

MO HealthNet Managed Care  
(Medicaid)



Healthy Blue

# Behavioral health provider orientation

# Agenda

- About us
- Who we serve
- Joining our network
- Provider roles and responsibilities
- Behavioral health services and covered benefits
- Claims tools and resources
- Health services
- Quality
- Resources
- Provider Experience





# About us

# History

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

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



# History (cont.)

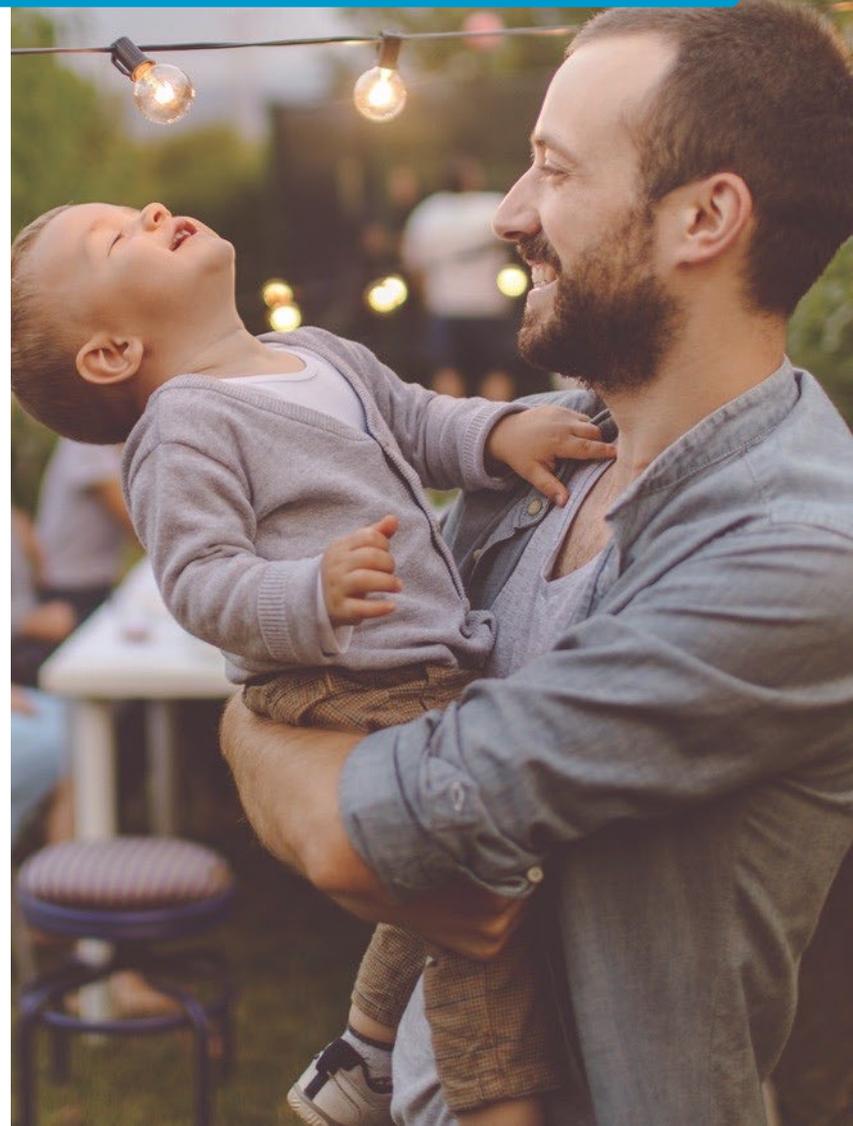
**We are proud to serve members statewide. Our mission is to provide access to quality healthcare for the members we serve.**

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

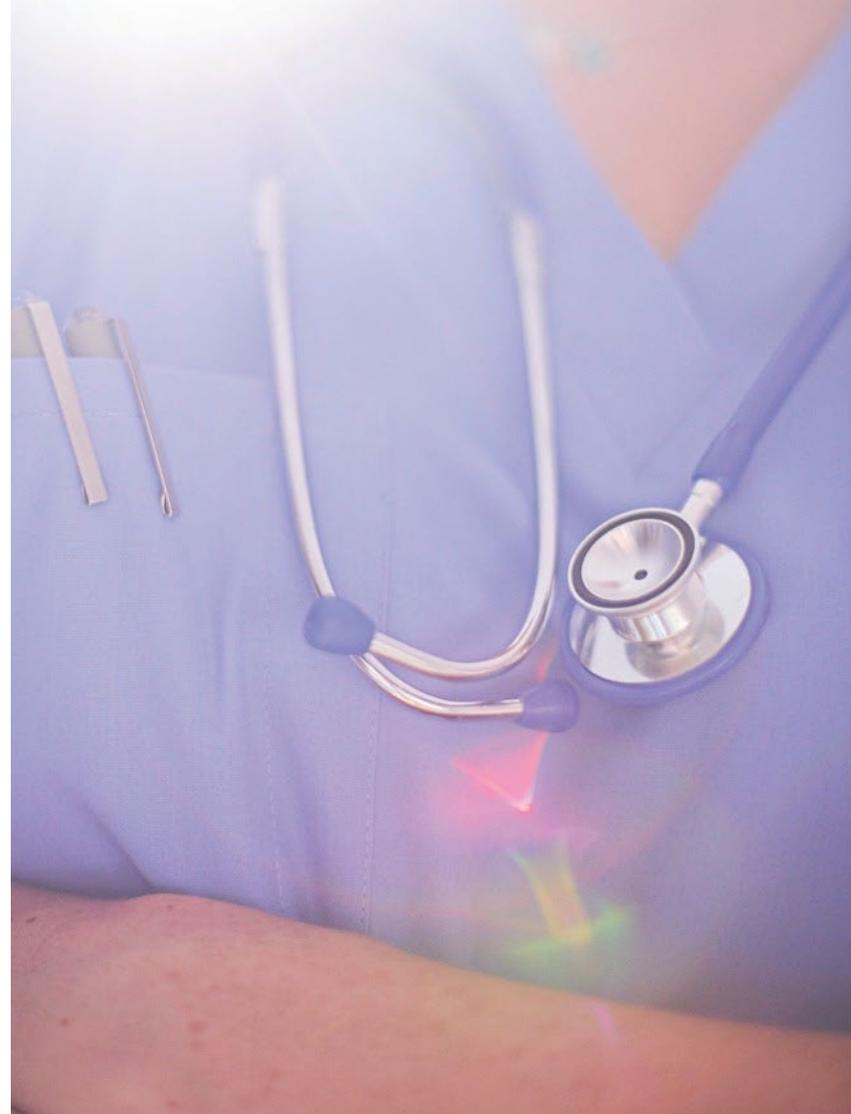


## Our values

Leadership  
Community  
Integrity  
Agility  
Diversity

# Our philosophy for behavioral health

- Health is not the absence of illness.
- Behavioral health (BH) is essential to overall health and is not separate from physical health.
- Acceptance, empowerment, responsibility, and hope are essential components of health.
- Our role is to support, enhance, and collaborate — not impede — the work of the caregiver/clinician.
- Each member is the CEO of his or her care.





## Who we serve



# Healthy Blue member ID card

 **Healthy Blue**

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Member ID #: \_\_\_\_\_ PCP Name: \_\_\_\_\_  
 DCN#: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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Effective Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

 **Healthy Blue**

**Members:** Please carry this card at all times. Show this card before you get medical care (except emergencies). In an emergency, go to the nearest emergency room even if it is not in Healthy Blue network or call 911. To file an appeal or grievance, call Member Services.

**Providers/Hospitals:** For preapproval/billing information, call 833-405-9086. For emergency admissions, notify Healthy Blue within 24 hours after treatment.

Payer ID: \_\_\_\_\_

**Submit medical claims to:**  
 Healthy Blue  
 P.O. Box 61010  
 Virginia Beach, VA 23466-1010  
 MOM1 01/21

**Important Contact Information:**  
[healthybluemo.com](http://healthybluemo.com)  
**Member Services:** 833-388-1407  
 Filing a Grievance: 833-388-1407  
 TTY: 711  
 24-Hour Nurse Help Line: 833-388-1407  
 24/7 Behavioral Health Crisis: 833-405-9088  
 Rides to covered services: 888-597-1193  
 Dental Services: 888-696-9533  
 Vision Services: 844-616-2724  
 Pharmacy Services: 800-392-2161  
 Care Management: 833-388-1407

Use of this card by any person other than the member is fraud. To report suspected fraud and abuse issues, call 833-388-1407.

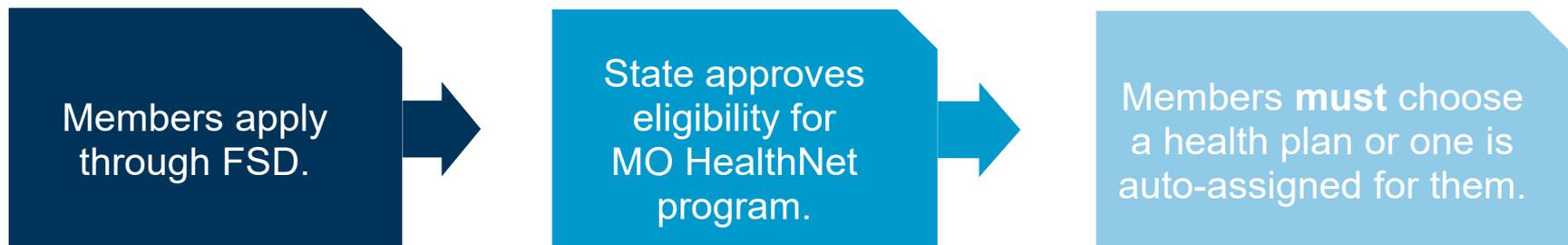
Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc.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



# 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 via Availity Essentials:
  - Go to [Availity.com](https://www.availity.com). Select Missouri > Patient Registration > Eligibility and Benefits. Select Healthy Blue from the drop-down box.
  - Complete required fields and submit.

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



Healthy Blue



## 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](https://www.availity.com) to obtain the member's current assigned PCP.



# eMOMED

- To the right 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 lock-in 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.
- BH providers are encouraged to check eligibility using eMOMED since this is the only place you can find the member's ME code.



Participant Information									
Participant DCN		Participant Name			Participant Date of Birth				
Participant Address		Participant SSN			Participant Date of Death				
Eligibility / Benefit Information1 of 6									
Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date	
B - Co-Payment	30 - Health Benefit Plan Coverage	60	7 - Day	\$0.00	MC - MO HealthNet	291		08/01/2016 12/31/2016	
Eligibility / Benefit Information2 of 6									
1 - Active Coverage	30 - Health Benefit Plan Coverage	60	7 - Day		MC - MO HealthNet	291		08/01/2016 12/31/2016	
Eligibility / Benefit Information3 of 6									
1 - Active Coverage	1 - Medical Care	60	7 - Day		MC - MO HealthNet	291		08/01/2016 12/31/2016	
	35 - Dental Care								
	47 - Hospital								
	48 - Hospital - Inpatient								
	50 - Hospital - Outpatient								
	88 - Emergency Services								
	89 - Pharmacy								
	99 - Professional (Physician) Visit - Office								
	AL - Vision (Optometry)								
	MH - Mental Health								
	UC - Urgent Care								
Eligibility / Benefit Information4 of 6									
I - Non-Covered	33 - Chiropractic	60	7 - Day		MC - MO HealthNet	291		08/01/2016 12/31/2016	
Eligibility / Benefit Information5 of 6									
R - Other or Additional Payor					HM - Health Maintenance Organization (HMO)	291		08/01/2016 12/31/2016	
Lock-in Information									
Name		Office Phone			Hotline Number (800)322-6027				

# 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 effective October 1, 2022, all BH 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.

A sample front view of a Healthy Blue ID card. The card features the Healthy Blue logo on the left and the Children's Mercy Pediatric Care Network logo on the right. The card is divided into sections for member information, PCP information, and effective dates. A large "SAMPLE" watermark is overlaid on the card.

Member ID #: DCN#:	PCP Name: Telephone #:
Effective Date: Date of Birth:	

A sample back view of a Healthy Blue ID card. The card features the Healthy Blue logo on the left and the Children's Mercy Pediatric Care Network logo on the right. The card contains important contact information, member instructions, and provider/hospital information. A large "SAMPLE" watermark is overlaid on the card.

**Important Contact Information:**  
healthybluemmo.com  
Member Services: 833-388-1407  
Filing a Grievance: 833-388-1407  
TTY: 711  
24-Hour Nurse Help Line: 855-670-2642  
24/7 Behavioral Health Crisis: 833-405-9088  
Rides to covered services: 888-587-1193  
Dental Services: 888-696-9533  
Vision Services: 844-616-2724  
Pharmacy Services: 800-352-2161  
Care Management: 877-347-5367

**Members:** Please carry this card at all times. Show this card before you get medical care (except emergencies). In an emergency, go to the nearest emergency room even if it is not in Healthy Blue network or call 911. To file an appeal or grievance, call Member Services.

**Providers/Hospitals:** For preapproval/billing information, call 877-347-5367. For emergency admissions, notify Healthy Blue within 24 hours after treatment.

Payer ID:

Use of this card by any person other than the member is fraud. To report suspected fraud and abuse issues, call 833-388-1407.

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 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 and Blue Shield Association.

Submit medical claims to:  
Healthy Blue  
P.O. Box 61010  
Virginia Beach, VA 23466-1010  
MOCMS 01/21

# CMPCN (cont.)

- CMPCN manages and issues all medical and effective October 1, 2022, all 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

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

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

- PA phone number: **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-Multispecialty Groups not Assigned to Carelon Behavioral Health

If you are a Behavioral Health Provider/Group that is multispecialty and not assigned to Carelon Behavioral Health, Inc. interested in joining the network, visit [provider.healthybluemo.com](https://provider.healthybluemo.com) and select **Join Our Network**.

**Welcome, Providers!**

Below is a list of resources that help health care professionals do what they do best — care for our members. At Healthy Blue, we value you as a provider in our network. That's why we've redesigned the website to make it more useful for you and easier to use.

Interested in joining our provider network? We look forward to working with you to provide quality services to our members.

[Join Our Network](#)



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# Submitting demographic data requests

## Including New Providers, Updates, and Terminations-Multispecialty groups not assigned to Carelon Behavioral Health

- 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-Delegated providers not assigned to Carelon Behavioral Health

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



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# Join the Network-Non-multispecialty groups assigned to Carelon Behavioral Health

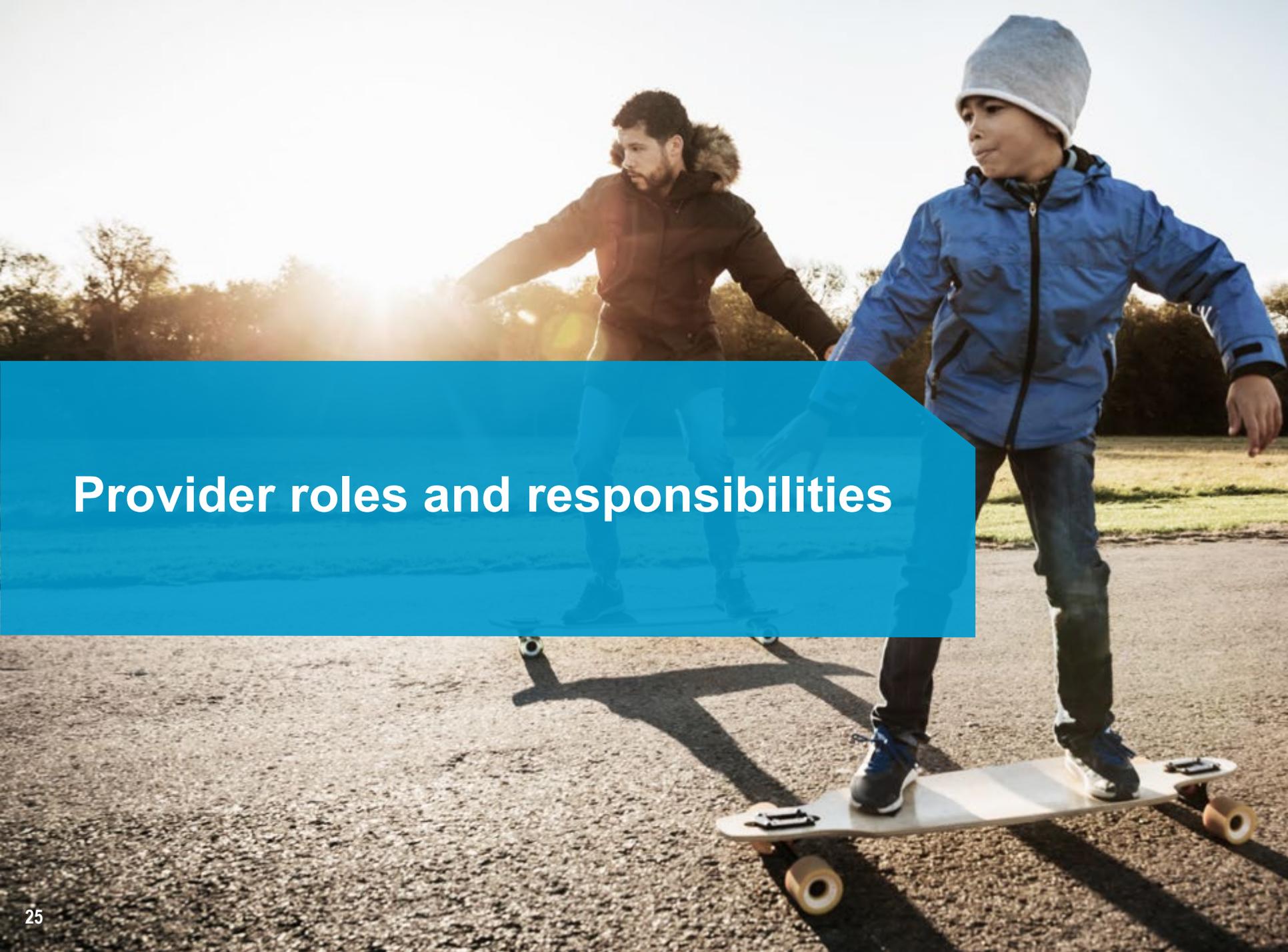
New Behavioral health providers/groups that are not multispecialty and existing groups that have been notified of their contract assignment to Carelon Behavioral Health, Inc. should enroll with Carelon Behavioral Health.

**To Join Carelon Behavioral HealthNetwork:** Please visit [Carelon Behavioral Health](#).

# Demographic Updates — Carelon Behavioral Health

**For Demographic updates:** Please visit [Carelon Provider Portal](#) and select ***Update Demographic Information*** on the Home Page (for example, updating addresses, names, NPI, TIN). Please also update demographics on [CAQH ProView](#).

For any additional questions, please contact their National Provider Service Line: **800-397-1630**, 8 a.m. to 8 p.m. ET, Monday through Friday.



# Provider roles and responsibilities



# Appointment availability

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



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# Appointment availability (cont.)

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



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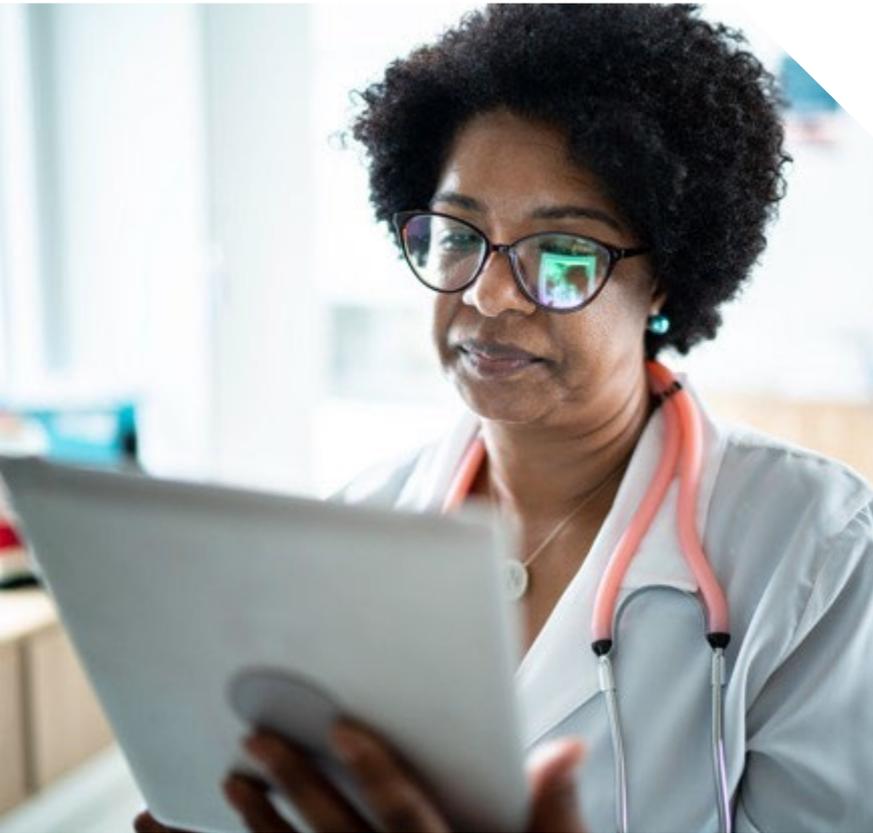
# Our goal for access and availability

## **The goals of the Behavioral Health program are to achieve the following:**

- Ensure adequacy of service availability and accessibility to eligible members
- Assist members and providers to utilize the most appropriate, least restrictive medical and behavioral healthcare in the right place at the right time
- Promote integration of the management and delivery of physical and behavioral health services to members
- Achieve Healthy Blue quality initiatives, including those related to HEDIS<sup>®</sup>, the National Committee for Quality Assurance (NCQA) performance requirements
- Work with members, providers and community supports to provide tools and an environment that supports members towards their recovery goals

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

# 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.

# Advance directives

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

- Durable power of attorney
- Living will

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

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



# 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.



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# Cultural Competency program



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

Call Healthy Blue Provider Services at **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 [mydiversepatients.com/resources-tools.html](https://mydiversepatients.com/resources-tools.html).



## **Behavioral health services and covered benefits overview**

# MO HealthNet billing manuals

The MO HealthNet billing manuals are available at  
[Provider Manuals | mydss.mo.gov](https://mydss.mo.gov/ProviderManuals)



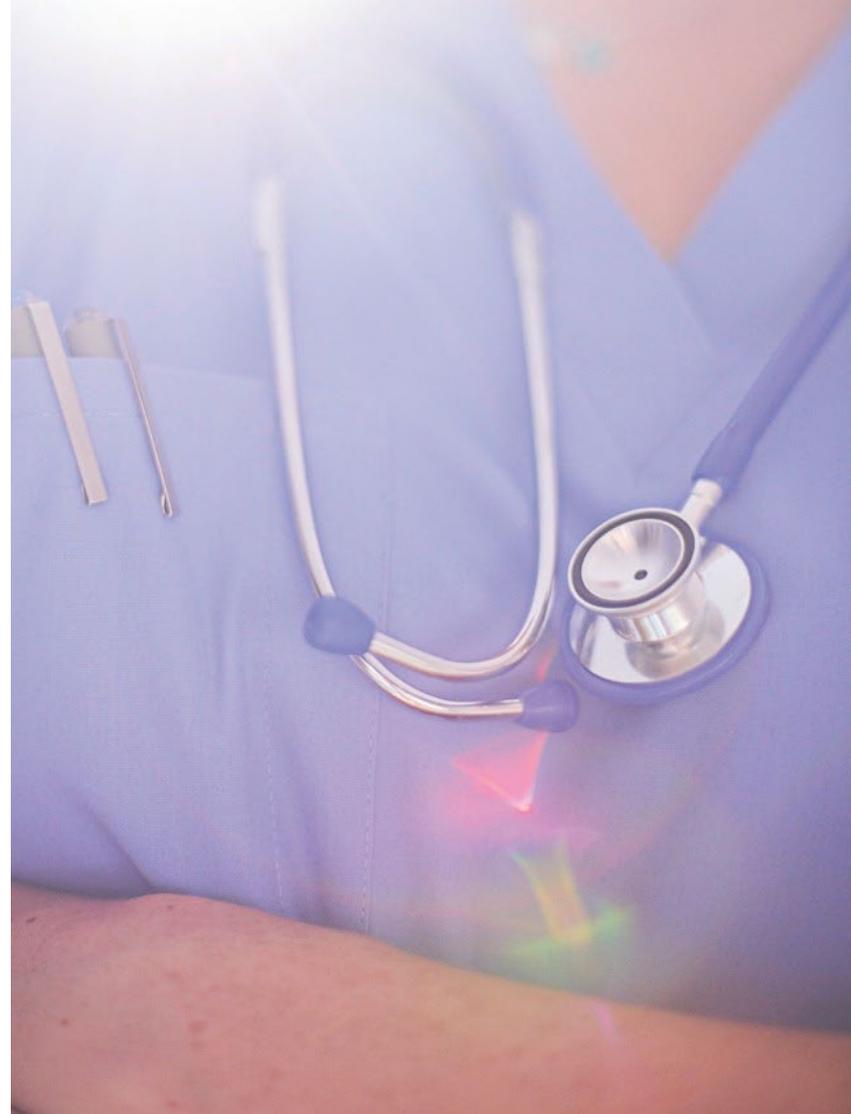
## Provider Manuals

### Provider Manuals

- AIDS Waiver
- Adult Day Care Waiver
- Aged & Disabled Waiver
- Ambulance
- Ambulatory Surgical Center
- Behavioral Health Adult Targeted Case Management
- Behavioral Health Services
- Behavioral Health Youth Targeted Case Management
- Certified Community Behavioral Health Clinics / Organizations Manual
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- Comprehensive Substance Treatment and Rehabilitation
- Comprehensive Substance Treatment and Rehabilitation / American Society of Addiction Medicine
- Developmental Disabilities Waiver
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Exceptions
- Healthy Children and Youth
- Hearing Aid
- Home Health
- Hospice
- Hospital
- Medicare / Medicaid Claims Processing
- Medically Fragile Adult Waiver
- Non-Emergency Medical Transportation
- Nurse Midwife
- Nursing Home
- Optical
- Personal Care
- Pharmacy
- Physician
- Private Duty Nursing
- Program of All-Inclusive Care for the Elderly
- Radiology
- Rehabilitation Centers
- Rural Health Clinic
- School District Administrative Claiming Manual
- School-Based IEP Direct Services Cost Settlement Manual
- School-Based IEP Specialized Transportation Services
- Targeted Case Management for Individuals with Developmental Disabilities
- Therapy
- Transplant

# Behavioral health services

- As of January 1, 2021, authorizations are required for inpatient admissions that commence on January 1 or thereafter.
- Many outpatient BH services do not require PA when rendered by a participating provider.
- Members must be Medicaid eligible and meet Medicaid eligibility requirements. As a reminder, the state determines Medicaid eligibility, not Healthy Blue.



# Scope of behavioral health covered benefits



Healthy Blue will cover, at a minimum, all covered BH benefits deemed medically necessary that are under our contract with MO HealthNet services. We follow the Medicaid schedule for all covered benefits.

## **Scope of covered behavioral health benefits:**

- Routine outpatient services when performed by a participating provider
- No age restrictions applied to members receiving outpatient service (LPC and LCSW can see members over the age of 21 per MO HealthNet guidelines)
- Medication management provided by a professional licensed to prescribe medication
- Inpatient hospital psychiatric services including, except as limited, services at the state operated psychiatric facilities
- Services that meet the concurrent substance use and mental health needs of individuals with co-occurring condition
- Lower levels of care including: Intensive outpatient programs and partial hospitalization programs

# Behavioral health referral and precertification

- Members may self-refer or may be referred for services to a participating Healthy Blue Behavioral Health provider. No referral form or approval is necessary.
- Participating BH providers may provide routine outpatient BH services without a PA as long as the visits rendered do not exceed the maximum number indicated on the *PA Authorization Grid* available on our [provider website](#). A PA is required prior to rendering services should the services exceed the maximum visit limitation outlined on the grid.
- Providers are required to adhere to the maximum daily and monthly limitations. Units billed over the daily, monthly, yearly limits represent a violation of MHD policy and are not reimbursed.
- Please refer to the *Behavioral Health Provider Manual* for limitations from MO HealthNet .

# Scope of substance use disorder services



Healthy Blue will cover, at a minimum, all covered substance use disorder services deemed medically necessary that are under our contract with MO HealthNet.

## **Scope of covered substance use disorder services:**

- Emergency services for substance use conditions
- Intake, assessment and diagnosis services not part of C-STAR
- Responsible for care coordination



# Pharmacy



**Effective since 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.



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A group of five people are sitting on a grassy field at sunset. They are all smiling and looking towards the camera. In the foreground, a woman in a bright pink shirt is holding a black and white sneaker. To her right, another person is holding a pink sneaker. The background is a warm, golden sunset with trees and a fence. A blue banner with white text is overlaid on the left side of the image.

## Claims, tools, and resources

# MO HealthNet fee schedule

- [MO HealthNet fee schedule](#)
- Select the link for the appropriate category for the CPT® code or modifier you want to view the allowed amount or modifier information for.
- Then select the radio button next to the *Proc Code* or *Modifier* and type in a procedure code or modifier.
- The search will show you if the CPT code and/or modifier combination are payable.

Missouri Department of SOCIAL SERVICES

Jay Nixon, Governor  
Brian Kinkade, Director

Professional and Technical Component  
Independent Lab - Professional Component  
Independent Lab - Technical Component  
Medical Services  
Nurse/Midwife  
Optical Services  
Other Medical  
Other Services  
Podiatry  
Radiology - Professional and Technical Component X-Ray / Nuclear Medicine / EEG / EKG  
Radiology - Professional Component X-Ray / Nuclear Medicine / EEG / EKG  
Radiology - Technical Component X-Ray / Nuclear Medicine / EEG / EKG  
Rehabilitation Center  
Surgery - Assistant Surgery  
Surgery - Postoperative Services  
Surgery - Without Postoperative Services  
Surgery and Epidermis

**Fee Schedule Search**

Medical Services

ProcCode	M1	M2	PA1	PA2	PA3	P1	ERDate	ReVal	Spec Fee	Qty
90791			0			3	01/01/2016	0.00	\$90.99	6
90791	AH		0			3	01/01/2016	0.00	\$30.30	6
90791	AJ					W	01/01/2015	0.00	\$0.00	6
90791	GT		0			3	01/01/2016	0.00	\$90.99	6
90791	GT	AH	0			3	01/01/2016	0.00	\$30.30	6
90791	HA	AH	0			3	01/01/2016	0.00	\$30.30	6
90791	TM		0			O	01/01/2013	0.00	\$90.08	6
90791	TM	AH	0			O	01/01/2013	0.00	\$30.00	6
90791	US		0			3	01/01/2016	0.00	\$96.03	6
90791	US	AH	0			3	01/01/2016	0.00	\$36.36	6
90791	UD					W	01/01/2015	0.00	\$0.00	6

Note: Should you have landed here as a result of a search engine or other link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the materials unless you read, agree to and abide by the provisions of the copyright statement.

Search Options  
Search For  
Proc Code  Modifier   
90791  Go  
MHD Price File Key  
Modifier Information

# Behavioral health modifiers

## Healthy Blue follows MO HealthNet guidelines for billing specialty modifiers:

- AH-Psychologist/Provisionally Licensed Psychologist
- AJ-Licensed Clinical Social Worker/Licensed Master Social Worker
- UD-Licensed Professional Counselor/Provisionally Licensed Professional Counselor

Where a specialty modifier is billed with U8, Healthy Blue expects the modifiers to be billed in the same order as they appear on *Missouri Medicaid Physicians Fee Schedule* provided by MO HealthNet.

[dss.mo.gov/mhd/providers/pages/cptagree.htm](https://dss.mo.gov/mhd/providers/pages/cptagree.htm)

# Availity Essentials

**Availity Essentials will be your exclusive, secure multipayer portal to access many Healthy Blue online tools and resources at [Availity.com](https://www.availity.com).**

- Your organization must be registered via Availity Essentials, and you need a unique ID and password.
- To begin registration, visit [Availity.com](https://www.availity.com) and select **Register**. You can sign up for a live webinar or explore other registration resources through the Availity Essentials training [microsite](#).
- Additional training can be found on the Availity Essentials Learning Center. Go to [Availity.com](https://www.availity.com) and select Help & Training > Get Trained.

# Healthy Blue provider website and Availity Essentials comparison

## Available through the Healthy Blue provider website:

[provider.healthybluemo.com](http://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 Essentials: [Availity.com](http://Availity.com)

- Registration/login required for access
- Precertification Look-Up Tool — Confirm if outpatient services require PA.
- Patient360 (provider facing)
- Multiple eligibility and benefits inquiry
- Provider Online Reporting
- PCP member panel listings
- Interactive Care Reviewer (ICR) – medical and behavioral health PA requests, notification of pregnancy and birth
- Pharmacy authorizations and benefits
- Claims dispute submission
- Claims dispute inquiry
- Medical appeal PA submission
- *Availity Essentials EDI Guide*
- *Maternity Attestation*
- Remittance inquiry



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# Provider Online Reporting registration

The provider organization's **Availity Essentials** 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 Essentials** homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select the **Application** tab, 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.



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# Claims submission information

- Healthy Blue encourages the submission of claims electronically through the electronic data interchange (EDI), either by using a clearinghouse, billing company, or sending directly. Availity Essentials serves as our gateway for all EDI transactions.
- Providers can register with Availity Essentials at [Availity.com](https://www.availity.com) to become a direct submitter using the organization's practice management software.
- Providers have the choice to enter claims using a single claim submission located under Claims & Payment > Professional or Institutional Claim.
- To initiate the electronic claims submission process or obtain additional information, contact Availity Essentials 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 Essentials.



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# Claims submission information (cont.)

## Availity Essentials:

- [Availity.com](https://www.availity.com)

## EDI submissions:

- Healthy Blue payer ID number — 00541

## Paper:

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



Healthy Blue

# Claim status inquiries

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

To access the information via **Availity Essentials**, perform a claim status inquiry:

- At the top of the Availity Essentials website, select **Claims & Payments | Claim Status**. On the Claims Status page, select your organization from the menu 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

do not enter the adjudication system because they have missing or incorrect information.

## Denied claims

go through the adjudication process but are denied for payment.

You can find claims status information via Availity Essentials at [Availity.com](https://www.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.



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# Corrected claims

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

## When to submit a corrected claim:

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



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# Provider claim payment 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.



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# Provider claim payment disputes (cont.)

## Claim payment disputes do not include:

- **Medical necessity/authorization denials:** A claim may deny for a denied authorization, not medically necessary or something similar. In these instances, the claim payment was denied due to a denial of the authorization/service. These should be managed through the grievance and appeals process.
- **No authorization denials:** When a service requires an authorization, but authorization was not requested, a claim will deny for no authorization. If you would like 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 Availity Essentials Appeal application payment dispute tool at [Availity.com](https://www.availity.com).

Through the Availity Essentials Appeal app, 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](https://www.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.



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# Claims overpayment recovery and refund process

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

Healthy Blue

P.O. Box 61010

Virginia Beach, VA 23466



# 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.



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# Electronic funds transfer (EFT)

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

- For 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](mailto:support@payeehub.org) for questions related to registration and enrollment.
- You can also refer to [enrollsafe.payeehub.org/content/pdf/EnrollSafe\\_User\\_Reference\\_Manual.pdf](https://enrollsafe.payeehub.org/content/pdf/EnrollSafe_User_Reference_Manual.pdf).
- For EFT decline questions, please contact Provider Services at **833-405-9086** or your provider relations 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 via EnrollSafe, you will receive a paper check or virtual card for services rendered.



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# Electronic remittance advice (ERA)

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

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



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# 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.



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# Remittance inquiry

**You will be able to view/receive remittance information through Availity Essentials. Providers will submit weekly remits. From Availity's 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. (An NPI is only required if you are searching by Date Range. 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.)

Select the **View Remittance** link associated with each remit to view, 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 into Availity Essentials and select **My Administrators**.

If you have 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 an outpatient 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* via **Availity Essentials**:

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



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# PA and notification



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

- Log in to **Availity.com** using your Availity Essentials credentials.
- From Availity's 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 also be faxed to the number listed on the [behavioral health authorization forms](#) on our provider website under the *Behavioral Health* tab.
- 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.

# Behavioral health precertification approval forms

All facility-based BH and substance use services require precertification, and some outpatient services require precertification. All services provided by nonparticipating providers require precertification. To obtain additional information about covered services and precertification requirements for covered BH services, please visit the provider website at [provider.healthybluemo.com](https://provider.healthybluemo.com) for information or to make referrals, call **833-388-1406**.

## **BH service request forms are found for the following services on the provider website:**

- Inpatient services (including Partial Hospitalization and Intensive Outpatient)
- Outpatient treatment
- Psychological testing
- Neuropsychological testing

# Clear Claim Connection

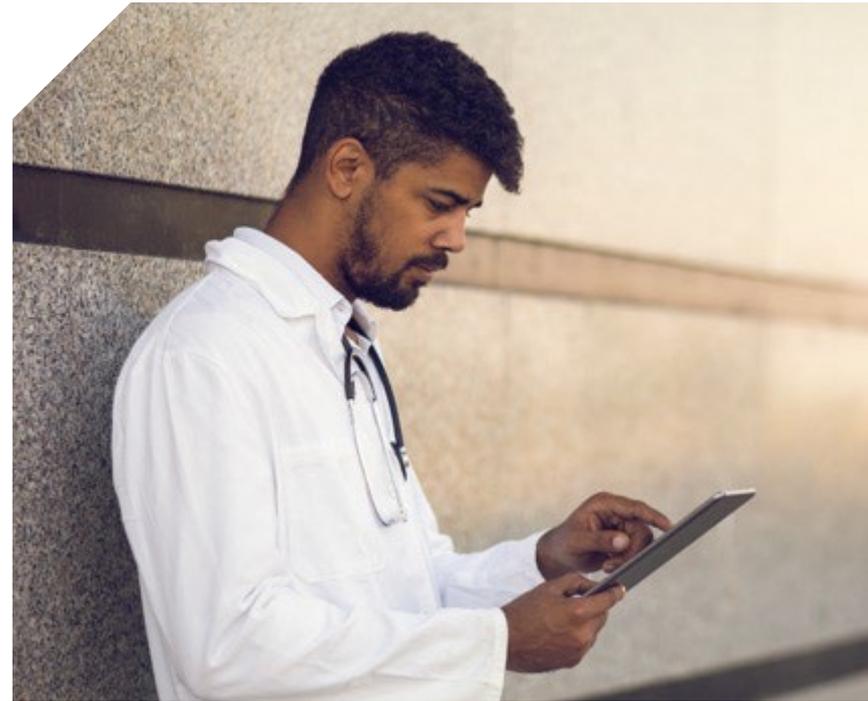
## **Use Clear Claim Connection™ for guidance when you submit a claim:**

- It is available via Availity Essentials 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.

# 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.



# 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](http://provider.healthybluemo.com) and completing the *Report Waste, Fraud and Abuse* form.
- Calling Healthy Blue Provider Services at **833-405-9086** Monday through Friday, from 7 a.m. to 8 p.m. CT.



Healthy Blue

A photograph of two men laughing together outdoors. The man on the left has brown hair and is wearing a blue and white striped shirt. The man on the right has dark curly hair and is wearing a white t-shirt with sunglasses hanging from the collar. A blue semi-transparent banner is overlaid on the lower half of the image.

# 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.



**Healthy Blue**



## Avoidable ER utilization (cont.)

- Offer extended hours (before or after regular work hours) or weekend hours to keep working patients and/or parents out of the ER.
- Use CPT code **99050** for services provided in the office at 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.



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# 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.

## **Neonatal care coordination services**

These services are provided directly by Healthy Blue. Healthy Blue's clinical team will work directly with providers and our Healthy Blue members, to continue to promote healthy outcomes for premature and medically complex newborns.

## **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.

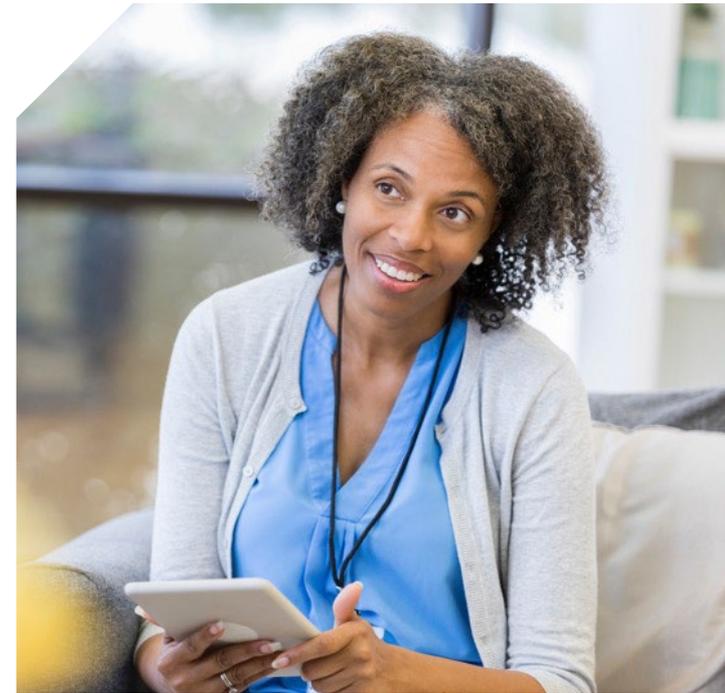


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# Care management

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



Healthy Blue

# Care management qualifications



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

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



# 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 Findhelp platform.
- Healthy Blue is broadening our partnership to close social determinant needs, including food, housing, transportation, job training, and others.



# LiveHealth Online (LHO): introducing telehealth



- In 2021, Healthy Blue introduced a web- and app-based telehealth platform to complement the existing services available from our providers.
- LHO\* increased access to services for our members, particularly in our rural areas where provider availability and transportation are a challenge.
- LHO also served 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 BH needs.

# Helpful phone numbers

Topic	Phone number	Additional information
PA	<b>833-405-9086</b>	Follow the prompts
Provider relations	<b>833-405-9086</b>	Follow the prompts
Member services	<b>833-388-1407</b>	Follow the prompts
MTM Transportation Services	<b>888-597-1193</b>	Contact number for members
24-Hour Nurse HelpLine	<b>833-388-1407</b>	For members' questions
DentaQuest	<b>844-234-9832</b>	Provider Services
March Vision Care	<b>888-493-4070</b>	Option 2 for members, option 3 for providers
MO HealthNet eligibility verification	<b>573-635-8908</b>	Option 1 (or go to <a href="https://www.eMOMed.com">eMOMed.com</a> )
Social resource team	<b>833-439-1058</b>	



# Your support system and staff

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

- Our Provider Relations team
- Our Medical Management staff
- 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.

**Provider Relations 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 Experience associate with any questions you may have.



**Healthy Blue**



# Key takeaways

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

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



Healthy Blue



# 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 Provider Relationship Account Representative.





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

**<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.

MOHB-CD-060533-24 June 2024