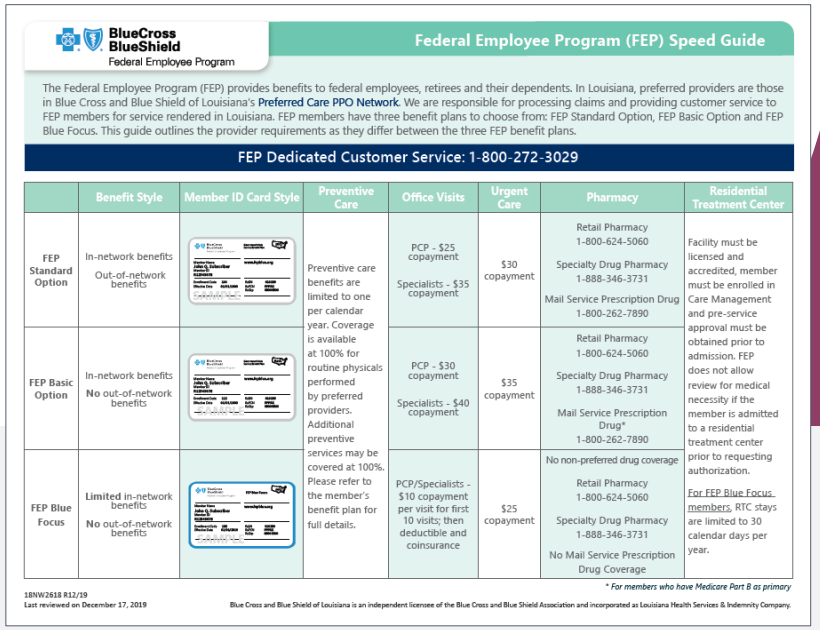
Additionally, members must be enrolled in care management through **Lucet**, before any authorization request is approved.

Please allow 72 hours to complete assessments. An authorization will not be approved before that assessment is complete.

Blue Cross' FEP speed guide is available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Failure to obtain prior authorization and/or enroll an FEP member in care management will result in an administrative denial.

Email **DL_Louisiana_CM@lucethealth.com** or call 1-800-762-2382 to request a care management assessment on behalf of a member.



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	

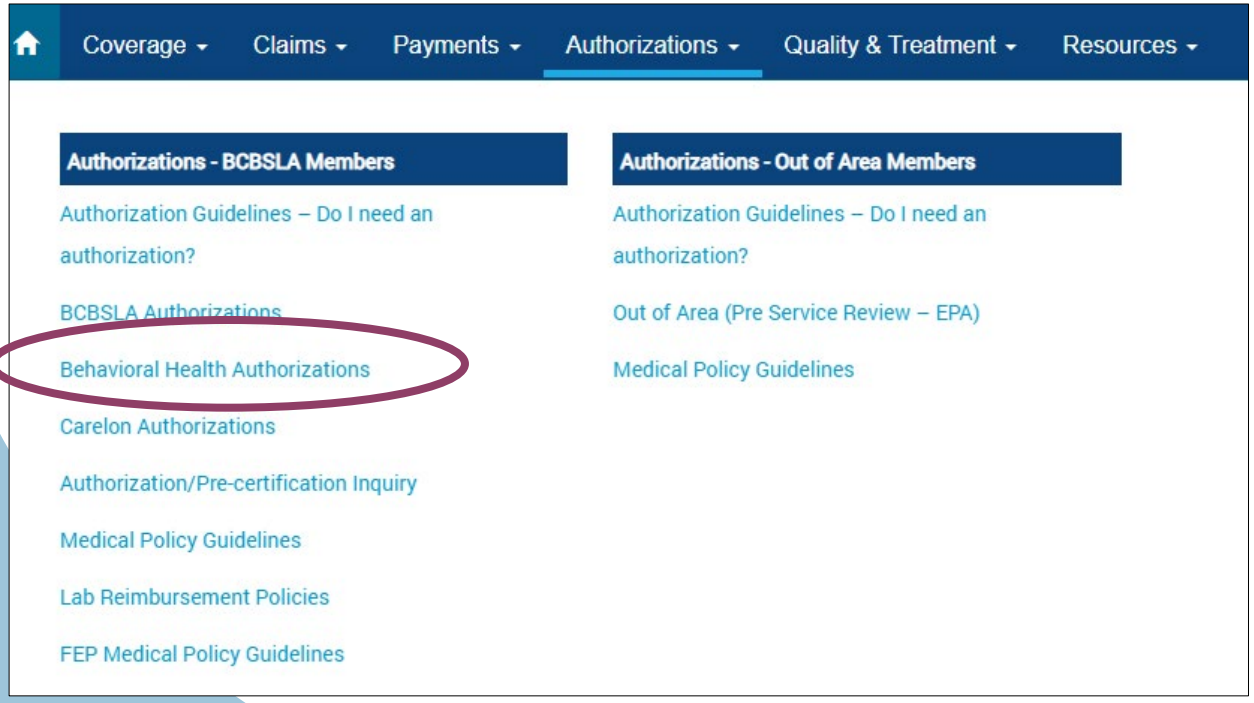
** For members who have Medicare Part B as primary*

18NW2618 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.

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**, requests can also be made directly to Lucet by calling 1-800-991-5638.

Lucet's Authorization Standards

- ✓ Lucet's UM team members are clinically licensed staff members.
- ✓ Lucet applies nationally recognized medical necessity criteria, including LOCUS, CALOCUS, ASAM and ECSII for all utilization determinations.
- ✓ In denial situations, a board-certified psychiatrist will make the final decision.
- ✓ Lucet looks at the least restrictive levels of care for each member's treatment focusing on appropriate utilization of behavioral health services to ensure quality and member safety.

The MNC criteria can be found at **https://lucethealth.com/providers/resources/mnc/**.

Be Specific on Authorization Requests

Include a Fax Number

A fax number for the Utilization Review (UR) department/treating practitioner allows Lucet to provide timely communication of adverse determinations for requests considered urgent.

Urgent Care Coverage Review Schedule

Submit continued stay and step-down reviews for Inpatient and Residential on the last authorized day. Lucet completes continued stay and step-down reviews for urgent care on the last covered day.

Diagnosis

Provide the most accurate diagnosis and make each update as reflected in the medical record.

Progress

Provide Clinical Institute Withdrawal Assessment (CIWA) scores, vitals and labs, as indicated. Include the most recent results and scores.

Medications

Medications must be updated in each submission.

Overdose on Prescribed Medications

Inpatient facilities are required to notify prescribing providers when a patient has attempted to overdose on their prescribed medications. Lucet tracks this information for HEDIS®.

Be Specific on Authorization Requests

Depression Screening

- It is expected that a depression screening will be conducted for substance use admissions.
- This is a yes/no question on WebPass.
- A depression screening does NOT have to be a formalized tool like the Beck Depression Inventory (BDI) or the Patient Health Questionnaire (PHQ-9). It can simply be a licensed clinician or MD assessing their patient for depression via their clinical interview or history and physical.
- Lucet tracks this information for HEDIS®.

Medication Assisted Treatment (MAT)

- When MAT is clinically indicated for someone in substance use treatment, it is imperative that the facility discuss the options and benefits to the patient.
- If MAT is not going to be prescribed, it needs to be documented why.
- If MAT is prescribed, please provide which MAT the patient is taking.
- Also ensure the patient will be able to continue this treatment once discharged.
    - Which prescriber will they see to continue it?
    - Is it covered under their insurance?

Be Specific on Authorization Requests

Timely submissions

For members in inpatient and residential, please submit continued stay and step-down review requests prior to 12:30 p.m. CT. Reviews should be submitted on the last covered day. This allows Lucet to provide a timely and complete review of information, which may require consultation or coordination with the treatment team and other sources of support for the members.

Continued stay requests

Updated clinical information is required to reflect member's most current status and progress on measurable goals, as listed on the member's individualized treatment plan.

Discharge plan

Please ensure that established outpatient providers are listed on the initial request and referrals, or appointment detail is updated at each review as discharge plans are developed.

Forms

Please submit all needed forms, including releases of information, and consent for referral to other providers to coordinate care.

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

Letter is sent to member and provider letting them know denial was overturned and processing instructions are communicated to Blue Cross to pay claim.

Decision to Uphold Denial

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

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.

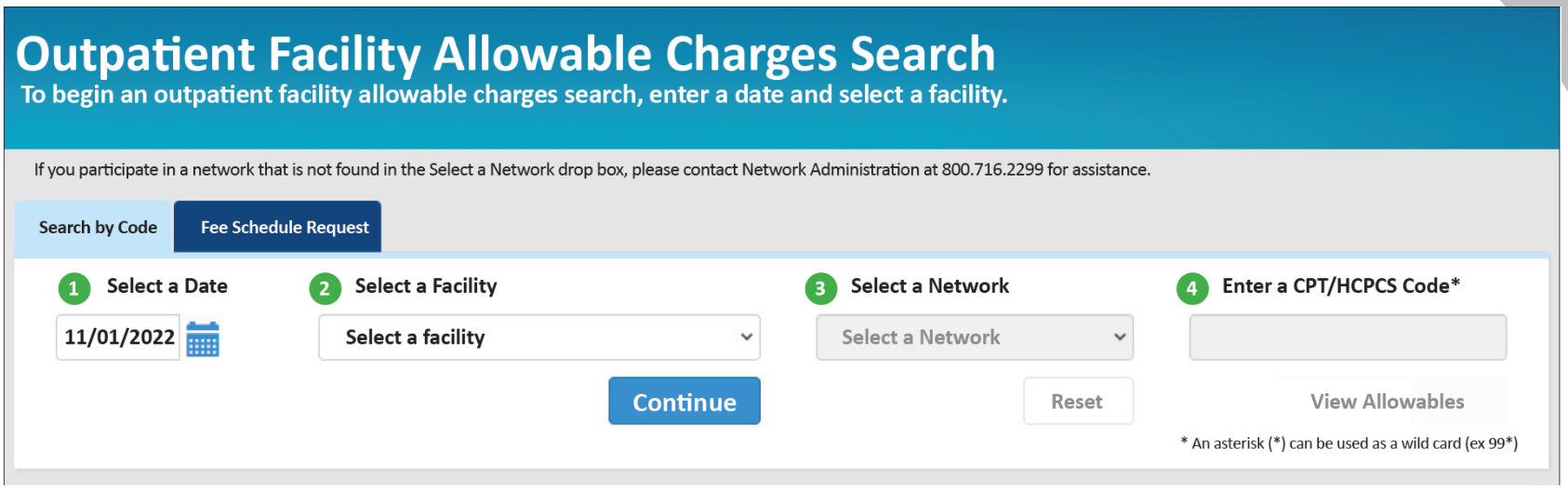
FILING CLAIMS

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.

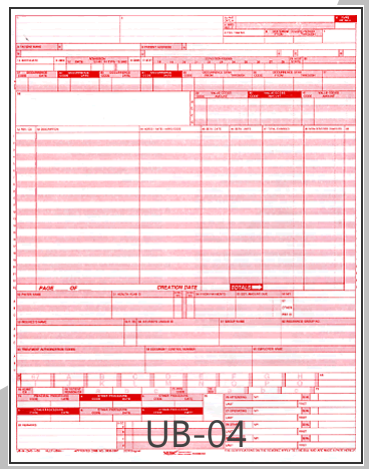
For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue, BlueHPN, Signature Blue, OGB and BlueCard Claims:

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



IOP and PHP Billing Instructions

When filing a UB-04 claim for IOP/PHP services the following combination of HCPCS/revenue codes are appropriate to ensure accurate reimbursement per your provider contract.

The combination you use will be determines based on the primary reason the member is receiving IOP/PHP services:

Level of Care	Type of Service	Revenue Code	Required HCPCS Code (with short description)*	Service Units
IOP	Psychiatric	905	S9480: intensive outpatient psychiatric services, per diem	1
IOP	Chemical Dependency	906	H0015: alcohol and/or drug services; intensive outpatient treatment	1
PHP	Chemical Dependency or Psychiatric	912	H0035: mental health partial hospitalization treatment less than 24 hours	1
PHP	Chemical Dependency or Psychiatric	913	H0035:mental health partial hospitalization treatment less than 24 hours	1

**Please refer to the most current HCPCS books for complete descriptions.*

When the UB-04 Statement Cover Period, Block 6,is longer than one day, each date of service should be billed on a separate claim line and include Revenue Code, HCPCS, service unit of one and Total charges, Blocks 42-47.

As outlined in your provider agreement, billed services that are not defined in your IOP or PHP network agreement are not separately payable.

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

Institutional Claims Report

SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME H12345

BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE

BC ID# 12345

RECEIVE DATE: 07-24-23 PROCESSING DATE: 07-24-23

837I ACCEPTED REPORT

PAGE 8

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST	BC CONTRACT NM NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	CH TRACKING NUMBER
00000000	LAST NAME	FIRST	OGS000000000	071919	071919	1991.96	1234567890123456789

PROVIDER BC ID# 12345 837I SUMMARY:

837I TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $1991.96

837I TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0

837I TOTAL CLAIMS: 1 CLAIMS FOR $1991.96

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.

Not Accepted Report Example

Blue Cross and Blue Shield of Louisiana

837 Accepted / Not Accepted / Warning Report

Institutional Claims Report

SUBMITTER NUMBER: P0001234 SUBMITTER: SENDER NAME HERE

BC REG# 7200000000 NPI#1234567890 PROVIDER: PROVIDER NAME HERE

BC ID# 12345

RECEIVE DATE: 07-24-23 PROCESSING DATE: 07-24-23

837I NOT ACCEPTED REPORT PAGE 25

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	CLAIM AMOUNT	ERROR DESCRIPTION	ERROR DATA
1234567	DOE	121212121212121	XUP000000000	062919	070619	157323.24	PAT LAST NAME NOT ON BC FILE	DOE

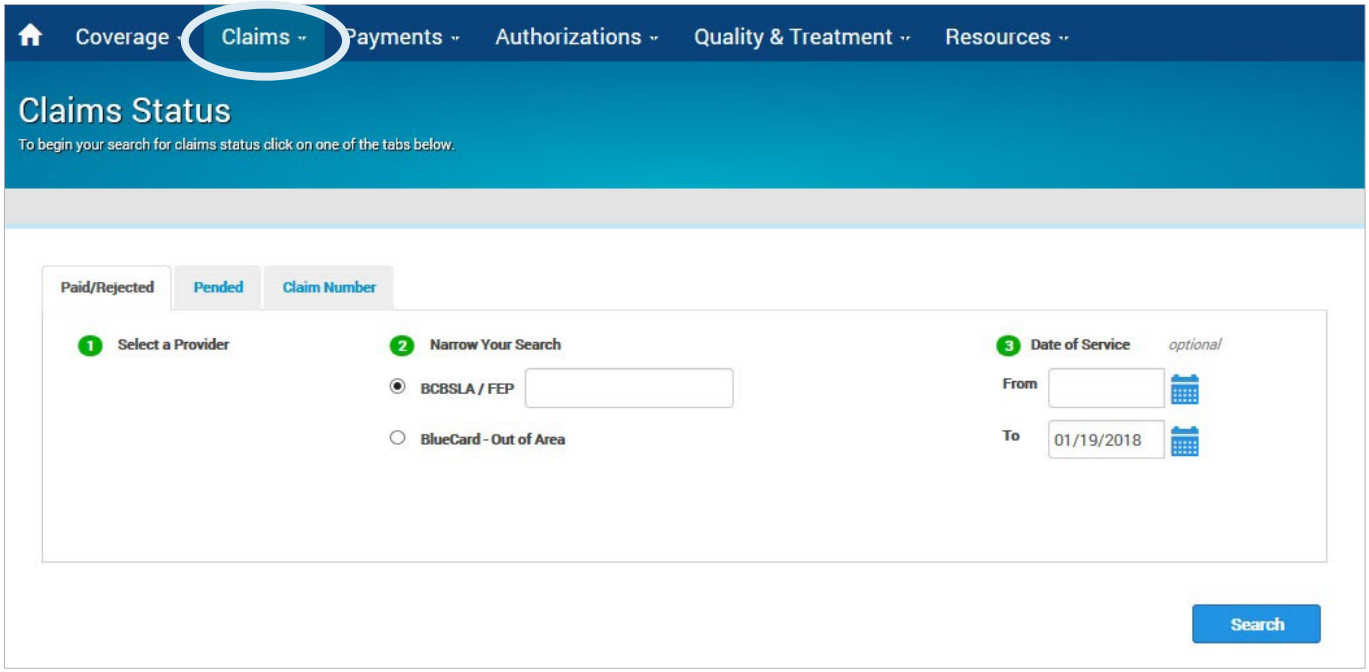
PROVIDER BC ID# 12345 837I SUMMARY:

837I TOTAL CLAIMS ACCEPTED: 28 CLAIMS FOR $185282.36

837I TOTAL CLAIMS NOT ACCEPTED: 1 CLAIMS FOR $157323.24

837I TOTAL CLAIMS: 29 CLAIMS FOR $342605.60

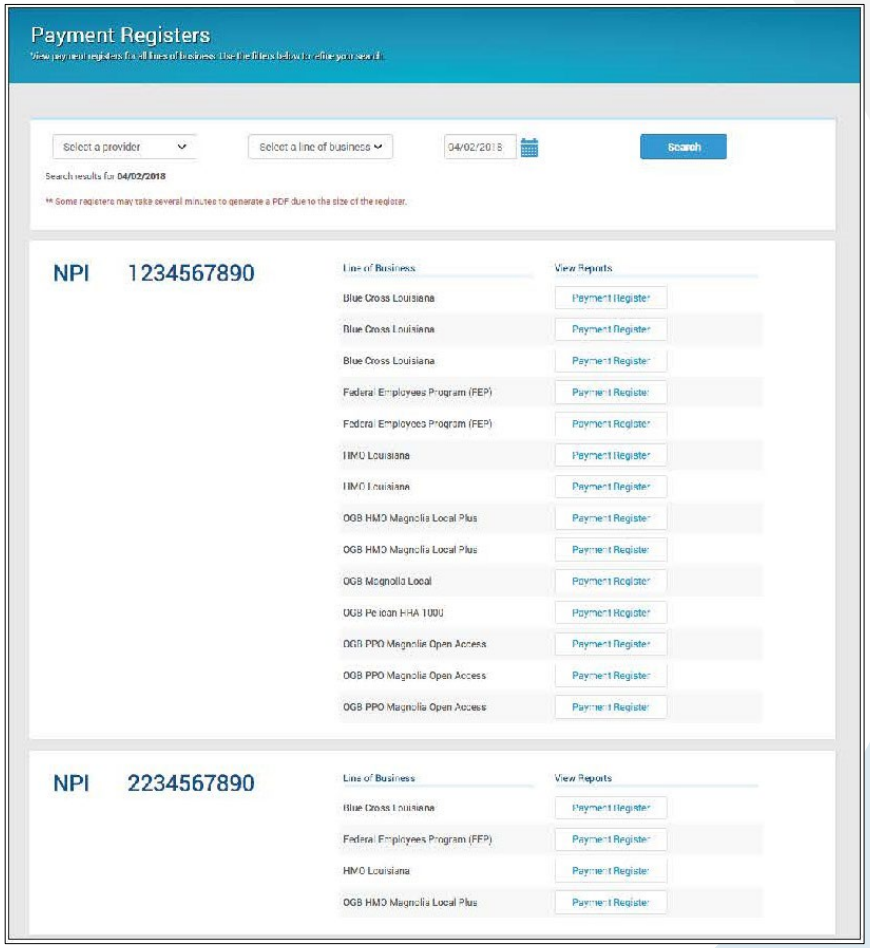
Claims Research



- 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.



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.

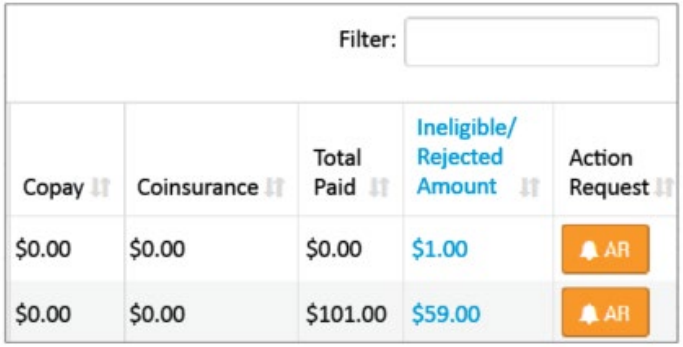
Common reasons to submit an Action Request

- 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

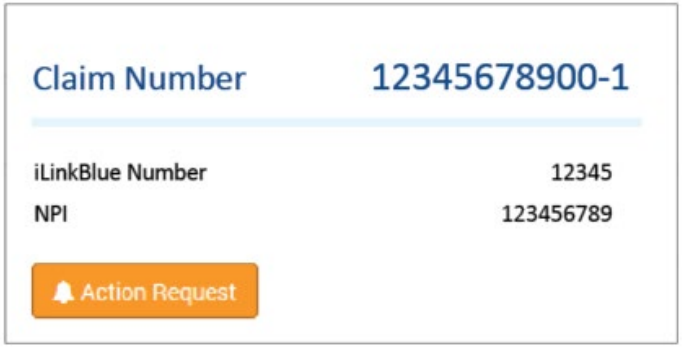
In iLinkBlue, on each claim, there is an **Action Request** button. It opens an electronic form that prepopulates with information on the specific claim. There are multiple places within iLinkBlue that include the action request buttons.



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

and

on the **Pended Claims Results** screen

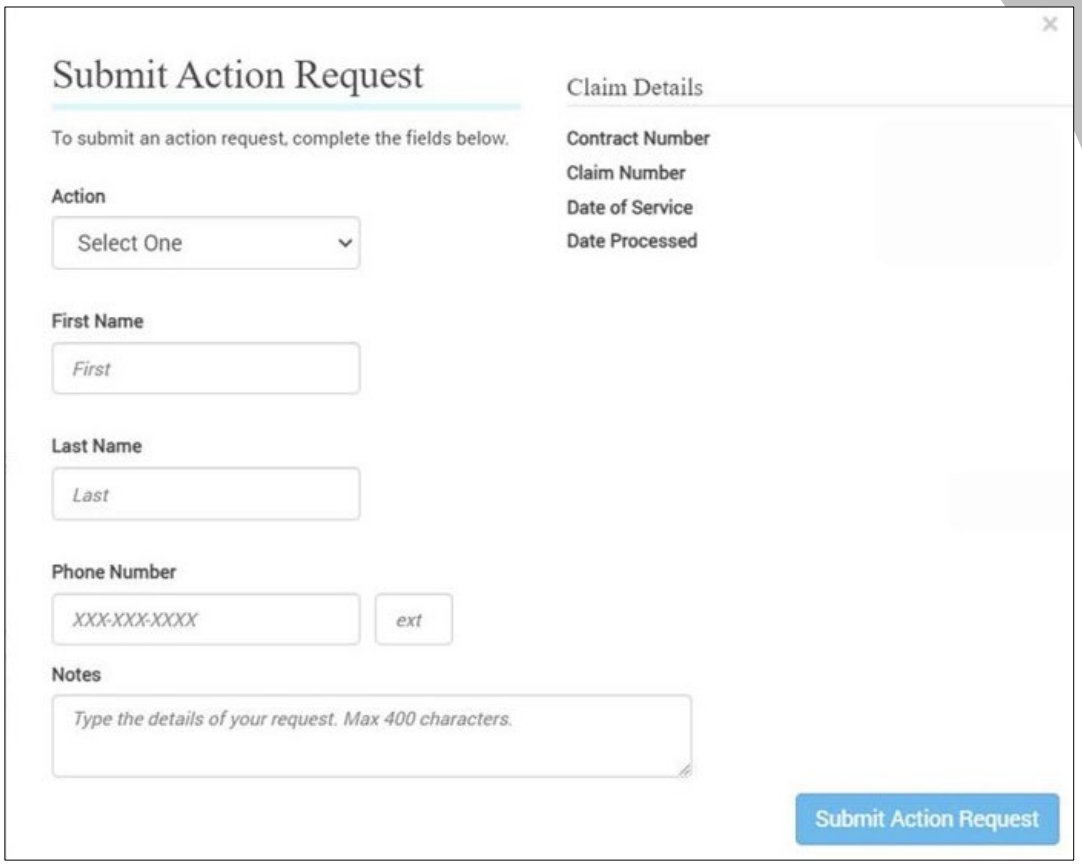


on the **Claims Detail** screen

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

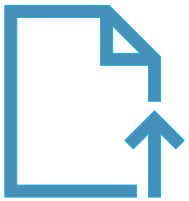


As a second step to **submitting an Action Request,** if you did not get a resolution, you may also contact the **Customer Care Center** using the number on the back of the patient's member ID card.

How Do I Correct or Void a Claim?

For facility 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) 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?

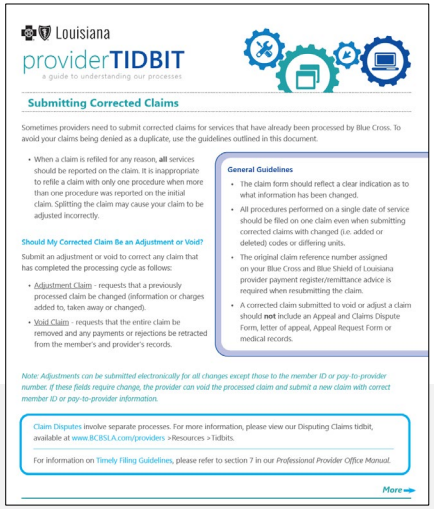
For facility claims submitted hardcopy:

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 UB-04 can be changed:

- Adjust Claim – In Block 4, enter "7" for a claim adjustment (information or charges added to, taken away or changed).
- Void Claim – In Block 4, 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 64, enter the original claim reference number.



Louisiana
providerTIDBIT
a guide to understanding our processes

Submitting Corrected Claims

Sometimes providers need to submit corrected claims for services that have already been processed by Blue Cross. To avoid your claims being denied as a duplicate, use the guidelines outlined in this document.

- When a claim is refiled for any reason, **all** services should be reported on the claim. It is inappropriate to refile a claim with only one procedure when more than one procedure was reported on the initial claim. Splitting the claim may cause your claim to be adjusted incorrectly.

Should My Corrected Claim Be an Adjustment or Void?

Submit an adjustment or void to correct any claim that has completed the processing cycle as follows:

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

General Guidelines

- The claim form should reflect a clear indication as to what information has been changed.
- All procedures performed on a single date of service should be filed on one claim even when submitting corrected claims with changed (i.e. added or deleted) codes or differing units.
- The original claim reference number assigned on your Blue Cross and Blue Shield of Louisiana provider payment register/remittance advice is required when resubmitting the claim.
- A corrected claim submitted to void or adjust a claim should **not** include an Appeal and Claims Dispute Form, letter of appeal, Appeal Request Form or medical records.

Note: Adjustments can be submitted electronically for all changes except those to the member ID or pay-to-provider number. If these fields require change, the provider can void the processed claim and submit a new claim with correct member ID or pay-to-provider information.

Claim Disputes involve separate processes. For more information, please view our Disputing Claims tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

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

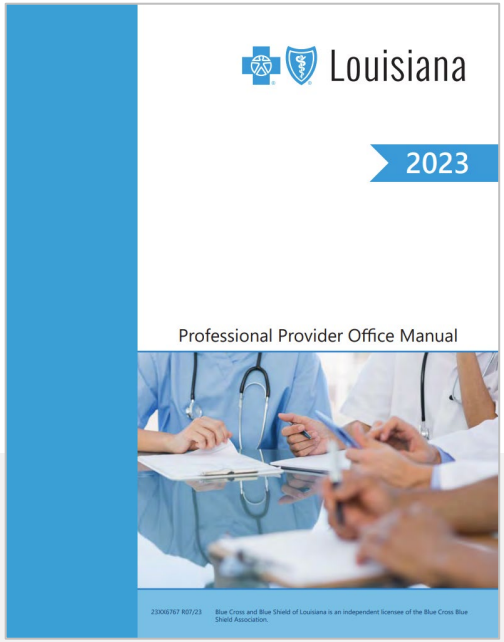
More

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

IOP & PHP Telehealth

Providers should adhere to the following guidelines for delivering intensive outpatient program (IOP) services via telehealth.

- The following criteria apply for IOP services:
  - Provider must operate within the scope of its license to deliver IOP services through telehealth encounters.
  - Provider must accept Blue Cross' allowable charges.
  - The telehealth visit must be fully documented in the patient's medical record.
  - Services must be provided using a non-public-facing platform for telehealth services that is either HIPAA-compliant or approved by the Health and Human Services Office of Civil Rights.

IOP & PHP Telehealth

- Billing guidelines for telehealth IOP services:
  - Blue Cross will allow reimbursement for up to three hours per day; three days per week; for a maximum of nine hours per week.
  - Providers filing outpatient hospital claims for IOP telehealth services should bill with the appropriate CPT®/HCPCS code, along with Modifier GT or 95. IOP providers must continue to follow the IOP guidelines outlined in Section 5.6 Behavioral Health of the *Member Provider Policy & Procedure Manual,* available on iLinkBlue (**www.bcbsla.com/ilinkblue**) under the Resources section.
- PHP Services
  - Blue Cross will not reimburse partial hospitalization program (PHP) telehealth encounters (revenue codes 0912 and 0913) due to the complexity of services. PHP services are typically six hours in length and must essentially be the same nature and intensity (including medical and nursing) as would be provided in a hospital, except that the patient is in the program less than 24 hours per day.

OTHER BILLING GUIDELINES

Taxonomy Codes

If you file multiple specialties under your NPI number, it is very important to also include the appropriate taxonomy code that clearly identifies the specialty.

You must file the code for the services on the authorization from Lucet.

Example: A facility that has two specialties with same Tax ID and NPI (e.g., acute and psych) must use a taxonomy code on **all** claims to identify the specialty.

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

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™

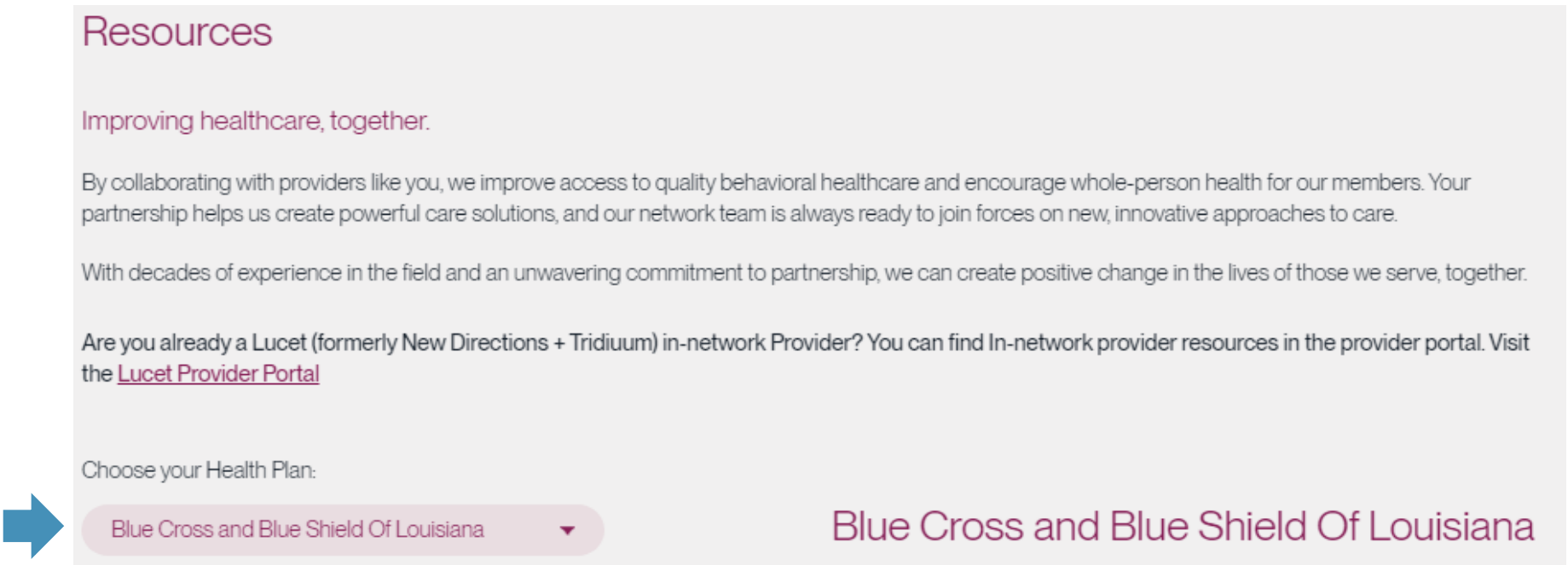
ONLINE RESOURCES & TOOLKITS

Online Provider Resources

www.lucethealth.com

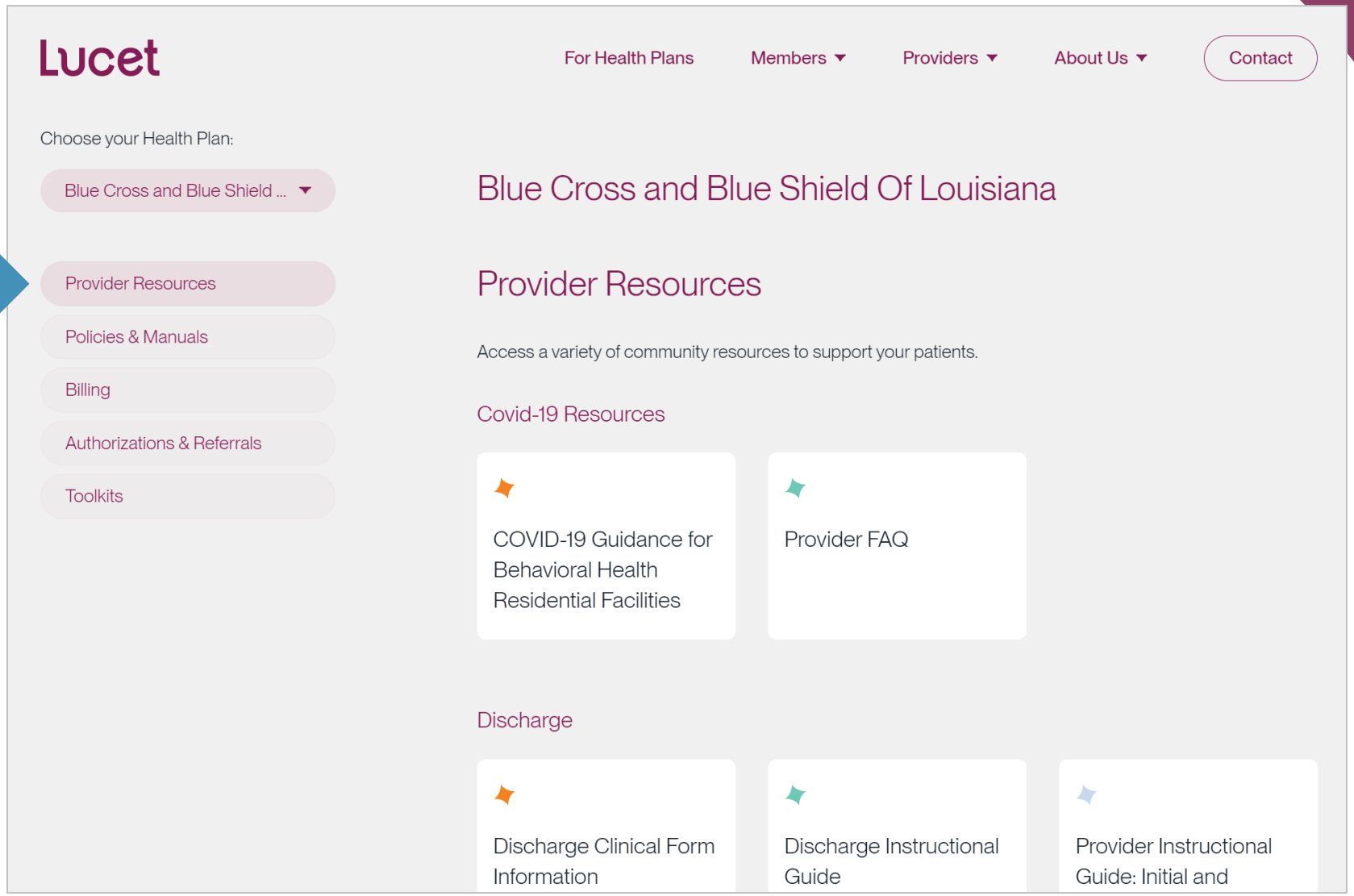
Choose "Providers," then "**Out of Network**" and "**Choose your Health Plan**" as **Blue Cross and Blue Shield of Louisiana**.

Note: "Out-of-network" simply indicates resources for non-Lucet providers.



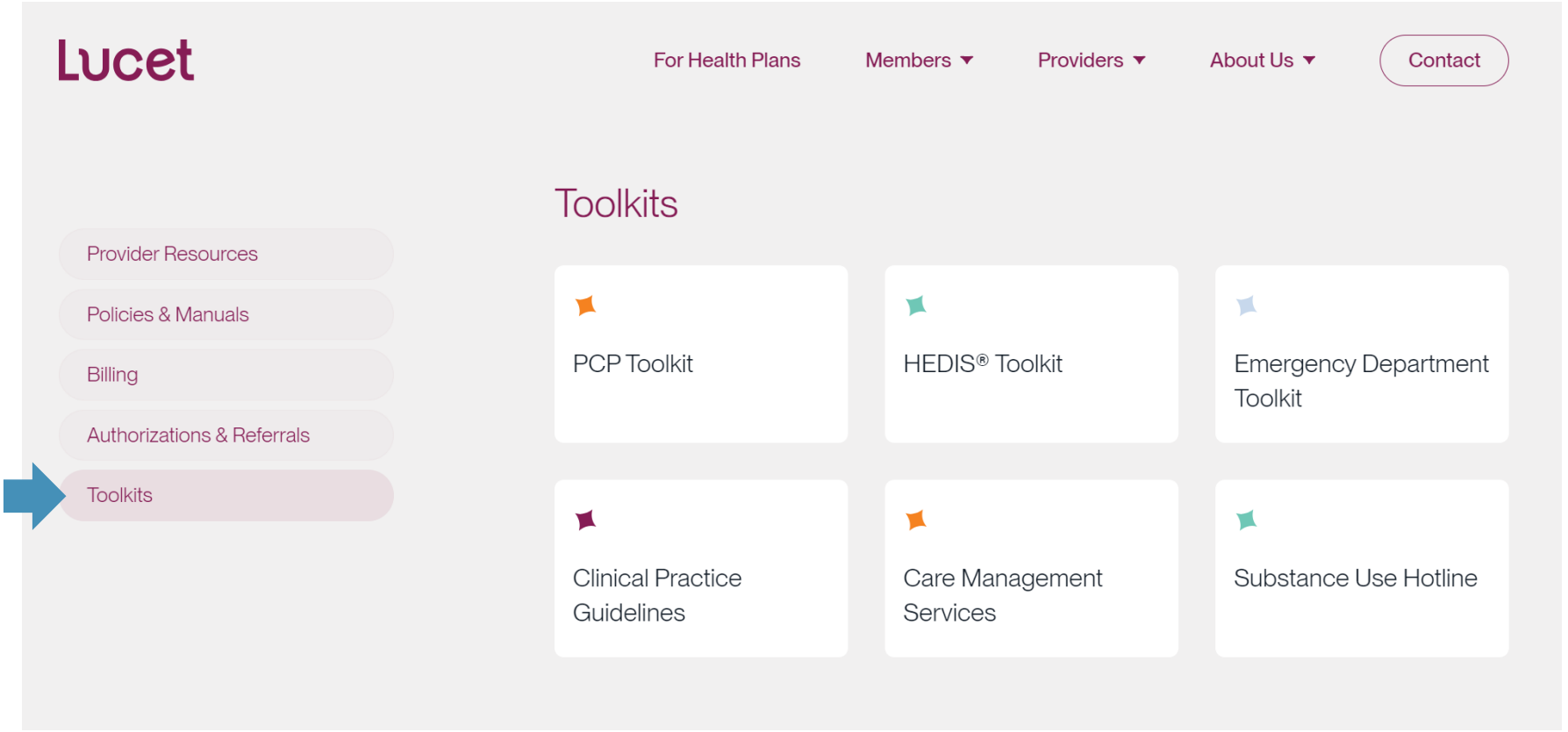
https://lucethealth.com/providers/outside-network/

Online Provider Resources



https://lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana/#resources

Online Provider Toolkits



https://lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana/#resources

PCP TOOLKIT

- SUICIDE TOOLKIT
- TRAUMA / PTSD TOOLKIT
- SUBSTANCE USE DISORDER TOOLKIT

- SUICIDE TOOLKIT

September is Suicide Awareness Month

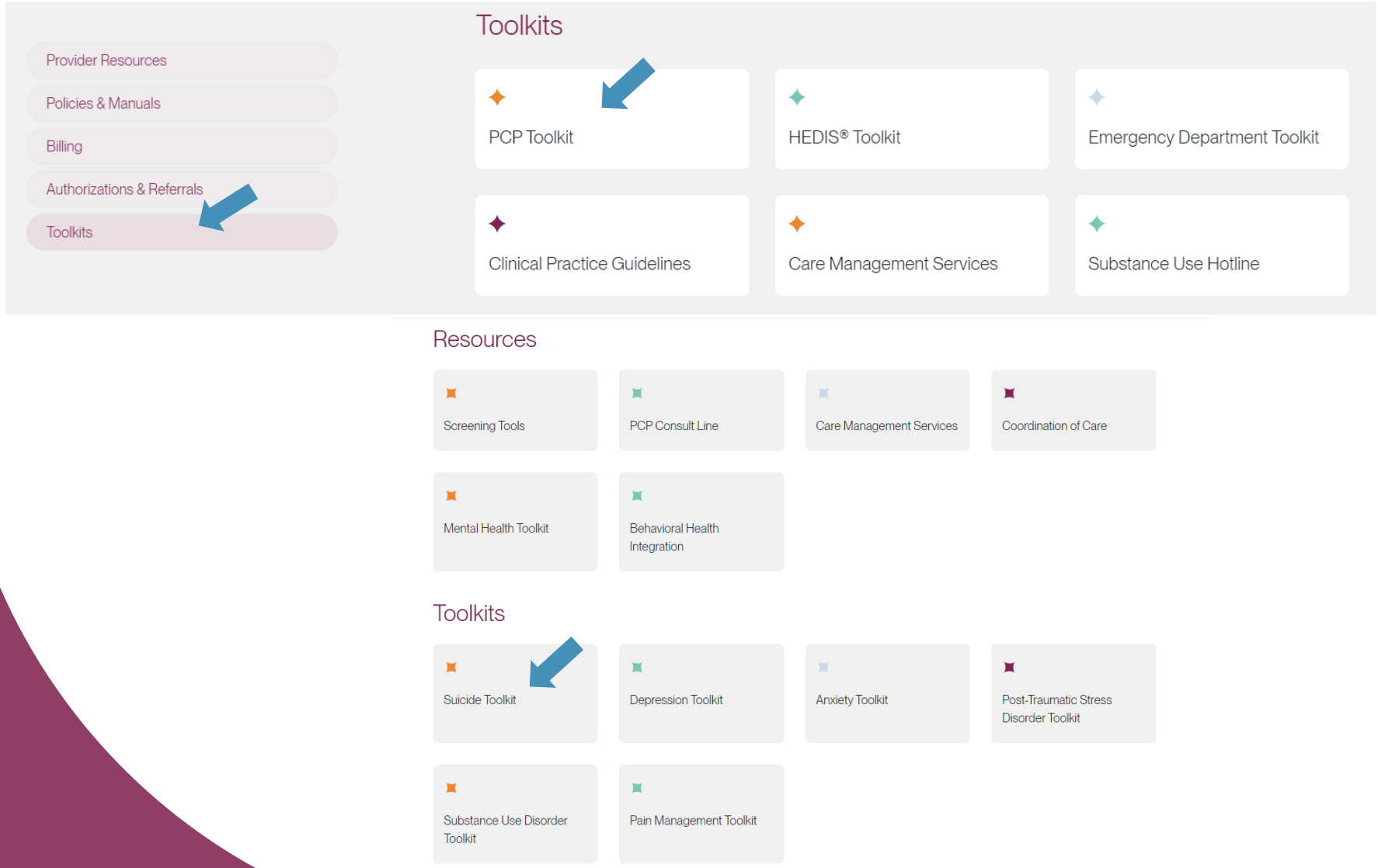
The prevalence of suicide deaths in the U.S. is alarming, but together we can create positive change. September is National Suicide Prevention & Awareness Month — help us spread the facts about suicide and educate others on how we can help those who may be struggling. You can print, distribute or share via social media the materials in this toolkit during September and all year long. You just might save a life.

Articles

- September is National Suicide Prevention & Awareness Month
- Young People & Suicide, Ways to Help
- Preventing Suicide LGBTQIA+
- Guns' Hidden Victims
- Suicide & It's Survivor

https://lucethealth.com/members/resources/suicide-awareness-toolkit

Suicide Toolkit



https:// lucethealth.com/providers/resources/pcp/suicide-toolkit

Suicide Toolkit

Lucet can help you when you or one of your staff identifies that a patient exhibits warning signs for suicide. The tools below can help you develop and implement a suicide prevention strategy for your organization and support the patient in accessing needed interventions.

Screening Tools

- Ask Suicide-Screening Questions (ASQ) Toolkit
- Columbia-Suicide Severity Rating Scale (C-SSRS)

Additional Screening Tools

Provider Resources

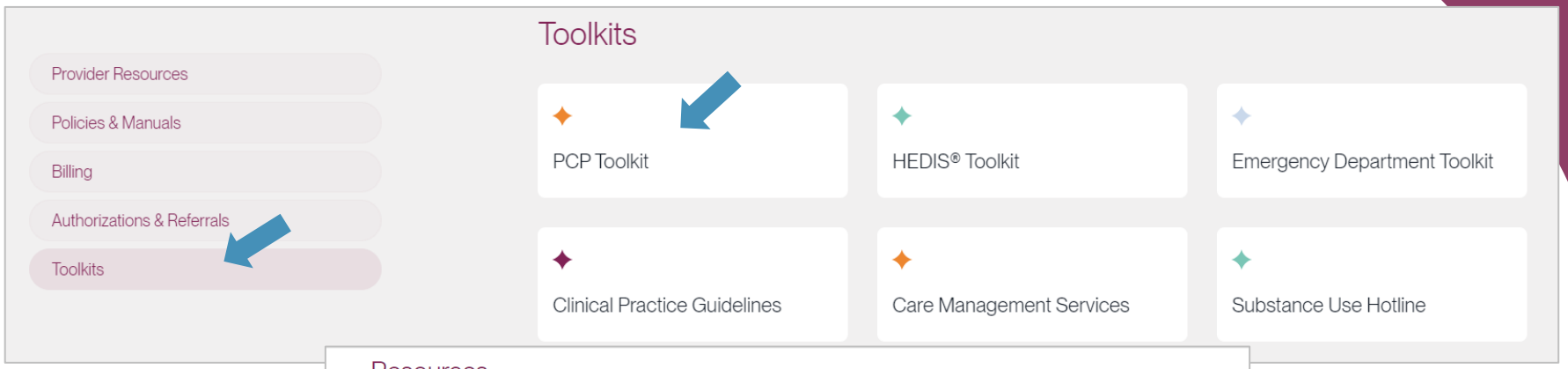
- SAMHSA – Suicide Prevention in Primary Care
- Suicide Prevention Toolkit for Primary Care Practices
- Zero Suicide
- Lucet Depression Toolkit

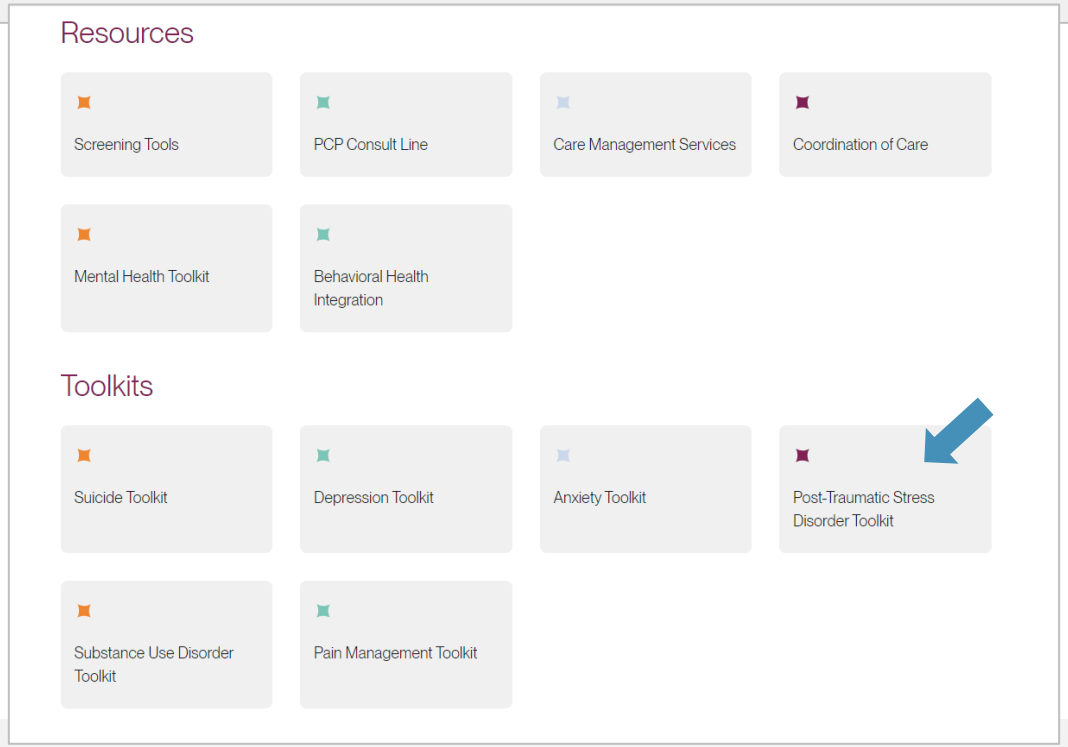
Additional Educational Articles

https://lucethealth.com/providers/resources/pcp/suicide-toolkit

- TRAUMA / PTSD TOOLKIT

PTSD Toolkit





https://lucethealth.com/providers/resources/pcp/post-traumatic-stress-disorder-toolkit

PTSD Toolkit

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

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

Screening Tools

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

Additional Screening Tools

Provider Resources

- U.S. Department of Veteran Affairs: PTSD
- Posttraumatic Stress Disorder (PTSD)
- American Academy of Pediatrics: Trauma Toolbox for Primary Care

Additional Educational Articles

https://lucethealth.com/providers/resources/pcp/post-traumatic-stress-disorder-toolkit

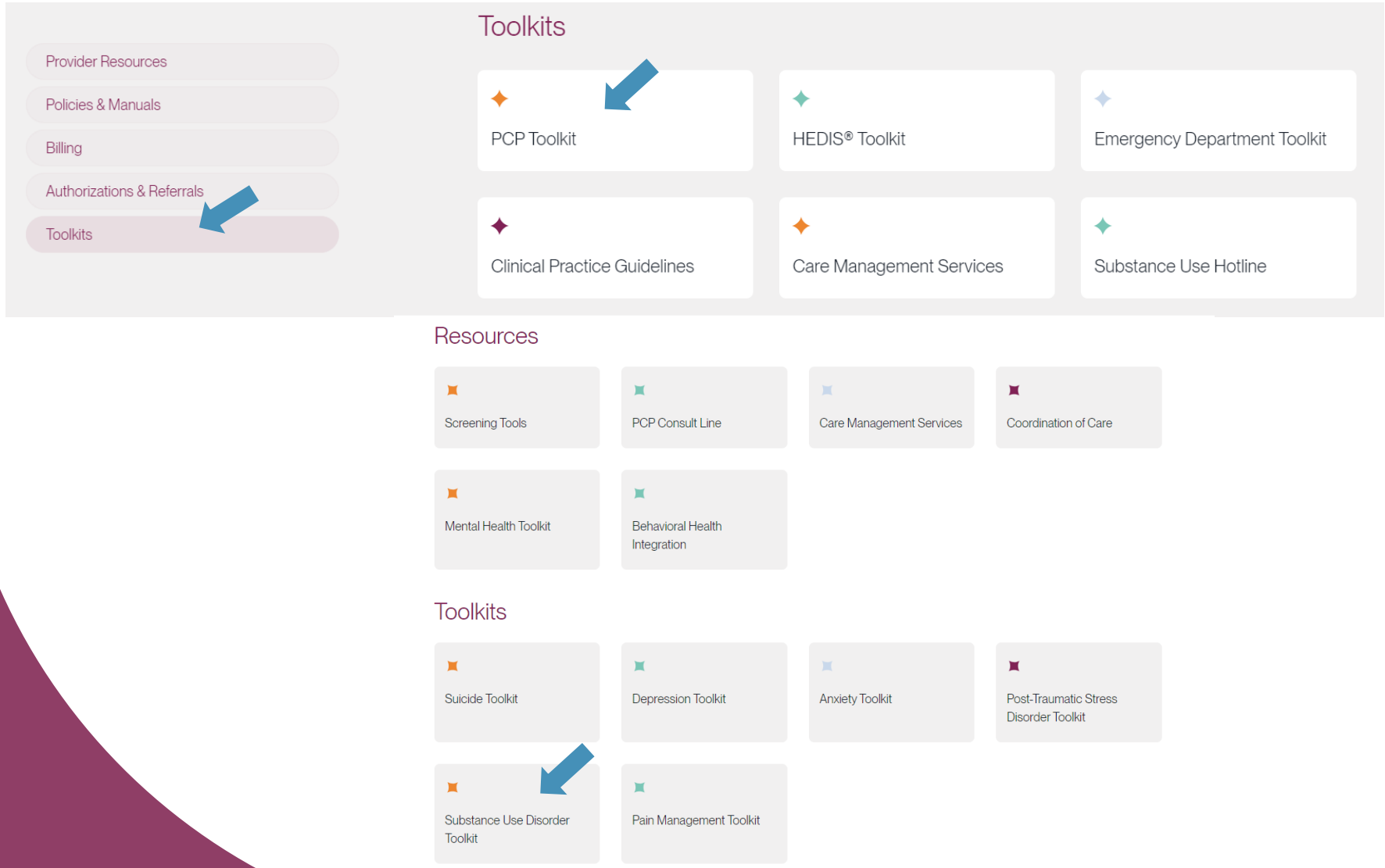
Helping to Heal Trauma

A majority of adults in the United States have experienced a traumatic event. Lucet has an online **toolkit** to promote PTSD awareness. The toolkit includes posters, articles and other sharable materials.

https://lucethealth.com/members/resources/ptsd-toolkit

- SUBSTANCE USE DISORDER TOOLKIT

Substance Use Toolkit



https://lucethealth.com/providers/resources/pcp/sudtoolkit

Substance Use Toolkit

Approximately 22% of all patients who present in healthcare settings have a substance use condition, such as alcohol, opioid, or other drug abuse or dependence. Consequently, medical settings are important places to identify individuals with Substance Use Disorders (SUD), engage them in treatment and begin providing them services. (Urada et al, 2012).

The following tools and practice guidelines are provided to assist in the identification of Substance Use Disorders in the United States.

Screening Tools

Alcohol

- Youth Alcohol Screening and Brief Intervention Practitioner's Guide
- CRAFFT Screening Tool for Adolescent Substance Abuse
- Short Michigan Alcoholism Test Geriatric Version (SMAST-G)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- The Cage and Cage-Aid Questionnaires

Other Drugs

- Screening for Drug Use in General Medical Settings
- Tobacco, Alcohol, Prescription Medication, and Other Substance Use Tool (TAPS)
- Opioid Risk Tool (ORT)
- Drug Abuse Screening Test (DAST)
- NIDA Quick Screen

Additional Screening Tools

Provider Resources

Alcohol

- Alcohol Screening and Brief Intervention for Youth: Practitioner Guide
- Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse Screening and Brief Interventions
- Implementing Care for Alcohol and Other Drug Use in Medical Settings, An Extension of SBIRT
- SBIRT Training Presentation

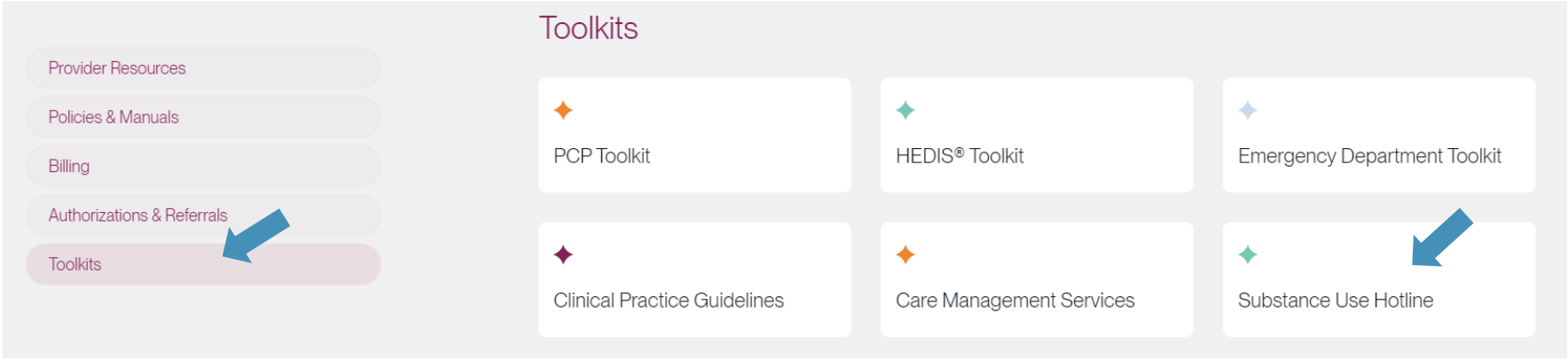
Other Drugs

- Screening for Drug Use in General Medical Settings
- National Institute on Drug Abuse: Medical & Health Professionals
- General Guidelines for Substance Use Screening and Early Intervention in Medical Practice

Additional Educational Articles

https://lucethealth.com/providers/resources/pcp/sudtoolkit

Substance Use Resources



Clinical 365

Substance Use Disorder Hotline

The decision to seek drug and/or alcohol treatment for yourself or a loved one can be a difficult, but important step. Simply identifying what type of treatment is needed and what is available can be tough. That's where the New Directions Clinical 365 team can help.

The Clinical 365 team is comprised of licensed clinicians that are available 24 hours a day, 7 days a week. A licensed team member will take time to fully understand and assess potential treatment needs, provide you with information regarding treatment options and search for the right provider for you or a loved one.

To reach the Clinical 365 team

Call the Substance Use Disorder Hotline at 877-326-2458.
For additional resources, visit the Substance Use Disorders Center

https://lucethealth.com/providers/resources/member-hotline

HEDIS®

(FOLLOW-UP AFTER HOSPITALIZATION)

Follow-up After Hospitalization

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

One measure is ensuring patients who have had inpatient treatment for mental illness have a follow-up visit with a **behavioral health professional within seven calendar days of discharge**.

- ✓ LUCET tracks appointments made within seven days, but also wants patients to **attend those appointments**.
- ✓ Patients who attend these scheduled follow-up appointments are less likely to **readmit** into inpatient treatment.

Help Us Meet the Measure

Behavioral Health Facilities can:

- Schedule patients within seven calendar days of discharge from an inpatient stay.
- These appointments can be made with psychiatrists, psychologist, psychiatric nurse practitioners, social workers (LCSW), counselors (LPC), marriage and family therapist (LMFT) or addiction counselors (LAC).
- The discharge information provided to Lucet for the outpatient appointment **must** include, full name of individual provider, credentials, appointment date and time and contact information for the provider
- Allow Lucet staff to schedule appointments for members on their behalf, if needed.

How to Increase Appointment Attendance

- Provide appointment reminders:
  - Include the time, date and location.
  - Please be sure to provide a return phone number and/or email address along with a contact person for the member to speak with for any questions, concerns and assistance.

- Initiate discussion to find out what works best for the member.

Behavioral Health Rainmakers

- Lucet actively seeks outpatient behavioral health professionals who can schedule appointments for patients being discharged from an inpatient setting, within seven days.
- The Rainmaker list is used as a "**first call**" list for discharge planners at the facilities and the Lucet care managers and care transitions staff.
- If you are not currently receiving the Rainmaker List, please email Lucet at **LouisianaPR@Lucethealth.com**

CARE MANAGEMENT SERVICES

Lucet Focused Care Management

- Improve member experience and quality of care.
  - 90-day pre/post symptom/functional improvement.
  - Professional and community services referred and utilized.
  - Gaps closed (seven-days after discharge follow-up appointment, MAT education and follow-up, substance use and depression screening follow-up, blood glucose screening, OUD screenings, treatment adherence)
- Decrease ED utilization and inpatient admissions.

Care Solutions	Member Care Link
Complex Care Management (CM) NCQA/ URAC accredited	**Non-Complex Care Management (CM)**
• Opt-in services with high intensity CM outreach • Comprehensive CM assessment • Member centric CM goals, CM survey • Coordination of care with health care providers	• Condition specific and service related programs • Coordination of care • Healthcare gaps • Members who have not opted in for Care Solutions
Referral Source: CM Daily Census Report (predictive modeling)	**Referral Sources:** Condition & LOC specific programs, GAP closure, and members who opt out or do not engage in Care Solutions
Care Transitions Activities CM services designed to help members transition from higher levels of care to the community with the goal of community tenure	
Integrated Co-Care Management Activities Collaboration and coordination of CM services between medical and behavior health care managers with the goal to provide comprehensive medical/ behavioral care management expertise	

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:

Michelle Sims

Clinical Network Manager

Email: **msims@lucethealth.com**

Phone: 1-816-416-7672

Debbie Crabtree

Provider Relations Specialist

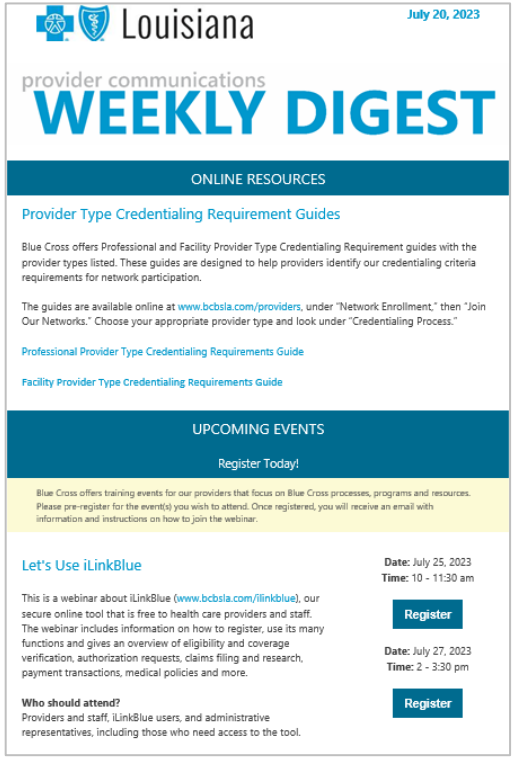
Email: **dcrabtree@lucethealth.com**

Phone: 1-904-371-6942

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**.

APPENDIX

Benefits of Proper Documentation

Allows identification of high-risk patients.

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

Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross.

Reduces costs associated with submitting corrected claims.

Provider's Role in Documenting

- Each page of the patient's medical records should include the following:
  - Patient's name
  - Date of birth or other unique identifier
  - Date of service, including the year
- Provider signature (must be legible and include credentials)
  - Example: John Doe, MD (acceptable)
  - Example: Dr. John Doe (not acceptable)
- Report ALL applicable diagnoses on claims and report at the highest level of specificity.
- Include all related diagnoses, including chronic conditions you are treating the member for.
- Medical records **must support ALL** diagnosis codes on claims.

Accuracy and specificity in medical record documentation and coding is critical in creating a complete clinical profile of each individual patient.

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.

Commercial Risk Score

- Blue Cross identifies those members with potential diagnostic gaps by review of claims data.
- Diagnostic gaps are identified through:
  - History: prior year Dx
  - Pharmacy: prescribed medication
  - Diagnostic: lab or diagnostic test
  - Other: diagnosis with potential co-existing condition

What can providers do?

1. Close gaps in care.
2. Ensure all documentation reflects what is being billed.
3. Ensure chart reflects complete clinical profile for the patient.

Risk Adjustment Data Validation Audits

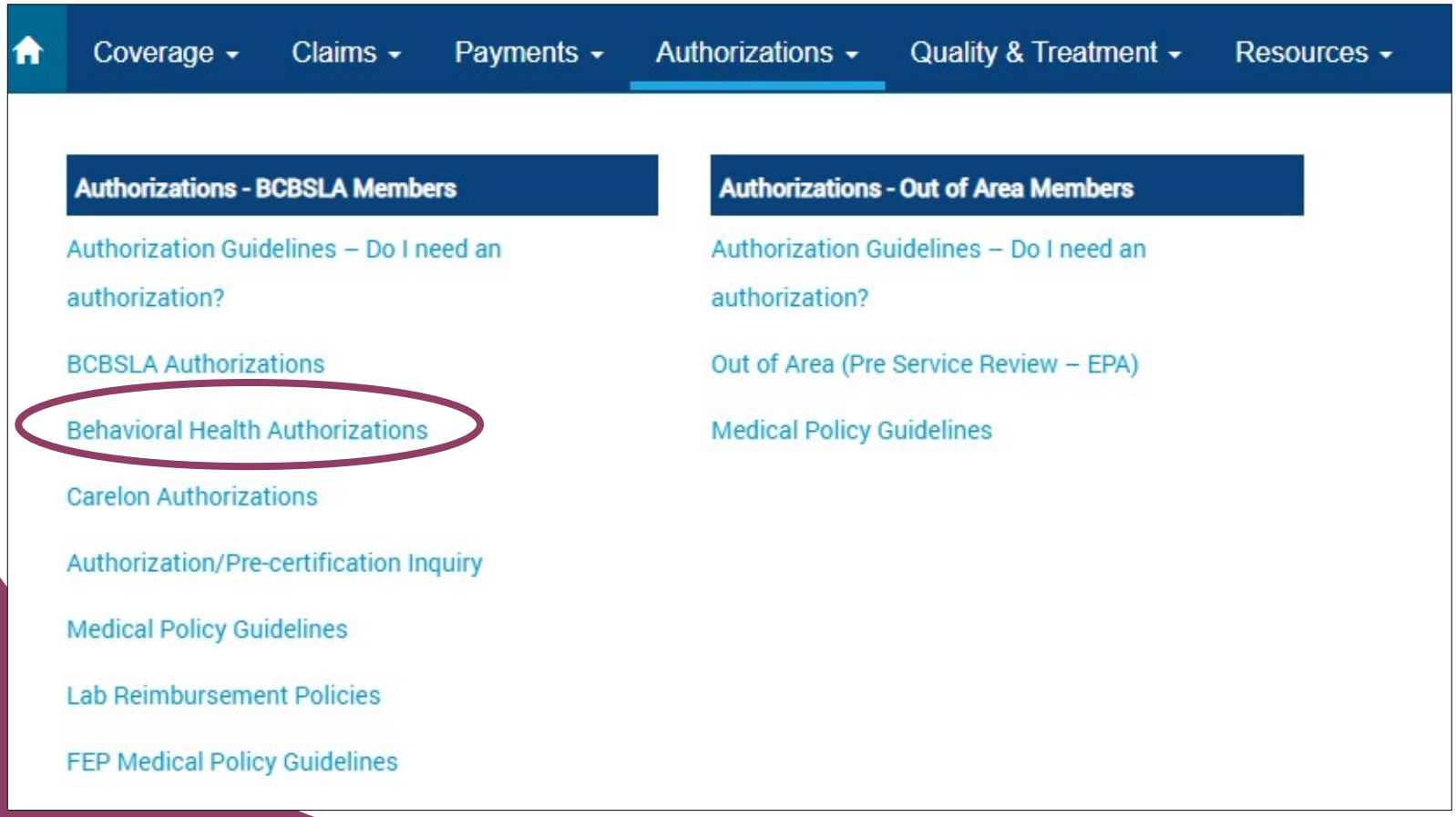
Required through the ACA, the framework for the risk adjustment data validation (RADV) audit process for the risk adjustment program was established.

Components of the RADV audits:

- Annual CMS mandate
- Required audit for every insurer who sells a policy on the ACA marketplace.
  - Will be used to confirm risk reported.
  - To confirm providers' medical records substantiate the reported data and accurately reflect the care rendered and billed.
- The Accountable Care Law mandates medical records be provided.
- RADV audit requests for medical records begin in June.

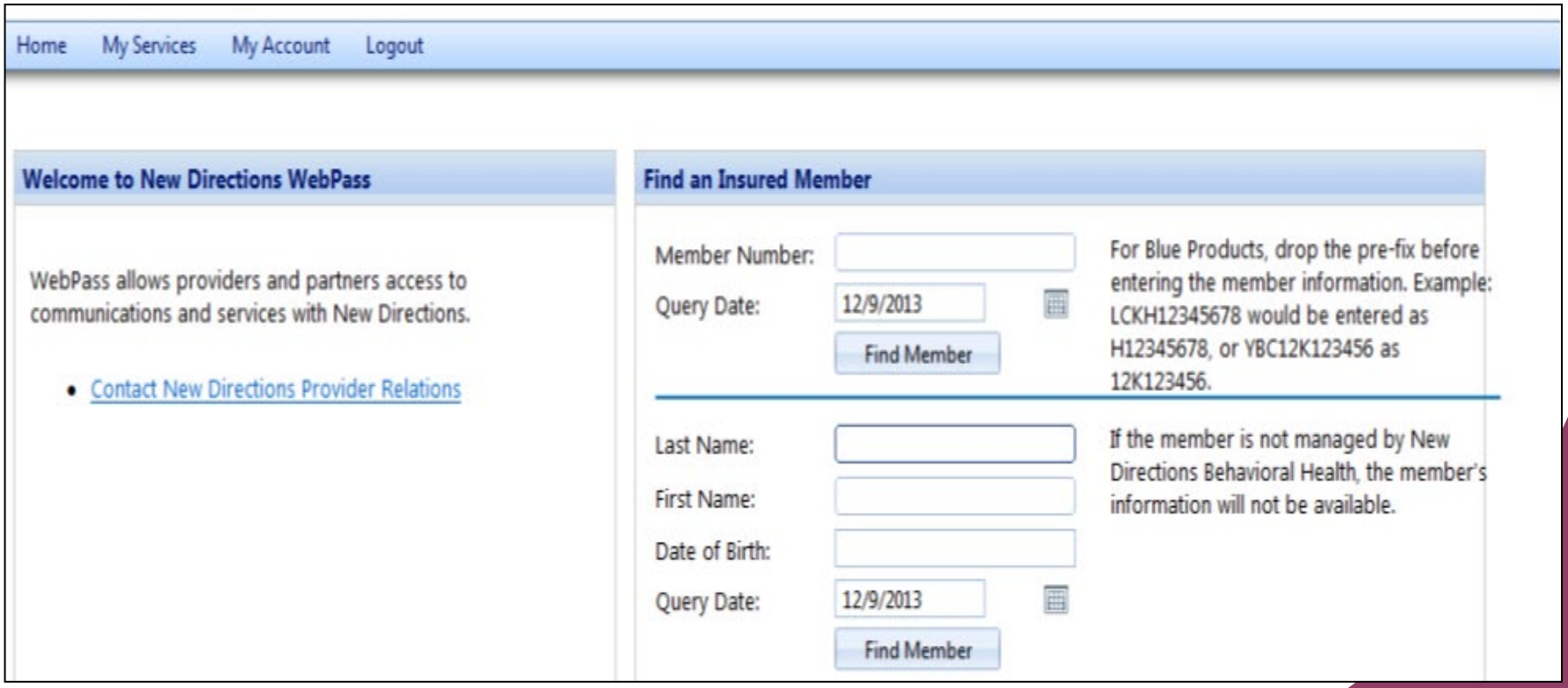
Using WebPass Portal

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**.



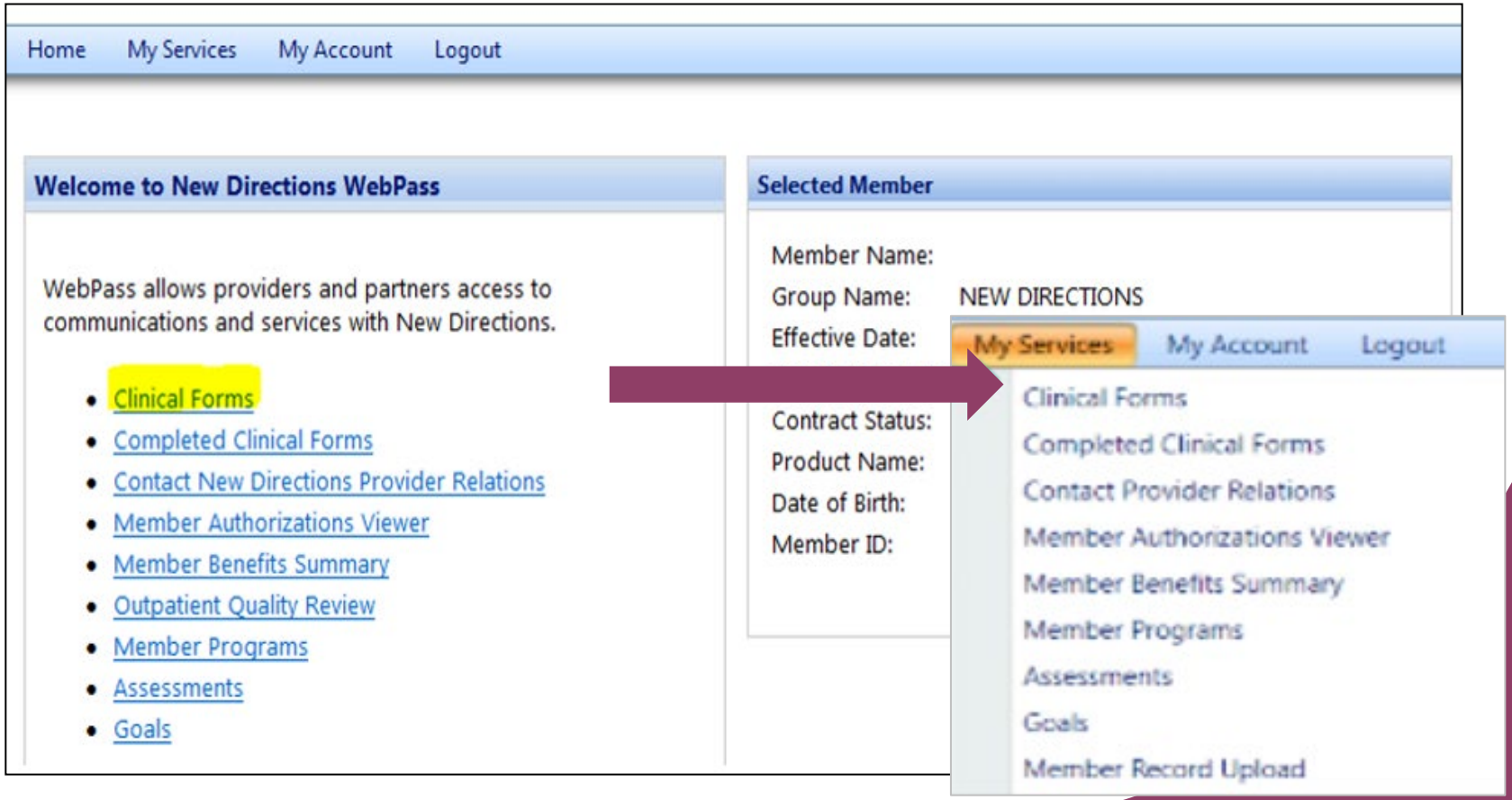
Getting Started

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

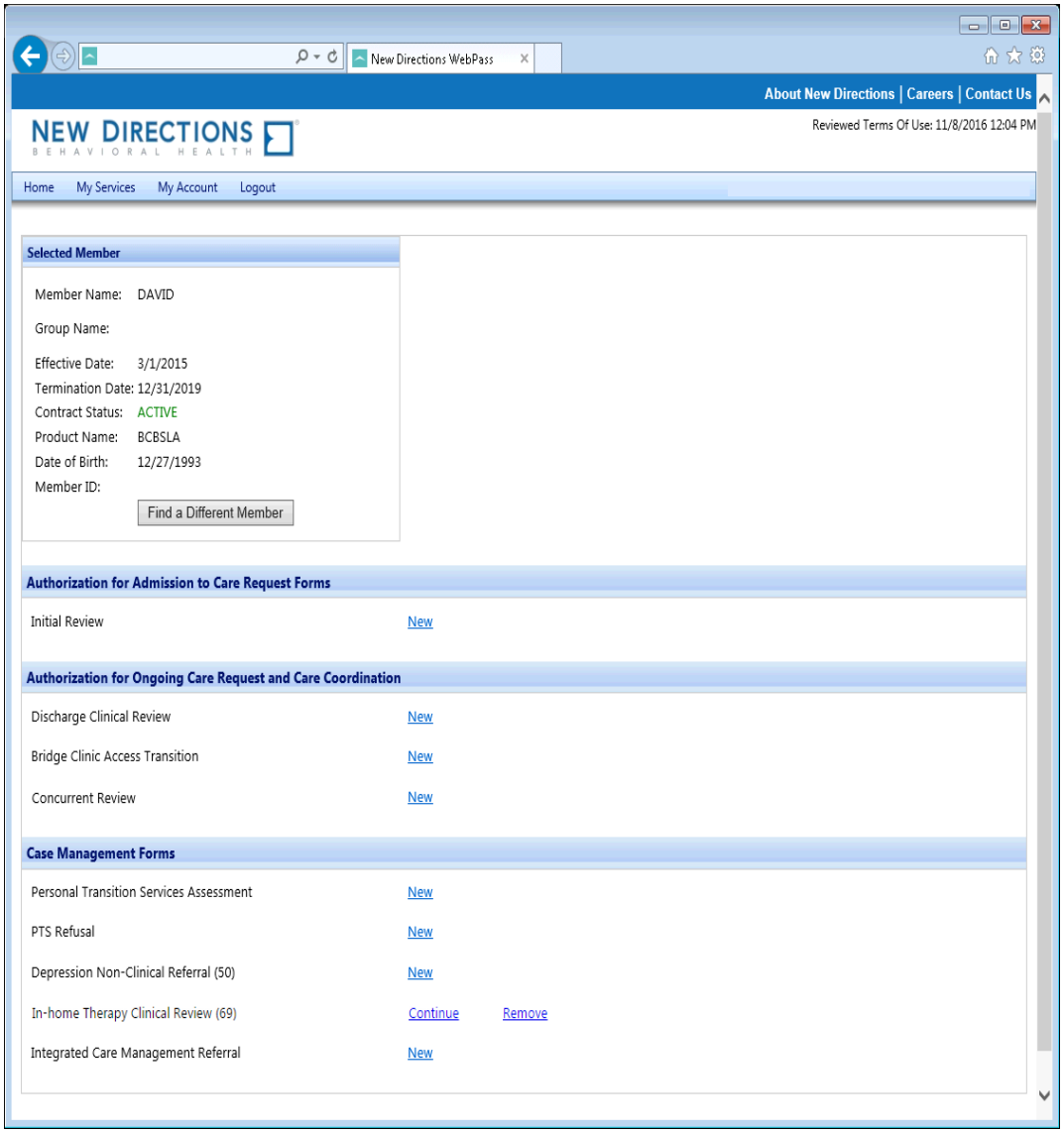


Completing Clinical Forms

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



Clinical Forms Page



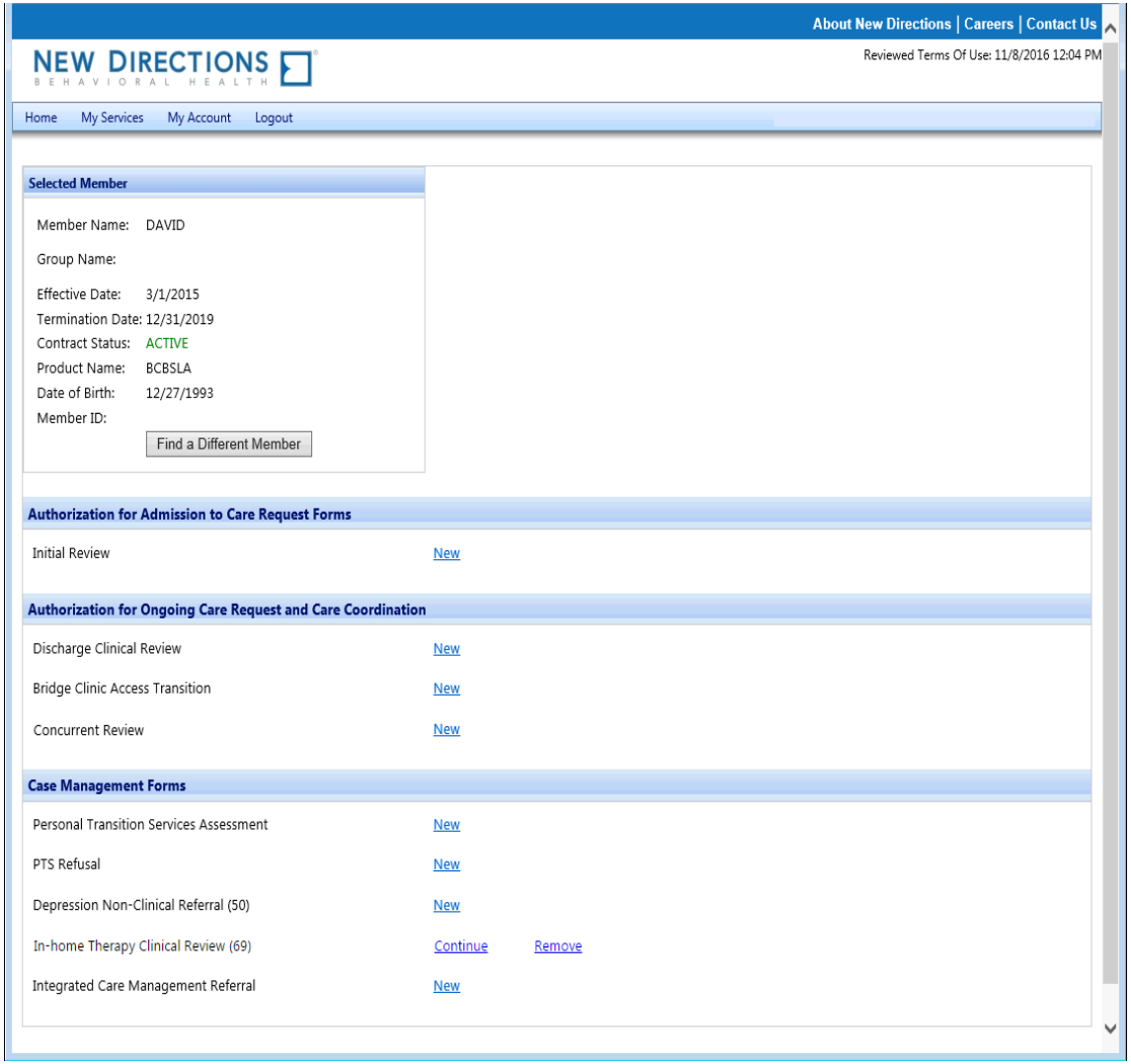
The Forms page is divided into three sections:

1. Admission
2. Ongoing
3. Management

If there are no forms to select under a specific category, the word "None" will appear.

If there are no authorizations available to link to, the Clinical Forms page will be all that is shown. If there are available authorizations to link, you will first see another page.

Forms List



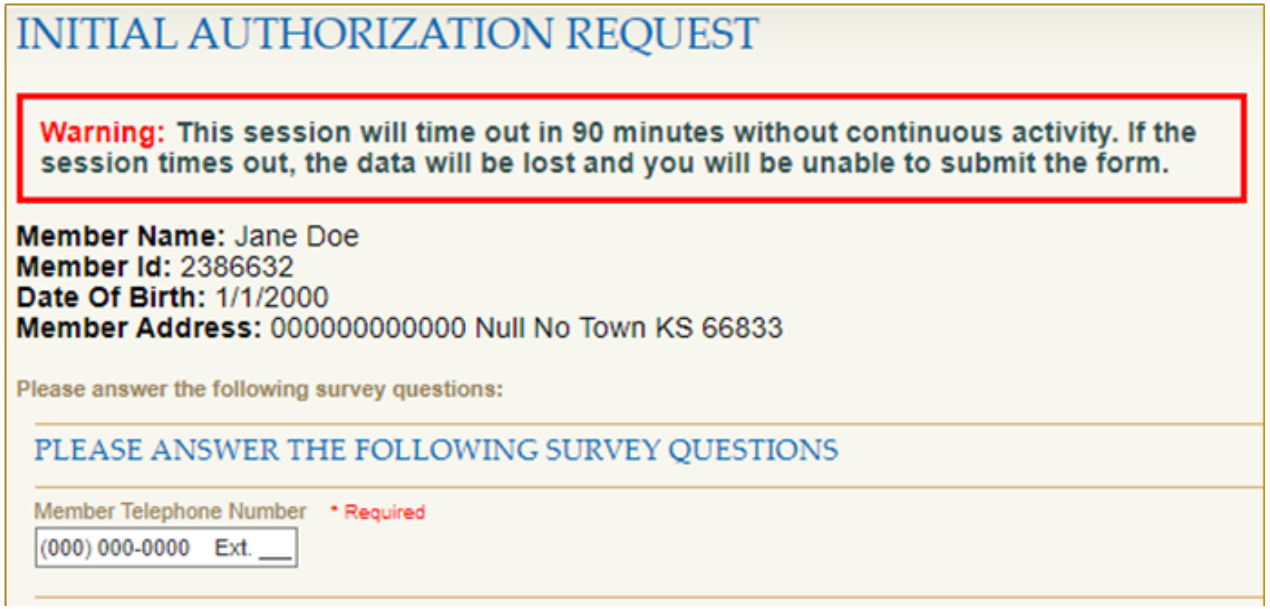
After users select an authorization or "New Request," the Forms list will display.

Note: Even if an Authorization is selected, an Initial Review will never be linked to an existing Authorization in WebPass.

Note: Partially saved surveys will remain tied to the original selection unless removed/ expired.

Filling Out Clinical Forms

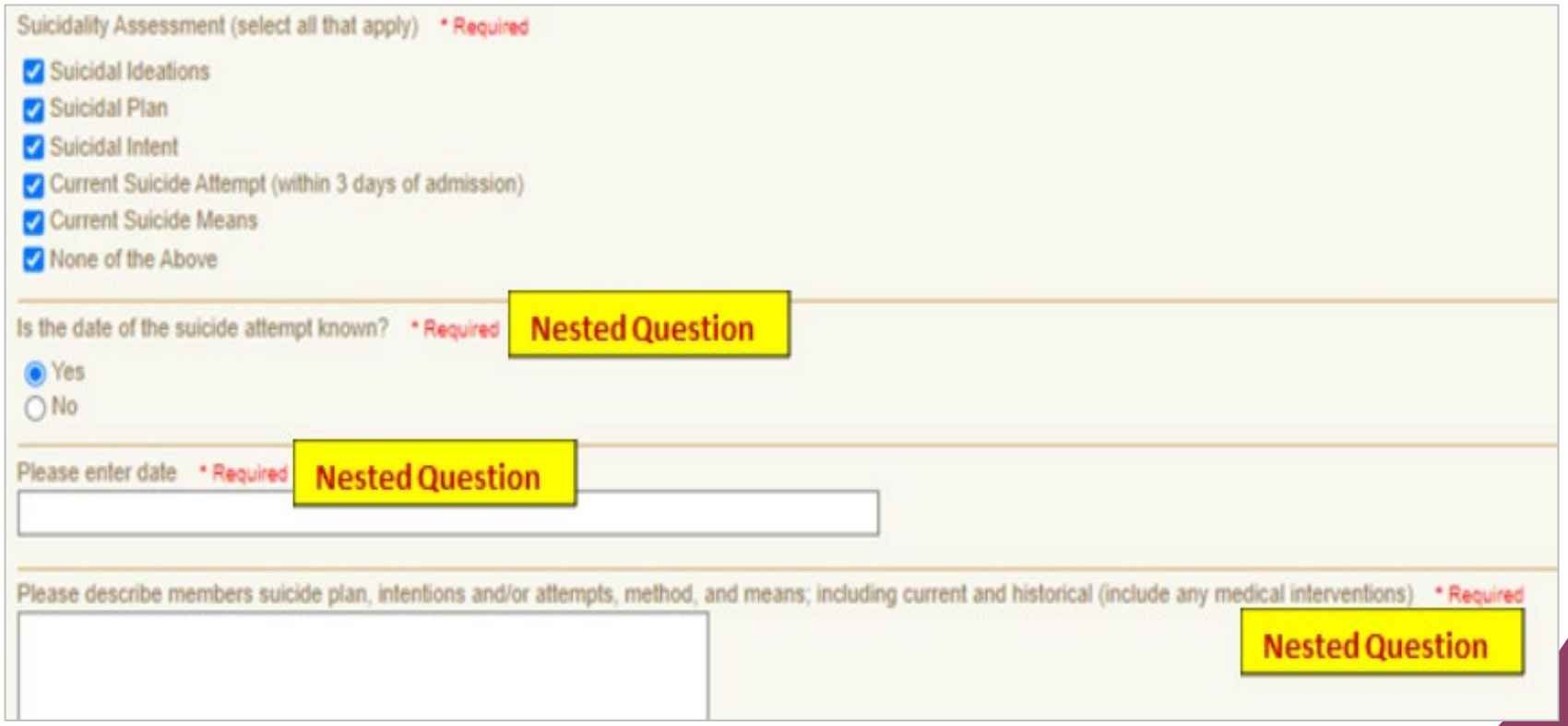
After users select a form, they will enter the clinical information needed for Lucet to conduct a higher level of care review.



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

Interactive Questions

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

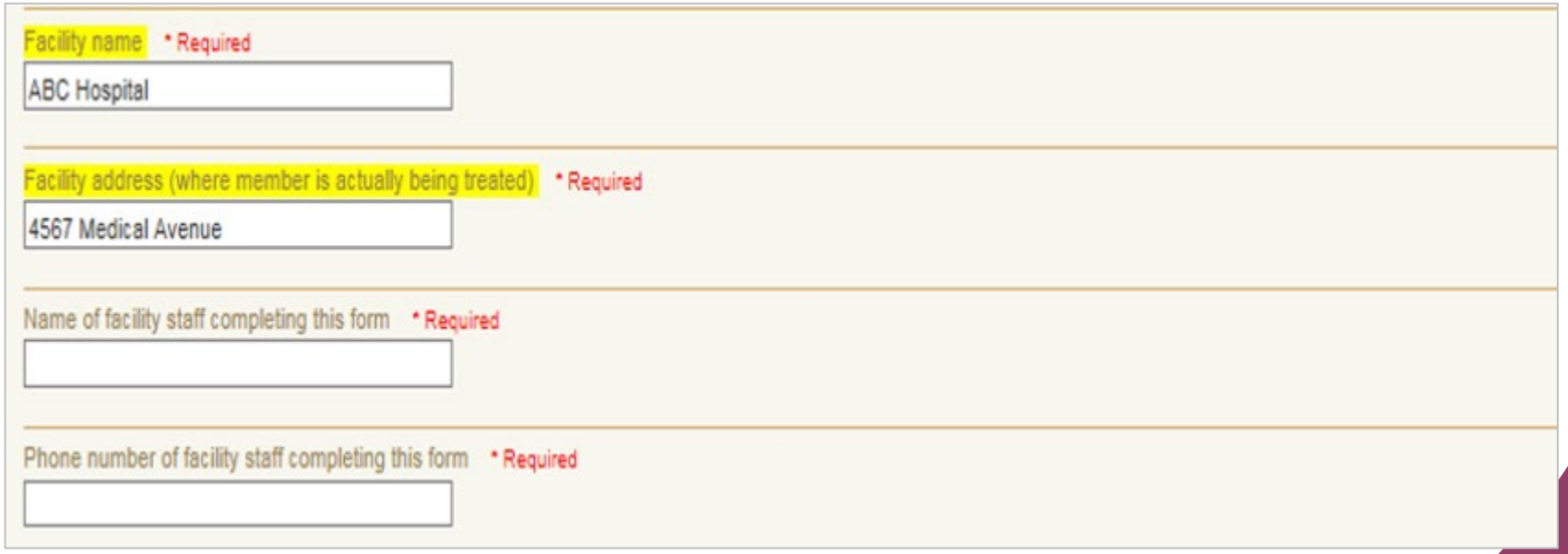


Text Box

Some questions will enable a text box if "other" is selected.

Prepopulated Information

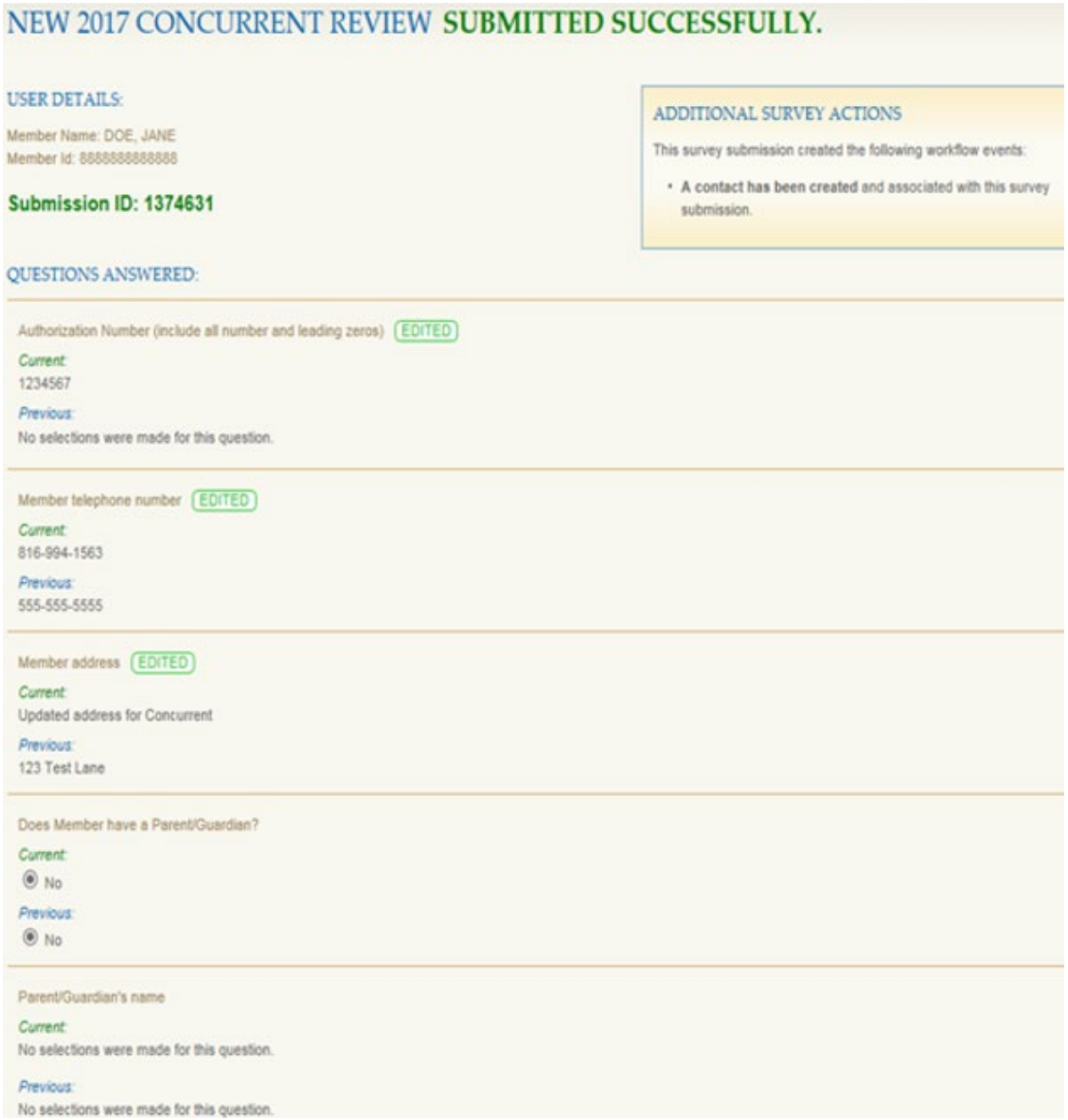
Questions that have prepopulated answers will be highlighted to ensure they are visible by the user. **All highlighted answers need to be reviewed and updated as applicable.** Not all questions will be prepopulated. Some questions are not present on both initial and concurrent forms and some questions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



Review of Prepopulated Information

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

Edited Information



NEW 2017 CONCURRENT REVIEW **SUBMITTED SUCCESSFULLY.**

USER DETAILS:

Member Name: DOE, JANE
Member Id: 8888888888888

Submission ID: 1374631

ADDITIONAL SURVEY ACTIONS

This survey submission created the following workflow events:

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

QUESTIONS ANSWERED:

Authorization Number (include all number and leading zeros) EDITED

Current:
1234567

Previous:
No selections were made for this question.

Member telephone number EDITED

Current:
816-994-1563

Previous:
555-555-5555

Member address EDITED

Current:
Updated address for Concurrent

Previous:
123 Test Lane

Does Member have a Parent/Guardian?

Current:
(•) No

Previous:
(•) No

Parent/Guardian's name

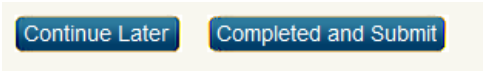
Current:
No selections were made for this question.

Previous:
No selections were made for this question.

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

Saving Partially Completed Forms

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



CONCURRENT REVIEW FORM **Survey has been partially saved successfully.**

You will have 24 hours to complete this form from 2/6/2015 3:05:32 PM CST

Select A Clinical Form		
Personal Transition Services Assessment	New	
PTS Refusal	New	
Depression Non-Clinical Referral (50)	New	
Discharge Clinical Review (57)	New	
In-home Therapy Clinical Review (69)	New	
Integrated Care Management Referral	New	
Pre-Certification Form	New	
Concurrent Review Form	Continue	Remove
Discharge Clinical Review	New	

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

Users will have the option to continue or remove forms.

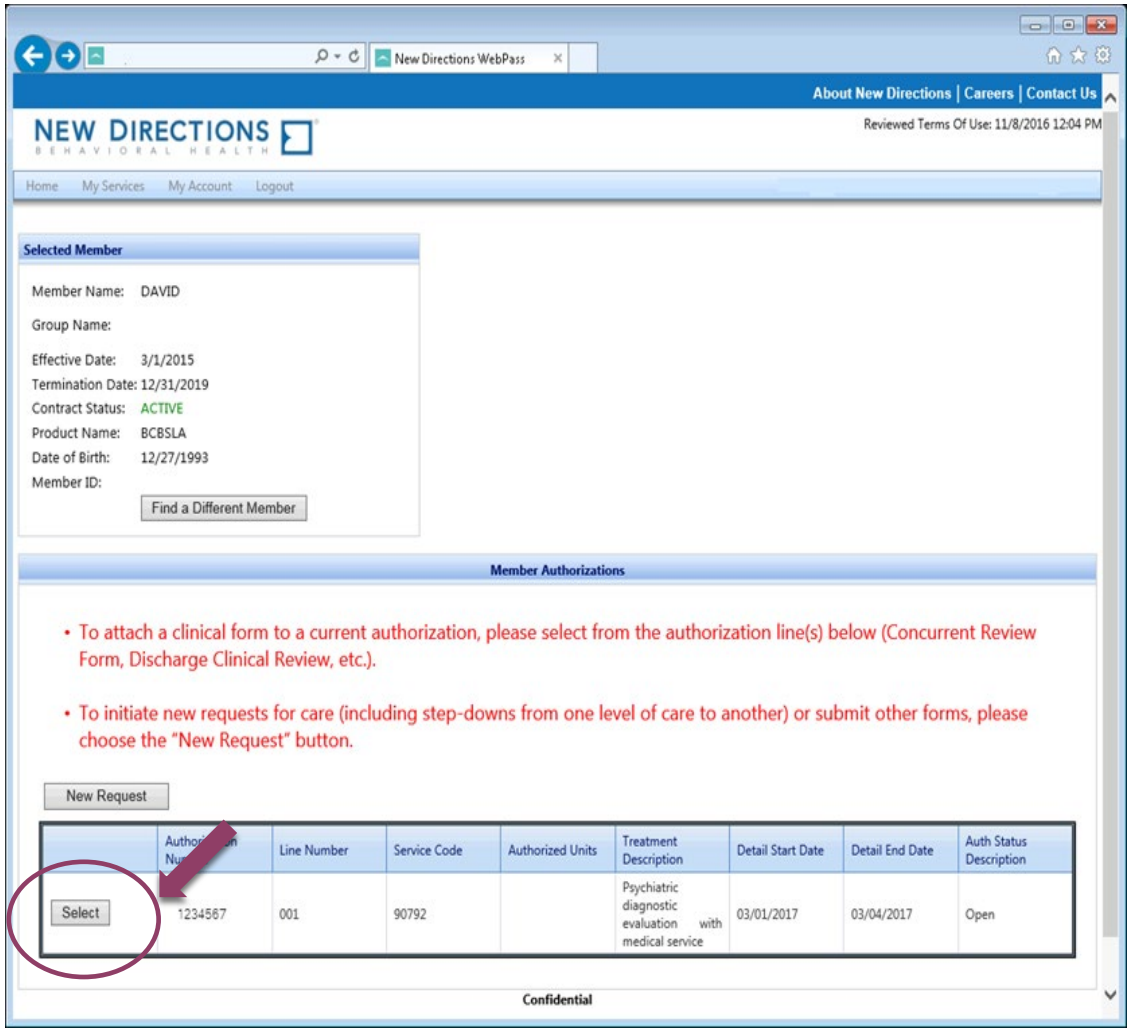
Reviewing Previous Request Forms

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

Reviewing Status of Request Form

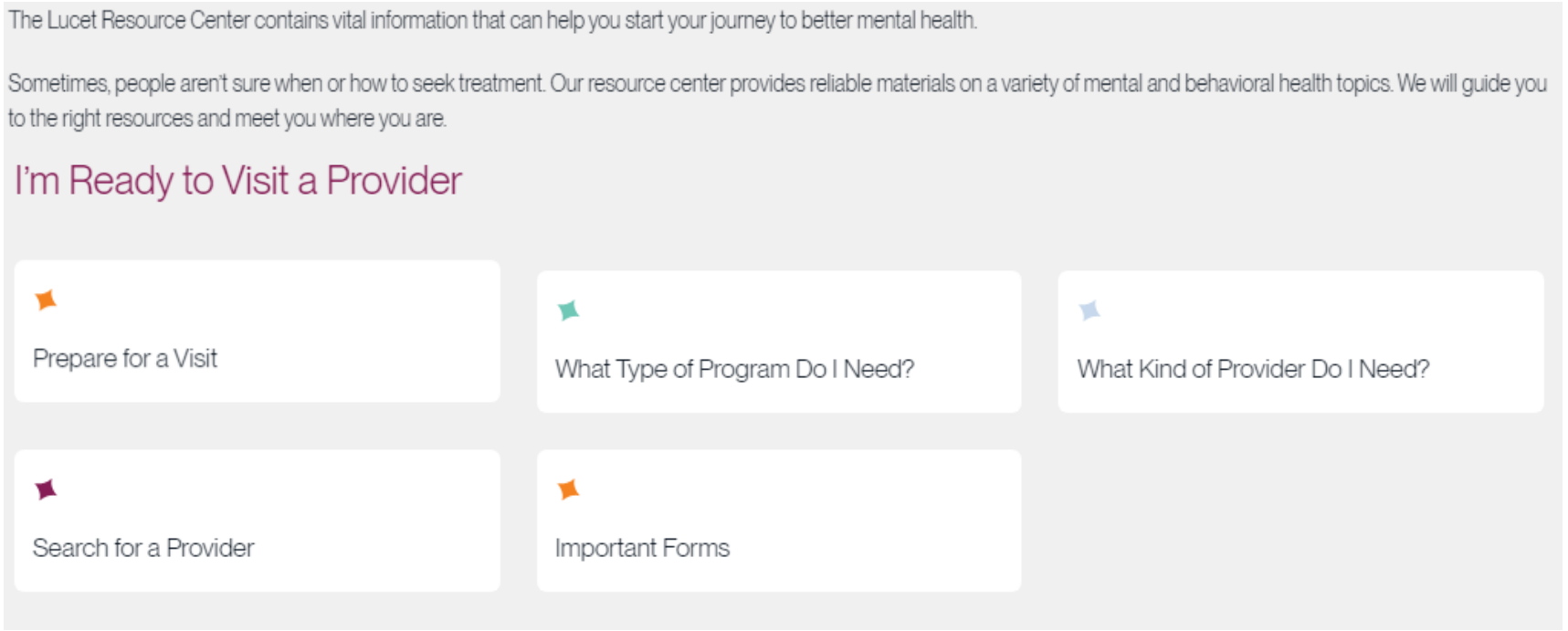
- To view the status of a request, click on "Member Authorization Viewer."
- Users will be able to view all authorization requests and statuses on the selected member. Click on "Details" or "History" to view more information about the authorization.

Linking Forms



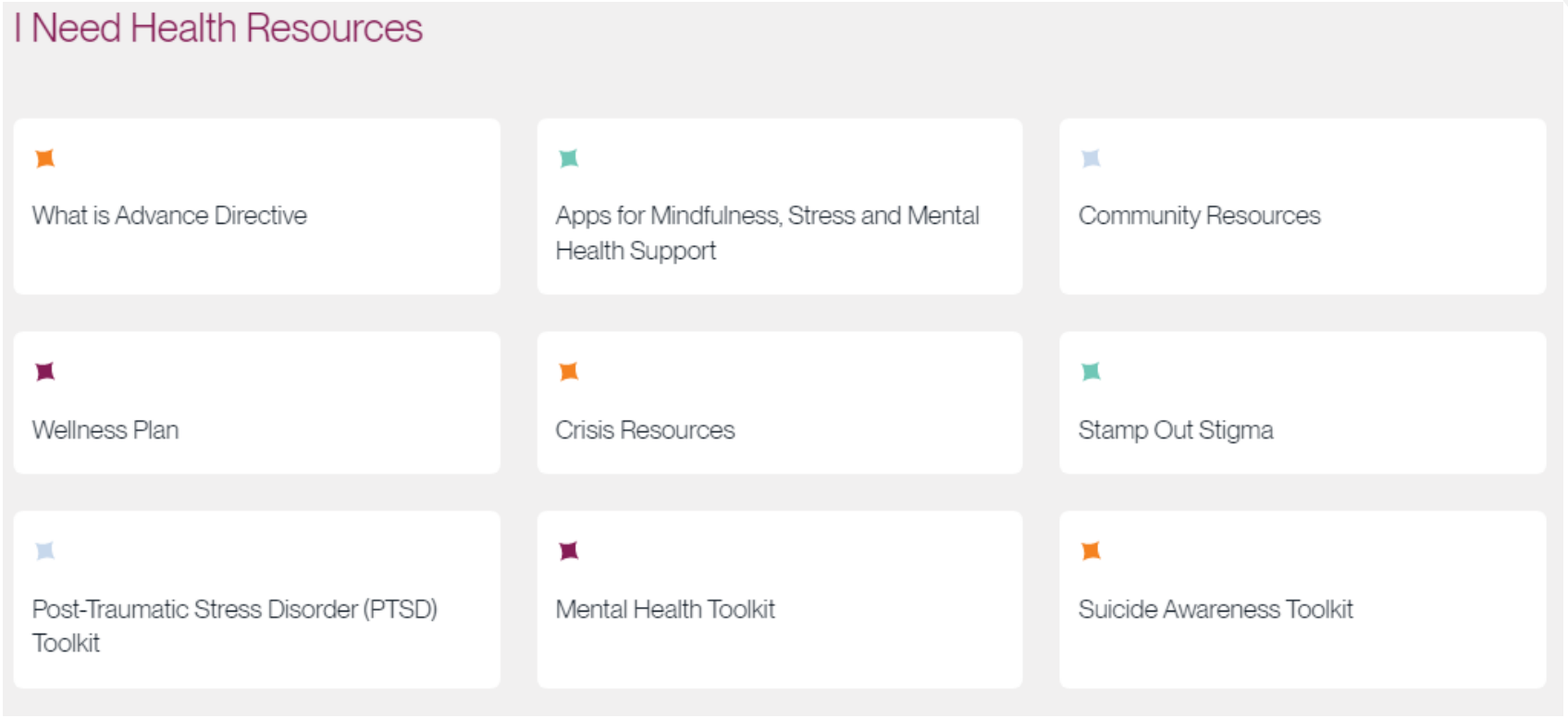
- After an authorization has been created, users can link additional forms to that authorization.
- By linking forms to an existing Authorization, certain information will be automatically carried over to prepopulate the new forms (when the same question appears on both forms).
- To link a form, click "Select" next to the authorization number.
- To start an initial review or to submit a form that does not need to be linked, click on "New Request."

Member Resources



https://lucethealth.com/members/resources

Member Resources



https://lucethealth.com/members/resources

Member Resources

I Need Help with My Diagnosis

- Substance Use Disorders Center
- Autism Resource Center
- Care Management

Important Forms

- My Health Record
- Consent to Release Information
- Consent to Release Information – Authorization to Disclose PHI Form – Form Instruction
- Name an Authorized Delegate

https://lucethealth.com/members/resources

Helping You Help Others

Provider FAQ, Initial, Continued Stay, and Discharge Forms information. MAT, Substance Use Disorders, and Telehealth Best Practices.

Medical Necessity Criteria, Provider and Facility Manual, rTMS, ECT, PNT policies. Appeals procedures.

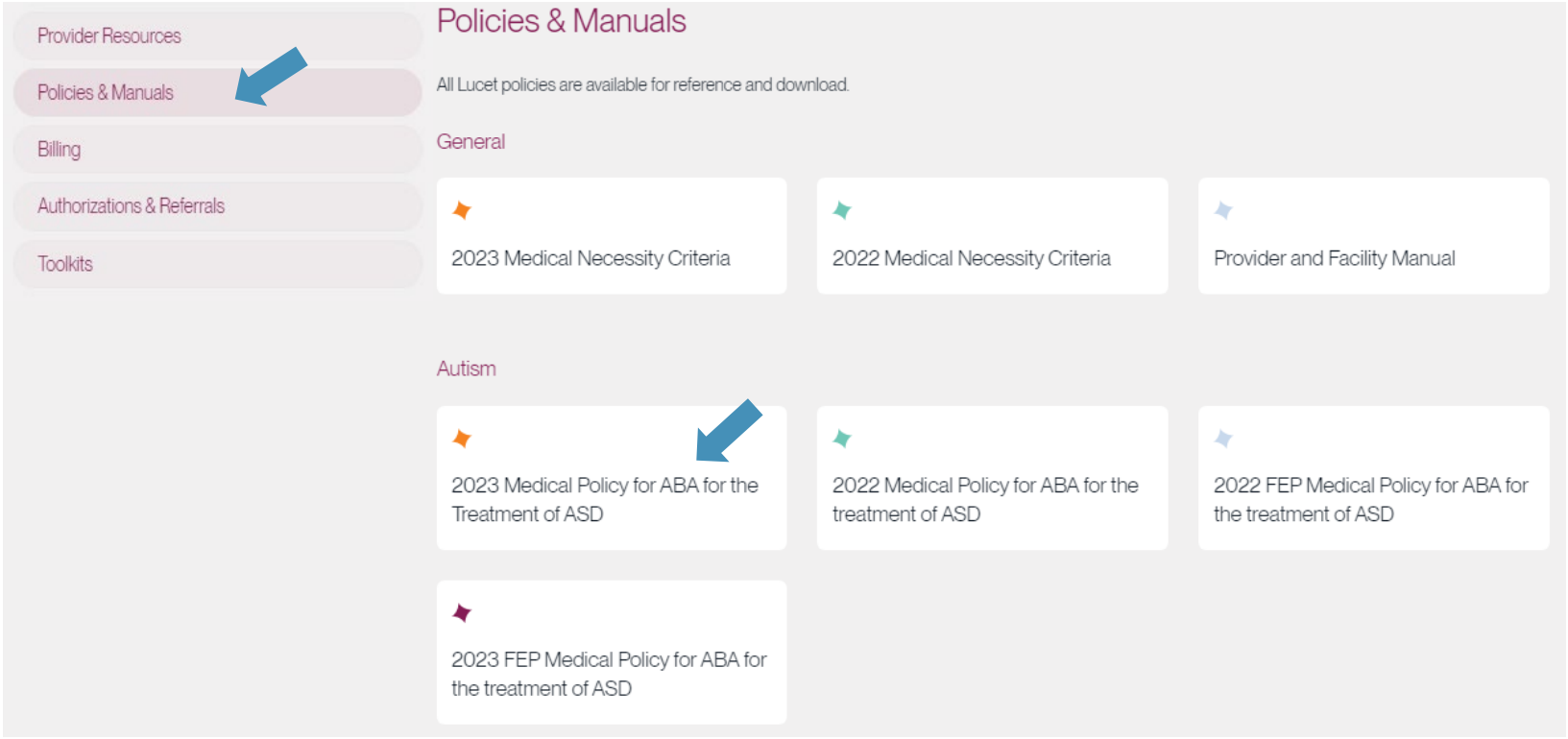
Refer to BCBSLA Provider/Facility Manuals

Access to WebPass to submit your authorizations.

PCP Toolkit, HEDIS Toolkit, Emergency Department Toolkit, Clinical Practice Guidelines, Care Management Services, Substance Use Hotline

https://lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana/#resources

Policies and Manuals



https://lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana/#resources