Blue Advantage Behavioral Health Webinar

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

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

How to submit questions:

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

November 2024

BEHAVIORAL HEALTH

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

LOUISIANA BLUE

Blue adVantage (HMO) | Blue adVantage (PPO)

Marie Davis,
Senior Provider Relations Representative

Y0132_24999PVLA_C

Our Mission

To improve the health and lives of Louisianians.

Our Core Values

- Health
- Affordability
- Experience
- Sustainability
- Foundations

Our Vision

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

Agenda

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

Welcome to the Blue Advantage Network

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

LOUISIANA BLUE

Blue adVantage (HMO) | Blue adVantage (PPO)

Who are we?

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

Member ID Cards

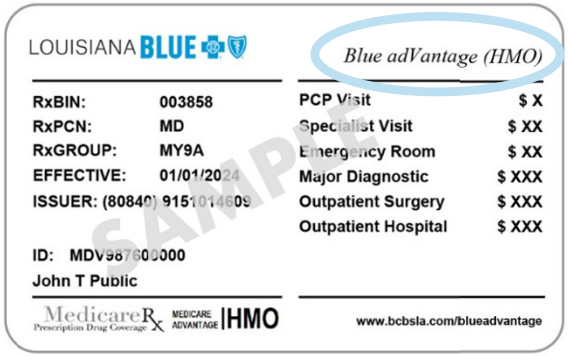
Member ID Cards

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

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

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

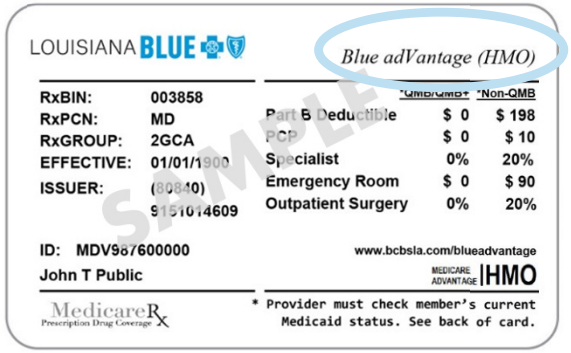
Prefix: PMV



Prefix: MDV

D-SNP Member ID Card

Dual eligible special needs plans (D-SNPs) are a type of Medicare Advantage plan designed to meet the specific needs of dually eligible members currently available to Medicare-eligible members statewide. D-SNP members must use Blue Advantage network providers except for select situations such as emergency care.



Prefix: MDV

Reminders & Resources

Credentialing Information

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

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

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

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

Compliance Reminders

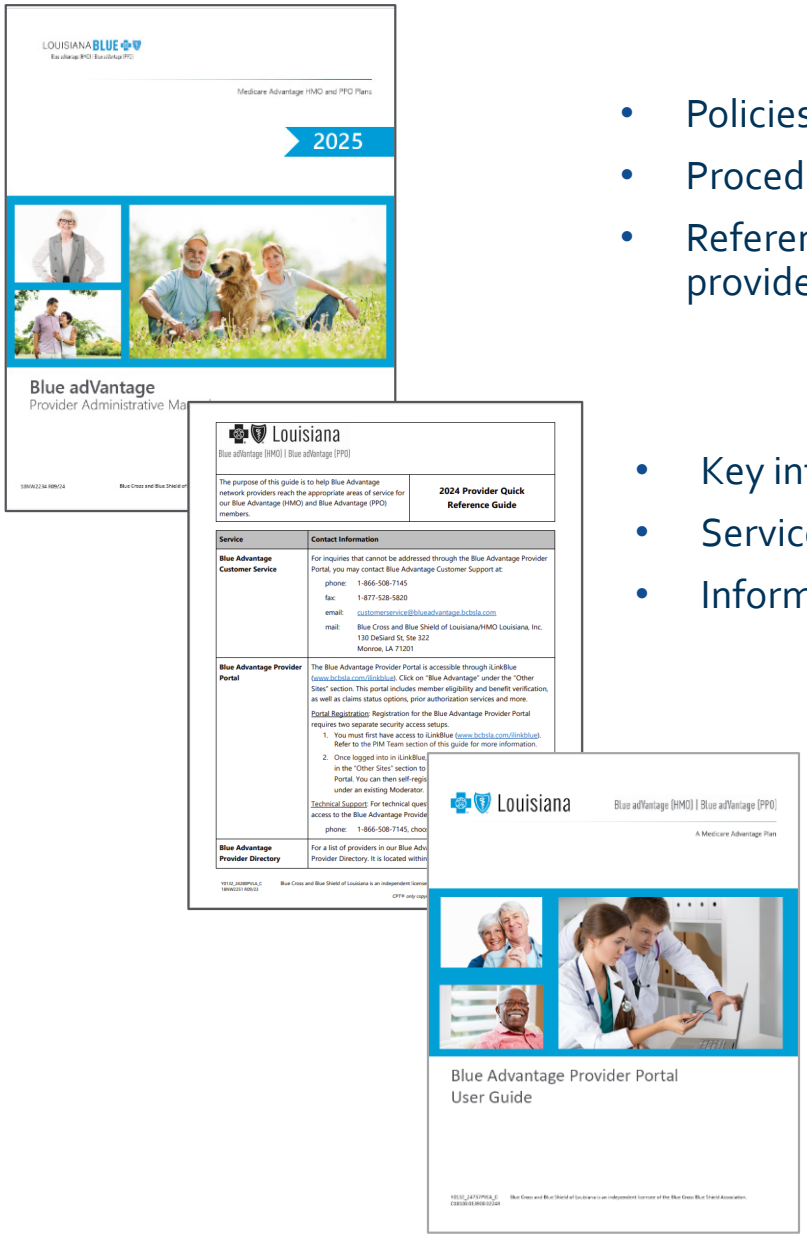
As a Blue Advantage provider, you are required to:

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

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

To notify us of any practice changes, use our Provider Update Request Form found online at **www.lablue.com/providers** under "Resources" then "Forms."

Blue Advantage Manuals and Guides



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

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

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

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

Blue Advantage Customer Service

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

1-866-508-7145

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

1-877-528-5820

customerservice@blueadvantagela.com

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

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

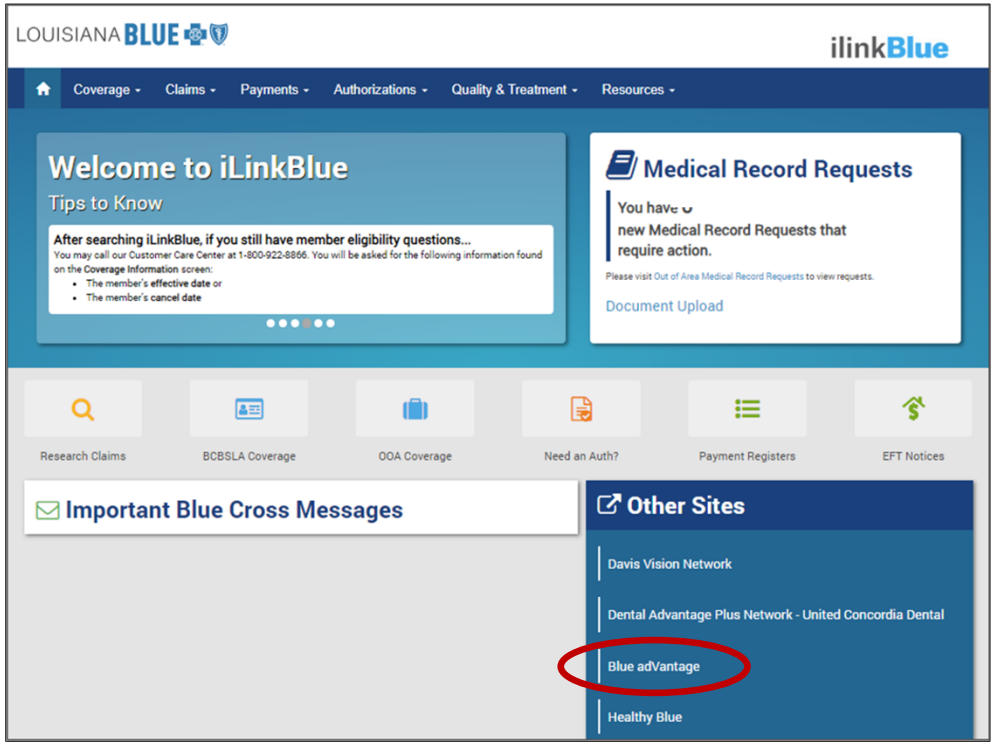
Blue Advantage Provider Portal

Accessing Our Secure Online Services

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

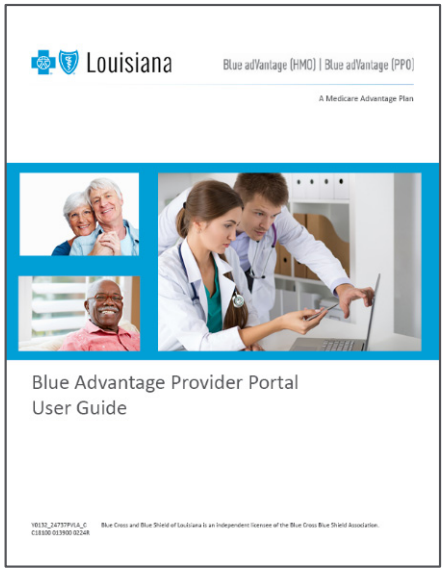
- iLinkBlue
- Blue Advantage Provider Portal

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



Helpful Hints

- For additional details on how to register for the Blue Advantage Provider Portal, download the *Blue Advantage Portal User Guide*. Go to **www.lablue.com/ilinkblue**, then click "Blue Advantage" under the "Other Sites" section.
- We recommend using Google Chrome to access the Blue Advantage Provider Portal.
- The portal uses cookies to remember your login information and you **must** enable cookies for the portal, in order to successfully log in and access all its features.

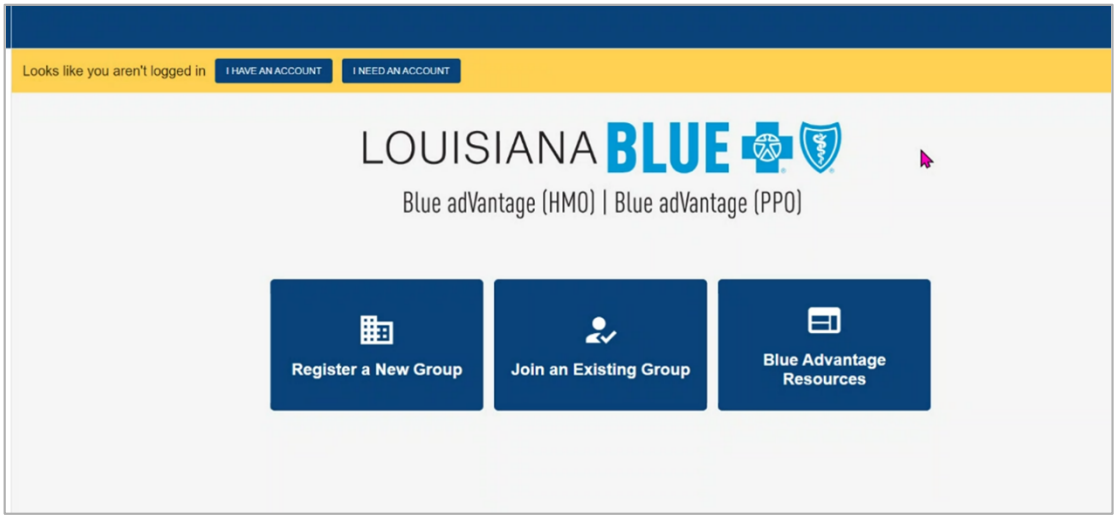


For additional information, please see the "Troubleshooting" section of the *Blue Advantage Provider Portal User Guide* for detailed instructions.

Blue Advantage Provider Portal

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

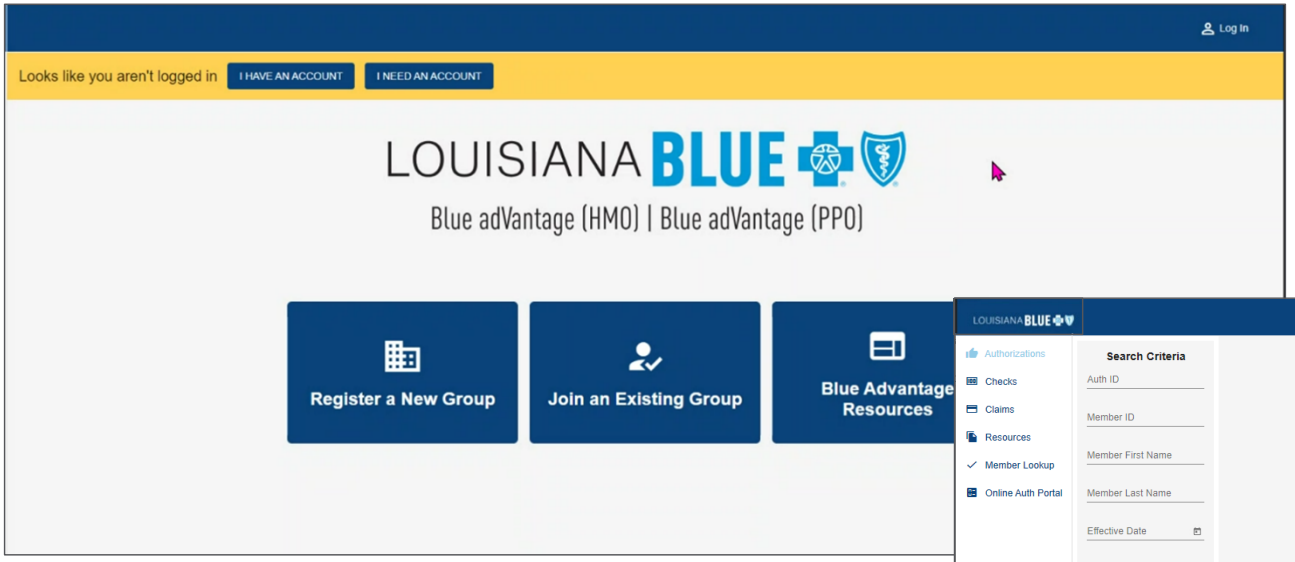
- Claims Inquiry
- Member Eligibility
- Provider/Pharmacy Directory
- Pharmacy Benefit Resources
- Provider Administrative Manual
- Provider Quick Reference Guide
- Provider Forms
- And more



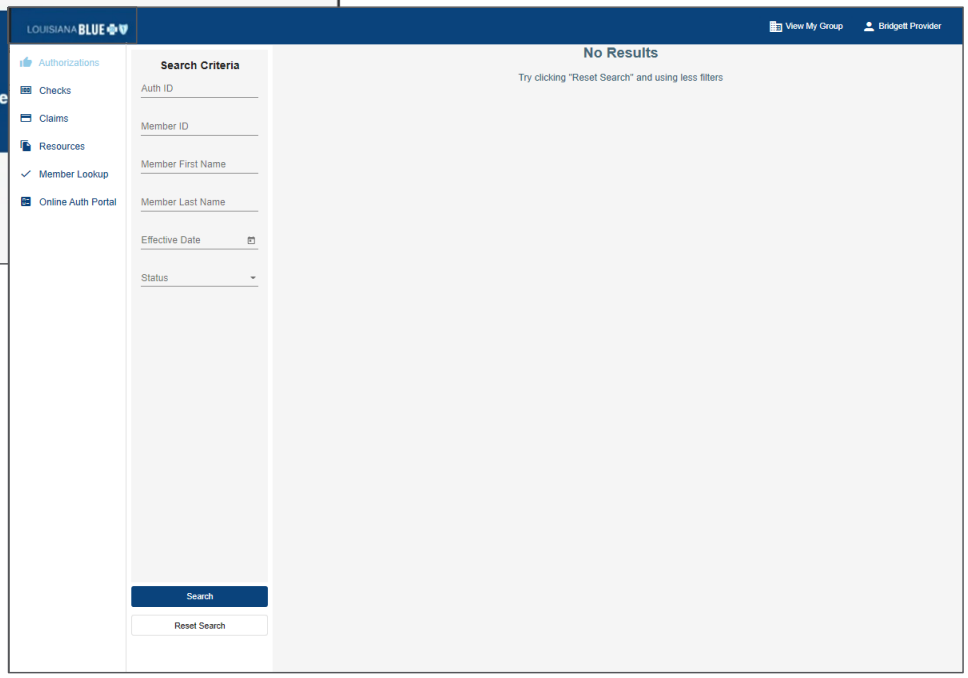
The Blue Advantage Provider Portal is available through iLinkBlue (**www.lablue.com/ilinkblue**) >**Blue Advantage** (under Other Sites).

Accessing the Blue Advantage Portal

Provider Portal Login



Provider Portal Home Page



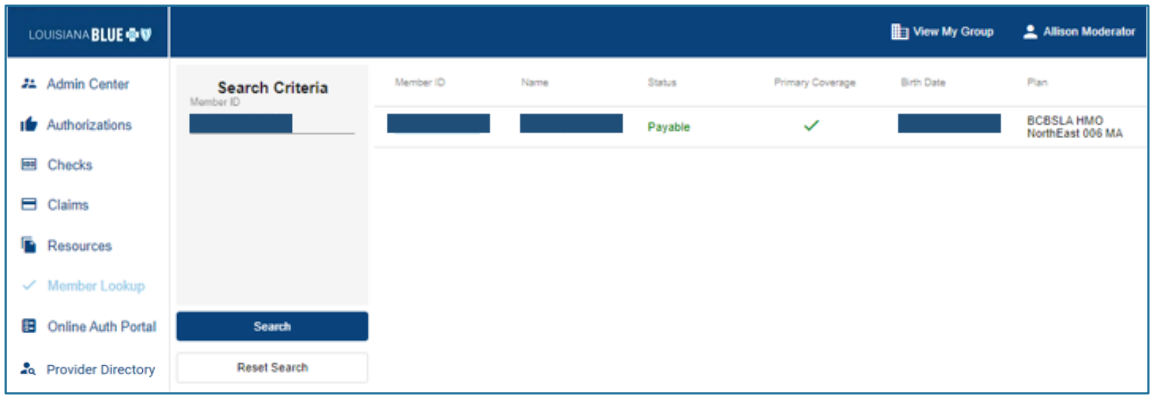
Once registration is complete, providers will be able to log in and access all available portal features.

Member Lookup

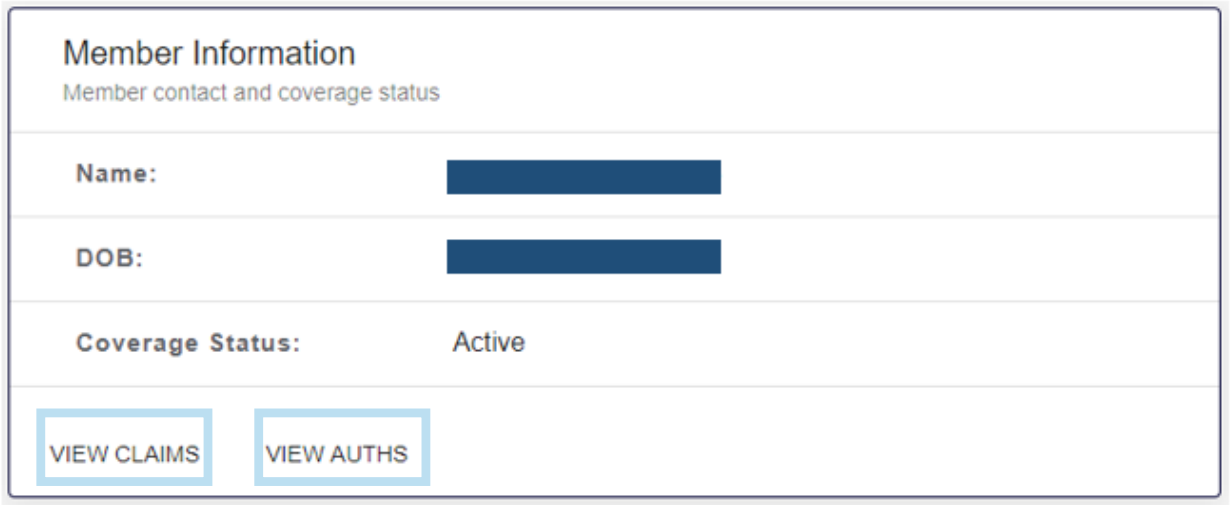
In order to lookup member information users **must** have the member ID. Users will not be able to view more than one member's information at a time. If you don't have the member ID, you can use the member's name and date of birth.

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

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



Member Lookup

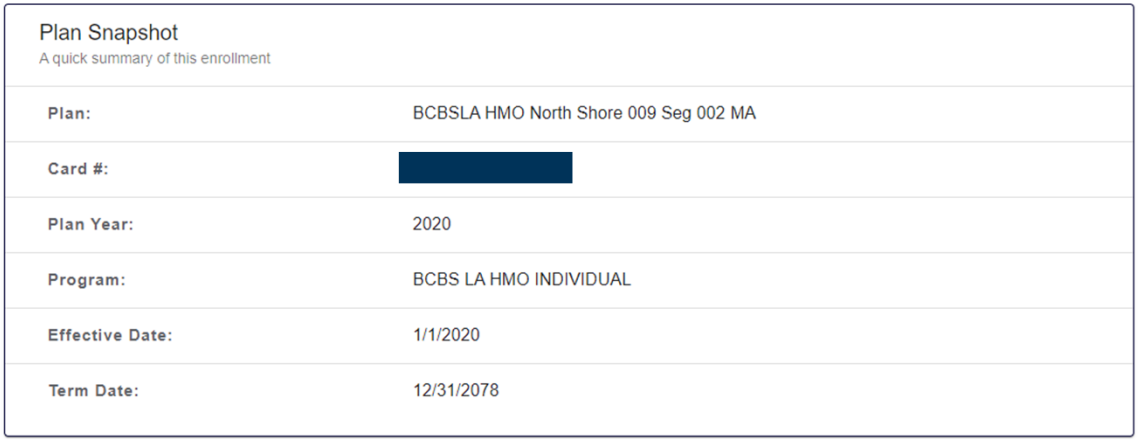


Member Information

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

Plan Snapshot

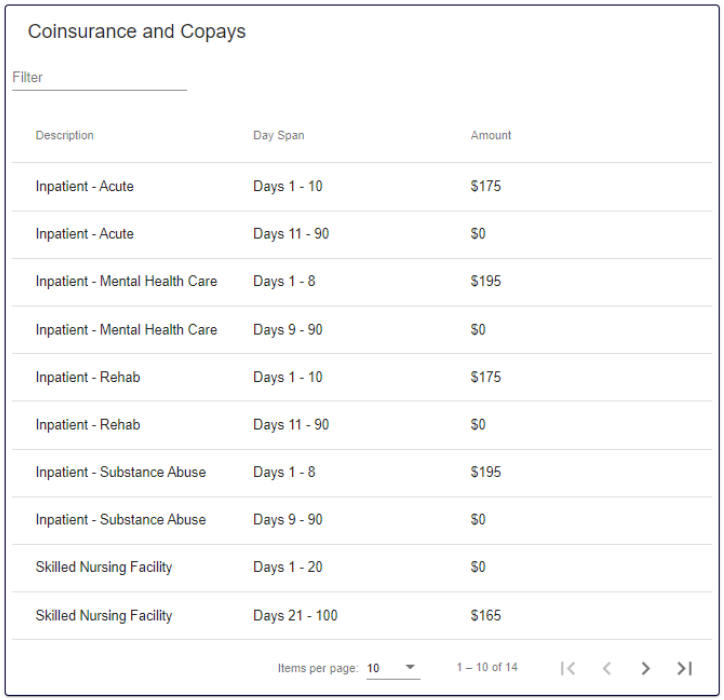
- Includes a summary of the member's enrollment information such as plan year, program and effective date.



Member Lookup

Documents and Accumulators

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



Coinsurance and Copays

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

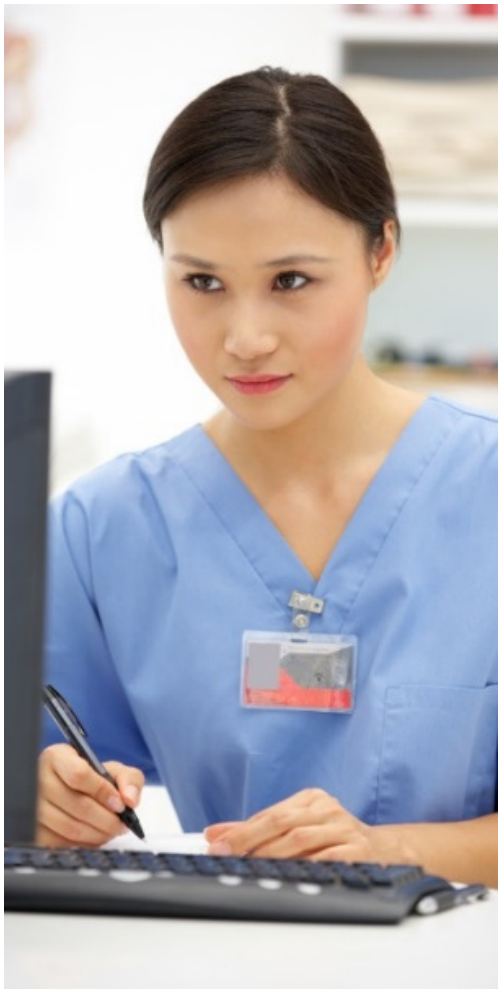
Medicare Advantage Members from Other Blue Plans

Medicare Advantage Members from Other Blue Plans

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

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

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



Medicare Advantage PPO Network Sharing

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

If you are a participating provider in our MA PPO network…	If you are NOT a participating provider in our MA PPO network…	If your practice is closed to new members…
you should provide the same access to care for Blue MA PPO members as you do for our members. Services will be reimbursed in accordance with your Louisiana Blue MA PPO allowable charges. The Blue MA PPO member's in-network benefits will apply.	but do accept Medicare and you see Blue MA PPO members; you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergent care, you will be reimbursed at the member's in-network benefit level.	you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members.

MA | PPO
MEDICARE ADVANTAGE

MA PPO Network Sharing

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

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

Telehealth

Telehealth Policy

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

Place of Service Codes in Telehealth

- Use **POS 10** for all direct to consumer (DTC) telehealth services.
- Bill non-DTC telehealth with the appropriate place of service based on the member's location when services are provided.
- For example, if the member is in the inpatient hospital setting when receiving telehealth services, bill POS 21.

- Do **not** bill POS 02 for telehealth services; Louisiana Blue does not consider POS 02 valid for claims submission. Claims billed with POS 02 will reject.
- Use **Modifier GT or 95,** whichever is appropriate, to indicate delivery of telemedicine services in real time.

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

Telemedicine Codes

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

Direct-to-consumer Codes

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

Providers should use the most current CMS appropriate codes.

HEDIS®

Follow-up after Hospitalization

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

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

Follow-up Appointment Guidelines

The behavioral health professional can be a:

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

The discharge information provided to Blue Advantage for the outpatient appointment needs to include each of the following:

- Name of individual provider
- His or her credentials
- Appointment date and time
- Contact information for this provider

Follow-up Appointment Guidelines

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

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

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

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

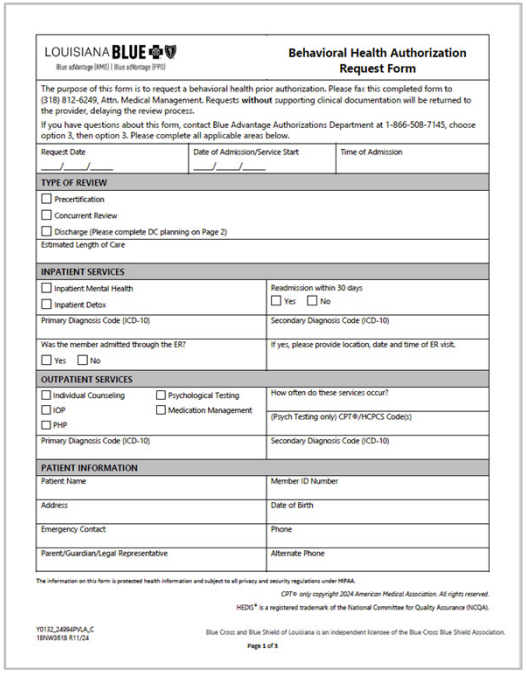
Authorizations

Services Requiring Authorization

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

Behavioral Health Authorization Request Form

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



LOUISIANA BLUE
Blue advantage (HMO) | Blue advantage (PPO)

Behavioral Health Authorization Request Form

The purpose of this form is to request a behavioral health prior authorization. Please fax this completed form to (318) 812-6249, Attn. Medical Management. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Authorizations Department at 1-866-508-7145, choose option 3, then option 3. Please complete all applicable areas below.

Request Date	Date of Admission/Service Start	Time of Admission
___/___/___	___/___/___	

TYPE OF REVIEW

- ☐ Precertification
- ☐ Concurrent Review
- ☐ Discharge (Please complete DC planning on Page 2)

Estimated Length of Care

INPATIENT SERVICES

☐ Inpatient Mental Health ☐ Inpatient Detox	Readmission within 30 days ☐ Yes ☐ No
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)
Was the member admitted through the ER? ☐ Yes ☐ No	If yes, please provide location, date and time of ER visit.

OUTPATIENT SERVICES

☐ Individual Counseling ☐ Psychological Testing ☐ IOP ☐ Medication Management ☐ PHP	How often do these services occur?
	(Psych Testing only) CPT®/HCPCS Code(s)
Primary Diagnosis Code (ICD-10)	Secondary Diagnosis Code (ICD-10)

PATIENT INFORMATION

Patient Name	Member ID Number
Address	Date of Birth
Emergency Contact	Phone
Parent/Guardian/Legal Representative	Alternate Phone

The information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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Page 1 of 3

To download the authorization form, go to **www.lablue.com/providers**, then click on "Blue Advantage" under the Other Sites section. Click "Resources," then "Forms."

The *Provider Quick Reference Guide* includes the list of services requiring prior authorization. It is available on the Blue Advantage Resources page, **www.lablue.com/providers**, then click "Go to BA Resources" at the bottom of the page.

Behavioral Health Authorization Request Process

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

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

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

Please include all pertinent clinical information with your request.

Behavioral Health Authorization Request Process

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

Documentation Requirements for Behavioral Health Authorization Requests

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

Documentation Requirements for Behavioral Health Authorization Requests

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

Documentation Requirements for Behavioral Health Authorization Requests

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

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

Documentation Requirements for Behavioral Health Authorization Requests

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

Documentation should be legible.

Medical Necessity

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

Retroactive Authorization

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

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

Online Auth Portal

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

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

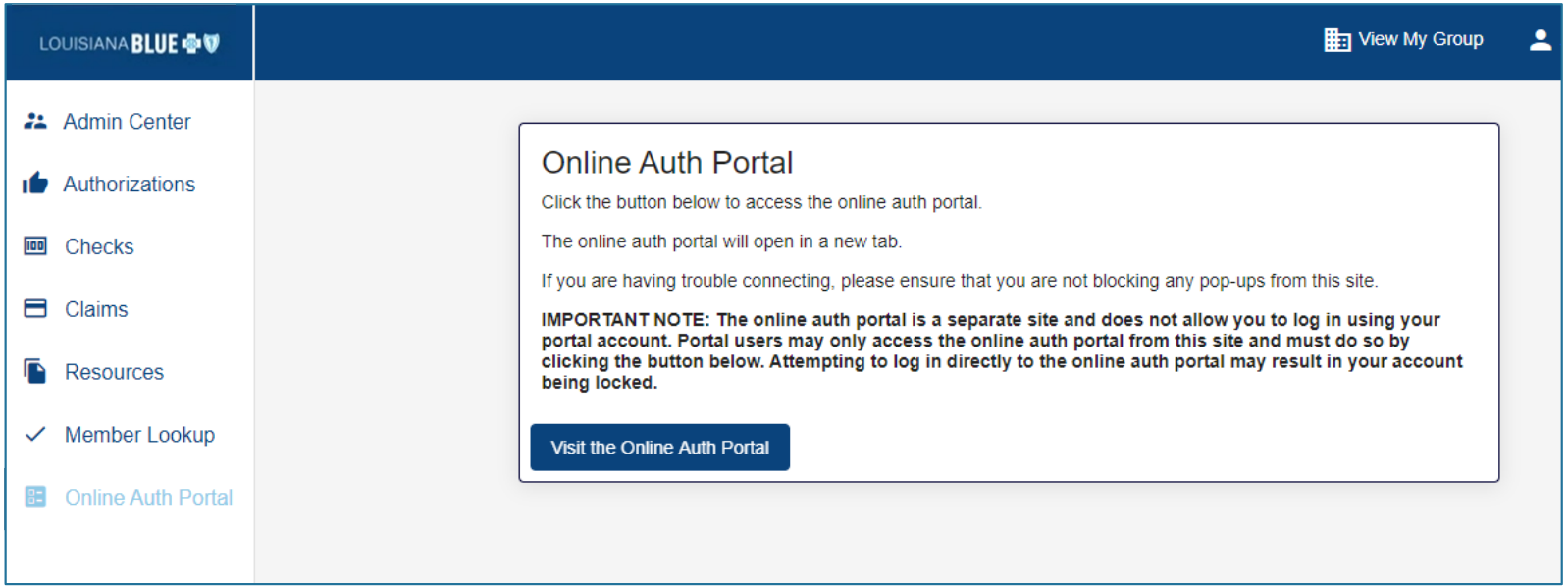
Creating An Outpatient Authorization

For Behavioral Health Requests:

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

Online Auth Portal

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

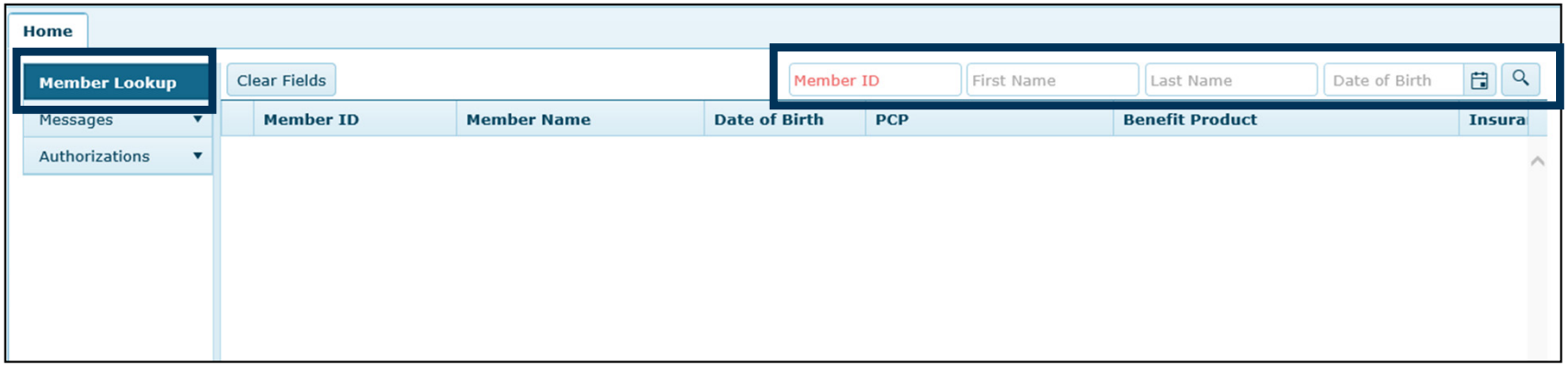


Creating An Outpatient Authorization

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

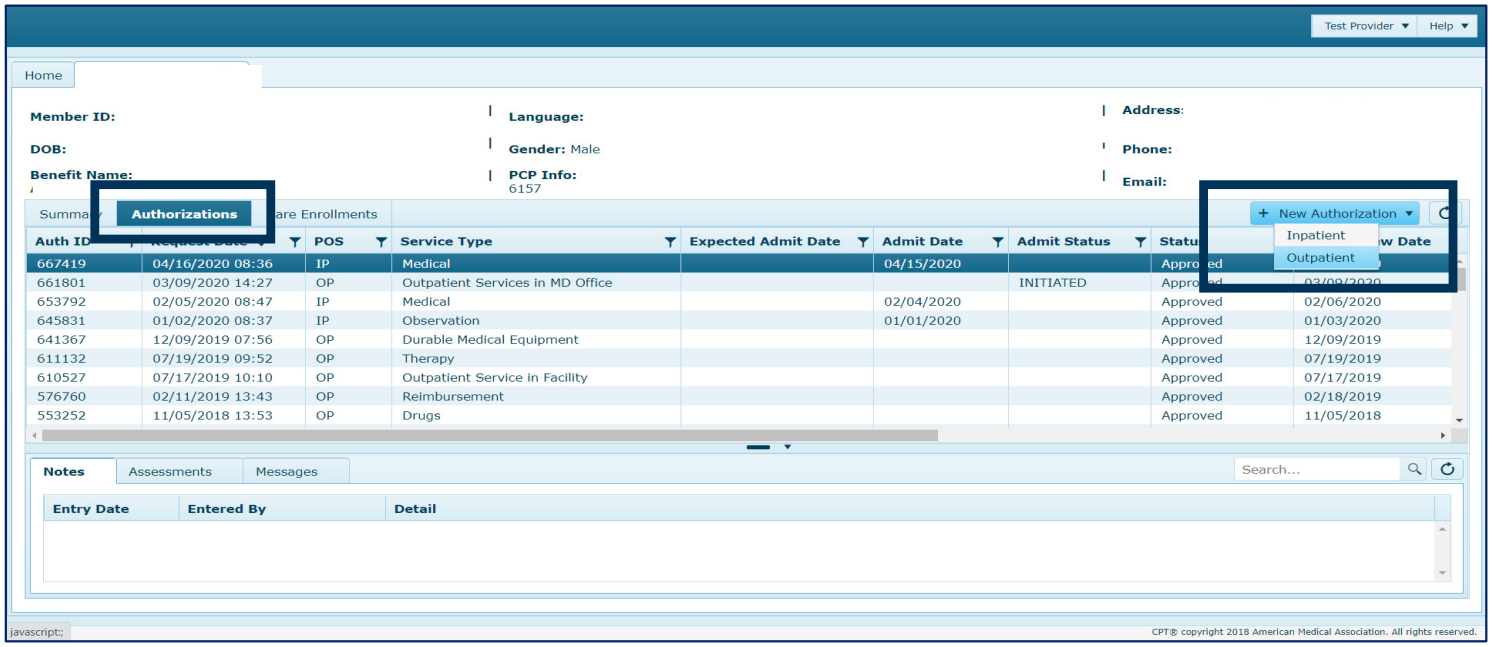
- First Name and Last Name or Date of Birth

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



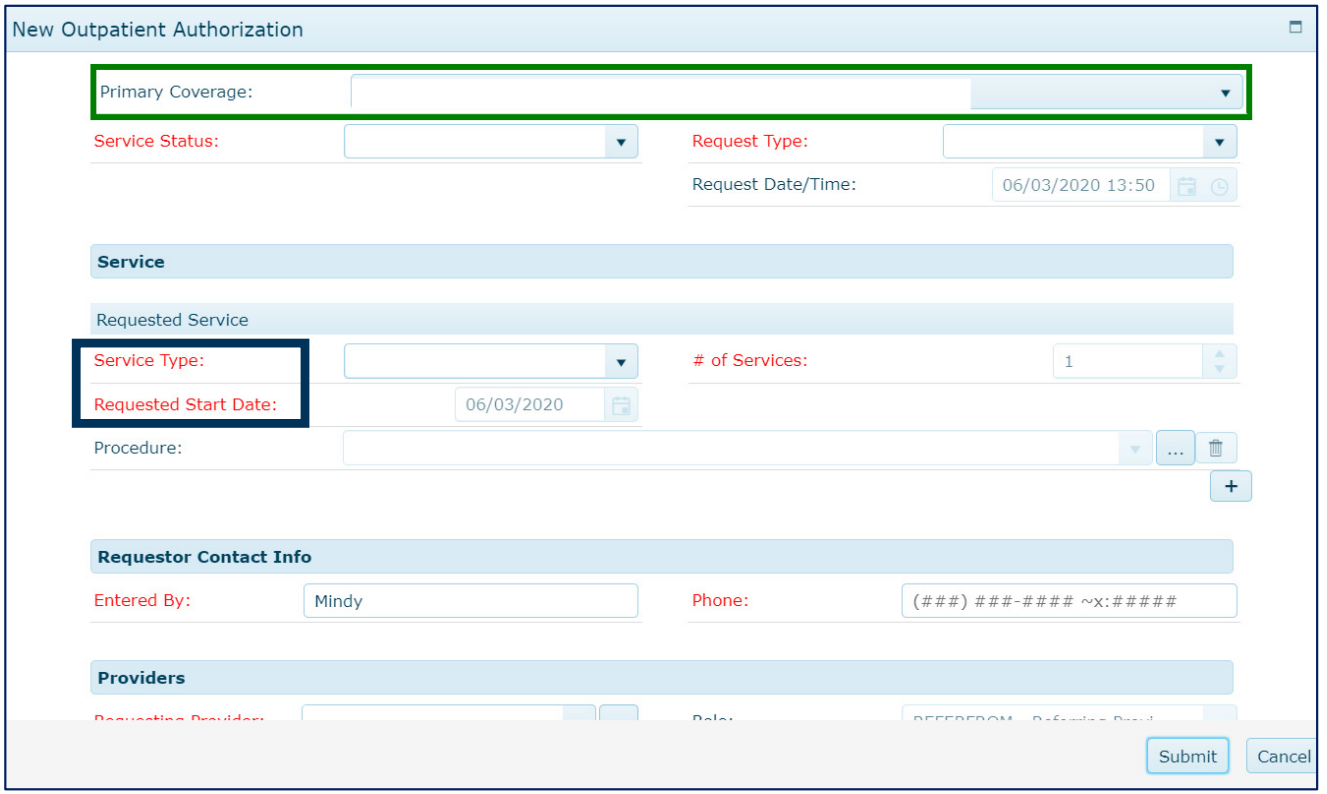
Creating An Outpatient Authorization

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



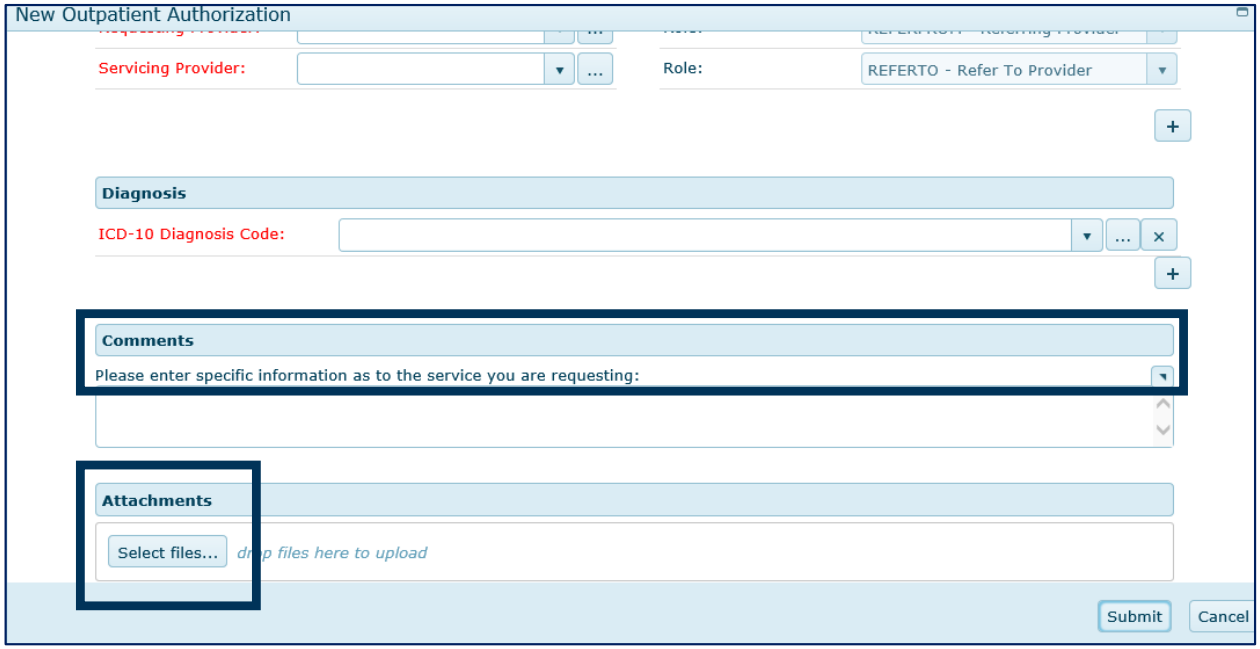
Creating An Outpatient Authorization

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



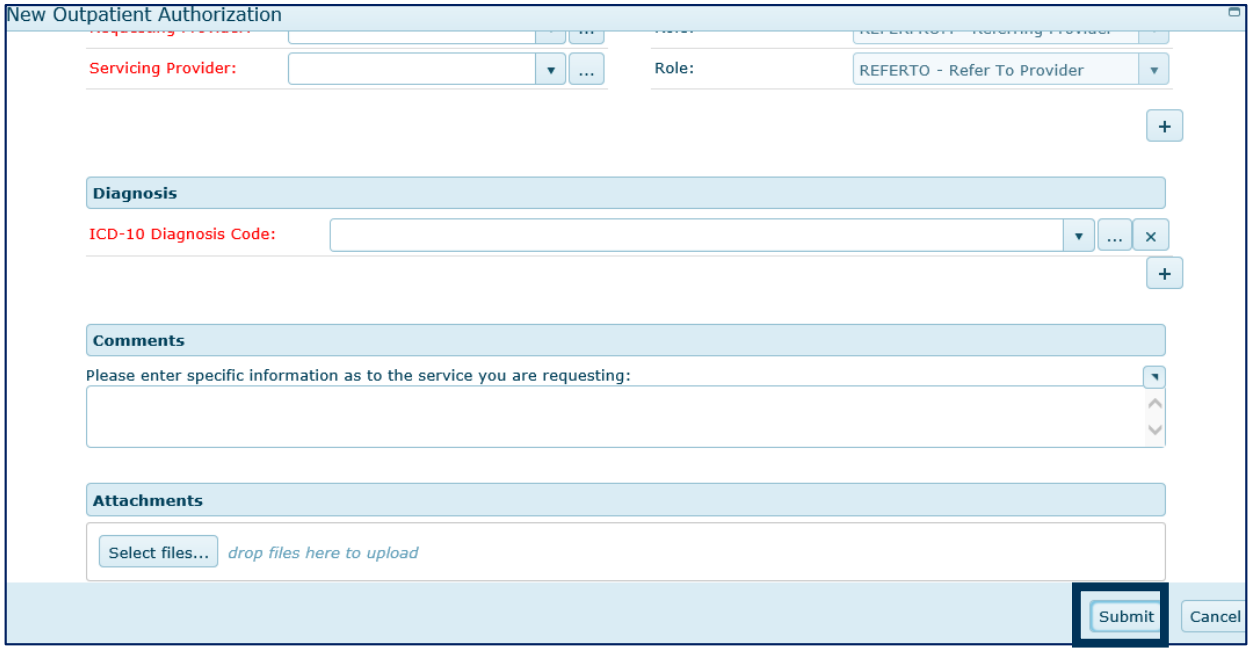
Creating An Outpatient Authorization

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



Creating An Outpatient Authorization

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



Call Centers

Authorizations (including Medical Management)

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

Behavioral Health

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

Blue Advantage Customer Service

1-866-508-7145
customerservice@blueadvantagela.com

Blue Advantage Provider Portal

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

Provider Disputes

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

Pharmacy

1-800-935-6103/TTY:711

Provider Relations

Jami Zachary Director

Paden Mouton Provider Relations Manager

Mary Reising Health System Representative

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

Brittany Fields
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Lisa Roth
Online Portal Training

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

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

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

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

PCDM Department

Provider Network Setup, Credentialing, Contracting & Demographic changes

Sam Measels, Director, Provider Information (Credentialing)
sam.measels@lablue.com

Kaci Guidry, Manager, Provider Data Management & PCDM Status
kaci.guidry@lablue.com

Kristin Ross, Manager, Provider Contract Administration
kristin.ross@lablue.com

To check the status on your credentialing application or provider data update, please email **PCDMstatus@lablue.com** or call 1-800-716-2299, option 2.

Questions

Addendum

ABNs Not Used for Blue Advantage

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

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

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

Billing Requirements

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

- Faxed claims are not accepted.

Timely Filing

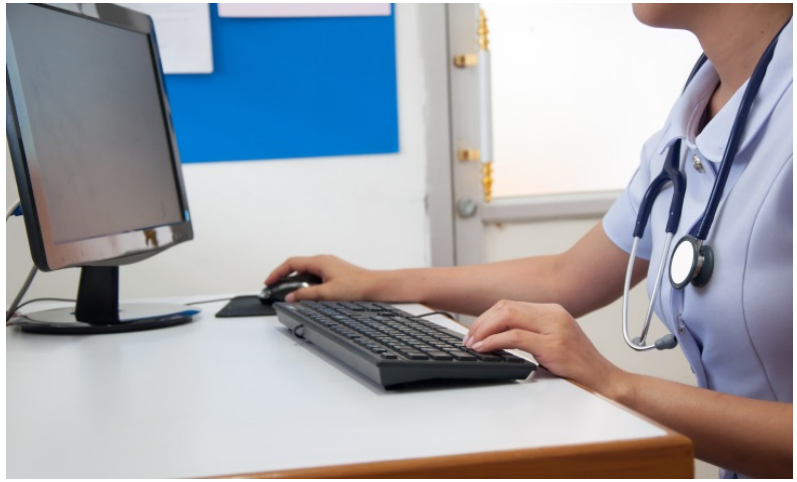
- Providers should check the language in their Blue Advantage agreement.

Refer to **www.CMS.hhs.gov** for specific details.

Checking Claim Status

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

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



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

Claims

Resubmission

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

Corrected

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

CMS-1500 Corrected Claims

EDI/1500/Professional claims can be submitted electronically as "Corrected Claims."

- In Loop 2300 ~ CLM05-03 must contain a "7," REF01 must contain an "F8" and REF02 must contain the original reference claim number.
- Indicate a reason for the correction in the note field.

1500 paper claim forms can be submitted as "corrected claims."

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

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

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

UB-04 Corrected Claims

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

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

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

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

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

Resolving Claims Issues

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

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

When to Contact Provider Relations for Claims Help

If unresolved after second request, you may email an overview of the issue along with documentation of your two requests to Provider Relations, **provider.relations@lablue.com**.

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

Adjustments, Additional Payments, Overpayments & Voluntary Refunds

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

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

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

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

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

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

Timely Filing Disputes

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

Electronically

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

Paper

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

OR

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

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

Subrogation

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

Provider Pay Disputes

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

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

Once a decision has been made:

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

Provider Pay Dispute Address:

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

Member Appeals

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

1. Must be filed within **60 days** from the date of the organizational determination (e.g., EOB or provider remit is issued, whichever is applicable).

2. Must be submitted in writing and **does not apply to participating providers unless it involves a pre-service request**.

3. Claim appeals can be filed by either a member or a non-contracted provider.

4. Pre-service appeals can be filed by both participating and non-participating providers, the member or the member's authorized representative, and can be submitted in writing or requested by calling Blue Advantage Customer Service at 1-866-504-7145.