MO HealthNet Managed Care
(Medicaid)

Healthy Blue

Provider orientation

Agenda

- About us
- Who we serve
- Joining our network
- Claims tools and resources
- Health services
- Quality
- Resources
- Network relations

About us

History

- Healthy Blue, formally Missouri Care, Inc., has been a MO HealthNet managed care health plan since 1998.
- In January 2020, we purchased the Missouri Care, Inc. health plan.
- Our plan is now called Healthy Blue.

Healthy Blue is proud to continue to serve our Missouri members.

History (cont.)

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

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

- St. Louis.
- Columbia.
- Springfield.

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

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

Purpose, vision, and values

Our mission

Improving lives
and communities.
Simplifying healthcare.
Expecting more.

Our vision

To be the most
innovative, valuable,
and inclusive partner

Our values

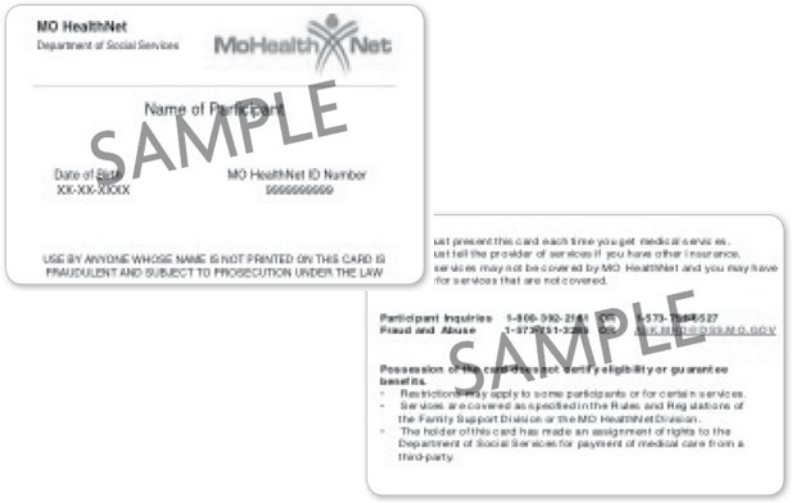
Leadership
Community
Integrity
Agility
Diversity

Who we serve

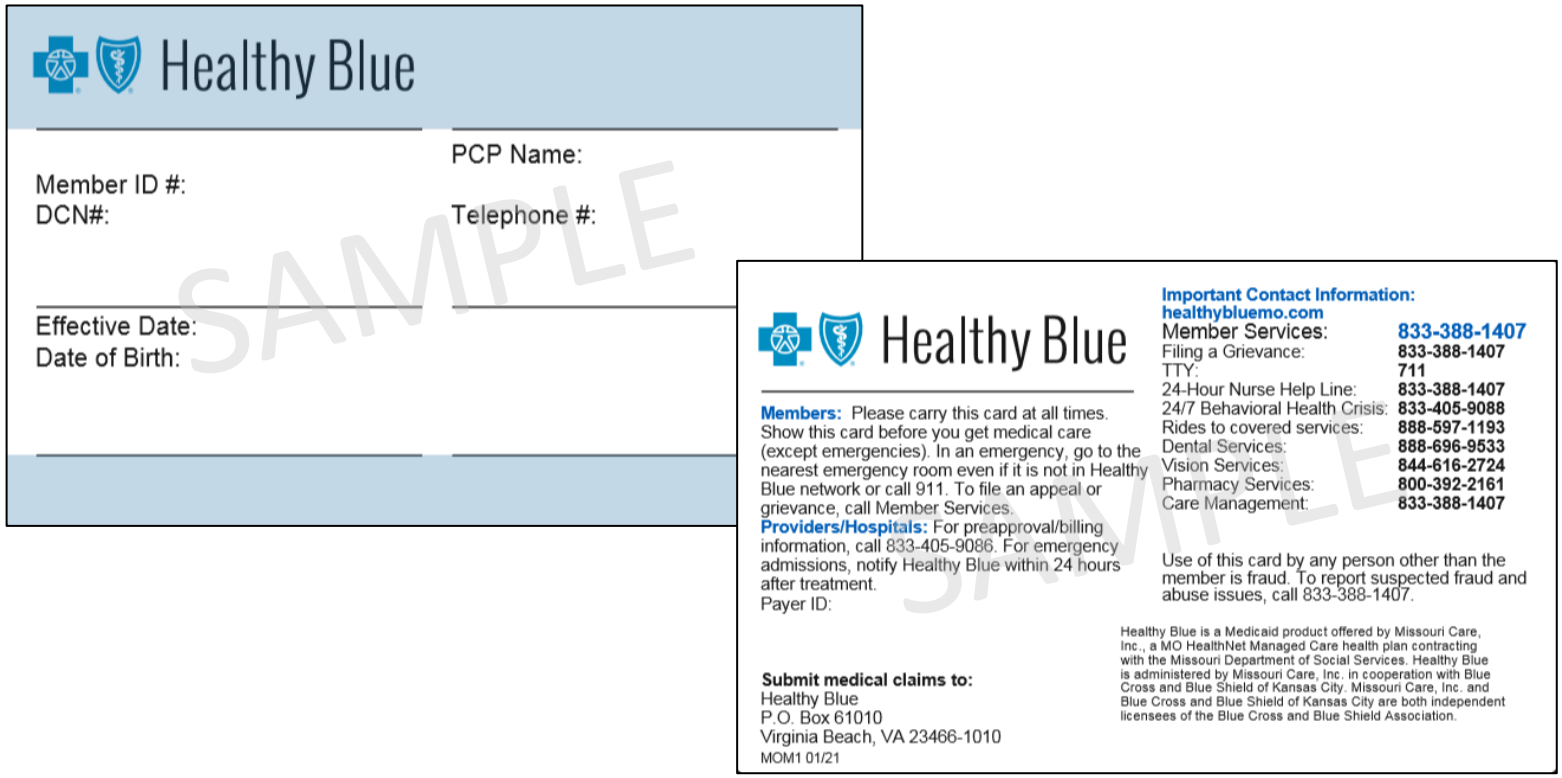
About MO HealthNet

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

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



Healthy Blue card image



Enrollment

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

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

Eligibility verification

Eligibility and benefits associated with a member and/or their dependents can be determined by:

- Submitting a 270/271 electronic data interchange (EDI) transaction through using your EDI software or through your clearinghouse.
- Submitting an eligibility and benefits inquiry through Availity Essentials:
  - Go to Availity.com. Select **Patient Registration** > **Eligibility and Benefits** Select **Healthy Blue** from the drop-down box.
  - Complete required fields and submit.

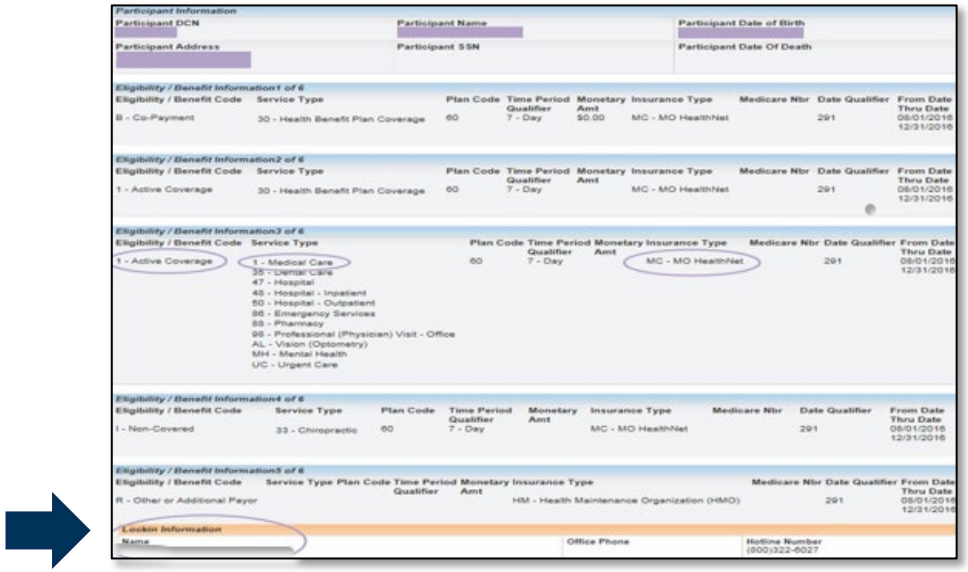
You will continue to be able to verify member eligibility information through the state. Eligibility can be verified by calling Interactive Voice Response unit at **573-635-8908** or through MO HealthNet's online system, eMOMed, available at emomed.com.

Eligibility verification (cont.)

- As a contracted Healthy Blue provider, you can see any Healthy Blue member, even if you are not the PCP of record. Healthy Blue will accept claims billed with either the member ID number or the MO HealthNet data communication network (DCN).
- Please note: A member's eligibility status can change at any time. Therefore, providers are encouraged to check eligibility on the date of service (DOS) and to request a copy of the member's ID card, along with additional proof of ID, such as photo identification, and file these in the patient's medical record.
- Providers should access Healthy Blue's secure provider website at Availity.com

eMOMed

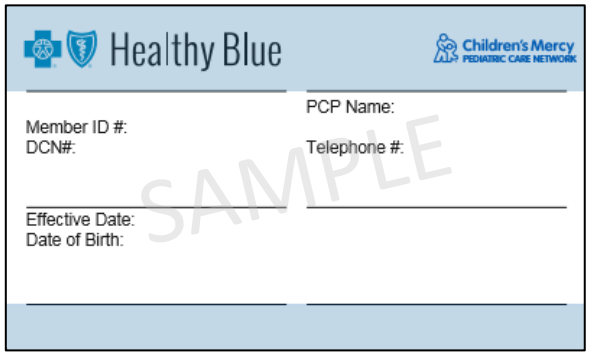
- Below is a screen capture of a member's eligibility information on MO HealthNet's website, eMOMed.
- *Insurance Type MC* indicates the member is enrolled in a managed care plan.
- The *Lockin Information* indicates which managed care health plan the member is enrolled in.
- Eligibility may change daily.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



Children's Mercy Pediatric Care Network (CMPCN)

CMPCN is an integrated pediatric network operated by the Children's Mercy Hospital System.

- CMPCN provides delegated medical and (since October 1, 2022), all behavioral health management services, including case management, utilization management, and disease management for select Healthy Blue members in the following counties: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon.
- Healthy Blue members who are part of this network can be identified by the CMPCN logo on their ID card.



CMPCN (cont.)

- CMPCN manages and issues all medical and (effective October 1, 2022) all behavioral health (BH) prior authorization requests for these members.
- The authorization approvals are shared by CMPCN with Healthy Blue. Healthy Blue will process the claims for these members.
- A Healthy Blue member is still free to choose any contracted provider to receive services.
- If an authorization is necessary, or you have a referral for case management, you will contact CMPCN instead of Healthy Blue.

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

CMPCN authorization requests and claims submission information

Prior authorization (PA) requests

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

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

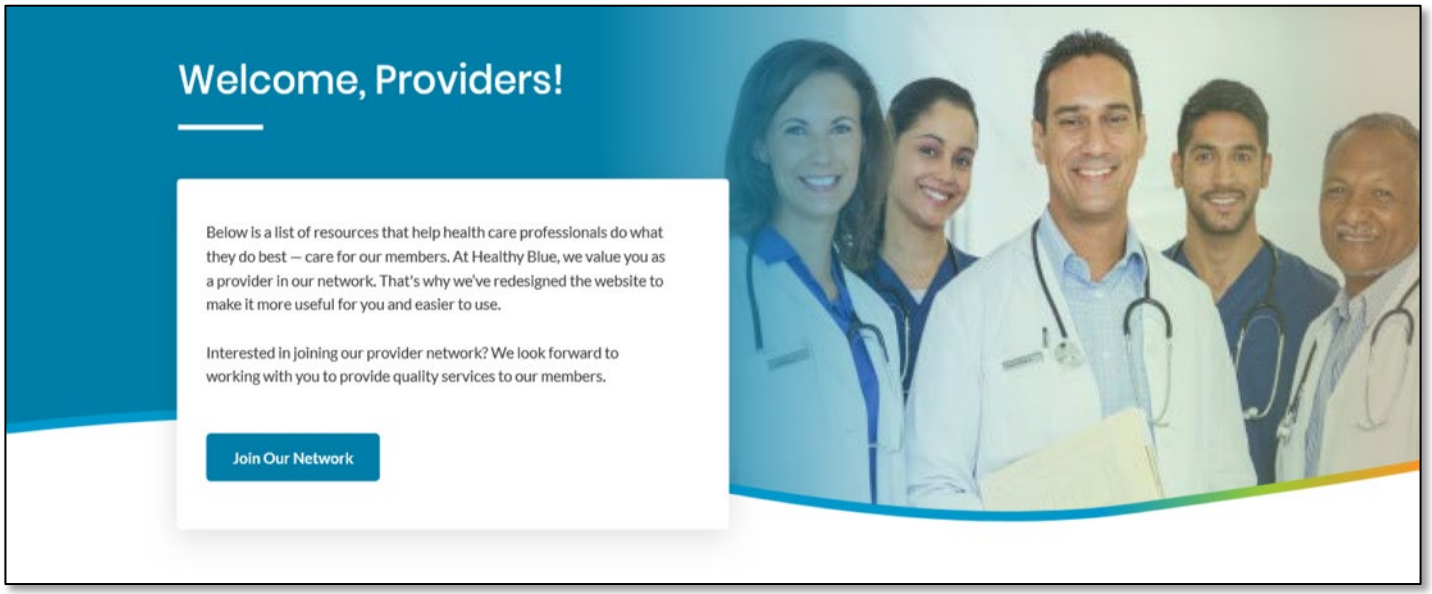
Claims submission

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

Joining our network

Join the network

If you are interested in joining the network,
visit provider.healthybluemo.com and select **Join Our Network**.



Submitting demographic data requests

Including *New Providers*, *Updates*, and *Terminations*

- Use the Provider Data Management (PDM) application on Availity Essentials to submit requests for all professional and facility providers.
- Within the PDM application, users can submit requests via the standard PDM experience or through Roster Automation by submitting a spreadsheet via a roster upload, using the **Rules of Engagement** and **Standard Template**.
- To maintain the quality of our provider data, we ask that changes to your practice contact information or the information of participating providers within a practice be submitted as soon as you are aware of the change.

Roster Automation Rules of Engagement and Roster Automation Standard Template

- Visit provider.healthybluemo.com, then under *For Providers*, select **Forms and Guides**. **The Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.
- **Roster Automation Rules of Engagement**: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template**: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (User Reference Guide).

Accessing *PDM Application*

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

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.

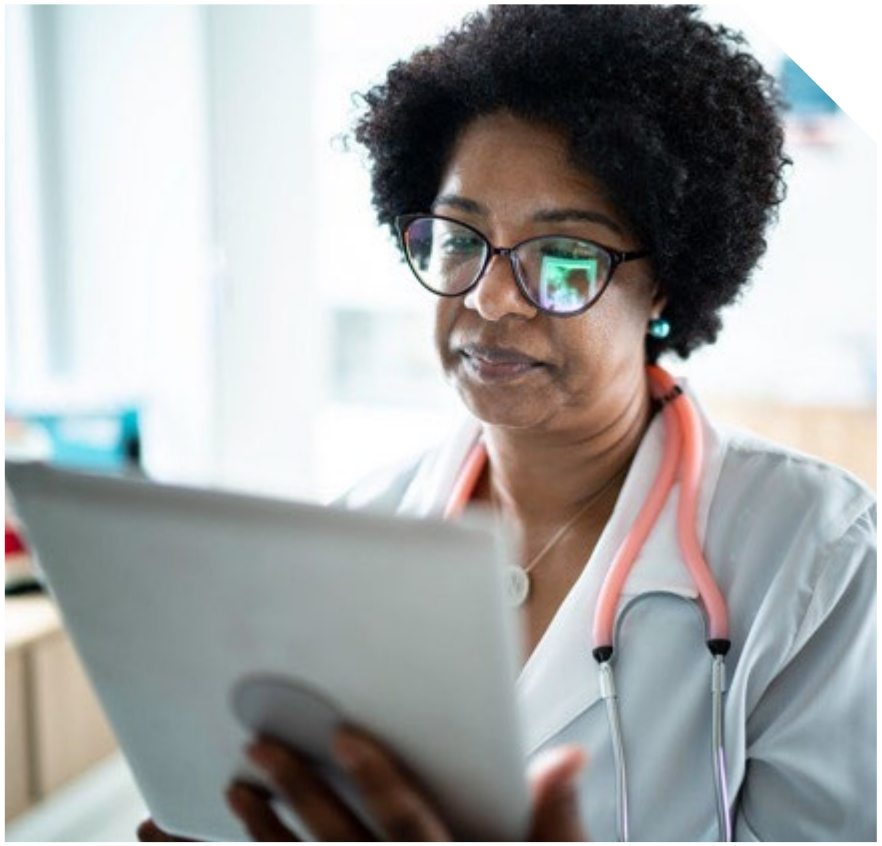
Credentialing process

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

Primary care physicians — roles and responsibilities

Primary care providers

- A primary care physician (PCP), or primary care provider, is a healthcare professional who practices general medicine.
- PCPs serve as the entry point into the healthcare system for the member.
- Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all of the patient's healthcare needs and appropriately arranging care with other qualified professionals.



Role and responsibilities of primary care physicians

As a PCP, you are responsible for, but not limited to:

- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions.
- Coordinating and monitoring referrals to specialist care and to specialized behavioral health in accordance with state requirements.
- Maintaining the continuity of care.
- Ensuring all medically necessary services are made available in a timely manner.
- Complying with all applicable federal and state laws regarding the confidentiality of patient records.
- Providing complete information concerning their diagnoses, evaluations, treatments, and prognoses, and giving members the opportunity to participate in decisions involving their healthcare.
- Participating in:
  - Internal and external quality assurance.
  - Utilization review.
  - Continuing education.
  - Complaint and grievance procedures when notified of a member grievance.

Healthy Blue

PCP access and availability

Type of care	Time frame requirement for appointment
Emergency	Immediately
Urgent care	Within 24 hours
Non urgent sick care	Within 72 hours
Follow-up to hospital discharge	Within 7 calendar days from the discharge date
Routine or preventive care	Within six weeks
Maternity care — 1st trimester	Within 7 calendar days
Maternity care — 2nd trimester	Within 7 calendar days
Maternity care — 3rd trimester	Within 3 calendar days
Maternity care — High-risk pregnancy initial visit	Within 3 calendar days or immediately if emergency exists
In-office wait time for scheduled appointments	Not exceed 1 hour

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment.

Appointment availability

- The state of Missouri requires us to ensure our provider network's member appointment wait times do not exceed the standards outlined in the provider contract and handbook.
- In order to assess appointment timeliness, Healthy Blue conducts quarterly phone audits. We make these calls to assess your compliance level to the requirements outlined on the following slide.

PCP onsite availability

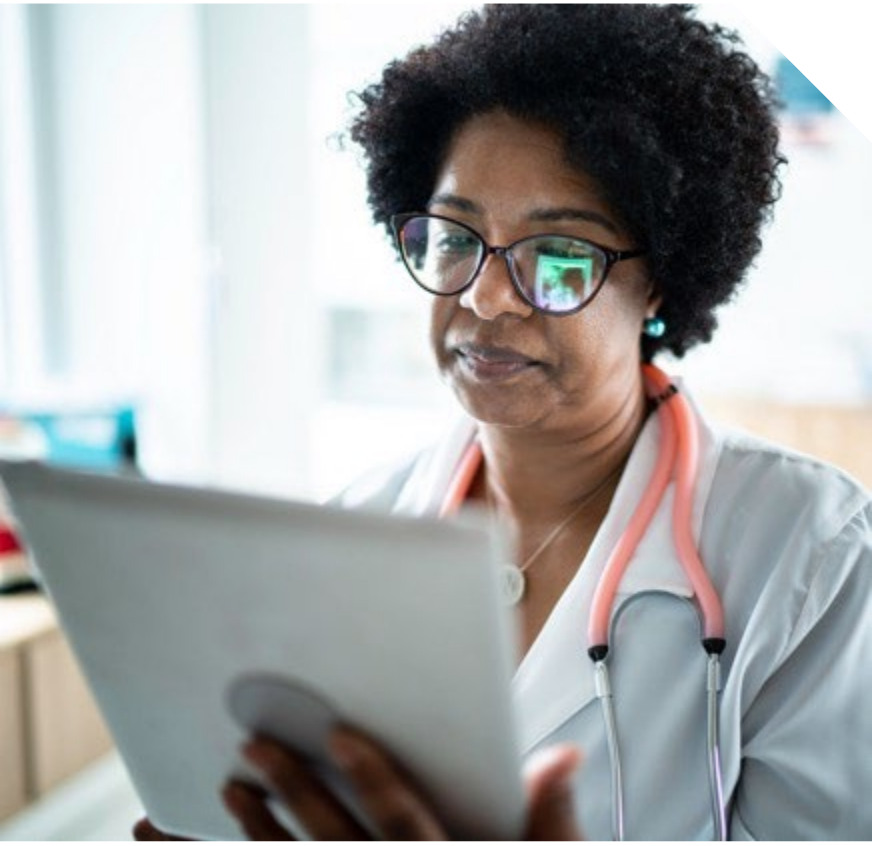
After-hours availability

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

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

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

Appointment availability fails



What if a requirement isn't met?

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

Provider roles and responsibilities — specialist

Specialty care providers

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

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

Specialty care providers — roles and responsibilities

As a specialist, you are responsible for:

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

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Appointment availability

- The state of Missouri requires us to ensure our provider network's member appointment wait times do not exceed the standards outlined in the provider contract and handbook.
- In order to assess appointment timeliness, Healthy Blue conducts quarterly phone audits. We make these calls to assess your compliance level to the requirements outlined on the following slide.

Specialty care providers' access and availability

Type of care	Time frame requirement for appointment
Medically necessary	Same day (within 24 hours of referral)
Urgent care	Within 24 hours of referral
Routine	Within one month of referral
Lab referrals or X-rays — urgent care	Within 48 hours or as clinically indicated
Lab referrals or X-rays — regular appointments	Not to exceed three weeks
In-office wait time for scheduled appointments	Not to exceed 1 hour

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment.

Resources to support care for members

Advance directive

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

- Durable power of attorney
- Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will let a member state his or her wishes on medical treatment in writing. We encourage members ages 18 and older to ask you for an advance directive form and education at their first appointment.

Please document their forms in your medical records. We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to their own care. Please note, a Healthy Blue associate cannot act as a witness to an advance directive, nor serve as a member's advocate or representative.

Cultural competency

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

Cultural competency can enable you to:

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

Cultural barriers between provider and patient can:

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

Cultural competency program

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

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

- Interpreter services for Provider Services.
- Telephonic interpreter services.
- In-person interpreter services for care management.

Provider cultural competency resources

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

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

Cultural Competency training (cultural competency and patient engagement), which includes but is not limited to:

- The impact of culture and cultural competency on healthcare.
- A cultural competency continuum that can help providers assess their level of cultural competency.
- Disability sensitivity and awareness.

Provider cultural competency resources (cont.)

Caring for Diverse Populations Toolkit, which includes but is not limited to:

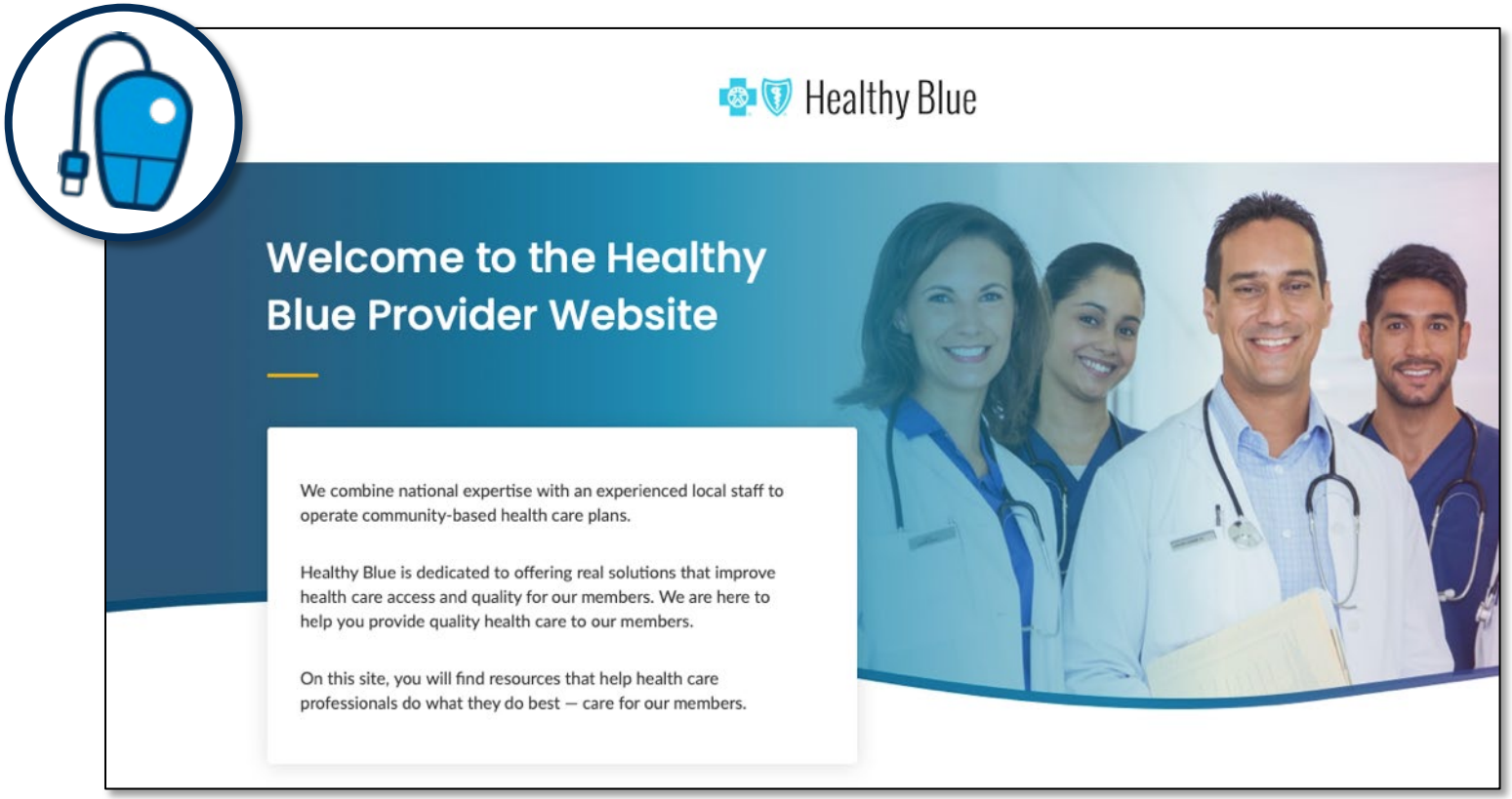
- Comprehensive information, tools, and resources to support enhanced care for diverse patients and mitigate barriers.
- Materials that can be printed and made available for patients in provider offices.
- Regulations and standards for cultural and linguistic services.

My Diverse Patients:

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

Claims, tools, and resources

Public provider website



Availity

Availity will be your exclusive, secure, multi-payer platform to access many Healthy Blue online tools and resources at Availity.com.

- Your organization must be registered on Availity Essentials, and you need a unique ID and password.
- To begin registration, visit Availity.com and select **Register**.
- Training is available on Availity:
  - Visit Availity.com > **Help & Training** > **Get Trained.**

Healthy Blue provider website and Availity comparison

Available through the Healthy Blue provider website:
provider.healthybluemo.com

- 24/7 access to all providers, regardless of participation status
- Open access without registration
- Claims forms
- Precertification Look-Up Tool — PA Requirements Look-Up Tool
- Provider manual
- *Clinical Practice Guidelines*
- News and announcements
- Provider directory
- Fraud, waste, and abuse resources
- *Preferred Drug List*
- *Medical Policies*

Available through Availity: Availity.com

- Registration/login required for access
- Precertification Look-Up Tool — PA Requirements Look-Up Tool
- Patient360 (provider facing)
- Multiple eligibility and benefits inquiry
- Provider Online Reporting
- PCP member panel listings
- ICR — medical PA requests, notification of pregnancy and birth
- Pharmacy authorizations and benefits
- Claims dispute submission
- Claims dispute inquiry
- Medical appeal PA submission
- *Availity EDI Guide*
- *Maternity Attestation*
- Remittance inquiry

Provider Online Reporting registration

The provider organization's Availity administrator is responsible for registering the tax IDs and users for Provider Online Reporting.

The administrator will take the following steps to register:

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

Timely filing and coordination of benefits information

Healthy Blue as the primary payer:

- First submission timely filing is defined by your contract.

Healthy Blue as the secondary payer:

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

Corrected claims:

- Within 365 days from the date of service

Coordination of benefits:

- Healthy Blue is always the final payer. If our member has primary insurance, please file the claim with the primary insurance carrier first, then submit a claim with the primary carrier's remittance advice to Healthy Blue for processing. We will coordinate benefits from the primary insurance carrier's *EOB*.
- Healthy Blue will reimburse the difference between what the primary insurance pays and the allowable if there is a remaining balance.
- The member cannot be balance billed for the difference or the contractual write-off amounts.

Claims submission information

- Healthy Blue encourages the submission of claims electronically through the electronic data interchange (EDI), either by using a clearinghouse, billing company or sending directly. Availity serves as our gateway for all EDI transactions.
- Providers can also register with Availity at Availity.com to become a direct submitter.
- To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at **800-AVAILITY (800-282-4548)**. If you have a relationship with a clearinghouse, please work with them to ensure connectivity with Availity.

Claims submission information (cont.)

Availity:

- Availity.com

EDI submissions:

- Healthy Blue payer ID number — 00541

Paper:

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

Claim status inquiries

You can obtain claim status information through Availity or by calling Provider Services.

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

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

Rejected versus denied claims

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

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

You can find claims status information through Availity at Availity.com or by calling Provider Services at **833-405-9086** Monday through Friday, from 7 a.m. to 8 p.m. CT.:

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

Corrected claims

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

When to submit a corrected claim:

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

Provider claim payment disputes

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

The claim payment dispute process consists of two steps. Providers will not be penalized for filing a claim payment dispute, and no action is required by the member:

- **Claim payment reconsideration:** This is the first step in the claim payment dispute process. The reconsideration represents the initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
- **Claim payment appeal:** This is the second step in the claim payment dispute process. If a provider disagrees with the outcome of the reconsideration, the provider may request an additional review as a claim payment appeal.

Provider claim payment disputes (cont.)

Claim payment disputes do not include:

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

How to submit a provider dispute

There are several options for filing a dispute:

Online:

Use the secure *Provider Availity Payment Dispute Tool* at Availity.com.

Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.

Verbally
(reconsiderations only):

Call
Provider Services at
833-405-9086
Monday through Friday
from 7 a.m. to 8 p.m. CT.

Written
(reconsiderations and claim payment appeals):

The reconsideration form is located at provider.healthybluemo.com.

Mail all required documentation to:
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

Grievances and appeals

Grievance

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

Medical appeals

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

For grievances and appeals, contact Provider Services at **833-405-9086** Monday through Friday from 7 a.m. to 8 p.m. CT.

Claims overpayment recovery and refund process

- Healthy Blue seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable.
- When an overpayment is discovered, Healthy Blue initiates the overpayment recovery process by sending written notification.
- If you are notified of an overpayment or discover that you have been overpaid, mail the refund check along with a copy of the notification or other supporting documentation to the following address:

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

Encounter data

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

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

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

Electronic funds transfer (EFT)

You will need to register and enroll with the EnrollSafe tool at enrollsafe.payeehub.org and select the payer name that includes **Healthy Blue:**

- If you have registration-related questions, contact EnrollSafe at **877-882-0384** Monday through Friday from 9 a.m. to 8 p.m. ET or email support@payeehub.org.
- You can also refer to enrollsafe.payeehub.org/content/pdf/EnrollSafe_User_Reference_Manual.pdf.
- If you have EFT decline questions, please contact Provider Services at **833-405-9086** or your provider relationship management representative, Monday through Friday from 7 a.m. to 8 p.m. CT.
- Even if you are registered and enrolled with another payer, you will need to enroll in the payer name that includes Healthy Blue to receive payments via EFT for services rendered.
- If you do not enroll in EnrollSafe, you will receive a paper check or virtual card for services rendered.

Electronic remittance advice (ERA)

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

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

Electronic payment benefits

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

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

Registering for electronic remittance advice (ERA) provides the following benefits:

- You can easily access your remittance advice online.
- Transactions can be posted to your system automatically.

Remittance inquiry

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

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

Remittance inquiry (cont.)

You have the option to sort your results by:

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

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

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

If you questions or additional registration assistance, contact Availity Client Services at **800-AVAILITY** (**800-282-4548**) Monday through Friday, from 7 a.m. to 7 p.m. CT.

Precertification Lookup Tool

- Certain medical procedures require the submission and approval of PA. To verify if PA is required, use the Precertification Lookup Tool.
- Detailed authorization requirements can be found using the Precertification Lookup Tool:
  - Search by market, member product, and CPT® code.
  - This is for outpatient services only; all inpatient services require an authorization.

Precertification Lookup Tool is located under *Payer Spaces* in Availity:

- From the Availity homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select the **Applications** tab.
- Select **Precertification Lookup Tool**.

PA and notification

You can submit a PA request, look up a status, or submit a clinical appeal online:

- Log in to Availity.com using your Availity credentials.
- From the Availity homepage, select **Patient Registration** from the top navigation bar.
- Select **Authorizations & Referrals**.
- Select **Authorizations**.
- Select the payer and organization.
- Select **Submit**:
  - The Interactive Care Reviewer (ICR) application, our online authorization tool, will open.
  - Use ICR to submit and manage (appeal) your medical PAs.
- Online PA submission is preferred, but PA can be faxed to **800-964-3627**.
- Urgent requests can be submitted via ICR or by calling Provider Services at **833-405-9086** Monday through Friday, from 7 a.m. to 8 p.m. CT.

Carelon Medical Benefits Management, Inc.

Carelon Medical Benefits Management, Inc. manages precertification for the following modalities: radiology, cardiology, sleep, musculoskeletal, rehabilitation (physical therapy, occupational therapy, speech therapy), genetic testing, and radiation oncology.

How to place a review request:

- Online via the ***Provider***Portal: The provider website is available 24/7 and processes requests in real-time using clinical criteria. Go to providerportal.com to register.
- By phone: Call Carelon Medical Benefits Management toll free at **855-574-6479**, Monday through Friday, from 7 a.m. to 7 p.m. CT.

Access the ***Provider***Portal for Carelon Medical Benefits Management training information.

Clear Claim Connection

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

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

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

MO HealthNet fee schedule

The MO HealthNet fee schedule is available at the following link: apps.dss.mo.gov/fmsfeeschedules/Default.aspx.

Select the link for the appropriate category for the CPT code or modifier you want to view the allowed amount or modifier information for:

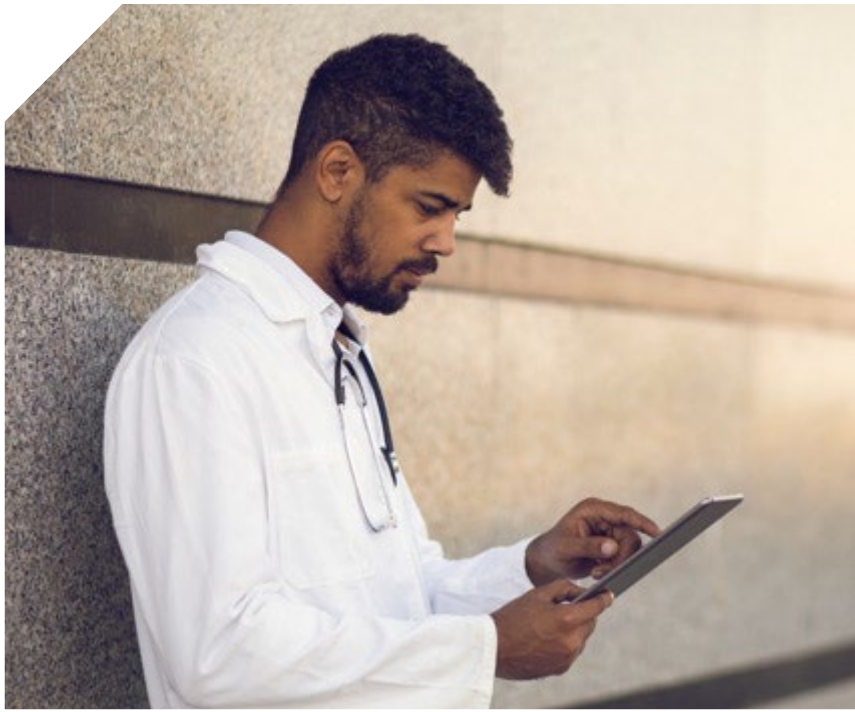
- Next, select the radio button next to the procedure code or modifier, and type in the procedure code or modifier.
- The search will show you if the CPT code and/or modifier combination are payable.

MO HealthNet billing manuals

The MO HealthNet billing manuals are available at the following website address: Provider Manuals | mydss.mo.gov.

Cost avoid versus pay and chase

- If there is a third-party payer indicated on the eligibility file for the member, Healthy Blue will cost avoid the claim and require that the provider file the claim first with the primary insurance carrier.
- If there is not a third-party payer indicated on the eligibility file for the member, Healthy Blue will pay the claim.
- If, after paying a claim, Healthy Blue determines there is a third-party payer, we will seek to recover payment from the primary insurance carrier.



Pharmacy

Effective for dates of service after July 1, 2020, all medications administered in an outpatient observation setting are carved-out of managed care.

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

Billing members

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

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

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

Fraud, waste, and abuse

CMS defines fraud, waste, and abuse as:

Fraud

Intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit.

Waste

Overusing services or other practices that directly or indirectly result in unnecessary costs; generally not considered driven by intentional actions, but from misusing resources.

Abuse

When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

Fraud, waste, and abuse (cont.)

- If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.), or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it.
- No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting the Healthy Blue provider website at provider.healthybluemo.com and completing the *Report Waste, Fraud and Abuse* form.
- Calling Provider Services at **833-405-9086**
  Monday through Friday, from 7 a.m. to 8 p.m. CT.

Health services

Avoidable ER utilization

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

Consider the following:

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

Avoidable ER utilization (cont.)

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

Concurrent review/discharge planning

Concurrent review/discharge planning

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

ProgenyHealth

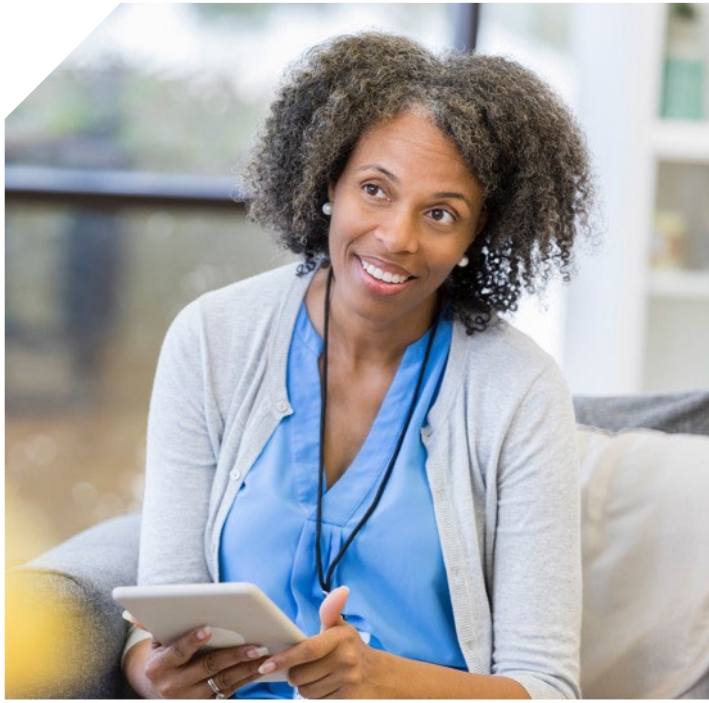
ProgenyHealth specializes in neonatal care coordination services for the first year of life. Their neonatologists and pediatricians work with the Healthy Blue clinical team to provide telephonic care coordination for NICU stays. Please continue to contact Healthy Blue for any NICU level of care admissions.

Discharge planning

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

Care management role

- All our members are eligible to be assigned to one of our care managers. Our care managers work directly with our members and establish relationships with our members to manage their care.
- Our care managers' role is to assist the member in gaining access to consistent quality care and services including the following essential functions: assessment, planning, coordination, monitoring/evaluation, facilitation, and support.



Care management qualifications

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

- Complex illnesses that require the coordination of many services
- Had or are going to have a transplant
- High-risk pregnancy
- Experienced domestic abuse
- High-risk BH needs
- Major depression
- Asthma
- Multiple chronic illnesses
- Children with special healthcare needs

New Baby, New Life Maternity program

We encourage all of our moms-to-be to take part in our New Baby, New Life℠ program, a comprehensive care management and care coordination program offering:

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

Healthy Blue requires notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in the online ICR or fax the forms to **800-964-3627**.

Disease management/population health

- Our disease management/population health program provides telephonic coaching and written educational materials to assist members in managing conditions such as asthma, coronary artery disease, congestive heart failure, diabetes, hypertension, smoking cessation, weight management, and depression.
- Additional services will now include bipolar disorder, chronic obstructive pulmonary disease, HIV/AIDS, schizophrenia, and substance use disorder.
- Contact the Disease Management department at **888-830-4300** (**TTY 711**).

Resources

Community Resource Link — addressing social drivers of health (SDOH)

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

LiveHealth Online (LHO) — introducing telehealth

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

Helpful phone numbers

Topic	Phone number	Additional information
PA	**833-405-9086**	Follow the prompts
Provider Relations	**833-405-9086**	Follow the prompts
Member Services	**833-388-1407**	Follow the prompts
MTM Transportation Services	**888-597-1193**	Contact number for members
24-Hour Nurse Help Line	**833-388-1407**	For members' questions
DentaQuest*	**844-234-9832**	Provider Services
March Vision Care	**888-493-4070**	Option 2 for members, option 3 for providers
MO HealthNet Eligibility Verification	**573-635-8908**	Option 1 (or go to eMOMed.com)
Social Resource Team	**833-439-1058**	

Your support system and staff

As you provide care to our members, we support you through many different departments, including:

- Our Health Care Networks team of Healthy Blue.
- Our Medical Management staff for Healthy Blue.
- Specialized teams to help you with your claim questions.
- Our Provider Services.

Call Provider Services for assistance with claim issues, member enrollment and general inquiries at **833-405-9086** Monday through Friday, from 7 a.m. to 8 p.m. CT.

The Health Care Networks team of Healthy Blue serves the following functions:

- Provider ongoing education and training
- Engaging providers in quality initiatives
- Building and maintaining the provider network
- Offering support for claims and billing questions and issues

You can always contact your local provider relationship management representative with any questions you may have.

Key takeaways

Key items to prepare you for doing business with Healthy Blue:

- Sign up for the secure provider website at Availity.com:
  - Use Availity to register for ERA (835)
  - Payer ID **00541**
- Register for EFT payments with EnrollSafe tool under the payer name Healthy Blue enrollsafe.payeehub.org.
- Review content on the Healthy Blue provider website at provider.healthybluemo.com, including the Training Academy, provider manual, communications and other tools.
- Contact Provider Services Phone: **833-405-9086** Monday through Friday, from 7 a.m. to 8 p.m. CT.

Thank you

- Thank you for participating in our provider orientation and for serving our members.
- We look forward to supporting you so that you improve the health of our Healthy Blue members.
- If you need additional information, please contact your Network Relations contacts.

Appendix

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

What is CAHPS®?

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

CAHPS (cont.)

Why focus on the patient experience?

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

How to improve the patient experience?

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

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

Healthy Blue

* Carelon Medical Benefits Management, Inc. is an independent company providing some utilization review services on behalf of Healthy Blue. Carelon Behavioral Health is an independent company providing some utilization review services on behalf of Healthy Blue.

https://provider.healthybluemo.com

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross Blue Shield Association.

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