MO HealthNet Managed Care
(Medicaid)

Healthy Blue

Provider Orientation

Agenda

- About us
- Who we serve
- Joining our network
- Claims tools and resources
- Health services
- Quick resources
- Provider Relations

Healthy Blue

About Us

Healthy Blue

History

Healthy Blue, formally Missouri Care, Inc., has been a MO HealthNet managed care health plan since 1998. In January 2020, Anthem, Inc. purchased the Missouri Care, Inc. health plan. Our plan will now be called Healthy Blue. Healthy Blue will be proud to continue to serve our Missouri members starting January 1, 2021 under this new brand.

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History (cont.)

We are proud to serve members statewide. Our mission is to provide access to quality health care for the members we serve.

Healthy Blue has three regional offices. They are located in:

- St. Louis.
- Columbia.
- Springfield.

In addition, Healthy Blue has three welcome centers. They are located in:

- St. Joseph.
- Cape Girardeau.
- Columbia.

Healthy Blue

Purpose, Vision And Values

Our mission
Improving Lives and Communities. Simplifying Healthcare. Expecting More.

Our vision
To be the most innovative, valuable and inclusive partner

Our values
- Leadership
- Community
- Integrity
- Agility
- Diversity

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Who We Serve

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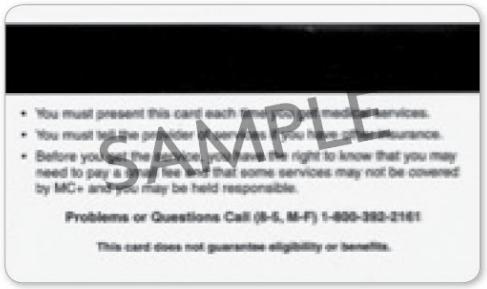
About MO HealthNet

The first ID card example is the Missouri Medicaid ID card, issued to eligible Missouri Medicaid recipients.



This second ID card example is the MO HealthNet ID card, issued to Missouri Medicaid recipients who are eligible for MO HealthNet managed care.

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Healthy Blue Card Image

Members will receive new ID cards that are effective as of January 1, 2021.

Image coming soon

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Enrollment

Enrollment is managed by the state and updated in our system daily. Once determined eligible to participate in the MO HealthNet program, members may choose Healthy Blue as their health care plan.

Once enrolled, MO HealthNet managed care-eligible members must choose a PCP or one will be assigned by their designated health plan. Members have two identification numbers. They have a DCN number, assigned by MO HealthNet, and a subscriber ID number, assigned by Healthy Blue. Both of these numbers are listed on the member's ID card.

Members apply through FSD → State approves eligibility for MO HealthNet program → Members **must** choose a health plan or one is auto-assigned for them

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Eligibility Verification

As of January 1, 2021, eligibility and benefits associated with a member and/or their dependents can be determined by:

- Submitting a 270/271 electronic data interchange (EDI) transaction through using your EDI software or through your clearinghouse.
- Submitting an eligibility and benefits inquiry through the Availity Portal.*
- Go to https://www.availity.com Select Patient Registration > Eligibility and Benefits. Select **Healthy Blue** from the drop-down box.
- Complete required fields and submit.
- You will continue to be able to verify member eligibility information through the state. Eligibility can be verified by calling MO HealthNet's Interactive Voice Response unit at 1-573-635-8908 or through MO HealthNet's online system, eMOMed, available at www.emomed.com.

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Eligibility Verification (cont.)

As a contracted Healthy Blue provider, you can see any Healthy Blue member, even if you are not the PCP of record. Healthy Blue will accept claims billed with either the member ID number or the MO HealthNet DCN.

Please note: A member's eligibility status can change at any time. Therefore, providers are encouraged to check eligibility on the date of service (DOS), and to request and copy a member's ID card, along with additional proof of ID, such as photo identification, and file these in the patient's medical record.

Providers should access Healthy Blue's secure provider website at https://www.availity.com to obtain the member's current assigned PCP.

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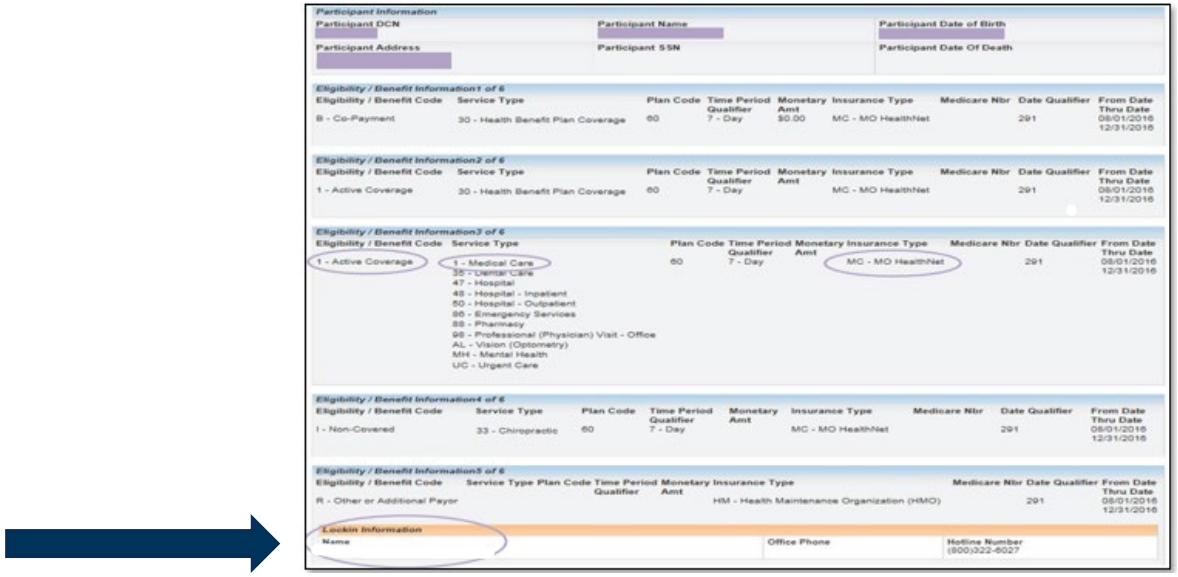
eMOMed

Below is a screen capture of a member's eligibility information on MO HealthNet's website, eMOMed. *Insurance Type MC* indicates the member is enrolled in a managed care plan. The *Lockin Information* indicates which managed care health plan the member is enrolled in. Eligibility may change daily. As a result, it is important to check eligibility on the date of service.



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Children's Mercy Pediatric Care Network (CMPCN)

CMPCN is an integrated pediatric network operated by the Children's Mercy Hospital System. CMPCN provides delegated medical management services, including: case 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.

Healthy Blue members who are part of this network can be identified by the CMPCN logo on their ID card.

Children's Mercy
PEDIATRIC CARE NETWORK

Image coming soon

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CMPCN (cont.)

CMPCN manages and issues prior authorization requests for these members. The authorization approvals are shared by CMPCN with Healthy Blue. Healthy Blue will process the claims for these members.

A Healthy Blue member is still free to choose any contracted provider to receive services. If an authorization is necessary, or you have a referral for case management, you will contact CMPCN instead of Healthy Blue. All behavioral health (BH) management services will continue to be managed by Healthy Blue.

Whom to contact for:	Healthy Blue or CMPCN?
Prior authorization request for Healthy Blue	CMPCN
BH case management and utilization management	Healthy Blue
Filing a claim	Healthy Blue
Eligibility verification	eMOMed (MO HealthNet)
Filing an appeal or grievance	Healthy Blue

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CMPCN Authorization Requests And Claims Submission Information

Prior authorization (PA) requests
Please check the CMPCN website at http://www.cmpcn.org to determine if a service requires authorization, and for related PA forms and the PA quick guide.

PA requests for Healthy Blue or CMPCN members should be directed to CMPCN at the phone numbers below.

- PA phone number : **1-877-347-9367**
- PA fax phone number: **1-888-670-7260**
- Clinical Services phone number: **1-888-670-7262**

Claims submission
Claims for CMPCN members are submitted to Healthy Blue for processing.

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Joining Our Network

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Adding New Provider To Existing Contract

Below is the information we need if your office has a new provider who is interested in joining our provider network:

- Completed *Provider Profile Sheet*
- Full review of the provider checklist

Please email this information to our Provider Operations Coordinator team at MOProviderOperations@healthybluemo.com.

After the provider is entered into our system, you will receive a welcome letter email advising of the provider's effective date and their Healthy Blue provider ID number, etc.

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Credentialing Process

- Healthy Blue follows the specific credentialing process set forth by NCQA.
- Once the CAQH application has been attested to and Healthy Blue has been given access, Healthy Blue's credentialing team will conduct primary source verification as appropriate and prepare the provider's file for review by the Credentials Committee.
- Clean credentialing files are reviewed daily by our Medical Director and approved accordingly. We are contractually obligated to complete processing of all clean credentialing applications within 60 days.
- Chaired by our Medical Director, the Credentials Committee meets monthly to review files based on the credentialing criteria.
- Healthy Blue recredentials every three years and providers are asked to keep their CAQH applications current and available.

Healthy Blue

Provider Changes

In order to keep provider information current, Healthy Blue relies on the provider network to advise us of demographic changes. To ensure our members and care management staff have up-to-date information, please provide us with 90 days' notice of the following demographic changes by calling Provider Services at **1-833-405-9086** or submitting a written notification via email to our Provider Operations team at MOProviderOperations@healthybluemo.com.

Demographic change examples:

- Group name or affiliation
- Panel status
- Physical or billing address
- *1099* mailing address
- Office hours
- Hospital affiliations
- Languages spoken
- Telephone or fax number
- Tax identification number
- Age limitation
- New NPI number
- Terminations

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Provider Roles and Responsibilities

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Appointment Availability

The state of Missouri requires us to ensure our provider network's member appointment wait times do not exceed the standards outlined in the provider contract and handbook.

In order to assess appointment timeliness, Healthy Blue conducts quarterly phone audits. We make these calls to assess your compliance level to the requirements outlined on the following slide.

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Appointment Availability (cont.)

Service	Time frame requirement for appointment
Medical — urgent care	Within 24 hours
Medical — routine care with symptoms	Within 1 week or 5 business days, whichever is earlier
Medical — routine care	Within 30 calendar days
Medical — follow-up to hospital discharge	Within 7 calendar days from the discharge date
BH — routine care	Within 10 business days
BH — routine care with symptoms	Within 1 week or 5 business days, whichever is earlier
BH — urgent care	Within 24 hours
BH — non-life-threatening emergency care	Within 6 hours
BH — follow-up to hospital discharge	Within 7 calendar days from the discharge date
Maternity care — 1st trimester	Within 7 calendar days
Maternity care — 2nd trimester	Within 7 calendar days
Maternity care — 3rd trimester	Within 3 calendar days
Maternity care — High-risk pregnancy initial visit	Within 3 calendar days or immediately if emergency exists

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Appointment Availability (cont.)

After-hours availability
PCPs must provide or arrange for coverage of services, consultations or approval for referrals 24/7.

To ensure accessibility and availability, PCPs must provide one of the following:

- Answering service or system that will page physician
- Advice nurse with access to physician
- Answering system with option to page physician
- Answering service that will page the provider after a message is left
- Answering service or system that provides number to access physician

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Appointment Availability Fails

What if a requirement isn't met?

- If the requirement is not met during the survey call, the provider will receive a letter advising of the requirement(s) not met.
- It is up to the provider's office to educate their staff and ensure that the requirements are being met.
- A future follow-up call will be made to determine if the provider's office will meet all requirements.

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Advance Directive

We adhere to the *Patient Self-Determination Act* and recognize and support the following advance directives:

- Durable power of attorney
- Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A 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.

Healthy Blue

Cultural Competency

We are committed to fostering cultural competency within our company and provider networks.

Cultural competency can enable you to:

- Acknowledge the importance of culture and linguistic differences.
- Recognize the cultural factors which shape personal and professional behavior.
- Enhance support of diverse patients by incorporating cultural insights into practice where appropriate.
- Strive to expand cultural knowledge.

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Cultural Competency (cont.)

Cultural barriers between provider and patient can:

- Impact the patient's level of comfort and fear of what you might find upon examination.
- Result in differences in understanding of our health care system.
- Cause a fear of rejection of the patient's personal health beliefs.
- Impact your patient's expectation of you and of treatment.

Cultural Competency Program

Please use an interpreter, when necessary, to ensure your patient understands all of his or her options and is able to make an informed decision. Free interpreter services are available to Healthy Blue members 24/7, with over 170 languages.

Call Healthy Blue Provider Services at **1-833-405-9086** (**TTY 711**) for:

- Interpreter services for provider services.
- Telephonic interpreter services.
- In-person interpreter services for care management.

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Provider Cultural Competency Resources

Patient panels are growing more diverse and needs are becoming more complex; more support may be necessary to help address these needs.

Healthy Blue offers support by ensuring resources are available to providers on the provider website. Resources include:

- **Cultural Competency Training** (cultural competency and patient engagement), which includes but is not limited to:
  - The impact of culture and cultural competency on health care
  - A cultural competency continuum that can help providers assess their level of cultural competency
  - Disability sensitivity and awareness

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Provider Cultural Competency Resources (cont.)

- **Caring for Diverse Populations Toolkit**, which includes but is not limited to:
  - Comprehensive information, tools, and resources to support enhanced care for diverse patients and mitigate barriers
  - Materials that can be printed and made available for patients in provider offices
  - Regulations and standards for cultural and linguistic services

- **My Diverse Patients**
  - Online resource offering comprehensive information to increase awareness of the needs of diverse patients, disparities that are present, and ways to enhance care and address those gaps.
  - Includes courses offering **free** continuing medical education credit through American Academy of Family Physicians.
  - Site access is free; no account or login required; site is accessible from any device (desktop computer, laptop, phone, tablet). These resources are available at [state-specific provider portal and pathway to resources].

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Claims, Tools and Resources

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Introducing New Public And Secure Provider Websites

As of November 1, 2020, the Healthy Blue public provider website will be available at https://provider.healthybluemo.com. The Healthy Blue public website will include resources that help health care professionals do what they do best — care for our members.

Beginning January 1, 2021, the secure Availity Portal at https://www.availity.com will be your exclusive, secure multipayer portal to access many Healthy Blue online tools and resources. You can register today and select Healthy Blue as payer starting January 1, 2021.

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Public Provider Website

The Healthy Blue provider website will be available starting November 1, 2020.

Placeholder for image of public portal

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Healthy Blue Provider Website And Availity Portal Comparison

Available through the Healthy Blue provider website	Available through the Availity Portal
• 24/7 access to all providers, regardless of participation status • Open access without registration • Claims forms • Precertification Look-Up Tool – PA Requirements Look-Up Tool • Provider manual • *Clinical Practice Guidelines* • News and announcements • Provider Directory • Fraud, waste and abuse resources • *Preferred Drug List* • *Medical Policies*	• Registration/login required for access • Precertification Look-Up Tool – PA Requirements Look-Up Tool • Patient360 (provider facing) • Multiple eligibility and benefits inquiry • Provider Online Reporting • PCP member panel listings • ICR – medical PA requests, notification of pregnancy and birth • Pharmacy authorizations and benefits • Claims dispute submission • Claims dispute inquiry • Medical appeal PA submission • *Availity EDI Guide* • *HEDIS® Maternity Attestation* • Remittance inquiry
https://provider.healthybluemo.com	https://www.availity.com

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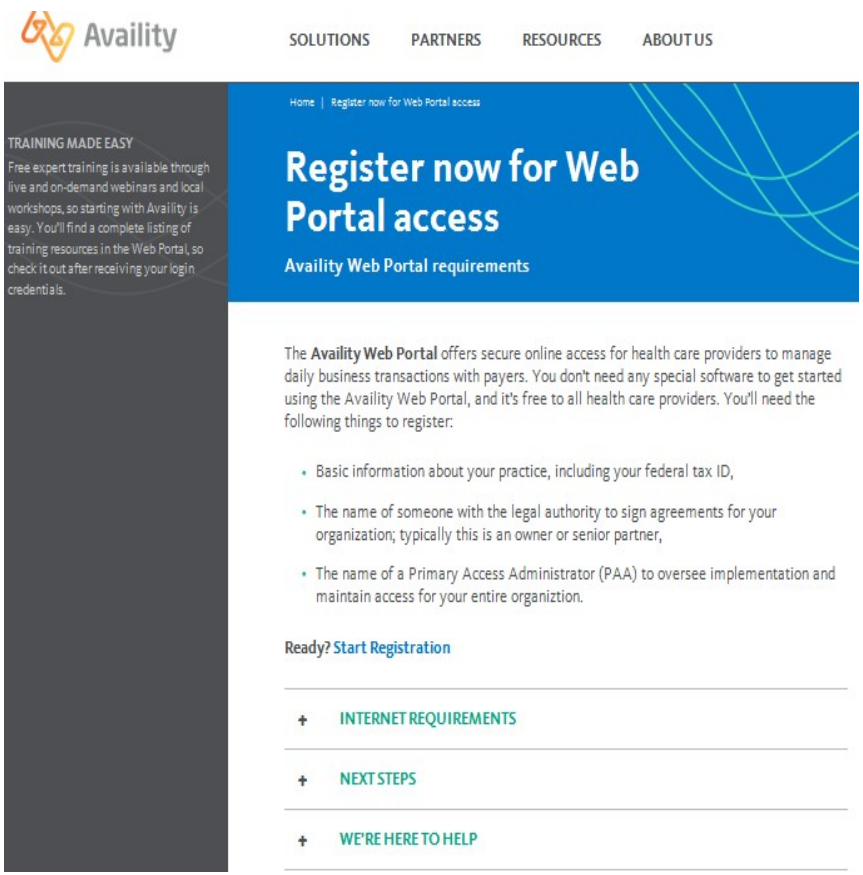
Availity Portal

Availity will be the new secure provider website to use for services completed on or after January 1, 2021.

Be ready by starting the registration process now. To begin registration, visit https://www.availity.com and select **Register**.

Your organization must be registered on the Availity Portal, and you need a unique ID and password.

If you are new to Availity, you will need to name an administrator who can grant you access to the tools you need.



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Availity Portal Training

Healthy Blue providers will be invited to take advantage of training webinars to learn how to use the Availity Portal. Training sessions will be offered starting in November 2020 to prepare for the transition to using Availity.

Registration information will be posted to the Healthy Blue website at https://provider.healthybluemo.com and the Availity Portal at https://www.availity.com.

Webinars offered:

- Availity Administrator Training
- Availity Overview for New Users
- Getting Started with EDI Services at Availity

Additional training available on Availity:

- Visit https://www.availity.com > Help & Training > Get Trained

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Provider Online Reporting Registration

The provider organization's Availity administrator is responsible for registering the tax IDs and users for provider online reporting. The administrator will take the following steps to register:

- From the Availity homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select **Application**, then select **Provider Online Reporting**.
- Select **Register/Maintain Organization** to register your organization's tax ID to the applicable program. Select **Register Tax ID** to register for the eligible program (member reports or panel listings).
- Select **Maintain User/Register User** to grant access to users.
- Complete all fields on the *Register User* page. Select **ADD TO PREVIEW** and **Save**.

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Timely Filing And Coordination Of Benefits Information

Healthy Blue as the primary payer

- First submission timely filing is defined by your contract

Healthy Blue as the secondary payer

- Within 365 days from date of service for first submission or resubmission
- Within 90 days from the date of the primary *EOB* if that is longer than 365 days from date of service

Corrected claims

- Within 365 days from the date of service

Coordination of benefits

Healthy Blue is always the final payer. If our member has primary insurance, please file the claim with the primary insurance carrier first, then submit a claim with the primary carrier's remittance advance to Healthy Blue for processing. We will coordinate benefits from the primary insurance carrier's *EOB*.

Healthy Blue will reimburse the difference between what the primary insurance pays and the allowable if there is a remaining balance.

The member cannot be balance billed for the difference or the contractual write-off amounts.

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Claims Submission Information

Healthy Blue encourages the submission of claims electronically through the electronic data interchange (EDI), either by using a clearinghouse, billing company or sending directly. Availity serves as our gateway for all EDI transactions.

Providers can also register with Availity at https://www.availity.com to become a direct submitter.

To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**). If you have a relationship with a clearinghouse, please work with them to ensure connectivity with Availity.

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Claims Submission Information (cont.)

Availity:

- https://www.availity.com

EDI submissions:

- Healthy Blue Payer ID number — 00541

Paper:

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

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Claim Status Inquiries

You can obtain claim status information through the Availity Portal or by calling Healthy Blue Provider Services.

To access the information on the Availity Portal, perform a claim status inquiry:

- At the top of Availity Portal, select **Claims & Payments | Claim Status and Remittance Viewer**. On the *Claim Status & Remittance Viewer* page, select **Claim Status**. In the *Organization* field, select the organization and in the *Payer* field, select **Healthy Blue**.
- You must be assigned the claim status role to access the claim status application.
- Tip: Start from an eligibility and benefits response (patient card) and select the **Go To** button located in the top right-hand corner of the inquiry, and then select **Check Claim Status**.
- For more claims training, select **Help & Training**, then **Get Trained** and search for *Claim Status Inquiry – Training Demo*.

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Rejected Versus Denied Claims

There are two types of notices you may get in response to your claim submission: rejected or denied.

- **Rejected claims** do not enter the adjudication system because they have missing or incorrect information.
- **Denied claims** go through the adjudication process but are denied for payment.

You can find claims status information on the Healthy Blue provider website at https://provider.healthybluemo.com or by calling Healthy Blue Provider Services at **1-833-405-9086**.

- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment (EOP),* letter of explanation and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

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Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes, or any information that would change the way the claim originally processed.

When to submit a corrected claim:

- Original claim was filed with an incorrect procedure code or diagnosis code, etc.
- Original claim was filed with an incorrect billed charge amount
- Original claim filed with incorrect units
- Original claim filed with the incorrect primary insurance payment information
- Original claim was filed in error
- Original claim was filed under an incorrect patient
- A duplicate claim was billed in error for the same services
- Original claim filed as primary instead of secondary

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Provider Claim Payment Dispute

The simplest way to define a claim payment dispute is: a claim has been finalized, but you disagree with the outcome. If a provider disagrees with the outcome of a claim, you may begin the claim payment dispute process. We must receive your dispute within 365 calendar days from the date of the *EOP*.

The claim payment dispute process consists of two steps. Providers 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 claim payment dispute process. The reconsideration represents the 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 claim payment dispute process. If a provider disagrees with the outcome of the reconsideration, the provider may request an additional review as a claim payment appeal.

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Provider Claim Payment Disputes (cont.)

Claim payment disputes do not include:

- Medical necessity/authorization denials: A claim may deny for a denied authorization, not medically necessary or something similar. In these instances, the claim payment was denied due to a denial of the authorization/service. These should be managed through the grievance and appeals process.
- No authorization denials: When a service requires an authorization, but authorization was not requested, a claim will deny for no authorization. If you would like have the service considered, submit the medical record for review through the correspondence process.

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How To Submit A Provider Dispute

There are several options for filing a dispute:

- **Online:** Use the secure Provider Availity Payment Dispute Tool at https://www.availity.com. Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- **Verbally (reconsiderations only):** Call Healthy Blue Provider Services at **1-833-405-9086**.
- **In writing: (reconsiderations and claim payment appeals):** The reconsideration form is located at https://provider.healthybluemo.com. Mail all required documentation to:
  Payment Dispute Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

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Grievances and Appeals

- **Grievance:** A grievance is your expressed dissatisfaction about any matter **except** a payment dispute or a proposed adverse medical action. A grievance can be submitted either by a member or a physician, hospital, facility or other health care professional licensed to provide health care services.

- **Medical appeals:** There are separate and distinct appeal processes for our members and providers that depend on the services denied or terminated. Refer to the denial letter issued to determine the correct appeals process.

For grievances and appeals, contact Healthy Blue Provider Services at **1-833-405-9086**.

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Claims Overpayment Recovery And Refund Process

Healthy Blue seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable.

When an overpayment is discovered, Healthy Blue initiates the overpayment recovery process by sending written notification.

If you are notified of an overpayment or discover that you have been overpaid, mail the refund check along with a copy of the notification or other supporting documentation to the following address:
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

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Encounter Data (cont.)

Services provided to Healthy Blue members by our providers are required to be reported to state and federal entities as encounters. Encounters are used by government entities for quality assessments and rate calculations.

The Missouri Health Department collects and uses encounter data for many purposes, such as:

- Federal reporting.
- Rate setting.
- Risk adjustment.
- Payment indication of delivery and NICU.
- Services verification.
- Managed care quality improvement activities.
- Utilization patterns.
- Access to care.
- Hospital rate setting.
- Research studies.

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Electronic Payment Benefits

Enrolling in electronic funds transfer (EFT) provides the following benefits:

- Reimbursements are deposited to your account faster.
- EFT payments don’t get delayed or lost in the mail.
- EFT payments are more protected from fraud.
- Bank fees are lower.
- You save time with fewer trips to the bank.
- You save money by reducing your associated labor and case security costs.

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Electronic Payment Services

You will need to register and enroll with the CAQH© Solutions EnrollHub™ tool at https://www.caqh.org/solutions/enrollhub and select the payer name that includes **Healthy Blue**.

- For registration-related questions, contact EnrollHub Help Desk at **1-844-815-9763** or efthelp@EnrollHub.CAQH.org. You can also refer to https://solutions.caqh.org/bpas/Common/HelpGettingStarted.pdf.
- Even if you are registered with CAQH and enrolled with another payer, you will need to enroll in the payer name that includes Healthy Blue to receive payments via EFT for services rendered on or after January 1, 2021.
- If you do not enroll in CAQH EnrollHub you will receive a paper check for services rendered on or after January 1, 2021.

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Electronic Payment Services (cont.)

For even more convenience, you can also enroll for online electronic remittance advice (ERA) via Availity:

- If you have a relationship with a clearinghouse, please work with them to ensure you are enrolled.
  - Visit https://apps.availity.com/web/welcome/#/edi to get started. If you have any questions, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**), Monday through Friday, from 7 a.m. to 6:30 p.m., Central time.

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Remittance Inquiry

You will be able to view/receive remittance information through the Availity Portal. Providers will submit weekly remits. From the Availity Portal homepage:

- Select **Payer Spaces**, then **Healthy Blue [MO]** and then **Applications**. The *Remittance Inquiry* application will appear as an option. Choose **Remittance Inquiry** to gain access to the Remittance Inquiry functionality.
- Choose your organization and tax ID number. If the administrator previously loaded NPIs, select your NPI from the *Express Entry* drop-down menu. Otherwise, enter an NPI number in the allotted box.
- You can choose from one of three search options:
  - EFT number
  - Check number
  - Date range
- You can easily access your remittance advice online.
- Transactions can be posted to your system automatically.

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Remittance Inquiry (cont.)

You have the option to sort your results by:

- Provider name.
- Issue date.
- Check/EFT number.
- Patient or claim.

For questions or additional registration assistance, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**) Monday through Friday, from 7 a.m. to 6:30 p.m., Central time.

If you need an image of the remittance for your files, select the **View Remittance** link associated with each remit and **Print** or **Save**.

Contact your administrator if you do not see this tool to request claims status access. If you don't know who the administrator is for your organization, log in to Availity and select **My Administrators**.

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Precertification Look-Up Tool

- Certain medical procedures require the submission and approval of PA. To verify if PA is required, use the Precertification Lookup Tool.
- Detailed authorization requirements can be found using the Precertification Lookup Tool:
  - Search by market, member product and CPT® code.
  - This is for outpatient services only — All inpatient services require an authorization.
- Precertification Lookup Tool is located under *Payer Spaces* on the Availity Portal:
  - From the Availity Portal homepage, select **Payer Spaces** from the top navigation bar.
  - Select the health plan.
  - From the *Payer Spaces* homepage, select the **Applications** tab.
  - Select **Precertification Lookup Tool**.

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PA and Notification

You can submit a PA request, look up a status or submit a clinical appeal online. Log in to https://www.availity.com using your Availity credentials.

- From the Availity Portal homepage, select **Patient Registration** from the top navigation bar.
- Select **Authorizations & Referrals**.
- Select **Authorizations**.
- Select the payer and organization.
- Select **Submit**.
  - The Interactive Care Reviewer (ICR) application, our online authorization tool, will open.
  - Use ICR to submit and manage (appeal) your medical PAs.
  - PA fax can be faxed at **1-800-964-3627.**
  - Urgent request can be submitted via ICR or by calling Healthy Blue Provider Services at **1-833-405-9086**.

AIM Specialty Health

AIM Specialty Health®* manages precertification for the following modalities: radiology, cardiology, sleep, musculoskeletal, rehabilitation (physical therapy, occupational therapy, speech therapy), genetic testing and radiation oncology.

- For services that are scheduled to begin on or after January 1, 2021, all providers must contact AIM beginning December 21, 2020, to obtain PA review.

How to place a review request:

- Online via the AIM Provider Portal The provider portal is available 24/7 and processes requests in real-time using clinical criteria. Go to www.providerportal.com to register.
- By phone: Call AIM Specialty Health toll free at **1-855-574-6479**, Monday through Friday, 7 a.m. to 7 p.m. Central time.

Healthy Blue providers will be invited to take advantage of training webinars to learn how to place a review request online via AIM Provider Portal.

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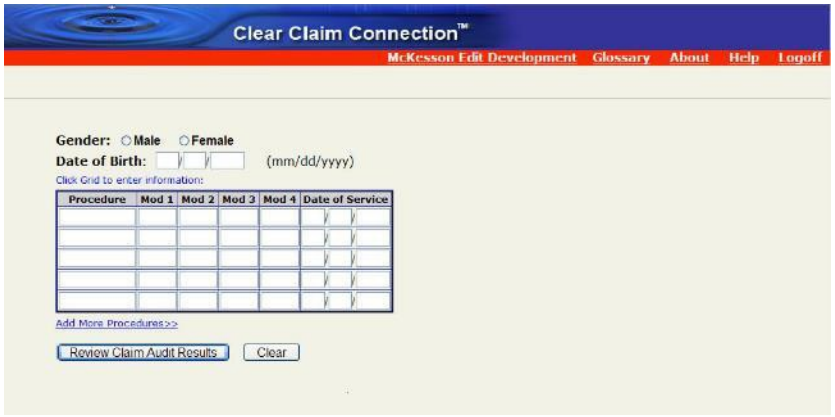
Clear Claim Connection

Use Clear Claim Connection™ for guidance when you submit a claim.

- It is available on the Availity Portal and can help you determine whether procedure codes and modifiers will likely pay for your patient's diagnosis.
- It contains editing features that will determine the validity of items like diagnosis codes or revenue codes. If the codes are not valid, it will produce an edit showing such.



Note: Clear Claim Connection does not guarantee coverage under a member's benefit plan. Member benefit plans vary in coverage, and some plans may not provide coverage for certain services.

Healthy Blue

MO Healthnet Fee Schedule

The MO HealthNet fee schedule is available at the following link:
https://dssapp3.dss.mo.gov/FeeSchedules/maindisclaimer.shtml

- Click on the link for the appropriate category for the CPT code or modifier you want to view the allowed amount or modifier information for.
- Next, click the radio button next to the Proc Code or Modifier and type in the procedure code or modifier.
- The search will show you if the CPT code and/or modifier combination are payable.

Healthy Blue

MO Healthnet Billing Manuals

The MO HealthNet billing manuals are available at the following website address: http://manuals.momed.com/manuals.

Healthy Blue

Cost Avoid Versus Pay and Chase

If there is a third-party payer indicated on the eligibility file for the member, Healthy Blue will cost avoid the claim and require that the provider file the claim first with the primary insurance carrier.

If there is not a third-party payer indicated on the eligibility file for the member, Healthy Blue will pay the claim.

If, after paying a claim, Healthy Blue determines there is a third-party payer, we will seek to recover payment from the primary insurance carrier.

Healthy Blue

Pharmacy

Effective for dates of service on or after July 1, 2020, all medications administered in an outpatient observation setting will be carved-out of Managed Care.

Pharmacy services provided during inpatient stays should be billed to Healthy Blue.

Healthy Blue

Billing Members

Healthy Blue members should not be billed or reported to a collection agency for any **covered services** your office provides.

Missouri *Code of State Regulations Title 13 CSR 70-4.030* states, in part, “When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient’s Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules.”

- If a member receives a bill and contacts our office, a Healthy Blue staff member may contact your office as well to confirm the member will no longer be charged for the service.
- The provider’s office can file a claims dispute or an appeal if the service was paid incorrectly or denied. The provider must submit the claims dispute or appeal within the appropriate time frames.

Healthy Blue

Fraud, Waste and Abuse

CMS defines fraud, waste and abuse as:

- **Fraud:** intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit
- **Waste:** overusing services or other practices that directly or indirectly result in unnecessary costs; generally not considered driven by intentional actions, but from misusing resources
- **Abuse:** when health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

Fraud, Waste and Abuse (cont.)

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 their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting the Healthy Blue provider website at https://provider.healthybluemo.com, and completing the *Report Waste, Fraud and Abuse* form.
- Calling Healthy Blue Provider Services at **1-833-405-9086**.

Healthy Blue

Health Services

Healthy Blue

Avoidable ER Utilization

Inappropriate ER utilization is costly and inefficient. Healthy Blue encourages providers to help reduce avoidable ER utilization by educating their patients on when it is appropriate to go to the ER.

Consider the following:

- During new patient consultations, talk to your new patients about when to use the ER.
- Give them your 24-hour phone number and make sure they know where the nearest urgent care center is located.
- Offer same day appointments and walk-ins, if possible.
- Provide clear instructions on your website for patients who need care outside of office hours. Be sure to list your after-hours phone number, as well as nearby urgent care centers that may provide services, if needed.

Healthy Blue

Avoidable ER Utilization (cont.)

- Offer extended hours (before or after regular work hours) or weekend hours to keep working patients and/or parents out of the ER.
- Use CPT code 99050 for services provided in the office at time other than regularly scheduled office hours or days when the office is closed (for example, holidays, Saturday or Sunday), in addition to your evaluation and management code for additional reimbursement.
- Follow up with your patients that visit the ER for nonemergent conditions to reinforce appropriate use of the ER.
- If you have a patient who is a frequent ER user, please make a referral to our Case Management team.

Healthy Blue

Concurrent Review/Discharge Planning

Concurrent review/discharge planning

- Planning is initiated as soon as Healthy Blue is notified of a member's admission to a hospital, skilled nursing facility or acute rehabilitation facility.

ProgenyHealth*

- ProgenyHealth specializes in neonatal care coordination services for the first year of life. Their neonatologists and pediatricians work with the Healthy Blue clinical team to provide telephonic care coordination for NICU stays. Please continue to contact Healthy Blue for any NICU level of care admissions.

Discharge planning

- Discharge planning begins upon admission and is designed to identify the member's post-hospital needs. The attending physician, hospital discharge planner, PCP, ancillary providers and/or community resources are required to coordinate care and post-discharge services to ensure that the member receives the appropriate level of care. Care managers will be consulted for complex discharges and can assist with ensuring a smooth transition.

Healthy Blue

Care Management Role

All of our members are eligible to be assigned to one of our care managers. Our care managers work directly with our members and establish relationships with our members to manage their care.

Our care managers' role is to assist the member in gaining access to consistent quality care and services including the following essential functions: assessment, planning, coordination, monitoring/evaluation, facilitation and support.

Healthy Blue

Care Management Qualifications

Members may qualify for care management services for the following reasons:

- Complex illnesses that require the coordination of many services
- Had or are going to have a transplant
- High-risk pregnancy
- Children in foster care
- Experienced domestic abuse
- High-risk BH needs
- Major depression
- Asthma
- Multiple chronic illnesses
- Children with special health care needs
- NICU CM performed by ProgenyHealth

Healthy Blue

New Baby, New Life Maternity Program

- We encourage all of our moms-to-be to take part in our New Baby, New Life℠ program, a comprehensive care management and care coordination program offering:
  - Individualized, one-on-one care management support for women at the highest risk.
  - Care coordination for moms who may need a little extra support.
  - Educational materials and information on community resources.
  - Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.
- Healthy Blue requires notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in the online ICR or fax the forms to **1-800-964-3627.**

Healthy Blue

Disease Management/Population Health

Our disease management/population health program provides telephonic coaching and written educational materials to assist members in managing conditions such as asthma, coronary artery disease, congestive heart failure, diabetes, hypertension, smoking cessation, weight management and depression.

Additional services will now include bipolar disorder, chronic obstructive pulmonary disease, HIV/AIDS, schizophrenia and substance use disorder.

Contact the Disease Management department at **1-888-830-4300** (**TTY 711**).

Healthy Blue

Resources

Healthy Blue

Community Resource Link — Addressing Social Determinants of Health (SDoH)

- In 2021, Healthy Blue will introduce a new web-based platform interconnecting our members, providers and community-based organizations:
  - 24/7 SDoH resource platform availability
  - Electronic community resource referrals
  - Universal member screening of SDoH needs using the PRAPARE assessment tool
- Using Z codes, we identify and assess the Member's needs as we connect them to services via Aunt Bertha platform.
- Healthy Blue is broadening our partnership to close social determinant needs, including food, housing, transportation, job training and others

Healthy Blue

Live Health Online (LHO) — introducing telehealth

- In 2021, Healthy Blue will introduce a web- and app-based telehealth platform to compliment the existing services available from our providers.
- LHO will increase access to services for our members, particularly in our rural areas where provider availability and transportation are a challenge.
- LHO will also serve as an access alternative for urgent care and some emergency department visits in access needs areas.
- Healthy Blue is partnering to expand the quality care you provide for your patient's medical and behavioral health needs.

Healthy Blue

Helpful Phone Numbers

Topic	Phone number	Additional information
PA	**1-833-405-9086**	Follow the prompts
Provider Relations	**1-833-405-9086**	Follow the prompts
Member Services	**1-833-388-1407**	Follow the prompts
MTM Transportation Services	**1-800-695-5791**	Contact number for members
24-Hour Nurse Help Line	**1-833-388-1407**	For members' questions
DentaQuest*	**1-800-307-6547**	Provider Services
March Vision Care*	**1-888-493-4070**	Option 2 for members, option 3 for providers
MO HealthNet Eligibility Verification	**1-573-635-8908**	Option 1 (or go to www.eMOMed.com)
ProgenyHealth	**1-888-832-2006**	

Healthy Blue

Your Support System and Staff

As you provide care to our members, we support you through many different departments, including:	Healthy Blue Provider Relations serves the following functions:
• Our Healthy Blue Provider Relations team • Our Healthy Blue Medical Management staff • Specialized teams to help you with your claim questions • Healthy Blue Provider Services	• Provider ongoing education and training • Engaging providers in quality initiatives • Building and maintaining the provider network • Offering support for claims and billing questions and issues
Call Healthy Blue Provider Services for assistance with claim issues, member enrollment and general inquiries at **1-833-405-9086**.	You can always contact your local Healthy Blue Provider Relations representative with any questions you may have.

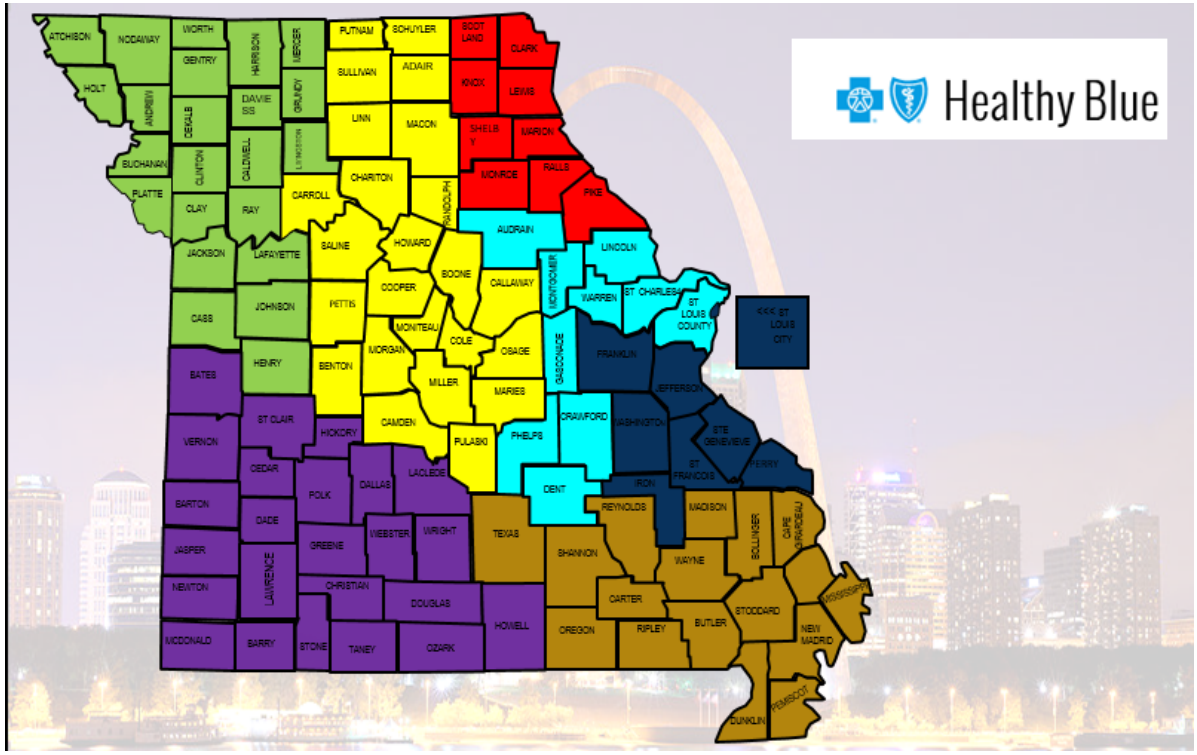
Healthy Blue

Network Relations

Healthy Blue

Network Relations Territory Map

Healthy Blue contracts with providers statewide. Below is a copy of the Provider Relations territory map.



Healthy Blue

Network Relations Contact Details

Name	Phone	Email	Counties	Health systems	Boarder
Ronald Caradine Sr, Network Relations Consultant	**1-314-591-0191**	ronald.caradine@ anthem.com	Scotland, Clark, Knox, Lewis, Shelby, Marion, Monroe, Ralls, Pike	Blessing Health System, Hannibal Regional, Quincy	Illinois
Barbara Wheeler Sr, Network Relations	**1-573-318-1591**	barbara.wheeler@ anthem.com	Statewide Behavioral Health and Alternative Therapies rep	SSM	
Stephanie Thompson Network Relations Consultant	**1-573-225-0986**	stephanie.thompson @anthem.com	Adair, Benton, Boone, Callaway, Camden, Carroll, Chariton, Cole, Cooper, Howard, Linn, Macon, Maries, Miller, Moniteau, Morgan, Osage, Pettis, Putnam, Pulaski, Randolph, Saline, Schuyler, Sullivan	Bothwell Regional, Capital Region, Fitzgibbon Memorial, Lake Regional, University of Missouri	Iowa and Nebraska

Healthy Blue

Network Relations Contact Details (cont.)

Name	Phone	Email	Counties	Health systems	Boarder
Kristin Boyd Network Relations Consultant	**1-314-346-6688**	kristin.boyd@anthem.com	Audrain, Crawford, Dent, Gasconade, Lincoln, Montgomery, Phelps, St. Charles, St. Louis, Warren	Phelps Regional	
Wanda Panick Network Relations Consultant	**1-314-399-0446**	wanda.panick@anthem.com	Franklin, Iron, Jefferson, Perry, St. Francois, Ste. Genevieve, St. Louis City, Washington,	BJC, Washington University, SLU, Mercy East	
Theresa Johnson Network Relations Consultant	**1-816-591-9130**	theresa.johnson@anthem.com	Andrew, Atchison, Buchanan, Caldwell, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Harrison, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Platte, Ray, Worth,	St. Luke's, Truman, Heartland Regional, HCA Midwest Health System	Kansas

Healthy Blue

Network Relations Contact Details (cont.)

Name	Phone	Email	Counties	Health systems	Boarder
Cristy Peck Network Relations Consultant	**1-417-509-1038**	cristy.peck@ anthem.com	Barry, Barton, Bates, Benton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Henry, Hickory, Jasper, Laclede, Lawrence, McDonald, Newton, Ozark, Polk, St. Clair, Stone, Taney, Vernon, Webster, Wright	Cox, Freeman, Mercy, Springfield	Arkansas and Oklahoma
Christa Hudson Network Relations Consultant	**1-573-270-1307**	christa.hudson @anthem.com	Bollinger, Butler, Cape Girardeau, Carter, Dent, Dunklin, Iron, Madison Ste. Genevieve, Howell, Mississippi, New Madrid, Oregon, Pemiscot, Perry, Reynolds, Ripley, Texas, Scott, Shannon, Stoddard, St. Francois, Washington, Wayne,	Saint Francis, Southeast Health, Poplar Bluff Regional, Missouri Delta, Ozarks Medical, Washington County Memorial	Kentucky and Tennessee

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Appendix

Healthy Blue

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

What is CAHPS®?

- Annual survey to assess consumers' experience with their health plan and health care services
- Asks your patient to rate and evaluate their experience with:
  - Their personal doctor.
  - The specialist they see most often.
  - Their health plan.
  - Their health care.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Healthy Blue

CAHPS (cont.)

Why focus on the patient experience?

- There is a strong correlation between patient experience and health care outcomes.
- Patients with chronic conditions demonstrate greater self-management skills and quality of life.
- Patient retention is greater when there is a high-quality relationship with the provider.
- Decreased malpractice risk.
- Efforts to improve patient experience have resulted in decreased employee turnover.

Healthy Blue

CAHPS (cont.)

How to improve the patient experience?

- Ensure all office staff are courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all of their concerns.
- Provide clear explanation of treatments and procedures.
- Obtain and review records from hospitals and other providers.

Additional resource: What Matters Most: Improving the Patient Experience www.patientexptraining.com; for a full CAHPS Overview, visit the Provider Training Academy/Provider Education web page

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Quality

Healthy Blue

2020 Provider Incentive — PCP

PCP Incentive HEDIS Measure	Age	Care Needed	Sample Codes Used	Incentive Amount
Well-Child Visits - 15 Months (6+ visits)	0-15 months	Seen 6+ times on or before their 15-month birthday, which falls in 2020	**CPT Codes:** 99381, 99391, 99461, 99382, 99392 **ICD-10-Dx Codes:** General Exam - Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	**$50**
Well-Child Visits - 3-6 Years Old	3-6 years	Well-child visit with PCP during 2020	**CPT Codes:** 99382, 99392, 99383, 99393 **ICD-10-Dx Codes:** General Exam - Z00.110, Z00.111,Z00.121, Z00.129, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	**$30**
Adolescent Well Care Visits	12-21 years	Well-child visit with PCP or OB/GYN during 2020	**CPT Codes:** 99384, 99394, 99385, 99395 **ICD-10-Dx Codes:** General Exam - Z00.00, Z00.01, Z00.121, Z00.129, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	**$30**
Childhood Immunization Status (Combo 10)	By age 2	4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 or 3 RV, and 2 influenza (flu) vaccines by their second birthday	**DTaP CPT:** 90698, 90700, 90721, 90723 **IPV CPT:** 90698, 90713, 90723 **MMR CPT:** 90707, 90710 **HiB CPT:** 90644-90648, 90698, 90721, 90748 **HepB CPT:** 90723, 90740, 90744, 90747, 90748; HCPC: G0010 **VZV CPT:** 90710, 90716 **PCV CPT:** 90670, HCPC: G0009 **HepA CPT:** 90633 **RV CPT:** 90680 – Three Doses, 90681 – Two Doses **Influenza CPT:** 90655, 90657, 90661, 90662, 90673, 90685-90688, HCPC: G0008	**$50**

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2020 Provider Incentive — PCP (cont.)

Adolescent Immunizations (Combo 1)	By age 13	1 meningococcal and 1 Tdap by their 13th birthday	**Meningococcal CPT:** 90734 **Tdap CPT:** 90715	**$50**
Blood Lead Test	By age 2	At least one capillary or venous lead blood test completed on or before their 2nd birthday	**CPT Code:** 83655	**$50**

Chlamydia Testing	16-24 years	Women who were identified as sexually active and who had at least one chlamydia test in 2020	**CPT Codes:** 87110, 87270, 87320, 87490-87492, 87810	**$40**
Diabetes HbA1c < 8	18-75 years	Members with diabetes (Type 1 and Type 2) whose most recent HbA1C level (performed in 2020) is < 8	**CPT II Code:** 3044F (HbA1C <7.0%)	**$50**

Healthy Blue

2020 Provider Incentive — PCP

Medication Management for People w Asthma **- Med Compliance 75% (12-18 years old)**	12-18 years	Members in 2020 identified as having persistent asthma, were dispensed appropriate medications who remained on an asthma controller medication for at least 75% of treatment period	**FDA-Approved Asthma Medications:** For a complete list of medications and NDC codes, please visit www.ncqa.org	**$50**
Antidepressant Med Management **- Continuation Phase**	18 years and older	Treated with antidepressant medication, had a diagnosis of major depression and who remained on antidepressant medication treatment for at least 180 days (6 months)	For a complete list of medications and NDC codes, please visit www.ncqa.org.	**$15**

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- Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue. AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue. Aunt Bertha is an independent company providing social services on behalf of Healthy Blue.Progeny Health is an independent company providing neonatal care coordination services on behalf of Healthy Blue. DentaQuest is an independent company providing dental benefit management services on behalf of Healthy Blue. March Vision Care is an independent company providing vision services on behalf of Healthy Blue.

https://provider.healthybluemo.com

BMOPEC-0336-20 October 2020