MO HealthNet Managed Care (Medicaid)

Provider Manual

833-405-9086

provider.healthybluemo.com

MOHB-CD-PM-033909-23

Healthy Blue

How to apply for participation
If you are interested in participating in the Healthy Blue network, please visit **provider.healthybluemo.com** or call **833-405-9086**.

Table of Contents

Dear Provider,

Welcome to the Healthy Blue Missouri Medicaid network! We're pleased you've joined us.

We combine national expertise with an experienced local staff to operate community-based health-care plans. We are here to help you provide quality healthcare to our members.

Along with hospitals, pharmacies, and other providers, you play the most important role in managing care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of healthcare.

We want to hear from you. We invite you to participate in one of our quality improvement committees. Or feel free to call Provider Services at **833-405-9086** with any suggestions, comments, or questions.

Together, we can make a real difference in the lives of our members — your patients.

Sincerely,

Healthy Blue

1. INTRODUCTION

Who is Healthy Blue?

Healthy Blue is an expert in the Medicaid market, focused solely on meeting the healthcare needs of financially vulnerable Missouri members. We're dedicated to offering real solutions that improve healthcare access and quality for our members, while proactively working to reduce the overall cost of care. Healthy Blue does not use any policy or practice that has the effect of discriminating on the basis of race, skin color, national origin, gender, sexual orientation, gender identity, or disability.

We help coordinate physical and behavioral healthcare, and we offer education, access to care and condition care programs. As a result, we lower costs, improve quality and encourage better health status for our members.

We:

- Improve access to preventive primary care services
- Ensure selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services
- Improve health status outcomes for members
- Educate members about their benefits, responsibilities and appropriate use of care
- Utilize community-based enterprises and community outreach
- Integrate physical and behavioral healthcare
- Encourage:
    - Stable relationships between our providers and members
    - Appropriate use of specialists and emergency rooms (ERs)
    - Member and provider satisfaction

In a world of escalating healthcare costs, we work to educate our members about the appropriate utilization of healthcare services and their involvement in all aspects of their healthcare.

Whom Do We Serve?

Eligibility for enrollment in Healthy Blue is limited to individuals who are determined eligible for Medicaid or CHIP with physical health, behavioral health and substance use disorders, pregnancy, or who belong to mandatory or voluntary managed care populations.

Updates and Changes

This provider manual, as part of your *Provider Agreement* and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **provider.healthybluemo.com**. To request a free, printed copy of this manual, call Provider Services at **833-405-9086**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Healthy Blue, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

Quick Reference Information

Healthy Blue Website
Our provider website, **provider.healthybluemo.com**, offers a full complement of online tools such as:

- Enhanced account management tools.
- Detailed eligibility look-up tool with downloadable panel listing.
- Comprehensive, downloadable member listings.
- Easier authorization submission.
- New provider data, termination and roster tools.

Healthy Blue Office Addresses
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

Contact Information

Provider Services	**833-405-9086** 8 a.m. to 6 p.m. CT Monday to Friday Interpreter services available
Member Services	**833-388-1407** 8 a.m. to 5 p.m. CT Monday to Friday
Behavioral Health 24/7 Crisis Line	**833-405-9088**
24/7 NurseLine	**833-388-1407 (TTY: 711)** 24 hours a day, 7 days a week
AT&T Relay Services	**800-855-2880 (Spanish 800-855-2884)**
DentaQuest* (Dental Services)	**844-234-9832**
March Vision* (Vision Services)	**844-616-2724**
MTM* (Nonemergent Transportation)	**888-597-1193**
Durable Medical Equipment, Home Health and Home Infusion Services	Phone: **833-405-9086** Fax: **844-886-2750** **provider.healthybluemo.com**
Carelon Medical Benefits Management (Hi-Tech Radiology, Radiation Oncology, Cardiology, Genetic Testing, Rehabilitation (Physical, Occupational, Speech Therapies) and Sleep Medicine)	Carelon Medical Benefits Management manages precertification for the following solutions: • Hi-Tech Radiology • Radiation Oncology • Cardiology • Genetic Testing • Rehabilitation (Physical, Occupational, Speech Therapies) • Sleep Medicine • Musculoskeletal Programs

	Request prior authorization by visiting **providerportal.com** or by calling **855-574-6479**. *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **provider.healthybluemo.com**.
Electronic Data Interchange	Availity* Client Services: **800-282-4548** **Availity.com/contact-us**
Member Eligibility	**833-405-9086** **provider.healthybluemo.com**
Precertification/Notification – Physical Health	**Fax: 800-964-3627** **Phone: 833-405-9086** **provider.healthybluemo.com** Please provide the following: • Member ID number • Legible name of referring provider • Legible name of person referred to provider • Number of visits/services • Date(s) of service • Diagnosis • CPT® code • Clinical information Forms are available on our provider website.
Claims Information	**provider.healthybluemo.com** Mail paper claims to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing is 180 calendar days of the date of service for paper and electronic claims. Check claim status online or through our Interactive Voice Response (IVR) system at **833-405-9086**.
Member Medical Appeals	Member medical necessity appeals must be filed within 60 calendar days of the adverse benefit determination. You may appeal on behalf of the member with the member's written consent. Submit a member medical appeal to: Member Grievances and Appeals: P.O. Box 62429 Virginia Beach, VA 23466
Care Managers	Available from Monday through Friday from 8 a.m. to 5 p.m. Central time.

	For urgent issues at all other times, call **833-405-9086**.
Claim Payment Dispute	We have several options to file claim payment disputes: 1. Verbally (for reconsiderations only): Call Provider Services at **833-405-9086**. If you need to include supporting documentation (for example, *EOB*, *Consent Form*, medical records, etc.) please do not use this option. 2. Online (for reconsiderations and claim payment appeals): Use the secure Availity Payment Appeal application at **Availity.com**. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. 3. Written (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to: Healthy Blue Virginia Beach, VA 23466-1599 Healthy Blue requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal): • Your name, address, phone number, email, and either your NPI number or TIN • The member's name and his or her Healthy Blue ID number • A listing of disputed claims including the Healthy Blue claim number and the date(s) of service(s) • All supporting statements and documentation We must receive your dispute within 365 days from the date of the *EOP*. We will send a determination letter within 30 business days of receiving the dispute.
Member Grievances	Submit a member grievance to: Member Grievances and Appeals: P.O. Box 62429 Virginia Beach, VA 23466

2. PROVIDER INFORMATION

Member Medical Home

PCPs serve as the entry point into the healthcare system for the member — they are the foundation of the collaborative concept known as a patient-centered medical home (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.

Each Healthy Blue member chooses or is assigned a PCP, who takes primary responsibility for providing preventive health services, care of certain chronic conditions, and coordination of more complex or specialty care needs. This medical home model is a collaborative relationship between the member, the PCP, other healthcare providers, and Healthy Blue.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements; recognize areas for improvement; and ultimately develop more efficient, effective, and patient-centered care processes.

We offer the following support to practices that are seeking or have achieved PCMH recognition:

- A variety of reports based on Healthy Blue member data to help improve quality of care through our Medical Committee and other means, including email
- Our medical directors maintain an “open door” policy for all Healthy Blue providers
- Dedicated, local medical practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including care managers who work with your practice and may collaborate with you onsite
- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives through various performance improvement projects

Primary Care Providers

PCPs are responsible for the complete care of their patients, including:

- Providing primary care inclusive of basic behavioral health services
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring referrals to specialist care
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available
- Authorizing hospital services
- Maintaining the continuity of care
- Ensuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally competent manner

- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Maintaining a medical record of all services rendered by you and other referral providers
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations
- Providing a minimum of 20 office hours per week of appointment availability as a PCP
- Arranging for coverage of services to assigned members 24/7 in person or by an on-call physician
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs)
- Answering after-hours telephone calls from members immediately or returning calls within 30 minutes from when calls are received
- Continuing care in progress during and after termination of your contract for up to 30 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations

Responsibilities of the PCP

PCPs also have the responsibility to:

Communicate with Members

- Make provisions to communicate in the language or fashion primarily used by the member; contact our customer care center for help with oral translation services if needed
- Freely communicate with members about their treatment regardless of benefit coverage limitations
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their healthcare
- Advise members about their health status, medical care and treatment options regardless of whether benefits for such care are provided under the program
- Advise members on treatments that may be self-administered
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Treat all members with respect and dignity
- Provide members with appropriate privacy

Maintain Medical Records

- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non research-related care
- Share records subject to applicable confidentiality and HIPAA requirements
- Upon notification of the member's transfer to another health plan, Healthy Blue will request copies of the member's medical record, unless the member has arranged for the transfer. The provider must

transfer a copy of the member's complete medical record and allow the receiving health plan access (immediately upon request) to all medical information necessary for the care of that member
- Transfer of records should not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving health plan are the responsibility of the relinquishing health plan
- A copy of the member's medical record and supporting documentation should be forwarded by the relinquishing health plan's PCP within 10 business days of the receiving health plan's PCP's request or prior to the next scheduled appointment to the new primary care provider, whichever is earlier
- Obtain and store medical records from any specialty referrals in members' medical records
- Manage the medical and healthcare needs of members to ensure all medically necessary services are made available in a timely manner

Cooperate and Communicate With Healthy Blue
Participate in:
- Internal and external quality assurance
- Utilization review
- Continuing education
- Other similar programs
- Complaint and grievance procedures when notified of a member grievance
- Inform Healthy Blue if a member objects to provision of any counseling, treatments or referral services for religious reasons
- Identify members who would benefit from our care management or condition care programs
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Cooperate with the integration of behavioral health into our service delivery model in accordance with state mandates

Cooperate and Communicate With Other Providers
- PCPs are required to screen their patients for common behavioral health disorders, including screening for developmental delay and behavioral disorders as well as risk factors for child maltreatment, trauma and adverse childhood experiences. Members screening positive for any of these conditions should be referred to a behavioral health specialty provider for further assessment and possible treatment
- Screening tools for common disorders typically encountered in primary care are available on the Healthy Blue provider website at **provider.healthybluemo.com**.
- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid.
- Provide care management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's Medicaid program.
- Coordinate the services we furnish to the member with the services the member receives from any other Healthy Blue network program during member transition. Share with other healthcare providers serving the member the results of your identification and assessment of any member with special healthcare needs (as defined by the state) so those activities are not duplicated.
- Healthy Blue will work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for

developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma and adverse childhood experiences (ACEs). We will work to increase the percentage of children with positive screens who:
    - Receive a warm handoff to and/or are referred for more specialized assessment or treatment.
    - Receive specialized assessment or treatment.

Cooperate and Communicate With Other Agencies

- Maintain communication with the appropriate agencies such as:
- Local police
- Social services agencies
- Poison control centers
- Women, Infants and Children (WIC) program
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Coordinate the services we furnish to the member with the services the member receives from any other managed care plan during ongoing care and transitions of care

As a PCP, you may practice in a:

- Solo or group setting
- Clinic (for example, a federally qualified health center [FQHC] or rural health center [RHC])
- Private practice

Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Healthy Blue as a PCP:

- Advance practice nurse practitioner
- Family practitioner
- General practitioner
- General pediatrician
- General internist
- General OB/GYN
- Nurse practitioner certified as a specialist in family practice or pediatrics
- FQHC/RHC
- Specialist*

* Healthy Blue will allow vulnerable populations (for example, persons with multiple disabilities and/or acute or chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP as long as the specialist is willing to perform the responsibilities of a PCP. The specialist will provide and coordinate the member's primary and specialty care. Prior approval by the health plan is required for the authorization of a specialist as a PCP; we'll consider such requests on a case-by-case basis.

PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup.
- Utilize an answering service or pager system. This must be a confidential line for member information and/or questions. If you use an answering service or pager, the member's call must be returned within 30 minutes.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/precertification guidelines. This is a requirement for covering physicians.

Additionally, we strongly encourage you to offer after-hours office care in the evenings and weekend office hours. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturdays.

Examples of unacceptable PCP after-hours coverage:

- The PCP's office telephone is only answered during office hours.
- The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The PCP's office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning the member's after-hour calls outside of 30 minutes.

It is **not** acceptable to automatically direct the member to the ER when the PCP is not available.

PCP Access and Availability

Our ability to provide quality access to care depends upon your accessibility.* You are required to adhere to the following access standards:

Type of care	Standard
Emergency	Immediately
Urgent care	Within 24 hours
Non urgent sick care[1]	Within 72 hours
Routine or preventive care[1]	Within 30 days
Prenatal care[1,2] — initial visit	For first trimester: 7 days For second trimester: 7 days For third trimester: 3 days High risk: Within 3 days or sooner if needed

1 In-office wait time for scheduled appointments should not routinely exceed 1 hour, including time in the waiting room and examining room.
2 For women who are past their first trimester of pregnancy on the first day they are determined to be eligible for Healthy Blue, first prenatal appointments should be scheduled as outlined in the above table.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

You may not use discriminatory practices on the basis of insurance status, such as:

- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining separate appointment days.
- Offering hours of operation that are less than the hours of operation offered to patients with other insurance coverage.
- Denying or not providing to a member any covered service or availability of a facility.
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large.

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the *Americans with Disabilities Act of 1990*. healthcare services provided through Healthy Blue must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-Hours Care section.

Members' Eligibility Listing

You should verify each member receiving treatment in your office actually appears on your membership listing. Accessing your panel membership listing via our provider website online tool is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members, once registered and logged into our provider website.

To request a hard copy of your panel listing be mailed to you, call Provider Services at **833-405-9086**.

Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

Members and providers can access a searchable online directory by logging into our website with their secure IDs and passwords. Providers will receive an ID and password upon contracting with us and can view the online directory through the provider website at **provider.healthybluemo.com**.

Role and Responsibilities of Specialty Care Providers

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

Note that PCP referral is not required, but it is encouraged to ensure coordination of care.
You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to you
- Rendering covered services only to the extent and duration indicated on the referral
- Submitting required claims information, including source of referral and referral number
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and precertification of services at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval
- Coordinating care with other providers for:
- Physical and behavioral health comorbidities
- Co-occurring behavioral health disorders
- Adhering to the same responsibilities as the PCP

Specialty Care Providers' Access and Availability

You must adhere to the following access guidelines:

Type of care	Standard
Urgent	Within 24 hours of referral
Routine	Within one month of referral
Lab referrals or X-rays — urgent care	Within 48 hours or as clinically indicated
Lab referrals or X-rays — regular appointments	Not to exceed three weeks

Member Enrollment

Nondiscrimination and accessibility requirements update
On May 13, 2016, the MO HealthNet Division Office of Civil Rights (DHHS OCR) released the *Nondiscrimination in Health Programs and Activities Final Rule* (*Final Rule*) to improve health equity under the *Affordable Care Act* (*ACA*). *Section 1557* of the *ACA* prohibits discrimination on the basis of race, color, national origin, gender, sexual orientation, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under *Title I* of the *ACA*.

Network providers must ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

How does the Final Rule apply to managed care organizations?
Healthy Blue complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age, or disability in its health programs and activities. Healthy Blue provides free tools and services to people with disabilities to communicate effectively with us. Healthy Blue also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).

Who can I talk to if Healthy Blue isn't following these guidelines?
If you or your patient believe that Healthy Blue has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our compliance coordinator via:

Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

Call Provider Services: **833-405-9086**
Fax to Appeals Department: **855-860-9122**

If you or your patient need help filing a grievance, the compliance coordinator is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: **crportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201
- By phone at: 800-368-1019, TDD: 800-537-7697

Complaint forms are available at **hhs.gov/ocr/filing-with-ocr/index.html**. For additional details about *Section 1557* and the *Final Rule*, visit:

- The DHHS OCR information page:**hhs.gov/civil-rights/for-individuals/section-1557/index.html**
- Frequently asked questions published by the DHHS: **hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf**

We notified your Healthy Blue patients these services can be obtained by calling the Member Services phone number on their member ID card.

Medicaid recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Healthy Blue. Members are enrolled without regard to their health status. Our members:

- Are enrolled for a period of up to 12 months, contingent upon enrollment date and continued Medicaid eligibility.
- Can choose their PCPs and will be auto-assigned to a PCP if they do not select one.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.
- Coverage is provided for all newborn care rendered within the first month of life, regardless if provided by the designated PCP or another network provider. Providers will be compensated, at a minimum, ninety percent (90%) of the Medicaid fee for service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of

whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.

- The health plan is responsible for covering all newborn care rendered by contracted network providers within the first 30 days of birth regardless if provided by the designated PCP or another network provider.
- Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax the Newborn Delivery Notification to **800-964-3627**.
- The clinical information required is outlined as follows:
    - Date of birth
    - Indicate whether it was a live birth
    - Newborn's birth weight
    - Gestational age at birth
    - Apgar scores
    - Disposition at birth
    - Gender
    - Type of delivery (vaginal or cesarean); if cesarean, the reason the cesarean was required
    - Single/multi birth
    - Gravida/para/ab for mother
    - EDC and if NICU admission was required

Providers may use the standard reporting form specific to their hospital, as long as the required information outlined above is included.

PCP Automatic Assignment Process for Members

During enrollment, a member can choose his or her PCP. When a member does not choose a PCP at the time of enrollment or during auto-assignment:

- If we are the primary payer, we will auto-assign a PCP within eight days from the date we process the daily eligibility file from the state.
- If we are the secondary payer, we will not auto-assign a PCP unless the member asks us to do so.

Pregnant members have 14 calendar days after birth to select a PCP for their newborn. After 14 days, we will auto-assign a PCP for the newborn.

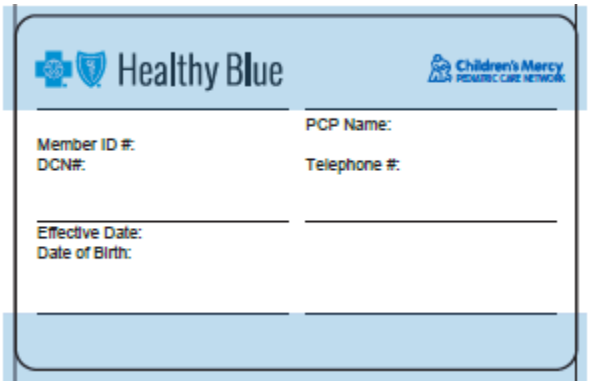
- There are two stages of auto-assignment logic for members who do not self-select a PCP: The first stage utilizes existing algorithms to assess data such as the distance of the PCP office from the member's home, languages spoken by provider and office staff, family link and prior relationship. Many providers receive an assignment of members based upon the first stage assignment logic.
- In the event there is more than one PCP meeting the first stage assignment logic for a member, the second stage will be activated. The second stage utilizes a rating system that has two components — quality and efficiency. The member will be assigned to the provider with the higher quality and/or efficiency ratings. To find out your current quality and efficiency ratings, as well as how to improve these ratings, please contact your local Provider Relations representative here: provider.healthybluemo.com/missouri-provider/contact-us.

Members receive a Healthy Blue-issued ID card that displays their PCP's name and phone number, in addition to other important plan contact information.

Members may elect to change their PCPs at any time by calling Healthy Blue Member Services. The requested changes will become effective no later than the following day, and a new ID card will be issued.

Member ID Cards

Healthy Blue member ID cards look similar to the following sample.



Member Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate him or her about the importance of keeping appointments.
- Encourage him or her to reschedule the appointment as soon as practicable.

For members who frequently cancel or fail to show up for appointments, please call Provider Services at **833-405-9086** to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and adhere to a plan of care recommended by their PCPs.

Noncompliant Members

Contact Provider Services if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

Members With Special healthcare Needs

Adults and children with special needs include those members with an intellectual disability, physical disability, complex chronic medical condition or other circumstances that place their health and ability to fully function in society at risk, requiring individualized healthcare requirements.

We have developed policies and procedures to manage care for:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for ensuring children or adults with serious, chronic and rare disorders receive appropriate assessment, management and diagnostic workups on a timely basis
- Coordinated care for individuals diagnosed with autism spectrum disorder (ASD), at risk of an ASD diagnosis or in need of applied behavioral analysis services

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. The plan may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities and/or acute and chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP as long as the specialist is willing to perform responsibilities of a PCP.

With the assistance of network providers, we will identify members who are at risk for or have special needs. Screening procedures for new members will include a review of hospital utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, and certain social determinants of health (SDOH). The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers, if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized healthcare services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions and materials and after-hours protocols for a provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

Covering Physicians

During your absence or unavailability, you need to arrange for coverage for your members assigned to your panel. You will be responsible for making arrangements with one of the following:

- One or more network providers to provide care for your members
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement.
- Any fees or monies due and owed to any non-network provider providing substitute coverage to a member on your behalf.

Provider Support

We support our providers by providing telephonic access to Provider Services at our national contact centers, in addition to local Provider Relationship Account Management Representatives (PRAM's)

- Providers Services supports provider inquiries about member benefits and eligibility and about authorizations and claims issues via our ProviderRelationship Account Management Program.
- PRAM's are assigned to all participating providers; they facilitate provider orientation and education programs that address our policies and programs. PRAM's visit provider offices to share information on at least an annual basis.

We also provide communications to our providers through newsletters, alerts, and updates. These communications are posted on our provider website and may be sent via email, fax, or regular mail.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual and/or quarterly telephonic surveys. These surveys include but are not limited to the verification of provider appointment availability, telephonic surveys to verify after-hours access, and any newly identified surveys that may assist in providing the best quality networks for our members.

To collect your feedback on how well Healthy Blue meets your needs, we conduct an annual provider satisfaction survey. You will receive this survey via mail or email. If you are selected to participate, we appreciate you taking the time complete the survey and provide input to improve our service to you.

Reporting Changes in Address and/or Practice Status

To maintain the quality of our provider data, we ask that changes to your practice contact information or the information of participating providers within a practice be submitted as soon as you are aware of the change.

Submitting Provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change**

requests, including submitting roster uploads. If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

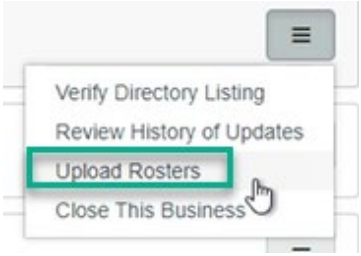
Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **provider.healthybluemo.com**, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement**: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:

Log onto **Availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

* Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Medically Necessary Services

Healthy Blue will be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age-appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

- In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents.
- Healthy Blue will provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an HCY/EPSDT screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Provider Bill of Rights

Each network provider who contracts with Healthy Blue to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
    - Any information the member needs to decide among all relevant treatment options, whether the benefits for such care or treatment are provided under the contract.
    - The risks, benefits and consequences of treatment or nontreatment.
    - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal and state fair hearing procedures.
- Have access to Healthy Blue policies and procedures covering the precertification of services.
- Be notified of any decision by Healthy Blue to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Medicaid/Children's Health Insurance Program member, the denial of coverage or payment for medical assistance.
- Be free from discrimination where Healthy Blue selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- Healthy Blue complies with the provisions of *42 CFR §438.102(a)(1)(ii)* concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

Provider Surveys

We will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward patient centered medical home implementation.

Our provider satisfaction survey tool and methodology will be submitted to the Department of Health Department of Health and Human Services for approval prior to administration. A results report summarizing the survey methods, findings and analysis of opportunities for improvement will be provided to the Department of Health and Human Services for review within 120 days after the end of the plan year.

Provider Marketing Guidelines

- When conducting any form of marketing in a provider's office, Healthy Blue must acquire and keep on file the written consent of the provider.
- Healthy Blue may not require its providers to distribute Healthy Blue-prepared marketing communications to their patients.
- Healthy Blue may not provide incentives or giveaways to providers to distribute them to Healthy Blue members or potential Healthy Blue members.
- Healthy Blue may not conduct member education or distribute member education materials in provider offices.
- Healthy Blue may not allow providers to solicit enrollment or disenrollment in Healthy Blue, or distribute Healthy Blue-specific materials at a marketing activity.
- Healthy Blue may not provide providers printed materials with instructions detailing how to change members of other MCOs to Healthy Blue.
- Healthy Blue shall instruct participating providers regarding the following communication requirements:
    - Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts;
    - Participating providers may display and/or distribute health education materials for Healthy Blue or they may choose not to display and/or distribute for Healthy Blue. Health education materials must adhere to the following guidance:
        - Health education posters cannot be larger than 16" x 24"
        - Children's books, donated by Healthy Blue must be in common areas
        - Materials may include the Healthy Blue name, logo, phone number and website
        - Providers are not required to distribute and/or display all health education materials provided by Healthy Blue with whom they contract. Providers can choose which items to display as long as they distribute items from Healthy Blue and that the distribution and quantity of items displayed are equitable.
        - Providers may display marketing materials for Healthy Blue provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract.
        - Providers may display Healthy Blue participation stickers but they must display stickers by all contracted MCOs or choose to not display stickers any contracted MCOs.

- Healthy Blue stickers indicating the provider participates with Healthy Blue cannot be larger than 5" x 7" and not indicate anything more than "Healthy Blue is accepted or welcomed here."
- Providers may inform their patients of the benefits, services and specialty care services offered through Healthy Blue. However, providers may not recommend one MCO over another MCO, offer patients incentives for selecting Healthy Blue over another MCO, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone or a computer in the office.
- Upon actual termination of a contract with Healthy Blue, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in Healthy Blue until the contract is terminated according to all terms and conditions specified in the contract between the provider and Healthy Blue.
- Healthy Blue shall not produce branded materials instructing members on how to change a plan. They must use State Medicaid-provided or approved materials and should refer members directly to the enrollment broker for needed assistance.

Benefits

Healthy Blue will provide all covered medical and behavioral health services in the comprehensive benefit package for each member as of the effective date of coverage and will provide covered services under this contract in the United States, including the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

Healthy Blue is prohibited from providing payments for items or services provided under the contract to any financial institution or entity located outside the United States.

Healthy Blue will provide services according to the medical and behavioral health needs of the member. Benefits may vary.

Covered service	Limitations/notes
Ambulatory Surgical Services	Covered services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient.
Audiology Services	Covered services include diagnostic, preventive or corrective services for individuals with speech, hearing and language disorders provided by or under the direction of an audiologist.
Behavioral Health Services	Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but *not* be limited to: • Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital • Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs:

Covered service	Limitations/notes
	• Crisis intervention/access services including but not limited to 1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and 2) mobile crisis teams for on-site interventions. • Alternative services that are reasonable, cost effective and related to the member's treatment plan • Referral for screening to receive care management services. • Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments. • If Healthy Blue staff believes a member may require residential services in order to receive appropriate care and treatment for a serious emotional disorder, the Healthy Blue Behavioral Health Utilization Management (UM) Team will now review prior authorization (PA) requests for residential treatment services in a Psychiatric Residential Treatment Facility (PRTF) with the application of appropriate clinical criteria guidelines to determine medical necessity and appropriate length of stay. To see the full list of covered services, limits and authorization rules, visit the provider website at **provider.healthybluemo.com**.
Chiropractic Services	Limited to examinations, diagnoses, adjustments, manipulations and treatments of mal articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The annual limit of chiropractic visits shall not exceed twenty (20) visits.
Clinic Services (Other than Hospitals)	Certain limits apply. Covered services include diagnostic, preventive, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility that is not part of a hospital (for example, mental health clinics, prenatal healthcare clinics, family planning clinics, end-stage renal disease facilities and radiation therapy centers). A maximum of one procedure per day per recipient for mental health clinic services is permitted. Recreational and music therapy are not provided. Prenatal care provided in a prenatal healthcare clinic is subject to limitations.
Clinical Lab Services and Diagnostic Testing	Quest Diagnostics or LabCorp is **the preferred lab providers for all Healthy Blue members**. Contact Quest Diagnostics or LabCorp at the numbers below to receive a specimen drop box. For more information, testing solutions and services, or to set up an account, contact • Quest Diagnostics: **866-MY-QUEST (866-697-8378)** • LabCorp: **800-345-4363**
Communicable Disease Services	Services include exams, treatment and health education to help control and prevent communicable diseases such as tuberculosis (TB), sexually transmitted infection (STI) and HIV/AIDS.

Covered service	Limitations/notes
	Healthy Blue network providers will report all cases of TB, STI and HIV/AIDS infection to the Department of Health and Human Services within 24 hours of notice from the date of service.
Durable Medical Equipment (DME)	Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/ Well-Child Visits	The EPSDT service is a complete and preventive child health program for Medicaid members younger than 21 years of age. Benefits cover a health and development history, complete physical exam, proper immunizations, screenings, and diagnostic services, including lead blood level assessment. Also included are vision, hearing and dental screenings to decide healthcare needs and other measures to identify, correct or improve physical or mental defects or chronic conditions.
Emergency Dental Services	Covered services include laboratory or radiological services that may be required to treat trauma of the mouth, jaw, teeth or to other contiguous sites as a result of injury. .
Emergency Medical Services In-and out-of-network emergency care Poststabilization care	Coverage includes emergency services given by a network or out-of-network provider under these conditions: • The member has an emergency medical condition; this includes cases in which the absence of getting medical care right away would not have had the outcome defined as an emergency medical condition. • Healthy Blue tells the member to get emergency services.
End-Stage Renal Disease Services	• End-stage renal disease services are covered. • Dialysis services are covered for all Medicaid recipients and include dialysis treatment (including routine laboratory services); medically necessary, nonroutine lab services; and medically necessary injections. Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte and acid-base balances in cases of impaired or absent kidney function. A free-standing clinic is a facility that operates solely for the provision of dialysis services. These services also include home dialysis services that are patient/patient's representative-managed under the supervision of the clinic. For locations other than free-standing, the services are rendered either in an inpatient or outpatient hospital setting.
Eye Care and Vision Services (includes vision services from a licensed ophthalmologist or optometrist)	Covered for members as follows: Optical services include one comprehensive or one limited eye examination every two years for refractive error; services related to trauma or treatment of disease/medical condition (including eye prosthetics); and one pair eyeglasses every two years. Additionally: • Services to child members under 21 include one comprehensive or one limited eye examination per year for refractive error and HCY/EPSDT optical screens and services. • Services to adult pregnant members with ME codes 18,43,44,45,61,95,96 and 98 include one comprehensive or one limited eye examination per year for refractive error.

Covered service	Limitations/notes
Family Planning Services	Coverage includes family planning services for members of childbearing age who choose to delay or prevent pregnancy. Examples of reproductive health services are: contraception management, insertion of Norplant, IUD, Depo Provera Injections, Pap test, pelvic exams, sexually transmitted infections testing, pregnancy testing and family planning counseling/education on various methods of birth control. Members do not need a referral for family planning services. Members may choose a network or non-network provider. We will make a reasonable effort to contract with all local family planning clinics and providers, including those funded by *Title X* of the *Public Health Services Act*. We will reimburse providers for all family planning services, regardless of whether that provider is a network provider, no less than the Medicaid fee-for-service rate on the date of service.
Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)	Coverage includes access to behavioral health and covered services offered through a FQHC if the member lives in the service area of the clinic and either: • Chooses the FQHC as his or her PCP. • Needs emergency care. • Requests to get these services from the clinic by calling Member Services.
Health and Behavior Assessment and Intervention (HBAI) and Screening, Brief Intervention, and Referral to Treatment	Primary Care Health Home Provider organizations are covered for HBAI and SBIRT services provided to their members and performed by certified providers.
Home Health Services	Prior authorization required: • Coverage includes skilled nursing visits, home health aide visits, and medical supplies in a member's residence.
Hospice	A recipient must be terminally ill to receive hospice care. An individual is considered terminally ill if he or she has a physician-certified medical **prognosis** that the individual's life expectancy is six months or less if the illness runs its normal course. Hospice services for children (ages 0 to 20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made. Prior authorization is required.

Covered service	Limitations/notes
Immunizations	Healthy Blue provides all members with all vaccines and immunizations in accordance with the Center's for Disease Control and Prevention (CDC) Advisory Committee on Immunizations Practice (ACIP) guidelines and follows MO HealthNet's immunization schedule, which is updated routinely in our member handbook and posted to our web site. ACIP vaccine recommendations can be found on the Centers for Disease Control and Prevention (CDC) website at **cdc.gov/vaccines/hcp/acip-recs**.
Inpatient Hospital Services Stays expected to last more than 24 hours Hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting	Prior authorization required: Covered services include: • A semi-private room for: • Routine care. • Surgical care. • Obstetrics and newborn nurseries. • A private inpatient room if a member's medical condition requires isolation. • Nursing services. • Dietary services. • Ancillary services such as: • Lab. • Radiology. • Medical supplies. • Blood and blood by-products.
Medical Transportation Services	Emergency transportation, including hospital-to-hospital transportation for physical and behavioral health, is covered. Ambulance transfer from a facility where a member is inpatient to another facility to render a treatment or testing not available at the facility housing the member is covered under certain circumstances as determined by our policy on ambulance transport policy Nonemergency medical transportation (NEMT) coverage should be provided to members who lack transportation to and from provider's office. Some dual-eligible members (Medicare and Medicaid) will also be covered for NEMT. For these members, care coordination must be sufficient to assure third-party liability (TPL), nonduplication of benefits, and effective coordination between Medicare- and Medicaid-funded behavioral health services. For adult members, NEMT coverage may be restricted. In addition, NEMT to access carved-out services should also be provided. The health plan will be responsible for providing transportation for the member if services cannot be provided in-network. For NEMT, members can call MTM at **888-597-1193** to set up a ride.
Nurse Midwife Services	A certified nurse midwife (CNM) is a registered professional nurse who is legally authorized under state law to practice as a nurse midwife and has completed a program of study and clinical experience for nurse midwives or equivalent. Covered services may be rendered by a CNM as defined above.

Covered service	Limitations/notes
Nurse Practitioner Services	A nurse practitioner certified (NP-C) is a registered professional nurse who is licensed by the state and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required for all registered nurses. Covered services may be rendered by an NP-C as defined above.
Organ Transplant and Related Services • Services for members diagnosed with certain medical conditions needing a heart, kidney, liver, bone marrow, small bowel or pancreas transplant	MO HealthNet Managed Care health plans are required to provide pre-surgery assessment/evaluation, care and post transplant discharge follow up care. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Covered transplants include: heart, lung, liver, kidney, pancreas, small bowel, and stem cell transplants (including bone marrow, peripheral, and cord blood stem cell) or any transplant approved by the MO HealthNet Division (MHD). Transplant services provided by MO HealthNet Fee-For-Service are the organ/stem cell procurement charges and the inpatient stay for the transplant from the date of transplant through the date of discharge. In addition to services covered as part of the transplant, MO HealthNet Fee-For-Service covers the transplant surgeon's fee, all physician, lab, etc. charges incurred during the transplant stay (date of transplant through date of discharge).
Outpatient Nonpsychiatric Hospital Services Stays not expected to last more than 24 hours	Covered services include: • Medically necessary Services that can be properly given on an outpatient or ambulatory basis such as: o Lab o Radiology o Therapies o Ambulatory surgery o Observation services (if needed to decide whether a member should be admitted for inpatient care)
Personal Care Services	Provided by attendants when physical limitations due to an illness or injury require assistance with eating, bathing, dressing and personal hygiene; does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters: • Requires prior authorization
Physician Services	Services performed in a physician's office, such as: • Medical assessments. • Treatments. • Surgical services. Services must be given by licensed allopathic or osteopathic physicians.
Podiatry Services	No precertification is required for a network provider for evaluation and management (E&M).

Covered service	Limitations/notes
Poststabilization Care Services	Poststabilization services are covered if: • Care is received within or outside the Healthy Blue network of providers and preapproved by Healthy Blue. • Care is received within or outside the Healthy Blue network of providers but is not preapproved by Healthy Blue because: o Services are given to maintain, improve or resolve a member's stabilized condition and: o We do not respond to a request for prior approval within 30 minutes. o The treating physician cannot get in touch with Healthy Blue. • Healthy Blue and the treating physician cannot agree on the member's care and a network physician is not on hand for consult; if this happens, we will: o Give the treating physician the chance to consult with a network physician. o Let the treating physician still give care until a network physician is reached or one of the following occurs: o A network physician with privileges at the treating hospital becomes responsible for the member's care. o A network physician becomes responsible for the member's care through transfer. o Healthy Blue and the treating physician reach an agreement on the member's care. o The member is discharged.
Preventive Medicine	Preventive medicine counseling and/or risk factor reduction intervention(s)
Rehabilitation Therapy Services Occupational, physical, and speech therapies	Services must be prescribed by the PCP or attending physician for an acute condition. Prior authorization is required. Note: For members receiving applied behavior analysis, these services may already be provided as part of the treatment plan.
School-based Health Clinic Services (SBHC)	SBHC (certified by the Department of Health and Human Services) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21. The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.

Covered service	Limitations/notes
Sterilization A medical procedure, treatment or operation that causes the person to no longer be able to reproduce	Requirements are as follows: • The person to be sterilized must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of a premature delivery or abdominal surgery) but not more than 180 calendar days before the date of the sterilization. • A new consent form is required if 180 days have passed before the surgery occurs. • The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances that affects a patient's awareness. • The person to be sterilized must: o Be at least 21 years of age at the time consent is received. o Be mentally competent. o Not be in an institution (that is, not involuntarily confined or kept under a civil or criminal status in a correctional or rehabilitation facility or confined in a mental hospital or other facility for the care and treatment of mental illness) • The patient must give informed consent on the approved *Sterilization Consent Form*, available at **manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf**
Women's Health Services — Abortions	Services are restricted to these reasons: • A physician has found and confirms in writing that, on the basis of his or her judgment, the life of the pregnant woman would be in danger if the fetus were carried to term. • In the case of ending a pregnancy due to rape or incest, certain requirements must be met: o The member must report the act to a law enforcement official unless the treating physician confirms in writing that, in his or her expert opinion, the victim was not physically or psychologically able to report the rape or incest. o The report of the act to the law enforcement official or the treating physician's statement that the victim was not able to report the rape or incest must be submitted to Healthy Blue. o The member must confirm that the pregnancy is the result of rape or incest; this certification must be witnessed by the treating physician. The treating physician must witness the Office of Public Health's *Certification of Informed Consent — Abortion* form and attach it to his or her claim form. Access the state's form at **health.mo.gov/living/families/womenshealth/pregnancyassistance/pdf/InformedConsentChecklist.pdf**

Covered service	Limitations/notes
Women's Health Services — Hysterectomies	Covered when they are nonelective, medically needed and meet the following requirements: • The person or her representative must be told orally and in writing that this procedure will leave the person unable to reproduce again. • The person or her representative, if any, must sign and date an *Acknowledgement of Receipt of Hysterectomy Information* form prior to the hysterectomy; this must be obtained despite diagnosis or age. This form can be submitted after surgery only if it clearly states the patient was told before surgery that she would be left unable to reproduce. This form is not required if: • The person was sterile prior to the hysterectomy. – A hysterectomy is required due to a life-threatening emergency and the physician decided prior acceptance was not possible. Access the state's form at **manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf**
Women's Health Services — OB/GYN Services	Covered services for female members include: • One routine annual visit. • A second visit based on medical need. • Follow-up treatment given within 60 days after either routine visit if the care relates to: • A condition diagnosed or treated during the visits. • A pregnancy. As part of the annual visit, the member should receive interconceptional health education to address physical health conditions that may impact future pregnancies. She may want to discuss her plans for future pregnancy with her OB/GYN.
Women's Health Services — Prenatal Services	Covered services include: • Offering direct access to routine OB/GYN services within the Healthy Blue network; the OB/GYN will contact the member's PCP to advise that: • These services are being delivered. • The OB/GYN will manage and coordinate this care with the PCP. • Arranging a risk assessment for all pregnant members. • Ensuring high-risk pregnant members in need of further assessment or care have access to maternal-fetal medicine specialists. • Counseling a pregnant member about plans for her child such as: • Choosing the family practitioner or pediatrician who will perform the newborn exam. Access the state's Women, Infants and Children (WIC) program at **health.mo.gov/living/families/wic**

Covered service	Limitations/notes
Women's Health Services — Postpartum Care	Coverage includes: • Postoperative care visit following cesarean delivery. • Postpartum care visit on or between the 7th and 84th day postdelivery. • Provides free electric breast pumps for members who are due to deliver within 6 weeks or members who have delivered within the past 30 days, or who had a NICU baby in the last 90 days If medically indicated, a hospital-grade electric breast pump may be rented. See also the Family Planning Services row.
Women's Health Services — 39 Weeks Initiative	Healthy Blue will not reimburse for Early Elective Deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated.

Healthy Blue Value-Added Services

We cover extra benefits, including but not limited to the following, which eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added benefits.

Community and social supports	Community Resource Link ** Resource**	Healthy Blue Community Resource link is an online resource which locates and displays all available local community-based programs, benefits, and services. Much more than a simple search engine, this proprietary model uses dedicated resources to make sure that information is always up-to-date. This easy-to-use online tool is continually updated, which enables us to assist members with access to affordable housing, food security, employment, and other SDOH to increase independence and stability and improve health outcomes.
	Free Additional Phone Minutes	Any member who qualifies for the Federal Lifeline program, which provides cell/smart phones to members meeting certain criteria, will be eligible to receive a free cell phone with minutes, unlimited text messages monthly, and new a minimum of 500MB data. The cell phone, minutes and data are supplied by the Federal Program. Members receive unlimited calls to service coordinators, member advocates and member services through our toll-free line, available to all members that qualify for the federal lifeline program. Members also receive bonus minutes during their birthday months.
	HiSET Assistance	Healthy Blue will provide qualifying members ages 16+ a voucher code at no cost to cover fees if they need to retake the HiSET test.
	Nonmedical Transportation	Provides enhanced transportation to WIC and HCY appointments, prescription pick-up following doctor appointment, Methadone dosing or administration of other medications at Methadone clinic, Behavioral health inpatient or residential facility for parents not eligible for MO Health Net to participate in family therapy.

	Youth Club Membership: 4-H Club	Covers program costs for 4-H club activities. Program includes activities where kids can complete hands-on projects in areas like science, health, agriculture and civic engagement, in a positive environment. Other fees may apply to participate in additional programs; Summer programs are not covered. ** Member may choose one Youth Club Membership per year. Healthy Blue will cover up to $30 towards membership fee.**
	Youth Club Membership: Boy Scouts	Covers the cost of one (1) membership; Benefit would include Cub Scouting, Boy Scouting, Venturing programs. Other fees may apply to participate in additional programs; Summer programs are not covered.** Member may choose one Youth Club Membership per year. Healthy Blue will cover up to $30 towards membership fee.**
	Youth Club Membership: Boys and Girls Club	Provides the annual membership fee to Boys and Girls Clubs. Other fees may apply to participate in additional programs; Summer programs are not covered. ** Member may choose one Youth Club Membership per year. Healthy Blue will cover up to $30 towards membership fee.**
	Youth Club Membership: Girl Scouts	Covers the cost of one membership, which would include: Girl Scout Daisies, Girl Scout Brownie, Girl Scout Junior, Girl Scout Cadette, and Senior and Ambassador programs. Other fees may apply to participate in additional programs; Summer programs are not covered. ** Member may choose one Youth Club Membership per year. Healthy Blue will cover up to $30 towards membership fee.**
	Healthy Blue Concierge/Welcome Room	Office location that provides support for medical and non-medical needs for Healthy Blue members. Includes benefit assistance, transportation assistance and community support and SDOH resources. Members and community partners can access various locations by appointment or telephonic outreach for one on one assistance.
Maternal and child supports	Maternity Program	Pregnant members will have access to a nurse 24 hours a day, 7 days a week to provide support, education, and high risk pregnancy monitoring.
	Breast Pump	Provides no-cost electric breast pumps for members who are due to deliver within 6 weeks or members who have delivered within the past 30 days, or who had a NICU baby in the last 90 day are eligible.
	Baby Showers	Fun, educational event that provides information on the following topics: Pre/Post Delivery Care, Healthy Eating Tips, and Family Planning.
	Home Delivered Meals	Program to bring free home delivered meals to members who have recently delivered a baby. Members must currently be in an active treatment plan with an appropriately designated provider, and have delivered a baby within the past two weeks. 14 meals per authorization. No annual limit implying member is eligible after any inpatient discharge.

	Maternity Support Hose and Belts	Provides maternity support hose and support belts for mothers at no cost. No prior authorization is required.
	Childbirth and Breast Feeding Classes	Healthy Blue recognizes the importance of Childbirth and Breastfeeding. Healthy Blue will cover the cost of Childbirth and Breastfeeding classes. The classes are being offered to help members make informed decisions about key issues surrounding the baby's birth. Many classes also address what to expect after the baby is born, including breastfeeding, baby care, and coping with the emotional changes of parenthood. Members might also need support from other expectant mothers at a childbirth class. Breastfeeding Classes provide information and skills to enhance the breastfeeding experience and gain confidence.
	Breastfeeding Support Kit	Breastfeeding Support Kit for new mothers who complete 6 prenatal appointments; includes: • An infant support nursing pillow • Washable nursing pads • Nursing cover • Educational fliers such as Breastfeeding Facts & Myths and How to Breastfeed ** Mother can choose **one** of the following benefits: Crib, Car Seat, Safe Sleep Kit, Breast Feeding Kit, or Diapers after completing 6 prenatal appointments.*
	Car Seat	No cost Car Seat for mothers who complete 6 prenatal appointments **Mother can choose **one** of the following benefits: Crib, Car Seat, Safe Sleep Kit, Breast Feeding Kit, or Diapers after completing 6 prenatal appointments.*
	Diaper Program	Free diapers for babies (one pack = 200 diapers) **Mother can choose **one** of the following benefits: Crib, Car Seat, Safe Sleep Kit, Breast Feeding Kit, or Diapers after completing 6 prenatal appointments.*
	Portable Crib	No Cost portable crib for new mothers who complete 6 prenatal appointments.**Mother can choose **one** of the following benefits: Crib, Car Seat, Safe Sleep Kit, Breast Feeding Kit, or Diapers after completing 6 prenatal appointments.*
	Safe Sleep Kit	Kit includes infant sleep guidelines and education, breastfeed facts and myths, how to breast feed educational materials, halo Sleep sack, and Soothe pacifier. **Mother can choose **one** of the following benefits: Crib, Car Seat, Safe Sleep Kit, Breast Feeding Kit, or Diapers after completing 6 prenatal appointments.*
Physical activity and healthy weight	ChooseHealthy **Resource**	Our ChooseHealthy Program offers over 1,000 resource materials including videos, articles and self-care tools.
	Gym Memberships	Gym vouchers for members ages 18+ for enrollment fees & monthly dues at participating gyms

	Kurbo	Eligible members receive a Kurbo voucher good for 3 months. This healthy lifestyle program includes a food and exercise tracker, educational videos, games and a Health Coach for support .
	WW (formerly Weight Watchers)	Eligible members receive a Weight Watchers voucher good for initiation fee and 13 weeks of classes.
Whole person health	Asthma Spacers	Provides qualified members with asthma spacer(s) at no additional cost
	Blood Pressure Cuffs	Blood pressure cuffs for members with Hypertension, Diabetes, CHF, CAD, or Obesity
	Digital Scales	Digital scales for members with Hypertension, Diabetes, CHF, CAD, or Obesity
	Art Therapy	Provides 10 Art Therapy sessions, per calendar year, to members for cancer treatment, autism, emotional abuse, and post-traumatic stress disorders (PTSD), based on medical necessity.
	Equine Therapy	Provides 10 equine sessions per calendar year, for eligible members, age 6 and older with cerebral palsy and autism. Provider referral required.
	Hypoallergenic Bedding	$100 credit towards the purchase of allergy relief bedding is available at no cost to members who have a diagnosis of asthma.
	myStrengths	Eligible members will receive access to myStrength™, an online well-being program that offers web and mobile *HIPAA* compliant tools to help Members with emotional health issues such as depression, anxiety, stress, and misuse of drugs and alcohol. It allows eligible Members to take an active part in improving their health and well-being. Focusing on mental health is important and our program includes resources to help strengthen mind, body and spirit as well as a dynamic and personalized website that offers clinically proven mental health applications to help with mental health challenges utilizing tailored wellness resources. Our self-help resources help ensure our Members can be active participants in their journey to becoming – and staying – mentally and physically healthy.
Adult Expansion Ages 19 to 64	Personal Care Items	Members receive a $25 gift card to purchase personal hygiene products annually
	Transportation Essentials	Members have a choice of a $50 Gas Card or a $35 Oil Change or a Bus Pass or a $25 Uber Card every year
	Industry Certification	Members can receive up to $100 to cover the cost of the industry certifications offered through Healthy Blue learning platforms
	Work Force Attire	Members provided $200 gift card to purchase uniforms or work attire upon completion of an Industry Certification.

	Household Essentials	Member receives a $50 gift card to buy household items for members moving onto independent living setting. Transition aged members 19-26 years of age.
	ULearn	Education training program to help members assess their skills, train, and search for jobs, and prepare for the HiSET

In Lieu of Services or Settings (ILOS)

An in lieu of service or setting is an alternative service or setting that the state agency, in accordance with *42 CFR 438.3(e)(2)* and any applicable state regulations, determines to be a medically appropriate and cost-effective substitute for a covered service or setting under the Medicaid State plan. To the extent the Healthy Blue would like to offer an ILOS, the Healthy Blue must submit a written request to the state agency for such service or setting and the state agency will make a determination if the alternative service or setting meets the criteria for an ILOS. Please see *In Lieu of Services Application* located and periodically updated on the MO HealthNet website at Bidder and Vendor Documents (**dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/**). If approved, Healthy Blue may offer the ILOS to members, as appropriate, but may not require a member to use an ILOS. In accordance with *42 CFR 438.3(e)(2)(iv)*, the utilization and actual cost of approved ILOS will be taken into account in developing the component of the capitation rate that represents the covered Medicaid State plan services. Healthy Blue will notify the state agency no less than 30 calendar days prior to discontinuing an approved ILOS. The health plan shall notify all members receiving an alternative service or setting no less than 10 calendar days prior to discontinuing an ILOS.

The health plan may offer the following services under this section:
Institution of Mental Disease (IMD) – The health plan may offer an inpatient stay in an IMD setting of no more than 15 days of the month for covered inpatient psychiatric or Substance Use Disorder (SUD) services to members 21-64.

Medical Day Care – The health plan may offer Medical Day Care in lieu of Private Duty Nursing**.**

Doula Services – The health plan may offer comprehensive doula services throughout pregnancy, during delivery, and in the post-partum period to complement and add to existing prenatal care resources offered to our members.

Services Covered Under the Missouri State Plan or Fee-for-Service Medicaid

Some services are covered by the Missouri state plan or fee-for-service Medicaid instead of Healthy Blue. These services are called carved-out services. Even though we do not cover these services, we expect you to:

- Provide all required referrals.
- Assist in setting up these services.

These services will be paid for by Department of Health and Human Services on a fee-for-service basis. Carved-out benefits include:

- Services given through the Department of Health and Human Services Early Steps program.
- Individualized education program services.
- Intermediate care facility (ICF)/developmentally disabled (DD) services for members under the age of 21.
- School-based individualized education plan services given by a school district and billed through the intermediate school district or school-based services funded with certified public expenditures.
- All home- and community-based waiver services.
- Targeted case management services.

For details on how and where to access these services, call the Department of Health and Human Services at **800-368-1019**

Copays may apply for certain services covered under the program. Copays do not apply to services provided to:

- Individuals younger than 21 years old
- Pregnant women
- Individuals who are inpatients in long-term care facilities or other institutions
- Native Americans and Alaskan Eskimos
- Enrollees of an Home- and Community-Based Waiver;
- Women whose basis of Medicaid eligibility is breast or cervical cancer and enrollees receiving hospice services.

Well-Child Visits Reminder Program

Based on our claims data, we send PCPs a list of members who have not received well-child services according to our schedule, which aligns with MO HealthNet and American Academy of Pediatrics guidelines. We also reach out to these members, encouraging them to contact their PCPs to set up appointments for needed services.

Please note:

- We list the specific service each member needs in the report.
- You must render the services in accordance with federal EPSDT and State Department of Health guidelines.
- We base our list on claims data we receive before the date on the list. Please check to see whether you have provided the services after the report run date.
- Please submit a completed claim form for those dates of services to the Healthy Blue Claims department at:

  Claims Department
  Healthy Blue
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

Immunizations

You must enroll in the Vaccines for Children Program, which is administered by the Missouri Department of Health and Senior Services. Contact the Bureau of Immunizations at vfc-smvsupport@health.mo.gov or call **800-219-3224** to enroll. The immunization program will review and approve your enrollment request. You will need to cooperate with the Bureau of Immunization for orientation and monitoring purposes.

Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices (ACIP) schedule. You must report all immunizations of children up to age 2 to the ShowMeVax immunization registry. If you do not have the capability to meet these requirements, we can help you.

We do not cover the costs of immunizations, biological products or other products that are available free of charge from the Vaccines for Children Program.

Our members can self-refer to any qualified provider in or out of our network.

We reimburse local health departments for the administration of vaccines regardless of whether they are under contract with us.

Through the VFC Program, Healthy Blue provides all members with all vaccines and immunizations in accordance with ACIP guidelines and follows MO HealthNet's immunization schedule, which is updated routinely in our member handbook and posted to our web site. ACIP guidelines can be found on the Center for Disease Control and Prevention website at **cdc.gov/vaccines/hcp/acip-recs**.

Blood Lead Screening

You must perform a lead poisoning risk assessment or screening, as appropriate, per recommendations of the AAP. Healthy Blue strongly encourages a proactive approach to childhood lead poisoning prevention by performing a blood test at 12 months and 24 months to determine lead exposure and toxicity. You should also give blood lead screening tests to children over the age of 24 months up to 72 months if you have no past record of a test. Children need a Blood Lead Level each year until age 6 if in a high-risk area. A Blood Lead Level is recommended for women of child-bearing age. You can find blood lead risk forms online at **provider.healthybluemo.com**.

Clinical Laboratory Improvement Amendments Reporting

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the *CLIA* requirements.

Healthy Blue providers may bill for laboratory services covered by Quest Diagnostics or LabCorp. To ensure proper payment, Healthy Blue will apply a *CLIA* claim edit to all claims for laboratory services that require a *CLIA* certification. Providers who do not have *CLIA* certification, who render services outside the effective dates of the *CLIA* certificate or who submit claims for services not covered by their *CLIA* certificate will deny.

Healthy Blue Member Rights and Responsibilities

Our Member Services representatives serve as our members' advocates. Below are the rights and responsibilities of our members.

Member Rights
As a member of Healthy Blue MO:

- Each member has the right to receive information about the health plan, its services, its practitioners and providers, and member rights and responsibilities.
- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and his or her right to privacy.
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Each member has the right to a candid discussion of appropriate or medically necessary treatment options for his or her condition(s), regardless of cost or benefit coverage.
- Each member has the right to make recommendations regarding the health plan's member rights and responsibilities policy.
- Each member is guaranteed the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Each member is guaranteed the right to request and receive a copy of his or her medical records and to request that they be amended or corrected, as specified in 45 CFR part 164.9.
- Each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan or its providers or the state agency treat the member.
- Each member has a right to voice complaints or appeals about the health plan or the care it provides.

Nondiscrimination
No member will be denied the benefits of, or participation in, covered services on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated.

Member, Parental and/or Legal Guardian Responsibilities
The health plan expects members to cooperate responsibly and to the full extent possible in matters regarding their healthcare. These include the following:

- The member must present his or her health plan identification card and the MO HealthNet insurance card to each provider before receiving service. Members are encouraged to carry a second form of identification.
- The member is responsible for providing, to the extent possible, any and all information needed by the health plan or his or her practitioner or provider to provide treatment and care.
- The member is responsible for contacting their primary care provider as their first point of contact when needing medical care.
- The member must inform their PCP of their desire for a second surgical and/or medical opinion.
- Each member is responsible for scheduling and canceling appointments for services, including transportation. If the member cannot keep a scheduled appointment, he or she must call the provider at least 24 hours in advance to cancel the appointment.
- Each member must act in a responsible manner at a provider's facility and when speaking with providers or health plan personnel and not use abusive language or aggressive body language toward any providers or other health plan personnel.
- Each member must inform the provider if he or she does not understand the provider's explanation(s) concerning the member's medical care and to participate in developing a mutually agreed-upon treatment goals, to the degree possible.

- Each member is responsible for complying with the provider's treatment plan for medications, diet and exercise that they have mutually agree upon and following instructions and guidelines given by practitioner.
- Members must bring immunization records to every appointment for members 21 years old or younger.
- Members are responsible for scheduling periodic checkups for infants and children in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Program and for keeping the appointments. Prenatal members must schedule obstetrical checkups at the recommended intervals. Members are encouraged to participate in other available prevention and wellness programs that correlate with their checkups and treatments.
- Each member must notify the Missouri Department of Social Services, Family Support Division of address changes, any changes in family size or changes that may affect eligibility or enrollment (for example, marriage, birth, adoption, divorce, death or guardianship).
- Each member must follow the procedures outlined in the health plan Member Handbook to obtain services or present questions or concerns.
- Co-payment requirements do not apply to MO HealthNet Managed Care members.
- Each member is responsible for informing the health plan and/or the Missouri Department of Social Services, Family Support Division if he or she is covered by any other insurance, including Medicare or if they have an accident at work, have a car accident, or are involved in a personal injury or malpractice lawsuit.
- Members with questions concerning benefits, grievances, appeals, medical provider qualifications, changing PCPs etc., are to contact the health plan Customer Services Department.

Member Grievances

Our members have the right to say they are dissatisfied with Healthy Blue or a provider’s operations. Members have the right to file a grievance at any time. A network provider may also file a grievance with the members signed consent allowing the provider to act as the member’s representative.

Member grievances do not involve:

- Medical management decisions.
- Interpretation of medically necessary benefits.
- Adverse determinations.

These are called appeals and are addressed in the next section.

The member must file grievance with as much information as possible, including:

Who is part of the grievance
What happened
When the incident happened
Where the incident happened
Why the member was not happy with the healthcare services

We will respond to a member’s grievance and attempt to resolve it to the member’s satisfaction in a timely manner. We investigate each grievance and all of its clinical aspects. We inform the member, investigate the grievance and resolve it within 30 calendar days from the date we received the grievance.

The member may file a grievance orally or in writing with either Department of Health and Human Services or the health plan. A member can file a grievance orally by calling Member Services at **833-388-1407**. Or a

member may choose to file a grievance only by mail; any supporting documents must be included. Grievances should be sent to:

Grievance and Appeals Representative
Healthy Blue
PO Box 62429
Virginia Beach, VA 23466

An acknowledgement letter is mailed within ten calendar days of receiving a written grievance. We will notify the member in writing of:

- The names(s), title(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance and our decision.
- The reason for the decision.
- How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative.

If the Grievances and Appeals department is unable to resolve the grievance within the 30-day period, we will notify the member in writing and explain the reason for the delay. This may extend the case up to an additional 14 days for members. If the time frame is extended, for any extension not requested by the member, Healthy Blue will give the member written notice of the reason for the delay.

Interpreter services and translation of materials into non-English languages and alternative formats are available, at no cost, to support members with the grievance and appeals process.

Medical Necessity Appeals

Medical necessity appeals apply to authorization requests that were denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process to:

Member appeals:
P.O, Box 62509
Virginia Beach, VA 23466

An **adverse benefit determination** is a clear expression by the member, or the member's authorized representative with written consent, following a decision that the member wants reconsidered or reviewed. Examples of an adverse benefit determination or decisions a member may choose to appeal include but are not limited to:

- Denial or limited authorization of a requested service, including the type and level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- For a resident of a rural area with only one MCO, the denial of the member's request to obtain services outside the network.
- The denial of the member’s request to dispute financial liability

An **appeal** is a review by Healthy Blue of an adverse benefit determination.

Healthy Blue will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for resolving requests to reconsider a decision they find unacceptable regarding denial of prior authorization.

A member will have a reasonable opportunity to present evidence — submit written comments, documents, records and other information relevant to the appeal along with allegations of fact or law — in person as well as in writing.

Healthy Blue also ensures the member and his or her representative are provided a copy of the entire case file, including any medical records or, and any other documents and records considered during the appeal process. This includes any evidence considered, relied upon or generated by Healthy Blue in connection with the appeal. This information is provided free of charge upon request of the appeal.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are as follows:

- Standard resolution of appeal: 30 calendar days from the date of receipt of the appeal
- Expedited resolution of appeal: 72 hours from receipt of the appeal
- We make every reasonable effort to give the member or his or her representative oral notification and then follow it up with a written notification.

The member, or the member's representative, can file an appeal within 60 calendar days from the date on the Healthy Blue *Notice of Action*. A provider or authorized representative acting on behalf of the member and with the member's written consent, may file an appeal verbally, in writing or in person. The provider must follow all requirements for a member appeal, including timely filing of the request for appeal.

An acknowledgement letter will be mailed within 10 calendar days of receiving an appeal.

We will inform the member of the limited time they have to present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

There may be one extension of 14 calendar days to this timeline upon the member's request, or if we can show that there is a need for additional information and the delay is in the interest of the member. When the delay is for this reason and not as a result of a member request, we will provide information describing the reason for the delay in writing to the member.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do it.
- The right to receive benefits while this hearing is pending and how to request it.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action.
-
- If Healthy Blue fails to respond to the appeal timely, the enrollee is deemed to have exhausted the appeals process. The enrollee may initiate a State Fair Hearing.

Expedited Appeals

Our expedited appeal process is available upon the member's request or when the provider indicates that a standard resolution could seriously jeopardize the member's life; health; or ability to attain, maintain or regain maximum function.

The member or provider may file an expedited appeal either orally or in writing, or the member may present evidence in person. A provider may file the request on behalf of the member if the provider has obtained written consent signed by the member authorizing the provider to act on the member's behalf. A provider who appeals on the member's behalf must follow all requirements for a member appeal, including timely filing of the request for appeal.

We will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within 72 hours after receipt of the expedited appeal request. There may be one extension of 14 calendar days to this timeline upon the member's request, or if we can show that there is a need for additional information and the delay is in the interest of the member. When the delay is for this reason and not as a result of a member request, we will provide information describing the reason for the delay in writing to the member.

If your request is deemed to be non-expedited or determined that the members life will not be jeopardized by Healthy Blue, our standard 30-day timeline for appeal resolution will apply. The member will be sent a letter advising of the downgrade and the right to file a grievance regarding the decision within 2 calendar days.

Continuation of Benefits During Appeals or State Fair Hearings

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action but no more than 30 days.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits.

If the decision is against the member, we may recover from the provider the cost of the services the member received while the appeal was pending.

State Fair Hearing Process

Member:
The member or a representative designated by the member to act on their behalf including an attorney,(with written consent signed by the member) should submit a request for a state fair hearing to the Division of Administrative Law within 120 calendar days from the date of the notice of resolution regarding the member's standard appeal. The request will be submitted within 10 calendar days of the date of the *Notice of Resolution* if the member wishes to have continuation of benefits during the state fair hearing. A provider may file a request for a state fair hearing only as a representative of a member, with written consent signed by the member. The state fair hearing is only for members who exhaust the member MCO level appeal.

Provider:
You have the right to ask for a State Provider Appeal when our appeal process is complete, the denial of services has been upheld, and your appeal request was not resolved wholly in your favor. You must ask for a State provider appeal within 120 calendar days from the date of our appeal resolution letter.

For help on how to ask for a State Provider Appeal, call the MO HealthNet Division Constituent Services Unit at **573-526-4274**.

Send your State Provider Appeal to MO HealthNet. Include a *Provider Appeal Form* and a copy of our appeal resolution letter. You can send your State Provider Appeal via e-mail, fax or mail:
Email: **MHD.PROVIDERAPPEAL@dss.mo.gov**
Fax: **573-526-3946**
Mail: MO HealthNet Division
Constituent Services Unit
P.O. Box 6500
Jefferson City, MO 65109

Note:
- The Constituent Services Unit will send you an acknowledgement letter within 10 business days.
- The Constituent Services Unit will seek clinical review from appropriate medical professionals regarding medical necessity decisions. A State Provider Appeal decision will be issued on every appeal.
- MO HealthNet will issue a State Provider Appeal decision within 90 days of receiving all requested information from you.
- State Provider Appeal decisions can have two outcomes:
    - If MO HealthNet overturns our decision, a State Provider Appeal decision will be sent to you and to us containing the explanation and requesting that we remediate the issue within 10 business days.
    - If MO HealthNet upholds our decision, the State Appeal decision will inform you and us of an explanation followed by a notification to you informing you of your right to appeal to the Administrative Hearing Commission.
- Upon receipt of a State provider appeal decision, you may file a petition for review with the Administrative Hearing Commission:
    - You have 30 calendar days to appeal to the Administrative Hearing Commission. Claims must total at least $500.
    - You have 90 calendar days to appeal cumulative claims, upheld by MO HealthNet, once they reach $500.
    - MO HealthNet will cooperate with the Administrative Hearing Commission throughout the appeal process.

MO HealthNet will promptly contact us to assist with remediating any decision overturned by the Administrative Hearing Commission.

Prevent, Detect and Deter Fraud, Waste and Abuse

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud* - Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it—or any other person. It includes any act that constitutes Fraud under applicable Federal or State law.
- *Waste* - includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to benefit programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; it also includes beneficiary practices that result in unnecessary cost to the benefit program.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a Healthy Blue member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Every member ID card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and 24/7 NurseLine telephone numbers

See the **Member ID Cards** section for a sample of a Healthy Blue member ID card.

Presentation of a member ID card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **833-405-9086**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible.

Understanding the various opportunities for fraud and working with members to protect their ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call our compliance hotline at **888-451-1155.** Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOB*s) for any errors and contact Member Services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against

for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website at **provider.healthybluemo.com**.
- Calling Provider Services at **833-405-9086** if you are a contracted Provider
- Calling customer service if you are a non-contracted provider.
- Visit our **fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling –when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding –when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID card
- Relocating to out-of-service Plan area and not notifying us via member services @ 833-388-1407
- Using someone else's ID card

When reporting concerns involving a **member**, include:

- The member's name.
- The member's date of birth, Member ID or case number if you have it.
- The city where the member resides.
- Specific details describing the fraud, waste or abuse.

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all the appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- Written warning and/or education: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education, requests for recoveries or may advise of further action.
- Medical record review: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- Prepayment Review: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

About Prepayment Review
One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and

supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan, with state approval.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Healthy Blue and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information); such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box or department at our company.
- Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address and tax identification number (TIN) or member's provider number.

Employee Education about the FCA

As a requirement of the *Deficit Reduction Act* of 2005, contracted providers who receive Medicaid payments of at least $5 million dollars (cumulative from all sources) must comply with the following: Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the *FCA*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws as described in *Section 1902(a)(68)(*A*)*.

- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste. Include in any employee handbook a specific discussion of the laws

described in *Section 1902(a)(68)(A)*, the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

Steerage of Membership

Per our contract with the US Department of Health and Human Services we cannot have contractual arrangements in which a provider represents that they will not contract with another health plan or in which we represent that we will not contract with another provider. Contractual arrangements between us and each provider must be nonexclusive.

Steerage of membership by us and/or our network providers is prohibited. If Department of Health and Human Services determines steerage has occurred, the department has wide discretion in assessing both financial penalties and nonfinancial penalties, such as member disenrollment.

3. MEMBER MANAGEMENT SUPPORT

Welcome Call

We give new members a welcome call to:

- Educate them about our services.
- Help them schedule initial checkups.
- Identify any health issues (for example, pregnancy or previously diagnosed diseases).

24/7 NurseLine

The 24/7 NurseLine is a telephonic, 24-hour triage service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after hours or weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.

Members can reach the 24/7 NurseLine at **833-388-1407** (**TTY**:**711**). Language translation services are also available.

Additionally, all our members may obtain physical health and behavioral health telemedicine services through Live Health Online (LHO), a telemedicine company that offers 24/7 non-emergent care for members and utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from healthcare providers. To participate, members must sign up with LHO. Signing up is free at **livehealthonline.com** or by downloading the free LHO mobile app.

Care Management

Healthy Blue offers a voluntary, comprehensive program to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. Integrated Care Management (CM) services includes patient assessment, planning and advocacy to improve health outcomes for patients. Healthy Blue trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Healthy Blue CM Programs.

Healthy Blue's multidisciplinary CM teams are led by specially trained Registered Nurses (RN) and/or Licensed Behavioral healthcare Managers who perform a comprehensive assessment of the Member's clinical status, develop an individualized care and treatment plan, establish goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The Care Managers work collaboratively with PCPs and specialists to coordinate care for the Member and expedite access to care and needed services.

Healthy Blue's philosophy is that the CM Program is an integral management tool in providing a continuum of care for Healthy Blue Members. Key elements of the CM process include:

Clinical Assessment and Evaluation - comprehensive assessment of the Member is completed to determine where he or she is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs;

Care Planning - comprehensive care planning including stated member/family centered activities, measurable, defined goals, interventions and evaluation of progress. Care Planning which is shared with

the PCP or designee and other health professional(s) involved in the member's care and demonstrates a mechanism to allow for provider updates and communication with CM staff.;
Service Facilitation and Coordination - working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the transportation and follow-up; and
Member Advocacy - advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care Managers assist Members with seeking the services to optimize their health. CM emphasizes continuity of care for Members through the coordination of care among physicians, Community Mental Health Centers, and other Providers.

Member Identification Referral Process
The CM process begins with Member identification and follows the Member until discharge from the program. Members may be identified for CM by:

- Referral from a Member's PCP or specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- Completion of a Health Risk Assessment (HRA)
- Condition Care Program referral; and/or
- Data mining for Members with high utilization.

Member Assessment
Our care manager conducts a comprehensive assessment to determine a member's needs, including but not limited to, evaluating that person's:

- Medical condition
- Previous pregnancy history (when applicable)
- Current pregnancy status (when applicable)
- Functional status
- Goals
- Life environment
- Support systems
- Emotional status
- Ability for self-care
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our care manager will coordinate current medical and nonmedical needs.

Members with the following concerns are commonly included in the CM Program:
Catastrophic-traumatic injuries, for example, amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas;
Multiple Chronic Conditions - Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD), hypertension, cancer, cardiac disease or multiple intricate barriers to quality healthcare, e.g. Acquired Immune Deficiency Syndrome (AIDS), and chronic pain;
Transplantation - Organ failure, donor matching, post-transplant follow-up;

Complex Discharge Needs - Members discharged home from an acute inpatient stay or Skilled Nursing Facility (SNF) with multiple service and coordination needs (i.e. DME, PT/OT, home health), complicated, non-healing wounds, advanced illness, etc.;
Special healthcare Needs - Children or adults who have serious medical or chronic conditions with severe physical, mental or developmental disabilities; sickle cell, hepatitis, pervasive development disorder, anxiety disorders;
Pregnant Members;
Members with Elevated Lead Levels - Any member with a lead level greater than 5 ug/dl must be referred for care management; and
Members with co-occurring Behavioral Health and Substance Abuse.

Plan of Care
After the assessment, our care manager:

- Determines the level of care management services
- Guides, develops and implements an individualized plan of care
- Works with the member, the member's representative, and his or her family and provider

Care managers consider our members' needs for:

- Social services
- Educational services
- Therapeutic services
- Other nonmedical support services such as personal care; Women, Infants and Children (WIC) Program; and transportation
- Other social determinants of health

Care Management and the Provider
Healthy Blue's CM teams also serve in a supportive capacity to the PCP and assist in actively linking the Member to Providers, medical and behavioral services, residential, social and other support services, as needed. A Provider may request Care Management services for any Healthy Blue Member.

Once we have identified a member's need, our clinicians will work with that member and the member's PCP to identify the:

Level of Care Management needed
Appropriate alternate setting to deliver care
healthcare services
Equipment and/or supplies
Community-based services
Communication between the member and their PCP

For members who are hospitalized, our clinicians will also work with the member, utilization review team, and PCP or hospital to develop a discharge plan of care and link the member to:

Community resources
Our outpatient programs
Our Condition Care program

Our care managers collaborate with the members' multidisciplinary team, including social workers, member advocates or outreach associates when necessary, to define ways to coordinate physical health, behavioral health, pregnancy and social services. We then make sure we send all care plans to you by fax or mail for your review and to return via fax (fax number) with signature.

We welcome your referrals of patients who can benefit from complex care management or assistance with special care needs. To make referrals, contact our Care Management department directly at **877-440-4065 ext. 106-103-5145**.

We have a voluntary, comprehensive program to meet our members' needs when they are pregnant. See the New Baby, New Life℠ section for more information.

Behavioral Health Care Management

The Healthy Blue offers integrated care management programs designed to improve member health outcomes by integrating our medical and behavioral healthcare programs and making reliable and proven protocols available to providers.

We view care management as a continuum of services and supports that are matched on an individualized basis to meet the needs of the member. Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing care management support. In addition, members discharged from inpatient stays are provided care management support for a minimum of 90 days post-discharge.

At Healthy Blue, care managers are responsible for utilization management and work with the providers to assure appropriateness of care, services, and existence of coverage. See the **Utilization Management section** in this manual for more details.

Healthy Blue providers are encouraged to engage and direct development and provide feedback to our members' care plans.

Healthy Blue members who would benefit from care management services but actively choose not to participate or are unable to participate may be managed through a provider-focused program.

Healthy Blue's clinical teams, which are staffed with behavioral health and medical care managers, work in close collaboration with community and provider-based care managers. The main functions of the Healthy Blue behavioral healthcare managers include but are not limited to:

- Using health risk appraisal data gathered by Healthy Blue from members upon enrollment to identify members who will benefit from engagement in individualized care coordination and care management.
- Using "trigger report data" based on medical and behavioral health claims to identify members at risk.
- Consulting and collaborating with our medical care managers and condition care clinicians regarding members who present with comorbid conditions.

    - Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder or the effect of such additional disorders or diseases.
- Referring members to provider-based care management for ongoing intensive care management and then continuing involvement with the member and the provider to coordinate care, when needed, among different agencies, medical providers, etc.
- Working directly with the member and provider based on the severity of the member's condition to develop a comprehensive, person-centered care plan.

Documenting all actions taken and outcomes achieved for members in the Healthy Blue information system to ensure accurate and complete reporting.

New Baby, New Life℠ Pregnancy Support Program

New Baby, New Life is a proactive care management program for mothers and their newborns that uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, lab reports, hospital census reports, Availity and notification of pregnancy forms as well as provider and member self-referrals. Once identified, we act quickly to assess the member's obstetrical risk and ensure she has the appropriate level of care and care management services to mitigate those risks.

Experienced care managers work with members and providers to establish a care plan for our pregnant members. Care managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive care management program offering:

- Individualized, one-on-one care management support for women at the highest risk
- Care management for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

As part of the New Baby, New Life program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the hightouch care management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our care managers, and improve member and baby outcomes. For more information on My Advocate, visit **myadvocatehelps.com**.

Healthy Blue encourages notification of pregnancy at the first prenatal visit and notification of delivery following birth. Please complete these forms via Availity Essentials Maternity application or fax completed forms to Healthy Blue at 1-800-964-3627.

We also encourage providers to complete the Maternity form in Availity:

- Perform an Eligibility and Benefits (E&B) request on the desired member.

- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose "Yes", if applicable. If you indicate "Yes" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. You may access the form by navigating to the "Applications" tab and selecting the "Maternity" link.

Members may also receive calls from OB care managers to provide interconceptional CM, with education and support in obtaining information to develop an interconception family life plan.

NICU Care Management

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Care Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Highly skilled and specialized NICU care managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge. Once discharged, the NICU care manager continues to foster improved outcomes, prevent unnecessary hospital readmissions, and ensure efficient community resource consumption.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

If you are caring for a member who would benefit from OB and/or NICU Care Management services, please call us at **877-440-4065 ext. 106-103-5145**. Parents/caregivers can also call our 24/7 NurseLine at **833-388-1407** (TTY **711**), available 24 hours a day, 7 days a week.

Condition Care/Wellness Program

Our Condition Care Program is based on a system of coordinated care management interventions and communications designed to assist physicians and other healthcare professionals in managing members with chronic conditions.

Our mission:
The mission of the Condition Care program is to improve the health and quality of life for Healthy Blue members served by encouraging member self-care efforts, coordinating healthcare education and providing interventions along the continuum of care.

Condition Care services focus on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment allows us to meet the changing healthcare needs of our member population.

Who is eligible?
Members diagnosed with one or more of the conditions listed below are eligible for Condition Care services:

- Asthma.
- Bipolar disorder.
- Chronic obstructive disorder (COPD).
- Congestive heart failure (CHF).
- Coronary artery disease (CAD).
- Diabetes.
- HIV/AIDS.
- Hypertension.
- Major depressive disorder — adult.
- Major depressive disorder — child/adolescent
- Substance use disorder.
- Schizophrenia.

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with weight management and smoking cessation education.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring, as well as care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Program features:

- Proactive population identification process
- Program content is based on evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models, which include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance (NCQA) accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all our programs are based on nationally approved clinical practice guidelines are located at **provider.healthybluemo.com**. A copy of the guidelines can be printed from the website, or you can call Provider Services at **833-405-9086** to receive a printed copy.

Wellness Program:

Our Wellness Program helps members with unhealthy weight by establishing individual goals and providing support and follow-up over a six-month period.

The Wellness Program:

Combines care management, education and community-based resources to support a healthy lifestyle. Assigns a health coach to support the member with motivational interviewing sessions, telephonic coaching, and education-based support measures designed to improve treatment plan compliance and increase healthy choices.
Allows the health coach to work directly with the member to set realistic and achievable short-term goals for a healthy lifestyle – optimizing success toward long-term goals.

Information related to your patient's individualized care plan and comprehensive clinical assessments completed for this program may be viewed via **provider.healthybluemo.com** secure provider website. We encourage you to review the care plan and reach out to a condition care manager if you have any input or questions.

Contacting the Wellness Program
Call **844-421-5661**, Monday to Friday, from 8:30 a.m. to 5:30 p.m. CT.

Condition Care Provider Rights and Responsibilities
You have the right to:

- Have information about Healthy Blue including:
- Provided programs and services.
- Our staff.
- Our staff's qualifications.
- Any contractual relationships.
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their healthcare.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about Condition Care as outlined in the Healthy Blue provider complaint and grievance procedure.

Hours of Operation
Our Condition Care care managers are registered nurses. They are available 8:30 a.m. to 5:30 p.m. Confidential voicemail is available 24 hours a day. The 24/7 Nurse Line is available for our members 24 hours a day, 7 days a week.

Contact
You can call a Condition Care team member at **888-830-4300**. Condition Care content is located at **provider.healthybluemo.com**, and printed copies are available upon request. Members can obtain information about Condition Care by visiting **provider.healthybluemo.com** or calling **888-830-4300**.

Provider Directories

We make provider directories available to members in online searchable and hard-copy formats. Because members use these directories to identify healthcare providers near them, it is important that your practice address(es), doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting **provider.healthybluemo.com**.
- Calling Provider Services at **833-405-9086**.
- Calling or emailing your local Provider Relations representative.

The provider directory is also available on the provider website at **provider.healthybluemo.com**.

Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Healthy Blue wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients. Simply appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Providers should attempt to collect member demographic data, including but not limited to, ethnicity, race, gender, sexual orientation, and religion. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Healthy Blue requires and provides training on the provider website on cultural competence, including tribal awareness, to behavioral health network providers for a minimum of three hours per year and as directed by the needs assessments.

Healthy Blue appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Member Records

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. You may maintain electronic records provided the record-keeping format is capable of being

printed for review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Healthy Blue credentialed providers are required to cooperate with the health plan to provide the state agency with access to all members' medical records, whether electronic or paper, within 30 calendar days of receipt of written request at no charge. Healthy Blue credentialed providers are required to cooperate with the health plan to provide the state agency with access to a single or small volume of medical records within 5 calendar days of receipt of written request at no charge. Healthy Blue credentialed providers are required to cooperate with the health plan to provide the state agency with immediate access for on-site review of medical records. For on-site review of medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. Healthy Blue credentialed providers are required to cooperate with the health plan to fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all providers.

The state agency is not required to obtain written approval from a member before requesting the member's record from the provider. If the state agency requests, you are required to cooperate with the health plan to gather all medical records.

Healthy Blue credentialed providers are required to maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within 10 business days from receipt of request or prior to the next scheduled appointment to the new primary care provider, whichever is earlier, at no charge. Members are entitled to one copy of their medical record per year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Healthy Blue credentialed providers are required to provide prompt transfer of member records upon request to other in-network or out-of-network providers for the medical management of our member.

Member records must be retained for at least 10 years after the last good, service or supply has been provided to a member or an authorized agent unless those records are subject to review, audit or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Any correction, addition, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

Healthy Blue requires access to member records for the purpose of conducting Medical Record Reviews.

Our medical records standards include:

- Patient identification information — patient name or ID number must be shown on each page or

electronic file
- Personal/biographical data — name, birth date, age, sex, address, employer, home and work telephone numbers and marital status (primary languages spoken and translation needs must be included)
- Date(s) member was seen and corroboration — dated, identified by the author, and signed
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
- Medication allergies
- Adverse reactions
- No Known Allergies (NKA)
- Past medical history — for patients seen three or more times, include serious accidents, operations, illnesses, and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members 20 years of age and younger with vaccines and dates of administration. Evidence of lead screening for ages 6 months to 6 years.
- Diagnostic information including growth charts, head circumference and developmental milestones, if applicable
- Medical information, including medication and instruction to patient
- Current list of medications
- The current status of the member, including the reason for the visit
- Observation of pertinent physical findings
- Assessment and clinical impression of diagnosis
- Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered
- Any informed consent for office procedures
- Serious illnesses
- Medical and behavioral conditions
- Health maintenance concerns
- Instructions, including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients ages 12 and older and seen three or more times
- Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician’s initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

Patient Visit Data

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment including at-risk factors:
- Danger to self/others
- Ability to care for self
- Affect
- Perpetual disorders
- Cognitive functioning
- Significant social health
- Admission or initial assessment including:
- Current support systems
- Lack of support systems
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating either:
- Decreased
- Increased
- Unchanged
- A plan of treatment including:
- Activities
- Therapies
- Goals to be carried out
- Diagnostic tests
- Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment
- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
- Referrals and results of all other aspects of patient care and ancillary services

HCY/ESPDT Well-Child Visit

Providers must complete A full HCY/EPSDT well child visit, including all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different providers. An interperiodic screen is defined as any encounter with a healthcare professional acting within his or her scope of practice:

- A comprehensive health and developmental history including assessment of both physical and behavioral health developments;
- A comprehensive unclothed physical exam;
- Health education (including anticipatory guidance);
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
- Appropriate immunizations according to age;
- Annual verbal lead risk assessment beginning at age 6 months and continuing through age 72 months using the HCY Lead Risk Assessment Guide Questionnaire that may be obtained at: **health.mo.gov/living/environment/lead/pdf/HCYLeadRiskAssessmentGuide.pdf**;
- Blood lead level testing is mandatory at 12 and 24 months of age for all MO HealthNet children or annually for all children 6 months to 72 months of age if residing in an area designated as high risk for

lead poisoning in Missouri as defined by Department of Health and Senior Services regulation *19 CSR 20-8.030*;
- Hearing screening;
- Vision screening; and
- Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommended that preventive dental services begin at age 6 through 12 months and be repeated every 6 months.

If a suspected problem is detected during a well child visit, the child must be evaluated as necessary, using the required assessment protocol, for further diagnosis. This diagnosis is used to determine treatment needs

Providers must conduct and document well-child visits (screenings).

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for 10 years from the date of service.

Clinical Practice Guidelines

We work with you and providers like you to develop clinical policies and guidelines. Each year, we select at least four evidence-based *Clinical Practice Guidelines* that are relevant to our members and measure at least two important aspects of each of those four guidelines. We also review and revise these guidelines at least every year. You can find these *Clinical Practice Guidelines* on our website at **provider.healthybluemo.com**.

Advance Directives

We adhere to the *Patient Self-Determination Act* and recognize and support the following advance directives:
- Durable power of attorney — lets a member name a patient advocate to act on his or her behalf
- Living will: lets a member state his or her wishes on medical treatment in writing

We encourage members ages 18 and older to ask you for an advance directive form and education at their first appointment. Please document their forms in your medical records. We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care. Please note, a Healthy Blue associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

4. BEHAVIORAL HEALTH SERVICES

Overview

Healthy Blue facilitates integrated physical and behavioral health services, and this integration is an essential part of our healthcare delivery system. Our mission is to comprehensively address the physical and behavioral healthcare of our members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members. Healthy Blue works collaboratively with hospitals, group practices, independent behavioral healthcare providers, community and government agencies, human service districts, federally qualified health centers (FQHC), rural health centers (RHCs), community mental health centers, and other resources to successfully meet the needs of members with mental health, substance use, and intellectual and developmental disabilities.

For assistance with behavioral health services:

- Providers can call Provider Services at **833-405-9086** 8 a.m. to 6 p.m. CT Monday to Friday.
- Members can call Member Services at **833-388-1407** 9 a.m. to 6 p.m. ET Monday to Friday.

Goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to include a comprehensive array of quality and evidenced-based supports and services for eligible members, while enhancing members' experiences.
- Integrate the management and delivery of physical and behavioral health services.
- Achieve quality initiatives, including those related to HEDIS®, NCQA, Department of Health and Human Services and other governmental entities performance requirements.
- Work with members, providers and community supports to provide recovery and resilience tools to create an environment that supports members' progress toward their recovery and resilience goals.
- Ensure utilization of the most appropriate and least restrictive medical and behavioral healthcare in the right place, at the right time.

Objectives

The objectives of the behavioral health program are to:

- Ensure continuity and coordination of care between physical and behavioral healthcare practitioners.
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery and resilience goals.
- Leverage individualized, person-centered planning approaches to assist members in life planning to increase their personal self-determination and optimize their own independence.
- Provide member education on treatment options and pathways toward recovery and resilience.
- Provide high quality care management and care coordination services that identify member needs and address them in a personal and holistic manner.
- Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, waiver services and outpatient care at the least restrictive level.
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives.
- Promote collaboration between all healthcare partners to achieve recovery goals through education, technological support and the promotion of recovery ideals.

- Use evidence-based practices, guidelines and clinical criteria and promote their use in the provider community.
- Maintain compliance with accreditation standards and with local, state and federal requirements.
- Deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations and policies and procedures set forth by the state of Missouri.
- Reduce repeat ER visits, unnecessary hospitalizations, out-of-home placements and institutionalizations.
- Improve member clinical outcomes through continuous quality monitoring of the health delivery service system.

Guiding Principles of the Behavioral Health Program

Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- **Self-direction:** Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
- **Individualized care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.
- **Empowerment:** Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives, and are educated and supported in so doing.
- **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and healthcare treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
- **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a

person recognizes that positive change is possible. This awareness enables the member to move on to fully engage in the work of recovery.

- **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
- **Peer support:** Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
- **Respect:** Community, systems and societal acceptance, and appreciation of members, including protecting their rights and eliminating discrimination and stigma, are crucial to achieve recovery.
- **Responsibility:** Members have a personal responsibility for their own self-care and journeys of recovery.
- **Hope:** Recovery provides the essential and motivating message of a better future — That people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges due to changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

Systems of Care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused, with the needs of the person and their family dictating the types and mix of services provided.
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized, as evidenced by an individualized service plan that meets unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services.
- Inclusive of care management or similar mechanisms to ensure multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Oriented to recovery and providing services that are flexible and evolve over time.

Integration of Behavioral Health and Physical Health Treatment

The integration of behavioral health and physical health treatment is the cornerstone of the Healthy Blue philosophy of treating the needs of the whole person. Principles that guide this integration of care include the following:

- Behavioral health is essential to overall health and not separate from physical health.
- Mental illness, substance use disorders and other healthcare conditions must be integrated into a comprehensive system of care that meets the needs of individuals in the setting where they feel most comfortable. This includes primary care settings and/or behavioral healthcare settings.
- Many people suffer from mental illness, substance use disorders and other healthcare conditions concurrently; as care is provided, the dynamic of having co-occurring illnesses must be understood, identified and treated as primary conditions.
- The system of care must be accessible and comprehensive and fully integrate an array of prevention and treatment services for all age groups. It is designed to be evidence-informed, responsive to changing needs and built on a foundation of continuous quality improvement.

It is our goal to make relevant clinical information accessible to all health providers on a member's treatment team, consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Key elements of our model for coordinated and integrated health services include but are not limited to:

- Ongoing communication, coordination and collaboration between primary care providers and specialty providers, including behavioral health (mental health and substance use) providers, with appropriate documented consent.
- The expectation that primary care providers will regularly screen members for mental health, substance use (including tobacco), co-occurring disorders and problem gaming and refer members to behavioral health specialty providers as necessary.
- The expectation that behavioral health providers will screen members for common medical conditions, including tobacco use, and refer members to the primary care provider for follow-up diagnosis and treatment.
- Collaboration between all healthcare providers with support from Healthy Blue in managing healthcare conditions of members.
- Referrals to primary care providers or specialty providers, including behavioral health providers, for assessment and/or treatment for members with co-occurring disorders and/or any known or suspected and untreated health disorders.
- Development of patient-centered treatment plans involving members, as well as caregivers and family members, and other community supports and systems when appropriate.
- Care management, disease management and population health management programs to support the coordination and integration of care between providers.

Fostering a culture of collaboration and cooperation helps Healthy Blue sustain a seamless continuum of care that positively impacts our member outcomes. To maintain continuity of care, patient safety and member well-being, communication between integrated healthcare providers is critical, especially for members with comorbidities receiving pharmacological therapy.

Coordination of Physical and Behavioral Health Services

As a network provider, you are required to notify a member's primary care provider when a member first enters behavioral healthcare and anytime there is a significant change in care, treatment, medications or need for medical services. You must secure the necessary release of information from each member or the member's legal guardian for the release of treatment information, including substance use information, in accordance with *42CFR Part II* requirements. Each offer of consent or release of substance use information should be documented and reported to Healthy Blue as requested. You should be able to provide initial and summary reports to the primary care provider or to Healthy Blue upon request. The minimum elements to include are as follows:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see their primary care provider if a medical is condition identified or need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician's name and contact information

Provider Roles and Responsibilities

The behavioral healthcare benefit is fully integrated with the rest of the healthcare programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each Healthy Blue member under your care.
- Seek prior authorization for all services that require it.
- Attempt to obtain appropriate consent for the disclosure of substance use treatment information to the member's PCP for all members treated for behavioral health conditions, document attempts and report information to Healthy Blue upon request.
- Provide Healthy Blue and the member's PCP with a summary of the member's initial assessment, primary and secondary diagnosis, and prescribed medications if the member is at risk for hospitalization; this information shouldbe provided within 24 hours after the initial treatment session.
- Provide, at a minimum, a summary of the findings from the member's initial visit to the PCP — This must be provided within five calendar days of the visit for members not at risk for hospitalization and must include the behavioral health provider's contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.
- Notify Healthy Blue and the member's PCP of any significant changes in the member's status and/or change in the level of care.
- Ensure members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge — this treatment must be provided within seven calendar days from the date of the member's discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Encourage members to consent to the sharing of substance use treatment information.
- Comply with mainstreaming requirements.
- Inpatient providers should utilize Cyberaccess^{sm} to obtain a member's recent healthcare service history at the time of authorization of a psychiatric inpatient admission. Cyberaccess includes claims history that will provide information such as psychiatric inpatient admissions and emergency room visits for the

prior year, psychiatric outpatient services for the prior six (6) months, and medications for the prior ninety (90) calendar days. The date, diagnosis, provider, and procedure is provided for each episode of care. To become a CyberAccess user, contact the Conduent help desk at **888-581-9797** or **573-632-9797**, or send an e-mail to CyberaccessHelpdesk@conduent.com. **cyberaccessonline.net/cyberaccess/Login.aspx**

Continuity of Care

When behavioral health services require a transition for the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the Healthy Blue health plan, we will authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Healthy Blue members until such time as the new Healthy Blue member has been transferred appropriately to the care of an in-network provider.

To assist in the transition of Healthy Blue members from one level of care to another, Healthy Blue recommends transition meetings or appointments are held prior to the member moving from higher to lower restrictive levels of care to assure continuity of treatment. Healthy Blue encourages providers to include Healthy Blue care managers in these meetings and appointments.

Provider Success

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral healthcare to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Supporting provider needs related to transitioning into the managed care environment.

Clinical Staff

All clinical staff members are licensed and have prior healthcare experience. Our behavioral health medical director is board-certified in adult, adolescence and child psychiatry and licensed in the state of Missouri. Our highly trained and experienced team of clinical care managers, and support staff provide high-quality care management and care coordination services to our members and strive to work collaboratively with all providers.

Member Records and Treatment Planning

Member Records and Treatment Planning: Comprehensive Assessment

Member records must meet the following standards and contain the following elements, if applicable, for effective service provision and quality reviews.

Information related to the provision of appropriate services to members must be included in the records, with documentation in a prominent place whether there is an executed declaration for mental health treatment.

Providers must complete a comprehensive assessment that provides a description of the member's physical and mental health status at the time of admission to services. It should include the following:

- Psychiatric and psychosocial assessment, including:
- Description of the presenting problem
- Psychiatric history and history of the member's response to crisis situations
- Psychiatric symptoms
- Multi-axial diagnosis using the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)
- Mental status exam
- Medical assessment, including:
- Screening for medical problems
- Medical history
- Present medications
- Medication history
- Substance use assessment, including:
- Frequently used over-the-counter medications
    - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
    - History of prior alcohol and drug treatment episodes and their effectiveness
    - History of alcohol and drug use
- Community functioning assessment or an assessment of the member's functioning in the following domains:
- Living arrangements, daily activities (vocational/educational)
- Social support
- Financial
- Leisure/recreational
- Physical health
- Emotional/behavioral health
    - An assessment of the member's strengths, current life status, personal goals and needs

Member Records and Treatment Planning: Personalized Support and Care Plan

When individualized treatment plans are required, they must be:

- Completed and submitted within the first 24 hours or next business day for members admitted to an acute mental health or acute care inpatient setting;
- Completed and submitted within the first 30 days of admission to or authorization of outpatient behavioral health services.

Treatment plans should be updated no less than every 180 days, or more frequently as necessary based on the member's progress toward goals, a significant change in psychiatric symptoms, medical condition and/or community functioning as well as the level of care where the member is receiving treatment. Additionally, the development of a crisis prevention plan is required for those members with multiple hospitalizations or more than three visits to the emergency room for urgent or nonemergent care.

There must be a signed release of information to provide information to the member's PCP, including disclosure of substance use information or evidence that the member refused to provide a signature. Such information must be reported to Healthy Blue upon request. Disclosures of substance use information must

include a prohibition against redisclosure. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled, and documentation should reflect the action taken.

The individualized treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent de-escalation or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member as well as family members, caregivers or legal guardian as appropriate

Member Records and Treatment Planning: Progress Notes
Progress notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the member's treatment, including signed and dated notations of phone calls concerning the member's treatment.
- Indication of active follow-up actions for referrals given to the member and actions to fill gaps in care.
- A brief discharge summary within 15 calendar days of a discharge from services or death.
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication; alternate medications; and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member, or if appropriate, a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, their treating provider's information and coordination efforts with that provider. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's PCP.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side effects and risks of medications and they regularly inquire about and look for any side effects. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines.
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers.
- Glucose tolerance test or hemoglobin A-1C tests, especially for those members on antipsychotics or mood stabilizers.
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers.
- ECG checks for members placed on medications with risk for significant QT prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our clinical practice guidelines, located on our website at **provider.healthybluemo.com**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

Timeliness of Decisions on Requests for Authorization

The following are guidelines around the timeliness of decisions on authorization requests for behavioral health services:

- If the referral is made from an emergency room or a facility that does not have a psychiatric unit, the decision will be made and communicated to the provider within 30 minutes of the request.
- Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider.
- Approval or denial shall be provided within thirty-six hours, which shall include 1 working day, of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within thirty-six hours, which shall include 1 working day, following the receipt of the request of service regarding any additional information necessary to make a determination. The health plan shall not exceed 14 calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the health plan justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.
- Involuntary detentions 96 hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect.
- To the extent known, Healthy Blue will inform inpatient providers of the member's recent healthcare service history at the time of authorization of a psychiatric inpatient admission. Such information shall include psychiatric inpatient admissions and emergency room visits for the prior year, psychiatric outpatient services for the prior 6 months, and medications for the prior 90 calendar days. The date, diagnosis, provider, and procedure shall be provided for each episode of care. Services related to substance use disorder or HIV disorders are exempt from this requirement. Claims history from CyberAccess[sm] may be used to fulfill this requirement (**cyberaccessonline.net/cyberaccess/Login.aspx**)

Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral healthcare.

Service type	Access standard

Emergent Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.	Immediately on presentation at the service delivery site; emergent, crisis or emergency behavioral health services must be available at all times and an appointment must be arranged within 1 hour of the request. Care for a nonlife-threatening emergency must be arranged within 6 hours.
Urgent care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services):	Appointments within 24 hours
Routine care with physical or behavioral symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever)	Appointments within 1 week or 5 business days whichever is earlier.
Routine care without physical or behavioral symptoms (e.g. well child exams, routine physical exams)	Appointments within 30 calendar days.
Aftercare Appointments	Aftercare appointments within 7 calendar days after hospital discharge.

Parity

Healthy Blue's services will comply with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (42 CFR part 438, subpart K)*, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. At the discretion of the state agency, Healthy Blue will provide the state agency with detailed analyses demonstrating the health plan's compliance with MHPAEA with respect to financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations. If additionally requested by the state agency, the Healthy Blue will provide information regarding how any additional services provided by the health plan, other than those set forth in the Medicaid State Plan, are necessary for compliance with MHPAEA. The required analyses are subject to change based on the requirements outlined in *42 CFR part 438, subpart K*. The health plan must comply with the following**:**

a. Healthy Blue will not have an aggregate lifetime or annual dollar limit (see *42 CFR 438.905*) on any behavioral health service.
b. As specified in *42 CFR 438.910(b)(1)*, Healthy Blue will not apply any financial requirement or treatment limitation to behavioral health services in any benefit classification (inpatient, outpatient, emergency care, or prescription drugs) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all physical health services in the same classification furnished to members (whether or not the benefits are furnished by Healthy Blue).
c. In accordance with *42 CFR 438.910(b)(2)*, the Healthy Blue will provide behavioral health services in all benefit classifications.
d. The Healthy Blue will not apply any cumulative financial requirements, see *42 CFR 438.910(c)(3)* for behavioral health services.

e. In accordance with *42 CFR 438.910(d)*, the Healthy Blue will not impose a non-quantitative treatment limitation (NQTL) for behavioral health services in any benefit classification unless, under the policies and procedures of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to behavioral health benefits in the benefit classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for physical health services in the benefit classification. NQTLs include, but are not limited to, medical management standards; standards for provider participation, including reimbursement rates; fail-first policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, or other criteria that limit the scope or duration of services; and standards for providing access to out-of-network providers, see *42 CFR 438.910(d)(2)*.
f. Healthy Blue will work with the state to ensure that all members are provided access to a set of benefits that meets the requirements of *42 CFR part 438, subpart K* regarding parity in behavioral health services, regardless of what behavioral health services are provided by the health plan.
g. Healthy Blue will cooperate with the state agency to establish and demonstrate initial and ongoing compliance with *42 CFR part 438, subpart K* regarding behavioral health parity. This shall include but not be limited to participating in meetings, providing information (documentation, data, etc.) requested by the state agency to assess parity compliance, working with the state agency to resolve and non-compliance, and notifying the state agency of any changes to benefits or limitations that might impact parity compliance.

Behavioral Health Services Requiring Preauthorization

All facility-based behavioral health and substance use services require precertification, and some outpatient services require precertification. All services provided by non-participating providers require precertification. To obtain additional information about covered services and precertification requirements for covered behavioral health services, please visit the provider website at **provider.healthybluemo.com**. For information or to make referrals, call **833-405-9086**.

Services not Included in the Comprehensive Benefit Package

Healthy Blue is not obligated to provide or pay for any services not included in the comprehensive benefit package. Information about some of the services not in the comprehensive benefit package is provided below. Healthy Blue is responsible for coordinating the provision of services in the comprehensive benefits package with services not included within the comprehensive benefit package.

Comprehensive Substance Treatment and Rehabilitation (C-STAR) Services

Services provided by a C-STAR MO HealthNet provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.
In order to ensure quality of care, the health plan and its behavioral health treatment providers shall maintain open and consistent dialogue with C-STAR providers. Healthy Blue will be responsible for care coordination of services included in the comprehensive benefit package and C-STAR services in accordance with the Behavioral Health Fee-For-Service Coordination and the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care policy statement in the MO HealthNet Managed Care Policy Statements located and periodically updated on the MO HealthNet website at Bidder and Vendor Documents (**dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/**).

Behavioral Health Services (CPR)

Services provided by a Community Psychiatric Rehabilitation provider will be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

Behavioral health adult targeted care management services will be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

Applied Behavior Analysis (ABA) services for children with Autism Spectrum Disorder will be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

Developmental Disability (DD) Waiver

Home and community-based waiver services for persons in the DD waiver are carved out of the MO HealthNet Managed Care Program. Healthy Blue will be responsible for MO HealthNet Managed Care comprehensive benefit package services for DD waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the DD waivers. Information regarding DD waiver services may be found in the MO HealthNet DD Waiver Provider Manual located on the internet at **http://manuals.momed.com/manuals**; MO HealthNet Provider Bulletins located on the internet at **dss.mo.gov/mhd/providers/pages/bulletins.htm**; and on the MO HealthNet Division website, Bidder and Vendor Documents (**dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents**/), in the *Waivers operated by the Department of Mental Health, Division of Developmental Disabilities which may include Managed Care Individuals.*

Behavioral Health Criteria

For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, as well as some outpatient reviews Healthy Blue will use LOCUS/CALOCUS. If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, Healthy Blue will continue to authorize inpatient care. In the event of disagreement, the health plan shall provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service. Healthy Blue will utilize MCG criteria for Psychological testing, Neuro-psychological testing, and Electroconvulsive Therapy (ECT).

How to Provide Notification or Request Preauthorization

You may request preauthorization for nonroutine inpatient mental health services that require it by accessing **Availity.com**, 24/7 and 365 days a year. Be prepared to provide clinical information in support of the request.

Notification or Request Prior Authorization

The quickest, most efficient way to request prior authorization is through Availity Essentials at **Availity.com**. From Availity's home page select Patient Registration | Authorizations & Referrals and follow the steps to request and submit the authorization.
Digital authorizations offer a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for our members. Providers can also use the authorization application to inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool).

Initiate preauthorization requests online, eliminating the need to fax. Detailed text, photo images and attachments can be submitted along with your request.
Review requests previously submitted via phone, fax, or other digital or electronic methods.

Request and check the status of clinical appeals for eligible denied prior authorization requests
Instant accessibility from almost anywhere, including after business hours.
Utilize the dashboard to provide a complete view of all utilization management requests with real-time status updates.
Real-time results for some common procedures.
Enhanced Analytics that can provide immediate authorizations for certain higher levels of care
Increased Efficiency so that use of fax is no longer needed

Ask your Availity administrator to grant you the required authorization role assignments now so you can begin using the tool immediately.

- **Do you create and submit prior authorization requests?**
  Authorization and Referral Request role assignment
- **Do you check the status of the case or results of the authorization request?**
  Authorization and Referral Inquiry role assignment

For an optimal on-line experience , use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome or Firefox.

You may also request authorization for inpatient mental health services through Availity **Availity.com**. Select Patient Registration | Authorizations & Referrals. Please be prepared to provide clinical information in support of the request and complete the appropriate clinical forms provided within the application.

You may provide notification or request preauthorization on the provider website at **provider.healthybluemo.com**. You may also request preauthorization by fax for certain levels of care. Fax forms are located on our website at **provider.healthybluemo.com**.

Emergency Behavioral Health Services

Primary care providers should immediately refer any member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

Behavioral Health Self Referrals

Healthy Blue allows members to seek in-network behavioral health services without a referral or authorization from the primary care provider. Members are allowed to contact an in-network behavioral health provider directly to access behavioral health services without prior authorization requirements. Healthy Blue requires that behavioral health providers complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. Healthy Blue behavioral health providers are required to refer members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition. If the member is unable or unwilling to access timely services through community providers, call Healthy Blue Provider Services for assistance.

PCPs should refer any member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health specialist:

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Multiple diagnosis
- Psychoses, involutional depression
- Schizophrenia
- Unipolar depression
- Problem gaming

Links to Forms, Guidelines and Screening Tools

For mental health and substance use +, noncovered diagnoses, and screening tools for PCPs and behavioral health providers, go to **provider.healthybluemo.com.**

For services requiring precertification, go to **provider.healthybluemo.com**.

5. UTILIZATION MANAGEMENT

Healthy Blue's Utilization Management (UM) Program is designed to meet contractual requirements with the state and federal regulations while providing Members with access to high quality, cost effective, medically necessary care.

The goal of the UM program is to achieve the best outcomes while providing quality healthcare at the most appropriate setting and the most appropriate time for the Members. Healthy Blue's UM Program includes components of prior authorization, prospective, concurrent and retrospective review activities. The UM Program:

- Ensures culturally sensitive delivery of services that are Medically Necessary, appropriate and are consistent with the Member's diagnosis and level of care required
- Provides access to the most appropriate and cost efficient healthcare services. Ongoing monitoring, tracking and trending of care rendered to Healthy Blue's Members in order to ensure that quality healthcare is provided
- Works collaboratively with the CM, DM, and QM Departments by identifying and referring potential quality of care issues for review and implementation of intervention plans, as indicated
- Monitors overutilization and underutilization, continuity and coordination of care and implements corrective action intervention plans, as needed
- Works collaboratively with the Provider Services Department and Appeals and Grievance Department to ensure timely review and response to Member or Provider grievances/appeals relating to UM decisions
- Facilitates communication and partnerships among participants, physician Providers, facility Providers, delegated entities and Healthy Blue in an effort to enhance cooperation and appropriate utilization of healthcare services
- Monitors, implements and maintains systems to enable compliance with government and legislative requirement of the UM processes

Providers can access Healthy Blue UM staff to discuss issues as follows:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

Healthy Blue provides TDD/TTY services and language assistance for members to discuss UM issues.

We are available 24/7 to accept precertification requests. When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Healthy Blue, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Healthy Blue does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

Criteria for UM Decisions

The UM Program currently uses numerous sources of information including but not limited to, the following when making coverage determinations:

- State Medicaid Contract
- State Provider Manuals, as appropriate
- Local and Federal Statutes and Laws
- MCG Care Guidelines
- LOCUS
- CALOCUS
- Healthy Blue Medical Policies and Clinical UM Guidelines
- Medicaid and Medicare guidelines

The reviewer and/or medical director involved in the UM process applies medical necessity criteria in context with the member's individual circumstances. When the above criteria do not address the individual member's needs or unique circumstances, the medical director will use clinical judgement in making the determination.

Upon requests, providers can obtain copies of the review criteria used for the specific determination of medical necessity by contacting the UM department via provider services by calling **833-405-9086** or visiting **provider.healthybluemo.com**.

Healthy Blue will manage specific services as long as Healthy Blue provides services that are medically necessary. Healthy Blue will have a process for allowing exceptions that are in accordance with *13 CSR 70-2.100*. Healthy Blue will develop criteria by which it reviews future treatment options, sets prior authorization criteria, or exercises other administrative options for the health plans administration of medical and behavioral healthcare benefits. Healthy Blue can place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The Healthy Blue will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Healthy Blue will follow the requirements outlined in the MO HealthNet Managed Care Policy Statements, located and periodically updated on the MO HealthNet website at Bidder and Vendor Documents (**dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents**).

Utilization Management Process

The UM process is comprehensive and included the following review processes:

- Notifications
- Referrals
- Prior Authorizations/Pre-Certifications (Prospective Reviews)
- Concurrent Review
- Discharge Planning
- Retrospective Review

The UM department adheres to state, federal and accreditation standards for service authorization decisions and adverse determinations, which include notification timeframes. These standards apply to urgent/expedited and routine requests for prospective, concurrent and retrospective reviews.

Notification

Notifications are communications to Healthy Blue with the information related to a service rendered to a member or a members admission to a facility. Notification is required for:

- Prenatal services. This enables Healthy Blue to identify pregnant members for inclusion in the prenatal program and identify members who may benefit from the High Risk Pregnancy Program. OB providers are required to notify Healthy Blue of pregnant members using the Notification of Pregnancy form via fax or Availity Essentials maternity notification alert within 2 business days of the initial visit. This process will expedite care management activities and claims reimbursement.
- A member's admission to a hospital, to include observation admissions. This enables Healthy Blue to log the admission and follow up with facility to determine medical necessity. The notification must be made within 24 hours or the next business day of the admission.

Referrals

For initial referrals, Healthy Blue does not require an authorization as a condition of payment if the services are done in the Healthy Blue network. However, certain specialty services, diagnostic test and procedures may require prior authorization. Please refer to the Healthy Blue website for at **provider.healthybluemo.com** for the authorization look up tool.

Prior Authorization

Prior authorization allows for efficient use of covered services by and ensures members receive the most appropriate level of care, in the most appropriate setting. Prior authorization may be obtained by the member's PCP or by a treating specialist or facility.

Prior authorization **may be required** for elective or non-emergency services. Elective and urgent inpatient admissions require authorization. Prior authorization requirements may be found on the Prior Authorization Lookup Tool on our provider website.**. Our prior authorization forms are located on our provider website at provider.healthybluemo.com.**

Request for prior authorization can be submitted to Healthy Blue by:

- Submitting an online authorization request via the secure provider web portal **Availity.com** (this is quickest most efficient option) Select Patient Registration > Authorizations & Referrals from Availity's home page.
- Contacting Provider Services at **833-405-9086** or faxing prior auth to: **800-964-3627 (physical health requests)**

To ensure timeliness, some prior authorization guidelines to note are:

- The prior authorization request should be completed in its entirety. The request should include the diagnosis to be treated and the current procedural terminology (CPT) code describing the anticipated procedure. The request should outline the plan of care, including the frequency and total number of visits requested, duration of care and supporting documentation to support the medical necessity of the services requested.

Concurrent Review

Concurrent review activities involve the evaluation of a 24-hour observation stay, a continued hospital stay, Long-Term Acute Care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic, fax or electronic chart review and communication with the attending physician, hospital utilization manager, CM staff or hospital clinical staff involved in the Member's care.

Concurrent review is initiated after Healthy Blue is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan, and discharge planning activity. The concurrent review process incorporates the use of nationally recognized criteria MCG Care Guidelines or LOCUS/CALOCUS criteria to assess quality care and appropriate level of care for continued treatment and lower levels of care. Reviews are performed by licensed clinicians under the direction of the Healthy Blue Medical Director.

To ensure the review is completed in a timely manner, Providers must submit notification and clinical information the next business day after the admission, as well as upon request of the Healthy Blue review clinician. Failure to submit necessary documentation for concurrent review may result in a denial for continued services and non-payment.

Hospitals must notify Healthy Blue by phone, provider portal or via the inpatient notification form by fax by the next business day following the admission. No authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next business day if not already presented at the time of notification.

A Healthy Blue clinician will review the clinical information, and will respond to the facility with an authorization status decision within one business day after receipt of the information.

If a Member is admitted, and subsequently discharged before the next business day (in other words, over a weekend), the facility must still notify Healthy Blue and provide clinical information so that an authorization decision can be made.

Facilities must notify Healthy Blue of admissions for the delivery of newborn or stillborn babies. Notification should be by fax, using the *Birth Notification Form*, by the next business day following the birth. Baby clinical

information (gender, weight, date of birth) must be provided no later than the next business day, if not included in the initial notification. Healthy Blue will respond to the facility with an authorization number within one business day, to include 36 hours of the receipt of complete information.

Failure of a hospital(s) to notify Healthy Blue of a Member's inpatient admission by the next business day, or failure to communicate information related to service(s) rendered to a Member will result in the denial of the submitted claim(s) associated with the said admission or service(s).

Discharge Planning

Discharge planning begins upon admission and is an essential part of the concurrent review process. It is designed to quickly identify medical and/or psychosocial issues that will need post hospital intervention. It may include coordinating services required to assist in arranging for and implementing a Member's transition to a more appropriate or lower level of care, as needed. The concurrent review clinician coordinates services with the attending physician, and/or the discharge planning personnel at the hospital.

When a covered Member is hospitalized, and is disenrolled from Healthy Blue during the hospital stay, Healthy Blue shall maintain responsibility for the coordination of care and discharge planning for that Member.

When a covered newborn remains hospitalized and is disenrolled from Healthy Blue during the hospitalization, healthy Blue shall remain responsible for the coordination of care and discharge planning until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

Retrospective Review

A retrospective review is any review of care that has already been provided. There are two types of retrospective reviews, which Healthy Blue may perform:

- Retrospective Review initiated by Healthy Blue: It is the policy of Healthy Blue to assure, through Retrospective Review, the compliance by providers to generally acceptable coding guidelines. Retrospective Review will request specific medical records from the provider in order to conduct this review to determine if coding compliance is accurate and appropriate.
- Retrospective Review initiated by providers: Under applicable situations (for example, if a Member is admitted and discharged from a hospital before concurrent review is conducted), providers may request retrospective review of services that have already been performed. Retrospective review determinations are reviewed applying the same approved medical criteria as for concurrent determinations. Post-service authorization requests are also reviewed to determine if any of the following circumstances exist:
    - The provider was not able to determine the member's eligibility.
    - The service was urgent in nature and there was not time to submit a request prior to service delivery.
    - The service is part of an ongoing plan of treatment for a newly eligible Member.
    - Extenuating circumstances existed that precluded the provider from submitting a timely pre-service or concurrent review authorization request, in other words, a procedure was performed that did not require prior authorization but while doing the procedure another procedure was warranted that required prior authorization. In this instance, please notify Healthy Blue's prior authorization department the next business day to request authorization.

Providers are expected to adhere to the business rules for submission of service authorization requests. Post-service requests that do not meet one of the above conditions may be administratively denied. Exceptions may be granted if specifically addressed through contract language. Retrospective review requests must be submitted in writing within 90 days of the member's discharge date. Healthy Blue will communicate decisions to the requesting practitioners/provider and the member, if applicable, within 30 calendar days of receipt of the request.

Service Authorization Decision Timeframes

Type of authorization	Decision	Extension
Standard Preservice	36 hours to include one working day	Not to exceed 14 calendar days from receipt of request
Expedited (Urgent) Preservice	24 hours	N/A
Concurrent	36 hours to include one working day	N/A
Post-service	30 calendar days	Not to exceed 14 calendar days

Standard Service Authorization

Healthy Blue will provide a service authorization decision as expeditiously as the Member's health condition requires and within state-established time frames, which will not exceed 36 hours to include one working day following receipt of the request for service. In no case shall the health plan exceed 14 calendar days following the receipt of the request of service to provide approval or denial.

The decision time frame may be extended beyond 14 days if:

- The Member, or the Provider, requests an extension, or
- Healthy Blue justifies (to the state agency upon request) a need for additional information and how the extension is in the Member's best interest.

Healthy Blue will fax an authorization response to the Provider fax number(s) included with the authorization request.

Expedited Service Authorization

If a Provider determines the services to be urgent for maximum function, Healthy Blue must make an expedited authorization decision and provide notice within 24 hours after receipt of the request for service.

Requests for expedited decisions for prior authorization can be submitted through Healthy Blue's secure online Provider portal, by fax or by phone.

Urgent Concurrent Authorization

An authorization decision for services that are ongoing at the time of the request, will be made within 36 hours to include on business day. of receipt of the request. An extension may be granted for an additional 48 hours if:

- The request to extend urgent concurrent care is not received at least 24 hours prior to the expiration of the previous authorization, or
- Previous care was not authorized, and Healthy Blue was not able to obtain needed clinical information within the initial 24 hours after the request, with at least one documented request for the clinical information.

Peer-to-Peer Reconsideration of Adverse Determination

In the event of an adverse determination following a Medical Necessity review, peer-to-peer reconsideration is offered to the treating physician on the Notice of Action (NOA) communication. The treating physician is provided the toll-free number of the health plan to request a discussion with the Healthy Blue Medical Director who made the denial determination. Peer-to-Peer Reconsideration is offered when requested within three business days of the denial determination. The health plan medical director will make two attempts to contact the treating practitioner and conduct the review. The physician will have the opportunity to discuss the decision with the peer clinical reviewer making the determination or with a different clinical peer if the original reviewer is not available. The peer-to-peer dialogue must be completed within five business days of the request for peer to peer. The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process. In the event the peer-to-peer dialogue does not occur during the specified time frames, the Provider will have the opportunity to use the standard Provider appeals process.

Healthy Blue Proposed Actions

A proposed action is an action taken by Healthy Blue to deny a request for services. In the event of a proposed action, Healthy Blue will notify the member and the requesting Provider in writing of the proposed action. The notice will contain the following:

- The action Healthy Blue has taken or intends to take
- The reason(s) for the action
- The member's or Provider's right to appeal
- The member's right to request a state fair hearing
- Procedures for exercising the member's rights to appeal or file a grievance
- The member's right to represent himself/herself or use legal counsel, a relative, or a friend
- The specific regulations that support or the change in federal or state law that requires the action
- The member's right to request a state agency hearing, or in cases of an action based on change in law, the circumstance under which a hearing will be granted
- Circumstances under which expedited resolution is available and how to request it
- The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued

Second Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the healthcare team, including a member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified healthcare professional within the network, or Healthy Blue shall arrange for the member to obtain one outside the network if there is not a participating Provider with the expertise required for the condition. The second opinion shall be provided at no cost to the member. Certain elective surgical procedures, pursuant to Missouri Law require a second medical opinion be provided prior to surgery.

A third surgical opinion, provided by a third Provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

Healthy Blue's Prior Authorization Department can assist in coordinating the second or third opinion with an in-network or out-of-network provider by calling Provider Services at **833-405-9086**.

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to prior authorization requirements and are available to Members 24 hours a day, seven days a week. Urgent care services are provided as necessary and are not subject to prior authorization or pre-certification.

Post-stabilization services are services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member's condition. Post-stabilization services are covered without prior authorization up to the point Healthy Blue is notified that the Member's condition has stabilized. The attending emergency physician or the provider treating the member will determine when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Healthy Blue for coverage and payment. If there is a disagreement between a hospital or other treating facility and Healthy Blue concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on Healthy Blue. Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

Services Requiring No Authorization

In order to facilitate timely and effective treatment of Members, Healthy Blue has determined that many routine procedures and diagnostic tests are allowable without medical review, including:

- Certain diagnostic tests and procedures considered by Healthy Blue to routinely be part of an office visit. Routine clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a *Clinical Laboratory Improvement Amendment* (*CLIA*) waiver do not require prior authorization. The exceptions to this rule are:
    - Reproductive laboratory tests
    - Molecular laboratory tests
    - Cytogenetic laboratory tests
- Certain tests described as *CLIA*-waived may be conducted in the physician's office if the Provider is authorized through the appropriate *CLIA* certificate. A copy of the certificate must be submitted to Healthy Blue.

Please check [X] for complete prior authorization requirements.

Note: ER visits do not require precertification or notification. If an ER visit results in an in-patient admission, you should notify us within 24 hours of the visit or the next business day.

No precertification is required for EPSDT services for in-network and out-of-area network providers.

Transition of Care

In the event that a physician should terminate his or her contract with Healthy Blue, Members in active treatment may continue to receive care from the terminated Provider in the following circumstances:

- Pregnancy;
- A disability, life-threatening illness;
- Active stage of an illness; or
- Serious medical condition.

If a Member is receiving treatment from the terminated Provider and the 90-day transition period has expired, Healthy Blue will consider whether an in-network Provider could provide the Medically Necessary services or if continued care with the terminated Provider must be continued.

For continued care under this provision, the terminated Provider accepts the following:

- Reimbursement rate of 100% of the Medicaid fee schedule
- Payment from Healthy Blue as payment in full (no balance billing) and shall not collect payment from Members except for:
    - Applicable MO HealthNet cost-sharing amounts.

When services are not in the comprehensive benefit package, the practitioner or Provider shall inform the Member that the services are not covered prior to providing the services, and shall obtain acknowledgement from the Member. If the Member still wants to proceed with the service, the practitioner or Provider shall obtain such acknowledgement in writing (a private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the practitioner or Provider and the Member about private payment, once the practitioner or Provider bills Healthy Blue for the service, the prior arrangement with the Member

Continuity of Care

The health plan shall provide continuation of Medically Necessary Covered Services for the lesser of 60 calendar days or until the Member has transferred, without disruption of care, to an in-network Provider. Healthy Blue will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside Healthy Blue's network until such time as Healthy Blue can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member's health. However, notification to Healthy Blue is necessary to properly document these services and determine any necessary follow-up care.

After the initial 60 days, Providers are required to follow Healthy Blue's prior authorization or concurrent review requirements.

When Healthy Blue becomes aware that a covered Member will be disenrolled from Healthy Blue and will transition to another health plan or to a fee-for-service (FFS) Missouri Medicaid program a Care Manager who is familiar with that Member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

Healthy Blue must identify and facilitate coordination of care for Members during changes or transitions between plans. Members with special circumstances may require additional and/or distinctive assistance during the transition period. Special circumstances include Members designated as having "special healthcare needs."

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation for reconsideration or mail it to:
Member Grievances and Appeals
P.O. Box 62429
Virginia Beach, VA 23466..

Except for newborns, the health plan shall not be responsible for any payments owed to providers for services rendered prior to a member's enrollment with the health plan, even if the date of service fell within an established period of retroactive MO HealthNet eligibility.

Limits to Abortion, Sterilization and Hysterectomy Coverage

The following services have special requirements from the State of Missouri.

Abortion
Abortions are covered for eligible Healthy Blue Members if the Provider certifies that the abortion is Medically Necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

Abortions are not covered if used for family planning purposes. A *Certification Of Medical Necessity For Abortion Form MO886-3255 (10-07)* must be properly executed and submitted to Healthy Blue with the Provider's claim. This form may be filled out and signed by the physician and is located at **manuals.momed.com**. Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate Medical Necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition, Healthy Blue also requires the submission of the History, Physical and Operative Report and the Pathology Report with all claims that have ICD-10-CM procedure codes to ensure that abortions are not being billed through the use of other procedure codes .

Sterilizations

Healthy Blue will not and is prohibited from making payment for sterilizations performed on any person who:
- Is under 21 years of age at the time he or she signs the consent; or
- Is not mentally competent.

The *Sterilization Consent Form (PSFL-200)* form is required for sterilizations. This form can be found at **manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf**. Prior authorization is not required for sterilization procedures. However, Healthy Blue will deny any Provider claims submitted **without** the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days. The signed consent form expires 180 calendar days from the date of the Member's signature. The day after the signing is considered the first day when counting the 30 days.

In the case of premature delivery, the consent form must be completed and signed by the Member at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. For emergency abdominal surgery, the consent form must be completed and signed by the Member at least 72 hours prior to the sterilization procedure. Although these exceptions are provided, the conditions of the waiver will be subject to review.

A sterilization consent form must be properly filled out, and signed for all sterilization procedures and attached to the claim at the time of submission to Healthy Blue. The Member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

Hysterectomy

Prior authorization is required for the administration of a hysterectomy to validate Medical Necessity when performed in an inpatient setting. Healthy Blue reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual and her representative (for example, legal guardian, husband, etc.) was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);

Prior to the hysterectomy, the Member and the attending physician must sign and date the *Acknowledgement of Receipt of Hysterectomy Information Form MO886-3280 (9-95).* The form can be found at **manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf**

- Exceptions to the requirement for an *Acknowledgement of Receipt of Hysterectomy Information Form* may be made in the following situations:
  The Member was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the Member was already sterile at the time of the hysterectomy and state the cause of the sterility. This must be documented by an operative report or admit and discharge summary;
  The Member requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgement is not possible. The physician must certify in writing to this effect and include a description of the nature of the emergency; or
  The Member was not MO HealthNet eligible at the time the hysterectomy was performed but eligibility was made retroactive to this time. The physician who performed the hysterectomy must certify in writing to one of the following situations:
    The Member was informed before the operation that the hysterectomy would make her permanently incapable ofreproducing;
    The Member was already sterile before the hysterectomy; or
    The Member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible.

A hysterectomy is not covered when:

- The hysterectomy was performed solely for the purpose of rendering a Member permanently incapable of reproducing; or
- There was more than one purpose to the procedure. The hysterectomy would not have been performed but for the purpose of rendering the Member permanently incapable of reproducing.

Healthy Blue will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. Healthy Blue does not accept documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for Medical Necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

Delegated Entities

Healthy Blue delegates some UM activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for UM activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required UM standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Healthy Blue and the delegated entities. Contract must be approved by MO HealthNet prior to implementation.

Children's Mercy Pediatric Care Network (CMPCN)

CMPCN is an integrated pediatric network operated by the Children's Mercy Hospital System. CMPCN provides medical and behavioral health management services, including: nurse advice line, care management, utilization management, and disease management for select Healthy Blue Members in the following counties: **Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair and Vernon**.

All medical and behavioral health management services will be provided by CMPCN for Healthy Blue Members up to the member's 21st birthday, who are assigned to a Primary Care Provider in any of the above counties. Claims for CMPCN members are submitted to Healthy Blue for processing.

CMPCN is comprised of Children's Mercy Hospital and its employed physicians and other contracting Primary Care Providers located in the counties above. Please note however, that although medical and behavioral health management services will be provided by CMPCN, a Healthy Blue member is still free to choose any contracted Provider to receive services. However, if an authorization is necessary, or you have a referral for care management, you will contact CMPCN instead of Healthy Blue. Please call **877-347-9367** for CMPCN Member prior authorization requests.

Carelon Medical Benefits Management, Inc.*

Carelon Medical Benefits Management, Inc.* is a leading specialty benefits management company with more than 25 years of experience and a growing presence in the management of radiology, cardiology, genetic testing, oncology, musculoskeletal, sleep management, and additional specialty areas. Carelon Medical Benefits Management's mission is to help ensure delivery of healthcare services are more clinically appropriate , safer,

and more affordable. Carelon Medical Benefits Management promotes the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services.

Carelon Medical Benefits Management manages precertification for the following modalities:

- Computed tomography (CT/CTA)
- Magnetic resonance (MRI/MRA)
- Positron emission tomography (PET) scans
- Nuclear cardiology
- Echocardiography
- Stress echo
- Resting transthoracic echo
- Transesophageal echo
- Radiation oncology
- Sleep medicine
- Cardiology services
- Genetic Testing
- Musculoskeletal Programs
- Physical, occupational, and speech therapy
- Spinal therapy

Carelon Clinical Appropriateness Guidelines and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **providerportal.com**.

You can contact Carelon Medical Benefits Management at **855-574-6479** or visit **providerportal.com** to submit a request.

Administrative Denial

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial (that is, why precertification was not obtained or why clinical was not submitted.)

If Healthy Blue overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a precertification is on file by:

- Visiting our provider website at **provider.healthybluemo.com**.
- Calling Provider Services at **833-405-9086**.

If coverage of an admission has not been approved, the facility should call Provider Services. We will contact the referring physician directly to resolve the issue.

We are available 24/7 to accept precertification requests. When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Our precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our precertification nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue a Healthy Blue reference number to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider can discuss the case with the Healthy Blue medical director prior to the determination.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal and fair hearing rights) will be mailed to the requesting provider, member's PCP and member.

For the most up-to-date precertification/notification requirements and the latest precertification forms, go to **provider.healthybluemo.com**.

Prenatal Ultrasound Coverage Guidelines

The following are frequently asked questions and answers about our prenatal ultrasound policies.

What are the requirements for precertification for total obstetric care?	For obstetric care, we do not require precertification; we only require **notification** to our Provider Services team.
In which trimester of a woman's pregnancy is she determined to be an obstetric patient?	A member is considered to be an obstetric patient once pregnancy is verified.
Are there precertification requirements for prenatal ultrasound?	There are no precertification requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.
Is there a medical policy covering prenatal ultrasound procedures?	Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy, go to **provider.healthybluemo.com**. The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.

Why was the policy created?	The policy was created to ensure members receive the most appropriate ultrasound for the diagnosis or condition(s) being evaluated.
Does the policy describe limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?	The policy covers two **routine** ultrasounds per pregnancy. Additional prenatal ultrasounds for fetal and maternal evaluations or for follow-up of suspected abnormalities are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study performed. Not all diagnosis codes are acceptable and appropriate for all ultrasounds. When submitted incorrectly, a claim will be denied.
Which ultrasound procedures are covered under this policy?	The policy does not apply to ultrasound studies with CPT codes not specifically listed in the policy, such as nuchal translucency screening, biophysical profile and fetal echocardiography. **For CPT codes 76801 (+76802) and 76805 (+76810),** two routine ultrasound studies are covered per pregnancy. **For CPT codes 76811 (+76812), 76815, 76816 and 76817,** additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT code 76811 (and +76812) is only reimbursable to maternal fetal medicine specialists.
Are there exceptions to this policy?	The policy does not apply to: • Maternal fetal medicine specialists (S142, S083, S055 and S088) • Radiology specialists (S164 and S232) • Ultrasounds performed in place of service code 23 — emergency department.

Precertification/Notification Coverage Guidelines

For code-specific precertification requirements, visit **provider.healthybluemo.com**.

Air Ambulance Services	Precertification is required for nonemergent air ambulance services. Emergent air ambulance would not require prior authorization.
Behavioral Health	All facility-based behavioral health and substance use services require precertification, and some outpatient services require precertification. All services provided by non-participating providers require precertification. To obtain additional information about covered services and precertification requirements for covered behavioral health services, please visit the provider website at **provider.healthybluemo.com**. For information or to make referrals, call **833-405-9086**.
Chemotherapy	Precertification is required for inpatient chemotherapy as part of the elective inpatient admission and for oncology drugs and adjunctive agents.

	However, precertification is not required, if done within network, for procedures performed in the following outpatient settings: • Office • Outpatient hospital • Ambulatory surgery center
Circumcision	Routine circumcisions are covered within the first 28 days of life, and medically necessary circumcisions are covered with no age limit.
Dermatology	No precertification is required for a network provider for: • Evaluation and Management (E&M). • Testing. • Procedures. Cosmetic services or services related to previous cosmetic procedures are not covered.
Diagnostic Testing	No precertification is required for a network provider for routine diagnostic testing. Non-participating providers out-of-network require an authorization for routine diagnostic testing. Precertification is required for the following: • MRA • MRI • CAT scan • Nuclear cardiac • Video EEG • PET imaging Carelon Medical Benefits Management manages precertification for the following modalities: • Computed tomography (CT/CTA) • Magnetic resonance (MRI/MRA) • Positron emission tomography (PET) scans • Nuclear cardiology • Echocardiography • Stress echo • Resting transthoracic echo • Transesophageal echo • Radiation oncology • Sleep medicine • Cardiology services *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **aimspecialtyhealth.com**.
Durable Medical Equipment (DME)	No precertification is required for a network provider for:

	• Nebulizers. • Standard walkers. • Orthotics for arch support. • Heels, lifts, shoe inserts and wedges. • Bedside commodes. • Canes and crutches. • Diabetic shoes. Precertification is required for: • All routine rentals and purchased DME equipment other than what is included above. • Breast feeding pumps. • Certain prosthetics, orthotics and DME. • Heavy-duty walkers. • Specialized wheelchairs. • Oxygen concentrators. • Insulin pumps and supplies. • Hospital beds. • Ventilators. • CPAP, BIPAP and APAP. • Enteral and parenteral nutrition. • Lymphedema pumps. • Hoyer lifts. • Support surfaces. • Power-operated vehicles and motorized wheelchairs. • Osteogenesis stimulators. • Seat-lift mechanisms. • Apnea monitors. • Wound care supplies. • Standing frames. • Incontinence products. • Hearing aids. • Chest wall oscillation devices. • Suction pumps. • Tracheostomy supplies. • IV therapy and supplies. • Humidifiers. • Cochlear implants. • Dialysis and end-stage renal disease equipment. • Gradient pressure stockings. • Light therapy/bili lights for jaundice babies. • Sphygmomanometers.

	For code-specific precertification requirements, visit **provider.healthybluemo.com** and enter codes to determine authorization requirements. To request precertification, submit a physician's order supporting documentation and fill out our precertification form, which can be found on **provider.healthybluemo.com**. We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment). Our policy for rent to purchase on most items is limited to 10 continuous/consecutive months including oxygen concentrators. For additional questions regarding rent to purchase items, please contact Provider Services at **833-405-9086**.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Visit	Self-referral; Use the EPSDT schedule and document visits. **Note:** Vaccine serum is received under the Vaccines for Children (VFC) program.
Educational Consultation	No precertification is required.
Emergency Room	No precertification is required for a network or out-of-network provider. We must be **notified within 24 hours or the next business day** if an ER encounter results in an observation stay or an inpatient admission.
ENT Services (Otolaryngology)	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for: • Tonsillectomy and/or adenoidectomy. • Nasal/sinus surgery. • Cochlear implant surgery and services.
Family Planning/Sexually Transmitted Infection (STI) Care	Members may self-refer to any in-network or out-of-network provider. Please encourage your patients to receive family planning services in-network to ensure continuity of service.
Gastroenterology Services	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for:

	• Bariatric surgery. • Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. • Upper endoscopy.
Gynecology	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures.
Hearing Aids	Precertification is required for digital hearing aids.
Hearing Screening	No precertification is required for a network provider for: • Diagnostic and screening tests. • Hearing aid evaluations. • Counseling.
Home healthcare and Home IV Infusion	Precertification is required for: • Skilled nursing. • Extended home health services. • IV infusion services. • Home health aide. • Physical, occupational and speech therapy services. • Physician-ordered supplies. • IV medications for in home therapy. **Note:** Drugs and DME require separate precertification.
Hospice	Precertification is required for hospice.
Hospital Admission	Precertification is required for: • Elective admissions. • Some same-day/ambulatory surgeries. We must be notified **within 24 hours or the next business day** if an ER encounter results in an observation or an inpatient admission. Preadmission testing must be performed by a Healthy Blue-preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing. We do not cover: • Rest cures. • Personal comfort and convenience items. • Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.). **We request notification of inpatient emergency admissions within one business day of admission**. Failure of admission notification after one business day may result in claim denial. Non-business days include the weekend, New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving Day and Christmas Day.

Laboratory Services (Outpatient)	Precertification is required for: • Genetic testing. Request prior authorization by visiting **providerportal.com** or by calling **855-574-6479**. • *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **providerportal.com**. • All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition. Quest Diagnostics and LabCorp are the preferred lab providers for all Healthy Blue members. Contact Quest Diagnostics or LabCorp at the numbers below to receive a specimen drop box. • For more information, testing solutions and services or to set up an account, contact : • Quest Diagnostics: 866-MY-QUEST (866-697-8378) • LabCorp: 800-345-4363
Medical Supplies	No precertification is required for a network provider for disposable medical supplies.
Neurology	No precertification is required for a network provider for: • E&M. • Testing. • Certain other procedures. Precertification is required for: • Neurosurgery. • Spinal fusion. • Artificial intervertebral disc surgery.
Observation	Observation requires authorization and is reviewed for medical necessity with a maximum observation benefit of 24 hours. In addition, if your observation extends beyond 24 hours or results in an admission, you must notify us within 24 hours or the next business day.
Obstetrical Care	No precertification is required for a network provider for: • Obstetrical services and diagnostic testing. • Obstetrical visits. • Certain diagnostic tests and lab services by a participating provider. • Prenatal ultrasounds. • Normal vaginal and cesarean deliveries. Notification requirements are as follows:

- Notify Provider Services of the first prenatal visit.
- For obstetric care, we require notification; we do not require precertification.
- All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries.
- Healthy Blue will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal cesarean delivery.
- The hospital is required to notify us of the mother's discharge date. Fax maternal discharge notifications to **844-886-2758** within one business day of discharge.
- For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for cesarean delivery, the hospital is required to notify Provider Services and provide clinical. Following notification, clinical updates can be faxed directly to the local health plan at **800-964-3627**.
- Healthy Blue is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an obstetrical admission exceeding 48 hours after a vaginal delivery and 96 hours after a cesarean section.
- If a member is admitted for an induction or labor and fails to deliver by day two of the admission, the hospital is required to submit clinical for the first two days of admission for medical necessity review. Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit birth information to us. Fax newborn delivery notifications to **800-964-3627** providers may use standard reporting forms specific to their hospital as long as the following required information is included:
- Indicate whether a live birth
- Newborn's birth weight
- Gestational age at birth
- Apgar scores
- Disposition at birth Type of delivery(vaginal or cesarean); if a cesarean, the reason the cesarean was required
- Date of birth
- Gender
- Single/multi-birth
- Gravida/para/ab for mother
- EDC and if NICU admission was required

If a newborn requires admission to the NICU, the hospital must notify Provider Services and submit clinical and updates.

Well babies are covered under the mother's hospitalization authorization. If a newborn requires hospitalization as a **border baby** beyond the mother's discharge date, the hospital **must provide notification** as directed for NICU admissions.

	Provider Services phone: **833-405-9086** Provider Services notification fax: **800-964-3627** Local health plan inpatient clinical fax: **844-886-2758** OB care management programs are available for all high-risk women.
Ophthalmology	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for repair of eyelid defects. We do not cover services that are considered cosmetic.
Oral Maxillofacial	See Plastic/Cosmetic/Reconstructive Surgery.
Out-of-Area/ Out-of-Network (OON) Care	Precertification is required for all OON services except for emergency care, EPSDT screening, family planning and OB care. Note: Precertification is not required for EPSDT screening for both in-network and out-of-area network providers.
Outpatient/Ambulatory Surgery	Our precertification requirement is based on the procedure performed; visit our provider website for more details.
Pain Management/ Physiatry/Physical Medicine and Rehabilitation	Precertification is required for non-E&M-level services. Pain management services are not a covered benefit.
Complementary Health and Alternative Therapies for Chronic Pain Management	Precertification is required. The combination of physical therapy, chiropractic therapy and acupuncturist's services are subject to an annual maximum limit of thirty (30) visits or one hundred twenty (120) units of service per year with one (1) unit equaling fifteen (15) minutes.
Plastic/Cosmetic/ Reconstructive Surgery (Including Oral Maxillofacial Services)	No precertification is required for a network provider for: • E&M services. • Oral maxillofacial E&M services. Precertification is required for: • All other services. • Trauma to the teeth. • Oral maxillofacial medical and surgical conditions. • TMJ. We do not cover: • Services considered cosmetic in nature. • Services related to previous cosmetic procedures. Reduction mammoplasty requires review by our medical director.

Podiatry	No precertification is required for a network provider for: • E&M. • Testing. • Most procedures.
Radiology	See Diagnostic Testing.
Rehabilitation Therapy (Short-Term):	Carelon Medical Benefits Management manages precertification for the following modalities: • Physical Therapy • Occupational Therapy • Speech Therapy Request prior authorization by visiting **providerportal.com** or by calling **855-574-6479.** *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **providerportal.com**.
Musculoskeletal Programs	Carelon Medical Benefits Management manages precertification for the following modalities: • Joint Surgery • Spine Surgery • Interventional Pain Management Request prior authorization by visiting **providerportal.com** or by calling **855-574-6479.** *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **providerportal.com**.
Skilled Nursing Facility	Precertification is required.
Nonemergent Transportation	For nonemergency transportation, members can call MTM at **888-597-1193** to set up a ride.
Urgent Care Center	No precertification is required for a participating or non-participating facility.
Well-Woman Exam	No precertification is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network GYN. The visit includes: • Examination. • Routine lab work. • STI screening. • Mammograms for members 35 and older. • Pap smears (Routine Pap smears are allowed once every three years per ACOG guidelines.). Members can receive family planning services without precertification at any qualified provider. Please encourage your patients to receive family planning services from an in-network provider to ensure continuity of service.

Revenue (RV) Codes	Precertification is required for services billed by facilities with RV codes for: • Inpatient. • OB. • Home healthcare. • Hospice. • CT, PET and nuclear cardiology. • Chemotherapeutic agents. • Pain management. • Rehabilitation (physical/occupational/respiratory therapy). • Rehabilitation short-term (speech therapy). For a complete list of specific RV codes and code-specific precertification requirements, visit **provider.healthybluemo.com**.

Precertification/Admission Notification: Precertification request and notification of intent to render covered inpatient and outpatient medical services	Fax: **800-964-3627** Call: **833-405-9086** Web: Log in at **provider.healthybluemo.com**
Inpatient Utilization Management: Emergent inpatient admissions require clinical information be submitted for medical necessity review	Fax: **844-886-2758** Call: **833-405-9086**
Behavioral Health Inpatient Utilization Management: Psychiatric and substance use inpatient admissions require clinical information be submitted for medical necessity review	Call: **833-405-9086** Web: Log in at **provider.healthybluemo.com**

Confidentiality of Information and Misrouted Protected Health Information

The following ensure members' protected health information (PHI) is kept confidential:

- Utilization management
- Care management
- DM
- Discharge planning
- Quality management
- Claims payment

PHI is shared only with those individuals who need access to it to conduct utilization management.

Providers and facilities are required to review all member information received from the state to ensure no misrouted PHI is included. Misrouted PHI includes information about members who a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it

is retained. In no event are providers or facilities permitted to misuse or disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, they should call our Provider Services team at **833-405-9086** for instructions on what to do with it.

Urgent Care and After-Hours Care

We strongly encourage our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer them to one of our participating urgent care centers or another provider who offers after-hours care. Precertification is not required.

We strongly encourage PCPs to provide evening and weekend appointment access to members. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturday. To learn more about participating in the after-hours care program, call your local Provider Relations representative.

6. CREDENTIALING

Healthy Blue's discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Healthy Blue's discretion in any way to amend, change or suspend any aspect of Healthy Blue's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Healthy Blue further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Healthy Blue
   - An independent relationship exists when Healthy Blue directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Healthy Blue's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of Healthy Blue's primary Network and include Healthy Blue Members who reside in the rental network area.
   - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Healthy Blue credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors

- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Healthy Blue credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
  End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission

- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Healthy Blue's networks or plan programs is conducted by a peer review body, known as Healthy Blue's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Healthy Blue affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Healthy Blue medical director designee and the vice-chair must be a lead medical officer or an Healthy Blue medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic

monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Healthy Blue's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Healthy Blue may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination policy

Healthy Blue will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Healthy Blue will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Healthy Blue will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Healthy Blue will take appropriate action to track and eliminate those practices.

Initial credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Healthy Blue when applying for initial participation in one or more of Healthy Blue's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Healthy Blue will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Healthy Blue will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Healthy Blue credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health delivery organizations

New HDO applicants will submit a standardized application to Healthy Blue for review. If the candidate meets Healthy Blue screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Healthy Blue Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing sanction monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Healthy Blue has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Healthy Blue departments
- Any other information received from sources deemed reliable by Healthy Blue.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals process

Healthy Blue has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Healthy Blue's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Healthy Blue may wish to terminate practitioners or HDOs. Healthy Blue also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Healthy Blue's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Healthy Blue will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Healthy Blue's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Healthy Blue's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Healthy Blue's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting requirements

When Healthy Blue takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Healthy Blue may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Healthy Blue credentialing program standards

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
D. Meet the education, training and certification criteria as required by Healthy Blue.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Healthy Blue's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

    2. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Healthy Blue education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Healthy Blue review and approval. Reports submitted by delegates to Healthy Blue must contain sufficient documentation to support the above alternatives, as determined by Healthy Blue.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA/CDS registration.
    d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Healthy Blue's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

    a. It can be verified that the applicant's application is pending; and
    b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA registration; and

d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Healthy Blue's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;

e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work.
   b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
   c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   e. Licensure to practice independently or in states without licensure or certification:
      i. Marriage & Family Therapists with a master's degree or higher:
         a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
      ii. Mental Health Counselors with a master's degree or higher:
         a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Healthy Blue Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
   e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
      i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
      ii. American Academy of Nurse Practitioners – Certification Program;
      iii. National Certification Corporation;
      iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
      v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
      vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

   If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
   f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information

regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in Healthy Blue's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

8. Process, Requirements and Verifications – Certified Nurse Midwives:

a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard

professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

k. The CNM applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
l. Upon completion of the credentialing process, the CNM may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
m. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Healthy Blue Health Plan and submitted for individual review by the CC.
    f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    g. The PA applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing

Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the PA may be listed in Healthy Blue provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
   iv. On the credentialing file;
   v. At presentation to the CC; and
   vi. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Healthy Blue's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:

a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
b. Voluntary surrender of state license related to relocation or nonuse of said license;
c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Healthy Blue standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Healthy Blue may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Healthy Blue standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Healthy Blue standards.

General Criteria for HDOs:

a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
b. Valid and current Medicare certification.
c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Healthy Blue's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
d. Liability insurance acceptable to Healthy Blue.
e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated

independent external entity survey for review by the CC to determine if Healthy Blue's quality and certification criteria standards have been met.

Additional Participation Criteria for HDO by Provider Type:

HDO type and Healthy Blue approved accrediting agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies

Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Contract Termination Without Cause. In the event of a Health Plan termination of a contact Agreement.
1. The Health Plan will provide an explanation of why the contract is being terminated, and
2. The Contracted Provider will be provided an opportunity for review and appeal, unless the termination involves imminent harm to patients, a determination of fraud, or a final disciplinary action by a State licensing board or other governmental agency.

5 QUALITY MANAGEMENT

Quality Management Program

We have a comprehensive Quality Management (QM) program to monitor the demographic and epidemiologic needs of the population served. We evaluate the needs of the health plan's specific population annually, including:

- Population characteristics (race, ethnicity, language)
- Utilization (inpatient, outpatient, emergent care)
- Over/under utilization
- Member care and disease management services

In this way, we can define high-volume, high-risk and problem-prone conditions.

To contact the QM department about quality concerns or to make recommendations for areas of improvement, call **833-405-9086**.

Quality of Care

We evaluate physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards.
- External regulatory and accrediting agencies' requirements.
- Contractual compliance.

Our quality program includes a review of quality of care issues for all care settings using:

- Member complaints.
- Reported adverse events.
- Other information.

The results are submitted to our Grievances and Appeals department and incorporated into a profile.

Quality Management Committee

The Quality Management Committee (QMC) responsibilities are to:

- Establish strategic direction - monitor and support implementation of the quality management program
- Establish processes and structure that ensure accreditation compliance
- Review and approve Enterprise and local policies and procedures, as appropriate
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical/service quality improvement studies (PIP)
- Coordinate communication of quality management activities throughout the Plan
- Review HEDIS® and CAHPS® data and action plans for improvement
- Review, monitor, and evaluate program compliance against GBD, state, federal, and accreditation standards
- Review and approve the annual quality management program description, work plan and program evaluation
- Provide oversight and ensure compliance with delegated services
- Assure inter-departmental collaboration, coordination, and communication of quality improvement activities
- Measure compliance with medical and behavioral health practice guidelines
- Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety
- Make information available about the QM program to members and practitioners
- Assure the availability of Quality Management program minutes to the appropriate state regulatory agency, as applicable
- Assure practitioner involvement through direct input from the Medical Advisory Committee (MAC) or other mechanisms that allow practitioner involvement
- Review and approve Health Equity (HE) program structure, processes, and evaluation of performance (e.g., program-specific trilogy documents)
- Review and approve the annual Utilization Management (UM) Program Description and Evaluation

Use of Performance Data

Practitioners and providers must allow Healthy Blue to use performance data in cooperation with our quality improvement program and activities.

Medical Advisory Committee

The Medical Advisory Committee's (MAC's) responsibilities are to:

- Utilize an ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns to identify the appropriateness of care and for improvement/risk prevention activities
- Review and provide input, based upon the characteristics of the local delivery system; approve evidence-based clinical protocols and/or guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study design and results
- Develop and approve action plans and/or recommendations regarding clinical quality improvement studies
- Consider and/or recommend actions regarding practitioner Quality of Care issues review including Peer Review

- Review and provide feedback regarding innovative technologies
- Review and provide feedback regarding data results
- Ensure the availability of meeting minutes to the QMC
- Provide quarterly updates to QMC

Clinical Services Committee

The Clinical Service Committee's (CSC's) responsibilities are to:

- Establish clinical structure and processes to ensure accreditation and regulatory compliance
- Review data and develop action plans for improvement as needed to include over and underutilization of healthcare resources, changes to the prior authorization requirements, UM and CM quality, and program metrics
- Monitor continuity of care between medical and behavioral health services
- Review, monitor, and evaluate program compliance with State, Federal, and accreditation standards and regulations
- At least annually, review and evaluate the CM and UM program description and work plans
- Consider the adequacy of resources, committee structure, practitioner participation, and leadership involvement in the UM and CM programs through annual evaluations
- Evaluate opportunities to increase inter-departmental collaboration, coordination, and communication of quality and utilization improvement activities
- Coordinate communication of clinical activities throughout the Plan
- Measure compliance with medical and behavioral health services
- Make information available about the UM and CM programs to members and practitioners
- Assure the availability of meeting minutes to the Quality Management Committee (QMC), as needed
- Assure practitioner involvement through direct input from our Medical Advisory Committee (MAC) or other mechanisms that allow practitioner involvement
- Provide quarterly updates to QMC

Credentialing Committee

The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management Committee and the National Credentials Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated

The CC's responsibilities are to:

- Consider/act in response to provider sanctions.
- Approve credentialing/recredentialing policies and procedures.
- Review practitioner and provider credentialing and recredentialing applicants for participation in the Plan's provider networks.
- Provide pre-delegation, ongoing oversight and annual review of delegated entities.
- Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation.
- Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation.

Delegated Credentialing
Provider groups with strong credentialing programs that meet our credentialing standards may be evaluated for delegation. As part of this process, we will conduct a predelegation assessment of a group's credentialing policy and program as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90% compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements.

We are responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review. Peer review responsibilities are to:

- Participate in the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed. Peer review information is protected and confidential.

We apply levels of severity to potential quality of care reviews. Peer review includes investigation of physician actions by the medical director. The medical director:

- Assigns a level of severity to the grievance.
- Invites the cooperation of the physician.
- Consults with and informs the MAC and peer review committee.
- Informs the physician of the committee's, recommendations, follow-up actions and/or disciplinary actions to be taken.

We report outcomes to the appropriate internal and external entities, including the quality management committee.

The peer review process is a component of the MAC's quarterly agenda. The peer review policy is available upon request.

6 PROVIDER DISPUTE PROCEDURES

Provider as Member Representative

A provider may act as the member's representative to file an appeal or grievance. To act as a member's representative, the provider must have the written consent signed by the member and follow the time frames and processes for member grievances and appeals (see the **Member Grievances Section**).

Release for Ethical Reasons

As a condition to participating in the Healthy Blue provider network, Healthy Blue cannot require a provider to perform any treatment or procedure which is contrary to the provider's conscience, religious beliefs, or ethical principles or policies; or, prohibit a provider from making a referral to another healthcare provider licensed to provide care appropriate to the member's medical condition. The provider may refer a member to another healthcare provider licensed to provide care appropriate to the member's medical condition, or withdraw from the case and the health plan shall assign the member to another provider licensed to provide care appropriate to the member's medical condition.
Healthy Blue may object, on moral and religious grounds, to providing or reimbursing for a service for which it is otherwise required to provide or reimburse. If Healthy Blue objects to providing or reimbursing for a service on moral or religious grounds, Healthy Blue will notify the state agency. Additionally, Healthy Blue will notify the state agency whenever the health plan adopts the policy during the term of the contract. Healthy Blue agrees that such an objection and subsequent release from providing, reimbursing for, or providing coverage of a counseling or referral service shall result in a reduction to the applicable capitation rates paid to the health plan to reflect such a release as outlined herein. Healthy Blue will also:

- Provide information to potential members prior to enrollment regarding the health plan's release of provision of such service;
- Notify its members thirty (30) calendar days prior to any change in its policy regarding coverage of a counseling or referral service; and
- Notify its members of how and where to obtain the service.

Provider Grievances

Providers can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.
Submit verbal grievances to:

- Provider Services at **833-405-9086**.
- Your local Provider Relationship Account Management representative.

Submit written grievances to:
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

If the outcome of our review is adverse to you, we will provide a written notice of adverse action. You can also appear in person at the address above to submit a complaint.

Avoiding an Administrative Adverse Decision

Most administrative adverse decisions result from nonadherence to, or a misunderstanding of, utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits. Such information is readily available by calling **833-405-9086**.

Adverse benefit determinations related to medical necessity are occasionally rendered by Healthy Blue . Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers.
Peer-to-peer conversations (between a medical director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-to-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process.

Provider Claim Payment Disputes

If you disagree with the outcome of a claim, you may begin the Healthy Blue provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

In cases where your claim is denied, the consent of a Member who received the services is not required in order for you to dispute the denial of the claim. You may pursue a claim dispute on the basis of non-payment for rendered services under the terms and conditions outlined in you contract with Healthy Blue. The Member who received the services is not required to sign an authorized representative form, or provide other forms of written consent, for you to dispute the denied claim for payment.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.

- Claim data issues.
- Timely filing issues.*

* Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Please be aware, there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim, but not a request to change a claim payment (see the **Claim Inquiry section** for more information).
- **Claims correspondence:** When Healthy Blue requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials are in the **Claim Correspondence** section of this provider manual.
- **Medical necessity appeal:** A preservice appeal for a denied service. For these, a claim has not yet been submitted (see the **Medical Necessity Appeals** section for more information).

The Healthy Blue provider payment dispute process consists of two internal steps. Additionally, there are two external options. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

Claim payment reconsideration: This is the first step in the Healthy Blue provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
Claim payment appeal: This is the second step in the Healthy Blue provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
Binding arbitration: The state of Missouri supports an external arbitrator review process if you have exhausted all steps in the Healthy Blue payment dispute process but still disagree with the outcome.

Claim Payment Reconsideration

The first step in the Healthy Blue claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.
We accept reconsideration requests in writing, verbally and through our provider website within 365 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 365 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Healthy Blue intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 90 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Healthy Blue claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately.

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 90 calendar days from the date on the reconsideration determination letter.

Claim payment appeals received beyond 90 calendar days will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

- A statement of the provider's claims payment appeal request.
- Date of initial filings of concern.
- A statement of what action Healthy Blue intends to take or has taken.
- The reason for the action.
- Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to Submit a Claim Payment Dispute

You can submit your verbal or written payment disputes within 365 calendar days of the date of the *EOP*. We have several options to file a claim payment dispute:

- **Verbally (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **833-405-9086**.
- **Online (reconsideration and claim payment appeal)**: Healthy Blue can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal application at **Availity.com**. You can upload supporting documentation, and you will receive immediate acknowledgement of your submission.
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the appropriate form, to:
  Healthy Blue
  Payment Dispute Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submission forms are available on the Healthy Blue provider website in the *Forms* section.

Required Documentation for Claims Payment Disputes

Healthy Blue requires the following information when submitting a claim payment dispute, reconsideration or claim payment appeal:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Healthy Blue or Medicaid ID number
- A listing of disputed claims, which should include the Healthy Blue claim number and the date(s) of service(s)
- All supporting statements and documentation, including a copy of the *EOP* and a copy of the claim

Binding Arbitration

After all internal dispute levels have been exhausted, either party may request binding arbitration, except to the extent the parties have agreed in the *Provider Agreement* to use an alternate means of binding dispute

resolution. The parties will select an arbitrator who has experience and expertise in the healthcare field, in accordance with the rules of the American Arbitration Association. The arbitrator will conduct a hearing and issue a final ruling. Any arbitration fees and expenses will be paid equally by Healthy Blue and the other party or parties within 30 calendar days of receipt of the bill or in a time frame otherwise required under the arbitration rules. Each party will be responsible for its own attorney's fees arising out of or related to the arbitration.

7 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Claims Submission

You have the option of submitting claims electronically or by mail. We encourage you to submit claims electronically, as you will be able to:

- Submit claims either through a clearinghouse or directly to Healthy Blue.
- Receive payments quickly.
- Eliminate paper.
- Save money.

Healthy Blue uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (ERA), and Electronic Funds Transfers (EFT) allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

Register with Availity
Choose administrator to register your organization
When the admin is ready to register, choose the ***register button*** on the top of the page
Select your organization type and complete the registration process
Admin should check email to verify account
Once account is verified, admin will agree to the disclaimer, set up your security questions, and change password and setup authorized users.

Advantages of Electronic Data Interchange (EDI)

Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions

- healthcare Claim: Professional (837P)
- healthcare Claim: Institutional (837I)
- healthcare Eligibility Benefit Inquiry and Response (270/271)
- healthcare Services Prior Authorization (278)
- healthcare Services Inpatient Admission and Discharge Notification (278N)
- healthcare Claim Payment/Advice (835)
- healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity EDI Gateway
Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

Availity EDI Payer ID
00541

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

Log in to **Availity apps.Availity.com/availity/web/public.elegant.login**
Select My Providers
Click on Enrollment Center and select Transaction Enrollment

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Contact Availity
Contact Availity Client Services with any questions at **800-AVAILITY (282-4548).**

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (**nrollsafe.payeehub.org/**) to register and manage EFT account changes.

Availity is available for online claim filing, claim status inquiries, member eligibility and benefits information at:

Availity.com (Select Claims & Payments from Availity's home page)
Provider Services: **833-405-9086**

Paper Claims Submission
You must submit a properly completed *CMS-1450* or *CMS-1500 (08-05)* claim form:

- Within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; EPSDT screening claims should be filed as soon as possible within the timely filing period.
- On the original claim form with "drop out" red ink.
- Computer-printed or typed.
- In a large, dark font.

Submit paper claims to:
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

There are exceptions to the timely filing requirements. They include the following:

- For cases of coordination of benefits/subrogation, the time frame for filing a claim is within 365 days from date of service for first submission or resubmission or within 90 days from the date of the primary *EOB* if that is longer than 365 days from date of service.

As a reminder, the following information applies to administrative retroactive correction claims:

- Claims must be submitted via paper/hard copy.
- A copy of the voided *Explanation of Payment* is required for documentation purposes.
- Claims received more than six months after the date the claim is voided will be denied for untimely filing.

Claim forms must include the following information (HIPAA-compliant where applicable):

- Member's ID number
- Member's name
- Member's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- Coordination of benefits/other insurance information
- Precertification number or copy of precertification
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data

We cannot accept claims with alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.

CMS-1500 and *CMS-1450* forms are available from the Centers for Medicare & Medicaid Services at **cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html.**

International Classification of Diseases, 10th Revision (ICD-10)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. MO HealthNet Division (HHS).

What is ICD-10?
International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) is used for diagnosis coding.
- ICD-10-PCS (Procedure Coding System) is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

Encounter Data

If you are reimbursed by capitation, you must send us encounter data for each member encounter.

You must submit encounter data no later than 365 calendar days from the date of service through:

- EDI submission methods.
- A *CMS-1500* (*02-12*) claim form.
- Other arrangements that are approved by Healthy Blue.

EPSDT screening claims should be filed as soon as possible within the timely filing period.

Include the following:

- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Healthy Blue provider ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)

- Provider tax ID number
- NPI/API

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports to the quality management committee on a quarterly basis. Lack of compliance will result in:

- Training.
- Follow-up audits.
- Even termination.

Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

You must use HIPAA-compliant billing codes when billing Healthy Blue electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

Whether you submit claims through EDI or on paper, use our claims guide charts in **Appendix A** to ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:

- Submit claims within 180 calendar days:
- From the date of service (including in cases of other insurance)
- From the date of discharge for inpatient claims filed by a hospital
- Submit claims for EPSDT services as soon as possible within the timely filing period
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within six months from the date Medicaid voided the claim

We will deny claims submitted after the filing deadline.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time.
- Is accurate.
- Is submitted on a HIPAA-compliant standard claim form (*CMS-1500* or *CMS-1450* or successor forms).
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse.
- Is not a claim under review for medical necessity.

We will adjudicate clean claims to a paid or denied status within 30 business days of receipt. If we do not pay the claim within 45 processing calendar days, we will pay all applicable interest as required by law.

We produce and mail an *Explanation of Payment* (*EOP*) twice a week. It shows the status of each claim that has been adjudicated during the previous claim cycle.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI Clearinghouse or practice management vendor.

Claim Correspondence

Claim correspondence is different from a claim payment dispute. Correspondence is when Healthy Blue requires more information to finalize a claim. Typically, Healthy Blue makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Healthy Blue will use it to finalize the claim.

The following table provides examples of the most common correspondence issues, along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
Rejected Claim(s)	EDI Rejected Claims – Contact Availity Client Services at **800-Availity** (**800-282-4548**). Availity Client Services is available Monday - Friday.
***EOP* Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)**	Submit a *Claim Correspondence* form, a copy of your *EOP* and the supporting documentation to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010
***EOP* Requests for Medical Records**	Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit a *Claim Correspondence* form and your corrected claim to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Healthy Blue to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a *Claim Correspondence* form, a copy of your *EOP* and the COB/TPL information to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010

Type of issue	What do I need to do?
Emergency Room Payment Review	Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records to: Claims Department Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010

Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claim submissions and outline the basis for reimbursement if services are covered by the member's Healthy Blue benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however Healthy Blue strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Healthy Blue business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through Healthy Blue. Those guidelines include, but are not limited to:

Correct modifier use
Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
Code editing rules are appropriately applied and within regulatory requirements
Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Healthy Blue allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are three CPT sections:

1. Category I Codes:
    a. Evaluation & Management Services
    b. Anesthesia Services
    c. Surgery
    d. Radiology Services (nuclear medicine and diagnostic imaging)
    e. Pathology and Laboratory Services
    f. Medical Services and Procedures
2. Category II Codes (supplemental tracking codes that can be used for performance measurement)
3. Category III Codes (temporary codes for emerging technology, services or procedures)

Outlier Reimbursement Audit And Review Process

Requirements and Policies
This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products
Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges
The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating room time and procedure charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes. The operating room charge will reflect the cost of:
The use of the operating room
The services of qualified professional and technical personnel

Personal care items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration

of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative care or holding room charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (set-up) charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, ~~Oxygen,~~ and isolation carts and supplies are not separately reimbursable.

In addition, oxygen charges, including but not limited to, oxygen therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bi-level positive airway pressure (BIPAP), when billed with room types ICU/CCU/ NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time calculation
Operating Room ("OR"): Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
Hospital/ Technical Anesthesia: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
Recovery Room: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
Post recovery room: Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or digital equipment used in operating room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional reimbursement guidelines for disallowed charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Coordination of Benefits and Third-Party Liability

We follow state-specific guidelines when coordination of benefits procedures are necessary. We use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

When third-party resources and third-party liability (TPL) resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, we will reject the claim and redirect you to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if we do not become aware of the resource until after payment for the service was rendered, we will pursue postpayment recovery of the expenditure. You must **not** seek recovery in excess of the Medicaid-payable amount.

Healthy Blue may pay-and-chase the full amount allowed under the payment schedule for the claim and then seek reimbursement from the TPL insurer within 60 days after the end of the month in which the payment was made, for any liable TPL of legal liability if:

- The claim is for prenatal care for pregnant women.
- The claim is for preventive pediatric services (including EPSDT and well-baby screenings).
- The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

Healthy Blue will cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed, except for the pay-and-chase circumstances as outlined above.

Claims for labor and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees.

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

Coordination of Benefits Claim Examples

Scenario 1: Professional Claim

Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (copay, coinsurance and/or deductible). The Medicaid allowed amount minus the TPL paid amount is **less** than the patient responsibility; thus, the Medicaid allowed amount is the payment. Healthy Blue is responsible up to the Medicaid allowable amount or the patient's responsibility, whichever is the lesser amount.

Scenario 2: Outpatient Claim

Medicaid "zero pays" the claim; when cost-compared, the private insurance paid more than the Medicaid-allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment **and** the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.

Scenario 3: Inpatient Claim

The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.

Billing for Specialized Behavioral Health Services for Dual-Eligibles

For dual-eligible members (Medicare and Medicaid), Healthy Blue will be the secondary payer on hospital and professional claims for specialized mental health and substance use services. Providers should submit claims for dual-eligible enrollees to Medicare as the primary payer for hospital and professional claims. Claims for services delivered by unlicensed staff should be submitted directly to Healthy Blue.

If you have any questions regarding paid, denied or pended claims, please call Provider Services at **833-405-9086**.

Billing Members

Before rendering a service that is not covered by Healthy Blue, inform our member that we do not cover the cost of the service; he or she will have to pay for the service. If you choose to provide services that we do not cover:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the Client Acknowledgment Statement, specifying the member will be held responsible for payment of services (see the **Client Acknowledgement Statement** section).
- Understand you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

You cannot balance bill for the amount above that which we pay for covered services.

In addition, you may **not** bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Healthy Blue
- Failure to submit a claim to Healthy Blue for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by the provider in claims preparation, claims submission or the appeal/dispute process

Client Acknowledgment Statement

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true**:

- The member requests the specific service or item.
- You notify the member of the financial liability in advance of the service.
- You obtain and keep a written acknowledgment statement signed by you and by the member **prior to the service being rendered**, stating the following:

"I understand my doctor, [insert provider's name], or Healthy Blue has said the services or items I have asked for on [insert dates of services] are not covered under my Healthy Blue plan. Healthy Blue will not pay for these services. Healthy Blue has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Healthy Blue decides they are not medically necessary or are not a covered benefit. I understand I am liable for payment if I sign an agreement with my provider prior to the services being rendered."

Signature: _____

Date: _____

Overpayment Process

Refund notifications may be identified by two entities, Healthy Blue and its contracted vendors *or* the providers. Healthy Blue researches and notifies the provider of an overpayment requesting a refund check.

The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Healthy Blue, Healthy Blue will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **provider.healthybluemo.com**. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, call Provider Services at **833-405-9086**.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. If the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *healthcare Reform Act*. The provision directly links the retention of overpayments to false claim liability. The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act*, including treble damages. To avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the *PPACA*.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at *42 U.S.C.A. § 1320a-7k*, clarifies the uncertainty left by the 2009 *Fraud Enforcement and Recovery Act*. This provision of the *healthcare Reform Act* applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

APPENDIX A: CLAIMS GUIDE CHARTS

CMS-1500

Field number	Field name	Required Y = Yes; N = No; S = Situational	Description format	Example
1	Type	N	Check appropriate box	X
1a	Insured ID	Y	Healthy Blue Member ID	123456789
2	Patient Name	Y	Last name, First name, Middle initial	Doe, John, E
3	Patient Date of Birth	Y	MM/DD/YY	07 04 99
3	Patient Sex	Y	Check M box for Male, F box for Female	X
4	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E
5	Patient's Address	Y	Number and Street	123 Somewhere St
5	Patient's City	Y	City	Anytown
5	Patient's State	Y	State abbreviation	VA
5	Patient's ZIP Code	Y	US Postal ZIP code	12345-0001
5	Patient Phone	N	Area code plus phone number (10 digits)	757-123-4567
6	Patient Relationship to Insured	N	Check appropriate box	X
7	Insured Street	S	Number and Street	123 Somewhere St
7	Insured City	S	City	Anytown
7	Insured State	S	State abbreviation	VA
7	Insured ZIP Code	S	US Postal ZIP code	12345-0001
7	Insured Phone	N	Area code plus phone number (10 digits)	757-123-4567
8	Patient Status	S	Check appropriate box	X
9	Other Insured Name	S	Last name, First name, Middle initial	Doe, Mary, D
9a	Other Insured Policy or Group Number	S	Other Insured Member ID	555666777888
9b	Other Insured Date of Birth	S	MM/DD/YY	03 15 87
9b	Other Insured Sex	S	Check M box for Male, F box for Female	X
9c	Other Employer/School	S	Name of employer or school	Some Bank Name Inc.
9d	Other Insurance Name	S	Name of other insurance	For All Commercial Insurance

Field number	Field name	Required Y = Yes; N = No; S = Situational	Description format	Example
10a	Work Related Condition	S	Check appropriate box	X
10b	Auto Related Condition	S	Check appropriate box	X
10b	Accident Place State	S	State abbreviation	VA
10c	Other	S	Check appropriate box	X
10d	Local Use	N		
11	Insured Policy Group or FECA Number	S	Insured Group Number	FAC111222B
11a	Insured Date of Birth	S	MM/DD/YY	07 04 99
11a	Insured Sex	S	Check M box for Male, F box for Female	X
11b	Insured Employer/School	S	Enter employer or school name	NONE
11c	Insured Plan Name	S	Insurance plan name	Medicaid
11d	Other Benefit Indicator	S	Check appropriate box	X
12	Patient/Authorized Signature	N		
12	Patient/Authorized Date	N		
13	Insured/Authorized Signature	N		
14	Illness/Injury Date	S	MM/DD/YY	02 09 2020
15	Similar Illness Date	S	MM/DD/YY	12 16 07
16	Disability Date — From	S	MM/DD/YY	02 05 2020
16	Disability Date — To	S	MM/DD/YY	02 11 2020
17	Referring Physician Name	S	Name of physician who referred patient for services	Jane A Smith
17a	Referring Physician ID Qualifier	S	Use corresponding qualifier for ID number submitted in 17a — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
17a	Referring Physician ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207QA0000X
17b	NPI	S	Valid 10-digit NPI number	9876543210

Field number	Field name	Required Y = Yes; N = No; S = Situational	Description format	Example
18	Hospitalization Date — From	S	MM/DD/YY	02 08 2020
18	Hospitalization Date — To	S	MM/DD/YY	02 09 2020
19	Local Use	N		
20	Outside Lab	S	Check appropriate box	X
20	Lab Charges	S	Dollar amount from outside lab	60 00
21 1.	Diagnosis Code	Y	Valid primary diagnosis code	S72.001D
21 2.	Diagnosis Code	S	Valid secondary diagnosis code	
21 3.	Diagnosis Code	S	Valid tertiary diagnosis code	
21 4.	Diagnosis Code	S	Valid fourth diagnosis code	
22	Medicaid Resubmission Code	N		123
22	Medicaid Original Reference	N	Original claim number	ABC123456789
23	Prior Authorization Number	S	If authorization for services was obtained, enter the Healthy Blue authorization number. If the services reported on the claim require a CLIA certificate number, the CLIA number should be reported in place of the authorization number.	1234AUTH5678 or 12D4567890
24	Shaded Area Data	S	Free-form text and/or NDC information	N400186115102 ML 1
24a	From Date	Y	MM/DD/YY	02 10 20
24a	To Date	Y	MM/DD/YY	02 10 20
24b	Place of Service	Y	2-digit place of service code	11
24c	EMG	N	Emergency Indicator "Y" or Blank = assumed "N"	Y
24d	Procedure Code	Y	Valid CPT/HCPCS code	99212
24d	Procedure Modifier 1	S	Valid 2-digit modifier	TN

Field number	Field name	Required Y = Yes; N = No; S = Situational	Description format	Example
24d	Procedure Modifier 2	S	Valid 2-digit modifier	TC
24d	Procedure Modifier 3	S	Valid 2-digit modifier	50
24d	Procedure Modifier 4	S	Valid 2-digit modifier	51
24e	Diagnosis Code Pointer	Y	Indicate which diagnosis code correlates to the line	1
24f	Charges	Y	Charges for line	$150.00
24g	Days or Units	Y	Appropriate number for days or units	1
24h	EPSDT	Y	Y = if EPSDT service or N = if not an EPSDT service	N
24i — shaded	ID Qualifier	S	Use corresponding qualifier for ID number submitted in 24j — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
24j — shaded	Rendering Provider ID #	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207XP3100X
24j — not shaded	Rendering Provider NPI	S	Valid 10-digit NPI number	1234567890
25	Federal Tax ID	Y	Valid 9-digit Tax ID or SSN	111223333
25	Federal Tax ID (SSN/EIN)	Y	Check SSN if social was used; check EIN if Tax ID was used	X
26	Patient Account Number	S	Patient account number with provider	123ACCT456
27	Accept Assignment	S	Check appropriate box	X
28	Submitted Total Charge	Y	Total charges on claim	$250.00
29	Patient Amount Paid	S	Amount patient paid	$0.00
30	Balance Due	S	Amount still due on claim	$250.00
31	Signature of Physician/ Physician Name	Y	Rendering provider's name	Jack T Specialist
31	Performing Provider Date	N	MMDDYY	2/10/2008
32	Service Facility Location Name	S	Name of facility were services were rendered	ABC Memorial Hospital

Field number	Field name	Required Y = Yes; N = No; S = Situational	Description format	Example
32	Service Facility Location Street	S	Number and Street	987 Somewhere St.
32	Service Facility Location City	S	City	Anytown
32	Service Facility Location State	S	State abbreviation	VA
32	Service Facility Location ZIP Code	S	US Postal ZIP code	12345-0001
32a	NPI	S	Valid 10-digit NPI number	9871234567
32b	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	ZZ282NC2000X
33	Billing Provider Group Name	Y	Name of billing group or provider	JTS Orthopedic Specialists
33	Billing Provider Street	Y	Number and Street	222 Somewhere St
33	Billing Provider City	Y	City	Anytown
33	Billing Provider First State	Y	State abbreviation	VA
33	Billing Provider First ZIP Code	Y	US Postal ZIP code	12345-0001
33	Phone Number	N	Billing provider phone number	757-555-4444
33a	NPI	Y	Valid 10-digit NPI number	9874561230
33b	Other ID	Y	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	ZZ207X00000X

UB-04

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Billing Provider Name	Y	Facility Name (Please ensure the name submitted matches the name used in the Healthy Blue processing system)	ABC Memorial Hospital

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Billing Provider Street Address	Y	Number and Street	987 Somewhere St.
1	Billing Provider Address — City	Y	City	Anytown
1	Billing Provider Address — State	Y	State abbreviation	VA
1	Billing Provider Address — ZIP Code	Y	US Postal ZIP code	12345-0001
1	Billing Provider Telephone	O	Area code plus phone number (10 digits)	757-555-4444
1	Billing Provider Fax	O	Area code plus fax number (10 digits)	757-444-5555
1	Billing Country Code	N		
2	Provider Info/Pay-to Name	S	Facility Name	123 Hospital System
2	Provider Info/Pay-to Street	S	Number and Street	111 Somewhere St.
2	Provider Info/Pay-to City	S	City	Anytown
2	Provider Info/Pay-to State	S	State abbreviation	NC
2	Provider Info/Pay-to ZIP Code	S	US Postal ZIP code	53211-0001
2	Provider Info/Pay-to Phone Number	O	Area code plus phone number (10 digits)	
3a	Patient Control Number	S	Provider's control number for patient	123CNTL456
3b	Medical Record Number	S	Provider's medical record number for patient	123REC456
4	Type of Bill	Y	Enter appropriate three digit code for type of bill	111
5	Federal Tax Number	Y	Valid 9-digit Tax ID or SSN	999887777
6	Statement Period From	Y	MMDDYY	021120
6	Statement Period To	Y	MMDDYY	021920
7	Local Use	N		

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
8a	Patient ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
8b	Patient Name	Y	Last name, First name, Middle initial	Doe, John E.
9a	Patient Street	Y	Number and Street	123 Somewhere St
9b	Patient City	Y	City	Anytown
9c	Patient State	Y	State abbreviation	VA
9d	Patient ZIP Code	Y	US Postal ZIP code	12345
9e	ZIP Code+4	S		0001
10	Birth Date	Y	MMDDYY	070499
11	Sex	Y	F=Female, M=Male	M
12	Admission Date	S	MMDDYY	021120
13	Admission Hour	S	Enter admission hour	13
14	Admission Type	S	Enter valid admission type	01
15	Admission Source Code	S	Enter valid admission source code	07
16	Discharge Hour	S	Enter discharge hour	12
17	Status	S	Enter valid discharge status	01
18	Condition Code	S	Enter valid condition code	A9
19	Condition Code	S	Enter valid condition code	04
20	Condition Code	S	Enter valid condition code	M0
21	Condition Code	S	Enter valid condition code	
22	Condition Code	S	Enter valid condition code	
23	Condition Code	S	Enter valid condition code	
24	Condition Code	S	Enter valid condition code	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
25	Condition Code	S	Enter valid condition code	
26	Condition Code	S	Enter valid condition code	
27	Condition Code	S	Enter valid condition code	
28	Condition Code	S	Enter valid condition code	
29	Accident State	S	State abbreviation	VA
30	Local Use	N		
31a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 01 021120 b. 04 021120
32a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 06 021120
33a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	
34a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	
35a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	a. 72 021108 021108
36a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	
37	Local Use	N		
38	Payer Name and Address	S	Enter the claims submission address	Healthy Blue P.O. Box 11111-1111 Virginia Beach, VA 23462
39a	Value Code/Amount	S	Enter valid value code and amount*	73 20 00
39b	Value Code/Amount	S	Enter valid value code and amount*	D3 45 00
39c	Value Code/Amount	S	Enter valid value code and amount*	54 30

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
39d	Value Code/Amount	S	Enter valid value code and amount*	
40a	Value Code/Amount	S	Enter valid value code and amount*	
40b	Value Code/Amount	S	Enter valid value code and amount*	
40c	Value Code/Amount	S	Enter valid value code and amount*	
40d	Value Code/Amount	S	Enter valid value code and amount*	
41a	Value Code/Amount	S	Enter valid value code and amount*	
41b	Value Code/Amount	S	Enter valid value code and amount*	
41c	Value Code/Amount	S	Enter valid value code and amount*	
41d	Value Code/Amount	S	Enter valid value code and amount*	
42	Revenue Code	Y	Enter valid revenue code	0450
43	Description	O		
	*Note: All newborn claims should contain a value code of 54 — Newborn birth weight in grams, along with the birth weight of the baby.			
44	HCPCS/Rates	S	Enter valid HCPCS/Rate/HIPPS code	L2126
45	Service Date	S	MMDDYY	021120
46	Service Units	Y	Enter number of units	1
47	Total Charges	Y	Enter total charges for line	500 00
48	Non-Covered Charges	N		
49	Local Use	N		
42–23	PAGE _ OF _	O	Enter page counts	1 OF 1
42–23	CREATION DATE	O	Enter date claim was created	21220
42–23	TOTALS →	O	Enter total charges for the claim	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
50a	Payer Name	Y	Enter the primary payer name	Healthy Blue
50b	Payer Name	S	Enter the secondary payer name	For All Commercial Ins
50c	Payer Name	S	Enter the tertiary payer name	
51a	Health Plan ID	N		
51b	Health Plan ID	N		
51c	Health Plan ID	N		
52a	Rel Info	Y	Indicate Release of Information statement on file	Y
52b	Rel Info	S		
52c	Rel Info	S		
53a	Assign Benefits	N		
53b	Assign Benefits	N		
53c	Assign Benefits	N		
54a	Prior Payments	S	Enter any prior payments	300 00
54b	Prior Payments	S	Enter any prior payments	
54c	Prior Payments	S	Enter any prior payments	
55a	Est. Amount Due	S	Enter estimate amount due from patient	15 00
55b	Est. Amount Due	S		
55c	Est. Amount Due	S		
56	NPI	Y	Valid 10-digit NPI number	9871234567
57a	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Taxonomy	ZZ282NC2000X
57b	Other Provider ID	S	Appropriate and valid qualifier and provider id number: Medicaid	1D 345678
57c	Other Provider ID	S	Appropriate and valid qualifier and provider	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			ID number: Healthy Blue ID	
58a	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E.
58b	Insured's Name	S	Last name, First name, Middle initial	
58c	Insured's Name	S	Last name, First name, Middle initial	
59a	Patient Relationship	R	Enter a valid patient relationship code	19
59b	Patient Relationship	R	Enter a valid patient relationship code	18
59c	Patient Relationship	R	Enter a valid patient relationship code	
60a	Insured's Unique ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
	Insured's Unique ID	S	Insured unique Identification number	23234545
60c	Insured's Unique ID	S		
61a	Group Name	S	Enter group name	Medicaid
61b	Group Name	S	Enter group name	For All Commercial Ins
61c	Group Name	S	Enter group name	
62a	Insurance Group Number	S	Enter group number	
62b	Insurance Group Number	S	Enter group number	F32415G
62c	Insurance Group Number	S	Enter group number	
63a	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	1234AUTH5678
63b	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
63c	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
64a	Document Control Number	N		

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
64b	Document Control Number	N		
64c	Document Control Number	N		
65a	Employer Name	S	Enter employer name	Some Bank Name Inc
65b	Employer Name	S	Enter employer name	
65c	Employer Name	S	Enter employer name	
66	DX Indicator	N	Enter diagnosis qualifier	9
67	Principle Diagnosis Code	Y	Enter valid diagnosis code	S72.001D
67a	Other diagnosis code A	S	Enter valid diagnosis code	S82.101B
67b	Other diagnosis code B	S	Enter valid diagnosis code	K25.3
67c	Other diagnosis code C	S	Enter valid diagnosis code	
67d	Other diagnosis code D	S	Enter valid diagnosis code	
67e	Other diagnosis code E	S	Enter valid diagnosis code	
67f	Other diagnosis code F	S	Enter valid diagnosis code	
67g	Other diagnosis code G	S	Enter valid diagnosis code	
67h	Other diagnosis code H	S	Enter valid diagnosis code	
67i	Other diagnosis code I	S	Enter valid diagnosis code	
67j	Other diagnosis code J	S	Enter valid diagnosis code	
67k	Other diagnosis code K	S	Enter valid diagnosis code	
67l	Other diagnosis code L	S	Enter valid diagnosis code	
67m	Other diagnosis code M	S	Enter valid diagnosis code	
67n	Other diagnosis code N	S	Enter valid diagnosis code	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
67o	Other diagnosis code O	S	Enter valid diagnosis code	
67p	Other diagnosis code P	S	Enter valid diagnosis code	
67q	Other diagnosis code Q	S	Enter valid diagnosis code	
68	Local Use	N		
69	Admit Diagnosis Code	Y	Enter valid diagnosis code	S72.001D
70a	Patient Reason DX A	S	Enter valid diagnosis code	S82.101B
70b	Patient Reason DX B	S	Enter valid diagnosis code	
70c	Patient Reason DX C	S	Enter valid diagnosis code	
71	PPS Code	S	Enter valid DRG code	123
72a	ECI A	S	Enter valid diagnosis code	E812
72b	ECI B	S	Enter valid diagnosis code	
72c	ECI C	S	Enter valid diagnosis code	
73	Local Use	N		
74	Principal Procedure Code	S	Enter valid procedure code	0QH634Z
74	Principal Procedure Date	S	MMDDYY	021120
74a	Other Procedure Code	S	Enter valid procedure code	
74a	Other Procedure Date	S	MMDDYY	
74b	Other Procedure Code	S	Enter valid procedure code	
74b	Other Procedure Date	S	MMDDYY	
74c	Other Procedure Code	S	Enter valid procedure code	
74c	Other Procedure Date	S	MMDDYY	
74d	Other Procedure Code	S	Enter valid procedure code	
74d	Other Procedure Date	S	MMDDYY	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
74e	Other Procedure Code	S	Enter valid procedure code	
74e	Other Procedure Date	S	MMDDYY	
75	Local Use	N		
76	Attending NPI	S	Valid 10-digit NPI number	2323232323
76	Attending Qualifier	S	Use corresponding qualifier for ID number submitted in 76: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
76	Attending ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	444556666
76	Attending Last Name	S	Attending physician's last name	Doe
76	Attending First Name	S	Attending physician's first name	Robert
77	Operating NPI	S	Valid 10-digit NPI number	2121212121
77	Operating Qualifier	S	Use corresponding qualifier for ID number submitted in 77: G2= Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
77	Operating ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	123456789
77	Operating Last Name	S	Operating physician's last name	Smith
77	Operating First Name	S	Operating physician's first name	Jane
78	Other (Space)	S	Enter qualifier for the provider reported: DN - — Referring, ZZ — Other Operating	82

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			Physician or 82 — Rendering Provider	
78	Other NPI	S	Valid 10-digit NPI number	1112223334
78	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 78: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
78	Other ID	S	Appropriate and valid provider ID; Medicaid, Healthy Blue, Tax ID or SSN	987654321
78	Other Last Name	S	Physician's last name	Jones
78	Other First Name	S	Physician's first name	Jack
79	Other NPI	S	Valid 10-digit NPI number	
79	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 79: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	
79	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	
79	Other Last Name	S	Physician's last name	
79	Other First Name	S	Physician's first name	
80	Remarks	S	Enter any free form remarks	Sample claim — Not Valid
81a	CC	N		
81b	CC	N		
81c	CC	N		
81d	CC	N		

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. DentaQuest is an independent company providing dental benefit management services on behalf of Healthy Blue. March Vision is an independent company providing vision benefit management services on behalf of Healthy Blue. MTM is an independent company providing nonemergency transportation services on behalf of Healthy Blue. Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.