Healthy Blue | HERITAGE HEALTH

New provider orientation

Agenda

- About us
- Eligibility and benefits
- Claims tools and resources
- Compliance
- Quality management
- Partner services
- Provider resources
- Joining our network

About us

Introducing Healthy Blue

In January 2020, Anthem, Inc. purchased the WellCare of Nebraska, Inc. health plan. Our program is now called Healthy Blue. Healthy Blue is proud to serve our Nebraska members.

Your local Provider Relations staff will serve our provider network across the state.

Current offices include Omaha, Norfolk, Scottsbluff, Kearney, and Lincoln.

☆ Corporate Office

★ Welcome Room

Purpose, vision and values

Our mission

Improving lives and communities.
Simplifying health care.
Expecting more.

Our vision

To be the most innovative, valuable and inclusive partner

Our values

Leadership
Community
Integrity
Agility
Diversity

Member eligibility and benefits

Verifying member eligibility

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

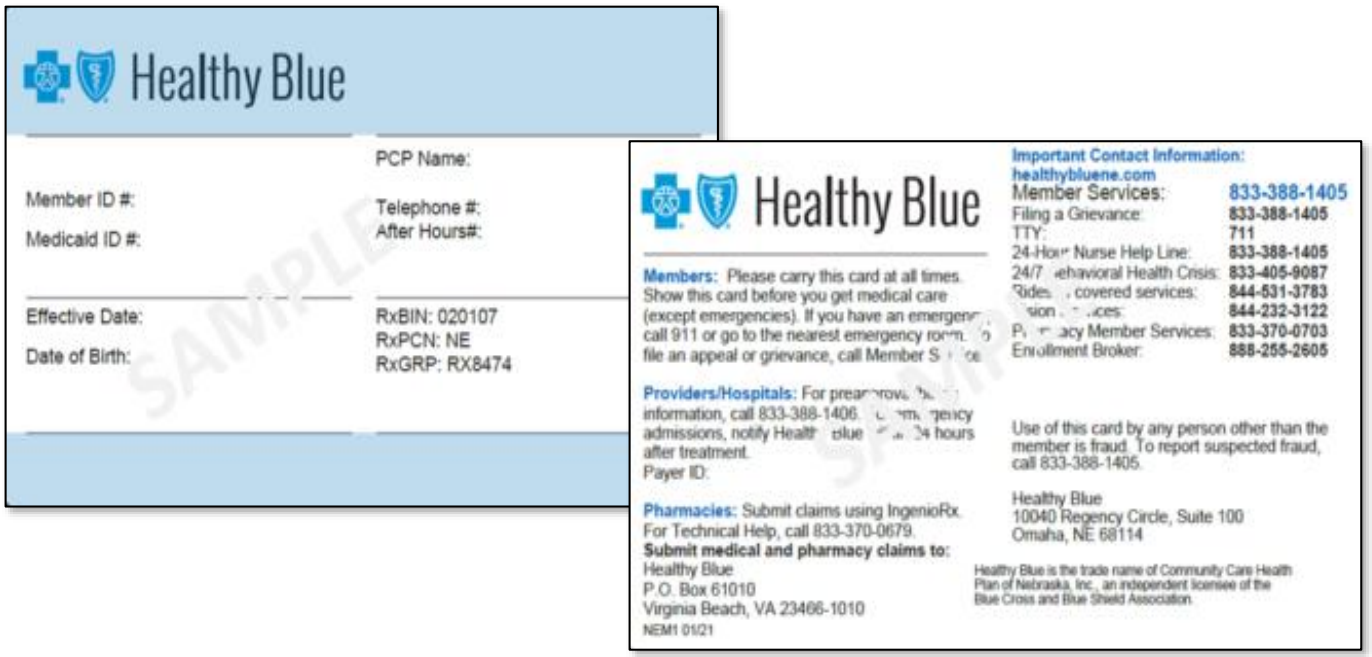
- Submitting a 270/271 electronic data interchange (EDI) transaction using your EDI software or through your clearinghouse.
- Submitting an eligibility and benefits inquiry through the Availity Portal.*
  - The secure Availity Portal is your exclusive, secure multipayer portal to access many Healthy Blue online tools and resources.
- Go to https://www.availity.com Select Patient Registration > Eligibility and Benefits. Select **Healthy Blue** from the drop-down box.
- Complete required fields and submit.
  - When checking eligibility for 599 CHIP Unborn population the gender field will need to remain blank.

Verifying member eligibility (cont.)

You will continue to be able to verify member eligibility information through the state.

- Nebraska Medicaid eligibility system interactive voice response — Telephone voice response system:
  - Log in and password request: **1-800-967-7902**
  - Eligibility verification phone number: **1-800-642-6092**
- Web access to direct eligibility verification via MMIS at http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx.

Sample member ID cards



Required covered benefits and services

- Healthy Blue will cover, at a minimum, all benefits and services deemed medically necessary that are covered under our contract with the Department of Health and Human Services.
- While some Healthy Blue members have copays for certain services, there are certain exceptions. A complete listing of covered benefits and copays can be found in our provider manual.

For more information on covered benefits, refer to the **Healthy Blue Provider Manual.**

There are no copays for:

- Members who are 18 years of age or younger.
- Pregnant members, during pregnancy and through postpartum — the last day of the month following the 60-day postpartum period.
- Members who are in an institution and whose services are reduced because of personal income.
- Members receiving hospice care.
- American Indian members.
- Members who are receiving Medicaid for treatment of breast or cervical cancer.

Behavioral health services

Healthy Blue will continue providing members with a comprehensive array of mental health and substance abuse services for adults, adolescents and children including:

- Behavioral health inpatient services.
- Standard outpatient services.
- Residential treatment.
- Halfway house services.
- Community based services
- Peer support services.
- Psychological testing (requires prior authorization)
- Members can self-refer and do not need to call their PCP for a referral for a mental health or substance abuse assessment.
- Emergency behavioral health services do not require authorization.
- Inpatient admission notification is required on the next business day following admission.
- For some outpatient services, members can schedule appointments and access services with no prior authorization from Healthy Blue required.

For more information on Behavioral health benefits,
refer to the Provider Manual.

Pharmacy services

To ensure members receive the most out of their pharmacy benefit, consider the following guidelines when writing prescriptions:

- Follow national standards of care guidelines for treating conditions.
- Prescribe preferred drugs (see provider website for link to covered drugs).
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class.
- Evaluate medication profiles for appropriateness and duplication of therapy.

Review the new Healthy Blue pharmaceutical utilization management (UM) tools that are used to optimize the pharmacy program and they include:

- PDLs
- Medication prior authorization process
- Mandatory Generic Policy
- Step therapy (ST)
- Quality Level Limit (QL)
- Restrictive services

For more information on pharmaceutical utilization management (UM) tools, refer to the Provider Manual and https://provider.healthybluene.com.

Maternal Child Services — The New Baby, New Life Program

- Healthy Blue offers the New Baby, New Life$_{SM}$ Program. For newly-identified pregnant women, complete the *Maternity Notification Form* and fax it to **1-800-964-3627**.
- For pregnant women that have delivered, complete the *Newborn Notification of Delivery Form* and fax it to **1-800-964-3627**.
- Or complete these forms using the Interactive Care Reviewer (ICR) platform.
- Care management is available for those members with high risk pregnancies.

As part of the New Baby, New Life program, members may receive the My Advocate®* program as well.

This program provides pregnant and postpartum women proactive, culturally appropriate outreach and education though interactive voice response (IVR), web or smartphone application.

For more information on My Advocate, visit www.myadvocatehelps.com.

Disease Management program

Healthy Blue offers a Disease Management program that is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions.

- Asthma
- Bipolar disorder
- Diabetes
- Chronic Obstructive Pulmonary Disorder (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- HIV/AIDS
- Hypertension
- Major Depressive Disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder (SUD)
- Weight management and education

Disease Management can be reached **1-888-830-4300**
Monday to Friday 8 a.m. to 6 p.m. CT.

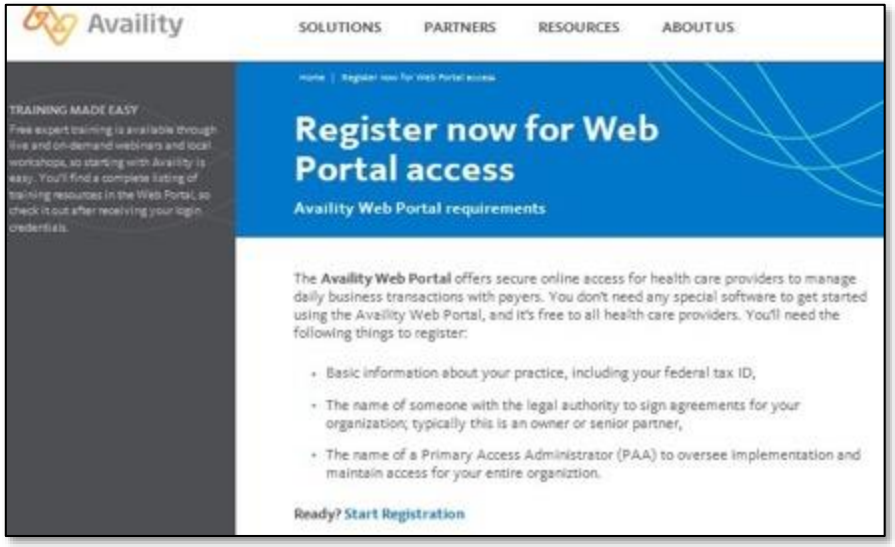
Tools and resources

Availity Portal

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

To register:

- Visit https://www.availity.com and select **Register**.
- To access Availity training, login to Availity.
- Click **Help & Training | Get Trained**.
- If you are new to Availity, you will need to name an administrator who can grant you access to the tools you need.
- If you already use Availity, no additional registration is needed. Healthy Blue will appear as one of your options in the payer drop-down.



Public website

Provider online reporting registration

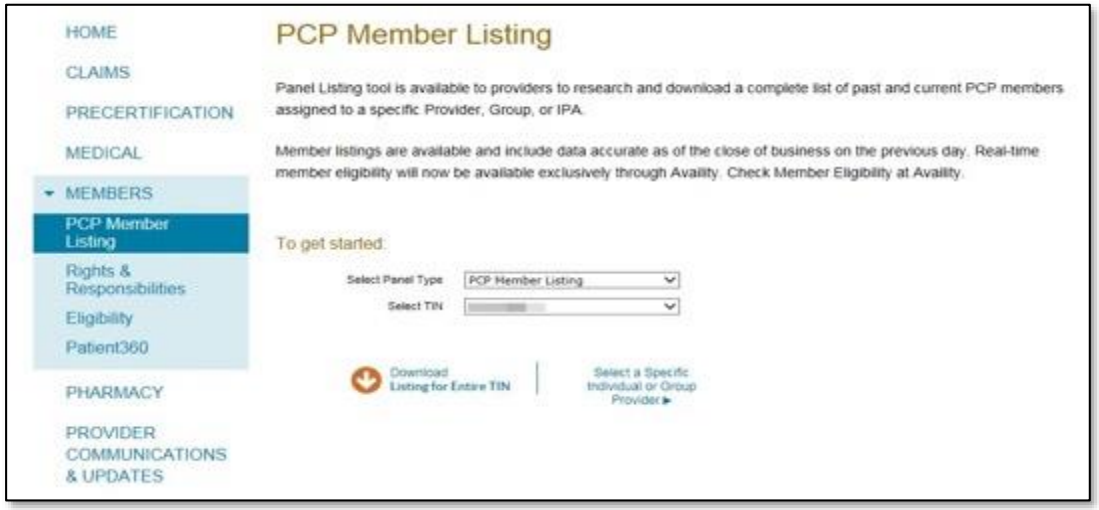
The provider organization's Availity administrator is responsible for registering the tax IDs and users for provider online reporting.

The administrator will take the following steps to register:

- From the *Availity* homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select **Applications**, 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. (Users also must be given the Provider Online Reporting role assignment on the Availity Portal)
- Complete all fields on the *Register User* page. Select **ADD TO PREVIEW** and **Save**.

Provider Panel Listing Tool

- The Provider Panel Listing Tool is a tool for providers to research and download a complete list of past and current members assigned to a specific provider, group or independent practice association.
- Member listings include data captured at the close of business on the previous day.
- Real-time member eligibility is available through the Availity Portal.
- Member panel listings and reports are accessible via the provider online reporting application under *Payer Spaces*.
- Registration for provider online reporting is required.



Healthy Blue provider website and Availity Portal comparison

Available through the Healthy Blue provider website:
https://provider.healthybluene.com

- 24/7 access to all providers, regardless of participation status
- Open access without registration/login
- Claims forms
- Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool
- Provider manual
- *Clinical Practice Guidelines*
- News and announcements
- *Provider Directory*
- Fraud, waste and abuse resources
- *Preferred Drug Lists* (*PDLs*)
- *Medical Policies*

Available through the Availity Portal:
https://www.availity.com

- Registration/login required for access
- 24/7 access
- Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool
- Patient360 (provider facing)
- Multiple eligibility and benefits inquiry
- POR — Provider Online Reporting
- PCP member panel listings
- Interactive Care Reviewer (ICR) — medical prior authorizations requests
- Pharmacy authorizations and benefits
- Claims dispute submission and inquiry
- Medical appeal prior authorization submission
- *Availity EDI Guide*
- Maternity identification
- *HEDIS® Attestation*
- Remittance Inquiry

Claims and encounters

Clean claims

A clean claim is a claim submitted for reimbursement that contains the required data elements and any attachments requested by Healthy Blue.

To qualify as a clean claim, we require the following attachments:

- A Medicare remittance notice if the claim involves Medicare as a primary payer and Healthy Blue provides evidence it does not have a crossover agreement to accept an electronic remittance notice.
- Description of the procedure or service, which may include the medical record if a procedure or service rendered has no corresponding CPT® or HCPCS code.
- Documents referenced as contractual requirements in a global contract (if applicable).
- Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute.

Find more information on the required data elements and attachments
in the Healthy Blue provider manual.

Claims submissions

Claims submission timeframes.

- Claims must be submitted within 180 days of the date of service and 365 days of the date of service, where Healthy Blue is the secondary payer.
- Claims will be processed and paid or denied within 15 business days of receipt.
- Daily check runs for both paper checks and electronic funds transfer (EFT) payments, except for Sundays and the last day of each month.

Healthy Blue encourages the submission of claims electronically through the Electronic Data Interchange (EDI).

Using our electronic tool reduces claims/payment processing expenses and offers:

- Faster processing than paper.
- Enhanced claims tracking.
- Real-time submissions directly to our payment system.
- *HIPAA*-compliant submissions.
- Reduced claim rejections and adjudication turnaround time.

Claims submissions (cont.)

Electronically: Electronic claims submission can be done either by using a clearinghouse or sending directly. Availity serves as our gateway for all EDI transactions.

- If you have a relationship with a clearinghouse, please work with them to ensure connectivity with Availity.
- Healthy Blue Payer ID number is 00544.
- Providers can also register with Availity at http://www.availity.com to become a direct submitter.
  - To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**).
  - Availity Client Services is available Monday to Friday 9 a.m. to 8 p.m. CT.

Fax: We do not accept faxed claims — 365 days is the timely filing limit when Healthy Blue is the secondary payer.

Paper Claims address: Healthy Blue, PO Box 61010, Virginia Beach, VA 23466-1010

Claim status inquiries

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

To access the information on Availity Portal:

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

Rejected versus denied claims

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

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

- You can find claims status information on the Healthy Blue provider website at https://provider.healthybluene.com or by calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 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.

Claims overpayment recovery and refund procedure

- Healthy Blue seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable and 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 the address below.
- The *Recoupment Notification Form* and *Overpayment Refund Notification Form* are located at https://provider.healthybluene.com.
- For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 30 days, the overpayment amount is deducted from your future claims payments.
- If you believe the overpayment notification was created in error, contact Healthy Blue Provider Services **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Healthy Blue
P.O. Box 61599
Virginia Beach, VA 23466-1599

Provider claim payment disputes

- If a provider disagrees with the outcome of a claim, you may begin the claim payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome. We must receive your dispute within **90** 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.

Submitting claim payment disputes

How to submit a provider dispute
There are several options for filing a dispute:

Online:

Use the secure Provider Availity Payment Dispute Tool at https://www.availity.com

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

Verbally
(reconsiderations only):

Call Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Written
(reconsiderations and claim payment appeals):

Reconsideration Form is located a https://provider.healthybluene.com

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

Provider claim payment disputes

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.

Claim correspondence

- Correspondence is when Healthy Blue requests more information to finalize a claim.
- Correspondence is **not** considered a provider claim payment dispute.
- Typically, request for information is done through the *EOP*.
  - Examples: Submit medical record, submit itemized bill, submit other health information.
- The claim or part of the claim will appear as denied on the *EOP*.
  - However, this is only because more information is required to finalize the claim.
  - Once the information is received, Healthy Blue will use it to finalize the claim.

You may submit correspondence:

- **Online** — This is the most efficient way to submit correspondence. You can submit through Availity. You can access the online tool at https://www.availity.com.
- **In writing** – Mail all required documents to:
  Healthy Blue
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Reimbursement Policies

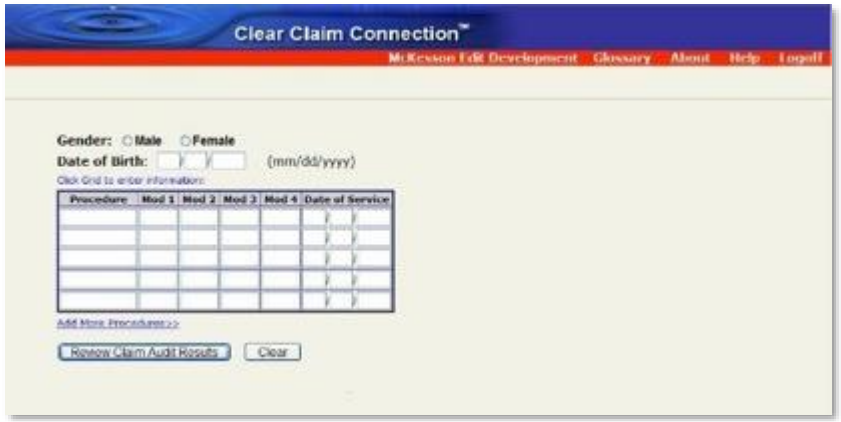
- *Reimbursement Policies* serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan.
- Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard compliant codes on all claim submissions.
- The billed code(s) should be fully supported in the medical record and/or office notes.

Reimbursement Policies are located on the
Healthy Blue provider website https://provider.healthybluene.com
and the Availity Portal https://www.availity.com.

Clear Claim Connection

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

- The tool is available on the Availity Portal through Payer Spaces, 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.



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.

Code and clinical editing

- Healthy Blue applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits.
- Healthy Blue uses sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices.
- Editing sources include but are not limited to CMS National Correct Coding Initiative, *Medical Policies* and *Clinical Utilization Management Guidelines*.
- We are committed to working with you to ensure timely processing and payment of claims.
- For additional information, refer to the provider manual and/or your *Provider Agreement* as a guide for reimbursement criteria. You can also contact Healthy Blue Provider Services Monday to Friday 8 a.m. to 9 p.m. CT. for more information.

Electronic payment services

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

- Claims 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) providers the following benefits:

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

Electronic payment services (cont.)

- In order to receive EFT payments you will need to register and enroll with the CAQH© Solutions EnrollHub™ tool at https://www.caqh.org/solutions/enrollhub and select the payer name containing Healthy Blue.
- For registration-related questions, contact EnrollHub Help Desk at **1-844-815-9763** Monday to Thursday 8 a.m. to 10 p.m. CT. Friday 8 a.m. to 8 p.m. CT. or efthelp@EnrollHub.CAQH.org.
- Even if you are registered with CAQH and enrolled with another payer, you will need to enroll in Healthy Blue to receive payments via EFT.

For even more convenience, you can also enroll for online Electronic Remittance Advice (ERA):

- If you wish to enroll for ERA (835), use Availity to register and manage account changes.
- If you have a relationship with a clearinghouse, (Please work with them to ensure connectivity to the Availity EDI Gateway.)
- Visit https://apps.availity.com/web/welcome/#/edi to get started. If you have any questions, contact Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** Monday to Friday 8 a.m. to 7:30 p.m. CT.

Remittance inquiry

- You will be able to view/receive remittance information through the Availity Portal.
- From the Availity Portal homepage Select Payer Spaces > Healthy Blue NE > Applications. The *Remittance Inquiry* application will appear as an option. Choose *Remittance Inquiry* to gain access to the *Remittance Inquiry* functionality.
- Choose your organization and tax ID number. If the administrator previously loaded NPIs, select your NPI from the *Express Entry* drop-down menu. Otherwise, enter an NPI number in the allotted box.
- You can choose from one of three search options:
  - EFT number
  - Check number
  - Date range
- If you need an image of the remittance for your files, select the **View Remittance** link associated with each remit on the list and **Print** or **Save**.
- Contact your administrator if you do not see this tool to request claims status access. If you don’t know who the administrator is for your organization, log in to Availity and select **My Administrators**.

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 Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care (MLTC) collects and uses this data for many purposes such as:

- Federal reporting.
- Rate setting.
- Risk adjustment.
- Service verification.
- Managed care quality improvement.
- Utilization patterns.
- Access to care determinations.
- Various research studies.

Utilization management and prior authorizations

Inpatient concurrent review

- Inpatient concurrent review is the process of obtaining clinical information to establish medical necessity for a continued inpatient stay including review for extending a previously approved admission. Failure to submit clinical information may results in a lack of information adverse determination (denial).
- Facilities are required to supply the requested clinical information within 24 hours of the request to support continued stay.
- During each concurrent review interval, the clinician will assess member progress and needs to help coordinate such needs prior to discharge. This is done to help facilitate a smooth transition for the member between levels of care or home and to avoid delays in discharge due to unanticipated care needs.
- In addition, the attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

Inpatient level of care review guidelines

- MCG Care Guidelines are evidence-based guidelines used for clinical decisions and care planning. There are separate guidelines covering specific areas of care. MCG Care Guidelines for inpatient level of care will be used on go-live.
- Healthy Blue has the right to customize MCG Care Guidelines based on determinations by Its Medical Policy and Technology Assessment committee.

Precertification Lookup Tool

- Certain medical procedures require the submission and approval of PA.
- To verify if PA is required, use the Precertification Lookup Tool.

Detailed authorization requirements can be found using the Precertification Lookup Tool:

- Search by market, member product and CPT code.
- This is for outpatient services only — All inpatient services require an authorization.

Precertification Lookup Tool is located under *Payer Spaces* on the Availity Portal:

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

Prior authorization and notification

You can submit a PA request, look up a status or submit a clinical appeal online using our self service authorization tool – Interactive Care Reviewer.

- Log in to https://www.availity.com using your Availity. Then:
- From the Availity Portal homepage, select **Patient Registration** from the top navigation bar.
- Select **Authorizations & Referrals**.
- Select **Authorizations**.
- Select the payer and organization.
- Select **Submit**.
  - The Interactive Care Reviewer (ICR) application will open.
  - Use ICR to submit and manage (appeal) your medical PAs.
  - Urgent request can be submitted via ICR or by calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

AIM Specialty Health

- AIM Specialty Health®* manages precertification for the following modalities: Radiology, Cardiology, Sleep, Musculoskeletal, Rehabilitation (PT, OT, ST), Genetic Testing and Radiation Oncology.
- **How to place a review request:**
  - **Online** — via the AIM Provider Portal. Provider Portal is available 24/7, and processes requests in real-time using clinical criteria. Go to www.providerportal.com to register.
  - **By phone** — Call AIM Specialty Health toll free at **1-855-574-6478** Monday to Friday 7 a.m. to 7 p.m. CT.
- For resources to help your practice get started with AIM specialty benefits program, visit www.providerportal.com to learn more and gain access to useful information and tools such as order entry checklists, Clinical Guidelines and FAQs.

PA for inpatient admissions

- All medical emergent inpatient hospital admissions will be reviewed within 72 hours or three calendar days of the facility notification to Health Blue.
- Emergent inpatient admissions require notification within one business day following the admission.
- Authorizations can be submitted via phone, fax or Availity Portal.
- Failure to comply with notification and authorization rules will result in an administrative denial.

Availity:
https://www.availity.com

Fax: Nonbehavioral health:
1-800-964-3627

Fax: BH:
- **Inpatient: 1-844-462-0024**
- **Outpatient: 1-844-462-0027**

Healthy Blue Provider Services:
1-833-388-1406
Monday to Friday 8 a.m. to 9 p.m. CT.

PA for inpatient admissions (cont.)

Elective admissions

- Healthy Blue requires precertification of all inpatient elective admissions. The referring primary care provider (PCP) or specialist physician is responsible for precertification.
- The referring physician identifies the need to schedule a hospital admission and must submit the request to the Healthy Blue Medical Management department.
- Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow us to verify benefits and process the precertification request.
- For services that require precertification, Healthy Blue makes case-by-case determinations that consider the individual's health care needs and medical history in conjunction with medical necessity criteria.

PA for inpatient admissions (cont.)

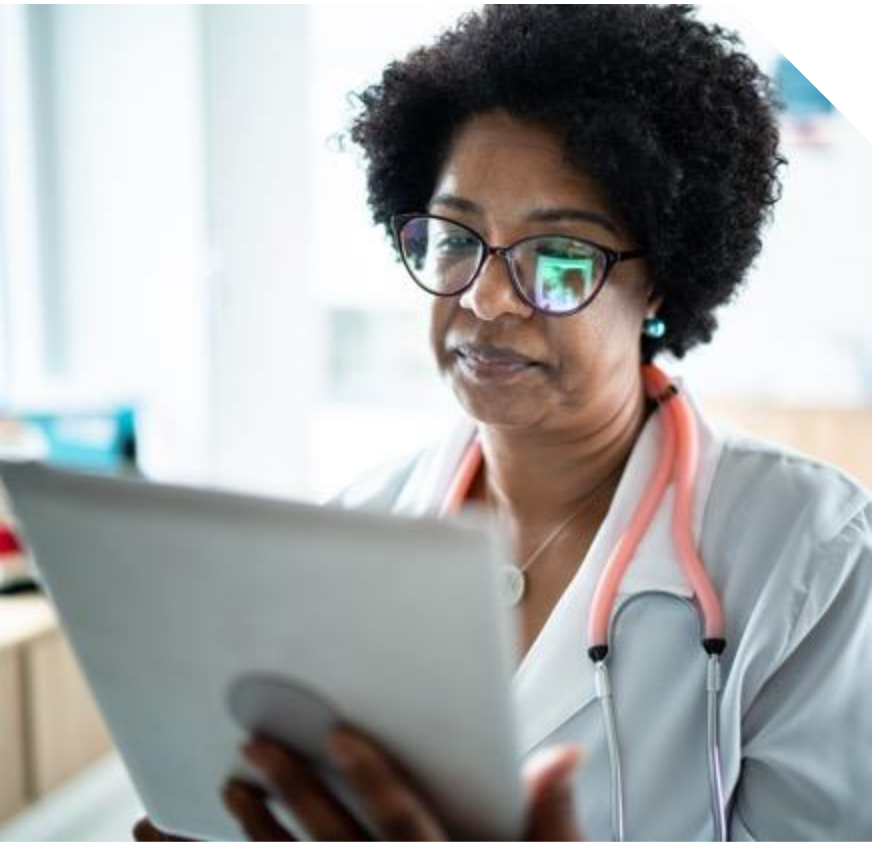
Emergent admissions

- We require immediate notification by network hospitals of emergent admissions. Network hospitals must notify us of emergent admissions within one business day.
- Healthy Blue Medical Management staff will verify eligibility and determine benefit coverage. No prior authorization is required for emergency admissions.

Observation stays

- For participating facilities, observation stay does not require notification or prior authorization.
- For nonparticipating facilities, authorization is required within one business day

PA for inpatient admissions (cont.)



- Clinical information for the initial (admission) review will be requested at the time of the admission notification.
- **If the information is not received within 24 hours, a secondary fax request will be sent.** If the clinical information is not received, then a lack of information adverse determination (denial) will be issued.
- If the clinical information **is received**, a medical necessity review will be conducted using applicable Nebraska *Clinical Coverage Policies*.
- Decisions are communicated verbally or via fax within 24 hours of the determination.

Grievances and appeals

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

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

For grievances and appeals, contact Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Medical Polices and *Clinical Utilization Management Guidelines*

Clinical Coverage Polices are the primary guidelines and *Medical Policies* and *Clinical Utilization Management Guidelines* are the secondary guidelines used to determine whether services are considered to be:

- Investigational/experimental
- Medically necessary
- Cosmetic or reconstructive

A list of the specific *Medical Policies* and *Clinical Utilization Management Guidelines* will be posted and maintained on the Healthy Blue provider website and can be obtained in hard copy by written request.

To request a copy of the criteria on which a medical decision was based, call Healthy Blue Provider Services **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Compliance

Compliance program

- All providers, including provider employees and subcontractors, their employees and delegated entities, are required to comply with the Healthy Blue Compliance Program requirements, including those contracted with Healthy Blue.
- Requirements include, but are not limited to, the following:
  - Provider training requirements
  - Limitations on provider marketing
  - *HIPAA* Privacy and Security Training
  - Adherence to code of conduct and business ethics
  - Cultural competency and sensitivity
  - *Americans with Disabilities Act (ADA)* requirements
    - For more information on the *ADA* please visit http://www.ada.gov
    - To access interpreter and sign language services, please contact our Customer Service toll free line.
  - Fraud, Waste and Abuse (FWA) detection and prevention

For more information on program and specific compliance requirements,
refer to the *Healthy Blue Provider Manual*.

Cultural competency

Healthy Blue embraces the fundamental importance of cultural competency in reducing health disparities and improving access to high-quality health care.

- The purpose of the Cultural Competency program is to ensure that Healthy Blue meets the unique, diverse needs of all members, to provide that the associates of Healthy Blue value diversity within the organization and to see that members in need of linguistic services have adequate communication support.
- In addition, Healthy Blue is committed to ensuring that its staff and its provider partners, as well as its policies and infrastructure, are attuned to meeting the diverse needs of all members they serve.

The components of Healthy Blue's Cultural Competency Program include:

- Data analysis
- Diversity and language abilities of Healthy Blue's staff
- Linguistic services
- Provider education
- Community-based support
- Diversity of provider network
- Electronic media

Provider cultural competency resources

- Patient panels are growing more diverse and needs are becoming more complex; more support may be necessary to help address these needs.
- Healthy Blue offers support by ensuring resources are available to providers on the provider website. Resources include:
- **Cultural competency training (Cultural Competency and Patient Engagement)**, which includes but is not limited to:
  - The impact of culture and cultural competency on health care.
  - A cultural competency continuum which 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 Medicaid Education (CME) credit through American Academy of Family Physicians (AAFP).
- 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 https://provider.healthybluene.com.

Americans with Disabilities Act

- **The *Americans with Disabilities Act* (*ADA*)** became law in 1990. The *ADA* prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life.
- To be protected by the *ADA*, one must have a disability, which is defined by the *ADA* as a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The *ADA* does not specifically name all of the impairments that are covered.
- Participating Healthy Blue providers must:
  - Provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities.
  - Use waiting rooms and exam room furniture that meet the needs of all members, including those with physical and nonphysical disabilities.
  - Provide accessibility along public transportation routes and/or provide enough parking.
  - Use clear signage throughout the facilities (in other words, color and symbol signage).

Federal Fund Laws

Provider acknowledges that payments provider receives from Healthy Blue to provide Medicaid covered services to Medicaid members are, in whole or part, from federal funds. Therefore, provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, *Title VI* of the *Civil Rights Act of 1964* as implemented by 45 CFR Part 84; the *Age Discrimination Act of 1975* as implemented by 45 CFR Part 91; the *Americans with Disabilities Act*; the *Rehabilitation Act of 1973*, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, *Title IX* of the *Educational Amendments of 1972*, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

In accordance with section 6032 of the *Deficit Reduction Act of 2005* (*DRA*), provider shall, and shall require the other Providers to, comply with the Healthy Blue *Fraud and Abuse Prevention Policy*, as revised from time to time by Healthy Blue, and as otherwise may be required under the government contract.

Fraud, waste and abuse

CMS defines fraud, waste and abuse as:

Fraud

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

Waste

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

Abuse

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

Fraud, waste and abuse (cont.)

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

You can report your concerns by:

- Visiting the Healthy Blue provider website and completing the *Report Waste, Fraud and Abuse* form.
- Calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Quality

Quality Improvement Program

Healthy Blue Quality Improvement (QI) Program activities include, but are not limited to:

- Monitoring and improving clinical indicators and outcomes.
- Monitoring appropriateness of care.
- Quality studies.
- HEDIS measures.
- Medical records audits.
- Improving member and provider satisfaction.

Providers are contractually responsible for participating in QI projects and medical record review activities.

HEDIS is a mandatory process that occurs annually. It is an opportunity for Healthy Blue and its providers to demonstrate the quality and consistency of care that is available to members.

For more information on Healthy Blue Quality Improvement program, refer to the Healthy Blue website https://provider.healthybluene.

Partner services

Partner services

Healthy Blue to partners with IntelliRide* for transportation needs and Avesis* for vision needs.

Transportation:
IntelliRide

Trip reservations and ride assistance:
1-844-531-3783

Vision Services:
Avesis

Member and provider number:
1-844-232-3122

Provider resources

Your support system and staff

We support you through many different departments as you provide care to our members including:

- Our Healthy Blue Provider Relations team
- Our Healthy Blue Medical Management staff
- Specialized teams to help you with your claim questions
- Healthy Blue Provider Services

Call Healthy Blue Provider Services for assistance with claim issues, member enrollment and general inquiries at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Healthy Blue 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 Healthy Blue Provider Relations representative with any questions you may have.

For more information

- Review the *Provider Manual* for more detailed information about provider requirements and how-to instructions, including:
  - Provider and member administrative guidelines
  - Claims
  - Credentialing
  - Utilization management and care and disease management
  - Quality improvement
  - Appeals and grievances
  - Delegated entities
  - Compliance
  - Pharmacy services
- Refer to the *Quick Reference Card* as your resources for the most common transactions with Healthy Blue, including:
- Registering for, and how to use Healthy Blue secure provider portal to review member eligibility and copay information, authorization requests, claims status and inquiry, provider news and more.
- How to file an electronic or paper claim.
- How to file a grievance.
- How to file an appeal.

Interpreter services

Use an interpreter, when necessary, to ensure your patient understands all his or her options and is able to make an informed decision.

Free interpreter services are available to Healthy Blue members, 24/7 with over 170 languages.

Call Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT. (TTY number) for:

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

Access and availability

It’s our responsibility to make sure our members have access to primary care services for:

- Routine care services.
- Urgent and emergency services.
- Specialty care services for chronic and complex care.

We make sure our providers respond to members’ needs in a timely manner by conducting telephonic surveys to confirm providers are meeting these standards. Availability and access standards are specifically outlined in the provider manual.

Access and availability standards

PCPs must provide or arrange for coverage of services, consultation or approval for Referrals 24/7. Please refer to the provider manual for a complete list of access and availability standards.

Type of appointment	Access standard
PCP	
Urgent care	Same day
Sick care	≤ 72 hours
Preventive care	≤ 28 calendar days
Family planning	≤ 7 calendar days
Emergency medical need	Immediately
Office hours — 20	20 hours per week
Office hours — 30	30 hours per week
Wait time	≤ 45 minutes
Wait time update	≤ 90 minutes

After hours access standards

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

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP.
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes.
- An advice nurse with access to the PCP or on-call physician within 30 minutes.

Credentialing and provider updates

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 30 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.

Provider changes

- Provider demographic changes should be submitted to Healthy Blue via email at NEProviderOperations@healthybluene.com or contact Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.
- To ensure our members and Care Management staff have up-to-date information, please submit demographic updates 30 days and terminations 90 days prior to the effective date.
  - Group name or affiliation
  - Telephone or fax number
  - Panel status
  - Tax identification number
  - Physical or billing address
  - Age limitation
  - 1099 mailing address
  - New NPI number
  - Office hours
  - Terminations
  - Hospital affiliations
  - Language spoken

* Demographic updates also need to be made with Maximus, the state Provider Enrollment system.

Key takeaways

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

- Sign up for the secure provider website. You can register with Availity and access training (https://www.availity.com)
- Use Availity to register for ERA (835); Payer ID 00544
- Register for electronic funds transfer (EFT) payments with CAQH EnrollHub
- Review the Healthy Blue provider website communications and other tools at https://provider.healthybluene
- Review your handouts
- Provider Service number and email address:
  - Provider Service: **1-833-388-1406** Monday to Friday 7 a.m. to 8 p.m. CT
  - Provider Relations: ProviderRelations_NE@healthybluene.com

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue.
* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.
* Change Healthcare is an independent company managing the My Advocate program on behalf of Healthy Blue.
* Avesis is an independent company providing vision services on behalf of Healthy Blue.
* IntelliRide is an independent company providing nonemergent transportation services on behalf of Healthy Blue.

https://provider.healthybluene.com

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