Healthy Blue | HERITAGE HEALTH

Provider Bulletin
March 2021

Healthy Blue FAQ

General questions:

1. Is there a local health plan?

Yes, the local Provider Relations staff serves our provider network across the state. Offices locations include Omaha, Norfolk, Scottsbluff, Kearney and Lincoln.

2. What is the number for Provider Services?

The Provider Services phone number is **1-833-388-1406**. Callers choose from a series of prompts to obtain information needed such as eligibility, primary medical group assignment verification, prior authorization requirements, status of prior authorization requests, claim status, etc.
Healthy Blue Provider Services: **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

3. Is there a provider website?

Yes, the Healthy Blue public provider website at **https://provider.healthybluene.com** includes resources that help healthcare professionals do what they do best — care for our members.

Please be sure to bookmark it as a favorite.

4. Is there a secure provider website?

The Availity Portal* at **https://www.availity.com** is the exclusive secure provider website to access many of your Healthy Blue online tools and resources.

Some of the self-service features available on the Availity Portal include:

- Eligibility and benefits.
- Claims status inquiry.
- Claims submission.
- Claims payment disputes.
- Interactive Care Reviewer (ICR) for authorization requests and inquiries.
- Payer Spaces for Healthy Blue proprietary tools and resources.

Availity provides access to real-time information and instant responses in a consistent format, regardless of the payer. Start exploring how you can use the Availity Portal during patient check-ins, checkouts, billing or whenever you might benefit from easy, instant access to health plan information.

To begin registration, visit **https://www.availity.com** and select **Register**. If you need help with registration, contact Availity Client Services (ACS) at **1-800-AVAILITY** (**1-800-282-4548**). ACS is available Monday to Friday 7 a.m. to 6 p.m. CT.

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue. AIM Specialty Health® is an independent company providing some utilization review services on behalf of Healthy Blue.

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5. Where are medical policies located?

A list of the specific *Medical Policies* and *Clinical Utilization Management Guidelines* is 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 at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

6. Where is the provider manual located?

The *Healthy Blue Provider Manual* contains everything you need to know about our programs and how we work with you. For the most up-to-date information, refer to the online version at **https://provider.healthybluene.com**. If you would like a hard copy, please contact your Provider Relations representative, and we'll be happy to provide one.

7. How is eligibility verified?

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

- Submitting a batch 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
    - 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.
    - Providers also have easy online access to view member ID cards on the Availity Portal.
        - When conducting an eligibility and benefits (E&B) inquiry, simply select **View Member ID Card** on the *Eligibility and Benefits results* page.
            - If the member does not have their Healthy Blue ID Card the State Medicaid ID can be used to verify eligibility.
- Nebraska Medicaid Eligibility System (NMES) interactive voice response — telephone voice response system:
    - 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**

8. Will Healthy Blue be following the new 2021 CMS guidelines for coding and billing (for example, ER visits)?

Yes, as of January 1, 2021, the CMS guidelines for 2021 will be followed.

9. How does Healthy Blue handle transplant cases?

Healthy Blue manages transplants across all product lines. We have developed best practice transplant pricing for all organ types. We use this pricing in our Single Case Agreements for Transplant.

10. What are the credentials of the team that reviews medical records?

Prior authorization reviewers are clinical, medical utilization management reviewers are licensed nurses, and behavioral health utilization management reviewers are either licensed social workers or nurses.

11. Will providers get a Healthy Blue provider ID assigned to them?

No, there will be no provider ID that the provider will need to track.

12. Will members get a Healthy Blue member ID assigned to them? Will it be the same as their Medicaid numbers?

Members will be assigned a Healthy Blue member ID; the number will be included on the Healthy Blue member ID card. The Healthy Blue ID number will not be the same as the Medicaid number.

13. Where do we send provider rosters?

Send roster updates to NEProviderOperations@healthybluene.com. Reach out to your Provider Relations representative to obtain the roster template.

Credentialing:

1. What credentialing process does Healthy Blue follow?

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. Healthy Blue recredentials every three years and providers are asked to keep their CAQH applications current and available.

EDI questions:

1. What is electronic data interchange (EDI)?

EDI allows you to submit claims, retrieve ERAs and retrieve claim file acknowledgements from EDI to the insurance carrier or clearinghouse. It allows you to directly exchange 837 (claims), 270/271 (eligibility), 276/277 (claim status) and 835 (ERA) X12 transactions for claim payments for members covered by Healthy Blue.

Healthy Blue has a strategic relationship with Availity to serve as our electronic data interchange (EDI) partner for all Medicaid electronic transactions.

Healthcare professionals, billing services and clearinghouses who are new to the EDI space can register electronic transactions with Healthy Blue in Availity.

2. What are the methods to exchange EDI transmissions with the Availity EDI Gateway?

1. **Already exchanging EDI files?** Providers can use existing clearinghouses or billing companies for Healthy Blue transmissions. **(Please work with them to ensure connectivity to the Availity EDI Gateway.)**
2. Become a direct trading partner with the Availity EDI Gateway.
3. Use Direct Data Entry for single claim submission through the Availity Portal.
    - The payer name is **Healthy Blue Nebraska**, and the **payer ID is 00544**.

3. How do you enroll for electronic funds transfer (EFT)?

Even if you are already registered with CAQH EnrollHub, you will need to enroll with Healthy Blue as a payer to receive EFT payments. If you do not register and enroll, you will receive a paper check or virtual card:

- To register or manage account changes for EFT only, **use the EnrollHub™, a CAQH Solutions™ enrollment tool**, a secure electronic EFT registration platform.
- This tool eliminates the need for paper registration, reduces administrative time and costs, and allows providers to register with multiple payers at one time.
- If you are a registered provider with EnrollHub for other payers, you can add EFT for **Healthy Blue** to your account.

    - You will find there is more than one choice with Healthy Blue when enrolling for EFT. This is because EnrollHub has multiple participating plans and some Heathy Blue plans preferred to be listed specifically by state. For Heritage Health in Nebraska, your choice will be **Healthy Blue**, not specific to a state and listed with Amerigroup, Simply Healthcare and Summit Community Care.
- For your convenience, we always recommend you register for EFT at the TIN level if there is 1 TIN, 1 billing NPI, and payments are going to one back account. Enrolling at the TIN level reduces administrative burden, as any new providers added to your practice or organization will automatically be set up under your existing EFT enrollment.

If you have registration-related questions, contact EnrollHub Help Desk at **1-844-815-9763** Monday to Thursday 6 a.m. to 8 p.m. CT., Friday 6 a.m. to 6 p.m. CT or email efthelp@EnrollHub.CAQH.org.

If you have questions regarding declined EFT, please contact your Provider Relations representative or **Healthy Blue Provider Services**: **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

4. What happens if I don't register for EFT?

If you do not register and enroll, you will receive a paper check or virtual card.

Prior authorization (PA)

1. Where can I find the PA requirements?

To help you determine whether authorization is required, we encourage you to utilize the Precertification Lookup Tool to search for specific codes and their requirements. Log in to **https://www.availity.com** using your Availity credentials. Under the *Payer Spaces* heading, choose the Healthy Blue payer logo and select **Provider Self Services** under *Resources*. You will be redirected to the provider self-service portal, and then select **Precertification Lookup Tool** from the *prior authorization* left-hand navigation.

2. How do I request a PA?

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**. 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, our online authorization tool, will open.
    - Use ICR to submit and manage) your medical PAs.
- Use the PA fax number if you would like to fax a paper request:
    - PA fax number: **1-800-964-3627**

Urgent requests 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®* manages prior authorization for the following modalities: radiology, cardiology, sleep, musculoskeletal, rehabilitation (PT, OT, ST), genetic testing, and radiation oncology:

- To obtain prior authorization review for the following non-emergency services:
    - How to place a review request:

- *Online:* via the AIM provider website. Provider website is available 24/7 and processes requests in real-time using clinical criteria. Go to **www.providerportal.com** to register.
- *By phone:* call AIM toll free at **1-855-574-6478 on** Monday to Friday 7 a.m. to 7 p.m. CT.

Inpatient admissions can be submitted via:

- Availity: **https://www.availity.com**
- Fax:
  - Non-behavioral health: **1-800-964-3627**
  - Behavioral health:
    - 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.

3. Are authorization numbers required to be put on the claims to be paid?

Yes, authorization numbers are required on claims.

4. Is an authorization required if a member is admitted for observation?

Claims can be submitted for observation without an authorization. At the point the member goes inpatient, the facility has 24 hours to notify.

5. Will the provider need to obtain another authorization if the procedure changes intraoperatively?

If the procedure is pre-authorized and additional circumstances arise during the procedure that require further intervention, the clinical documentation will need to be submitted for review. No additional authorization would be required. If the procedure is a pre-authorized outpatient procedure that ends up having to go inpatient, an inpatient authorization request would need to be submitted within 24 hours of admission with supporting clinical documentation.

Claims:

1. What are the claims submission options?

Claims submissions can be completed using a clearinghouse or submitting directly to Availity. While we strongly encourage electronic submission for the quickest processing and payment and immediate notification of filing errors, we do accept paper claims:

- **Availity:**
  - **https://www.availity.com**
- **EDI submissions:**
  - Payer ID number for Healthy Blue — 00544
- **Paper:**
  - Healthy Blue Claims
    P.O. Box 61010
    Virginia Beach, VA 23466-1010

2. Will code or clinical editing be applied to claims?

Yes, we utilize software products to ensure compliance with standard code edits and rules, policies, national industry standards and plan benefits. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to the Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI), and *Medical Policies* and *Clinical Utilization Management (UM) Guidelines*.

3. What is required when submitting claims?

Paper and electronic claims must include the submitting provider's National Provider ID (NPI), taxonomy and ZIP code (plus four). Healthy Blue will validate these data elements with the state of Nebraska Medicaid enrollment file. Failure to submit claims in accordance with your Medicaid enrollment may result in rejections.

4. Can claims be submitted with the member's Medicaid ID?

Claims can be submitted with the member's Healthy Blue member ID or their Medicaid ID.

5. How to submit claims disputes

Claims disputes can be submitted verbally or in writing within 90 calendar days of the date of the *EOP* to Healthy Blue.

Complete the *Claim Payment Appeal Submissions Form* located on our website at **https://provider.healthybluene.com** and note the following submission methods:

- Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at **1-833-388-1406 Monday to Friday** 8 a.m. to 9 p.m. CT.
- **Online (reconsideration and claim payment appeal)**: via the secure Provider Availity Payment Appeal Tool at **https://www.availity.com**
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the appropriate form, to:
  Payment Dispute Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599
- Submission forms are available on the Healthy Blue provider website in the *Forms* section at **https://provider.healthybluene.com/nebraska-provider/resources/forms**.

6. What are the advantages to submitting claims electronically?

- Electronic claims aren't subject to postal delays.
- Claims can be transmitted 24 hours a day, 7 days a week.
- Electronic claims are faster and more accurate.
- Electronic claims are acknowledged through notification and error reports delivered to your electronic mailbox.
- ERAs are offered to all electronic submitters. ERAs result in cost savings and allow you to post payments automatically.

7. What is the 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.

Refund notifications may be identified by two entities, Healthy Blue and its contracted vendors or the providers. Healthy Blue researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

8. **Does Healthy Blue accept medical records electronically when requested in order to process a claim?**
   Yes, medical records are accepted through EDI and Availity.

9. **How does Healthy Blue handle Modifier 22? Do they require med records to support?**
   Healthy Blue does not pay additional for Modifier 22 and, therefore, does not require medical records to support. Claims with services appended with Modifier 22 are reimbursed at 100%.

10. **When Healthy Blue is a secondary payer, is the primary *EOB* required, or will CAS codes on the electronic claim showing primary payer payments be sufficient?**
    Yes, *EOB* is required. The only time we do not require the primary *EOB* is if it's a Medicare claim and on the Medicare non-covered list.

Healthy Blue transition-specific questions

These questions are specific to address the transition from Wellcare of Nebraska, Inc. to 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 starting January 1, 2021.

1. **Will behavioral health benefits for Medicaid members be affected by the changes on January 1, 2021?**
   Behavioral health benefits will be provided by Healthy Blue as part of the integrated care for behavioral health and physical health. Some of the current referral forms have been consolidated into one document, so there is no need for multiple forms for services. We are also encouraging the utilization of the Interactive Care Reviewer (ICR) for quicker *HIPAA* compliance submissions.

2. **Do we need to be credentialed again before the January 1, 2021, transition to Healthy Blue?**
   You do not need to be credentialed again until your next recredentialing date or during recontracting.

3. **Is there a transition of care period?**
   The transition of care period is 90 days and continuity of care is 60 days.

4. **Will Healthy Blue honor WellCare prior authorizations for dates on and after January 1, 2021?**
   Yes, we will honor prior authorizations for DOS after January 1, 2021.

   How will retroactive authorizations be handled? Retroactive authorization will be processed within 30 days of submission? Retro authorizations are required to be submitted within 90 days from the effective date of the member.

5. **How will retroactive eligibility be handled?**
   Please continue to submit those to us for review and we will review the cases as usual.

6. How long is the WellCare claims runout?
The claims runout is in place for 18 months. All claims are required to comply with the timely filing requirements under your WellCare of Nebraska agreement.

7. If a member is in the hospital from December 30, 2020, to January 2, 2021, does the hospital need to split bill?
Multi-day facility/inpatient hospital stays spanning January 1, 2021, are serviced based on the admission date.

Admission dates <= December 31, 2020, should be sent to WellCare.

Admission dates >= January 1, 2021, should be sent to Healthy Blue.

Inpatient professional fees with DOS on or after January 1, 2021 should be sent to Healthy Blue

8. Claims submission chart:

Type of submission	Submit to
New claims Date of Service (DOS) <= 12/31/2020	WellCare
New claims Date of Service (DOS) >= 1/1/2021	Healthy Blue
Adjusted claim Original DOS <= 12/31/2020, adjusted between1/1/2021 and 6/30/2022	WellCare
Adjusted claim Original DOS >= 1/1/2021	Healthy Blue
Multi-Day Facility / Inpatient Hospital Claim Admission Date / First DOS <=12/31/2020 with stay spanning EOY (discharge >= 1/1/2021)	WellCare **Multi-Day Facility / Inpatient Hospitals** stays spanning 1/1/2021 are serviced based on the **Admission Date** • Professional Claims paid based on DOS

9. Will there be any changes to the Medicaid reimbursement policies?
Claims will be paid in accordance with your current contract terms.

10. Under which member ID should the claims be submitted with dates of service prior to January 1, 2021?
All claims with dates of service prior to January 1, 2021, should continue to be submitted to WellCare with your existing member ID via the same way you submit them today. Use the member's Healthy Blue member ID or the member's Medicaid ID on claims January 1, 2021, or after.

11. How are claims disputes handled for claims with dates of service prior to January 1, 2021?
Continue to submit claim disputes for service dates before January 1, 2021 via the current process.

What if I need assistance?

Our Provider Services phone number is changing. Providers should continue to the existing phone number for services rendered before January 1, 2021. For services rendered on or after January 1, 2021, or questions related to the upcoming changes, use the new Healthy Blue Provider Services phone number at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.