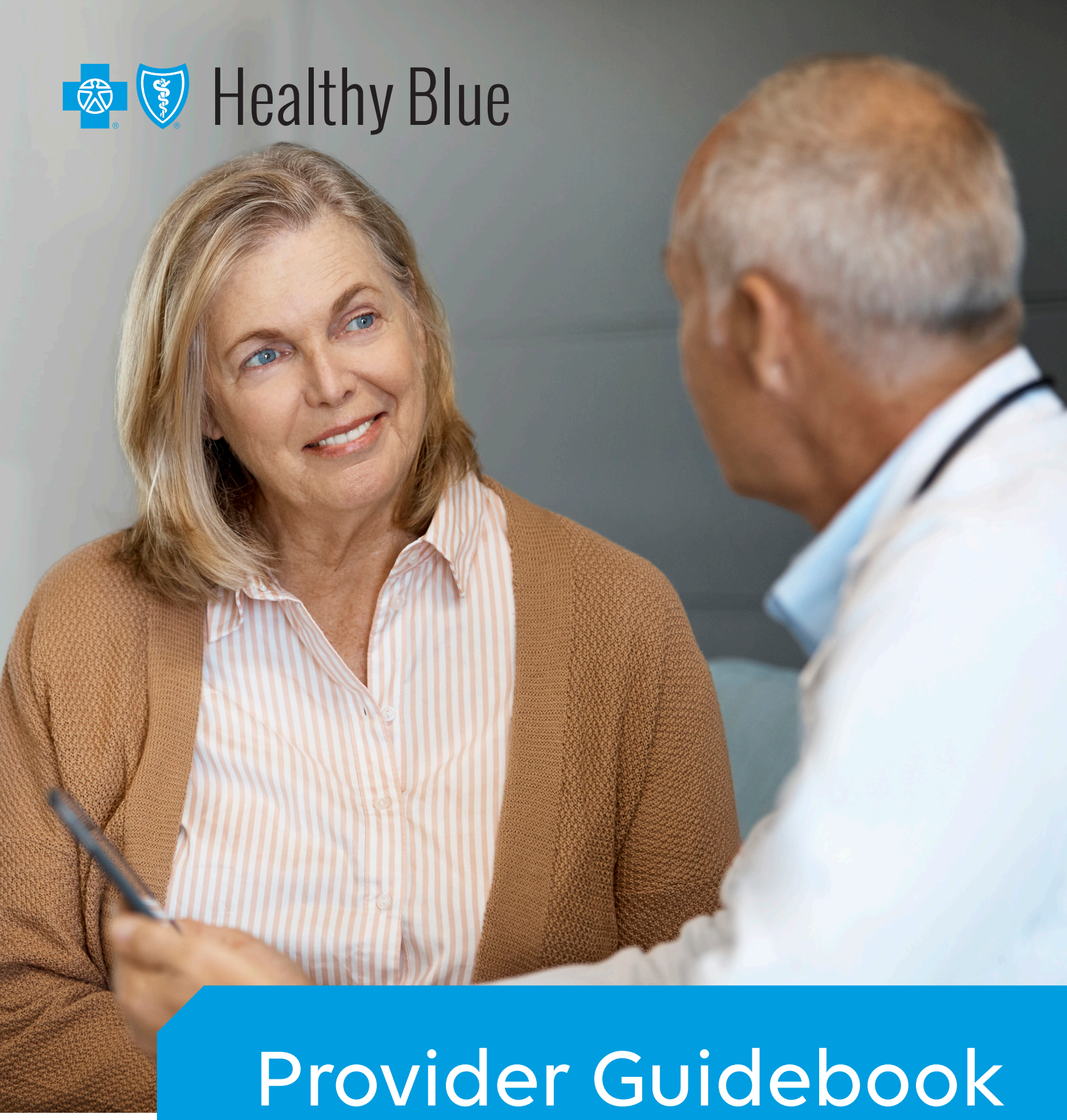
Healthy Blue



Provider Guidebook

April 1, 2026

https://medicareprovider.healthybluemo.com

MO-HB-CR-PM-008697-26-GRP2620

This page is intentionally left blank.

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.
Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

Provider Manual Table of Contents

1 Introduction and Guide to Medicare Advantage ..... - 4 -
1.1 Medicare Program ..... - 4 -
1.2 Part A ..... - 4 -
1.3 Part B ..... - 4 -
1.4 Medicare Advantage Plans ..... - 4 -
1.5 Medicare HMO ..... - 5 -
1.6 Managed Care Plan Enrollment ..... - 5 -
1.7 Medicare Dual Eligible Special Needs Plans ..... - 6 -
1.8 Healthy Blue Individual Medicare Advantage Plans ..... - 6 -
1.9 Effective/Termination Date Coincides with a Hospital Stay ..... - 7 -
1.10 Hospice Election for Medicare Advantage (MA) Members ..... - 7 -
2 Provider Participation in Healthy Blue MA Plans ..... - 9 -
2.1 Participation Procedures for Physicians and Physician Group(s) ..... - 9 -
2.2 Restrictions on AI use in Performing a Health Plan Function ..... - 10 -
2.3 Provider and Facility Digital Guidelines ..... - 10 -
2.4 Submitting Provider demographic data requests and roster submissions through Roster Automation ..... - 16 -
2.5 Terminating Participation with Healthy Blue Medicare Advantage Plans ..... - 17 -
2.6 Termination of a Provider Contract with Cause ..... - 17 -
2.7 Professional and Respectful Communication Standards ..... - 18 -
2.8 Termination of a Provider Contract without Cause ..... - 18 -
2.9 Provider Anti-Discrimination Rules ..... - 18 -
2.10 Compliance with Medicare Laws, Audits, and Record Retention Requirements ..... - 18 -
2.11 Denying claims by excluded and precluded providers ..... - 19 -
2.12 Encounter Data ..... - 19 -
2.13 Encounter Data for Risk Adjustment Purposes ..... - 20 -
2.14 Medical Record Review Process ..... - 22 -
2.15 Federal Funds ..... - 23 -
2.16 Prompt Payment by Medicare Advantage (MA) Organization ..... - 23 -
2.17 Billing Members and Balance Billing ..... - 24 -
2.18 Recoupment/Offset/Adjustment for Erroneous Payments ..... - 26 -
2.19 Use of Healthy Blue Name, Symbols, Service Mark(s) and Trademark(s) Within Communications ..... - 26 -
2.20 Contracted Provider Assistance with Medicare Advantage Material ..... - 27 -
2.21 Delegation ..... - 28 -
2.22 Misrouted Protected Health Information (PHI) ..... - 28 -
3 Credentialing ..... - 28 -
4 Utilization Management Medicare Advantage Plans ..... - 50 -
4.1 Use of *Clinical Guidelines* ..... - 51 -
4.2 Referral Management ..... - 52 -
4.3 Self-Referral Guidelines ..... - 52 -
4.4 Referral Guidelines ..... - 52 -
4.5 Providing Noncovered Services Advanced Notification ..... - 53 -
4.6 Access to Care and Services ..... - 53 -
4.7 Direct Access to Preventive/Routine Gynecological and Mammography Services ..... - 54 -
4.8 Direct Access to Influenza and Pneumococcal Immunizations with no Cost Sharing ..... - 55 -
4.9 Prior Authorization ..... - 55 -
4.10 Availity Authorization Application ..... - 55 -
4.11 How to Request a Prior Authorization ..... - 56 -

4.12 Inpatient Acute Concurrent Review ..... - 57 -
4.13 Skilled Nursing Facility ..... - 57 -
4.14 Home Health Services ..... - 59 -
4.15 Denials ..... - 59 -
4.16 Preservice denials ..... - 62 -
4.17 Special Rules for Emergency and Urgently Needed Services, ... - 62 -
4.18 Case Management ..... - 63 -
4.19 Stars Outbound Call (OBC) Program ..... - 64 -
4.20 Under and Over Utilization ..... - 65 -
4.21 Readmission Review Process Readmission ..... - 65 -
4.22 Model of Care ..... - 66 -
4.23 Healthy Blue Care Transition Protocols and Management ..... - 68 -
5 Healthy Blue Medicare Advantage Provider Payment Disputes, Administrative Pleas, and Standard Appeals ..... - 69 -
5.1 Distinguishing between Provider and Medicare Advantage Member Appeals ..... - 69 -
5.2 Provider Claim Payment Disputes and Administrative Plea Processes ..... - 70 -
5.3 Claim Payment Reconsideration ..... - 71 -
5.4 Claim Payment Appeal ..... - 72 -
5.5 How to submit a Claim Payment Dispute ..... - 73 -
6 Healthy Blue Medicare Advantage Participating Provider Standard Appeals ..... - 75 -
6.1 Participating Provider Standard Appeals ..... - 75 -
6.2 Medicare Participating Provider Standard Appeal ..... - 75 -
7 Healthy Blue Medicare Advantage Non Participating Provider Payment Disputes and Appeals ..... - 76 -
7.1 Nonparticipating Provider Payment Disputes ..... - 76 -
7.2 Nonparticipating Provider Appeals Rights ..... - 76 -
8 Healthy Blue Medicare Member Complaints, Appeals, and Grievances ..... - 77 -
8.1 Distinguishing Between Member Appeals and Member Grievances ..... - 77 -
8.2 Medicare Member Liability Appeals ..... - 77 -
8.3 Participating Provider Responsibilities in the Medicare Member Appeals Process ..... - 77 -
8.4 Further Appeal Rights ..... - 78 -
8.5 Medicare Member Grievances ..... - 79 -
8.6 Resolving Medicare Member Grievances ..... - 80 -
9 Reimbursement Requirements and Policies ..... - 80 -
9.1 Reimbursement Hierarchy ..... - 80 -
9.2 Review Schedules and Updates ..... - 80 -
9.3 Medical Coding ..... - 81 -
9.4 Reimbursement by Code Definition ..... - 81 -
9.5 Healthy Blue Medicare Advantage Coordination of Benefits ..... - 81 -
9.6 Changes to the Healthy Blue Medicare Advantage Rates ..... - 82 -
10 Fraud, Waste, and Abuse Detection ..... - 82 -
10.1 Reporting fraud, waste, and abuse ..... - 82 -
10.2 Investigation process ..... - 83 -
10.3 Prepayment Review ..... - 84 -
10.4 Acting on Investigative Findings ..... - 85 -
10.5 Recoupment/Offset/Adjustment for Erroneous Payments ..... - 85 -

1 Introduction and Guide to Medicare Advantage

1.1 Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care, and other medical services not covered by Part A.

1.2 Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare-eligible member or spouse has paid Medicare taxes for at least 10 years, is age 65, and is a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium-free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80% of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

1.3 Part B

Medicare Part B pays for many medical services and supplies, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services.
- X-rays and laboratory tests.
- Certain ambulance services.
- DME.
- Services of certain specially qualified, nonphysician practitioners.
- Physical and occupational therapy.
- Speech/language pathology services.
- Partial hospitalization (PHP) for behavioral health.
- Intensive Outpatient Services for behavioral health.
- Mammograms and Pap tests.
- Home Health care if a beneficiary does not have Part A.

1.4 Medicare Advantage Plans

The Balanced Budget Act of 1997 (*BBA*) established Medicare Part C, also referred to as Medicare Advantage (MA). Prior to January 1, 1999, Medicare Health Maintenance Organizations (HMOs) existed as Medicare Risk or Medicare Cost plans. The *Balanced Budget Act of 1997* was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

1.5 Medicare HMO

Missouri Care, Inc. contracts with a network of hospitals, skilled nursing facilities, home health agencies, doctors, and other professionals to provide services to our members. Healthy Blue Medicare Advantage HMO members must select a PCP (primary care physician) from those that are part of the plan's network. The PCP is responsible for managing the member's medical care, including admissions to a hospital. The member's PCP is also responsible for referring the member to a specialist. PCPs should refer the member to an in-network specialist and note the referral in the member's chart. PCPs are not required to notify the plan of the referral.

HMO members may have the option to choose a primary care physician (PCP) through a contract PMG (provider medical group) or a PCP directly contracted with Healthy Blue under a fee-for-service agreement:

- Members assigned to a PCP through an Independent Practice Association (IPA) or PMG will have an ID card indicating the PCP name and IPA/Group name. Referrals are coordinated through the PMG.
- Members may select a PCP directly contracted with Healthy Blue. The member ID card will indicate the assigned PCP and will **not** indicate an IPA/PMG. The PCP coordinates referrals utilizing the Healthy Blue Medicare Advantage HMO network. Authorizations are coordinated directly through Healthy Blue.

Medicare HMOs have "lock-in" requirements. This means that in order to access benefits, a member is locked into receiving all covered care from doctors, hospitals, and other health care providers who are contracted with the plan. In most cases, if a member goes outside the plan for services, neither the plan nor Original Medicare will pay. The member will be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which a member may receive anywhere in the world; for urgently needed care, which members may receive while temporarily away from the plan's service area; for out-of-area renal dialysis services; and if the service is prior authorized by the plan. Urgent care is also covered inside the service area if the plan's delivery system is temporarily unavailable or inaccessible. When possible, providers should refer HMO members to providers within the network.

1.6 Managed Care Plan Enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums.
- Live in the plan's service area.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7 each year, with a January 1 plan effective date.

Special Election Period

CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, Medicare beneficiaries who relocate to a different service area can enroll in a different plan that is available in the new location.

Note: Special Needs Plan (SNP) enrollees may change Medicare Advantage plans once per quarter for the first three quarters of the year. The new plan will be effective the first day of the month the following month subject to CMS approval.

1.7 Medicare Dual Eligible Special Needs Plans

Dual Eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs are open to beneficiaries in all Medicaid eligibility categories, including: Qualified Medicare Beneficiary without other Medicaid (QMB only), QMB+, Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only), SLMB+, Qualifying Individual (QI), other full benefit dual eligible (FBDE), and Qualified Disabled and Working Individual (QDWI).

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare zero-cost-sharing D-SNPs
- Medicare non-zero cost-sharing D-SNPs

1.8 Healthy Blue Individual Medicare Advantage Plans

Below is a link to the Medicare Advantage *Summary of Benefits* (*SOB*), *Evidence of Coverage* (*EOC*), and formularies for Individual Medicare Advantage Products. If the product you are searching for is not on the list below, please call the number on the back of the member's ID card for *EOC*, *SOB*, and formulary information **medicareprovider.healthybluemo.com.**

Supplemental Benefits

Our Medicare Advantage plans may include supplemental benefits. Supplemental benefits are items or services that are not covered under Medicare Part A, Part B, or Part D but are covered by the plan in addition to what Medicare covers. Please refer to each plan's benefit materials to locate any supplemental benefit coverage. Most supplemental benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit, or they are considered non-covered benefits.

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly. Providers **not contracted with the vendor network** to render such a benefit will only be reimbursed or able to bill a member for non-covered services if:

- You have provided the member with advanced notice of noncoverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's MA plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. Per the *Medicare Advantage HMO & PPO Provider Guidebook*, CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

1.9 Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, Healthy Blue is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility.)

Healthy Blue is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered by the Medicare Advantage plan beginning on the effective date of enrollment.

If the member's Medicare Advantage coverage terminates while the members is hospitalized, Healthy Blue is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

1.10 Hospice Election for Medicare Advantage (MA) Members

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a Medicare Advantage (MA) member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services rendered during the election period. The Medicare Advantage plan is responsible for supplemental services covered under the member's MA plan and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of Hospice Election. Some members may have hospice coverage through their Medicare Advantage plan. Please verify the member's benefits.

The following are submission guidelines for Hospice claims:

Hospice-related Services

- Submit the claim directly to CMS

Nonhospice-related Services

- For Part A services not related to the member's terminal condition, submit the claim to the Medicare Fiscal Intermediary using the condition code 07.
- For Part B services not related to the member's terminal condition, submit the claim to the Medicare Carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by an attending physician that is not employed or paid by the hospice provider, submit the claim to the Fiscal Intermediary/Medicare Carrier with a "GV" modifier.

Coordination of Member Cost-Share Amount and Supplemental Benefits

- Submit the claim to the Medicare Advantage Plan with the Original Medicare Explanation of Medicare Benefits (EOMB).

Note: The Healthy Blue MA plan will coordinate based on the EOMB in the situation where the MA plan liability if the member cost sharing is less than the MA plan cost-share amount. Please submit the claim with the EOMB for consideration.

For additional detail on hospice coverage and payment guidelines, please refer to *42 CFR 422.320 — Special Rules for Hospice Care. Section (C)* outlines the Medicare payment rules for members who have elected hospice coverage. The M*edicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and beneficiary Protections Sections 10.22 – 10.4* and the *CMS Change Request 8727* dated May 1, 2014, all-outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: **cms.gov**.

Quick reference information	
Eligibility, Claim Status, Secure Messaging, single claim entry, online remittance advice, and commonly used forms	• **Online:** eligibility, claim status, single claim entry, links to secure messaging, commonly used forms, and remit information are all available through Availity Essentials at **Availity.com**. For questions on access and registration, call Availity Client Services at **800-Availity.** Availity Client Services is available Monday through Friday, 8 a.m. to 8 p.m. ET (excluding holidays) to answer your registration questions. • **Phone:** Call the provider service number on the back of the member's ID card
Claims Submission: (Paper)	**Submit Medicare Advantage individual paper claims to:** Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187
Medicare Advantage Participating Provider Appeals and Disputes	Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or *Explanation of Payment* (*EOP*) issued to determine the correct appeals process. **Medicare** Participating Provider Standard Appeal : A formal request for review of a previous Healthy Blue decision where medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered. Medicare Complaints, Appeals & Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040 **Medicare Participating Provider Administrative Pleas**: A formal request for review of a previous Healthy Blue decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter), where services have already been rendered. **and** **Medicare Provider Payment Disputes** A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative

Quick reference information	
	denial, and claims payment determinations have already been rendered. Provider Payment Disputes P.O. Box 105187 Atlanta, GA 30348-5187
EDI (Electronic Data Interchange) Electronic claim files, 835 (electronic remittance advice), batch eligibility and claim status, prior authorization, and medical attachments	• **Availity EDI Gateway:** Location for sending and receiving all EDI transactions • To **register** to become an Availity EDI trading partner, please visit **Availity.com/provider-portal-registration** • If using third party for your EDI transmissions such as a clearinghouse or billing company, please ensure they have connectivity to the Availity EDI Gateway. • For questions on access and registration, call Availity Client Services at **1-800-Availity (1-800-282-4548).** • **Phone:** Call the provider service number on the back of the member's ID card
Availity Training	• Visit the Digital Provider Learning Hub for live and on-demand courses.

2 Provider Participation in Healthy Blue MA Plans

2.1 Participation Procedures for Physicians and Physician Group(s)

The Healthy Blue MA plans must provide for the participation of individual health care professionals through reasonable procedures that include:

a. Written notice of rules of participation
b. Written notice of material changes in participation rules before they become effective
c. Written notice of adverse participation changes, and
d. Process for appealing adverse physician participation decisions

(These requirements also apply to physicians that are part of a subcontracted network.)

Provider agrees that in no event, including but not limited to nonpayment by plan, insolvency of plan or breach of the Agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered individual or persons other than plan acting on their behalf for covered services provided pursuant to the Agreement. This section does not prohibit the collection of supplemental charges or cost shares on plan's behalf made in accordance with the terms of the covered individual's health benefit plan or amounts due for services that have been correctly identified in advance as a non-covered service, subject to medical coverage criteria, with appropriate disclosure to the covered individual of their financial obligation. This advance notice must satisfy the CMS regulations for Medicare Advantage Organizations, which currently requires a provider to provide to covered individuals a coverage determination that includes CMS-mandated appeal rights. Both parties agree that failure to follow the CMS regulations will result in a provider's financial liability.

A provider further agrees that for covered individuals who are dual eligible enrollees for Medicare and Medicaid, that a provider will ensure they will not bill the covered individual for cost sharing that is not

the covered individual's responsibility, and such covered individuals will not be held liable for Medicare Parts A and B cost sharing when the state is liable for the cost sharing. In addition, provider agrees to accept the plan payment as payment in full or by billing the appropriate state source.

CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Providers are encouraged to call the toll-free customer service number with any questions around services that may or may not be covered.

Also see Billing Members and Balance Billing.

2.2 Restrictions on AI use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (e.g., Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement, and the health plan shall provide its written response in accordance with the notice provisions of the provider agreement.

2.3 Provider and Facility Digital Guidelines

Healthy Blue understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms. Healthy Blue expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Healthy Blue. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions, including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider Enrollment and Network Management
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Healthy Blue expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods, such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards
As our Members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Healthy Blue expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response
Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
    - Healthy Blue supports the industry-standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
    - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Healthy Blue has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Healthy Blue supports the industry-standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:

    - Healthy Blue supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation, including medical records via the HL7 payload.
- Availity Essentials:
    - The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Healthy Blue has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre-and post-payment), and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Healthy Blue supports the industry-standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Healthy Blue supports the industry-standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – The Claims & Payments application
    - The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - The Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Healthy Blue that electronic Claim payment disputes are adopted when and where they are integrated.
- Provider desktop integration via B2B APIs:
    - Healthy Blue has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Be certain to include the three-character prefix as part of the Member identification number. The Member's ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming membership and coverage, and key to facilitating prompt payments

Claim attachments
Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Healthy Blue supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation, including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
  - The Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation, including medical records, are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment
Electronic remittance advice
Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Healthy Blue supports the industry-standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll, and manage their ERA preferences through **Availity.com**. Printing and mailing remittances will automatically stop 30 days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two-year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment
Electronic claims payment is a secure and fast way to receive payment by, reducing administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT)**
  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost

payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual.**

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org.**

- **Virtual Credit Card (VCC)**
  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Healthy Blue is shifting some reimbursements to a virtual credit card (VCC). VCC allows Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Healthy Blue may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two options:
- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

  Or
- To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**
  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included, together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Healthy Blue may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.
  To disenroll from ZPN payment, there are two options:
  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    Or
- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

Simplified enrollment process: Providers and Facilities can enroll as a new care provider in our network for professional, ancillary, institutional, and facility provider types through Availity Essentials. **Real-**

Time Tracking: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Contract Changes

Streamlined Contract Change Requests: Providers and Facilities can easily submit certain requests for contract changes through Availity Essentials:

- Amendments requests to add a network or line of business
- Change of Ownership notice
- Contract, line of business, or Network Termination requests
- TIN Change

Real-Time Tracking: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

My Roster:

Providers and Facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to **Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and Facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by clicking **Download Requested Roster**. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and Facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

**See Section 7: Demographic Updates section for more information about Provider Data Management.*

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to **Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests – it is also where providers can upload a roster with

demographic changes. 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, and follow the prompts.

For Provider and Facilities using the roster upload option, additional resources are available:

- **Error Report:**
  - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
  - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed, and the addition, change, or termination will not be updated in our systems
- **Results Report:** When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the *Roster Submission Guide:*** For Provider and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at **Availity.com** > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

2.4 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. *** 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 **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 screenshot 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, Inc., 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.

2.5 Terminating Participation with Healthy Blue Medicare Advantage Plans

In the event a provider wishes to terminate his/her participation in either of the Healthy Blue Medicare Advantage networks or Healthy Blue terminates a provider for reasons other than cause, a mandatory 60-day notification is required for the termination by either party. Please refer to your contract for specific termination requirements.

Any provider requesting termination of his/her participation should send written notification to the Healthy Blue Network Management Department in his/her region. Upon receipt of the termination request, Healthy Blue will notify members according to CMS guidelines, generally 45 calendar days before the termination date for PCPs and behavioral health providers, and 30 calendar days for other providers. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

2.6 Termination of a Provider Contract with Cause

A Medicare Advantage Organization that suspends or terminates an agreement under which the health care professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- Reason for the action
- Standards and the profiling data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable
- Affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage Organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

2.7 Professional and Respectful Communication Standards

Healthy Blue maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the "Agreement") with Healthy Blue outlines your obligations as a participating provider with Healthy Blue regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, etc., are expected to conduct themselves in a professional and respectful manner in all interactions with Healthy Blue members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, Providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, Healthy Blue maintains a zero-tolerance policy for abusive or disruptive behavior, whether physical or verbal, from Providers, or those representing Providers, during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in Healthy Blue's provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

2.8 Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should send a written notification to the Healthy Blue Network Management Department in his/her region. Upon receipt of the termination request, Healthy Blue will notify members according to CMS guidelines, generally 45 calendar days before the termination date for PCPs and behavioral health providers, and 30 calendar days for other providers.

2.9 Provider Anti-Discrimination Rules

Plans are prohibited from discriminating with respect to reimbursement, participation, or indemnification solely on the basis of a provider's licensure or certification as long as the provider is acting within the scope of such licensure or certification. This prohibition does not preclude any of the following:

- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of enrollees; a Medicare Advantage (MA) plan may choose to contract with a doctor of medicine that meets the needs of enrollees and does not need to contract with another practitioner who can provide only a discrete subset of physician services.
- Use of different reimbursement amounts for different specialties or within the same specialty
- Implementation of measures designed to maintain quality and control costs consistent with the MA organization's responsibilities.

2.10 Compliance with Medicare Laws, Audits, and Record Retention Requirements

Medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Medicare Advantage member, Healthy Blue and providers are obligated to abide by all federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions *(422.504[I][4][v])*. First tier and downstream providers must also agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested **and** must maintain records for a minimum of 10 years.

For the purposes specified in this section, providers must agree to make available its premises, physical facilities and equipment, records relating to the MA Organization's members, including access to provider's computer and electronic system, and any additional relevant information that CMS may require.

Providers acknowledge that failure to allow the Department of Health and Human Services, the Comptroller General, or their designees the right to timely access as addressed in this section may result in a $15,000 noncompliance penalty.

2.11 Denying claims by excluded and precluded providers

Healthy Blue monitors appropriate sanction resource lists to identify providers for whom claims should be denied for its Medicare businesses. For pharmacy providers, the PBM shall be primarily responsible for reviewing the OIG and General Services Administration (GSA) sanction lists in their entirety to ensure no excluded providers are in the pharmacy network. Monthly updates to the sanctions lists are monitored to ensure pharmacies new to the list are not included in the network. For medical providers, Healthy Blue Medicare Claims monitors the OIG website on a monthly basis to identify sanctioned providers both to prevent payment for medical claims to ineligible providers, and to support correct claim determination, complying with Medicare regulations. Further, Healthy Blue Provider Data Management monitors the CMS website on a monthly basis to identify precluded providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries, both to prevent payment and to support correct claims determination complying with Medicare regulations.

2.12 Encounter Data

Medicare Advantage Organizations must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Facilities and providers who render services to Healthy Blue members are required to submit complete claim and encounter data to Healthy Blue. In addition, providers have contractually agreed to submit diagnosis code data that is accurate, complete, and truthful (based on their best knowledge, information, and belief). Data should be submitted through a compliant, electronic 837 submission or on a CMS-1500/UB-04 form, unless other arrangements are approved by Healthy Blue. Claim/Encounter submissions should follow industry standards as well as comply with all Healthy Blue and CMS requirements.

Electronic 837 industry standards are developed and maintained by the American National Standards Institute and the X12 organization. More information on formatting and compliant submission can be found here: **x12.org/**

Claim and Encounter data submissions are used in a variety of ways, including collecting data related to Healthcare Effectiveness Data and Information Set (HEDIS®) measures and calculating risk adjustment. Risk adjustment was implemented by CMS to pay Medicare Advantage Organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. The Medicare Advantage Organization is required to submit diagnosis information collected from encounter and claim data to CMS for the purposes of risk adjustment.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2.13 Encounter Data for Risk Adjustment Purposes

Risk Adjustment and Data Submission

Risk adjustment is the process used by CMS to adjust the payment made to the Medicare Advantage Organization based on the health status of the Medicare Advantage Organization's Medicare Advantage members. Risk adjustment was implemented to pay Medicare Advantage Plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. As an MA organization, diagnosis data collected from encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Medicare Advantage Organizations submit "all ICD-10 codes for each beneficiary", Healthy Blue also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the Medicare Advantage Organization is permitted to submit diagnosis data from an allowable service, including inpatient services, outpatient services, and professional services, delivered via face-to-face encounter between an acceptable risk adjustment provider type and physician specialty.

Supplemental Data

Healthy Blue Health plans offer provider groups the opportunity to submit supplemental data for submission to CMS to support the collection and submission of complete and accurate diagnosis code data.

Medicare Advantage risk adjustment supplemental files are intended to:

- Allow for submission of additional diagnosis code data to support previously submitted claims; and
- Enhance and/or correct diagnostic information for previously submitted medical claim records.

As a reminder, Supplemental data files are not intended to be the sole source of encounter data or to be used as an alternative to standard claim submission:

- Diagnosis code data must be supported by medical record documentation; and
- Diagnosis code data submitted via supplemental data file should be associated with a claim or encounter for services

CMS Medicare Risk Adjustment Data Validation Audits

As part of the risk adjustment process, CMS performs two different types of validation audits: Contract-Specific RADV and Part C Improper Payment Measure (IPM) Audits. Both audits are used to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a Contract-Specific RADV and/or Part C IPM Audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records for the diagnosis codes included in the audit sample. The medical records will be used by CMS to assess if the diagnosis data is supported by the medical record, an important CMS requirement.

More information related to risk adjustment can be found at **cms.gov**.

Other Risk Adjustment Documentation Reviews and Audits
Providers may be required to submit medical records to Healthy Blue for purposes of provider documentation and coding reviews and/or audits. Healthy Blue may also engage with providers regarding education and/or remediation to support submission of diagnosis code data that is truthful, accurate, and complete based on best knowledge, information, and belief. Based on the outcome of such documentation and coding reviews and/or audits, providers will be asked and are expected to participate in education and/or remediation.

Medicare Risk Adjustment Provider Education
Healthy Blue maintains a library of provider education and training regarding, for example, condition-specific information, Medicare Risk Adjustment (MRA) basics, MRA-related obligations, and medical record documentation and diagnosis coding guidance. Providers are encouraged to explore **medicareprovider.healthybluemo.com** and access available trainings. Providers should make their best effort to participate in live (in-person or virtual) and/or on-demand training and education opportunities when offered.

ICD-10-CM Codes
CMS requires that ICD-10-CM Codes (ICD-10 Codes) be used to report conditions. In all cases, the provider should fully document all conditions, including those that coexist, at the time of the encounter to the highest level of specificity. These should be coded using current coding guidelines to the highest level of specificity supported by the medical documentation.

Medical Record Documentation Requirements (Risk Adjustment)
Each diagnosis captured in a patient's medical record is the responsibility of the treating provider; Providers should maintain accurate and complete medical records supporting diagnosis data. A diagnosis documented in a medical record must be based on a face-to-face encounter with patient and an acceptable provider type. ICD-10 codes are then assigned based on medical record documentation and submitted to the Medicare Advantage Organization (MAO) before the MAO submits diagnosis code data to CMS. CMS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of the record.
- The date of service should be clearly documented for each encounter.
- All conditions impacting the patient's care/health, including coexisting conditions, should be documented, capturing the patient's true health status.
- Details based on the provider's independent clinical judgment to code to the highest level of specificity.
- Patient's condition(s) should be clearly documented in the record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed, or treated (MEAT).
- The documentation describing the condition and MEAT must be legible.
- The documentation must be clear, concise, complete, and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Provider's signature, credentials, and date must appear on record and must be legible.

2.14 Medical Record Review Process

Healthy Blue has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. Healthy Blue performs medical record reviews to assess network PCPs in relation to current medical record standards. Healthy Blue recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires practitioners to comply with the plans' standards for medical record documentation.

Medical record audits/reviews are performed annually on a sample of randomly chosen PCPs contracted for the plans' managed care products for Medicare Advantage networks. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics, and obstetrics/gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process. See "Medical Record Criteria" listed below.

Medical Record Criteria

The medical record will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.
2. Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
4. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
6. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
7. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or noncompliance to care plan).
8. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other, non-MA members.)
9. Continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.
10. Age-appropriate routine preventive services/risk screenings are consistently noted (in other words, childhood immunizations, adult immunizations, mammograms, Pap tests, etc.) or the refusal by the patient, parent, or legal guardian of such screenings/immunizations in the medical record.

Federal regulations require Medicare MCOs and their agents review medical records in an effort to avoid over or under payment and verify medical record documentation support for diagnostic conditions. Additionally, the vice president or local health plan leadership for quality management and the Quality

Management Committee conduct medical record audits periodically and use the results in the provider recredentialing process.

Healthy Blue may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under 45 CFR § 164.502 (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the *general consent* of the member. A general consent form should be an integral part of your medical record file.

2.15 Federal Funds

Healthy Blue has a contract with CMS to perform activities as a Medicare Advantage Organization. In performing its duties as a Medicare Advantage Organization, Healthy Blue receives federal payments and, as such, Healthy Blue agrees to comply, and must ensure that all related entities, contractors, and subcontractors paid by Healthy Blue to fulfill the Healthy Blue obligations under its Medicare Advantage contract with CMS agree to comply, with all federal laws applicable to those entities receiving federal funds. The payments you receive from Healthy Blue under this agreement for services rendered to the Healthy Blue Medicare Advantage covered individuals are, in whole or in part, from federal funds. Thus, you, as a recipient of said federal funds, agree to comply with the following:

-
- Title VI of the *Civil Rights Act of 1964* as implemented by 45 CFR part 80
- The *Age Discrimination Act of 1975* as implemented by 45 CFR part 91
- *The Americans with Disabilities Act*
- *Rehabilitation Act of 1973* as implemented by 45 CFR part 84
- *Lobbying restrictions* as implemented by 45 CFR part 93 and USC 1352
- Title IX of the *Education Amendments of 1972*, as amended (20 U.S.C. sections 1681, 1685-1686, and 1783). Other laws applicable to recipients to federal funds, and
- All other applicable laws and rules.

2.16 Prompt Payment by Medicare Advantage (MA) Organization

Receipt of claims by noncontracted providers will be considered a “clean claim” if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The MA organization is bound to adhere to the following prompt payment provisions for noncontracted providers:

- Pay 95% of clean claims within 30 days of receipt
- Pay interest on clean claims not paid within 30 days
- All other claims must be approved or denied within 60 calendar days from date of receipt

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider. Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended, and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified time frame, the claim will be closed, and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a physician or other practitioner who has opted out of the Medicare program by filing with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at **cms.gov**. You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

If you are a contracting provider, please refer to you contract for the prompt payment terms applicable to you.

2.17 Billing Members and Balance Billing

Cost-Sharing

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost sharing. Providers who are permitted to balance bill must obtain this balance billing from the Medicare Advantage Organization (MAO). Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Cost-Sharing Responsibility for Special Needs Plan Members

Members who are dually eligible for Medicare and for full Medicaid coverage of their Medicare Part A and Part B premiums and other cost sharing (such as deductibles, coinsurance, and copayments) through a Medicare Savings Program are protected from liability for payment of Medicare premiums, deductible, coinsurance, and copayment amounts. Some Medicare Savings Programs cover some but not all of these premium and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly, and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Healthy Blue processes the claim for reimbursement when Healthy Blue has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Healthy Blue does not have an arrangement with the state Medicaid agency. In states where Healthy Blue pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Healthy Blue does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Healthy Blue. Please check your *EOP* upon claims adjudication.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS-5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of the MA plan, noncontracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider
The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
    - The copay amount, if the MAO uses a copay for its cost-sharing; or
    - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in the "*MA Payment Guide for Out of Network Payments*," at **cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid Coverage for Special Needs Plan Members
Healthy Blue D-SNP (Dual Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services

Recovery Look-Back Period
To align with CMS guidelines, 42 CFR § 405.980, 405.986, Healthy Blue recovers Medicare Advantage claim overpayments within four years of the claim payment date. In addition, CMS' Medicare Integrity Program employs Recovery Audit Contractors to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

2.18 Recoupment/Offset/Adjustment for Erroneous Payments

Healthy Blue shall be entitled to recoup, offset, and adjust an amount equal to any Erroneous Payments (including but not limited to, any improper payment, duplicate payment, or overpayment) made by Healthy Blue to Provider against any payments due and payable by Healthy Blue to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all Erroneous Payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Healthy Blue that any Erroneous Payment is due from Provider, Provider must refund the amount to Healthy Blue within sixty (60) days of when Healthy Blue notifies Provider. If such reimbursement is not received by Healthy Blue within the sixty (60) days following the date of such notice, Healthy Blue shall be entitled to offset such Erroneous Payment against any payments due and payable by Healthy Blue to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, *including the Payment in Full and Hold Harmless section of the Provider Agreement.* Should Provider disagree with any determination by Plan that Provider has received an Erroneous Payment, Provider shall have the right to appeal such determination under Healthy Blue's procedures set forth in the provider manual(s), and such appeal shall not suspend Healthy Blue's right to recoup the Erroneous Payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Healthy Blue reserves the right to employ a third party collection agency in the event of non-payment.

2.19 Use of Healthy Blue Name, Symbols, Service Mark(s) and Trademark(s) Within Communications

Healthy Blue welcomes you to use our name, symbols, service mark(s), and trademark(s) along with other information, such as how a person may contact us, when you send out communications to your patients. In order to use the Healthy Blue name, symbols, service mark(s), and trademark(s) within a communication, a provider must first obtain permission from Healthy Blue as noted within your provider contract. Our provider contracts stipulate that any printed materials, including but not limited to letters to plan-covered persons, brochures, advertisements, telemarketing scripts, packaging prepared or produced by a provider or any of his/her/its subcontractors pursuant to the *Provider Agreement* must be submitted to the plan to assure compliance with federal, state, and Blue Cross/Blue Shield Association guidelines. Healthy Blue agrees its approval will not be unreasonably withheld or delayed. In order to make this easier on you, the provider, we have simplified the submission of the document(s) to Healthy Blue for review.

To submit a document for review, please send the copy to your local Provider Relations Consultant. Once the copy is submitted, it will be the responsibility of your local Provider Relations Consultant to ensure that the internal Healthy Blue legal review is completed in a timely manner. Although the Healthy Blue legal team will be reviewing the copy, it is your responsibility to comply, and to require any of your subcontractors to comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under the *Provider Agreement*, including but not limited to, the *National Marketing Guide* for Medicare Managed Care Plans, and any requirements for CMS prior approval of materials. We again welcome you to use our name, symbols, service mark(s), and trademark(s) when you send out communications to your patients in an effort to provide information to your patients.

2.20 Contracted Provider Assistance with Medicare Advantage Material

As part of the Healthy Blue goal to improve the health of the senior community, we are committed to providing them with the facts about our Medicare Advantage health care plans that help seniors make more informed decisions about their health care and coverage needs. To assist with meeting the goal to keep Medicare beneficiaries more informed, we need your help. Healthy Blue would like to make Medicare Advantage materials available to beneficiaries through our contracted providers. We are asking your permission to display Medicare Advantage materials in your offices. Our sales representatives will be contacting you and other contracted providers to work with Healthy Blue to provide this information to beneficiaries.

Your participation with this request is strictly voluntary; however, as with all provider-based activities, CMS has certain requirements for both the Medicare Advantage sponsor of these materials and the contracted providers (and any subcontractors, including providers or agents) who display the materials in their offices.

CMS Guidelines

Providers contracted with Medicare Advantage (and their contractors) are permitted to:

- Provide the names of Medicare Advantage sponsors with which they contract and/or participate to beneficiaries.
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials; rather, if providers agree to make available and/or distribute plan marketing materials for some of their contracted plans, providers should do so knowing they must accept future requests from other plans with which they participate.

To that end, providers are permitted to:

Provide objective information on Medicare Advantage sponsors' specific plan formularies, based on a particular patient's medications and health care needs.

- Provide objective information regarding Medicare Advantage sponsors, including information such as covered benefits, cost sharing, and utilization management tools.
- Make available and/or distribute plan marketing materials, including Prescription drug plan (PDP) enrollment applications, but not Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD enrollment applications, for all plans with which the provider participates.
- To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
- Refer their patients to other sources of information, such as State Health Insurance Plan SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at **medicare.gov,** or **1-800-MEDICARE (1-800-633-4277**).
- Print out and share information with patients from CMS' website.
- **Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all.**

The *Medicare & You Handbook* or Medicare Options Compare (from **medicare.gov**) may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously

approved by CMS. These materials may be distributed by Medicare Advantage sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Medicare Advantage sponsors should advise contracted providers of the provision, based on a particular patient's medications and health care needs.

2.21 Delegation

Delegated Activities

If Healthy Blue has delegated activities to the provider, then Healthy Blue will provide the following information to the provider, and the provider shall provide such information to any of its subcontracted entities:

- A list of delegated activities and reporting responsibilities;
- Arrangements for the revocation of delegated activities;
- Notification that the performance of the contracted and subcontracted entities will be monitored by the plan
- Notification that the credentialing process must be approved and monitored by the plan; and
- Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations, and CMS instructions.

Delegation of Provider Selection

In addition to the responsibilities as set forth above, to the extent that the plan has delegated selection of the providers, contractors, or subcontractor to the provider, the plan retains the right to approve, suspend, or terminate any such arrangement.

2.22 Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from Healthy Blue to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report receipt of misrouted PHI.

3 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:

- Individual or group practices
- Locum tenens:
    - Provisional Credentialing is required if these practitioners work less than 60 calendar days.
    - Full Credentialing is required if these practitioners work 60 calendar days or more.
    - Covering practitioners (e.g., locum tenens) who do not have an independent relationship with the Company are not included in the Credentialing scope.
- Facilities
- 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
- Telemedicine
- PPO network:
    - If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network when they are outside the network, NCQA considers this to be an
    - independent relationship if:
        - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), ***or***
        - There are incentives for members to see the PPO's practitioners.
        - In this type of contractual arrangement, the organization must credential the
        - practitioners or delegate credentialing to the PPO network.

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
- Durable Medical Equipment Providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process as directed by CMS, 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)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC), or The National Examining Board of Ocularists (NEBO))

CREDENTIALS COMMITTEE

The decision to accept, retain, deny, or terminate a practitioner's or HDO's participation in 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 a 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 a Healthy Blue medical director designee, and the vice-chair must be a lead medical officer or a 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 they have 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 programs or provider network(s) 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. Healthy Blue is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, Healthy Blue does not use such reports to discriminate against a practitioner, and the application includes a statement indicating the provision of such information is optional. 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. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Healthy Blue will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. In addition, annually, audits of practitioner complaints about credentialing shall be reviewed for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, Healthy Blue will take appropriate action(s) 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 website at www.CAQH.org.

Healthy Blue will verify those elements related to an applicant's 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 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation including work history verification must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

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.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ, or ACHC 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 the 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, exclusions, or limitations
Medicare, Medicaid, or FEHBP sanctions and exclusions
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 and exclusions

RE-CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions and exclusions, 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 monthly or 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 and State 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 a 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:

1. Must not be currently federally sanctioned, debarred, or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where they provide services to Members;
3. 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 they 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
4. 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:

A. 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.

B. 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.

C. 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.

D. 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.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), an Accreditation Commission

for Health Care (ACHC) 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.

F. 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.

G. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and coursework accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND accredited supervised practice program at a healthcare facility, community agency, or food services corporation, or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

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 or exclusion and no history of federal sanctions or exclusions (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 they 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 voluntarily have no DEA/CDS registration, the exception listed below may apply or if the applicant can provide evidence that they 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 a 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 based on state licensing regulations:
    a. Master or doctoral degree in social work.
    b. If a master's level degree does not meet the criteria and the practitioner obtained a 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 based on state licensing regulations:
    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.

5. 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.

6. 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.

7. 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.

      i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

      ii. Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements, and Verification – Nurse Practitioners:
   i. 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.
   ii. 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. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with policy.
   iii. 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.
   iv. 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.
   v. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:

a. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
b. American Academy of Nurse Practitioners – Certification Program;
c. National Certification Corporation;
d. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
e. 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. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

1. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC 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.

9. 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 via primary source verification of the license, provided that the state licensing agency performs verification of 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 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:
      i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or

ii. The American Midwifery Certification Board, previously known as the American College of Nurse-Midwives.

This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC 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.

i. 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.

10. 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. 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, DNV NIAHO, or ACHC 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.

11. Process, Requirements, and Verifications – Acupuncturists (non MD/DO):

a. The provider 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 an Acupuncturist, and all Acupuncturists applicants must have a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM).

c. 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.

d. The license status must be that of an Acupuncturist 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.

e. The provider applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. Acupuncturists 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, recredentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.

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 or exclusion and no new (since prior credentialing review) history of federal sanctions or exclusions (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 a site survey performed by a designated independent external entity within the past 36 months. If an 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.

1. General Criteria for HDOs:

    1. 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.
    2. Valid and current Medicare certification.
    3. 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.
    4. Liability insurance acceptable to Healthy Blue.
    5. 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.

2. 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, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, 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
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
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, ACHC, 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, ACHC, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

4 Utilization Management Medicare Advantage Plans

Components of utilization management for Healthy Blue Medicare Advantage plans:

- Application of Clinical Criteria Guidelines
- Referral management
- Referring out-of-network
- Providing *Integrated Denial Notice (IDN)*
- Prior Authorization
- Concurrent review
- Denials
- Emergency care/urgent care
- Case management
- Under and over utilization

Application of Clinical Criteria Guidelines
Healthy Blue uses Medicare Coverage Guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the criteria. Medical necessity decision-making includes assessing the needs of the individual patient and characteristics of the local delivery system.

Healthy Blue uses the following utilization management criteria for their MA plans:

- **Medicare Coverage Directives** are the primary criteria used in making decisions regarding coverage for the Healthy Blue Medicare Advantage plans. Medicare Advantage plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers. Medicare Coverage Directives include CMS National and Local Coverage Determinations or other Medicare guidance, including Medicare Policy Benefit Manuals, Medicare Managed Care Manuals, Medicare Claims Processing Manuals, and Medicare Learning Network, etc.
- **Healthy Blue Medical Policy** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request or at ***Medical Policies*** **and** ***Clinical UM Guidelines***.
- **Medically Necessary (or Medical Necessity)** means services, treatments, diagnostic procedures, or supplies provided to members that are medically required and appropriate to diagnose and/or treat a member's physical or mental condition. Also, such services, treatments, diagnostic procedures, or supplies must: 1) meet widely accepted evidence-based criteria and professionally recognized standards of health care; 2) not be used primarily for the comfort or convenience of the member, the member's family or caregiver, or the member's treating physician; 3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis and/or treatment of the member's physical or mental condition; and 4) not be provided to the member as an inpatient when the services or supplies could be safely and appropriately provided to the member in an outpatient setting.

Guidelines are also developed for disease management and preventive services. These guidelines are available upon request or at **https://medicareprovider.healthybluemo.com/missouri-provider/** within the MA Product pages under *Additional Information.*

4.1 Use of *Clinical Guidelines*

Application of criteria must be reviewed in the context of the individual member and consider age, co-morbidities, extenuating circumstances and/or complications, response to treatment, psychosocial issues, support network, and home environment. In the application of decision criteria for specific consumers, relevant characteristics of the local delivery system are considered, including, but not limited to, the availability of certain types of facilities or services within the service area and the capability of facilities or other providers to offer needed services.

The hierarchy for UM criteria application will be applied to all medically necessary determinations for coverage for services provided to members eligible for benefits under Medicare Advantage products. CMS national and local coverage guidelines are referenced first for all medically necessary reviews.

If there is no guidance or criteria available in CMS, the Healthy Blue Corporate *Medical Policies* followed by evidence-based guidelines, such as MCG Guidelines criteria, Compendia, NCCN (*National Comprehensive Cancer Network Clinical Practice Guidelines*) may be used.

Healthy Blue Corporate Medical Policy
Healthy Blue decision criteria incorporate nationally recognized standards of care and practice, current professional literature, and cumulative professional expertise and experience. The decision criteria used by senior business clinical reviewers are evidence-based and consensus-driven. Criteria are updated as standards of practice or technology change. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the review criteria. An annual review and approval is performed by the Medical Policy and Technology Assessment Committee (MPTAC) or, when applicable for certain specialty areas, another national clinical committee that utilizes comparable procedures for development of decision criteria. The criteria are reviewed annually for approval and adoption by the Healthy Blue-affiliated companies.

4.2 Referral Management

HMO members are required to select a PCP who serves as the coordinator of care to ensure access to appropriate medically necessary specialty care. When referring a member to a specialist, selecting a participating provider within our Medicare network will maximize the member's benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services, or if you believe you must refer to a provider outside of our network, you must contact Healthy Blue in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories; however, it does not include urgent, emergent, or out-of-area renal dialysis services.

4.3 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening, and preventive women’s health services, such as Pap tests)
- Case Management

Healthy Blue Medicare Advantage HMO members must obtain all routine services within the Healthy Blue provider network, unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan.

4.4 Referral Guidelines

HMO PCPs may only refer members to Healthy Blue Medicare contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member’s ongoing primary care relationship. If a member does not have out-of-network benefits, has expressed a desire to receive care from a different specialist, or you believe the required specialty is not available within the contracted network, contact Healthy Blue directly for prior authorization. Referring a Medicare member out-of-network who does not have the benefit will result in the claim being denied with member liability unless urgent, emergent, out-of-area renal dialysis, or if prior authorization was received by the plan. Contact Healthy Blue directly for prior authorization.

4.5 Providing Noncovered Services Advanced Notification

For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that Healthy Blue authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Healthy Blue authorization protocols, Healthy Blue may decline to pay the claim, in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS issued guidance concerning the Advanced Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-for-Service document and cannot be used for Medicare Advantage denials or notifications. Per the ***CMS Medicare Claims Processing Manual*** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If you have any doubt about whether a service is not covered, please seek a coverage determination from the plan.

4.6 Access to Care and Services

Healthy Blue may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability, except as it relates to end-stage renal disease. The Healthy Blue MA Plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare. The Medicare Advantage Organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24/7.

Healthy Blue has established performance measures to assist in developing and maintaining adequate providers and practitioners in all our Medicare Advantage networks. Performance is monitored at least annually, and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for Healthy Blue HMO members when providers and practitioners are not available or accessible in the members' geographic locations. There are also instances where an in-network provider is not available for members in our Local and Regional PPOs. In those instances, the in-network provider should collaborate with our utilization management area to obtain authorization for out of network services. In certain circumstances, the member may only be responsible for the in-network cost sharing.

Providers and suppliers must be located throughout the service area. Services are generally considered accessible if they reflect usual practice and travel patterns in the local area. Generally, hospital and PCP services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care services exceed 30 minutes, as in some rural areas.

Appointment access standards for primary care services are:

Service	Access Requirement
Emergency	Immediate 24 hours a day/seven days a week access available — for emergent diagnoses. Behavioral health providers must be available to assess a patient experiencing an emergent situation within 6 hours.
Urgent	Within 48 hours — including behavioral health urgent services.
Routine	Within 10 business days — including behavioral health routine services.

Organizations and providers who contract with the Healthy Blue MA network are required to establish and implement appropriate treatment plans for a member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty providers. Treatment plans must be time-specific and updated by the PCP.

The Healthy Blue medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a referral to another participating provider of that like specialty.

Plans may select the providers through whom services are provided as long as:

- The plan makes services available and accessible within the service area with reasonable promptness and in a manner that assures continuity.
- The plan provides access to appropriate providers, including credentialed specialists, for medically necessary care. and if a network provider is unavailable or inaccessible, the MA organization must arrange for services outside of the network.
- Coverage is provided for emergency services without regard to prior authorization or whether the provider was a participating provider.
- The plan maintains and monitors a network of appropriate providers.
- The plan gives women enrollees direct access to women's health specialists within the network for women's routine and preventive health care services.
- The plan establishes written standards for timeliness of access to care and customer service that meet or exceed standards established by CMS and continuously monitors to assure continuous compliance with standards.
- The plan ensures services are provided in a culturally competent manner.
- The plan ensures services are available 24/7 when medically necessary.
- The MA organization ensures continuity of care and integration of services and makes a "best effort" attempt to conduct an initial assessment of an enrollee's health care needs within 90 days of enrollment.

** Not all contracting providers have to be located within the service area, but CMS must determine that all services covered under the plan are accessible from the service area.*

4.7 Direct Access to Preventive/Routine Gynecological and Mammography Services

Women enrollees may choose direct access to a women's health specialist within the network for routine and preventive health care services provided under the plan as basic benefits. These services include annual Pap testing and mammography exams. No referrals are required for routine gynecological exams

or mammography services provided by a network provider for the Medicare HMO. Please refer to the most recent Medicare Advantage provider directory for the Mammography Center and OB/GYN specialty provider listings. Our provider directories are also available online at **medicareprovider.healthybluemo.com**.

4.8 Direct Access to Influenza and Pneumococcal Immunizations with no Cost Sharing

Healthy Blue strongly encourages all members to receive influenza and pneumococcal immunizations. No referral or copay for the immunization is required.

4.9 Prior Authorization

Healthy Blue must be notified as early as possible before all planned inpatient admissions and no later than one business day after an unplanned inpatient admission. For services including but not limited to: selected diagnostic, outpatient, and inpatient procedures, prior authorization must be requested at a minimum of 72 hours in advance. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results, medical records, and attempts at conservative treatment (when appropriate) in order to complete the prior authorization process.

Providers are required to provide notification in advance of services to allow Healthy Blue to meet CMS processing timeframes:
Medical:

- Standard — 07 calendar days
- Expedited — 72 hours

Pharmacy (Including Part B Medical injectables)

- Standard — 72 hours
- Expedited — 24 hours

Note: Healthy Blue requires notification within one business day for all ER admissions.

CMS defines an expedited/urgent request as a request in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

4.10 Availity Authorization Application

Availity is the preferred method for the submission of preauthorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical services. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent.

- Initiate preauthorization requests online, eliminating the need to call or fax. Availity allows detailed text, photo images, and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests using digital tools.
- Instant accessibility from almost anywhere, including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates, including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access under *Authorizations and Referrals* via Availity Essentials (**Availity.com**).

For an optimal experience, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox, or Safari. The Availity authorization tool is not currently available for the following:

- Transplant services.
- Services administered by vendors such as Carelon Medical Benefits Management, Inc. (For these requests, follow the same prior authorization process you use today.)

Our website will be updated as additional functionality and lines of business are added throughout the year.

A Healthy Blue Medical Management Clinician will review each request for admission, procedures or services. If evidence-based criteria are met, the review clinician will document clinical data and authorize the requested service. Approval letters are mailed to the member, **requesting provider, and servicing provider within one business day of the decision.** If the review nurse determines that the criteria are not met or that there is insufficient information to complete a review, the request for service is referred to a medical director for review. Only physicians or other appropriate healthcare professionals, as defined by CMS, are able to render medical necessity denials. If a denial is issued, the notification includes: (1) the reason, citing clinical criteria or benefit provisions; (2) an opportunity for an informational peer-to-peer discussion that will not alter the decision; and (3) appeal process details.

Appropriately licensed and trained professionals make UM decisions according to established criteria. Nonclinical associates, under the supervision of a licensed professional, may collect nonclinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Again, only physicians or other appropriate healthcare professionals, as defined by CMS, are able to render denials. Practitioners from appropriate specialty areas are used as needed for medical necessity reviews and appeals.

Please contact your local provider relations department to obtain the most current copy of the MA prior authorization list.

4.11 How to Request a Prior Authorization

Failure to request a prior authorization for an admission or provide notice of emergent inpatient admission will result in an administrative denial. Notify Healthy Blue as early as possible before a planned admission and no later than one business day after an unplanned inpatient admission.

If the required prior authorization is not obtained within the specified time frame, the claim will be administratively denied due to failure to notify Healthy Blue of the admission. The provider will not receive payment for the service. Providers cannot bill the member for these denied services.

If you do not notify us within the required time frame, you may file a plea indicating the reason for the failure to provide timely notification as per above. **Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.** When submitting a response to a denial for failure to notify, the reason for the failure to provide proper notification should be presented. If your justification is accepted, the case will be sent for initial review, and any adverse determination for medical necessity will be provided with subsequent appeal rights. Note, Healthy Blue will not request information to justify the reason for late or no notification, nor if the notification requirement is waived, will Healthy Blue request medical records for any subsequent review.

To verify member eligibility, benefits, and account information, or to request assistance on using our online authorization portal, please call the telephone number listed on the back of the member's identification card.

Prior Authorizations, Observation, and Timely Notification Reminders for Medicare Advantage Members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely requests for service and communication is essential.

Please be aware of the following considerations and requirements to help ensure effective coordination of care for Medicare Advantage members and assure consistent application of the Centers for Medicare & Medicaid Services guidelines and /or nationally recognized evidence-based medically necessary guidelines for pre- and post-service medical necessity and site of service reviews.

Emergent Inpatient Acute Medical Admissions

Hospitals are required to notify and/or obtain an authorization as early as possible, but no later than within one business day of admission. The process for decision making is fastest when all supporting clinical information is submitted and includes test results (as applicable) and member's response to emergency treatment.

Planned Inpatient Admissions

Prior authorization is required for **all** planned inpatient admissions. The request for prior authorization for a planned inpatient stay should occur as soon as the provider determines the need for the inpatient admission. Providers should submit prior authorization requests in advance of the inpatient admission to allow for CMS processing timeframes. CMS standard processing timeframe is 07 calendar days, expedited processing timeframe is 72 hours. Services may not be reimbursable if the prior authorization is not obtained.

Hospital observation, inpatient admission, and timely notification

Please notify us as soon as possible following admission but no later than within one business day of admission.

If we don't receive notification of admission, a retrospective review for medical necessity and site of service per the above hierarchy of review, will be conducted when the claim is submitted.

4.12 Inpatient Acute Concurrent Review

Healthy Blue performs concurrent review for Medicare Advantage members at contracted in-area hospitals. The review's purpose is to continuously improve medical care by:

- Determining the need for continued stay
- Initiating discharge planning and case management.

4.13 Skilled Nursing Facility

Prior Authorization for admission to skilled nursing facilities

According to CMS guidelines, patients should be admitted to a skilled nursing facility when "… as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.*

Skilled nursing, acute rehabilitation, and long-term care facilities are required to obtain prior authorization for Medicare Advantage members before that member can be admitted. For the member to receive maximum benefits, the health plan must authorize or precertify the admission. To assure payment according to contract, before a Medicare Advantage member is transferred to the receiving facility, the facility must notify the plan and receive prior authorization for that transfer.

Please note:

- Prior Authorization includes a review of both the service and the setting.
- Please present the request for admission to a skilled nursing facility, acute rehabilitation facility, and/or long-term acute care facility prior to admission.
- Please provide all supporting documentation with the request for prior authorization at the time of the request for admission.
- If the required prior authorization is not obtained prior to the service, the claim may be administratively denied for all days accrued prior to receiving an approval for admission, in accordance with your provider contract.
- To obtain prior authorization or to verify member eligibility, benefits, and account information, please call the telephone number listed on the back of the member's identification card.

Please refer to your provider agreement, this provider manual, and the Medicare Advantage *Prior Authorization Guidelines* found at the Medical Policy, UM Guidelines and Prior Authorization Requirements link on the Healthy Blue provider home page at **medicareprovider.healthybluemo.com** for further information on prior authorization and prior authorization requirements.

Please share this information with clinical staff and others involved with facility authorization and admissions.

We look forward to working with you and your colleagues to ensure our members are discharged at the right time clinically, to the right place, and achieve the best clinical outcome.

Healthy Blue will coordinate skilled nursing facility (SNF) benefits for our Medicare Advantage members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. Healthy Blue Medicare Advantage plans waive the Original Medicare requirement for the three-day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a member into a SNF from various sites, including the office, home, or from an observation stay.

Care in a SNF is covered if **all** of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, in other words, services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis.
- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained, and members will be assessed the applicable copays. A benefit period is used to determine coverage under the Healthy Blue Medicare Advantage plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

** Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 155, 04-20-12)*

Inpatient stays solely to provide custodial care are not covered under Healthy Blue Medicare Advantage plans. Custodial care is defined as care furnished for the purpose of meeting non-medically necessary personal needs that could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Healthy Blue Medicare Advantage plans or Original Medicare does not cover custodial care unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

The obligation on the provider to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare, SNF, and inpatient hospital services to enrollees of Medicare Advantage Organizations. This obligation applies to all SNFs and applies to both teaching and nonteaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code 04). It is also the provider's obligation to keep an audit trail on these claims.

4.14 Home Health Services

For a member to qualify for home health benefits, the member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary, qualifying skilled service. Under the Healthy Blue Medicare Advantage plans, the member does not have to be bedridden to be considered confined to home. The condition of the member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the member leaves the home, the member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration, or to receive medical treatment. Home care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- DME
- Portable X-rays and EKGs
- Laboratory tests

4.15 Denials

Pre-Service Denials and Lack of Information

Lack of information denials may not be issued to Healthy Blue Medicare Advantage (MA) members CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested service requiring utilization management review, further attempts must be made to collect the missing information. If sufficient information is not received, the pre-service request will be referred to the medical director or physician consultant for medical necessity determination.

Denials for emergent inpatient admissions, discontinuation of coverage

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. If a medical necessity decision results in an adverse determination, the practitioner may discuss the denial decision with a Medical Director through the request of peer-to-peer. Any peer-to-peer discussion that occurs after an adverse determination is informational only. An adverse

determination will not be changed based solely on the discussion. Any reconsideration must proceed through the formal appeals process.

For additional information, to speak to the Medical Director, or to obtain UM criteria, contact the Customer Services department by calling the number on the member's identification card.

Hospitals must notify Medicare Beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to: **cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

Notice of Medicare Noncoverage Requirements
CMS requires 100% compliance of providers to deliver a *Notice of Medicare Non-Coverage* (*NOMNC*) to every Medicare beneficiary at least two days prior to the end of their skilled nursing facility, home health, or comprehensive outpatient rehabilitation facility (CORF) care. Additionally, CMS requires Medicare inpatients to receive written information about their discharge rights. CMS has defined how this "Important Message from Medicare" (IM) is to be delivered by hospital facilities to Medicare beneficiaries.

Healthy Blue has established policies and procedures that require skilled nursing facilities, home health agencies, and CORFs to comply with the CMS mandatory requirement for all Medicare beneficiaries enrolled in Medicare Advantage Plans to receive a valid *Notice of Medicare Non-Coverage* (*NOMNC*), in a timely manner at the termination of care by a skilled nursing facility (SNF), home health agency, or CORF to allow the member the opportunity to appeal to the Quality Improvement Organization (QIO), in the event they disagree with the termination of services.

Healthy Blue responsibility and liability for SNF termination of services
When Healthy Blue makes a decision to terminate coverage of a member's services in a SNF, a valid *NOMNC* is sent to the SNF for the member to receive the *NOMNC* at least two calendar days in advance of the services ending, even if the member agrees with services ending, in compliance with CMS regulation.

Healthy Blue is extending the notice period up to 8 p.m. (in the time zone the facility is located), with the next two calendar days following the date of the denial notice to be considered the required two-day notice.

Following is an outline of determining the last approved day after the decision has been rendered to end services:

If denial notice (*NOMNC*) issued with confirmation of verbal notification and appeal information provided to the member, on the below day and time in the time zone the facility is located	Then last approved day (LAD) will be on	Members' discharge will occur, or member financial responsibility will begin on
Monday (12 a.m. to 8 p.m.)	Wednesday	Thursday
Tuesday (12 a.m.to 8 p.m.)	Thursday	Friday
Wednesday (12 a.m. to 8 p.m.)	Friday	Saturday
Thursday (12 a.m. to 8 p.m.)	Saturday	Sunday
Friday (12 a.m. to 8 p.m.)	Sunday	Monday
Saturday (12 a.m. to 8 p.m.)	Monday	Tuesday
Sunday (12 a.m.to 8 p.m.)	Tuesday	Wednesday

The Healthy Blue verbal notification to the member and/or verbal or fax receipt confirmation of the delivery of the *NOMNC* submitted prior to 8:01 p.m. (in the time zone the facility is located), will be considered a valid delivery date/time to the facility.

Healthy Blue Contracted SNF Provider Responsibility and Liability

The SNF providers are responsible for delivering the *NOMNC* on behalf of Healthy Blue to the member or representative **and** for obtaining signature(s) the same day received by Healthy Blue, but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the *NOMNC* and obtain signature(s) the same day Healthy Blue issues the *NOMNC*, the SNF provider is responsible for reissuing a *NOMNC* with the appropriate LAD to allow the member at least two calendar days in advance of the services ending.

In the event the member is in need of an authorized representative to acknowledge/sign the *NOMNC*, and the SNF is unable to deliver it to the authorized representative the same day Healthy Blue issues it, the SNF should telephone the representative the same day the *NOMNC* is issued, to advise him/her when the beneficiary's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the staff person initiating the contact, the name of the member representative contacted by telephone, the date and time of the telephone contact, and the telephone number called. The annotated *NOMNC* must be mailed on the same day. The SNF must retain a copy of the annotated NOMNC in the member's medical records.

The SNF provider is also responsible to issue a *NOMNC* (created by the SNF provider) for members who services are expected to be fewer than two days duration or when a guaranteed discharge date is in place.

Liability will remain with the SNF in the event the acknowledgement of receipt and delivery of the *NOMNC* to the member or member's representative is not completed within the same day received. The authorization through the last approved day (LAD) will remain the same for the facility. The member may receive a new *NOMNC* with a new LAD to extend the covered services, with no liability to the member or Healthy Blue, in order to allow the member adequate days/time to appeal to the QIO, should the member disagree with the termination of services.

Healthy Blue Medicare Advantage Member Responsibility and Liability
The member or representative is responsible for acknowledging receipt of the *NOMNC* by signing the document. The member or representative is also responsible for contacting the QIO (no later than noon of the first day after receiving the *NOMNC*) if they wishes to appeal the termination and obtain an expedited review.

In the event a member or their representative misses the deadline for a timely fast-track appeal, the member or their representative can contact the QIO, the QIO will also process untimely fast-track appeals.

Liability for the member will begin the day following the last approved day as specified on the *NOMNC*, should the member choose not to appeal the termination of services.

Note: QIOs must be available to receive a member's appeal request 24 hours a day, seven days a week.

Refer to the Provider and Member liability section of the provider contract with Healthy Blue for further details.

4.16 Preservice denials

When a provider is denied a pre-service request for a member, federal regulations require the Medicare Advantage Organization to issue a written notice of the denial (a Notice of Denial of Medical Coverage (NDMC), also known as the Integrated Denial Notice (IDN)) informing the member of his/her appeal rights. Therefore, a physician or practitioner is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan.

4.17 Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care and Ambulance Services

The Healthy Blue MA plans are financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The plan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

A Medicare Advantage Organization is required to cover emergency services for its MA members regardless of whether the services were preauthorized, or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Urgently needed services are not emergency services as defined above, but are covered services which are medically necessary and immediately required as a result of unforeseen illness, injury, or condition, and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- An enrollee is temporarily absent from the MA plan's service area.
- When the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

Post-stabilization care is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and, under specific circumstances, includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the purposes of this requirement, post-stabilization care and maintenance care are used synonymously. The plan's financial responsibility for post-stabilization care services includes:

- Any service administered, even though not preapproved by the plan or its representative, during the one-hour period following the request to the MA organization for preapproval of further post-stabilization care.
- Services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for preapproval within one hour.
- The MA organization's representative and the treating physician cannot reach an agreement concerning care decisions, and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes care through transfer.
- The MA organization's representative and the treating physician reach an agreement on the member's care.
- The member is discharged.

4.18 Case Management

Case management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes. The program utilizes proprietary predictive models to identify members with a variety of conditions who may potentially benefit from case management. Members who might benefit from case management are identified through a referral process. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, and sales staff.
- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other health care providers, members or their families.
- Healthy Blue discharge planners collaborate with all pertinent parties in the development of the discharge plan (in other words, PCP, specialist, Medical Director) to ensure the member's needs are met before the member leaves the hospital setting. Healthy Blue has designed a platform that provides a single point of contact to providers and facilities to ensure effective and collaborative discharge planning – of which streamlines the process for our providers while providing a more

proactive, informative, and comprehensive transition for the member and their care partner to fully understand the care plan in other words, ensuring ancillary needs are met (DME received before member returns home, home infusion training is required, etc.). Additional intensified discharge planning efforts also include:

- Performing medication reconciliation
- Refer members to high-risk condition management programs, where applicable
- Manage palliative care needs and refer to hospice when appropriate
- Integrate psych and social workers where necessary

In addition, case referrals can be generated prospectively from the UM system during the prior authorization process and retrospectively from the claims system through claims data analysis and data review activities. Referrals may also be made as part of the new enrollee health screening outreach process that occurs within 90 days of the effective date of enrollment.

Essential functions of a Healthy Blue case manager include the following:
Assessment: The case manager collects and analyzes data about actual and potential member needs. This may involve gathering data in relation to the member's medical issues, cognitive status, and functional status. After the data is analyzed, there is the planning, implementing, and evaluation of the case management plan.

Planning: The case manager develops a member-centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best way possible. This means identifying both short and long-term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

Linking/coordination: The case manager helps ensure continuity of care and integration of benefits across a variety of settings. Coordination is achieved through communication with the member, family and providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual member to help promote continuity of care.

Monitoring/evaluation: Case management will monitor interventions, based upon benefits, to help make sure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met, then the case manager should work with the member to modify the plan for the member.

Advocacy: The case manager should incorporate the member's needs and goals in the plan. Case managers should gather input from all relevant parties to help ensure continuity of benefits so that the member will achieve optimal results. Case managers are required to help protect the privacy and confidentiality of members at all times. Case managers should also present their limitations due to potential conflicts of interest between the member and Healthy Blue.

4.19 Stars Outbound Call (OBC) Program

The Medicare Advantage Stars Outbound Call (OBC) Program plays a key role in addressing the Healthy Blue approach for Medicare Advantage members in improving their healthy by getting the quality of care they need at the right time and in the right setting through conducting an outbound call to members and or providers to communicate the importance of obtaining preventive services such as colorectal screening, mammograms, annual wellness visits, and retinal eye exams.

By closing members' gaps in care, this will help improve member health outcomes. Focused questioning by our Patient Education Coordinators (PEC), pharmacists, and technicians address key clinical measures to ensure our members receive the right care at the right time.

This program allows members to be proactively involved in their own care by notifying them of preventive screenings that can detect and help prevent chronic illness and highlighting the potential benefit of the proactive behavior. Focused scripting and call messaging allows for barrier assessment and provides actionable messaging aligned with behavior change. Members with barriers to care are offered assistance with transportation coordination, financial needs, or provided access to community resources within their respective area. Care coordination is offered along with referrals to a pharmacist, nurse, or social worker to address any issues or to receive assistance with scheduling recommended care.

4.20 Under and Over Utilization

Healthy Blue has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

Healthy Blue does not compensate, reward, or give incentives, financially or otherwise, to its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision-making for the Healthy Blue MA plans is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

4.21 Readmission Review Process Readmission

For all services reimbursed by a DRG Rate or Case Rate, a readmission within 30 days of the discharge of the first admission for a related diagnosis or procedure, a complication arising out of the first admission, a readmission for services that should have been rendered during the previous admission, or a premature discharge is considered part of the original admission for reimbursement.

The specific situations for which the readmission payment may be considered part of the original admission for reimbursement are:

- Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.
- Member is discharged without discharge criteria being met, including the clinical and level of care criteria.
- Member is discharged from the hospital after surgery but is readmitted within 30 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.
- Member discharged from the hospital with a documented plan to readmit within 30 days for additional services (doctor requested, member requested).
- Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.
- Member is discharged meeting discharge criteria but nonclinical factors have not been addressed, and member has had previous 30-day admits. Member has issues or barriers that require discharge plans beyond the typical.

If a subsequent admission is reimbursed at a methodology other than a DRG or Case Rate (in other words, Per Diem Rate or %age Rate), then Healthy Blue shall only reimburse the facility for the DRG or Case Rate of the original admission. None of these scenarios shall be combined to qualify for outlier

reimbursement, if applicable If facility is an acute care hospital and is part of a hospital system operating under the same *Facility Agreement*, and/or if the facility shares the same tax identification number with one or more acute care hospitals, then a readmission during the same 30 day period to another acute care hospital within the system, and/or another acute care hospital operating under the same tax identification number as the facility, shall be subject to this readmission provision.

4.22 Model of Care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of, but not limited to, the following:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. Goals are defined in our model of care and are specific to the population. The SNP model of care is designed to improve the care of our members in all of the following areas:
   - Improving access and affordability of the healthcare needs of the population. Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP), and interdisciplinary care team (ICT).
   - Enhanced care transitions across all health care settings and providers
   - Ensuring appropriate utilization of services for preventive health and chronic conditions.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an individualized interdisciplinary care team assigned that includes the primary care physician/provider, case manager/care coordinator, and the member/caregiver as appropriate. Additional ICT members may be identified and include any of the following: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.
3. We work to complete a health risk assessment (HRA) on each member. For new members the goal is to complete the initial HRA within 90 days of eligibility and annually before the anniversary of the last HRA. We perform outreach in multiple ways to attempt to reach all our members. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional, and environmental topics and serves as the basis for the member's individualized care plan (ICP). Providers have access to the HRA results and the individualized care plan (ICP) through the provider portal.
4. Based on the results of the health risk assessment, an ICP will be developed by the case manager working directly with the member, and the interdisciplinary care team (ICT) to address identified needs. The care plan includes interventions designed to educate, inform, and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care
5. The interdisciplinary care team (ICT) assigned to each member is responsible for reviewing the care plans, collaborating with providers, and providing recommendations for management of care. Primary care physicians with special needs plan (SNP) members are responsible to review these documents available in the provider portal, or as provided, and give feedback as needed. You and/or your patient may be asked to participate in the care planning and management of the plan of care, and are recommended to review information prior to, or during, member visits and following transitions.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact

provider relations at the number on the members' identification card or discuss with the case manager.

7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members, and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results, and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments, or recommendations about the care plan or the needs that have been identified during the care planning process. As an enhancement, our PCPs have the ability to register and receive a daily list of the members who have completed the HRA and/or have an updated care plan available for you to review. You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.
8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed, and reported to measure health outcomes and quality measures, and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include any of the following measures:
    - HEDIS — used to measure performance on dimensions of care and service
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
    - Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
    - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations, and procedure frequency
    - Medication therapy measurement measures
    - Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees, and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual Program Evaluation

We conduct an annual evaluation of the model of care to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we review our program to identify any issues. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that are not trending toward our benchmarks. We compare our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets, we are meeting or exceeding in many areas. We are also showing an upward trend when we compare the year-over-year results. We continue to work on ways to improve our outreach to our members and

improve our completion rates for the health risk assessments, individualized care plans, and interdisciplinary care teams for each of our special needs plan members. We manage use of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post-discharge management, which continue to improve in most markets. Preventive care goals are established for our programs and managed as part of the HEDIS program. Multiple interventions are put in place to improve the HEDIS and STAR measures.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

4.23 Healthy Blue Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals, and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with the goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual, or on the provider portal. Below are protocols when managing transitions

- Participate in the interdisciplinary care team meetings and/or communication processes as appropriate.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member and other ICT participants as needed about the

transition process.

- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.
- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer the member to external or internal programs.
- Coordinate care with behavioral health services.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease-specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

5 Healthy Blue Medicare Advantage Provider Payment Disputes, Administrative Pleas, and Standard Appeals

5.1 Distinguishing between Provider and Medicare Advantage Member Appeals

Healthy Blue has separate and distinct processes for requests to reconsider a Healthy Blue decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare member liability denials are subject to the Medicare Complaints, Appeals, and Grievances (MCAG) process as outlined in the *Medicare Member Liability Appeals* and *Medicare Member Grievance* sections of this Provider Manual. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member follow the Healthy Blue Medicare Advantage participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with Healthy Blue and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Healthy Blue to make an expedited decision. Your participation in and the member's election of the Medicare Advantage plan are an indication of consent to release those records as part of health care operations.

Medicare Member Liability
Healthy Blue has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled, or is considered Medicare member cost share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with subsequent review by the Independent Review Entity (IRE).
- The *Notice of Denial of Medicare Prescription Drug Coverage* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- *Notice of Medicare Non-Coverage* (*NOMNC*) is delivered as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability
If Healthy Blue has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment, the participating provider is prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
Healthy Blue has determined that the nonparticipating provider failed to follow Medicare requirements unless the plan has determined member liability and issued the appropriate notices as above, and has procedures for the nonparticipating provider to follow.

5.2 Provider Claim Payment Disputes and Administrative Plea Processes

Provider Claim Payment Dispute Process
If you disagree with the outcome of a claim, you may begin the provider payment dispute process. Provider Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute**: The claim has been finalized, but you disagree with the amount that you were paid.
- **Provider Administrative Plea**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two 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.

- 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 correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Healthy Blue decision where medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary, but services were rendered, and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.

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

1. Claim Payment Reconsideration: This is the first step in the 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.
2. Claim Payment Appeal: The second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. Claim Payment Appeals must be submitted in writing or via the web and should explain the basis for disputing the outcome of the Claim Payment Reconsideration.

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

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues. *

*Timely filing issues: Healthy Blue will consider reimbursement of a claim which 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.

5.3 Claim Payment Reconsideration

The first step in the Healthy Blue claim payment dispute process is called the reconsideration. It 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 web portal within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how

to submit). Reconsiderations filed more than 120 days from the *EOP* will be considered to be 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.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claims payment reconsideration within 45 calendar days of receipt.

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

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan 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 63 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 claim payment appeal process is a necessary requirement before requesting a state fair hearing (where applicable).

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

5.4 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 63 calendar days of the date on the reconsideration determination letter. Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be 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 professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt.

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

5.5 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **Availity.com**. For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you'll need the Medical Attachments role.
- Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard, add the documentation, and submit.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  - Provider Payment Disputes
    P.O. Box 105187
    Atlanta, GA 30348-5187

Required Documentation for Claims Payment Disputes

The health plan 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 Medicaid or Medicare ID number.
- A listing of disputed claims, which should include the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but 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.

Claim status online

Providers can confirm the status and payment detail of their claims by logging in to **Availity Essentials** with their username and password.

When viewing the status of a claim on Availity, there may be options available to submit medical records or an itemized bill or dispute the claim.

Our Provider Experience program helps you with claim inquiries. Call Provider Services and select the Claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

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

Claim Correspondence
Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order 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 the most common ccorrespondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
EDI Rejected Claim(s)	Contact Availity or your EDI Vendor Please contact Availity Client Services with any questions at **800-Availity (800-282-4548)**
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 Correspondence Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP,* and the medical records to: Claims Correspondence Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187
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 Correspondence Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187 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

Type of Issue	What Do I Need to Do?
	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 Correspondence Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence Healthy Blue P.O. Box 105187 Atlanta, GA 30348-5187

6 Healthy Blue Medicare Advantage Participating Provider Standard Appeals

6.1 Participating Provider Standard Appeals

Healthy Blue participating providers may initiate provider appeals under the provider appeal procedures. Healthy Blue typically determines provider appeals within 65 days when sufficient information is received to make a decision.

6.2 Medicare Participating Provider Standard Appeal

A formal request for review of a previous Healthy Blue decision where medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the Healthy Blue decision letter date. *
- Include a cover letter with:
  - Member identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Healthy Blue's original decision
- Include necessary attachments:
  - Copy of the original Healthy Blue decision
  - All applicable medical records

N**ote**: Healthy Blue will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals, and Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Healthy Blue Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirements.

7 Healthy Blue Medicare Advantage Non Participating Provider Payment Disputes and Appeals

7.1 Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process. For more information regarding the disputes process, please see the appropriate section within this manual.

7.2 Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 65 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability Statement* must be included. To obtain this form, visit **cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip**.

The purpose of the *Waiver of Liability Statement* is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address:

Medicare Complaints, Appeals & Grievances
Attention: Non-Contracted Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

8 Healthy Blue Medicare Member Complaints, Appeals, and Grievances

8.1 Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility, or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and the Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Therefore, it is important for the physician to be aware of the difference between appeals and grievances.

8.2 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Healthy Blue to reconsider and change an initial coverage/organization determination (by Healthy Blue or a provider) about what services, benefits, or prescription drugs are necessary or covered or whether Healthy Blue will reimburse for a service, a benefit, or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Healthy Blue denies it, the member has the right to appeal. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Healthy Blue or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Healthy Blue concerning reimbursement for a health care service
- An adverse initial organization determination by Healthy Blue concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- Any service where Healthy Blue is reimbursing less than what Medicare would reimburse (non-par only)

Appeals should be sent to:

Medicare Complaints, Appeals, and Grievances (MCAG)
Attention: Member Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

8.3 Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at **cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207**

- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

Appeal time frames

- Members or their authorized representatives have 65 days from the date of the denial of service to file an appeal. The 65-day filing deadline may be extended where good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe
    - If the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are resolved within 72 hours unless it is in the member's interest to extend this time period.
    - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
    - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
    - Part D payment appeals must be resolved within 14 days from the date the request was received.
    - Part D appeals timeframes cannot be extended.

**Note: Integrated DSNP plans with unified grievance and appeal procedures for Medicare and Medicaid and MMPs may have different timeframes for Part C appeals.

8.4 Further Appeal Rights

If Healthy Blue is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Healthy Blue will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
    - Within 72 hours if expedited.
    - Within 30 days if the appeal is related to authorization for health care that is not a Part B drug.
    - Within 7 days if the appeal is related to authorization of a Part B drug.
    - Within 60 days if the appeal involves reimbursement for care. (or 30 days for integrated DSNP plans with unified grievance and appeal procedures)
    - Part D prescription drug appeals are not forwarded to the IRO by Healthy Blue but may be requested by the member or representative; information will be provided on this process during the Healthy Blue Medicare member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).

- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Healthy Blue continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

8.5 Medicare Member Grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Healthy Blue or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Healthy Blue must accept grievances from members orally or in writing within 60 days of the event.* Healthy Blue must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Healthy Blue has 24 hours to respond. An expedited grievance can only be initiated if Healthy Blue refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Healthy Blue can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

* Some plans may not limit the time in which a member grievance is filed (for example, certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.

8.6 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Healthy Blue, the Medicare Advantage plan, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals, and Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

9 Reimbursement Requirements and Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Healthy Blue benefit plan. These policies can be accessed on the provider site **here**. 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 services 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 setup may prevent the loading of policies into the claims platforms in the same manner as described; however Healthy Blue strives to minimize these variations.

9.1 Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. 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, authorization requirements, or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

9.2 Review Schedules and Updates

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements and/or Healthy Blue business decisions. We reserve the right to review and revise our policies when necessary. Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. When there is an update we will publish the most current policy on the provider website at the link above.

9.3 Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout 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.

9.4 Reimbursement by Code Definition

Healthy Blue allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements. There are eight CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

9.5 Healthy Blue Medicare Advantage Coordination of Benefits

Healthy Blue and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Healthy Blue is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Healthy Blue does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Healthy Blue will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Healthy Blue will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Healthy Blue handles the filing of liens and settlement negotiations both internally and externally via its vendors.

The information contained in this handbook should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for Healthy Blue members and enrollees are the responsibility of providers and practitioners. Please encourage the patient to review his/her Policy or Evidence of Coverage and Schedule of Benefits for details concerning benefits, procedures, and exclusions prior to receiving treatment, as this Handbook does not supersede the Policy or Evidence of Coverage and Schedule of Benefits. The information in this Handbook may change from time to time.

9.6 Changes to the Healthy Blue Medicare Advantage Rates

Healthy Blue compensates providers based on the Healthy Blue Medicare Advantage Rate in effect at the time a provider furnishes a covered service. However, when the Healthy Blue Medicare Advantage Rate is based on Medicare rates published by CMS, Healthy Blue compensates based on the rates that are available in its systems at the time it processes a provider's claim. Healthy Blue will use best efforts to promptly implement CMS' changes to Medicare rates prospectively. Healthy Blue will not retroactively adjust claims or otherwise compensate providers for any differences between its compensation and the compensation a provider receives from CMS for traditional Medicare. Such differences have many causes, including (but not limited to): the time needed to implement CMS' changes in Medicare rates; CMS' delay in publishing Medicare rates; CMS' retroactive changes to Medicare rates; CMS finalizing interim values or rates; Medicare demonstration program or quality program rates; or CMS compensation to providers outside of the usual Medicare claims process (including but not limited to bonuses, settlements, and remedies.)

10 Fraud, Waste, and Abuse Detection

Healthy Blue is committed to protecting the integrity of healthcare programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA 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—or any other person—committing it. This 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 excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse**: behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

10.1 Reporting fraud, waste, and abuse

If someone suspects any Member or provider (a person who receives benefits) has committed fraud, waste or abuse, they 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.

Report concerns by:

- Visit **medicareprovider.healthybluemo.com**, scroll to the bottom footer, and select "Waste, Fraud and Abuse" to be directed to the **fighthealthcarefraud** education site; at the top of the page, select "Report it" and complete the ***Report Waste, Fraud, and Abuse*** form
- Calling Customer Service

Any incident of fraud, waste, or abuse may be reported to Healthy Blue anonymously; however, the ability to investigate an anonymously reported matter may be limited if Healthy Blue doesn't have enough information. Healthy Blue encourages Providers and Facilities to give as much information as

possible. Healthy Blue appreciates referrals for suspected fraud, but be advised that Healthy Blue do not routinely update individuals who make referrals as it may potentially compromise an investigation.
Examples of Member Fraud, Waste, and Abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the Member's ID (Identification) card
- Relocating to out-of-service Plan area
- 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 available
- The city where the Member resides
- Specific details describing the fraud, waste, or abuse

Examples of Provider Fraud, Waste, and Abuse (FWA):

- 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 available
- 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

To learn more about health care fraud and how to aid in the prevention of it, visit **fighthealthcarefraud.com.**

10.2 Investigation process

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. Healthy Blue may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education*: Healthy Blue sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or may advise of further action.
- *Medical record review*: Healthy Blue reviews medical records to investigate allegations or validate the appropriateness of Claims submissions. Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review.

- *Prepayment Review*: Specific to a Provider or Facility under investigation, a certified professional coder in the SIU evaluates Claims prior to payment. Edits in Healthy Blue's Claims processing systems identify these Claims for review to prevent automatic Claims payments in specific situations.
- *Recoveries*: Healthy Blue recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, and/or legal action.

10.3 Prepayment Review

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

Once a Claim, or a Provider or Facility is identified as an outlier or has otherwise come to the attention of Healthy Blue 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 that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Healthy Blue 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 to Healthy Blue in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

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

The Provider or Facility will remain subject to the prepayment review process until Healthy Blue is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services Healthy Blue 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 or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures, and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

10.4 Acting on Investigative Findings

In addition to the previously mentioned actions, Healthy Blue may refer suspected criminal activity committed by a Member, Provider, or Facility to the appropriate regulatory and/or law enforcement agencies.

10.5 Recoupment/Offset/Adjustment for Erroneous Payments

Healthy Blue shall be entitled to recoup, offset, and adjust an amount equal to any Erroneous Payments (including but not limited to any improper payment, duplicate payment, or overpayment) made by Healthy Blue to Provider against any payments due and payable by Healthy Blue to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all Erroneous Payments, regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Healthy Blue that any Erroneous Payment is due from Provider, Provider must refund the amount to Healthy Blue within sixty (60) days of when Healthy Blue notifies Provider. If such reimbursement is not received by Healthy Blue within the sixty (60) days following the date of such notice, Healthy Blue shall be entitled to offset such Erroneous Payment against any payments due and payable by Healthy Blue to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, *including the Payment in Full and Hold Harmless section of the Provider Agreement.* Should Provider disagree with any determination by Plan that Provider has received an Erroneous Payment, Provider shall have the right to appeal such determination under Healthy Blue's procedures set forth in the provider manual(s), and such appeal shall not suspend Healthy Blue's right to recoup the Erroneous Payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Healthy Blue reserves the right to employ a third party collection agency in the event of non-payment.

Healthy Blue is the trade name of Missouri Care, Inc., an independent licensee of the Blue Cross Blue Shield Association.