Provider Quick Reference Card

MO HealthNet Managed Care (Medicaid)

Healthy Blue

https://provider.healthybluemo.com

MOHB-CD-018487-23-CPN18476

Healthy Blue Prior Authorization/Notification Coverage Guidelines

Easy access to prior authorization/notification requirements and other important information

For more information about requirements, benefits and services, visit **https://provider.healthybluemo.com** for the most recent version of our provider handbook.

If you have questions about this document or recommendations to improve it, call your local Provider Experience associate or Provider Services at **833-405-9086**.

Prior authorization/notification instructions and definitions

Request prior authorization and give us notifications:

- Online using our preferred method, the Interactive Care Reviewer (ICR) via **availity.com**. Select Patient Registration > Authorizations & Referrals. Ask your Availity administrator to assign you the Authorization and Referral Request role.
- By phone: **833-405-9086**.
- Physical health inpatient notifications fax: **844-886-2758**.
- Outpatient fax: **800-964-3627**.
- Behavioral health inpatient fax: **844-462-0025**.
- Behavioral health outpatient fax: **844-462-0026**.
- Carelon Medical Benefits Management, Inc. phone: **855-574-6479** (services managed by Carelon Medical Benefits Management, Inc. are detailed below).

Prior authorization — The act of authorizing specific services or activities before they are rendered or occur

Notification — Telephonic, fax or electronic communication from a provider to inform us of your intent to render covered medical services to a member

- Provide notification prior to rendering services outlined in this document.
- For emergency or urgent services, provide notification within 24 hours or the next business day.
- There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.
- It is our policy to cover two routine prenatal ultrasounds for fetal anatomic survey per member per pregnancy (CPT codes 76801, 76802, 76805 and 76810). For CPT codes 76811, 76812, 76815, 76816 and 76817, additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT codes 76811 and 76812 are only reimbursable to maternal fetal medicine specialists.

The policy does not apply to the following specialists:

- Maternal fetal medicine specialists (S142, S083, S055 and S088)
- Radiology specialists (S164 and S232)

The policy also does not apply to ultrasounds performed in place of service code 23 — emergency department.

For code-specific requirements for all services, visit our provider self-service website and from the **Payer Spaces** homepage select the **Applications** tab and select **Precertification Lookup Too**l.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request prior authorization for services when network providers do not.

Air ambulance services — non-emergent air ambulance services go through MTM*

Authorization is required for all services. Providers have 30 days from the date of transportation to provide medical necessity documentation and request authorization of services. Emergent air ambulance request do not require prior authorization.

Applied Behavioral Analysis (ABA)

ABA services are carved out to MO HealthNet.

Behavioral health/substance abuse services

No prior authorization is required for basic behavioral health services provided in a primary care provider (PCP) or medical office. Prior authorization is required for inpatient services and some outpatient behavioral health services. All services require prior authorization for out-of-network providers. Substance abuse services are carved out to MO HealthNet. For more information on coverage and prior authorization requirements for Behavioral Health services, refer to the Prior Authorization Lookup Tool on our provider website.

Chemotherapy

- Prior authorization is required for inpatient chemotherapy as part of inpatient admission and for oncology drugs and adjunctive agents.
- Prior authorization is required for outpatient chemotherapy drugs.
- Prior authorization is not required for procedures performed in the following outpatient settings:
  - Office
  - Outpatient hospital
  - Ambulatory surgery center

For information on coverage and prior authorization requirements on chemotherapy drugs, refer to the Precertification Look Up Tool on the provider self-service website. Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

- Routine circumcisions are covered within the first 28 days of life.
- Medically necessary circumcisions are covered with no age limit.

Dermatology

- No prior authorization is required for a network provider for evaluation and management (E/M), testing, and procedures.
- Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic imaging

- No prior authorization is required for routine diagnostic testing.
- Prior authorization is required for magnetic resonance angiograms (MRAs), MRIs, CT scans, nuclear cardiology, video electroencephalograms (EEGs) and positron emission tomography (PET) imaging.
- Carelon Medical Benefits Management, Inc. manages prior authorization for the following modalities:
  - Computed tomography (CT/CTA)
  - Magnetic resonance (MRI/MRA)
  - Positron emission tomography (PET) scans
  - Nuclear cardiology
  - Echocardiography
    - Stress echo
    - Resting transthoracic echo
    - Transesophageal echo
  - Radiation oncology
  - Sleep medicine
  - Cardiology services
- *Carelon Medical Benefits Management Clinical Appropriateness Guidelines* and our *Medical Policies* will be used. Carelon Medical Benefits Management, Inc. guidelines are available online at **www.carelon.com**.
- Contact Carelon Medical Benefits Management, Inc. by phone at **855-574-6479**.

Durable medical equipment (DME)

No prior authorization is required for:

- Nebulizers.
- Standard walkers.
- Orthotics for arch support.
- Heels, lifts, shoe inserts and wedges.
- Bedside commodes.
- Canes and crutches.
- Diabetic shoes.

Durable medical equipment (DME) (cont.)

- Electric breast pump:
  - No authorization required.
  - To order breast pump, member contacts Edgepark via **855-504-2099** or **edgepark.com**.
  - Members are eligible during third trimester and up to 60 days post-NICU delivery.

Prior authorization is required for:

- All routine rentals and purchased DME equipment other than what is included above.
- Certain prosthetics and orthotics.
- Heavy duty walkers.
- Specialized wheelchairs.
- Oxygen concentrators.
- Insulin pumps and supplies.
- Hospital beds.
- Ventilators.
- Continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP) and automatic positive airway pressure (APAP) machines.
- Parenteral and enteral nutrition pumps.
- Lymphedema pumps.
- Hoyer lifts.
- Support surfaces.
- Power-operated vehicles (POV) and motorized wheelchairs.
- Osteogenesis stimulators.
- Seat lift mechanism.
- Apnea monitors.
- Wound care supplies.
- Standing frames.
- Incontinence products.
- Hearing aids.
- Chest wall oscillation devices.
- Suction pumps.
- Tracheostomy supplies.
- IV therapy and supplies.
- Humidifiers.
- Cochlear implants.
- Dialysis and end-stage renal disease equipment.
- Gradient pressure stockings.
- Light therapy/bili lights for jaundice babies.
- Sphygmomanometers.
- Continuous glucose monitoring devices.

For DME code-specific prior authorization requirements, visit **availity.com**. Select Payer Spaces > Applications > select Precertification Lookup Tool. Enter codes to determine authorization requirement.

To request prior authorization, submit a physician's order and fill out our prior authorization form, which can be found at **https://provider.healthybluemo.com**.

We must agree on the HCPCS and other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).

Our policy for rent-to-purchase on most items is limited to 10 continuous/consecutive months. For additional questions regarding rent-to-purchase items, contact **833-405-9086**.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit

- Members may self-refer for EPSDT visits.
- Use the EPSDT schedule and document visits.

Note: Vaccine serum is received under the Vaccines for Children (VFC) program. For questions about the VFC program, call **833-405-9086**.

Educational consultation

No prior authorization is required.

Emergency room

No prior authorization is required. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the ER.

Ear, nose and throat (ENT) services (otolaryngology)

- No prior authorization is required for a network provider for E/M, testing, and certain procedures.
- Prior authorization is required for:
  - Nasal or sinus surgery.
  - Cochlear implant surgery and services.

Family planning and sexually transmitted infection care

Members may self-refer to any in-network or out-of-network provider. Encourage patients to receive family planning services in-network to ensure continuity of service.

Gastroenterology services

No prior authorization is required for a network provider for E/M, testing, and certain procedures.

Prior authorization is required for:

- Bariatric surgery.
- Insertion, removal or replacement of adjustable gastric-restrictive devices and subcutaneous port components.
- Upper endoscopy.

Gynecology

No prior authorization is required for a network provider for E/M, testing, and certain procedures.

Hearing aids

Prior authorization is required for digital hearing aids.

Hearing screening

No prior authorization is required for:

- Diagnostic and screening tests.
- Hearing aid evaluations.
- Counseling.

Home health care and home IV infusion

Prior authorization is required for:

- Skilled nursing.
- Private duty nursing.
- Extended home health services.
- IV infusion services.
- Home health aide.
- Physical, occupational and speech therapy services.
- Physician-ordered supplies.
- IV medications for in-home therapy.

Note: DME require separate prior authorization.

Hospice care

A recipient must be terminally ill to receive hospice care. An individual is considered terminally ill if he or she has a physician-certified medical prognosis that the individual's life expectancy is six months or less if the illness runs its normal course.

Prior authorization is required.

Hospice services for children (newborn to 20 years old) may be concurrent with the care related to curative treatment of the condition for which a diagnosis for a terminal illness has been made. The hospice provider continues to be responsible for all services related to the palliation and support services for the terminally ill.

Hospital admission

- Prior authorization is required for elective and non-emergent admissions and some same-day or ambulatory surgeries.
- Notification is required within 24 hours or the next business day if a member is admitted into the hospital through the ER. This includes normal vaginal and cesarean deliveries. Pre-admission testing must be performed by a Healthy Blue preferred lab vendor or network facility outpatient department. See our provider directory for a complete listing.
- Notification of inpatient emergency admissions is requested within one business day of admission. Failure of admission notification after one business day may result in claim denial.
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.) are not covered.

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital.
- By telephone, fax or electronic medical record access.

It is the hospital's responsibility to submit clinical information for review by the specified next review date and time determined by the health plan at the time of admission and for continued length of stay.

The clinical submission deadline for Healthy Blue is 3 p.m. Central time. We will implement a 10-minute grace period to alleviate time discrepancies on fax machines. A fax confirmation for the transmittal of documentation prior to a specified time will be accepted by the plan as meeting the deadline.

If the clinical information is not submitted within the required time frame, the case will be administratively denied — reason: lack of timely submission of clinical information. The receipt of an administrative denial is based on the timely notification and submission of clinical information and is not based on medical necessity.

Hospital admission (cont.)

Administrative denials are not subject to our informal reconsideration or peer-to-peer process.

We will communicate to hospitals all approved days, denied days and bed-level coverage for any continued stay.

Your utilization management resources:
Hospital prior authorization/admission notification: Prior authorization request and notification of intent to render covered medical services

- Fax: **800-964-3627**
- Call: **833-405-9086**
- Web: **https://provider.healthybluemo.com**

Inpatient utilization management:
Inpatient admission and concurrent clinical information submissions for medical necessity review

- Fax: **844-886-2758**
- Call: **833-405-9086**

Hyperbaric oxygen and supervision of hyperbaric oxygen therapy

Prior authorization is required for the following:

- G0277 — Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval
- 99183 — Physician attendance and supervision of hyperbaric oxygen therapy, per session

To request PA, you may use one of the following methods:

- Interactive Care Reviewer (ICR) which is accessed through **availity.com** > select Patient Registration > Authorizations & Referrals. Ask your Availity administrator to assign you the Authorization and Referral Request role.
- Fax: **800-964-3627**
- Phone: **833-405-9086**

Laboratory services (outpatient)

Prior authorization is required for:

- Genetic testing.
- All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition.

It is important to use an in network laboratory provider for your lab testing needs. Access **https://provider.healthybluemo.com/missouri-provider/resources/referrals** for a current listing of contracted labs.

Medical injectables

Contact MO HealthNet for information about Pharmacy or Medical injectables.

- Phone: **800-392-8030**

Musculoskeletal

Request prior authorization by submitting complete clinical information as follows:

- Carelon Medical Benefits Management, Inc.
  - Phone: **855-574-6479**
  - Website: **www.carelon.com**

Requests submitted with incomplete clinical information may result in a denial.

Neurology

- No prior authorization is required for a network provider for E/M, testing, and certain other procedures.
- Prior authorization is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

Non-emergency medical transportation (NEMT)/Non-emergency ambulance transportation (NEAT)

No prior authorization is required. For nonemergency transportation, members can call MTM at **888-597-1193** to set up a ride.

Observation

All observation stays require authorization and medical necessity review. Prior authorization is required for observation up to 24 hours.

Obstetrical (OB) care

No prior authorization is required for:

- OB services and diagnostic testing.
- OB visits.
- Certain diagnostic tests and lab services by a participating provider.
- Prenatal ultrasounds (clinical guideline for medical necessity applies).
- OB care management programs are available for all women, with a focus on high-risk pregnancies.
- Normal vaginal and cesarean deliveries.

Notification requirements are as follows:

- Notify Provider Services of the first prenatal visit.
- For obstetric care, we require notification via fax **800-964-3627** or ICR; we do not require prior authorization.

Obstetrical (OB) care (cont.)

- We request you complete an Availity Maternity Application in addition to the notification of pregnancy and delivery.
- All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries.

Termination of pregnancy is carved out to the State and not a managed care benefit.
Prior authorization is required. Termination is only covered when:

- A woman suffers from a physical disorder, physical injury or physical illness — including a life-endangering physical condition caused by or arising from the pregnancy itself — that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of an act of rape or incest.

Baby delivery:

- Healthy Blue will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal Cesarean delivery. The hospital is required to notify Healthy Blue of the discharge date of the mother. Fax maternal discharge notifications to **844-886-2758** within one business day of discharge.
- For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for a Cesarean delivery, the hospital is required to provide:
  - Notification to our Provider Services team by phone at **833-405-9086** or fax at **800-964-3627**.
  - Initial hospital medical records and subsequent medical justification directly to the local health plan by fax at **844-886-2758**.
- The health plan is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an OB admission exceeding 48 hours after a vaginal delivery and 96 hours after a Cesarean section. In these cases, the health plan is allowed to deny only the portion of the claim related to the inpatient stay.
- If a member is admitted for an induction of labor and fails to deliver by day two of the admission, the hospital is required to submit inpatient medical records via fax for the first two days of admission for medical necessity review.

Birth notification:

- Hospitals are required to report the births of newborns within 24 hours of birth for enrolled members using ICR or fax **800-964-3627**.
- Within 24 hours of the birth (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Fax newborn delivery notification to **800-964-3627**.
- The clinical information required includes:
  - Whether it is a live birth
  - Newborn's birth weight
  - Gestational age at birth
  - Apgar scores
  - Disposition at birth
  - Type of delivery (vaginal or Cesarean*)
  - Date of birth
  - Gender
  - Single or multiple birth
  - Gravida, para, abortus for mother
  - Estimated date of confinement (EDC) and if neonatal intensive care unit (NICU) admission was required

* If delivery is by Cesarean section, the reason must be given.

- You may use the standard reporting form specific to your hospital as long as the required information outlined above is included.
- Providers are required to register all births through the *Notification of Delivery* form. We require notification via fax to **800-964-3627** or ICR.
- Well babies are covered under the mother's hospitalization authorization. If a newborn requires hospitalization as a boarder baby beyond the mother's discharge date, the hospital must provide notification as directed.

Ophthalmology

- No prior authorization is required for a network provider for E/M, testing, and certain other procedures.
- Prior authorization is required for repair of eyelid defects.
- We do not cover services that are considered cosmetic.

Oral maxillofacial

See *Plastic, cosmetic or reconstructive surgery*.

Out-of-area or out-of-network care
Prior authorization is required for all out-of-network services except for emergency care, EPSDT screening, family planning and OB care.

Outpatient or ambulatory surgery
Prior authorization is required based on the procedure performed; visit our provider website for more details.

Pain management, physiatric medicine, physical medicine and rehabilitation
Prior authorization is required for non-E/M-level testing and procedures.

Personal care services
- Personal care services are tasks that assist a member in activities of daily living related to a stable chronic condition. Personal care services are provided as a cost effective alternative to nursing home placement.
- Requires prior authorization.

Pharmacy services — carved out to MO HealthNet
- All pharmacy services are carved out to MO HealthNet except for medications billed as part of an inpatient admission stay.
- The pharmacy benefit covers medically necessary prescription and over the counter drugs prescribed by a licensed provider. Refer to the MO HealthNet Pharmacy Services at **800-392-8030** or **573-751-6527** for the preferred products within therapeutic categories, as well as requirements for prior authorization, prior use therapy, quantity edits and age edits. Note that some medications require a diagnosis code to be submitted on the prescription.
- Requests for nonformulary or nonpreferred drugs will require prior authorization by calling the MO HealthNet Pharmacy Services at **800-392-8030**.
- Pharmacy providers who need to check pharmacy eligibility can call Provider Services at **800-392-8030**.
- Members can call Member Services at **833-405-9086**.

Plastic, cosmetic or reconstructive surgery (including oral maxillofacial services)
- No prior authorization is required for E/M services, including oral maxillofacial E/M services.
- Prior authorization is required for:
  - All other services.
  - Trauma to the teeth.
  - Oral maxillofacial medical and surgical conditions.
  - Temporomandibular joint and muscle disorders.
- We do not cover services considered cosmetic in nature or related to previous cosmetic procedures.
- Reduction mammoplasty requires our medical director's review.

Podiatry
No prior authorization is required for E/M, testing, and most procedures.

Radiology
See *Diagnostic Testing*.

Rehabilitation therapy (short-term): speech, physical and occupational therapy
Request prior authorization by submitting complete clinical information as follows:
- Fax requests to Carelon Medical Benefits Management, Inc.

Requests submitted with incomplete clinical information may result in a denial. Initial outpatient therapy evaluations and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be completed and submitted with prior authorization requests.

Skilled nursing facility
Prior authorization is required.

Sterilization
- No prior authorization is required for sterilization, tubal ligation or vasectomy.
- We require a sterilization consent form for claims submissions. We do not cover reversal of sterilization.

Telemedicine

Healthy Blue offers telemedicine through LiveHealth Online* (LHO) for our members. LHO is a mobile app and website (**startlivehealthonline.com**) that provides members with a convenient way to have live video visits with board-certified doctors, psychologists or psychiatrists. This service is available through mobile devices or computers from anywhere for nonemergency health conditions.

Additionally, our behavioral health members may obtain telemedicine mental health services through One TeleMed,* a telemedicine company that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from healthcare providers. To make a referral to One TeleMed for a member, call **337-565-0843** and select **option 2.** Healthy Blue case management can also assist with care coordination for a member and can be reached by calling Provider Services at **833-405-9086**.

Urgent care center

No prior authorization is required for a participating or non-participating facilities.

Well-woman exam

No prior authorization is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network gynecologist.

The visit includes:

- Examination.
- Routine lab work.
- Sexually transmitted infections screening.
- Mammograms for members 35 and older.
- Pap smears. (One routine Pap test is allowed every three years per American College of Obstetrics and Gynecology [ACOG] guidelines).

Members can receive family planning services from any qualified provider without prior authorization. Encourage patients to receive family planning services from an in-network provider to ensure continuity of service.

Revenue (RV) codes

Prior authorization is required for services billed by facilities with RV codes for:

- Inpatient.
- OB.
- Home healthcare.
- Hospice.
- CT and PET scans and nuclear cardiology.
- Chemotherapeutic agents.
- Pain management.
- Rehabilitation (physical/occupational/respiratory therapy).
- Rehabilitation, short-term (for example, speech therapy).
- Specialty pharmacy agents.

Refer to our provider self-service website for code-specific prior authorization requirements and a complete list of specific RV codes.

Our service partners

Current listing of contract labs (lab services and diagnostic testing)	**https://provider.healthybluemo.com/missouri-provider/resources/referrals**
MTM Transportation (nonemergency medical transportation [NEMT]/ nonemergency ambulance transportation [NEAT])	Member service line: **888-597-1193**
March Vision* (vision services)	**844-616-2724**
DentaQuest* (dental services)	Member: **888-696-9533** Provider: **844-234-9832**
Carelon Medical Benefits Management, Inc. • Diagnostic or imaging services • Musculoskeletal (Spine therapy) • Radiation oncology • Cardiology services • Sleep medicine	**855-574-6479**

Provider experience program

Our Provider Services team offers prior authorization, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call **833-405-9086**, Monday through Friday from 8 a.m. to 6 p.m. Central time.

Local Provider Relations

We also offer local Provider Relations representatives who will help your office with ongoing education, contract and fee issues, procedural issues, and more.

Provider website and interactive voice response available 24/7. To verify eligibility, check claims and referral authorization status, and look up prior authorization/notification requirements, visit our provider self-service website.

Can't access the internet?

Call Provider Services and simply say your national provider ID when prompted by the recorded voice. The recording guides you through our menu of options; just select the information or materials you need when you hear it.

Claims services

Timely filing is within 180 calendar days from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility.

Because of the importance of EPSDT screenings and the collection of data related to these services, we encourage you to submit EPSDT claims as soon as possible within the timely filing period. For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date the third-party documents the resolution of the claim. In situations of enrollment in Healthy Blue with a retroactive eligibility date, the time frame for filing a claim will begin on the date we receive notification from the enrollment broker of the member's eligibility/enrollment.

Electronic data interchange (EDI)

Call our EDI hotline at **800-470-9630** to get started. If you use a different clearinghouse, contact your clearinghouse for instruction.

Paper claims

Submit claims on original claim forms (*CMS-1500 or CMS-1450*) printed with dropout red ink or typed (not handwritten) in large, dark font. AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

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

Payment disputes

First-level disputes/reconsiderations must be filed within 365 days of the adjudication date on your *Explanations of Payment (EOP)*. Second-level disputes/claims payment appeals (CPAs) must be filed within 90 calendar-days from the *EOP* date of the reconsideration to submit a CPA dispute. Forms for provider dispute and appeals are available on our provider self service website.

Mail to:
Payment Dispute Unit
Healthy Blue
P.O. Box 61599
Virginia Beach, VA 23466-1599

Payment disputes (cont.)

Changes or errors on claims, responses to itemized bill requests and submission of coordination of benefits/third-party liability information are not considered payment disputes. These should be resubmitted with a notation of corrected claim or claim correspondence to:
Claims Department
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

Peer-to-peer discussion

If our medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or servicing physician, and the member.

As a provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Health Care Management department at **833-405-9086**.

Peer-to-peer (P2P) discussion guidelines:

- The member, or provider/agent on behalf of a member, may request a P2P within three business days from the notification of a medical necessity denial.
- A provider, acting on behalf of a member, must submit the member's written consent in order to be eligible to participate in a P2P discussion concerning a prospective service (proposed admission, procedure, or service not yet rendered).
- Consent of the member who received a service is not required for a provider to act regarding a concurrent or post-service denial.
- Requests for P2Ps will be handled within one working day of the request.
- If the P2P discussion is not completed within the specified time frame, the formal appeal process will need to be followed.
- We will not complete P2P discussions on retrospective eligible, post-discharge hospitalizations. The medical director will make two attempts to connect with you at your specified contact number. If you fail to contact the health plan medical director, the request for a P2P will be closed, and your next course of action will be to follow the formal medical necessity appeal process.

Medical appeals

Medical appeals, or medical administrative reviews, can be initiated by members or providers on behalf of the member with the member's written consent and must be submitted within 60 calendar days from the date of the notice of proposed action.

A provider submitting on behalf of a member can write a letter, call, fax or use the provider appeals form on our provider self-service website. Submit in writing to:
Appeals and Grievance Processing
Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

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

Health services

Care Management (CM) services:

833-388-1407

We offer care management services to members who are likely to have extensive health care needs. Our care managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Disease Management (DM)/Population Health services:

888-830-4300

DM services include addressing the health needs of our members through education and connecting members to local community support agencies and events in the health plan's service area as applicable. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, major depressive disorder for adults and child/adolescents, schizophrenia, and substance use disorder.

Wellness Program services:

844-421-5661

We offer assistance with weight management and nutrition. The wellness program helps members by establishing individual goals and providing support and follow-up over a six-month period.

Quality Management (QM) program:
573-876-1522

We have a comprehensive QM program to monitor the demographic and epidemiological needs of the populations we serve. We evaluate the needs of our member populations annually, including age/sex distribution and inpatient, emergent/urgent care and office visits by type, cost and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

You have opportunities to make recommendations for areas of improvement. To contact the QM department about quality concerns or to make recommendations, call **573-876-1522.**

24-Hour Nurse Help Line:
833-388-1407

24-Hour Nurse Help Line is a telephonic, 24-hour triage service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed whether after-hours or on weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.
- Obtain a virtual physician visit directly with a Missouri-licensed online physician through LiveHealth Online at **livehealthonline.com**.

We encourage you to tell your Healthy Blue patients about this service and share with them the advantages of avoiding the ER when a trip there isn't necessary or the best alternative. Members can call our nurse line for health advice 24/7, 365 days a year.

Healthy Blue has a behavioral health 24-Hour Nurse Help Line crisis line that is staffed with licensed mental health clinicians who are trained to provide telephonic crisis intervention services. For members who are experiencing a crisis, licensed behavioral health clinicians can be reached at **833-405-9088**.

TTY services are available for the hearing impaired, and language translation services are also available.

Member Services:
833-388-1407

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. MTM is an independent company providing nonemergency transportation services on behalf of the health plan. One TeleMed and LiveHealth Online are independent companies providing telemedicine services on behalf of the health plan. March Vision is an independent company providing vision benefit management services on behalf of the health plan. DentaQuest is an independent company providing dental services on behalf of the health plan.

https://provider.healthybluemo.com

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