Provider Quick Reference Card

Healthy Blue | HERITAGE HEALTH

https://provider.healthybluene.com

NEHB-CD-012062-22

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.healthybluene.com** for the most recent version of our provider manual.

If you have questions about this document or recommendations to improve it, call your local Provider Services at **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday.

Prior authorization/notification instructions and definitions

Request prior authorization and give us notifications:

- Online using our preferred method via the secure provider website at **https://www.availity.com**.*
- By phone: **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday
- Physical health inpatient and outpatient fax: **800-964-3627**
- Rehabilitation request fax: **844-886-2754**
- Carelon Medical Benefits Management, Inc. phone: **855-574-6478** Monday through Friday, 7 a.m. to 7 p.m. CT (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 nonnetwork) are verified.
- It is our policy to cover two routine prenatal ultrasounds for fetal anatomic survey per member per pregnancy (CPT® codes 76801 and 76805). For CPT codes 76811, 76815, 76816, and 76817, additional prenatal ultrasounds for fetal and maternal evaluations or for follow-up of suspected abnormalities are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study performed. CPT codes 76811 and 76812 are only reimbursable to maternal fetal medicine specialists.

The policy does not apply to:

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

Ultrasounds performed in place of service code 23 — emergency department.

For code-specific requirements for all services, visit our provider website at **https://provider.healthybluene.com**.

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

Preauthorization is required for all services. Providers have 30 days from the date of the initial transport to seek prior authorization for services.

Applied Behavioral Analysis (ABA)

Prior authorization is required for all ABA services.

Behavioral health/substance abuse services

No prior authorization is required for basic behavioral health services provided in a PCP or medical office or for routine outpatient behavioral health services provided by behavioral health specialists.

Prior authorization is required for inpatient services, residential services, and some outpatient services. All services (except ER services) require prior authorization for out-of-network providers. For more information on coverage and prior authorization requirements for Behavioral Health services, please 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 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, please refer to the Prior Authorization Lookup Tool on our provider website. Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

- Routine circumcisions are covered within the first 30 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 **855-574-6478**, Monday through Friday, 7 a.m. to 7 p.m. CT

Durable medical equipment (DME)

- Prior authorization is required for items greater than $750.
- Refer to the Medicaid fee schedule for a full list of codes that require authorization despite a reimbursement rate of less than $750.
- Rental items require prior authorization when the cost for the entire rental period requested is greater than $750.
  - All DME providers are required to obtain the *Electric Breast Pump Request Form* signed by the patient at the point of sale: **https://provider.healthybluene.com**.

Durable medical equipment (DME) (cont.)

Prior authorization is required for:

- All routine rentals and purchased DME equipment other than what is included above.
- Certain prosthetics and orthotics.
- Specialized wheelchairs.
- Insulin pump supplies.
- Hospital beds.
- Continuous positive airway pressure (CPAP), bi-level positive airway pressure (BPAP), and automatic positive airway pressure (APAP) machines.
- Lymphedema pumps.
- Hoyer lifts.
- Support surfaces.
- Power-operated vehicles (POV) and motorized wheelchairs.
- Osteogenesis stimulators.
- Seat lift mechanism.
- Wound care supplies.
- Standing frames.
- Chest wall oscillation devices.
- Suction pumps.
- IV therapy and supplies.
- Humidifiers.
- Cochlear implants.
- Light therapy/bili lights for jaundice babies.
- Sphygmomanometers.
- Continuous glucose monitoring devices.

For DME code-specific prior authorization requirements, visit our provider website at **https://provider.healthybluene.com**. Select Resources > Prior Authorization Requirements. Enter codes to determine authorization requirements.

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

We must agree on the Healthcare Common Procedure Coding System (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. If you have additional questions regarding rent-to-purchase items, please contact Provider Services at **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday.

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.

Educational consultation

No prior authorization is required.

Elective termination of pregnancy

Prior authorization is required. Termination is only covered when either:

- 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.

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 healthcare and home IV infusion

Prior authorization is required for:

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

Notes:

- Drugs and DME require separate prior authorization.

Hospice care

Preauthorization is required for hospice.

Hospital admission

- Prior authorization is required for elective and nonemergent 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. Preadmission testing must be performed by a Healthy Blue preferred lab vendor or network facility outpatient department. Please 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 or fax.
- By EMR (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 a continued length of stay.

The clinical submission deadline for Healthy Blue is 3 p.m. CT. 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: **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday
- Web: Log in at **https://www.availity.com**

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

- Fax: **800-964-3627**
- Call: **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday

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:

- Web: **https://www.availity.com**
- Fax: **800-964-3627**
- Phone: **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday

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.

Medical injectables

We cover most specialty drugs under the pharmacy benefit. These drugs can be obtained through any specialty pharmacy in our network that dispenses these medications. For a complete list of specialty drugs, visit our provider website.

Some medical injectables require prior authorization when covered under the medical benefit and administered in the physician's office. Some specialty drugs under the pharmacy benefit may also require prior authorization per the *Preferred Drug List (PDL)* at **https://provider.healthybluene.com**.

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.

Observation

No prior authorization is required for observation up to 48 hours. Observation care beyond 48 hours requires authorization. If your observation extends beyond 48 hours or results in admission, you must notify us within 24 hours or the next business day.

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).
- Normal vaginal and cesarean deliveries.

Notification requirements are as follows:

- Notify Provider Services of the first prenatal visit via fax at **844-843-3890** or ICR platform.
- For obstetric care, we require notification; we do not require prior authorization.
- All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries.

Obstetrical (OB) care (cont.)

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. Please fax maternal discharge notifications to **800-964-3627** 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 UM by fax to **800-964-3627** or through interactive care reviewer (ICR) in Availity.
  - Initial hospital medical records and subsequent medical justification directly to the local health plan by fax at **800-964-3627**.
- 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 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.
- For 599 CHIP members, please use the faxed form.

Birth notification:

- 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. Please complete the notifications through ICR in Availity or fax the forms to **800-964-3627**.
- The clinical information required is outlined as follows:
  - 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 births
  - Gravida, para, abortus for mother
  - Estimated date of confinement (EDC) and if neonatal intensive care unit (NICU) admission was required

Obstetrical (OB) care (cont.)

- You may use the standard reporting form specific to your hospital as long as the required information outlined above is included.
- If a newborn requires admission to the NICU, the hospital must provide notification and send initial inpatient medical records directly to the local health plan by fax at **800-964-3627**.
- 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 for NICU admissions.
- OB care management programs are available for all women with high-risk pregnancies.
- The NICU Care Management program is available for high-risk NICU infants.

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

Musculoskeletal

Request prior authorization by submitting complete clinical information as follows:

- Carelon Medical Benefits Management, Inc.:
  - Phone: **855-574-6478**
    Monday through Friday, 7 a.m. to 7 p.m. CT
  - Requests submitted with incomplete clinical information may result in a denial.

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

Nonemergency medical transportation (NEMT)

No prior authorization is required. For non-emergency transportation, members can call ModivCare* at **844-531-3783** Monday through Friday, 7 a.m. to 6 p.m. CT to set up a ride. 48 business hours are required for routine trips and urgent trips and hospital discharges will be handled same day. Providers or Facilities scheduling rides can call Modivcare at **866-333-4918**.

Ophthalmology

To request benefit or prior authorization information, please contact our vision vendor for routine and medical vision services at:

- **Avesis***
- Phone: **844-232-3122** 8 a.m. to 5 p.m. CT, Monday to Friday
- Website: **www.avesis.com**
- 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, psychiatric medicine, physical medicine, and rehabilitation

Prior authorization is required for non-E&M-level testing and procedures.

Pharmacy services

- The pharmacy benefit covers medically necessary prescription and over the counter drugs prescribed by a licensed provider. Please refer to the *PDL* 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 Healthy Blue Pharmacy department at **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday.
  - Faxing a request to **833-370-0702** for retail pharmacy or **833-370-0678** for medical injectables.
  - Submitting electronically through CoverMyMeds* at **https://www.covermymeds.com**.
- Pharmacy providers who need to check pharmacy eligibility can call Healthy Blue Provider Services at **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday.
- Members can call Pharmacy Member Services at **833-370-0703 (TTY 711)**.
- A link to the *PDL* and PA criteria are available on our provider self-service website.

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:
- 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 services

Healthy Blue will approve the initial evaluation plus the first 12 visits for:

- Physical therapy
- Occupational therapy
- Speech therapy

The provider is required to notify Healthy Blue of the initial evaluation and 12 visits by fax to **844-886-2754** within one business the initial evaluation:

- For services beyond the first 12 visits, provider will submit authorization requests with clinical information to the health plan by fax to **844-886-2754**.
- Submit medical records and subsequent medical justification directly to the local health plan by fax at **844-886-2754**.

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 the reversal of sterilization.

Telemedicine

Healthy Blue offers telemedicine through LiveHealth Online* for our members. LiveHealth Online is a mobile app and website (**https://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 non-emergency health conditions.

Urgent care center

No prior authorization is required for a participating facility.

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

CarelonRx, Inc.* (Pharmacy Benefits Manager)	**833-370-0679** 24 hours a day, 7 days a week **https://www.availity.com**
Modivcare nonemergency medical transportation (NEMT)	**844-531-3783** Monday through Friday 7 a.m. to 7 p.m. CT
Avesis (vision services)	**844-232-3122** 8 a.m. to 5 p.m. CT Monday to Friday
Carelon Medical Benefits Management, Inc. • Radiology • Cardiology • Sleep services • Musculoskeletal services • Genetic testing • Radiation oncology	**855-574-6478** Monday through Friday 7 a.m. to 7 p.m. CT

Provider Experience program

Our Provider Services team offers prior authorization, case and condition care, automated member eligibility, claims status, health education materials, outreach services, and more. Call **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday.

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. Your office has a designated representative.

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.

Local Provider Relations (cont.)

Can't access the website? 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)

Healthy Blue uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (ERA), and Electronic Funds Transfers (EFT) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Healthy Blue Payer ID: Nebraska — 00544

Contact Availity — Please contact Availity Client Services with any questions at **800-AVAILITY (800-282-4548)** Monday to Friday 7 a.m. to 7 p.m. CT

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

Payment disputes

Providers have the ability to submit claim disputes electronically through **https://www.availity.com** using the *Dispute Claim* option accessed from the claim status page.

Claims payment disputes must be filed within 90 days of the adjudication date on your *EOP*. Forms for provider appeals are available on our provider website.

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

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. A corrected claim must be received within 180 days of the date of service. 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 Utilization Management Healthcare department at **833-434-1213**, Monday to Friday, 8 a.m. to 5 p.m. CT

Peer-to-peer (P2P) discussion guidelines:

- A provider, acting on behalf of a member, must submit the member's written consent within five business days 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. For retrospective-eligible, post-discharge adverse determinations, follow the formal appeal process.

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:
Central Appeals and Grievance Processing
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

Call Provider Services: **833-388-1406**
7 a.m. to 8 p.m. CT, Monday to Friday

Fax to appeals department: **866-387-2968**

Health services

Care Management (CM) services

Provider Line **833-388-1406**
7 a.m. to 8 p.m. CT, Monday to Friday

This number takes you to the Customer Service and there is a prompt to speak to a nurse.

We offer care management services to members who are likely to have extensive healthcare 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.

Health services (cont.)

Condition Care/Population Health services

888-830-4300
8:30 a.m. to 5:30 p.m. CT

Condition Care (CNDC) services includes 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. We also have a wellness program offering assistance with smoking cessation and weight management.

Quality Management (QM) program

833-388-1406
7 a.m. to 8 p.m. CT, Monday to Friday

We have a comprehensive QM program to monitor the demographic and epidemiological needs of the populations we serve. We evaluate the needs of our Nebraska 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, please call **833-388-1406**: 7 a.m. to 8 p.m. CT, Monday to Friday.

Health services (cont.)

24/7 NurseLine

833-388-1405
8 a.m. to 5 p.m. CT, Monday to Friday
(Spanish: **833-388-1405**)

24/7 NurseLine 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 Nebraska-licensed online physician through LiveHealth Online at **www.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 24/7 Nurse Line for health advice 24 hours a day, 7 days a week, 365 days a year.

Healthy Blue has a behavioral health 24/7 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 **833-405-9087**.

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

- Member Services: **833-388-1405 (TTY 711)**, 8 a.m. to 5 p.m. CT, Monday to Friday
- Behavioral Health services: **833-388-1406**, 7 a.m. to 8 p.m. CT, Monday to Friday
- Pharmacy Member Services: **833-370-0703 (TTY 711)** 24 hours a day, 7 days a week

https://provider.healthybluene.com