New Directions
Blue Cross Partners with New Directions

We have partnered with New Directions for their expertise in the provision of mental health services.

Beginning Jan. 1, 2016, New Directions will manage authorizations for our members, perform all utilization and case management activities, as well as ABA case management. New Directions will also engage with our providers to improve quality outcomes.

New Directions’ team of mental health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.

New Directions’ authorization tool, the Webpass Portal, will be available to facilities through iLinkBLUE beginning Jan. 1, 2016. By using this tool to request authorizations, facilities are able to seek a higher level of care for patients.

Clinical Network Manager and Provider Relations Coordinator

Cindy Aiello, Director Network Operations
Barbara Hanks, Clinical Network Manager
Clinical Network Manager & PR Coordinator’s Role

Networking - Developing relationships and collaboration to enhance quality

HEDIS Quality Measures
- 7-day appointment scheduled
- 7-day appointment kept
- 30 day readmission.

Facility and Provider Forums
- Sharing Best Practices
- Develop solutions

Medical and BH Integration
- Sculpting the Network
  - Rainmaker
  - BHH – In home Services

Analytics – Using data to identify opportunities, trends and needs
- Hot Spotting
- Heat maps
- Trends to identify high risk/high utilizers
- Scorecards

Community-Based Resource Development
- New programs developed by New Directions
  - Transportation
  - Aftercare programs

Network Innovation & Analytics in Action

Identifying Best Practice Facilities
Identify hospitals that avoid readmissions for particular conditions. Coach/Educate those who don’t

Hot-Spotting
Implement localized strategies to improve quality of care and member outcomes
Network Changes

- Magellan Network Ends
- Expanding HMO Louisiana Network
- BlueConnect & Community Blue Networks
- Preferred Care PPO Network
- Office of Group Benefits (OGB)
- Finding a Network Provider
- Refer to Network Providers
- Continuity of Care
- How to Join Our Networks
- Credentialing / Recredentialing
- Behavioral Health Areas of Focus

Magellan Network Ends for Our Members

Today:
Magellan Health manages the behavioral health network for our HMO Louisiana, BlueConnect, Community Blue, Federal Employee Program (FEP) and Office of Group Benefit (OGB) Magnolia Local members.

Effective Jan. 1, 2016:
Effective Jan. 1, 2016, we will no longer use Magellan as the behavioral health network for behavioral health services.

HMO Louisiana members will use HMO Louisiana network providers.

BlueConnect members will use BlueConnect network providers.
OGB Magnolia Local members will use either the BlueConnect or Community Blue network, based on where the member resides.
Community Blue members will use Community Blue network providers

FEP members will use Preferred Care PPO network providers.
Expanding Our HMO Louisiana Network

Today:
The HMO Louisiana, Inc. network is only available in select parishes.

Effective Jan. 1, 2016:
We will have a statewide HMO Louisiana provider network (including behavioral health providers).

BlueConnect & Community Blue

These are select area networks:

BlueConnect is available to members residing in Jefferson, Orleans and St. Tammany parishes.

Community Blue is available to members residing in Ascension, Bossier, Caddo, East Baton Rouge and West Baton Rouge parishes.

Effective Jan. 1, 2016, these networks will include behavioral health providers.
Preferred Care PPO Network

**Today:**

Blue Cross' Preferred Care PPO network is offered to member's statewide.

**Effective Jan. 1, 2016:**

FEP members will access the Preferred Care PPO network of behavioral health providers.

Office of Group Benefits (OGB)

OGB Has 5 Benefits Plans:

- **Pelican HRA 1000**
- **Pelican HAS 775**
- **Magnolia Local Plus**
- **Magnolia Open Access**

**Today** these benefit plans use our Preferred Care PPO network of behavioral health providers

**Effective Jan. 1, 2016**, these benefit plans will continue to use our Preferred Care PPO network of behavioral health providers

**Magnolia Local**

- **Today** this benefit plan uses Magellan Health's network of behavioral health providers
- **Effective Jan. 1, 2016**, this benefit plan will use the BlueConnect or Community Blue network of behavioral health providers*

*Magnolia Local members residing in the Baton Rouge and Shreveport areas use the Community Blue network. Magnolia Local members residing in the New Orleans area use the BlueConnect network.
Finding a Network Provider

Today:
Go to www.bcbsla.com, then click on:
FIND A DOCTOR OR DRUG

Members have two options of networks:
1. Magellan
2. Preferred Care PPO

In Nov. 2015, we will update our online directory so members can research behavioral health providers for 2015 and 2016 dates of service.

Refer to Network Providers

Network providers should **ALWAYS** refer members to **CONTRACTED** providers

Referrals to non-network providers result in significantly higher cost-shares (deductibles, coinsurance and copayments) to our members and it is a breach of your Blue Cross provider contract.
Continuity of Care

We ask that providers—no longer in our members’ covered network—transition members to a network provider

Continuity of Care is a provision that allows the out-of-network provider to continue treating a patient diagnosed with a life-threatening illness for up to three months for the purpose of transitioning the patient to a network provider for treatment.

If you feel it is necessary that you should continue treatment for an out-of-network member on or after Jan. 1, 2016, please complete a Continuity of Care Request Form; available online at www.bcbsla.com/providers >Forms for Providers.

You must notify Blue Cross within 30 days after the member’s benefit change to be eligible for continuity of care services.

How to Join Our Networks

Are You In-network for ALL of Your Patients?

If you only participate in our Preferred Care PPO and Magellan’s networks today, you will become out-of-network on Jan. 1, 2016, for your existing HMO Louisiana, BlueConnect, Community Blue and OGB Magnolia Local patients (as applicable).

To join our networks:

1. You must have admitting privileges at a hospital in the network you wish to join (as applicable)

2. You must meet the credentialing requirements for the network you wish to join

3. Contact our Network Development department at network.development@bcbsla.com or (800) 716-2299, option 1
Credentialing/Recredentialing

- Blue Cross has a comprehensive credentialing and recredentialing program* and information and forms are available online at www.bcbsla.com/providers.
- Blue Cross credentials both individual providers and facilities.
- To participate in our networks, we require you to meet certain criteria.
- The credentialing process can take 60-90 days when all required information is received.
- Network providers are recredentialed every three years.

* While Magellan Health credentials providers to be in the Magellan network, we will no longer use the Magellan network as of Jan. 1, 2016, therefore you must complete our credentialing/recredentialing process to participate in our networks.

Areas of Focus for Behavioral Health Providers

Recently, we began asking our behavioral health providers to complete the Behavioral Health Provider Clinical Profile form when:

- Joining our network(s)
- Going through the recredentialing process

While the form is not required at this time, we are collecting this information in preparation for a future enhancement to our provider directories where we will reflect your areas of focus so members can select behavioral health providers based on their needs.

Once we update our online directories, providers who have already submitted this information will have their areas of focus immediately reflected.
EMTALA does not impose any legal responsibility on health insurance issuers.

- It requires facilities to screen, treat and stabilize any patient that shows an emergency medical condition, disregarding whether the patient has health insurance coverage or the capability to pay for his treatment.
- Facilities cannot turn away, refer or transfer those patients to another facility until they have been properly stabilized according to the facility’s capabilities.
- EMTALA requires any transfer to another facility to be done taking into consideration the best interests and wellbeing of the patient.
- We are under no obligation to pay for services rendered by a facility in furtherance of its EMTALA obligations, unless the patient has coverage and the services provided are covered.
- We do not have any obligations under EMTALA to pay for emergency services rendered by a non-network facility as if they had been rendered in-network.

EMTALA applies to facilities that:
1. Provide emergency room services
2. Accept payment from Medicare

We want to ensure we are able to secure the member the highest level of benefits by using network providers whenever possible. Thus we work with the facilities to transfer patients when appropriate.
Authorizations

• Services that Require an Authorization
• Transition of Authorizations
• Webpass Portal & Designating an Administrative Representative
• Post Discharge Standards

Behavioral Health Services That Require an Authorization

We require prior authorization for certain behavioral health services:

• Inpatient Hospital (including detox)
• Intensive Outpatient Program (IOP)
• Partial Hospitalization Program (PHP)
• Residential Treatment Center (RTC)
• Applied Behavior Analysis (ABA)
Management of Behavioral Health Authorizations

Today:

Magellan Health Services manages authorizations for all networks:

• Preferred Care PPO
• HMO Louisiana, Inc.
• BlueConnect
• Community Blue
• FEP

Call Provider Services at (800) 922-8866
or
Call Magellan at (800) 991-5638*

Effective Jan. 1, 2016:

New Directions will manage behavioral health authorizations for all networks.

Facility authorization requests will be submitted electronically through New Direction’s Webpass Portal, available on iLinkBLUE.

www.bcbsla.com/ilinkblue

For authorization requests for professional services such as ABA, call New Directions (the Webpass Portal is not available to professional providers).

Call New Directions at (800) 991-5638*

*This phone number will transition from Magellan to New Directions, effective Jan. 1, 2016.

For BlueCard® members, call the authorization number on the back of the member ID card.

Transition of Authorizations

Inpatient Hospital (including detox) & Residential Treatment Center Admissions

Authorization requests for admissions prior to Jan. 1, 2016, should be submitted to Magellan Health Services for approval.

Admissions that begin in 2015 with a discharge date on or after Jan. 1, 2016, do not require an additional authorization from New Directions. Authorizations and claims are based on the date of admission; not the date of discharge.

Authorization requests for admissions that begin on or after Jan. 1, 2016, should be submitted to New Directions for approval via the Webpass Portal.

Magellan will not accept authorization requests on and after Jan. 1, 2016.
**Transition of Authorizations**

**Intensive Outpatient Program (IOP) & Partial Hospitalization Program (PHP) Services**

Authorization requests for dates of service prior to Jan. 1, 2016, should be submitted to Magellan Health Services for approval.

Authorizations that are requested in 2015 for dates of service that begin in 2015 and extend into 2016 are handled by Magellan.

Authorization requests for dates of service on or after Jan. 1, 2016, should be submitted to New Directions for approval via the Webpass Portal.

If you requested an authorization in 2015 for dates of service that extended into 2016, you should contact New Directions after Jan. 1, 2016, to confirm your existing authorization or establish a new one for your 2016 dates of service.

*Blue Cross will work with Magellan to transfer to New Directions any open authorizations that were requested in 2015 for dates of service in 2016.*

---

**Applied Behavior Analysis (ABA) Services**

Authorization requests for dates of service prior to Jan. 1, 2016, should be submitted to Magellan Health Services for approval.

Magellan will not accept authorizations for dates of service in 2016.

For authorization requests for dates of service on or after Jan. 1, 2016, call New Directions:

(800) 991-5638*

If you requested an authorization in 2015 for dates of service that extended into 2016, you should contact New Directions after Jan. 1, 2016, to confirm your existing or establish a new authorization for your 2016 dates of service.

*This phone number will transition from Magellan to New Directions, effective Jan. 1, 2016.*
Accessing the Webpass Portal

For Behavioral Health Facilities Only:
The Webpass Portal is New Direction’s electronic authorization tool that will be available beginning Jan. 1, 2016, only through iLinkBLUE (www.bcbsla.com/ilinkblue). Facilities must use Webpass Portal to request authorizations for behavioral health services. **Without access to iLinkBLUE, you cannot access the Webpass Portal.**

By using this tool to request authorizations, facilities are able to seek a higher level of care for patients.

It will be located under the Authorizations and Medical Policy Menu option.

By using this tool to request authorizations, facilities are able to seek a higher level of care for patients.

An administrative representative is needed to grant users access to this portal.

**Designating an Administrative Representative**

**What is an administrative representative?**

The role of an administrative representative is to serve as the key person at your organization who will:

- delegate electronic access to appropriate users
- ensure those appropriate users adhere to our guidelines.
- only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- promptly terminate employee access at such time as an employee changes roles or terminates employment with the organization.
Designating an Administrative Representative

First Steps for Designation:

1. Determine who at your organization should be an administrative representative.
2. Each designated administrative representative must complete the Administrative Representative Acknowledgment Form and Associated spreadsheet. To obtain these documents, email our Provider Relations department at provider.relations@bcbsla.com.
3. Once all completed documents have been received, Blue Cross’ IT Security Team will then set up each administrative representative with access to our Security Setup Tool.
4. The designated administrative representative will then begin the delegation process of giving appropriate employees at your facility access to our online tools.

Post Discharge Standards

Discharge Planning Tips:

Discharge Planning should include the utilization review staff, discharge planner, the member’s family, significant others, guardian, or others as desired by the member.

Admitting facilities should ensure that patients are provided follow-up appointments within 7 days of discharge from an acute inpatient setting with a behavioral health provider.

The 7 Day appointment does not need to be with a Psychiatrist, instead can be scheduled with a therapist or other behavioral health provider.
Claims

- Processing for 2015 and 2016
- Runout for Magellan Claims
- Timely Filing
- Electronic Claims & iLinkBLUE
- Hardcopy Claim Standards
- Interim Bill Types
- Taxonomy Codes
- Disputing Claims & Reimbursement Reviews
- Medical Record Requests

Who Processes My Behavioral Health Claims?

Behavioral Health Claims by Network:

**Preferred Care PPO & FEP** – Claims are submitted to and processed by Blue Cross (no change on and after Jan. 1, 2016)

**HMO Louisiana, BlueConnect & Community Blue** – Claims are submitted to and processed by Magellan (this changes on Jan. 1, 2016)

**Preferred Care PPO & FEP** – Claims are submitted to and processed by Blue Cross

**HMO Louisiana, BlueConnect & Community Blue** – Claims are submitted to and processed by Blue Cross
HMO, BlueConnect, Community Blue & OGB Magnolia Local Claims

2015

Professional: Claims are based on the date of service. Dates of service through Dec. 31, 2015, should be filed to Magellan. Dates of service for Jan. 1, 2016, and after should be filed to Blue Cross.

Inpatient Facility: Claims are based on the admission date. If the admission date is in 2015, file the claim to Magellan. If the admission date is Jan. 1, 2016, or after, file the claim to Blue Cross.

Outpatient Facility: Claims are based on the date of service. Dates of service through Dec. 31, 2015, should be filed to Magellan. Dates of service for Jan. 1, 2016, and after should be filed to Blue Cross.

Runout for Magellan Claims

For HMO Louisiana, BlueConnect, Community Blue, FEP & Magnolia Local members:

Behavioral health claims with a 2015 date of service should be filed directly to Magellan. The runout period for Magellan to process these claims is 15 months*.

On April 1, 2017, Magellan will no longer accept 2015 behavioral health claims for our members. Blue Cross will not process these claims.

2015 claims denied for timely filing or refused by Magellan on and after April 1, 2017, are not billable to the member or Blue Cross.

*Claims are subject to the member’s timely filing standards, which may be less than 15 months.
Timely Filing Standards

Blue Cross, HMO Louisiana, BlueConnect & Community Blue:
• Claim must be filed within 15 months* of date of service
• Claims received after 15 months* are denied & the member and Blue Cross are held harmless

FEP:
• Claim must be filed by December 31 of the following year after the service was rendered
• Claims received after the filing period are denied & the member and Blue Cross are held harmless

OGB:
• Claim must be filed within 12 months of the date of service
• Claims received after 12 months are denied & the member and Blue Cross are held harmless

Self-insured & BlueCard®:
• Timely filing standards may vary. Always verify the member’s benefits, including timely filing standards.

File Claims Electronically

Both Blue Cross and Magellan accept your claims electronically. Filing claims hardcopy is not preferred.
• For Magellan claims, use the services you have in place today with Magellan.
• For Blue Cross claims, we accept claims through iLinkBLUE or your clearinghouse.

REASONS WHY...
• Potential for less errors when filing claims electronically (more accurate)
• Faster processing of clean claims
• Blue Cross accepts Medicare-cross over claims
• Blue Cross accepts COB claims electronically
• Blue Cross accepts corrected claims electronically
• Resubmission claims
Filing Claims Through iLinkBLUE

The Claims Entry option allows for the direct data entry of certain UB-04 (hospital) and CMS-1500 (professional) claims.

To submit claims, your user ID must be authorized for claims entry access.

To get iLinkBLUE access for claims entry or to become an iLinkBLUE user call the LinkLine at (800) 216-BLUE (2583) or send an email to ilinkblue.providerinfo@bcbsla.com.

Detailed manuals on how to submit claims through iLinkBLUE are under the “Manuals” section of iLinkBLUE:
- The Blue Cross UB-04 Claims Entry Manual is under “Hospital”
- The Blue Cross Professional Claims Entry Manual is under “Professional”

Hardcopy Claim Standards

If it necessary that you must file a claim hardcopy, we only accept original claim forms.

- We no longer accept faxed claims
- We only accept **RED original claim forms.**
Interim Bill Types

- Facility claims must be submitted with a bill type. Bill types are three digits and each digit position represents specific information about the claim being filed.

- Blue Cross does not exclude any first or second digits of the bill type. However, there ARE exclusions related to the frequency digit (third position of bill type).

- Blue Cross will not accept bill types with a frequency code of 2, 3, 4, 5, 6 or 9. We do not accept interim billings for inpatient.

  Exception: an interim bill will be accepted only if the total charge is $200,000 or greater and at least 60 days of service

- Interim bills or replacement claims for submission should have a frequency code of 1 or 7.

* If you meet the above exception criteria for filing an interim bill, please contact Kent Graves at (225) 297-2654 to discuss how to submit your claim.

These guidelines are outlined in the Member Provider Policy & Procedure Manual, available on ilinkBLUE (www.bcbsla.com/ilinkblue) under the Manuals section.

Taxonomy Codes on Claims

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

Example: Hospital facilities that share a single NPI and Tax ID for Acute Care and Psychiatric should have an acute taxonomy and a psychiatric taxonomy to use as appropriate based on the services being billed.

Failure to use a specific taxonomy 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.
Disputing Claims Guide

We recognize that disputes may arise between providers and Blue Cross regarding covered services.

Use the “Disputing Claims” guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross.

Examples of issues that qualify as appeals include:

- claim issues related to authorizations
- claims based on adverse determinations of medical necessity or benefit determinations
- reimbursement reviews

Use the “Disputing Claims” guide to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross.

Available online at www.bcbsla.com/providers

Reimbursement Review Form

Use the “Reimbursement Review” form to properly request a review of how your claim was reimbursed.

Use the Reimbursement Review Form when:

- You disagree with Medical Coding Edit or Denial such as how codes were bundled and/or denied (include your coding logic or applicable operative notes).
- The claim did not pay according to fee schedule and/or reimbursement amount is interpreted as incorrect. Providers must include clear details on why your facility interprets the claim reimbursement as incorrect and specifics on how it should have been reimbursed.
- A reason of “I disagree with the payment” is not acceptable.

Be sure to attach the reimbursement review form on top of your claim form when submitting it for review.
Medical Record Requests

Reasons we request medical records:

• Chronic or coexisting conditions are not documented or are left out of the clinical documentation for an office visit.
• Discrepancies exist between the medical records and the reported diagnosis codes.
  • The historical status of a diagnosis is unclear;
  • The electronic health record was not authenticated.
  • The record contains nonstandard abbreviations or up and down arrows to indicate diagnoses.
• For HEDIS reviews – HEDIS makes it possible to compare the performance of health plans on an “apples-to-apples” basis. We use HEDIS results to see where we can make improvement efforts.
ICD-10 was implemented on Oct. 1, 2015:

- Blue Cross **WILL NOT ACCEPT** claims that contain both ICD-9 and ICD-10 codes on a single claim.
- Blue Cross **WILL REJECT** electronic claims not adhering to these guidelines/conditions on the electronic Not Accepted Report.
- Blue Cross **WILL REJECT** paper claims not adhering to the guidelines/conditions above. Claims will be returned to the provider in a “send back” letter.

Make sure claims include the most specific ICD-10 codes and can be supported by the patient’s medical records.

**Filing ICD-10 Codes on Claims**

On **Oct. 1, 2015**, ICD-10 codes became effective for claims.

**How to correctly code claims using ICD-10 codes:**

**For professional & outpatient facility claims:**
- If all dates of service are before Oct. 1, 2015, file with ICD-9 codes.
- If dates of service span Oct. 1, 2015, split into two claims:
  - File all services prior to Oct. 1, 2015, with ICD-9 codes on one claim form.
  - File all services on or after Oct. 1, 2015, with ICD-10 codes on a separate claim form.
- If all dates of services are on and after Oct. 1, 2015, file with ICD-10 codes.

**For inpatient facility claims:**
- If the discharge date is prior to Oct. 1, 2015 – file with ICD-9 codes.
- If the admit date is before Oct. 1, 2015 and the discharge date is after Oct. 1, 2015 – file with ICD-10 codes.
- If the admit date is on or after Oct. 1, 2015 – file with ICD-10 codes.
### Specificity of Codes

#### Example of specific ICD-10 coding:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F90.0</td>
<td>predominantly inattentive type</td>
</tr>
<tr>
<td>F90.1</td>
<td>predominantly hyperactive type</td>
</tr>
<tr>
<td>F90.2</td>
<td>combined type</td>
</tr>
<tr>
<td>F90.8</td>
<td>other type</td>
</tr>
<tr>
<td>F90.9</td>
<td>unspecified type</td>
</tr>
</tbody>
</table>

*Header codes are considered incomplete and are not valid billable codes*

Only bill the unspecified code when no other code is appropriate.

### Billing Guidelines

- Autism Benefits & ABA
- Psychotherapy E&M Codes
- IOP / PHP
- Off-Campus Services
Autism Benefits

We cover the diagnosis and treatment of autism for persons under the age of 21 on most policies*

Authorization Required for ABA Services – all reviews and authorizations related to the diagnosis and treatment of autism are handled by Magellan through Dec. 31, 2015. Services on and after Jan. 1, 2016, are handled by New Directions.

Filing Autism Claims – file all claims related to the diagnosis and treatment of autism directly to Blue Cross for processing.

*Autism Benefits do not apply for Federal Employee Program (FEP) or some individual policies and may vary for self-insured groups and BlueCard® members. Always verify members’ benefits to determine applicable benefits and any maximum benefit limitations.

Applied Benefits Analysis
Billing Guidelines

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>H032</td>
<td>ABA – Initial Assessment and Plan Development per house up to 4 hours</td>
<td>HO, HP</td>
</tr>
<tr>
<td>H2019</td>
<td>ABA – Follow-up and Reassessment per 15 minutes</td>
<td>HO, HP, HN, HM</td>
</tr>
<tr>
<td>G9012</td>
<td>Supervision of ABA Follow-up per 15 minutes</td>
<td>HO, HP</td>
</tr>
</tbody>
</table>

Modifier Descriptions:
- HP – Doctoral level
- HO – Master’s degree level
- HN – Bachelor’s degree level
- HM – Less than bachelor’s degree level

Failure to include a modifier may result in your claim being returned or denied.

Claims filed with a primary diagnosis of autism will be subject to the patient’s autism maximum and limitations. Claims filed with a secondary diagnosis of autism will be processed according to the primary diagnosis code listed on the claim.

Before the end of the year, we will contact providers who render ABA services to update them on our new ABA process that will be effective Jan. 1, 2016.
Psychotherapy
E&M Codes

We allow payment for evaluation and management (E&M) codes and the following psychotherapy codes when billed on the same claim:

- Psychiatrists and psychologists may bill E&M codes, if appropriate for the service provided and licensed to do so
- New psychotherapy codes bundle as mutually exclusive to all E&M codes
- When psychotherapy and E&M codes are billed on same claim, payment is applied to the line with the highest billed charge
- Pharmacologic management CPT code 90863 will bundle as incidental to psychotherapy codes, which are already incidental to E&M codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90833</td>
<td></td>
</tr>
<tr>
<td>90836</td>
<td></td>
</tr>
<tr>
<td>90838</td>
<td></td>
</tr>
</tbody>
</table>

IOP / PHP

In June 2015, we added billing guidelines for Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP) services to the Member Provider Policy & Procedure Manual.

Available on iLinkBLUE:
Go to www.bcbsla.com/ilinkblue, then click on Manuals

Billing Guidelines Include:
- General IOP and PHP coverage criteria
- IOP-specific patient eligibility criteria
- PHP-specific patient eligibility criteria
- Frequency and duration of IOP/PHP services
- Individualized treatment plan
- Physician supervision and evaluation
- Discharge planning
- Expectation of improvement
- Documentation requirements and physician supervision
- Billing instructions
IOP / 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 will be determined based on the primary reason the member is receiving IOP/PHP services:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Type of Service</th>
<th>Revenue Code</th>
<th>Required HCPCS Code</th>
<th>Service Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOP Psychiatric</td>
<td>905</td>
<td>S9480: intensive outpatient psychiatric services, per diem</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>IOP Chemical Dependency</td>
<td>906</td>
<td>H0015: alcohol and/or drug services; intensive outpatient treatment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PHP Chemical Dependency or Psychiatric</td>
<td>912</td>
<td>H0035: mental health partial hospitalization treatment less than 24 hours</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PHP Chemical Dependency or Psychiatric</td>
<td>913</td>
<td>H0035: mental health partial hospitalization treatment less than 24 hours</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Only one IOP/PHP revenue code is allowed per day with a unit of “1.” Claims should not be billed with individual therapy codes.

Off-campus Services

Effective Jan. 1, 2016

Facility:

For off-campus facility claims, Modifier PO should be reported for each service, procedure and/or surgery performed at off-campus provider-based outpatient departments.

Professional:

- Report place of service code 19 when a patient obtains services from a portion of the hospital’s off-campus provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.
- Report place of service code 22 when a patient obtains services from a portion of the hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons but does not require hospitalization or institutionalization.

Blue Cross is adopting CMS guidelines for off-campus services and will publish additional information as we have more details.
Online Resources

- Provider Page
- Provider Representative Map
- iLinkBLUE Provider Suite
- Multimedia Sites
- Provider Update Form

www.bcbsla.com/providers

- Authorizations
  - Inpatient & Outpatient
  - Imaging
- Credentialing
- Education on Demand
  - Manuals
  - Speed Guides
  - Tidbits
- Forms for Providers
- ICD-10 Conversion
- Newsletters
- OGB
- Pharmacy Management
- Provider Tools
- Quality Blue
- And more!
We have an interactive map of provider representatives:

- Network Development
- Provider Relations
- Statewide

Located under the “Provider Tools” section www.bcbsla.com/providers

Provider Rep Map

Roll over parish to see names and phone numbers of representatives for your service area

iLinkBLUE Provider Suite

iLinkBLUE is your one-stop for:

- Benefits
- Eligibility
- Claims Research
- Payment Information
- Authorizations
- Electronic Funds Transfer
- BlueCard Medical Record Requests
- Medical Policies
- Manuals
- Allowable Charges
- Estimated Treatment Cost
- Grace Period Notices
- Medical Code Editing
- And so much more!

www.bcbsla.com/linkblue
Allowable Charges in iLinkBLUE

<table>
<thead>
<tr>
<th>Contract # Search</th>
<th>Coverage Information</th>
<th>Claims Entry</th>
<th>Claims Research</th>
<th>Medical Record Requests</th>
<th>Out Of Area</th>
<th>Allowable Charges</th>
<th>Authorizations and Medical Policy</th>
<th>Continuation Reports</th>
<th>E&amp;F Notifications</th>
<th>Identification Advice</th>
<th>BlueCard - Out Of Area</th>
<th>MVP Update</th>
<th>Manuals</th>
<th>Medical Code Editing</th>
<th>Estimated Treatment Cost</th>
</tr>
</thead>
</table>

**Professional Provider Allowable Charges**

Please Select a Date: **2015-09-23**

Provider #

**Continue** (*Click on continue to enable the other selections.*)

**Network:** Select a Network

**CPT Code:**

An asterisk (*) can be used as a wildcard.

Using iLinkBLUE, you can look up allowables for a single code or a range of codes.

**Single Code Example:** 90833 (allowable results for 90833 only)

**Code Range Examples:**
- 908* (allowable results include all codes beginning with 908)
- 90* (allowable results include all codes beginning with 90)
- 9* (allowable results include all codes beginning with 9)

---

Multimedia

- Connect with us on Facebook:
  www.facebook.com/bluecrossla

- Follow Blue Cross & CEO Mike Reitz on Twitter:
  www.twitter.com/BCBSLA
  www.twitter.com/MikeReitzCEO

- Watch us on YouTube:
  www.youtube.com/bluecrossla
Need to Update Your Contact Information?

It is important that we always have your most current contact information in our files. If you have an address, phone, fax and/or email address change, submit your new information via our online interactive Provider Update Form:

www.bcbsla.com/providers >Forms for Providers

Support Teams

- Electronic Services
- Provider Call Centers
- Provider Relations
- Network Development
- Network Operations
Electronic Services

iLinkBLUE Provider Suite
https://www.bcbsla.com/ilinkblue
(800) 216-BLUE (2583) or (225) 293-LINK (5465)
ilinkblue.providerinfo@bcbsla.com

Electronic Funds Transfer
Network Administration
(800) 716-2299, option 3 or (225) 297-2758
network.administration@bcbsla.com

EDI Clearinghouse Services
EDI Clearinghouse Support Desk
(225) 291-4334
EDICH@bcbsla.com

Provider Call Centers

Provider Services (800) 922-8866
FEP Dedicated Unit (800) 272-3029
OGB Dedicated Unit (800) 392-4089

Other Provider Phone Lines
BlueCard Eligibility Line® – (800) 676-BLUE (2583)
for out-of-state member eligibility and benefits information
Fraud & Abuse Hotline – (800) 392-9249
Call 24/7. You can remain anonymous. All reports are confidential.
Network Administration – (800) 716-2299
Option 1 – for questions regarding provider contracts
Option 2 – for questions regarding credentialing/recredentialing
Option 3 – for questions regarding your provider file record
Option 4 – for questions regarding provider relations

For information NOT available on iLinkBLUE
Protocol for Contacting Provider Relations

1. Research claim on iLinkBLUE.

2. Submit an Action Request through iLinkBLUE & request that claim be reviewed for correct processing. Be specific and detailed. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

3. If no satisfactory resolution, contact Provider Services (number on back of member ID card). Provider Services will issue a reference/task number. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

4. If claim is still not resolved, place a second call to Provider Services. Ask for a supervisor to escalate claim for correct processing. An additional reference/task number will be issued. Allow 10-15 working days, then check iLinkBLUE for a claims resolution.

5. If you have made at least two attempts to have your claims reprocessed and have been issued two separate call reference numbers by Provider Services you may then email an overview of the issue and the two reference numbers to provider.relations@bcbsla.com.

Provider Relations

Merle Francis – merle.francis@bcbsla.com
  director

Kim Gassie – kim.gassie@bcbsla.com
  manager

Anna Granen
anna.granen@bcbsla.com
  Jefferson, Plaquemines, Orleans, St. Bernard, St Charles, St. James, St. John the Baptist, St Tammany, Washington

Jami Zachary
jami.zachary@bcbsla.com
  Caldwell, E. Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Terre, Union, W. Carroll, and E. Baton Rouge

Kelly Smith
kelly.smith@bcbsla.com
  Acadia, Evangeline, Iberia, Jefferson Davis, St. Landry, St. Martin, Vermilion  |  Statewide e-Business Representative – assists with EFT and iLinkBLUE set-up

Marie Davis
marie.davis@bcbsla.com
  Allen, Beauregard, Calcasieu, Cameron, Lafayette

Mary Guy
mary.guy@bcbsla.com
  Ascension, Assumption, E. Feliciana, Iberville, Lafourche, Livingston, Point Coupée, St. Helena, St. Mary, Tangipahoa, Terrebonne, W. Baton Rouge, W. Feliciana and E. Baton Rouge

Patricia O’Gwynn
patricia.ogwynn@bcbsla.com
  Avoyelles, Bienville, Bossier, Caddo, Claiborne, Concordia, De Soto, Grant, La Salle, Natchitoches, Rapides, Red River, Sabine, Vernon, Webster, Winn

provider.relations@bcbsla.com  |  (800) 716-2299, option 4
Network Development

Shannon Taylor – shannon.taylor@bcbsla.com
director

Vicki Hughes – vicki.hughes@bcbsla.com
manager

Dayna Roy
dayna.roy@bcbsla.com
Alexandria/Lake Charles

Jason Heck
jason.heck@bcbsla.com
Shreveport/Monroe

Mary Reising
mary.reising@bcbsla.com
Northshore

Mica Toups
mica.toups@bcbsla.com
Lafayette

Sue Condon
sue.condon@bcbsla.com
Baton Rouge

New Orleans Area
network.development@bcbsla.com or
(800) 716-2299, option 1

(800) 716-2299, option 1
Doreen Prejean
Mary Landry
Karen Armstrong

Network Operations

Vicki Jones [manager] – vicki.jones@bcbsla.com or (225) 298-1842

Rhonda Dyer [supervisor] – rhonda.dyer@bcbsla.com or (225) 295-2068

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Alpha</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batson Rouge Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linda McKay – credentialing</td>
<td>A-Z</td>
<td>(225) 298-1558</td>
<td><a href="mailto:linda.mckay@bcbsla.com">linda.mckay@bcbsla.com</a></td>
</tr>
<tr>
<td>Mert Terrance – provider file</td>
<td>A-Z</td>
<td>(225) 297-2639</td>
<td><a href="mailto:mercedes.terrance@bcbsla.com">mercedes.terrance@bcbsla.com</a></td>
</tr>
<tr>
<td>Lafayette, Lake Charles and Alexandria Regions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eve Jupiter – credentialing</td>
<td>A-L</td>
<td>(225) 298-7871</td>
<td><a href="mailto:eve.jupiter@bcbsla.com">eve.jupiter@bcbsla.com</a></td>
</tr>
<tr>
<td>Linda Denicola – provider file</td>
<td>A-L</td>
<td>(225) 298-1537</td>
<td><a href="mailto:linda.denicola@bcbsla.com">linda.denicola@bcbsla.com</a></td>
</tr>
<tr>
<td>Hope Pace – provider file</td>
<td>M-Z</td>
<td>(225) 295-2301</td>
<td><a href="mailto:hope.pace@bcbsla.com">hope.pace@bcbsla.com</a></td>
</tr>
<tr>
<td>Monroe and Shreveport Regions/Out-of-State Facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kim Walker – credentialing</td>
<td>A-Z</td>
<td>(225) 298-1440</td>
<td><a href="mailto:kimberly.walker@bcbsla.com">kimberly.walker@bcbsla.com</a></td>
</tr>
<tr>
<td>Dannay Bourgeois – provider file</td>
<td>A-Z</td>
<td>(225) 295-2263</td>
<td><a href="mailto:dannay.bourgeois@bcbsla.com">dannay.bourgeois@bcbsla.com</a></td>
</tr>
<tr>
<td>New Orleans Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaquisha Huston – credentialing</td>
<td>A-L</td>
<td>(225) 295-2046</td>
<td><a href="mailto:jaquisha.huston@bcbsla.com">jaquisha.huston@bcbsla.com</a></td>
</tr>
<tr>
<td>Cheryl Ward – credentialing</td>
<td>M-Z</td>
<td>(225) 297-2873</td>
<td><a href="mailto:cheryl.ward@bcbsla.com">cheryl.ward@bcbsla.com</a></td>
</tr>
<tr>
<td>Shakeysha Gray – provider file</td>
<td>A-L</td>
<td>(225) 297-2756</td>
<td><a href="mailto:shakeysha.gray@bcbsla.com">shakeysha.gray@bcbsla.com</a></td>
</tr>
<tr>
<td>Dana Mitchell – provider file</td>
<td>M-Z</td>
<td>(225) 298-3162</td>
<td><a href="mailto:dana.mitchell@bcbsla.com">dana.mitchell@bcbsla.com</a></td>
</tr>
</tbody>
</table>

(800) 716-2299 • option 2 – credentialing • option 3 – provider file
Fax: (225) 297-2750 • network.administration@bcbsla.com
Coming Soon!

ICD-10 Open Forums – Oct. 16, 23 & 30
(full details will soon be available online at www.bcbsla.com/providers >ICD-10 Conversion)

Webpass Portal Webinar – Dec. 16
(invitations will be sent to all network behavioral health facilities)

Blue Advantage Workshops - Dec. 2015
(invitations will be sent to behavioral health providers who participate in our Blue Advantage network)

Blue Advantage

Blue Advantage (our Medicare Advantage network) is available for 2016 in four markets.

Jefferson, Orleans, St. Charles, St. James, St. John the Baptist

Ascension, E. Baton Rouge, W. Baton Rouge, Livingston, St. Helena

Lafayette, St. Landry

St. Tammany, Washington

Blue Advantage Workshops - Dec. 2015
(invitations will be sent to facilities who participate in our Blue Advantage network)
Your Questions?