Provider Manual

833-388-1406

https://provider.healthybluene.com

Healthy Blue | HERITAGE HEALTH

NEHB-CD-PM-008791-22

How to apply for participation
If you are interested in participating in the Healthy Blue network, please visit **https://provider.healthybluene.com** or call **833-388-1406, Monday to Friday 7 a.m. to 8 p.m. CT**.

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Dear Provider,

Welcome to the Healthy Blue network! We're pleased you've joined us.

We combine national expertise with an experienced local staff to operate community-based healthcare plans. We are here to help you provide quality healthcare to our members.

Along with hospitals, pharmacies, and other providers, you play the most important role in managing care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of healthcare.

We want to hear from you. We invite you to participate in one of our quality improvement committees. Or feel free to call Provider Services at **833-388-1406, Monday through Friday 7 a.m. to 8 p.m. CT** with any suggestions, comments, or questions.

Together, we can make a real difference in the lives of our members — your patients.

Sincerely,

Healthy Blue

1 INTRODUCTION

1.1 Who is Healthy Blue?

Healthy Blue is an expert in the Medicaid market, focused solely on meeting the healthcare needs of financially vulnerable Nebraska members. We're dedicated to offering real solutions that improve healthcare access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers. Healthy Blue does not use any policy or practice that has the effect of discriminating based on race, color, national origin, gender, sexual orientation, gender identity, or disability.

We help coordinate physical and behavioral healthcare, education, access to care and condition care programs. As a result, we lower costs, improve quality, and encourage better health status for our members.

We:

- Improve access to preventive primary care services
- Ensure selection of a primary care provider (PCP) who will serve as provider, care manager, and coordinator for all basic medical services
- Improve health status outcomes for members
- Educate members about their benefits, responsibilities, and appropriate use of care
- Utilize community-based enterprises and community outreach
- Integrate physical and behavioral healthcare
- Encourage:
    - Stable relationships between our providers and members
    - Appropriate use of specialists and emergency rooms (ERs)
    - Member and provider satisfaction

In a world of escalating healthcare costs, we work to educate our members about the appropriate utilization of healthcare and their involvement in all aspects of their healthcare.

1.2 Who Do We Serve?

Eligibility for enrollment in Healthy Blue is limited to individuals who are determined eligible for Medicaid and are mandatory managed care populations.

1.3 Updates and Changes

This provider manual, as part of your *Provider Agreement* and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **https://provider.healthybluene.com**. To request a free, printed copy of this manual, call Provider Services at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Healthy Blue, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web posted newsletters, provider bulletins, and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

1.4 Quick Reference Information

Healthy Blue Website
Our provider website, **https://provider.healthybluene.com** offers a full complement of online tools such as:

- Enhanced account management tools.
- Detailed eligibility look-up tool with downloadable panel listing.
- Comprehensive, downloadable member listings.
- Easier authorization submission.
- New provider data, termination and roster tools.
- Access to drug coverage information.

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

Contact Information

Provider Services	**833-388-1406**, Monday to Friday 7 a.m. to 8 p.m. CT. Interpreter services available
Member Services	**833-388-1405**, Monday to Friday 8 a.m. to 5 p.m. CT
Behavioral Health Member Services	**833-388-1405**, Monday to Friday 8 a.m. to 5 p.m. CT
Behavioral Health 24/7 Crisis Line	**833-405-9087**, 24 hours a day, 7 days a week
CarelonRx* (Pharmacy Benefits Manager)	**Pharmacy member services phone number** **833-370-0703, 24 hours a day, 7 days a week** **https://www.availity.com** **Prior authorization requests:** For Retail Pharmacy and Medical Injectable phone: 833-388-1406 **For Retail Pharmacy fax: 833-370-0702** **Medical Injectables Fax: 833-370-0678**
NurseLine	**833-388-1405 24 hours a day, 7 days a week** (TTY: **711**) **Spanish:** 24 hours a day, 7 days a week
AT&T Relay Services	**800-855-2880 (Spanish 800-855-2884)**
Avesis* (Vision Services)	**Member and provider number:** **844-232-3122**, 8 a.m. to 5 p.m. CT Monday through Friday
ModivCare* (Non-emergent medical Transportation)	**844-531-3783**, Monday through Friday 8 a.m. to 7 p.m. CT (members) 866-333-4918 (providers and facilities)
Durable Medical Equipment, Home Health and Home Infusion Services	**Phone: 833-388-1406,** Monday through Friday 7 a.m. to 8 p.m. CT **Fax: 844-886-2754** **https://provider.healthybluene.com**

Carelon Medical Benefits Management, Inc.* (Hi-Tech Radiology, Radiation Oncology, Cardiology, Genetic Testing, and Sleep Medicine.)	Carelon Medical Benefits Management manages preauthorization for the following solutions: • Hi-Tech Radiology • Radiation Oncology • Cardiology • Genetic Testing • Sleep Medicine • Musculoskeletal Programs **www.providerportal.com** Request prior authorization by visiting www.providerportal.com or by calling **855-574-6478**, Monday through Friday 7 a.m. to 7 p.m. *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **www.providerportal.com**.
Availity* Client Services	**800-AVAILITY (800-282-4548)** Monday through Friday 7 a.m. to 7 p.m. CT
Member Eligibility	Providers may do any of the following to verify eligibility: • Access the secure, online provider portal (**https://www.availity.com**) on the Healthy Blue website at **https://provider.healthybluene.com** • Contact Provider Services/Interactive Voice Response at **833-388-1406**, Monday to Friday 7 a.m. to 8 p.m. CT You can contact Availity by calling **800-AVAILITY** (**800-282-4548**), Monday through Friday, 7 a.m. to 7 p.m. Central time Support@availity.com
Preauthorization/Admission Notification	**Use our preferred method via Interactive Care Reviewer, our self-service authorization tool accessed through Availity https://www.availity.com, or if you prefer to paper fax: 800-964-3627** **Phone: 833-388-1406**, Monday through Friday 7 a.m. to 8 p.m. CT **PH: Inpatient Fax: 844-886-2757** **https://provider.healthybluene.com** Please provide the following: • Member ID number or Medicaid ID number • Legible name of referring provider • Referring provider NPI • Legible name of person referred to provider • Number of visits/services • Date(s) of service • Diagnosis code(s) • CPT® code(s) • Clinical information

	Forms are available on our provider website at **https://provider.healthybluene.com**
Claims Information	**www.availity.com** Mail paper claims to: Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing is within 180 calendar days of the date of service. Check claim status online or through our Interactive Voice Response (IVR) system at **833-388-1406** 24 hours a day, 7 days a week
Member Medical Appeals	Member medical necessity appeals must be filed within 60 calendar days of the date of action. You may appeal on behalf of the member with the member's written consent. Submit a member medical appeal to: P.O. Box 61010, Virginia Beach, VA 23466-1010
Care Managers	Available at **833-388-1405 Monday through Friday 8 a.m. to 5 p.m. CT** For urgent issues at all other times, call **833-388-1405**, Monday to Friday **8 a.m. to 5 p.m. CT** **If the member is already connected with their CM, the member will have a direct line to the care manager, including voicemail.**
Claim Payment Dispute	We have several options to file claim payment disputes: • Verbally (for reconsiderations only): Call Provider Services at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**. If you need to include supporting documentation (in other words, *Explanation of Benefits*, *Consent Form*, medical records, etc.) please do not use this option. • Online (for reconsiderations and claim payment appeals): Use Availity's secure Appeal tool at **https://www.availity.com**. Select Claims & Payments > Appeals Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. • Written (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to: Payment Dispute Unit Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599 Healthy Blue requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

	• Your name, address, phone number, email, and either your NPI number or TIN • The member's name and his or her Healthy Blue ID number • A listing of disputed claims including the Healthy Blue claim number and the date(s) of service(s) • All supporting statements and documentation We must receive your dispute within 90 calendar days from the date of the *Explanation of Payment* (*EOP)*. We will send a determination letter within 30 business days of receiving the dispute.
Member Grievances	Submit a member grievance to: P.O. Box 61010, Virginia Beach, VA 23466-1010

2 PROVIDER INFORMATION

2.1 Member Medical Home

PCPs serve as the entry point into the healthcare system for the member — they are the foundation of the collaborative concept known as a patient-centered medical home (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.

Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all the patient's healthcare needs and appropriately arranging care with other qualified professionals. A medical home is a collaborative relationship that provides high levels of care, access and communication, care coordination and integration, and care quality and safety, including provision of preventive services and treatment of acute and chronic illness. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements; recognize areas for improvement; and ultimately develop more efficient, effective, and patient-centered care processes.

We offer the following support to practices that are seeking or have achieved PCMH recognition:

- Suite of reports to assist with management of your patient population
- Opportunities for frequent interaction with our medical director
- Dedicated, local medical practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including care managers who work with your practice and may collaborate with you onsite
- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives

2.2 Primary Care Providers

PCPs are responsible for the complete care of their patients, including:

- Providing primary care inclusive of basic behavioral health services.
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions.
- Coordinating and monitoring referrals to specialist care.
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements.
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.
- Authorizing hospital services.
- Maintaining the continuity of care.
- Ensuring all medically necessary services are made available in a timely manner.

- Providing services ethically and legally and in a culturally competent manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment.
- Maintaining a medical record of all services rendered by you and other referral providers.
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations.
- Providing a minimum of 20 office hours per week of appointment availability as a PCP.
- Arranging for coverage of services to assigned members 24/7 in person or by an on-call physician.
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs).
- Answering after-hours telephone calls from members immediately or returning calls within 30 minutes from when calls are received.
- Continuing care in progress during and after termination of your contract for up to 30 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.

2.3 Responsibilities of the PCP

PCPs also have the responsibility to:

Communicate with Members

- Make provisions to communicate in the language or fashion primarily used by the member and contact our customer care center for help with oral translation services if needed
- Freely communicate with members about their treatment regardless of benefit coverage limitations
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their healthcare
- Advise members about their health status, medical care and treatment options regardless of whether benefits for such care are provided under the program
- Advise members on treatments that may be self-administered
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Treat all members with respect and dignity
- Provide members with appropriate privacy

Maintain Medical Records

- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non-research related care
- Share records subject to applicable confidentiality and HIPAA requirements
- Upon notification of the member's transfer to another health plan, Healthy Blue will request copies of the member's medical record, unless the member has arranged for the transfer. The provider must transfer a copy of the member's complete medical record and allow the receiving health plan access (immediately upon request) to all medical information necessary for the care of that member.

- Transfer of records should not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving health plan is the responsibility of the relinquishing health plan.
- A copy of the member's medical record and supporting documentation should be forwarded by the relinquishing health plan's PCP within 10 business days of the receiving health plan's PCP's request
- Obtain and store medical records from any specialty referrals in members' medical records
- Manage the medical and healthcare needs of members to ensure all medically necessary services are made available in a timely manner

Cooperate and Communicate with Healthy Blue

- Participate in:
    - Internal and external quality assurance
    - Utilization review
    - Continuing education
    - Other similar programs
    - Complaint and grievance procedures when notified of a member grievance
- Inform Healthy Blue if a member objects to provision of any counseling, treatments, or referral services for religious reasons
- Identify members who would benefit from our care management or condition care programs
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Cooperate with the integration of behavioral health into our service delivery model in accordance with state mandates

Cooperate and Communicate with Other Providers

- PCPs are required to screen their patients for common behavioral health disorders, including screening for developmental, behavioral, and social delays, as well as risk factors for child maltreatment, trauma, and adverse childhood experiences. Members screening positive for any of these conditions should be referred to a behavioral health specialty provider for further assessment and possible treatment. Screening tools for common disorders typically encountered in primary care are available on the Healthy Blue provider website at **https://provider.healthybluene.com.**
- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid.
- Provide care management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's Medicaid program.
- Coordinate the services we furnish to the member with the services the member receives from any other Nebraska care network program during member transition.
- Share with other healthcare providers serving the member the results of your identification and assessment of any member with special healthcare needs (as defined by the state) so those activities are not duplicated.
- Healthy Blue will work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for

developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma and adverse childhood experiences (ACEs). We will work to increase the percentage of children with positive screens who:
    - Receive a warm handoff to and/or are referred for more specialized assessment or treatment.
    - Receive specialized assessment or treatment.

Cooperate and Communicate with Other Agencies

- Maintain communication with the appropriate agencies such as:
    - Local police
    - Social services agencies
    - Poison control centers
    - Women, Infants and Children (WIC) program
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Coordinate the services we furnish to the member with the services the member receives from any other managed care plan during ongoing care and transitions of care

As a PCP, you may practice in a:

- Solo or group setting
- Clinic (for example, a federally qualified health center [FQHC] or rural health center [RHC])
- Outpatient clinic

2.4 Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Healthy Blue as a PCP:

- Advance nurse practitioner who practices in family practice, general practice, pediatrics, internal medicine, or OB/GYN
- Physician assistant who practices in family practice, general practice, pediatrics, internal medicine, or OB/GYN
- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioner who practices in family practice, general practice, pediatrics, internal medicine, or OB/GYN
- FQHC/RHC
- Specialist*
- OB/GYN

* Healthy Blue will allow vulnerable populations (for example, persons with multiple disabilities and/or acute or chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP if the specialist is willing to perform the responsibilities of a PCP. The specialist will provide and coordinate the member's primary and specialty care. Prior approval by the health plan is required for the authorization of a specialist as a PCP which we will consider on a case-by-case basis.

2.5 PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup.
- Utilize an answering service or pager system. This must be a confidential line for member information and/or questions. If you use an answering service or pager, the member's call must be returned within 30 minutes.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/preauthorization guidelines. This is a requirement for covering physicians.

Additionally, we strongly encourage you to offer after-hours office care in the evenings and on weekends. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturdays.

Examples of unacceptable PCP after-hours coverage:

- The PCP's office telephone is only answered during office hours.
- The PCP's office telephone is answered after hours by a recording that tells patients to leave a message.
- The PCP's office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning the member's after-hour calls outside of 30 minutes.

It is **not** acceptable to automatically direct the member to the ER (emergency rooms) when the PCP is not available.

2.6 PCP Access and Availability

Our ability to provide quality access to care depends upon your accessibility. * You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 24 hours
Nonurgent sick care[1]	Within 72 hours
Routine or preventive care[1]	Within 4 weeks
Prenatal care[1,2] — initial visit	For first trimester: 14 calendar days For second trimester: 7 calendar days For third trimester: 3 calendar days High risk: Within 3 calendar days or sooner if needed

1 In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.
2 For women who are past their first trimester of pregnancy on the first day they are determined to be eligible for Healthy Blue, first prenatal appointments should be scheduled as outlined in this chart.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

You may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining separate appointment days.
- Offering hours of operation that are less than the hours of operation offered to patients with other insurance coverage.
- Denying or not providing a member any covered service or availability of a facility.
- Providing a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large.

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Healthy Blue must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-Hours Care section.

2.7 Members' Eligibility Listing

You should verify each member receiving treatment in your office appears on your membership list. Accessing your panel membership listing via our provider website online tool is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members, once registered, and logged into our provider website.

To request a hard copy of your panel listing be mailed to you, call Provider Services at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**.

2.8 Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

Members and providers can access a searchable online directory by logging into our website with their secure IDs and passwords. Providers will receive an ID and password upon contracting with us and can view the online directory at **https://provider.healthybluene.com**

2.9 Role and Responsibilities of Specialty Care Providers

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to you.
- Rendering covered services only to the extent and duration indicated on the referral.
- Submitting required claims information, including source of referral and referral number.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and preauthorization of services at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis.
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval.
- Coordinating care with other providers for:
    - Physical and behavioral health comorbidities.
    - Co-occurring behavioral health disorders.
- Adhering to the same responsibilities as the PCP.

2.10 Specialty Care Providers' Access and Availability

You must adhere to the following access guidelines:

Type of Care	Standard
Medically necessary	Same day (within 24 hours of referral)
Urgent	Within 24 hours of referral
Routine	Within one month of referral
Lab referrals or X-rays — urgent care	Within 48 hours or as clinically indicated
Lab referrals or X-rays — regular appointments	Within 3 weeks

2.11 Member Enrollment

Nondiscrimination and accessibility requirements update

On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, sexual orientation, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?

Healthy Blue complies with all applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Healthy Blue provides free tools and services to people with disabilities to

communicate effectively with us. Healthy Blue also provides free language services to people whose primary language is not English (for example, qualified interpreters and information written in other languages).

Who can I talk to if Healthy Blue isn't following these guidelines?
If you or your patient believe that Healthy Blue has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance with our compliance coordinator via:

- Mail: Compliance Department, 10040 Regency Circle, Omaha NE 68114
- Phone: **531-233-6479 Monday through Friday, 8 a.m. to 5 p. m. CT**

If you or your patient need help filing a grievance, the compliance coordinator is available to help by calling Member Services at **833-388-1405 Monday through Friday 8 a.m. to 5 p.m. CT** You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

Complaint forms are available at **www.hhs.gov/ocr/filing-with-ocr/index.html**. For additional details about Section 1557 and the *Final Rule*, visit:

- The DHHS OCR information page: **www.hhs.gov/civil-rights/for-individuals/section-1557/index.html**
- Frequently asked questions published by the DHHS: **www.dhhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf**

We notified your Healthy Blue patients these services can be obtained by calling the Member Services phone number on their member ID card **833-388-1405 Monday through Friday 8 a.m. to 5 p.m. CT**

Medicaid recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Healthy Blue. Members are enrolled without regard to their health status. Our members:

- Are enrolled for a period of up to 12 months, contingent upon enrollment date and continued Medicaid eligibility.
- Can choose their PCPs or will be auto assigned to a PCP if they do not select one within 10 days.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.
- Coverage is provided for all newborn care rendered within the first month of life, regardless of whether provided by the designated PCP or another network provider. Providers will be compensated, at a minimum, ninety percent (90%) of the Medicaid fee for service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO (Managed Care Operation), but subject to the same requirements as a contracted provider.
- The health plan is responsible for covering all newborn care rendered by contracted network providers within the first 30 days of birth regardless of whether provided by the designated PCP or another network provider.
- Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax the *Newborn Delivery Notification* to **800-964-3627** or submit the form via Interactive Care Reviewer (ICR).

- The clinical information required is outlined as follows:
    - Date of birth
    - Indicate whether it was a live birth
    - Newborn's birth weight
    - Gestational age at birth
    - Apgar scores
    - Disposition at birth
    - Gender
    - Type of delivery (vaginal or cesarean); if cesarean, the reason the cesarean was required
    - Single/multi birth
    - Gravida/para/ab for mother
    - EDC (Expected Date of Confinement) and if NICU admission is required

Providers may use the standard reporting form specific to their hospital if the required information outlined above is included.

2.12 PCP Automatic Assignment Process for Members

During enrollment, a member can choose his or her PCP. When a member does not choose a PCP at the time of enrollment or during auto-assignment:

- If we are the primary payer, we will auto-assign a PCP within 10 days from the date we process the daily eligibility file from the state.
- If we are the secondary payer, we will not auto-assign a PCP unless the member asks us to do so.

Pregnant members have 10 calendar days after birth to select a PCP. After 10 days, we will auto assign a PCP for the newborn.

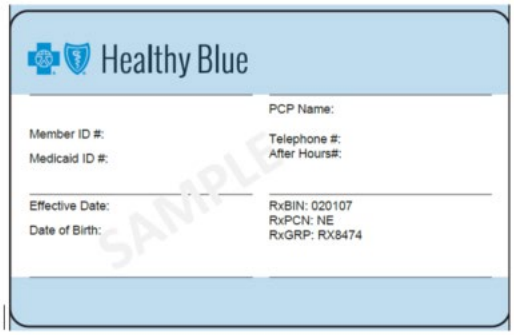
- There are two stages of auto-assignment logic for members who do not self-select a PCP: The first stage utilizes existing algorithms to assess data such as the distance of the PCP office from the member's home, languages spoken by provider and office staff, family link and prior relationship. Many providers receive an assignment of members based upon the first stage assignment logic.
- In the event there is more than one PCP meeting the first stage assignment logic for a member, the second stage will be activated. The second stage utilizes a rating system that has two components — quality and efficiency. The member will be assigned to the provider with the higher quality and/or efficiency ratings. To find out your current quality and efficiency ratings, as well as how to improve these ratings, please contact your local Provider Relations representative.

Members receive a Healthy Blue issued ID card that displays their PCP's name and phone number, in addition to other important plan contact information.

Members may elect to change their PCPs at any time by calling Healthy Blue Member Services. The requested changes will become effective no later than the following day, and a new ID card will be issued.

2.13 Member ID Cards

Healthy Blue member ID cards look similar to the following sample.



2.14 Medically Complex

Several individuals eligible for HHA have complex health conditions, undiagnosed or uncontrolled mental health disorders, or social determinants of health that may be barriers to improving their health.

Diagnoses or conditions that can lead to a medically complex determination include:

- Disabling mental health disorder.
- Chronic substance abuse disorder.
- Physical, intellectual, or developmental disability with functional impairment that significantly impairs performance of one or more activities of daily living.
- Disability determination based on Social Security criteria.
- Serious and complex medical condition.
- Homelessness, or risk of homelessness.

Healthy Blue HHA members can work with their Healthy Blue Care Manager if they think they may qualify as Medically Complex. Healthy Blue HHA members can also self-refer by completing the DHHS Medically Complex Self-Identification Form or the Homelessness Identification Form and return it to Healthy Blue. Some members may request assistance from their healthcare provider when completing this form, but DHHS does not require provider attestation in this process.

2.15 The Heritage Health Adult (HHA) Program

The Heritage Health Adult (HHA) Program is part of Nebraska's Medicaid Expansion Program. All Healthy Blue members enrolled in the Heritage Health Adult (HHA) Program will receive benefits for:

- Medical
- Behavioral Health
- Pharmacy
- Vision
- Personal Care Items (PCI)
- Ancillary
- Dental benefits through the dental prepaid ambulatory health program (PAHP)

Health Risk Screening (HRS)

The HRS is a questionnaire given by Healthy Blue to gather health information from its members. The HRS is a helpful tool that enables us to ask targeted questions to assist with identifying potential physical and emotional or behavioral problems or conditions. The HRS also includes questions designed to assess a member's Social Drivers of Health (SDoH), including a member's economic stability, housing stability, food

security, education and job opportunities, intimate partner violence, community and social support, and access to health care.

Members are asked to complete their initial HRS within 90 calendar days of enrollment and are encouraged to complete an HRS annually thereafter.

Annual Health Visit (AHV)

An AHV is an annual visit with a primary care provider or specialist for a comprehensive health evaluation. An AHV is an important part of taking a proactive approach to a member's overall health and can provide many benefits. Members should be encouraged to complete AHV each year. Codes for AHVs (Annual Health Visits) include:

- 99203, 99204, 99205, 99214 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99234, 99235, 99236, 99236, 99243, 99244, 99245, 99253, 99254, 99255, 99285, 99305, 99306, 99310, 99315, 99316, 99318, 99326, 99327, 99328, 99343, 99344, 99345, 99385, 99386, 99395, 99396, G0402, G0438, G0439

2.16 Noncompliant Members

Contact Provider Services if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

2.17 Members with Special Needs

Adults and children with special needs include those members with a mental disability, physical disability, complex chronic medical condition, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized healthcare requirements.

We have developed methods for:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for ensuring children or adults with serious, chronic, and rare disorders receive appropriate assessment, management, and diagnostic workups on a timely basis
- Coordinated care for individuals diagnosed with autism spectrum disorder (ASD), at risk of an ASD diagnosis or in need of applied behavioral analysis services

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. The plan may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities and/or acute and chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP if the specialist is willing to perform responsibilities of a PCP.

With the assistance of network providers, we will identify members who are at risk of or have special needs. Screening procedures for new members will include a review of hospital and pharmacy utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers, if applicable. We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires overly complex, highly specialized healthcare services over a prolonged period, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating life-threatening disease or specialized condition.

Training sessions and materials and after-hours protocols for a provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Care managers, providers and Member Services staff can serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

2.18 Covering Physicians

During your absence or unavailability, you need to arrange for coverage for your members assigned to your panel. You will be responsible for making arrangements for one of the following:

- One or more network providers to provide care for your members
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement.
- Any fees or monies due and owed to any non-network provider providing substitute coverage to a member on your behalf.

2.19 Provider Support

We support our providers by providing telephonic access to Provider Services **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** at our national contact centers, in addition to local Provider Relations representatives (PR reps), which you can contact through Provider Services.

- Providers Services supports provider inquiries about member benefits and eligibility and about authorizations and claims issues via our Provider Experience Program.
- Provider Experience representatives are assigned to all participating providers; they facilitate provider orientation and education programs that address our policies and programs. Provider Experience representatives regularly visit provider offices to share information.

We also provide communications to our providers through newsletters, alerts, and updates. These communications are posted on our provider website and may be sent via email, fax, or regular mail.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual and/or quarterly telephonic surveys. These surveys include but are not limited to the verification of provider appointment availability, telephonic surveys to verify after-hours access, and any newly identified surveys that may assist in providing the best quality networks for our members.

To collect your feedback on how well Healthy Blue meets your needs, we conduct an annual provider satisfaction survey. You will receive this survey via mail or email. If you are selected to participate, we appreciate you taking the time to complete the survey and provide input to improve our service to you.

2.20 Reporting Changes in Address and/or Practice Status

To maintain the quality of our provider data, we ask that changes to your practice contact information or the information of participating providers within a practice be submitted as soon as you are aware of the change.

If you have status or address changes, report them through;

www.availity.com
provider.healthybluene.com or to:
Email: NEProviderOperations@healthybluene.com

2.21 Second Opinions

The member, the member's parent or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion should be provided at no cost to the members.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion if the provider is not a network provider. Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider

- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform you and the members of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

2.22 Medically Necessary Services

Medically necessary services are those healthcare services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. To be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity, or malfunction.
- No more costly than an alternative service or sequence of services, at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, not approved by the U.S. Food and Drug Administration, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his or her discretion on a case-by-case basis.

We only cover items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

2.23 Provider Bill of Rights

Each network provider who contracts with Healthy Blue to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    - Any information the member needs to decide among all relevant treatment options, whether the benefits for such care or treatment are provided under the contract.
    - The risks, benefits, and consequences of treatment or nontreatment.
    - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal, and state fair hearing procedures.
- Have access to Healthy Blue policies and procedures covering the preauthorization of services.

- Be notified of any decision by Healthy Blue to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Medicaid/Children's Health Insurance Program member, the denial of coverage or payment for medical assistance.
- Be free from discrimination where Healthy Blue selection policies and procedures govern providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- Healthy Blue complies with the provisions of *42 CFR §438.102(a)(1)(ii)* concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

2.24 Provider Surveys

We will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward patient centered medical home implementation.

Our provider satisfaction survey tool and methodology will be submitted to the Department of Health and Human Services for approval prior to administration. A results report summarizing the survey methods, findings, and analysis of opportunities for improvement will be provided to the Department of Health and Human Services for review within 45 days after the end of the plan year.

2.25 Provider Marketing Guidelines

- When conducting any form of marketing in a provider's office, Healthy Blue must acquire and keep on file the written consent of the provider.
- Healthy Blue may not require its providers to distribute Healthy Blue-prepared marketing communications to their patients.
- Healthy Blue may not provide incentives or giveaways to providers to distribute to Healthy Blue members or potential Healthy Blue members.
- Healthy Blue may not conduct member education or distribute member education materials in provider offices.
- Healthy Blue may not allow providers to solicit enrollment or disenrollment in Healthy Blue or distribute Healthy Blue-specific materials at a marketing activity.
- Healthy Blue may not provide providers printed materials with instructions detailing how to change members of other MCOs (Managed Care Organizations) to Healthy Blue.
- Healthy Blue shall instruct participating providers regarding the following communication requirements:
    - Participating providers who wish to let their patients know of their affiliations with one or more MCOs (Managed Care Organizations) must list each MCO with whom they have contracts.
    - Participating providers may display and/or distribute health education materials for Healthy Blue or they may choose not to display and/or distribute for Healthy Blue. Health education materials must adhere to the following guidance:
        - Health education posters cannot be larger than 16" x 24"

- Children's books, donated by Healthy Blue must be in common areas
- Materials may include the Healthy Blue name, logo, phone number and website
- Providers are not required to distribute and/or display all health education materials provided by Healthy Blue with whom they contract. Providers can choose which items to display if they distribute items from Healthy Blue and that the distribution and quantity of items displayed are equitable.
- Providers may display marketing materials for Healthy Blue provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs (Managed Care Organizations) with whom the provider has a contract.
- Providers may display Healthy Blue participation stickers, but they must display stickers by all contracted MCOs (Managed Care Organizations) or choose not to display stickers of any contracted MCOs.
- Healthy Blue stickers indicating the provider participates with Healthy Blue cannot be larger than 5" x 7" and not indicate anything more than "Healthy Blue is accepted or welcomed here."
- Providers may inform their patients of the benefits, services and specialty care services offered through Healthy Blue. However, providers may not recommend one MCO over another MCO, offer patients incentives for selecting Healthy Blue over another MCO, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone or a computer in the office.
- Upon actual termination of a contract with Healthy Blue, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in Healthy Blue until the contract is terminated according to all terms and conditions specified in the contract between the provider and Healthy Blue.
- Healthy Blue shall not produce branded materials instructing members on how to change a plan. They must use provided or approved materials or should refer members directly to the enrollment broker for needed assistance.

2.26 Benefits

Benefit	Benefit description	Coverage status
Abortion	- Elective abortion is performed when a pregnant female chooses to terminate the life of the fetus rather than continue with the pregnancy. Elective abortion is a medically induced event. - Therapeutic abortion, also known as spontaneous abortion or miscarriage, is the loss or death of a fetus prior to the age of viability from natural causes or traumatic events, that is, from non-medically induced causation. Please reference: NAC 482 – Managed Care, Chapter 005.01(B) EXCEPTION. In addition to the health plans provision, abortions must be prior authorized by the department.	Covered
Acupuncture	A form of alternative medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions.	Not Covered

Benefit	Benefit description	Coverage status
Behavioral Health/Substance Abuse - Crisis Intervention/ Stabilization	Crisis Intervention/Stabilization services are provided to those experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of crisis interventions/stabilizations are engagement, symptom reduction, stabilization, and restoring members to previous level of functioning. Services include, but may not be limited to, the following components: a) Referral and linkage to appropriate community services to avoid more restrictive levels of treatment. b) A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the member, family, or other collateral sources (e.g., physician or qualified provider, caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level. c) May include admission to a more intensive level of care.	Covered
Behavioral Health/ Substance Abuse - Intensive Outpatient Program (IOP) - Facility	Outpatient facility-based program aimed at improving a member's functioning level to prevent relapse or hospitalization. Program usually meets several times a week for at least three (3) hours of behavioral health or substance abuse services.	Covered
Behavioral Health/ Substance Abuse - Inpatient Services	Medically necessary services that include, but are not limited to: - Psychiatric services for children, adolescents and adults provided in an acute care or free-standing psychiatric hospital. - Detoxification and/or rehabilitation services for substance or alcohol abuse in an inpatient hospital setting. Alcohol and substance abuse treatment and services are aimed at achieving the mental and physical restoration of alcohol and drug abusers. - Services may be provided by psychiatrists, psychologists, clinical social workers, therapists, and medical doctors or specialists. - Crisis stabilization may be a short-term inpatient intervention at a facility designed to restore the member to a level of functioning that does not require hospitalization.	Covered
Behavioral Health/ Substance Abuse - Outpatient Services	Outpatient Services are generally covered for the treatment of mental health and substance abuse issues. Services may be provided by physicians, psychologists, or other mental health professionals as authorized by the state. Services may include but are not limited to assessment and diagnosis, basic medical and therapeutic services, crisis services/respite, individual, family and/or group therapy, medication management, ambulatory detoxification, medication assisted treatment (MAT) for opioid addiction disorders, rehabilitation services, and case management services.	Covered
Behavioral Health/ Substance Abuse - Partial Hospital-Facility	Structured facility-based program provided in an outpatient setting, offering a variety of behavioral health/substance abuse treatment services as an alternative to inpatient care that is more intense than care rendered in a physician's or therapist's office.	Covered

Benefit	Benefit description	Coverage status
Behavioral Health/ Substance Abuse - Residential Treatment Centers	A residential treatment center is a facility which provides a total 24 hour therapeutically planned and professionally staffed group living and learning environment. For substance abuse, a facility provides treatment for alcohol and drug abuse to live-in residents who do not require acute medical care. For psychiatric problems, a facility offers mental health treatment to children and adolescents who do not require the intensity of acute inpatient care. Services may include but are not limited to individual, group, and family therapy along with medication management, medical treatment, lab testing, and room and board.	Covered
Blood Administration and Other Blood Products	Storage and administration of blood or blood components lost or damaged through surgery, trauma, or disease.	Covered
Cardiac Rehabilitation Services	Cardiac rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure, or other forms of heart disease or those who have undergone heart surgery. A cardiac rehabilitation program includes counseling and information about the patient's condition; a supervised exercise program; lifestyle and risk factor modification programs such as smoking cessation, information on nutrition and controlling high blood pressure; and emotional and social support.	Covered
Chemotherapy /Radiation	- Chemotherapy is the treatment of cancer with an antineoplastic drug or with a combination of such drugs into a standardized treatment regimen. - Therapeutic radiology (also called radiation oncology) is the treatment of cancer and other diseases with radiation.	Covered
Chiropractic Services	A health profession concerned with the diagnosis, treatment, and prevention of mechanical disorders of the musculoskeletal system, and the effects on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Covered
Cosmetic/ Plastics/ Reconstructive Procedures	- Cosmetic surgery includes any surgical procedure to enhancing a patient's appearance to improve aesthetic appeal, symmetry, and/or proportion in the absence of accidental injury or a malformed body member. - Reconstructive surgery includes surgical procedures whose goal is intended to restore form and function in structures deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.	Covered
Diagnostic Testing (Laboratory/ Radiology/ Nuclear Medicine)	- Laboratory and Radiology: Testing or clinical studies of materials, fluids or tissues from patients, services include but are not limited to, the obtaining and testing of blood samples, histology, hematology, blood chemistry, pathology, histopathology, microbiology, and other diagnostic testing using physical specimens such as tissue, sputum, feces, urine, or blood. May include but not limited to bone mass/density study, bone biopsy, photon absorptiometry, HIV/AIDS testing, lead blood screening, prostate-specific antigen (PSA) testing, thermography/thermograms, sleep studies and sleep therapy, portable x-ray services, pre-admission tests, radiology, and colorectal cancer screening procedures to include barium enemas, sigmoidoscopy, fecal occult blood tests (FOBT), and screening colonoscopy. - Nuclear Medicine (Diagnostic Advanced Imaging): Procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Examples may include but are not limited to CT, CTA, MRI, MRA, PET, and cardiac imaging.	Covered

Benefit	Benefit description	Coverage status
Diabetic Monitoring Supplies	Supplies used to self-monitor blood sugar levels, including blood sugar (glucose) test strips, digital blood sugar monitors, lancet devices and lancets, and glucose control solutions for checking test strips and monitor accuracy.	Covered
Durable Medical Equipment (DME)	Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use, and includes adaptive equipment/aids, humidifiers, oxygen and related respiratory equipment, nebulizers, and glucometers. DME does not include disposable medical supplies	Covered
Drugs	A medicine or other chemical substance which has a physiological effect when ingested or otherwise introduced into the body; used to treat, cure, prevent, or diagnose a disease or to promote well-being. Includes prescription drugs and over-the-counter drugs, whether purchased at a pharmacy or administered by a licensed medical professional, such as a physician. Refer to Prescription Drug benefit category for Medicare Part D benefit details. Over the Counter (OTC) are covered if listed on the covered OTC drug list.	Covered*
Employment Support Services	State supported assistance for Medicaid members with disabilities to gain and sustain paid competitive or self-employment.	Not Covered
Emergency Services	An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Emergency services are furnished by a qualified provider to evaluate or stabilize an emergency medical condition. This may include behavioral health emergency room services.	Covered
End-Stage Renal Disease/ Dialysis	- Renal failure (or kidney failure) occurs when the kidneys are not able to perform their normal functions. End stage renal disease (ESRD) is the term used to describe advanced renal failure. - Kidney disease education is for members with Stage IV chronic kidney disease (CKD) to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches members how to take the best possible care of their kidneys and gives them information they need to make informed decisions about their care. - Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis treatments are provided in various settings, including hospital inpatient, hospital outpatient, independent renal dialysis facility, or the home. - Dialysis home support services and self-dialysis training may be included if the member is a candidate for home dialysis.	Covered
Experimental, Investigational, Clinical Trials	A drug, device or service that has not been approved as safe and effective for general use by the Food and Drug Administration or other governing body.	Not Covered

Benefit	Benefit description	Coverage status
Family Planning	Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control.	Covered
Gastric Bypass/ Obesity Surgery/ Bariatrics	Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Covered
Genetic Testing	Genetic testing services evaluate the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders.	Covered
Transgender Related Care and Services	Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify, and who experience clinically significant distress as a result. Gender dysphoria may be manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria include counseling, hormone therapy, and gender reassignment surgery. Gender reassignment surgery (GRS) is a term for the surgical procedures by which the physical appearance and function of a person's existing sexual characteristics are altered to resemble those of the other sex.	Not Covered
Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse)	Services performed by licensed professionals, including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, and other professionals as licensed by the state. Physicians may include primary care physicians (PCP) and specialists. Services include, but are not limited to surgery, consultation, diagnostic testing, and home, office, institutional, and telehealth visits, and urgently needed services/urgent care.	Covered
Hearing Services	Outpatient diagnostic hearing and balance evaluations performed by a physician, audiologist, or other qualified provider to determine if member needs medical treatment. - Audiology is the branch of science that studies hearing, balance, and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g., hearing tests, optoacoustic emission measurements, and electrophysiologic tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle, or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss, he or she will provide recommendations to a patient as to what options (e.g., hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance. - Hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier, and a receiver.	Covered

Benefit	Benefit description	Coverage status
Health Homes	Health Homes is a care management service model where all the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all the services a member requires to facilitate optimum member health status. Federal core Health Home services include: - Comprehensive care management. - Care coordination. - Health promotion. - Comprehensive transitional care/follow-up. - Member and family support; and - Referral to community and social support services.	Not Covered
Home Healthcare	Home health services include skilled and non-skilled services, medication administration, and medication management. - Skilled services include skilled nurse services, PT/OT/RT/ST, dieticians, and social workers that are provided to eligible members at their place of residence. - Non-skilled services may or may not be under the supervision of a home health or social service agency, but for Medicare purposes must be under the supervision of a registered nurse and must be reasonable and necessary to the treatment of the patient's illness or injury. The reason for the visits by the home health aide must be to provide hands-on care of the members or services needed to maintain the member's health or to facilitate treatment of the member's illness or injury. - Medication administration is assistance with self-administration of medications, whether in the home or a facility. Includes taking the medication for where it is stored and delivering it to the member, removing a prescribed amount of medication from the container and placing it in the member's hand or in another container, helping the member by lifting the container to their mouth, applying topical medications, and keeping a record of when a member receives assistance with self-administration of their medications. - Medication management is reviewed by a licensed nurse of all prescriptions and over the counter medications taken by the member, in conjunction with the member's physician. The purpose of the review is to assess whether the member's medication is accurate, valid non-duplicative and correct for the diagnosis, that therapeutic doses and administration are at an optimum level, that there is appropriate laboratory monitoring and follow up taking place, and that drug interactions, allergies and contraindications are being assessed and prevented.	Covered

Benefit	Benefit description	Coverage status
Hospice Care	Hospice care or palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center, as well as in the home.	Covered
Immunizations /Vaccinations	Immunization: The process of becoming immune or the process of rendering a patient immune. Vaccination: The administration, usually by injection, of immunogens as a means of protecting individuals from developing specific diseases; included, but not limited to hepatitis B, influenza, pneumococcal pneumonia, and anthrax.	Covered
Inpatient Hospital Acute	An acute medical facility is a hospital that treats patients in the acute phase of an illness or injury. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more. Inpatient hospital services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.	Covered
Long Term Services and Support (LTSS) - Adult Companion Services	Adult companion services are non-medical care services, which provide supervision and socialization to functionally impaired adults. These are in-home services to ensure the safety and well-being of members who cannot be left alone. The provision of companion services does not entail hands-on nursing care.	Not Covered
Long Term Services and Support (LTSS) – Adult Day Health Services	- Adult day health provides social activities, meals, recreation, and some health-related services. Alzheimer's specific adult day care provides social and health services only to persons with Alzheimer’s or related dementia. - Day health services offer more intensive health, therapeutic, and social services for individuals with severe medical problems and for those at risk of nursing home care.	Not Covered
Long Term Services and Support (LTSS) - Adult Shared Living	Adult shared living provides a 24-hour living arrangement in a foster home for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, and nursing tasks that have been delegated by a registered nurse, help with activities of daily living, supervision, and the provision of or arrangement of transportation.	Not Covered

Benefit	Benefit description	Coverage status
Long Term Services and Support (LTSS) - Assisted Living/Residential Care	Assisted living or residential care refers to a system of housing and limited care designed for members who need some assistance with day-to-day activities but are not sufficiently incapacitated to require care in a nursing home. This service usually includes private quarters, meals, personal assistance, housekeeping aid, monitoring of medications, and nurses' visits.	Not Covered
Long Term Services and Support (LTSS) - /Personal Assistance Service (PAS)	PAS is a service provided by a trained attendant and include mainly activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include services such as bathing, grooming, and dressing. IADLs include activities such as meal preparation, laundry, light housekeeping, and routine household care.	Not Covered
Long Term Services and Support (LTSS) - Community Transition Services	Community transition services are services intended to assist individuals in transitioning out of non-acute care institutional settings back to their own home in the community through coverage of one-time transitional expenses. Services generally include the cost of moving furniture and belongings, security deposits to obtain a lease, purchase of furnishings and initial supplies (such as bed, table, chairs, window coverings, household products, dishes, eating utensils, etc.), utility connection fees or deposits, and health and safety assurances (such as pest removal, allergen control, or one-time cleaning prior to occupancy). Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances, or items that are intended for purely diversional or recreational purposes.	Not Covered
Long Term Services and Support (LTSS) - Habilitation	Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks. PAS (Pre Admission Screening) may be a component of Habilitation. However, habilitation can involve but is not limited to training, mobility, money management, management of caregivers, personal decision making, etc.	Not Covered
Long Term Services and Supports (LTSS) Home Delivered Meals	Meals delivered in a home and/or allowed in a congregate setting.	Not Covered
Long Term Services and Support (LTSS) - Home Environment Evaluation	Assessment and evaluation of the member's home for the purpose of determining the adequacy of the environment for promotion of health and well-being of the members, the presence of accessibility obstacles, the identification of any risks to safety, and the development of solutions to combat those obstacles and risks.	Not Covered
Long Term Services and Support (LTSS) - Homemaker Services	Homemaker services are services provided by a trained homemaker and include mainly activities of daily living such as bathing, grooming, dressing, instrumental activities of daily living services (IADLS) and general household activities such as meal preparation, laundry, light housekeeping, and routine household care.	Not Covered

Benefit	Benefit description	Coverage status
Long Term Services and Support (LTSS) - Home and Vehicle Modifications	Home modifications are those physical adaptations to the home which are medically necessary to avoid institutional placement of the member and enable them to function with greater independence in the home. Home modifications are also known as environmental accessibility adaptations. This category also includes vehicle modifications.	Not Covered
Long Term Services and Support (LTSS) – Long-Term Nursing Facility care	Nursing facilities are facilities that meet state licensure standards and provide health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury. Nursing facilities are considered custodial care and not skilled nursing facilities. Refer to category SNFS for skilled nursing facilities.	Not Covered
Long Term Services and Support (LTSS) - Pest Control	Extermination of household pests (i.e., bugs, rodents, etc.) for maintenance of a clean, sanitary, and safe home.	Not Covered
Long Term Services and Support (LTSS) - Chore Services	Non-medical services to maintain the home as a clean, sanitary, and safe living environment. These services include heavy household chores beyond simple housekeeping.	Not Covered
Medical Supplies	Medical supplies are generally disposable or consumable items designed for use by a single individual.	Covered
Nursing Hotline	The members can use this when their PCP is not available. When the member calls our Nurse Helpline (or Nurse Hotline), they can speak directly to a registered nurse who will help answer their health-related questions. As a member, they have access to a 24-hour Nurse Helpline (or Nurse Hotline) and after-hours triage service, 7 days a week, 365 days a year. Plus, the call is always confidential. It is not a tele monitoring benefit, as it requires no equipment.	Covered
Other Alternative Medical Therapies	- Other Alternative Medical Therapies - Encompass a broad category of treatment systems (e.g., herbal medicine, homeopathy, naturopathy, hypnosis, and spiritual devotions) or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science. Alternative medicine is also referred to as complementary medicine. Generally, it includes any medical practice or form of treatment not normally recognized as effective by the medical community at large. - Religious Non-Medical Healthcare Institution (RNHCI) - Previously known as Christian Science Sanatoria, these facilities provide healthcare furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a member, and the sole reliance on these religious tenets to fulfill a member's total healthcare needs.	Not Covered

Benefit	Benefit description	Coverage status
Outpatient Hospital/ Ambulatory Surgery Center Services	- Outpatient hospital services: Preventive, diagnostic, therapeutic, palliative care, and other services provided to a member in the outpatient portion of a health facility. - Observation: Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is an outpatient service. - Ambulatory Surgical Centers: Also known as outpatient surgery centers or same day surgery centers, are healthcare facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.	Covered
Podiatry	Podiatry is the diagnosis, treatment, and prevention of conditions of the human feet.	Covered
Private Duty Nursing	Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant.	Covered
Preventive Services	Routine healthcare includes check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems.	Covered
Prosthetics/ Orthotics	These are medical devices (other than dental) ordered by your doctor or other healthcare provider that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. - Orthotics: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. Shoe inserts are orthotics that are intended to correct an abnormal, or irregular walking pattern, by altering slightly the angles at which the foot strikes a walking or running surface. Other orthotics include neck braces, lumbosacral supports, knee braces, and wrist supports. - Prosthetics: Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.	Covered
Respite	Services provided on a short-term basis to members unable to care for themselves due to the absence or need for relief of persons normally providing their care. Respite care does not substitute for the care usually provided by a registered nurse, LPN (License Practical Nurse), or therapist.	Covered

Benefit	Benefit description	Coverage status
Rehabilitative Services for Medical Conditions - Short Term (OT, PT, RT, ST)	Performed in home or outpatient setting: - Occupational Therapy (OT) - Based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. - Physical Therapy (PT) - The treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity) -- also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength, and return patients to normal activities of daily living. - Respiratory Therapy (RT) - Assessment and therapeutic treatment of respiratory diseases. May include but not limited to airway management, mechanical ventilation, blood acid/base balance, and critical care medicine. - Pulmonary rehabilitation is designed for people who have chronic lung disease; the primary goal is to achieve and maintain the maximum level of independence and functioning. Although most pulmonary rehabilitation programs focus on the needs of people who have chronic obstructive pulmonary disease, people with other types of lung disease may benefit as well. - Speech Therapy (ST) - Rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing. - Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Hyperbaric oxygenation has been used to treat carbon monoxide poisoning, air embolism, smoke inhalation, acute cyanide poisoning, decompression sickness, clostridial myonecrosis, and certain cases of blood loss or anemia where increased oxygen transport may compensate in part for the hemoglobin deficiency.	Covered
School Based Services	A Medicaid benefit that provides special education programs to medically needy children under the Individuals with Disabilities Education Act. Programs include audiology and other health-related programs provided by schools. Member must have an Individual Education Plan or Individual Family Support Plan through the school.	Not Covered
Self-Referral Services	Services rendered to a member without requiring a referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the member's PCP.	Covered
Smoking Cessation Programs/ Supplies	Smoking cessation programs provide counseling and patient education as to the health risks of smoking and specific information related to the risks of specific diseases. Also includes items such as nicotine patches, gum or other non-smoking aids. These products are covered for members 18 and older.	Covered
Long-Term Services and Supports (LTSS) Skilled Nursing Facility (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided daily, i.e., on essentially seven days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services on at least five days a week.	Covered

Benefit	Benefit description	Coverage status
Sterilization/ Hysterectomy	- Sterilization surgery is called a tubal ligation in women and a vasectomy in men. Even though either procedure can occasionally be reversed, tubal ligation and vasectomy must be considered a permanent form of birth control. - Hysterectomy is the surgical removal of the uterus resulting in inability to become pregnant (sterility). The uterus may be removed through the abdominal wall or the vagina.	Covered
Telemonitoring	Telemonitoring services include in-home equipment and telecommunication technology from contracted vendors to monitor members with specific health conditions. An initial physician visit and a physician's order for monitoring of data related to a specific diagnosis are required. Physicians determine the frequency of data transmission and are trained in monitoring protocols and follow-up actions required. The member is instructed on the use of equipment, proper transmission, and related processes. Telemonitoring services supplement but do not replace face-to-face physician visits.	Covered
Medical Transportation	-Emergency transportation: Ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the member's health. - Non-emergent transportation: A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider or other approved program. This may include but is not limited to taxi, bus, or van transport.	Covered
Transplants	An organ transplant is the transplantation of a whole or partial organ from one body to another for the purpose of replacing the recipient's damaged or failing organ with a working one from the donor. Organ donors can be living or deceased (organ donor services are usually not covered).	Covered
Value-Added Benefits/ Services	Value-added benefits are defined as services for which eligible members are covered above and beyond the standard benefit set.	Covered
Vaccines for Children (VFC) Program	The Vaccines for Children (VFC) program provides free vaccinations to Medicaid-eligible children, Alaska Natives, American Indians, children who have no health insurance, and to privately insured children with no coverage for vaccinations (called underinsured children) who are served at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC).	Not Covered
Vision	Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the eye. - Ophthalmology is the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain, and areas surrounding the eye, such as the lachrymal system and eyelids. - Optometry is a healthcare profession concerned with examination, diagnosis, and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids. - Routine vision services include visual examination, fitting, dispensing and adjustment of eyeglasses, follow-up examinations, and contact lenses.	Covered

Benefit coverage — Kids 19-20 with copay, Kids 00-20 without copay and CHIP 00-18 without copay through age 18

Benefit	Benefit description	Coverage status
Abortion	- Elective abortion is performed when a pregnant female chooses to terminate the life of the fetus rather than continue with the pregnancy. Elective abortion is a medically induced event. - Therapeutic abortion, also known as spontaneous abortion or miscarriage, is the loss or death of a fetus prior to the age of viability from natural causes or traumatic events, that is, from non-medically induced causation. Please reference: NAC 482 – Managed Care, Chapter 005.01(B) EXCEPTION. In addition to the health plans provision, abortions must be prior authorized by the department.	Covered
Acupuncture	A form of alternative medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions.	Not Covered
Behavioral Health/ Substance Abuse - Crisis Intervention/ Stabilization	Crisis Intervention/Stabilization services are provided to those experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of crisis interventions/stabilizations are engagement, symptom reduction, stabilization, and restoring members to previous level of functioning. Services include, but may not be limited to, the following components: a) Referral and linkage to appropriate community services to avoid more restrictive levels of treatment. b) A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the member, family, or other collateral sources (e.g., physician or qualified provider, caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level. c) May include admission to a more intensive level of care.	Covered
Behavioral Health/ Substance Abuse - Intensive Outpatient Program (IOP) - Facility	Outpatient facility-based program aimed at improving a member's functioning level to prevent relapse or hospitalization. Program usually meets several times a week for at least three (3) hours of behavioral health or substance abuse services.	Covered
Behavioral Health/ Substance Abuse - Inpatient Services	Medically necessary services that include, but are not limited to: - Psychiatric services for children, adolescents and adults provided in an acute care or free-standing psychiatric hospital. - Detoxification and/or rehabilitation services for substance or alcohol abuse in an inpatient hospital setting. Alcohol and substance abuse treatment and services are aimed at achieving the mental and physical restoration of alcohol and drug abusers. - Services may be provided by psychiatrists, psychologists, clinical social workers, therapists, and medical doctors or specialists. - Crisis stabilization may be a short-term inpatient intervention at a facility designed to restore the member to a level of functioning that does not require hospitalization.	Covered

Benefit	Benefit description	Coverage status
Behavioral Health/ Substance Abuse - Outpatient Services	Outpatient Services are generally covered for the treatment of mental health and substance abuse issues. Services may be provided by physicians, psychologists, or other mental health professionals as authorized by the state. Services may include but are not limited to assessment and diagnosis, basic medical and therapeutic services, crisis services/respite, individual, family and/or group therapy, medication management, ambulatory detoxification, medication assisted treatment (MAT) for opioid addiction disorders, rehabilitation services, and case management services.	Covered
Behavioral Health/ Substance Abuse - Partial Hospital-Facility	Structured facility-based program provided in an outpatient setting, offering a variety of behavioral health/substance abuse treatment services as an alternative to inpatient care that is more intense than care rendered in a physician's or therapist's office.	Covered
Behavioral Health/ Substance Abuse - Residential Treatment Centers	A residential treatment center is a facility which provides a total 24 hour therapeutically planned and professionally staffed group living and learning environment. For substance abuse, a facility provides treatment for alcohol and drug abuse to live-in residents who do not require acute medical care. For psychiatric problems, a facility offers mental health treatment to children and adolescents who do not require the intensity of acute inpatient care. Services may include but are not limited to individual, group, and family therapy along with medication management, medical treatment, lab testing, and room and board.	Covered
Blood Administration and Other Blood Products	Storage and administration of blood or blood components lost or damaged through surgery, trauma, or disease.	Covered
Cardiac Rehabilitation Services	Cardiac rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure, or other forms of heart disease or those who have undergone heart surgery. A cardiac rehabilitation program includes counseling and information about the patient's condition; a supervised exercise program; lifestyle and risk factor modification programs such as smoking cessation, information on nutrition and controlling high blood pressure; and emotional and social support.	Covered
Chemotherapy/ Radiation	- Chemotherapy is the treatment of cancer with an antineoplastic drug or with a combination of such drugs into a standardized treatment regimen. - Therapeutic radiology (also called radiation oncology) is the treatment of cancer and other diseases with radiation.	Covered
Chiropractic Services	A health profession concerned with the diagnosis, treatment, and prevention of mechanical disorders of the musculoskeletal system, and the effects on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Covered
Cosmetic/ Plastics/ Reconstructive Procedures	- Cosmetic surgery includes any surgical procedure to enhancing a patient’s appearance to improve aesthetic appeal, symmetry, and/or proportion in the absence of accidental injury or a malformed body member. - Reconstructive surgery includes surgical procedures whose goal is intended to restore form and function in structures deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.	Covered

Benefit	Benefit description	Coverage status
Diagnostic Testing (Laboratory/ Radiology/ Nuclear Medicine)	- Laboratory and Radiology: Testing or clinical studies of materials, fluids or tissues from patients, services include but are not limited to, the obtaining and testing of blood samples, histology, hematology, blood chemistry, pathology, histopathology, microbiology, and other diagnostic testing using physical specimens such as tissue, sputum, feces, urine, or blood. May include but not limited to bone mass/density study, bone biopsy, photon absorptiometry, HIV/AIDS testing, lead blood screening, prostate-specific antigen (PSA) testing, thermography/thermograms, sleep studies and sleep therapy, portable x-ray services, pre-admission tests, radiology, and colorectal cancer screening procedures to include barium enemas, sigmoidoscopy, fecal occult blood tests (FOBT), and screening colonoscopy. - Nuclear Medicine (Diagnostic Advanced Imaging): Procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Examples may include but are not limited to CT, CTA, MRI, MRA, PET, and cardiac imaging.	Covered
Diabetic Monitoring Supplies	Supplies used to self-monitor blood sugar levels, including blood sugar (glucose) test strips, digital blood sugar monitors, lancet devices and lancets, and glucose control solutions for checking test strips and monitor accuracy.	Covered
Durable Medical Equipment (DME)	Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use, and includes adaptive equipment/aids, humidifiers, oxygen and related respiratory equipment, nebulizers, and glucometers. DME does not include disposable medical supplies	Covered With Personal Care
Drugs	A medicine or other chemical substance which has a physiological effect when ingested or otherwise introduced into the body; used to treat, cure, prevent, or diagnose a disease or to promote well-being. Includes prescription drugs and over-the-counter drugs, whether purchased at a pharmacy or administered by a licensed medical professional, such as a physician. Refer to Prescription Drug benefit category for Medicare Part D benefit details. Over the Counter (OTC) are generally covered if they are listed on the OTC drug list -.	Covered
Employment Support Services	State supported assistance for Medicaid members with disabilities to gain and sustain paid competitive or self-employment.	Not Covered
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.	Covered
End-Stage Renal Disease/ Dialysis	- Renal failure (or kidney failure) occurs when the kidneys are not able to perform their normal functions. End stage renal disease (ESRD) is the term used to describe advanced renal failure. - Kidney disease education is for members with Stage IV chronic kidney disease (CKD) to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches members how to take the best possible care of their kidneys and gives them information they need to make informed decisions about their care. - Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis treatments are provided in	Covered

Benefit	Benefit description	Coverage status
	various settings, including hospital inpatient, hospital outpatient, independent renal dialysis facility, or the home. - Dialysis home support services and self-dialysis training may be included if the member is a candidate for home dialysis.	
Emergency Services	An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Emergency services are furnished by a qualified provider to evaluate or stabilize an emergency medical condition. This may include behavioral health emergency room services.	Covered
Experimental, Investigational, Clinical Trials	A drug, device or service that has not been approved as safe and effective for general use by the Food and Drug Administration or other governing body.	Not Covered
Family Planning	Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control.	Covered
Gastric Bypass/ Obesity Surgery/ Bariatrics	Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Covered
Genetic Testing	Genetic testing services evaluate the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders.	Covered
Transgender Related Care and Services	Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify, and who experience clinically significant distress as a result. Gender dysphoria may be manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria include counseling, hormone therapy, and gender reassignment surgery. Gender reassignment surgery (GRS) is a term for the surgical procedures by which the physical appearance and function of a person's existing sexual characteristics are altered to resemble those of the other sex.	Not Covered
Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse)	Services performed by licensed professionals, including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, and other professionals as licensed by the state. Physicians may include primary care physicians (PCP) and specialists. Services include, but are not limited to surgery, consultation, diagnostic testing, and home, office, institutional, and telehealth visits, and urgently needed services/urgent care.	Covered

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Hearing Services	Outpatient diagnostic hearing and balance evaluations performed by a physician, audiologist, or other qualified provider to determine if member needs medical treatment. - Audiology is the branch of science that studies hearing, balance, and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g., hearing tests, optoacoustic emission measurements, and electrophysiologic tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle, or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss, he or she will provide recommendations to a patient as to what options (e.g., hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance. - Hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier, and a receiver.	Covered
Health Homes	Health Homes is a care management service model where all the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all the services a member requires to facilitate optimum member health status. Federal core Health Home services include: - Comprehensive care management. - Care coordination. - Health promotion. - Comprehensive transitional care/follow-up. - Member and family support; and - Referral to community and social support services.	Not Covered
Home Healthcare	Home health services include skilled and non-skilled services, medication administration, and medication management. - Skilled services include skilled nurse services, PT/OT/RT/ST, dieticians, and social workers that are provided to eligible members at their place of residence. - Non-skilled services may or may not be under the supervision of a home health or social service agency, but for Medicare purposes must be under the supervision of a registered nurse and must be reasonable and necessary to the treatment of the patient's illness or injury. The reason for the visits by the home health aide must be to provide hands-on care of the members or services needed to maintain the member's health or to facilitate treatment of the member's illness or injury. - Medication administration is assistance with self-administration of medications, whether in the home or a facility. Includes taking the medication for where it is stored and delivering it to the member, removing a prescribed amount of medication from the container and placing it in the member's hand or in another container, helping the member by lifting the container to their mouth, applying topical medications, and keeping a record of when a member receives assistance with self-administration of their medications. - Medication management is reviewed by a licensed nurse of all prescriptions and over the counter medications taken by the member, in conjunction with the member's physician. The purpose of the review is to assess whether the member's medication is accurate, valid non-duplicative and correct for the diagnosis, that therapeutic doses and administration are at an optimum level, that there is appropriate laboratory monitoring and follow up taking place, and that drug interactions, allergies and contraindications are being assessed and prevented.	Covered

Benefit	Benefit description	Coverage status
Hospice Care	Hospice care or palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center, as well as in the home.	Covered
Immunizations/ Vaccinations	Immunization: The process of becoming immune or the process of rendering a patient immune. Vaccination: The administration, usually by injection, of immunogens as a means of protecting individuals from developing specific diseases; included, but not limited to hepatitis B, influenza, pneumococcal pneumonia, and anthrax.	Covered
Inpatient Hospital Acute	An acute medical facility is a hospital that treats patients in the acute phase of an illness or injury. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more. Inpatient hospital services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.	Covered
Long Term Services and Support (LTSS) – Extra Care for Children with Disabilities	- Adult day care provides social activities, meals, recreation, and some health-related services. Alzheimer's specific adult day care provides social and health services only to persons with Alzheimer’s or related dementia. - Day health services offer more intensive health, therapeutic, and social services for individuals with severe medical problems and for those at risk of nursing home care.	Not Covered
Long Term Services and Support (LTSS) - Personal Assistance Service (PAS)	PAS is a service provided by a trained attendant and include mainly activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include services such as bathing, grooming, and dressing. IADLs include activities such as meal preparation, laundry, light housekeeping, and routine household care.	Not Covered
Long Term Services and Support (LTSS) - Habilitation	Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks. PAS (Pre Admission Screening) may be a component of Habilitation. However, habilitation can involve but is not limited to training, mobility, money management, management of caregivers, personal decision making, etc.	Not Covered
Long Term Services and Support (LTSS) Home Delivered Meals	Meals delivered in a home and/or allowed in a congregate setting.	Not Covered

Benefit	Benefit description	Coverage status
Long Term Services and Support (LTSS) - Home Environment Evaluation	Assessment and evaluation of the member's home for the purpose of determining the adequacy of the environment for promotion of health and well-being of the members, the presence of accessibility obstacles, the identification of any risks to safety, and the development of solutions to combat those obstacles and risks.	Not Covered
Long Term Services and Support (LTSS) - Homemaker Services	Homemaker services are services provided by a trained homemaker and include mainly activities of daily living such as bathing, grooming, dressing, instrumental activities of daily living services (IADLS) and general household activities such as meal preparation, laundry, light housekeeping, and routine household care.	Not Covered
Long Term Services and Support (LTSS) - Home and Vehicle Modifications	Home modifications are those physical adaptations to the home which are medically necessary to avoid institutional placement of the member and enable them to function with greater independence in the home. Home modifications are also known as environmental accessibility adaptations. This category also includes vehicle modifications.	Not Covered
Long Term Services and Support (LTSS) - Nursing Home/Facility	Nursing facilities are facilities that meet state licensure standards and provide health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury. Nursing facilities are considered custodial care and not skilled nursing facilities. Refer to category SNFS for skilled nursing facilities.	Not Covered
Long Term Services and Support (LTSS) - Pest Control	Extermination of household pests (i.e., bugs, rodents, etc.) for maintenance of a clean, sanitary, and safe home.	Not Covered
Long Term Services and Support (LTSS) - Chore Services	Non-medical services to maintain the home as a clean, sanitary and safe living environment. These services include heavy household chores above and beyond simple housekeeping.	Not Covered
Medical Supplies	Medical supplies are generally disposable or consumable items designed for use by a single individual.	Covered
Nursing Hotline	The members can use this when their PCP is not available. When the member calls our Nurse Helpline (or Nurse Hotline), they can speak directly to a registered nurse who will help answer their health-related questions. As a member, they have access to a 24-hour Nurse Helpline (or Nurse Hotline) and after-hours triage service, 7 days a week, 365 days a year. Plus, the call is always confidential. It is not a tele monitoring benefit, as it requires no equipment.	Covered

Benefit	Benefit description	Coverage status
Other Alternative Medical Therapies	- Other Alternative Medical Therapies - Encompass a broad category of treatment systems (e.g., herbal medicine, homeopathy, naturopathy, hypnosis, and spiritual devotions) or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science. Alternative medicine is also referred to as complementary medicine. Generally, it includes any medical practice or form of treatment not normally recognized as effective by the medical community at large. - Religious Non-Medical Healthcare Institution (RNHCI) - Previously known as Christian Science Sanatoria, these facilities provide healthcare furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a member, and the sole reliance on these religious tenets to fulfill a member's total healthcare needs.	Not Covered
Outpatient Hospital/ Ambulatory Surgery Center Services	- Outpatient hospital services: Preventive, diagnostic, therapeutic, palliative care, and other services provided to a member in the outpatient portion of a health facility. - Observation: Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is an outpatient service. - Ambulatory Surgical Centers: Also known as outpatient surgery centers or same day surgery centers, are healthcare facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.	Covered
Podiatry	Podiatry is the diagnosis, treatment, and prevention of conditions of the human feet.	Covered
Private Duty Nursing	Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant.	Covered
Preventive Services	Routine healthcare includes check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems.	Covered
Prosthetics/ Orthotics	These are medical devices (other than dental) ordered by your doctor or other healthcare provider that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. - Orthotics: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. Shoe inserts are orthotics that are intended to correct an abnormal, or irregular walking pattern, by altering slightly the angles at which the foot strikes a walking or running surface. Other orthotics include neck braces, lumbosacral supports, knee braces, and wrist supports. - Prosthetics: Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.	Covered

Benefit	Benefit description	Coverage status
Respite	Services provided on a short-term basis to members unable to care for themselves due to the absence or need for relief of persons normally providing their care. Respite care does not substitute for the care usually provided by a registered nurse, LPN (License Practical Nurse), or therapist.	Covered
Rehabilitative Services for Medical Conditions - Short Term (OT, PT, RT, ST)	Performed in home or outpatient setting: - Occupational Therapy (OT) - Based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. - Physical Therapy (PT) - The treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity) -- also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength, and return patients to normal activities of daily living. - Respiratory Therapy (RT) - Assessment and therapeutic treatment of respiratory diseases. May include but not limited to airway management, mechanical ventilation, blood acid/base balance, and critical care medicine. - Pulmonary rehabilitation is designed for people who have chronic lung disease; the primary goal is to achieve and maintain the maximum level of independence and functioning. Although most pulmonary rehabilitation programs focus on the needs of people who have chronic obstructive pulmonary disease, people with other types of lung disease may benefit as well. - Speech Therapy (ST) - Rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing. - Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Hyperbaric oxygenation has been used to treat carbon monoxide poisoning, air embolism, smoke inhalation, acute cyanide poisoning, decompression sickness, clostridial myonecrosis, and certain cases of blood loss or anemia where increased oxygen transport may compensate in part for the hemoglobin deficiency.	Covered
School Based Services	A Medicaid benefit that provides special education programs to medically needy children under the Individuals with Disabilities Education Act. Programs include audiology and other health-related programs provided by schools. Child must have an Individual Education Plan or Individual Family Support Plan through the school.	Not Covered
Self-Referral Services	Services rendered to a member without requiring a referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the member's PCP.	Covered
Smoking Cessation Programs/ Supplies	Smoking cessation programs provide counseling and patient education as to the health risks of smoking and specific information related to the risks of specific diseases. Also includes items such as nicotine patches, gum, or other non-smoking aids. These products are provided for members 18 and older.	Covered

Benefit	Benefit description	Coverage status
Skilled Nursing Facility (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided daily, i.e., on essentially seven days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services on at least five days a week.	Covered
Sterilization/ Hysterectomy	- Sterilization surgery is called a tubal ligation in women and a vasectomy in men. Even though either procedure can occasionally be reversed, tubal ligation and vasectomy must be considered a permanent form of birth control. - Hysterectomy is the surgical removal of the uterus resulting in inability to become pregnant (sterility). The uterus may be removed through the abdominal wall or the vagina.	Covered
Telemonitoring	Telemonitoring services include in-home equipment and telecommunication technology from contracted vendors to monitor members with specific health conditions. An initial physician visit and a physician's order for monitoring of data related to a specific diagnosis are required. Physicians determine the frequency of data transmission and are trained in monitoring protocols and follow-up actions required. The member is instructed on the use of equipment, proper transmission, and related processes. Telemonitoring services supplement but do not replace face-to-face physician visits.	Covered
Medical Transportation	- Emergency transportation: Ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the member's health. - Non-emergency transportation: A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider or other approved program. This may include but is not limited to taxi, bus, or van transport.	Covered
Transplants	An organ transplant is the transplantation of a whole or partial organ from one body to another for the purpose of replacing the recipient's damaged or failing organ with a working one from the donor. Organ donors can be living or deceased (organ donor services are usually not covered).	Covered
Value-Added Benefits/ Services	Value-added benefits are defined as services for which eligible members are covered above and beyond the standard benefit set. Certain criteria apply.	Covered
Vaccines for Children (VFC) Program	The Vaccines for Children (VFC) program provides free vaccinations to Medicaid-eligible children, Alaska Natives, American Indians, children who have no health insurance, and to privately insured children with no coverage for vaccinations (called underinsured children) who are served at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC).	Not Covered

Benefit	Benefit description	Coverage status
Vision	Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the eye. - Ophthalmology is the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain, and areas surrounding the eye, such as the lachrymal system and eyelids. - Optometry is a healthcare profession concerned with examination, diagnosis, and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids. - Routine vision services include visual examination, fitting, dispensing and adjustment of eyeglasses, follow-up examinations, and contact lenses.	Covered with Vendor

Benefit coverage — PW (Pregnant Women) with Ambulatory Presumptive without co-pay and Pregnant Women without co-pay

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Abortion	- Elective abortion is performed when a pregnant female chooses to terminate the life of the fetus rather than continue with the pregnancy. Elective abortion is a medically induced event. - Therapeutic abortion, also known as spontaneous abortion or miscarriage, is the loss or death of a fetus prior to the age of viability from natural causes or traumatic events, that is, from non-medically induced causation. Please reference: NAC 482 – Managed Care, Chapter 005.01(B) EXCEPTION. In addition to the health plans provision, abortions must be prior authorized by the department.	Not Covered	Covered
Acupuncture	A form of alternative medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions.	Not Covered	Not Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Behavioral Health/ Substance Abuse - Crisis Intervention/ Stabilization	Crisis Intervention/Stabilization services are provided to those experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of crisis interventions/stabilizations are engagement, symptom reduction, stabilization, and restoring members to previous level of functioning. Services include, but may not be limited to, the following components: a) Referral and linkage to appropriate community services to avoid more restrictive levels of treatment. b) A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the member, family, or other collateral sources (e.g. physician or qualified provider, caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level. c) May include admission to a more intensive level of care.	Not Covered	Covered
Behavioral Health/ Substance Abuse - Intensive Outpatient Program (IOP) - Facility	Outpatient facility-based program aimed at improving a member's functioning level to prevent relapse or hospitalization. Program usually meets several times a week for at least three (3) hours of behavioral health or substance abuse services.	Not Covered	Covered
Behavioral Health/ Substance Abuse - Inpatient Services	Medically necessary services that include, but are not limited to: - Psychiatric services for children, adolescents and adults provided in an acute care or free-standing psychiatric hospital. - Detoxification and/or rehabilitation services for substance or alcohol abuse in an inpatient hospital setting. Alcohol and substance abuse treatment and services are aimed at achieving the mental and physical restoration of alcohol and drug abusers. - Services may be provided by psychiatrists, psychologists, clinical social workers, therapists, and medical doctors or specialists. - Crisis stabilization may be a short-term inpatient intervention at a facility designed to restore the member to a level of functioning that does not require hospitalization.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Behavioral Health/ Substance Abuse - Outpatient Services	Outpatient Services are generally covered for the treatment of mental health and substance abuse issues. Services may be provided by physicians, psychologists, or other mental health professionals as authorized by the state. Services may include but are not limited to assessment and diagnosis, basic medical and therapeutic services, crisis services/respite, individual, family and/or group therapy, medication management, ambulatory detoxification, medication assisted treatment (MAT) for opioid addiction disorders, rehabilitation services, and case management services.	Not Covered	Covered
Behavioral Health/ Substance Abuse - Partial Hospital-Facility	Structured facility-based program provided in an outpatient setting, offering a variety of behavioral health/substance abuse treatment services as an alternative to inpatient care that is more intense than care rendered in a physician's or therapist's office.	Not Covered	Covered
Behavioral Health/ Substance Abuse - Residential Treatment Centers	A residential treatment center is a facility which provides a total 24 hour therapeutically planned and professionally staffed group living and learning environment. For substance abuse, a facility provides treatment for alcohol and drug abuse to live-in residents who do not require acute medical care. For psychiatric problems, a facility offers mental health treatment to children and adolescents who do not require the intensity of acute inpatient care. Services may include but are not limited to individual, group, and family therapy along with medication management, medical treatment, lab testing, and room and board.	Not Covered	Covered
Blood Administration and Other Blood Products	Storage and administration of blood or blood components lost or damaged through surgery, trauma, or disease.	Not Covered	Covered
Cardiac Rehabilitation Services	Cardiac rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure, or other forms of heart disease or those who have undergone heart surgery. A cardiac rehabilitation program includes counseling and information about the patient's condition; a supervised exercise program; lifestyle and risk factor modification programs such as smoking cessation, information on nutrition and controlling high blood pressure; and emotional and social support.	Not Covered	Covered
Chemotherapy/ Radiation	- Chemotherapy is the treatment of cancer with an antineoplastic drug or with a combination of such drugs into a standardized treatment regimen. - Therapeutic radiology (also called radiation oncology) is the treatment of cancer and other diseases with	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
	radiation.		
Chiropractic Services	A health profession concerned with the diagnosis, treatment, and prevention of mechanical disorders of the musculoskeletal system, and the effects on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Not Covered	Covered
Cosmetic/ Plastics/ Reconstructive Procedures	- Cosmetic surgery includes any surgical procedure to enhancing a patient's appearance to improve aesthetic appeal, symmetry, and/or proportion in the absence of accidental injury or a malformed body member. - Reconstructive surgery includes surgical procedures whose goal is intended to restore form and function in structures deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.	Not Covered	Covered
Diagnostic Testing (Laboratory/ Radiology/ Nuclear Medicine)	- Laboratory and Radiology: Testing or clinical studies of materials, fluids or tissues from patients, services include but are not limited to, the obtaining and testing of blood samples, histology, hematology, blood chemistry, pathology, histopathology, microbiology, and other diagnostic testing using physical specimens such as tissue, sputum, feces, urine, or blood. May include but not limited to bone mass/density study, bone biopsy, photon absorptiometry, HIV/AIDS testing, lead blood screening, prostate-specific antigen (PSA) testing, thermography/thermograms, sleep studies and sleep therapy, portable x-ray services, pre-admission tests, radiology, and colorectal cancer screening procedures to include barium enemas, sigmoidoscopy, fecal occult blood tests (FOBT), and screening colonoscopy. - Nuclear Medicine (Diagnostic Advanced Imaging): Procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Examples may include but are not limited to CT, CTA, MRI, MRA, PET, and cardiac imaging.	Covered	Covered
Diabetic Monitoring Supplies	Supplies used to self-monitor blood sugar levels, including blood sugar (glucose) test strips, digital blood sugar monitors, lancet devices and lancets, and glucose control solutions for checking test strips and monitor accuracy.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Durable Medical Equipment (DME)	Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use, and includes adaptive equipment/aids, humidifiers, oxygen and related respiratory equipment, nebulizers, and glucometers. DME does not include disposable medical supplies	Not Covered	Covered With Personal Care
Drugs	A medicine or other chemical substance which has a physiological effect when ingested or otherwise introduced into the body; used to treat, cure, prevent, or diagnose a disease or to promote well-being. Includes prescription drugs and over-the-counter drugs, whether purchased at a pharmacy or administered by a licensed medical professional, such as a physician. Refer to Prescription Drug benefit category for Medicare Part D benefit details. Over the Counter (OTC) products are generally covered if listed on the OTC drug list.	Covered	Covered
Employment Support Services	State supported assistance for Medicaid members with disabilities to gain and sustain paid competitive or self-employment.	Not Covered	Not Covered
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.	Not Covered	Not Covered
Emergency Services	An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Emergency services are furnished by a qualified provider to evaluate or stabilize an emergency medical condition. This may include behavioral health emergency room services.	Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
End-Stage Renal Disease/ Dialysis	- Renal failure (or kidney failure) occurs when the kidneys are not able to perform their normal functions. End stage renal disease (ESRD) is the term used to describe advanced renal failure. - Kidney disease education is for members with Stage IV chronic kidney disease (CKD) to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches members how to take the best possible care of their kidneys and gives them information they need to make informed decisions about their care. - Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis treatments are provided in various settings, including hospital inpatient, hospital outpatient, independent renal dialysis facility, or the home. - Dialysis home support services and self-dialysis training may be included if the member is a candidate for home dialysis.	Not Covered	Covered
Experimental, Investigational, Clinical Trials	A drug, device or service that has not been approved as safe and effective for general use by the Food and Drug Administration or other governing body.	Not Covered	Not Covered
Family Planning	Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control.	Not Covered	Covered
Gastric Bypass/ Obesity Surgery/ Bariatrics	Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Not Covered	Covered
Genetic Testing	Genetic testing services evaluate the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Transgender Related Care and Services	Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify, and who experience clinically significant distress as a result. Gender dysphoria may be manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria include counseling, hormone therapy, and gender reassignment surgery. Gender reassignment surgery (GRS) is a term for the surgical procedures by which the physical appearance and function of a person's existing sexual characteristics are altered to resemble those of the other sex.	Not Covered	Not Covered
Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse)	Services performed by licensed professionals, including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, and other professionals as licensed by the state. Physicians may include primary care physicians (PCP) and specialists. Services include, but are not limited to surgery, consultation, diagnostic testing, and home, office, institutional, and telehealth visits, and urgently needed services/urgent care.	Covered	Covered
Hearing Services	Outpatient diagnostic hearing and balance evaluations performed by a physician, audiologist, or other qualified provider to determine if member needs medical treatment. - Audiology is the branch of science that studies hearing, balance, and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g., hearing tests, optoacoustic emission measurements, and electrophysiologic tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle, or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss, he or she will provide recommendations to a patient as to what options (e.g. hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance. - Hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier, and a receiver.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Health Homes	Health Homes is a care management service model where all the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all the services a member requires to facilitate optimum member health status. Federal core Health Home services include: - Comprehensive care management. - Care coordination. - Health promotion. - Comprehensive transitional care/follow-up. - Member and family support; and - Referral to community and social support services.	Not Covered	Not Covered
Home Healthcare	Home health services include skilled and non-skilled services, medication administration, and medication management. - Skilled services include skilled nurse services, PT/OT/RT/ST, dieticians, and social workers that are provided to eligible members at their place of residence. - Non-skilled services may or may not be under the supervision of a home health or social service agency, but for Medicare purposes must be under the supervision of a registered nurse and must be reasonable and necessary to the treatment of the patient's illness or injury. The reason for the visits by the home health aide must be to provide hands-on care of the members or services needed to maintain the member's health or to facilitate treatment of the member's illness or injury. - Medication administration is assistance with self-administration of medications, whether in the home or a facility. Includes taking the medication for where it is stored and delivering it to the member, removing a prescribed amount of medication from the container and placing it in the member's hand or in another container, helping the member by lifting the container to their mouth, applying topical medications, and keeping a record of when a member receives assistance with self-administration of their medications. - Medication management is reviewed by a licensed nurse of all prescriptions and over the counter medications taken by the member, in conjunction with the member's physician. The purpose of the review is to assess whether the member's medication is accurate, valid non-duplicative and correct for the diagnosis, that therapeutic doses and administration are at an optimum level, that there is appropriate laboratory monitoring and follow up taking place, and that drug interactions, allergies and contraindications are being assessed and	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
	prevented.		
Hospice Care	Hospice care or palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center, as well as in the home.	Not Covered	Covered
Immunizations/ Vaccinations	Immunization: The process of becoming immune or the process of rendering a patient immune. Vaccination: The administration, usually by injection, of immunogens as a means of protecting individuals from developing specific diseases; included, but not limited to hepatitis B, influenza, pneumococcal pneumonia, and anthrax.	Covered	Covered
Inpatient Hospital Acute	An acute medical facility is a hospital that treats patients in the acute phase of an illness or injury. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more. Inpatient hospital services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.	Covered	Covered
Medical Supplies	Medical supplies are generally disposable or consumable items designed for use by a single individual.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Nursing Hotline	The members can use this when their PCP is not available. When the member calls our Nurse Helpline (or Nurse Hotline), they can speak directly to a registered nurse who will help answer their health-related questions. As a member, they have access to a 24-hour Nurse Helpline (or Nurse Hotline) and after-hours triage service, 7 days a week, 365 days a year. Plus, the call is always confidential. It is not a tele monitoring benefit, as it requires no equipment.	Not Covered	Covered
Out of Area/ Out of Country	- Out-of-area services are provided outside of the member's service area. This may be considered an area within or outside of the member's home state and plan location. - Out-of-country services are provided outside of the United States, or the U.S. territories of Guam, Puerto Rico, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands.	Not Covered	Covered
Other Alternative Medical Therapies	- Other Alternative Medical Therapies - Encompass a broad category of treatment systems (e.g., herbal medicine, homeopathy, naturopathy, hypnosis, and spiritual devotions) or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science. Alternative medicine is also referred to as complementary medicine. Generally, it includes any medical practice or form of treatment not normally recognized as effective by the medical community at large. - Religious Non-Medical Healthcare Institution (RNHCI) - Previously known as Christian Science Sanatoria, these facilities provide healthcare furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a member, and the sole reliance on these religious tenets to fulfill a member's total healthcare needs.	Not Covered	Not Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Outpatient Hospital/ Ambulatory Surgery Center Services	- Outpatient hospital services: Preventive, diagnostic, therapeutic, palliative care, and other services provided to a member in the outpatient portion of a health facility. - Observation: Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is an outpatient service. - Ambulatory Surgical Centers: Also known as outpatient surgery centers or same day surgery centers, are healthcare facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.	Covered	Covered
Podiatry	Podiatry is the diagnosis, treatment, and prevention of conditions of the human feet.	Not Covered	Covered
Private Duty Nursing	Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant.	Not Covered	Covered
Preventive Services	Routine healthcare includes check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems.	Not Covered	Covered
Prosthetics /Orthotics	These are medical devices (other than dental) ordered by your doctor or other healthcare provider that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. - Orthotics: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. Shoe inserts are orthotics that are intended to correct an abnormal, or irregular walking pattern, by altering slightly the angles at which the foot strikes a walking or running surface. Other orthotics include neck braces, lumbosacral supports, knee braces, and wrist supports. - Prosthetics: Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Respite	Services provided on a short-term basis to members unable to care for themselves due to the absence or need for relief of persons normally providing their care. Respite care does not substitute for the care usually provided by a registered nurse, LPN (License Practical Nurse), or therapist.	Not Covered	Covered
Rehabilitative Services for Medical Conditions - Short Term (OT, PT, RT, ST)	Performed in home or outpatient setting: - Occupational Therapy (OT) - Based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. - Physical Therapy (PT) - The treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity) -- also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength, and return patients to normal activities of daily living. - Respiratory Therapy (RT) - Assessment and therapeutic treatment of respiratory diseases. May include but not limited to airway management, mechanical ventilation, blood acid/base balance, and critical care medicine. - Pulmonary rehabilitation is designed for people who have chronic lung disease; the primary goal is to achieve and maintain the maximum level of independence and functioning. Although most pulmonary rehabilitation programs focus on the needs of people who have chronic obstructive pulmonary disease, people with other types of lung disease may benefit as well. - Speech Therapy (ST) - Rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing. - Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Hyperbaric oxygenation has been used to treat carbon monoxide poisoning, air embolism, smoke inhalation, acute cyanide poisoning, decompression sickness, clostridial myonecrosis, and certain cases of blood loss or anemia where increased oxygen transport may compensate in part for the hemoglobin deficiency.	Not Covered	Covered
School Based Services	A Medicaid benefit that provides special education programs to medically needy children under the Individuals with Disabilities Education Act. Programs include audiology and other health-related programs provided by schools. Member must have an Individual Education Plan or Individual Family Support Plan through the school.	Not Covered	Not Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Self-Referral Services	Services rendered to a member without requiring a referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the member's PCP.	Not Covered	Covered
Smoking Cessation Programs/ Supplies	Smoking cessation programs provide counseling and patient education as to the health risks of smoking and specific information related to the risks of specific diseases. Also includes items such as nicotine patches, gum, or other non-smoking aids.	Not Covered	Covered
Skilled Nursing Facility (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided daily, i.e., on essentially seven days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services on at least five days a week.	Not Covered	Covered
Sterilization / Hysterectomy	- Sterilization surgery is called a tubal ligation in women and a vasectomy in men. Even though either procedure can occasionally be reversed, tubal ligation and vasectomy must be considered a permanent form of birth control. - Hysterectomy is the surgical removal of the uterus resulting in inability to become pregnant (sterility). The uterus may be removed through the abdominal wall or the vagina.	Not Covered	Covered
Telemonitoring	Telemonitoring services include in-home equipment and telecommunication technology from contracted vendors to monitor members with specific health conditions. An initial physician visit and a physician's order for monitoring of data related to a specific diagnosis are required. Physicians determine the frequency of data transmission and are trained in monitoring protocols and follow-up actions required. The member is instructed on the use of equipment, proper transmission, and related processes. Telemonitoring services supplement but do not replace face-to-face physician visits.	Not Covered	Covered

Benefit	Benefit description	PW (Pregnant Women) with Ambulatory Presumptive w/o co-pay	Pregnant Women w/o co-pay
Medical Transportation	- Emergency transportation: Ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the member's health. - Non-emergency transportation: A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider or other approved program. This may include but is not limited to taxi, bus, or van transport.	Not Covered	Covered
Transplants	An organ transplant is the transplantation of a whole or partial organ from one body to another for the purpose of replacing the recipient's damaged or failing organ with a working one from the donor. Organ donors can be living or deceased (organ donor services are usually not covered).	Not Covered	Covered
Value-Added Benefits/ Services	Value-added benefits are defined as services for which eligible members are covered above and beyond the standard benefit set.	Not Covered	Covered
Vaccines for Children (VFC) Program	The Vaccines for Children (VFC) program provides free vaccinations to Medicaid-eligible children, Alaska Natives, American Indians, children who have no health insurance, and to privately insured children with no coverage for vaccinations (called underinsured children) who are served at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC).	Not Covered	Not Covered
Vision	Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the eye. - Ophthalmology is the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain, and areas surrounding the eye, such as the lachrymal system and eyelids. - Optometry is a healthcare profession concerned with examination, diagnosis, and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids. - Routine vision services include visual examination, fitting, dispensing and adjustment of eyeglasses, follow-up examinations, and contact lenses.	Not Covered	Covered

2.27 Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers. Members have access to contracted independent retail pharmacies and most national pharmacy chains.

Monthly Limits

- Most prescriptions are limited to a maximum 31-day supply per fill.
- Up to a 90-day supply will be allowed for certain maintenance medications

Covered Drugs

The Healthy Blue Pharmacy program uses both a state managed and the Healthy Blue *Preferred Drug List* (*PDL*). These comprise of a list of the preferred drugs within the most prescribed therapeutic categories. The *PDL* comprises drug products reviewed and approved by either the Healthy Blue or state Pharmacy and Therapeutics (P&T) committee. These P&T committees includes network physicians, pharmacists and other healthcare professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. Our *PDL* also includes several over the counter (OTC) products that are recommended as first-line treatment where medically appropriate. To prescribe medications that do not appear on our *PDL*, call Healthy Blue Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**. Please refer to the Healthy Blue *PDL* on our website at **https://provider.healthybluene.com**

Prior Authorization Drugs

You are strongly encouraged to write prescriptions for preferred products as listed on our *PDLs*. If a member cannot use a preferred product because of a medical condition, either fax a completed uniform PA form or call our Provider Services department at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** to obtain prior authorization. You must be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.

Over-The-Counter Drugs

The Healthy Blue *PDL* includes coverage of several OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes:

- Analgesics/antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Contraceptives
- Cough and cold preparations (age restrictions apply)
- Decongestants
- Laxatives
- Pediculocides
- Respiratory agents (including spacing devices)
- Topical anti-inflammatories

Excluded Drugs
The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Weight control products
- Anti-wrinkle agents (for example, Renova)
- Drugs used for cosmetic reasons or hair growth
- Experimental or investigational drugs
- Drugs used for experimental or investigational indication
- Immunizing agents
- Infertility medications
- Implantable drugs and devices (except IUDs which contain a drug as a pharmacy benefit)
- Erectile dysfunction drugs to treat impotence
- Drug Efficacy Study Implementation (DESI) drugs
- Prescription drug for Medicaid members who also qualify for Medicare (referred to as "dual eligible") are paid through Medicare Part D effective January 1, 2006. Medicaid does not cover any drugs covered under Medicare Part D for these members.

Specialty Drug Program
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.

2.28 Healthy Blue Value-Added Services

We cover extra benefits, including but not limited to the following, which eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added services.

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
24-Hour BH (BEHAVIORAL HEALTH) Crisis Line	Provides a 24 hours a day, 7 days a week crisis line when member are experiencing behavioral health crisis	All Populations	No Eligibility Limitations	No Benefit Limitations
Baby Showers	Benefit offers Moms fun activities and educational information that covers pre and post-delivery care, post-partum, healthy eating, and family planning.	Pregnant Members Only	Pregnant Members Only	No Benefit Limitations
Barnes & Noble Gift Cards	Provides a $25 Barnes and Noble Gift Card to members ages 4-12 to encourage reading and focus on boosting learning.	All Populations	Members ages 4-12	One (1) $25 Gift Card per member, per calendar year

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
Blood Pressure Cuffs	To help members manage their blood pressure and stay healthy, Healthy Blue will offer an electric blood pressure cuff for eligible members.	All Populations	Members must have a diagnosis of Hypertension, Diabetes, CHF, CAD, Obesity	One per member per year
Breast Pump	Provides consumer grade electric breast pumps for members who are due to deliver within 6 weeks or members who have delivered within the past 30 days, or who had a NICU baby in the last 90 days are eligible.	Pregnant or newly delivered Members Only	All currently enrolled members who are expected to deliver in the next 30 days, have delivered a well-baby in the past 30 days, or a NICU baby in the last 90 days.	Member can receive one (1) consumer grade electric breast pump with a delivery diagnosis, with a script
Bus Passes	Provides bus passes to qualified members.	All Populations	Members must be: • Be a current active Foster Care member ages 16-19, or • Be a current active member with refugee status, or • Be a current active ABD member	Members can receive two (2) thirty-day (30) bus passes annually, a thirty-day (30) bus pass will be issued per request.
College Bound Dorm Room Items	Qualified members who are college bound will receive a gift card to purchase items for their dorm rooms.	Foster Care Members Only	Be an active foster or former foster care member currently aging out of foster care, age 15 or older, members must also submit proof that they are continuing their education at either a college or university (i.e., Admission letter). Must be attending a college or University	$50 per member, one time lifetime benefit

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
College Support Fund	College Support Fund will include textbook support, college app, and school supply assistance for members ages 18 and up who are entering college.	All Populations	Members ages 17 and older who are entering college	$100 per member, one time lifetime benefit
Community Resource Link	Healthy Blue Community Resource link is an online resource which locates and displays all available local community-based programs, benefits, and services	All Populations	No Eligibility Limitations	No Benefit Limitations
Digital Scales	To help members manage their weight and stay healthy, Healthy Blue will offer a digital scale for eligible members.	All Populations	Members must have a diagnosis of Hypertension, Diabetes, CHF, CAD, Obesity	One per member per year
Extracurricular Support	Assistance for eligible members with youth club memberships fees.	All Populations	Youth, ages 5-18	
ChooseHealthy	Our Fitness Coach Program offers over 1,000 resource materials including videos, articles, and self-care tools.	All Populations	No Eligibility Limitations	No Benefit Limitations
Fresh Fruit and Veggie Program	Our fresh fruits and veggies program offers fruit and vegetable delivery, for three months.	All Populations	Eligible members who have a diagnosis of obesity or diabetes	3 boxes maximum per year

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
GED Assistance	To help encourage members to obtain a high school-level education, Healthy Blue will cover the costs of the GED high school equivalency test.	All Populations	• Members ages 16 and older • Has not graduated from an accredited high school or received a high school equivalency certificate or diploma • Not currently enrolled in a regular high school • Have a valid State ID Card • Must complete all pre-testing and classroom hours (to get ready for the GED test) before receiving a voucher number	Covers the cost of one (1) GED exam, per calendar year (one exam consists of 4 tests)
Health Fairs	Community advocates attend and participate in health-focused events to share information, resources and education concerning a variety of health topics such as diabetes management, back-to-school health, the importance of physical activity and general overall health and well-being.	All Populations	No Eligibility Limitations	No Benefit Limitations
Healthy Blue Days	On-site events called Healthy Blue Days to promote health plan resources and health information.	All Populations	No Eligibility Limitations	No Benefit Limitations
Healthy Rewards Program	Rewards members who complete specific preventive health, wellness, and engagement milestones. Enrollees will receive a gift card or e-gift card.	All Populations	Members must meet the eligibility requirements for the individual incentives	Reward quantity limits for each incented activity are defined by incentive and are counted at the time of service.
Hypoallergenic Bedding	Qualified members receive up to $100 in free hypoallergenic bedding to avoid asthma triggers. Hypoallergenic Bedding includes	All Populations	Active member with a diagnosis of Asthma	One time lifetime benefit

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
	mattress cover and pillow casings			
Jump Start Program	Members will receive access to an Employment and Training platform that provides high quality individualized and customized training that is conveniently accessible anytime, from anywhere for adult learners and job seekers. The platform will offer Skills assessment, employment training, GED preparation and job search.	All Populations	Members age 18 and older	3-month enrollment per member
Mail Order Pharmacy	This benefit provides members with an option to have their medication shipped to their home.	All Populations	No Eligibility Limitations	No Benefit Limitations
Mini Farmers Market	Collaboration with local mini farmer's markets and other community partners throughout the state to educate and promote health nutrition.	All Populations	No Eligibility Limitations	No Benefit Limitations
New Mom Essentials	Provides essential items for expectant and new moms.	All Populations	Expectant and New Mothers	Items and options vary per package.
Non-Medical Transportation	Provides non-medical transportation to WIC appointments and educational classes (childbirth, breastfeeding).	All Populations	A member must meet the criteria listed below to qualify for the expanded transportation benefit: • Member does not have a working vehicle or member has a working vehicle, but is medically unable to drive as certified by ModivCare and meets the below criteria to qualify for the expanded transportation benefit: • Member is pregnant or the parent of a member utilizing benefit. • Member can confirm	Covers transportation to WIC (Women, Infants, and Children) Appointments 1 round trip per month. Case management approval is required if more round trips are needed. Breastfeeding classes Six (6) round trips per pregnancy. Childbirth classes Six (6) round trips per pregnancy.

VAB	What is it?	Who is eligible?	Eligibility limit	Benefit limits
			signup of childbirth/breastfeeding classes with sponsoring entity.	
Personal Care Items	Eligible members can receive a gift card to be used on personal care items.	All Populations	One per household	One per quarter
Summer Camp	Provides members ages 4-12 with the opportunity to attend one week of summer camp. Healthy Blue will provide members with a Visa debit card valued at $35 dollars that they can use towards the cost of summer camp.	All Populations	Members age 4-12	One (1) summer camp gift card per member, per calendar year
Swim Lessons	Offers swimming lessons for qualified members.	All Populations	Members ages 6 months - 13 years	One (1) swimming lesson gift card per member, per calendar year
Transportation Essentials	To help our members live the lives they choose and to achieve positive outcomes, we offer a choice of gasoline card, buss pass, or Uber Gift Card once per quarter to help them access grocery stores, and other community locations and events.	All Populations	Members age 18 and older	One card per year
Waived Copayments	Members receive co-pay wavier for applicable Medicaid-covered services.	All Populations	No Eligibility Limitations	No Benefit Limitations
Weight Watchers (WW)	Provides Weight Watchers membership benefit to qualified members.	All Populations	Members 18 and over	This program is offered at no cost for six months.
Welcome Room	Provides support for medical and non-medical needs. Includes application assistance, transportation assistance and community support needs.	All Populations	No Eligibility Limitations	No Benefit Limitations

2.29 Services Covered Under the Nebraska State Plan or Fee-for-Service Medicaid

Some services are covered by the Nebraska state plan or fee-for-service Medicaid instead of Healthy Blue. These services are called carved-out services. Even though we do not cover these services, we expect you to:

- Provide all required referrals.
- Assist in setting up these services.

These services will be paid for by the Department of Health and Human Services on a fee-for-service basis. Carved-out benefits include:

- Services given through the Department of Health and Human Services early intervention services.
- Dental services, with exception of the EPSDT varnishes provided in a primary care setting.
- Individualized education program services.
- Intermediate care facility (ICF)/developmentally disabled (DD) services for members under the age of 21.
- Personal care services for members over the age of 21.
- School-based individualized education plan services given by a school district and billed through the intermediate school district or school-based services funded with certified public expenditures.
- All home- and community-based waiver services.
- Targeted care management services.

For details on how and where to access these services, call the Department of Health and Human Services at **402-471-3121**

Copays may apply for certain services covered under Healthy Blue Copays do not apply to services provided to:

- Individuals age 18 or younger
- Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and continues through the end of the month in which the 60-day period following termination of pregnancy ends)
- Any individual who is an inpatient in a hospital, long-term care (LTC) facility (nursing facility (NF) or ICF/MR)), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for person needs for medical care costs
- Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes
- Indians who receive items and/or services furnished directly by an Indian Healthcare Provider or through referral from an Indian Healthcare Provider under contract health services
- Individuals who are receiving waiver services provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Intellectual Disabilities or Related Conditions; The Home and Community-Based Model Waiver for Children with Intellectual Disabilities and their Families; or the Home and Community-Based Wavier for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver
- Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met)
- Individuals who receive assistance under the State Disability Program (SDP)

2.30 Well-Child Visits Reminder Program

Based on our claims data, we can send PCPs a list of members who have not received well-child services according to our schedule. We also reach out to these members, encouraging them to contact their PCPs to set up appointments for needed services. If you are interested in obtaining this information to close these gaps in care, please contact your Provider Relations representative at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT.**

Please note:

- We list the specific service each member needs in the report.
- You must render the services on or after the due date in accordance with federal EPSDT and State Department of Health guidelines.
- We base our list on claims data we receive before the date on the list. Please check to see whether you have provided the services after the report run date.

Please submit a completed claim form (on the provider website **https://provider.healthybluene.com)** to
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

2.31 Immunizations

You must enroll in the Vaccines for Children Program, which is administered by Department of Health & Human Services (DHHS). Contact the DHHS Immunization Program at dhhs.immunization@nebraska.gov to enroll. The immunization program will review and approve your enrollment request. You will need to cooperate with the DHHS Immunization Program for orientation and monitoring purposes.

Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices (ACIP) schedule. You must report all immunizations of children up to age 2 to the Nebraska State Immunization Information System immunization registry. If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available free of charge from the Vaccines for Children Program.

Our members can self-refer to any qualified provider in or out of our network.

We reimburse local health departments for the administration of vaccines regardless of whether they are under contract with us.

Healthy Blue provides all members with all vaccines and immunizations in accordance with ACIP guidelines. ACIP guidelines can be found on the Center for Disease Control and Prevention website at **www.cdc.gov/vaccines/hcp/acip-recs**.

2.32 Blood Lead Screening

You must screen for the presence of lead toxicity during a well-child visit for children between six months and six years of age. Please perform a blood test at 12 months and 24 months (or through 72 months if the child has not been previously screened) to determine lead exposure and toxicity.

2.33 Clinical Laboratory Improvement Amendments Reporting

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the *CLIA* requirements.

Healthy Blue providers may bill for laboratory services included in Nebraska Medicaid. To ensure proper payment, Healthy Blue will apply a *CLIA* claim edit to all claims for laboratory services that require a *CLIA* certification. Providers who do not have *CLIA* certification, who render services outside the effective dates of the *CLIA* certificate or who submit claims for services not covered by their *CLIA* certificate will deny.

For providers with a waiver or provider-performed microscopy certification types, you must add a QW modifier to the procedure code for all applicable *CLIA* tests. If the QW modifier is not billed, the claim will be denied.

2.34 Healthy Blue Member Rights and Responsibilities

Our Member Services representatives serve as our members' advocates. Below are the rights and responsibilities of our members.

Members have the right:

- To get details about what the health plan covers and how to use its services and the health plan Providers
- To have their privacy protected
- To know the names and titles of doctors and others who treat them
- To talk openly about care needed for their health, no matter the cost or benefit coverage or risks involved
- To have this information shared in a way they understand
- To know what to do for their health after they leave the hospital or provider's office
- To refuse to take part in research
- To create an advance directive
- To suggest ways the health plan can improve
- To file complaints or appeals about the health plan or the care it provides
- To have a say in the health plan's Member rights and responsibilities
- To have all these rights apply to the person who can legally make healthcare decisions for them
- To have all the health plan staff members observe their rights

- To use these rights no matter what their sex, age, race, ethnic, economic, educational, or religious background
- To receive information about the health plan, its services, its practitioners and providers, and member rights and responsibilities
- To participate with practitioners in making decisions about their healthcare
- To a candid discussion of appropriate or medical necessary treatment options for their conditions, regardless of cost or benefit coverage
- To make recommendations regarding member rights and responsibilities
- To be treated with respect and with due consideration for dignity and privacy
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- To obtain available and accessible healthcare services covered under the Nebraska Contract
- To participate in decisions regarding healthcare, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To ask for and receive a copy of medical records, and ask that they be amended or corrected:
  - Requests must be received in writing from the member, or the person chosen to represent him or her
  - The records will be provided at no cost
- To be responsible for cost sharing only as specified under Covered Services copayments and to be responsible for cost sharing only as specified in the Nebraska Contract
- To be furnished healthcare services in accordance with federal and state regulations the state must make sure a member is:
  - Free to exercise their rights
- The exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member

Member, Parental and/or Legal Guardian Responsibilities

The health plan expects members to cooperate responsibly and to the full extent possible in matters regarding their healthcare. These include the following:

- To know how their plan works by reading their Handbook
- To carry their ID card and MLTC-issued ID card with them at all times and to present them when they get healthcare services
- To get non-emergency care from a primary doctor, to get referrals for specialty care, and to work with those giving them care
- To be on time for appointments
- To cancel or set a new time for appointments ahead of time
- To report unexpected changes to their provider
- To respect doctors, staff, and other patients
- To understand medical advice and ask questions
- To know about the medicine they take, what it is for, and how to take it
- To make sure their doctor has their previous medical records
- To tell the health plan within 48 hours, or as soon as they can, if they are in a hospital or go to an emergency room

- To supply information (to the extent possible) that the health plan and its practitioners and providers need to provide care
- To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To follow the treatment plan they and their provider agree on

2.35 Member Grievances

Our members have the right to say they are dissatisfied with Healthy Blue or a provider's operations. Members have the right to file a grievance at any time. A network provider may also file a grievance with the members signed consent allowing the provider to act as the member's representative.

Member grievances do not involve:

- Medical management decisions.
- Interpretation of medically necessary benefits.
- Adverse determinations.

These are called appeals and are addressed in the next section.

We will respond to a member's grievance and attempt to resolve it to the member's satisfaction in a timely manner. We investigate each grievance and all its clinical aspects. We inform the member, investigate the grievance, and resolve it within 90 calendar days from the date we received the grievance. Urgent grievances that are clinical in nature are reviewed for clinical criteria by our clinical staff. If the grievances are deemed urgent, we will resolve them within as expeditiously as the medical condition warrants.

The member may file a grievance orally or in writing with either the Department of Health and Human Services or the health plan. If a member would like assistance with this process, or would like to file a grievance orally, they can call Member Services at **833-388-1405 Monday through Friday 8 a.m. to 5 p.m. CT**

A member may choose to file a grievance by mail; any supporting documents must be included. Grievances should be sent to: P.O. Box 61010, Virginia Beach, VA 23466-1010

An acknowledgement letter is mailed within 10 calendar days of receiving a grievance. We will notify the members in writing of:

- The names(s), title(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance. Our decision.
- The reason for the decision.
- Policies and procedures regarding the decision.
- How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative.

2.36 Medical Necessity Appeals

Medical necessity appeals apply to authorization requests that were denied prior to the service or authorization concurrent requests made during confinement. Medical necessity appeals/prior authorization appeals are

different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

If you are required to obtain prior authorization on a concurrent or post-service basis, the consent of the Member who received the services will not be required for you to dispute the denied authorization for service.

Healthy Blue will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for resolving requests to reconsider a decision they find unacceptable regarding denial of prior authorization.

A member will have a reasonable opportunity to present evidence — submit written comments, documents, records, and other information relevant to the appeal along with allegations of fact or law — in person as well as in writing.

Healthy Blue also ensures the member and his or her representative are provided the opportunity before and during the appeal process to examine the member's case file (including medical records), and any other documents and records considered during the appeal process. This includes any evidence considered, relied upon, or generated by Healthy Blue in connection with the appeal. This information is provided free of charge and sufficiently in advance of the date by which we resolve the appeal.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are as follows:

- An acknowledgement letter is mailed within 10 calendar days of receiving an appeal
- Standard resolution of appeal: 30 calendar days from the date of receipt of the appeal
- Expedited resolution of appeal: 72 hours from receipt of the appeal
    - We make every reasonable effort to give the member or his or her representative oral notification and then follow it up with a written notification.

The member, or the member's representative, can file an appeal within 60 calendar days from the date on the Healthy Blue *Notice of Action*. The member can file an appeal orally or in writing. A provider may file an appeal on behalf of the member. The provider must follow all requirements for a member appeal.

We will inform the member of the limited time he or she must present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not resolved in favor of the member, the notice will include:

- The right for our members to request a state fair hearing and how to do it.
- The right to receive benefits while this hearing is pending and how to request it.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action.

2.37 Expedited Appeals

Our expedited appeal process is available upon the member's request or when the provider indicates that a standard resolution could seriously jeopardize the member's life; health; or ability to attain, maintain or regain maximum function.

The member or provider may file an expedited appeal either orally or in writing, or the member may present evidence in person. A provider may file the request on behalf of the member if the provider has obtained written consent signed by the member authorizing the provider to act on the member's behalf. A provider who appeals on the member's behalf must follow all requirements for a member appeal, including timely filing of the request for appeal. No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

We will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within 72 hours after receipt of the expedited appeal request. There may be one extension of 14 calendar days to this timeline upon the member's request, or if we can show that there is a need for additional information and the delay is in the interest of the member. When the delay is for this reason and not because of a member request, we will provide information describing the reason for the delay in writing to the member within 2 calendar days and make reasonable efforts to notify the member by phone of the delay The member is also notified of the right to file a grievance if the member disagrees with the decision.

If your expedited appeal request is reviewed and is denied expedited resolution because it does not meet criteria, we will transfer the appeal to the timeframe for a standard resolution of no longer than 30 calendar days.. We will make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within 2 calendar days to inform the member of the right to file a grievance if member disagrees with that decision.

2.38 Continuation of Benefits During Appeals or State Fair Hearings

We are required to continue a member's benefits while the appeals process, or the state fair hearing is pending if all the following are true:

A provider cannot request continuation of benefits.

- The request for continuation of benefits is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits.

If the decision is against the member, we may recover from the provider the cost of the services the member received while the appeal was pending.

2.39 State Fair Hearing Process

If the member or his or her representative (with written consent signed by the member) do not agree with appeal decision, and the appeal process has been exhausted or if the appeal decision was not made within the required time frames, 30 calendar days (for standard appeals) or 72 hours (for expedited appeals), the appeal is then deemed exhausted should submit a written request for a state fair hearing to the Division of Administrative Law within 120 calendar days from the date of the notice of resolution regarding the member's standard appeal. The request will be submitted within 10 calendar days of the date of the *Notice of Resolution* if the member wishes to have continuation of benefits during the state fair hearing. A provider may file a request for a state fair hearing only as a representative of a member, with written consent signed by the member. The state fair hearing is only for members who exhaust the member MCO level appeal. The member and his/her authorized representative or the representative of a deceased member's including the health plan are part of the state fair hearing process.

You may request a written State Fair Hearing at this address:

Department of Health and Human Services
MLTC Appeal Coordinator
P.O. Box 94967
Lincoln, NE 68509-4967

2.40 Prevent, Detect and Deter Fraud, Waste and Abuse

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste, and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud*: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person. The attempt itself is fraud regardless of whether it is successful.
- *Waste*: Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- *Abuse*: When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at **www.fighthealthcarefraud.com**
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Every member ID card lists the following:

- Effective date of membership
- Member date of birth

- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and 24/7 Nurseline telephone numbers

See the **Member ID Cards** section for a sample of a Healthy Blue member ID card.

Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a Healthy Blue member ID card. Presentation of a member ID card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call our Member Services phone number at **833-388-1405 Monday through Friday, 8 a.m. to 5 p.m. CT**. Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOB*s) for any errors and contact Member Services if something is incorrect.

2.41 Reporting Fraud, Waste and Abuse

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 his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website at **https://provider.healthybluene.com**.
- Visit our **www.fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- Calling Provider Experience at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**
- Calling Member Services
- Visiting our website at **https://provider.healthybluene.com**.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring to suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

2.42 Examples of Provider Fraud, Waste and Abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed

When reporting concerns involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address, and phone number of provider(s)
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

2.43 Examples of Member Fraud, Waste and Abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID card
-
- Relocating to out-of-service plan area and not notifying Healthy Blue
- Using someone else's ID card

When reporting concerns involving a **member**, include:

- The member's name.
- The member's date of birth, member number or case number if you have it.
- The city where the member resides.
- Specific details describing the fraud, waste, or abuse.

2.44 Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract. If appropriate, allegations and the investigative findings are reported to all the appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include but is not limited to:

- Written warning and/or education: We send letters to the provider documenting the issues and the need for improvement by mail service or secure email. Letters may include education, requests for recovery or may advise of further action.

- Medical record review: We review medical records to substantiate allegations or validate claims submissions.
- Special claims review: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are sent to a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

2.45 Acting on Investigative Findings

We refer to all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste or abuse, the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will be referred to other authorities as applicable and/or designated by the State

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan, with state approval.

2.46 Relevant Legislation

False Claims Act
We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or “whistleblower” provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government.

Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Healthy Blue and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verifying the receiving fax number is correct, notifying the appropriate staff at our company and verifying the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information); such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box, or department at our company.
- Our company voicemail system is secure, and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address, and tax identification number (TIN) or member's provider number.

Employee Education about the FCA

- As a requirement of the *Deficit Reduction Act* of 2005, contracted providers who receive Medicaid payments of at least $5 million dollars (cumulative from all sources) must comply with the following: Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the *FCA*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse, and waste. Include in any employee handbook a specific discussion of the

laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse, and waste.

2.47 Steerage of Membership

Per our contract with the Department of Health and Human Services we cannot have contractual arrangements in which a provider represents that they will not contract with another health plan or in which we represent that we will not contract with another provider. Contractual arrangements between us and each provider must be non-exclusive.

Steerage of membership by us and/or our network providers is prohibited. If the Department of Health and Human Services determines steerage has occurred, the department has wide discretion in assessing both financial penalties and nonfinancial penalties, such as member disenrollment.

3 MEMBER MANAGEMENT SUPPORT

3.1 Welcome Call

We give new members a welcome call to:

- Educate them about our services.
- Help them schedule initial checkups.
- Identify any health issues (for example, pregnancy or previously diagnosed diseases).

3.2 24/7 Nurseline

The 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 weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.

Members can reach the 24/7 Nurseline at **833-388-1405** (TTY:711). Language translation services are also available.

3.3 Care Management

We have a voluntary, comprehensive program to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. Once we have identified a member's need, our clinicians will work with that member and the member's PCP to identify the:

- Level of care management needed.
- Appropriate alternate settings to deliver care.
- Healthcare services.
- Equipment and/or supplies.
- Community-based services.
- Communication between the member and his or her PCP.

For members who are hospitalized, our clinicians will also work with the member, utilization review team, and PCP or hospital to develop a discharge plan of care and link the member to:

- Community resources.
- Our outpatient programs.
- Our Condition Care (CNDC).

Member Assessment
Our care manager conducts a comprehensive assessment to determine a member's needs, including but not limited to, evaluating that person's:

- Medical condition.
- Previous pregnancy history (when applicable).
- Current pregnancy status (when applicable).
- Functional status.
- Goals.

- Life environment.
- Support systems.
- Emotional status.
- Ability for self-care.
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our care manager will coordinate current medical and nonmedical needs.

Plan of Care

After the assessment, our care manager:

- Determines the level of care management services.
- Guides, develops, and implements an individualized plan of care.
- Works with the member, the member's representative, and his or her family and provider.

Care managers consider our members' needs for:

- Social services.
- Educational services.
- Therapeutic services.
- Other nonmedical support services such as personal care; Women, Infants and Children (WIC) Program; and transportation.

They also consider the strengths and needs of our members' families.

Our care managers collaborate with the members' multidisciplinary team, including social workers, member advocates or outreach associates, when necessary, to define ways to coordinate physical health, behavioral health, pregnancy, and social services. We then make sure we forward all written care plans to you by fax or mail.

We welcome your referrals of patients who can benefit from complex care management or assistance with special care needs. To make referrals, contact our Care Management department directly **at 833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**

3.4 Behavioral Healthcare Management

The Healthy Blue integrated care management programs are designed to coordinate and improve member health outcomes by integrating our medical and behavioral healthcare programs and making reliable and proven protocols available to providers.

We view care management as a continuum of services and supports that are matched on an individualized basis to meet the needs of the member. Members who are identified as at-risk for hospitalization, having complex needs or rising risk due to behavioral health or substance use disorders are offered ongoing care management support.

The **key characteristics** of the BH (BEHAVIORAL HEALTH) Care Management model involves several essential unique elements. These include and are not limited to:

- Targeted outreach and data-driven identification of potential members that are eligible for care management services/programs.
- Direct telephonic, face-to-face, and or digital solution contact and collaboration with the member, physician and others involved in managing the member's health.
- Using an interdisciplinary approach, BH care managers and non-clinical associates consult with
- Medical Directors, Behavioral and Physical Health Departments, Social Workers and/or the
- Pharmacy Department as needed. (BH CM specific rounds, BH CM and BH UM rounds, and
- integrated rounds).
- Use of Motivational Interviewing (MI) to improve member engagement and progress toward successful health behavior changes.
- Assisting the member with identifying and addressing barriers and gaps in care.
- Assisting the member in navigating the healthcare system.
- Assisting the member to coordinate care between Medicare, Medicaid, and/or other health insurance if applicable.
- Assisting the member with transitions of care (e.g., pediatric to adult care, or when a benefit is exhausted)
- Referrals to community resources and/or other resources, as necessary, when benefits are not available to meet the member's healthcare needs.
- Assisting members with self-management of their conditions by providing health education specific to their needs and utilizing digital platforms, such as myStrength.
- Working within the member's benefit structure to optimize their benefits.
- Respecting a member's privacy by upholding all applicable laws and regulations.
- Promote optimal client safety through programs and services including Condition Care, Pharmacy, Utilization Management, Physical and Behavioral Health.
- Use a comprehensive, holistic approach to culturally competent care management.
- Demonstrate awareness, respect for diversity, and sensitivity to individual learning and linguistic needs.

Healthy Blue providers are encouraged to engage and direct development and provide feedback on our members' care plans.

Healthy Blue members who would benefit from care management services but actively choose not to participate or are unable to participate may be managed through a provider focused program.

Healthy Blue's clinical teams, which are staffed with behavioral health and medical care managers, work in close collaboration with community and provider-based care managers. The main functions of the Healthy Blue behavioral healthcare managers include but are not limited to:

- Using health risk appraisal data gathered by Healthy Blue from members upon enrollment to identify members who will benefit from engagement in individualized care coordination and care management.
- Using "trigger report data" based on medical and behavioral health claims to identify members at risk.
- Consulting and collaborating with our medical care managers and condition care clinicians regarding members who are present with comorbid conditions.
    - Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder or the effect of such additional disorders or diseases.
- Referring members to provider-based care management for ongoing intensive care management and then continuing involvement with the member and the provider to coordinate care, when needed, among different agencies, medical providers, etc.

- Working directly with the member and provider based on the severity of the member's condition to develop a comprehensive, person centered care plan.

Documenting all actions taken and outcomes achieved for members in the Healthy Blue information system to ensure accurate and complete reporting.

3.5 New Baby, New Life℠ Pregnancy Support Program

New Baby, New Life℠ is a proactive care management program for mothers and their newborns that uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, hospital census reports, Availity and notification of pregnancy forms as well as provider and member self-referrals. Once identified, we act quickly to assess the member's obstetrical risk and ensure she has the appropriate level of care and care management services to mitigate those risks.

Experienced care managers work with members and providers to establish a care plan for our highest-risk pregnant members. Care managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That is why we encourage all our moms-to-be to take part in our New Baby, New Life program — a comprehensive care management and care coordination program offering:

- Individualized, one-on-one care management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups (599 CHIP members not eligible for postpartum incentives).

As part of the New Baby, New Life program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high touch care management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our care managers, and improve member and baby outcomes. For more information on My Advocate, visit **www.myadvocatehelps.com**.

Healthy Blue requires notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in the online Interactive Care Reviewer or fax the forms to Healthy Blue at **800-964-3627.**

You should also complete the Availity platform's Maternity Module.

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.

- Before the benefit results screen, you will be asked if the member is pregnant. Choose "Yes", if applicable. If you indicate "Yes" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. You may access the form by navigating to the "Applications" tab and selecting the "Maternity" link.

NICU Care Management
For parents with infants who are admitted to the NICU, we offer the NICU Care Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Highly skilled and specialized NICU care managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge.

Once discharged, NICU care managers continue to provide education and support to foster improved outcomes, prevent unnecessary hospital readmissions and ensure efficient community resource consumption as needed.

The stress of having an infant in the NICU may result in Post-Traumatic Stress Disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:
- Guiding parent(s) into hospital-based support programs, if available
- Screening parent(s) for PTSD approximately one month after their baby's date of birth
- Referring parent(s) to behavioral health program resources, if indicated
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness

Members may also receive calls from OB care managers to provide interconceptional CM, with education and support in obtaining information to develop an interconception family life plan.

Our care managers are here to help you. If you have a member in your care that would benefit from OB and/or NICU care management, please call us at **833-388-1406** Monday to Friday 7 a.m. to 8 p.m. CT. Members can also call our 24-hour Nurse Helpline at **833-388-1405** Monday to Friday 8 a.m. to 5 p.m. CT (TTY:711)

3.6 Condition Care

Our Condition Care (CNDC) is based on a system of coordinated care management interventions and communications designed to assist physicians and other healthcare professionals in managing members with chronic conditions.

Condition Care Program services include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment. The ability to manage more than one disease to meet the changing health care needs of our member population.
Our programs include:
- Asthma
- Bipolar disorder

- Chronic obstructive disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child/adolescent
- Substance use disorder
- Schizophrenia

In addition to our condition-specific Condition Care Program programs, we also assist members with weight management and smoking cessation education.

Program Features

- Proactive population identification process
- Program content is bases on evidence-based clinical practice guidelines
- Collaborative practice models, which include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance (NCQA) accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all our programs are based on nationally approved clinical practice guidelines are located at **https://provider.healthybluene.com**. A copy of the guidelines can be printed from the website.
833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT

Who is eligible?
Members diagnosed with one or more of the above conditions are eligible for CNDC services.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk -stratified based on the severity of their disease. They are provided with continuous education on -self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

CNDC Provider Rights and Responsibilities
You have the right to:

- Have information about Healthy Blue including:
  - Provided programs and services
  - Our staff

    - Our staff's qualifications
    - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their healthcare.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about CNDC as outlined in the Healthy Blue provider complaint and grievance procedure.

Hours of Operation
Our Condition Care (CNDC) case managers are registered nurses. They are available 8:30 a.m. to 5:30 local time. Confidential voicemail is available 24 hours a day. The 24/7 Nurse Line is available for our members 24 hours a day, 7 days a week **at 833-388-1405 Monday through Friday 8 a.m. to 5 p.m. CT (TTY:711)**

Contact
You can call a Condition Care (CNDC) team member at **888-830-4300**. CNDC program content is located at **https://provider.healthybluene.com**. Members can obtain information about CNDC program by visiting **https://provider.healthybluene.com** or calling **888-830-4300** 8:30 a.m. to 5:30 local time

3.7 Provider Directories

We make provider directories available to members in online searchable and hard-copy formats. Because members use these directories to identify healthcare providers near them, it is important that your practice address(es), doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting **https://provider.healthybluene.com**.
- Calling Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**
- Calling or emailing your local Provider Relations representative.

The provider directory is also available on the provider website at **https://provider.healthybluene.com**.

3.8 Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Healthy Blue wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,

- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Healthy Blue encourages providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **Creating an LGBT-Friendly Practice:** Helps providers understand the fears and anxieties LGBT patients often feel about seeking medical care, learn key health concerns of LGBT patients, and develop strategies for providing effective health care to LGBT patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma and develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Healthy Blue requires and provides training on cultural competence, including tribal awareness, to behavioral health network providers for a minimum of three hours per year and as directed by the needs assessments.

In addition, providers should attempt to collect member demographic data, including but not limited to, ethnicity, race, gender, sexual orientation, and religion. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Healthy Blue appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

3.9 Member Records

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to skilled professional medical practice and must be permanently maintained at the primary care site.

Our member's previous provider must forward a copy of all medical records to you within 10 business days from receipt of your request at no charge. Members are entitled to one copy of their medical record per year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Member records must be retained for online retrieval and access for six years in live systems and ten years in archival systems after the last good, service or supply has been provided to a member or an authorized agent unless those records are subject to review, audit, or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government, for audit and reporting purposes.

Healthy Blue requires access to member records for the purpose of conducting Medical Record Reviews.

Our medical records standards include:

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers and marital status (primary languages spoken and translation needs must be included)
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
    - Medication allergies
    - Adverse reactions

    - No Known Allergies (NKA)
- Past medical history — for patients seen three or more times, include serious accidents, operations, illnesses, and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members 20 years of age and younger with vaccines and dates of administration. Evidence of lead screening for ages 6 months to 6 years.
- Diagnostic information including growth charts, head circumference and developmental milestones, if applicable
- Medical information, including medication and instructions to patients
- Current list of medications
- Identification of current problems
- Serious illnesses
- Medical and behavioral conditions
- Health maintenance concerns
- Instructions, including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients ages 12 and older and seen three or more times
- Consultations, referrals, and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

3.10 Patient Visit Data

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment including at-risk factors:
    - Danger to self/others
    - Ability to care for self
    - Affect
    - Perpetual disorders
    - Cognitive functioning
    - Significant social health
- Admission or initial assessment including:
    - Current support systems
    - Lack of support systems
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating either:
    - Decreased
    - Increased
    - Unchanged
- A plan of treatment including:

    - Activities
    - Therapies
    - Goals to be carried out
- Diagnostic tests
- Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment
- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months, or PRN
- Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

3.11 Clinical Practice Guidelines

We work with you and providers like you to develop clinical policies and guidelines. Each year, we select at least four evidence-based *Clinical Practice Guidelines* that are relevant to our members and measure at least two important aspects of each of those four guidelines. We also review and revise these guidelines at least every two years. You can find these *Clinical Practice Guidelines* on our website at **https://provider.healthybluene.com**.

3.12 Advance Directives

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

- Durable power of attorney — lets a member name a patient advocate to act on his or her behalf
- Living will: let a member state his or her wishes on medical treatment in writing

We encourage members ages 18 and older to ask you for an advance directive form and education at their first appointment. Please document their forms in your medical records. We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care. Please note, a Healthy Blue associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

4 BEHAVIORAL HEALTH SERVICES

4.1 Overview

Healthy Blue integrated physical and behavioral health services are an essential part of our healthcare delivery system. Our mission is to comprehensively address the physical and behavioral healthcare of our members by offering a wide range of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for members. Healthy Blue works collaboratively with hospitals, group practices, independent behavioral healthcare providers, community and government agencies, human service districts, federally qualified health centers (FQHC), rural health centers (RHCs), community mental health centers, and other resources to successfully meet the needs of members with mental health, substance use, and intellectual and developmental disabilities.

For assistance with behavioral health services:

- Providers can call Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**
- Members can call Member Services at **833-388-1405 Monday to Friday 7 a.m. to 8 p.m. CT**

4.2 Target Audience

The Healthy Blue provider network is inclusive of specialized behavioral healthcare providers, as well as a comprehensive array of supports and services designed to serve the following target populations:

- Medicaid eligible adults, adolescents, and children with behavioral health (mental health and substance use) needs that are not best managed by basic behavioral health services in the primary care setting by a primary care provider
- Adults, adolescents, and children who have severe mental illness and/or substance use disorders
    - Adults and children enrolled in Medicaid home- and community-based waiver programs who have not opted into state Medicaid program if applicable for physical health and do not have Medicare
    - Individuals residing in nursing facilities who do not have Medicare
    - Children enrolled in a home and community-based waiver program who have not opted into state Medicaid program for physical health and do not have Medicare

4.3 Goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to include a comprehensive array of quality and evidenced-based supports and services for eligible members, while enhancing members' experiences.
- Integrate the management and delivery of physical and behavioral health services.
- Achieve quality initiatives, including those related to HEDIS®, NCQA, Department of Health and Human Services and other governmental entities performance requirements.
- Work with members, providers and community supports to provide recovery and resilience tools to create an environment that supports members' progress toward their recovery and resilience goals.
- Ensure utilization of the most appropriate and least restrictive medical and behavioral healthcare in the right place, at the right time.

4.4 Objectives

The objectives of the behavioral health program are to:

- Ensure continuity and coordination of care between physical and behavioral healthcare practitioners.
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery and resilience goals.
- Leverage individualized, person-centered planning approaches to assist members in life planning to increase their personal self-determination and optimize their own independence.
- Provide member education on treatment options and pathways toward recovery and resilience.
- Provide high quality care management and care coordination services that identify member needs and address them in a personal and holistic manner.
- Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, waiver services and outpatient care at the least restrictive level.
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives.
- Promote collaboration between all healthcare partners to achieve recovery goals through education, technological support and the promotion of recovery ideals.
- Use evidence-based practices, guidelines and clinical criteria and promote their use in the provider community.
- Maintain compliance with accreditation standards and with local, state and federal requirements.
- Deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations and policies and procedures set forth by the state of Nebraska.
- Reduce repeat ER visits, unnecessary hospitalizations, out-of-home placements and institutionalizations.
- Improve member clinical outcomes through continuous quality monitoring of the health delivery service system.

4.5 Guiding Principles of the Behavioral Health Program

Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- **Self-direction:** Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a -self-determined life.
- **Individualized care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.

- **Empowerment:** Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives, and are educated and supported in so doing.
- **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and healthcare treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
- **Nonlinear:** Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the member to move on to fully engage in the work of recovery.
- **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
- **Peer support:** Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
- **Respect:** Community, systems and societal acceptance, and appreciation of members, including protecting their rights and eliminating discrimination and stigma, are crucial to achieve recovery.
- **Responsibility:** Members have a personal responsibility for their own self-care and journeys of recovery.
- **Hope:** Recovery provides the essential and motivating message of a better future — That people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges due to changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

4.6 Systems of Care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused, with the needs of the person and their family dictating the types and mix of services provided.
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized, as evidenced by an individualized service plan that meets unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing, and coordinating services.

- Inclusive of care management or similar mechanisms to ensure multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Oriented to recovery and providing services that are flexible and evolve over time.

4.7 Integration of Behavioral Health and Physical Health Treatment

The integration of behavioral health and physical health treatment is the cornerstone of the Healthy Blue philosophy of treating the needs of the whole person. Principles that guide this integration of care include the following:

- Behavioral health is essential to overall health and not separate from physical health.
- Mental illness, substance use disorders and other healthcare conditions must be integrated into a comprehensive system of care that meets the needs of individuals in the setting where they feel most comfortable. This includes primary care settings and/or behavioral healthcare settings.
- Many people suffer from mental illness, substance use disorders and other healthcare conditions concurrently; as care is provided, the dynamic of having co-occurring illnesses must be understood, identified and treated as primary conditions.
- The system of care must be accessible and comprehensive and fully integrate an array of prevention and treatment services for all age groups. It is designed to be evidence informed, responsive to changing needs and built on a foundation of continuous quality improvement.

It is our goal to make relevant clinical information accessible to all health providers on a member's treatment team, consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Key elements of our model for coordinated and integrated health services include but are not limited to:

- Ongoing communication, coordination and collaboration between primary care providers and specialty providers, including behavioral health (mental health and substance use) providers, with appropriate documented consent.
- The expectation that primary care providers will regularly screen members for mental health, substance use (including tobacco), co-occurring disorders and problem gambling or gaming and refer members to behavioral health specialty providers as necessary.
- The expectation that behavioral health providers will screen members for common medical conditions, including tobacco use, and refer members to the primary care provider for follow-up diagnosis and treatment.
- Collaboration between all healthcare providers with support from Healthy Blue in managing healthcare conditions of members.
- Referrals to primary care providers or specialty providers, including behavioral health providers, for assessment and/or treatment for members with co-occurring disorders and/or any known or suspected and untreated health disorders.
- Development of patient-centered treatment plans involving members, as well as caregivers and family members, and other community supports and systems when appropriate.
- Care management, condition care and population health management programs to support the coordination and integration of care between providers.

Fostering a culture of collaboration and cooperation helps Healthy Blue sustain a seamless continuum of care that positively impacts our member outcomes. To maintain continuity of care, patient safety and member well-being, communication between integrated healthcare providers is critical, especially for members with comorbidities receiving pharmacological therapy.

4.8 Coordination of Physical and Behavioral Health Services

As a network provider, you are required to notify a member's primary care provider when a member first enters behavioral healthcare and anytime there is a significant change in care, treatment, medications or need for medical services. You must secure the necessary release of information from each member or the member's legal guardian for the release of treatment information, including substance use information, in accordance with *42CFR Part II* requirements. Each offer of consent or release of substance use information should be documented and reported to Healthy Blue as requested. You should be able to provide initial and summary reports to the primary care provider or to Healthy Blue upon request. The minimum elements to include are as follows:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see their primary care provider if a medical condition is identified or need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician's name and contact information

4.9 Provider Roles and Responsibilities

The behavioral healthcare benefit is fully integrated with the rest of the healthcare programs and inclusive of our fee-for-service Medicaid members requiring behavioral health services only. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each Healthy Blue member under your care.
- Seek prior authorization for all services that require it.
- Attempt to obtain appropriate consent for the disclosure of substance use treatment information to the member's PCP for all members treated for behavioral health conditions, document attempts and report information to Healthy Blue upon request.
- Provide Healthy Blue and the member's PCP with a summary of the member's initial assessment, primary and secondary diagnosis, and prescribed medications if the member is at risk for hospitalization.
- Provide, at a minimum, a summary of the findings from the member's initial visit to the PCP
- Notify Healthy Blue and the member's PCP of any significant changes in the member's status and/or change in the level of care.
- Ensure members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge — this treatment must be provided within seven calendar days from the date of the member's discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.

- Encourage members to consent to the sharing of substance use treatment information.
- Comply with mainstreaming requirements.
- Refrain from excluding treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DHHS or Juvenile Probation) involvement or referral.

4.10 Continuity of Care

To assist in the transition of Healthy Blue members from one level of care to another, Healthy Blue recommends transition meetings or appointments are held prior to the member moving from higher to lower restrictive levels of care to assure continuity of treatment. Healthy Blue encourages providers to include Healthy Blue care managers in these meetings and appointments.

4.11 Provider Success

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral healthcare to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Simplifying preauthorization rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Supporting provider needs related to transitioning into the managed care environment.

4.12 Clinical Staff

All clinical staff members are licensed and have prior healthcare experience. Our behavioral health medical director is board certified in adult psychiatry and licensed in the state of Nebraska. Our highly trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our members and strive to work collaboratively with all providers.

4.13 Member Records and Treatment Planning

Member Records and Treatment Planning: Comprehensive Assessment
Member records must meet the following standards and contain the following elements, if applicable, for effective service provision and quality reviews.

Information related to the provision of appropriate services to members must be included in the records, with documentation in a prominent place whether there is an executed declaration for mental health treatment.

Providers must complete a comprehensive assessment that provides a description of the member's physical and mental health status at the time of admission to services. It should include the following:

- Psychiatric and psychosocial assessment, including:
    - Description of the presenting problem
    - Psychiatric history and history of the member's response to crisis situations
    - Psychiatric symptoms

    - Multi-axial diagnosis using the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)
    - Mental status exam
- Medical assessment, including:
    - Screening for medical problems
    - Medical history
    - Present medications
    - Medication history
- Substance use assessment, including:
    - Frequently used over-the-counter medications
    - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
    - History of prior alcohol and drug treatment episodes and their effectiveness
    - History of alcohol and drug use
- Community functioning assessment or an assessment of the member's functioning in the following domains:
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
    - Physical health
    - Emotional/behavioral health
    - An assessment of the member's strengths, current life status, personal goals and needs

Member Records and Treatment Planning: Personalized Support and Care Plan
When individualized treatment plans are required, they must be:

- Completed and submitted within the first 24 hours or next business day for members admitted to an acute mental health or acute care inpatient setting.
- Completed and submitted within the first 30 days of admission to or authorization of outpatient behavioral health services.

An Initial Diagnostic Interview (IDI) shall be completed prior to the beginning of treatment. This comprehensive assessment shall serve as the initial treatment plan until a treatment plan is developed.

Treatment plans must be completed within 14 days of admission to the treatment program. Treatment plans will be reviewed by clinical staff every 30 days. Treatment plan reviews shall be based on the member's progress toward goals, a significant change in psychiatric symptoms, medical condition and/or community functioning as well as the level of care where the member is receiving treatment.

There must be a signed release of information to provide information to the member's PCP, including disclosure of substance use information or evidence that the member refused to provide a signature. Such information must be reported to Healthy Blue upon request. Disclosures of substance use information must include a prohibition against redisclosure. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible for helping the member get that gap in care fulfilled, and documentation should reflect the action taken.

The individualized treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent de-escalation or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member as well as family members, caregivers or legal guardian as appropriate

Member Records and Treatment Planning: Progress Notes
Progress notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the member's treatment, including signed and dated notations of phone calls concerning the member's treatment.
- Indication of active follow-up actions for referrals given to the member and actions to fill gaps in care.
- A brief discharge summary within 15 calendar days of a discharge from services or death.
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

4.14 Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication; alternate medications; and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member, or if appropriate, a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, their treating provider's information and coordination efforts with that provider. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's PCP.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side effects and risks of medications, and they regularly inquire about and look for any side effects. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines.

- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers.
- Glucose tolerance test or hemoglobin A-1C tests, especially for those members on antipsychotics or mood stabilizers.
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers.
- ECG checks for members placed on medications with risk for significant QT prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our clinical practice guidelines, located on our website at **https://provider.healthybluene.com**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

4.15 Timeliness of Decisions on Requests for Authorization

The following are guidelines around the timeliness of decisions on authorization requests for behavioral health services:

Type of Request	Decision	Extension
Standard Request	14 calendar days	14 calendar days
Expedited Request	72 hours	14 calendar days
Retrospective	30 calendar days	14 calendar days

- If the referral is made from an emergency room or a facility that does not have a psychiatric unit, the decision will be made and communicated to the provider within one hour of the request.
- If in an inpatient facility where they will be hospitalized, the decision will be made and communicated to the provider within 72 hours of the request.

4.16 Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral healthcare.

Service type	Access standard
Emergent Treatment is considered to be an on-demand service and does not require preauthorization. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.	Immediately on presentation at the service delivery site, emergent, crisis or emergency behavioral health services must be available at all times and an appointment must be arranged within 1 hour of the request. Care for a nonlife-threatening emergency must be arranged within 6 hours.
Urgent A service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has	Within 24 hours of referral/request

Service type	Access standard
substance use problems, she is to be placed in the urgent category.	
Routine A service need that is not urgent and can be met by receiving treatment within 10 days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.	**Routine outpatient:** within 10 days of request **Outpatient following discharge from an IP hospital:** within seven days of discharge

All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, prior to discharge, which includes the specific time, date, place, and name of the Provider to be seen. Outpatient treatment must occur within seven days from the date of discharge.

4.17 Behavioral Health Parity

Healthy Blue will comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

This includes, but is not limited to:

a. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more strictly than the medical management techniques that are applied to medical and surgical benefits.
b. Ensuring compliance with MHPAEA for any benefits offered by Healthy Blue to members beyond those specified in the Medicaid State Plan.
c. Making the criteria for medical-necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracted provider, on request.
d. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.
e. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

Behavioral Health Criteria

Healthy Blues uses MCG Clinical Guidelines for behavioral health services and the American Society for Addiction Medicine (ASAM) criteria for substance use disorder services. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health and substance use disorder services. MCG Care Guidelines can be accessed at **https://www.mcg.com** and ASAM criteria can be accessed at **www.asam.org.**

Healthy Blue uses our Clinical Utilization Management (UM) Guidelines for Applied Behavior Analysis (ABA) services. A list of the specific Clinical UM Guidelines used will be posted and maintained on our website **https://provider.healthybluene.com** and can be obtained in hard copy by written request.

4.18 Behavioral Health Covered Services and Services Requiring Preauthorization

Behavioral Health Covered services for adults age 21 and over consist of Inpatient psychiatric hospital services, Crisis stabilization services, Rehabilitation services and Outpatient assessment and treatment services. (see section 2.25 Benefits)

Behavioral health covered services for members age 20 and under, unless otherwise indicated consist of Crisis stabilization services (includes treatment crisis intervention), Inpatient psychiatric hospital services, Psychiatric residential treatment facility (PRTF) services (age 19 and under –Certificate of Need (CON) is needed for admission), Rehabilitation services, and Outpatient assessment and treatment services. (see section 2.25 Benefits)

All facility-based behavioral health and substance use services require preauthorization. All services provided by non-participating providers require preauthorization. To obtain additional information about covered services and preauthorization requirements for covered behavioral health services, please visit the provider website at **https://provider.healthybluene.com**. For information or to get referrals, call **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

4.17 How to Provide Notification or Request Preauthorization

Notification or Request Prior Authorization

The quickest, most efficient way to request prior authorization is via the secure provider website at **https://www.availity.com.** Through the secure provider website, you can access the Interactive Care Reviewer (ICR), which offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Healthy Blue members. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or other online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, ICR or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Request a clinical appeal for eligible denied prior authorization requests**
- **Access the ICR** by selecting *Patient Registration > Authorizations and Referrals* via the Availity Portal.
- **Enhanced Analytics** that can provide immediate authorizations for certain higher levels of care
- **Increased Efficiency** so that use of fax is no longer needed

For an optimal experience with the ICR, use a browser that supports 128-bit encryption.

The most efficient and streamlined process to submit authorizations for your organization is through ICR.

You may also request behavioral health prior authorization via paper fax if preferred.

Fax forms are on our website at **https://provider.healthybluene.com**

4.18 Emergency Behavioral Health Services

Primary care providers should immediately refer any member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

Behavioral Health 24/7 Crisis Line
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**.

4.19 Behavioral Health Self Referrals

Members may self-refer to any behavioral healthcare provider in the Healthy Blue network. If the member is unable or unwilling to access timely services through community providers, call Healthy Blue Provider Services **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** for assistance.

PCPs may treat members with situational behavioral health disorders, the most common of which are depression and anxiety. For members whose behavioral health does not respond to treatment in a primary care setting, contact us for referral and authorization information regarding assessment and ongoing services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

PCPs are required to refer members that are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms or are in a crisis state. Please refer to the benefits matrix for the range of services covered. PCPs are also required to make referrals for members whose symptoms of anxiety and mild depression persist or become worse. Any member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications.

PCPs should refer any member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health specialist:

- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Multiple diagnoses
- Psychoses
- Schizophrenia
- Problem gaming or gambling

4.20 Behavioral Health Services: Criteria for Provider Type Selection

Psychiatrist
All the criteria below should be met before directing a member to a psychiatrist.

The member:

- Can self-refer for behavioral health treatment.

- Is taking psychoactive medication.
- Is referred by their PCP or under PCP treatment for the relevant problem.
- If a child had prior treatment for the same problem without medication, and the problem is severe or disabling in some areas of life.

The problem:

- Is cognitive, and the member has had previous inpatient or day treatment.
- Is cognitive, and overall dysfunction severe or disabling.
- Is recurrent for greater than six months, and the member has had prior treatment.
- Is recurrent for greater than six months, and dysfunction is severe or disabling in any area of functioning.
- Is somatic, and the referral was not from the PCP.
- Is somatic, and the member is under PCP care, and the problem is severe or disabling in some area of functioning.

Psychologist or Licensed Mental Health Professional (LMHP)
The following criteria should be met before directing a member to a psychologist or licensed mental health professional:

- The member can self-refer for behavioral health treatment.
- An identifiable stressor is present.
- The member is not referred by their PCP and is not under PCP treatment for the relevant problem.
- The problem is not recurrent and is not greater than six months duration.
- The problem is not severe or disabling in any area of functioning.

4.21 Links to Forms, Guidelines and Screening Tools

For mental health and substance use covered services, noncovered diagnoses, and screening tools for PCPs and behavioral health providers, go to **https://provider.healthybluene.com.**

For services requiring preauthorization, go to **https://provider.healthybluene.com.**

4.22 Applied Behavior Analysis

Applied behavior analysis (ABA) is a form of adaptive behavioral treatment. ABA therapy is a set of behavior treatments that work to increase useful or desired behaviors. ABA applies scientific principles about learning and behavior to reduce behaviors that may be harmful or interfere with learning.

ABA treatment is rendered by an ABA assistant or technician under the supervision of a board-certified behavior analyst (BCBA). Healthy Blue works closely with members on an integrated and holistic clinical approach with the assistance of PCPs, BCBAs, specialized care managers and dedicated ABA staff.

The following sections provide more information on ABA. All ABA providers and services are subject to the same guidelines as other providers and services outlined throughout this manual including our utilization management guidelines. You may also refer to the Department of Health and Human Services' manual or website as an additional resource.

ABA: Target Audience

The Healthy Blue provider network for ABA services includes the following:

- Licensed psychologists
- Licensed medical psychologists
- Behavior analysts
- Certified assistant behavior analysts
- Technicians with experience serving the needs of the following target populations:
    - Adolescents and children under 21 years of age
    - Individuals exhibiting excesses and/or deficits of behaviors that significantly interfere with home or community activities
    - Individuals diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate by a qualified healthcare professional
    - Individuals who had a comprehensive diagnostic evaluation by a qualified healthcare professional
    - Individuals who have a prescription for ABA-based therapy services ordered by a qualified healthcare professional

ABA: Goals and Objectives

In addition to the goals and objectives of the overall behavioral health program, the goals and objectives specific to the ABA program include:

- Working with members, providers and caregivers to identify appropriate goals and treatments for the individual's age and impairments to improve social and communication skills.
- Having objectives that are specific, measurable, based on clinical observations of the outcome measurement assessment and tailored to the recipient.
- Ensuring interventions are consistent with ABA techniques.
- Clearly identifying the schedule of services planned and the individual providers responsible for delivering the services.
- Delineating the frequency of baseline behaviors and the treatment development plan to address the behaviors.
- Identifying long-term, intermediate and short-term goals and objectives that are behaviorally defined.

Qualified Healthy Blue associates will ensure:

- Clinical guidelines support the Department of Health and Human Services' recommendations and are person-centered and based on individualized goals.
- Providers' treatment plans are appropriate, applicable and consistent with best practices through oversight and monitoring throughout the entire continuum of treatment.

When a member is approaching ABA discharge readiness, Healthy Blue associates will:

- Work with a member, member's caregiver(s), and providers to develop a discharge/transition plan that may include:
    - Utilization management activities focused on a gradual step down of service.
    - Parent/caregiver training, support and participation.
    - Collaboration between all healthcare partners and caregiver(s), school state disability programs, and others as applicable to achieve goals through education, technological support and community resources.

    - Efforts to ensure services are delivered in accordance with best-practice guidelines, rules and regulations, and policies and procedures set forth by the state of Nebraska.
- Assist with members' transitional needs prior to discharge.
- Evaluate members for any other care management needs.
- Work with members and their families on ABA discharge planning, including:
    - Reviewing ongoing needs.
    - Making referrals as needed.
    - Assisting in the evaluation of alternative therapies (speech, occupational, feeding, etc.).
    - Continuing with care coordination activities.

ABA: Provider Roles and Responsibilities

In addition to the provider roles and responsibilities of the overall behavioral health program, the roles and responsibilities specific to ABA providers include:

- Performing a complete comprehensive diagnostic evaluation (CDE) indicating the need for ABA services.
- Performing a functional assessment and developing the behavior treatment plan.
- Frequently reviewing progress using ongoing objective measurement and adjusting the instructions and goals in the behavior treatment plan as needed.
- Conducting regular meetings with family members to plan ahead, review progress and make any necessary adjustments to the behavior treatment plan.
- Ensuring the behavior treatment plan:
    - Is person-centered.
    - Is based on individualized goals, delineating the frequency of baseline behaviors and addressing the behaviors.
    - Identifies long-term, intermediate and short-term goals and objectives that are behaviorally defined.
- Identifying the criteria that will be used to measure achievement of behavior objects.
- Clearly identifying the schedule of services planned and the individual providers responsible for delivering the services.
- Having specific objectives.
- Providing recommendations for any additional treatment; care; services; specialty medical or behavioral referrals; specialty consultations; and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

ABA: Care Management

Healthy Blue has a team of behavioral healthcare managers to serve this population.
Care management is designed to proactively respond to a member's needs when conditions or diagnoses require coordination of services. The purpose of the care management program is to provide a coordinated comprehensive approach to ensure members receive efficient and cost-effective services at the appropriate level of care through the development of individualized, innovative programs and coordination with community services.

We view care management as a continuum of services and supports that is matched on an individualized basis to meet the needs of the member. The Healthy Blue case/care manager helps identify medically appropriate

alternative methods or settings in which care may be delivered. Care management activities will focus on the care coordination of the whole person and include:

- Evaluating for other care management programs.
- Reviewing ongoing needs.
- Making referrals as needed.
- Assisting in the evaluation for alternative therapies (speech, occupational, feeding, etc.).

These measures ensure members in need of ABA treatment have access to care and are continually engaged with care management to provide ongoing support.

A provider may request participation in the program on behalf of the member. The care manager will work with the member, provider and caregiver(s) to identify the:

- Appropriate alternate settings where care may be delivered.
- Healthcare services required.
- Equipment and/or supplies required.
- Community-based services available.
- Support and/or training for caregiver(s).

Healthy Blue ABA providers are encouraged to engage, assist in the development of and provide feedback on the care plans of members they're serving.

ABA: Member Record and Treatment Plan

Members' records must include the following:

- Documentation of a completed comprehensive diagnostic evaluation (CDE) performed by a qualified healthcare professional (QHCP)
- A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history
- Direct observation of the member, including an assessment of current functioning in the areas of social and communicative behaviors and peer interactive behaviors
- A review of available records
- A valid diagnosis
- Justification/rationale for referral for an ABA functional assessment
- Recommendations for any additional treatment, care of services, specialty medical or behavioral referrals, specialty consultations, and any additional recommended standardized measures, labs, or diagnostic evaluations considered clinically appropriate and/or medically necessary

When there is any lack of clarity about the primary diagnosis, comorbid conditions or medical necessity of services requested, the CDE must be specific to the recipient's age and cognitive abilities and include additional assessments (as appropriate), such as:

- Autism specific assessments.
- Assessments of general psychopathology.
- Cognitive assessment.
- Assessment of adaptive behavior.

The licensed professional must perform a functional assessment of the member utilizing the outcomes from the CDE to develop a behavior treatment plan. The behavior treatment plan will identify the treatment goals along with providing instructions to increase or decrease the targeted behaviors. Treatment goals should emphasize skills required for both short- and long-term goals. The instructions should break down the desired skills into manageable steps that can be taught from the simplest to more complex.

The behavior treatment plan must:

- Be person-centered and based on individualized goals.
- Delineate the frequency of baseline behavioral and the treatment development plan to address the behaviors.
- Indicate that direct observation occurred and describe what happened during the observation.
- Identify long-term, intermediate and short-term goals and objectives that are behaviorally defined.
- Identify the criteria that will be used to measure achievement of behavior objectives.
- Clearly identify the schedule of services planned and the individual providers responsible for delivering the services.
- Include care coordination, involving the parents or caregiver(s), school, state disability programs, and others as applicable.
- Include parent/caregiver(s) training, support and participation.
- Have objectives that are specific, measurable, based on clinical observations of the outcome measurement assessment and tailored to the member.
- Ensure interventions are consistent with ABA techniques.
- Include a weekly schedule detailing the number of expected hours per week and the location for the requested ABA services.

The licensed professional must frequently review the member's progress using ongoing objectives and conduct monthly meetings with family members.

ABA: Providing Notification or Requesting Preauthorization

All ABA services require prior authorization. Be prepared to provide:

- Member information.
- Procedure codes.
- All supporting medical documentation.

Note: This list is not all-inclusive.
You may also provide notification or request preauthorization on the provider website at **https://provider.healthybluene.com**.

5 PREAUTHORIZATION AND NOTIFICATION PROCESS

Referrals to in-network specialists are not required. However, some specialty services require preauthorization as specified below. We encourage members to consult with their PCPs prior to accessing nonemergency specialty services. The two processes are defined below.

Preauthorization is defined as the **prospective** process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. **Prospective** means the coverage request occurred prior to the service being provided.

Elective services require preauthorization, meaning the provider should notify Healthy Blue by phone, fax or through our self-service authorization tool, Interactive Care Reviewer accessed through the secure Availity Portal, **https://www.availity.com** before providing the service. Member eligibility, provider status (network and non-network), and medical necessity will be verified.

Healthy Blue may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose.

Note: ER visits do not require preauthorization or notification. If an ER visit results in an in-patient admission, you should notify us within 24 hours of the visit or the next business day.

No preauthorization is required for EPSDT services for in-network and out-of-area network providers.

5.1 Timeliness of Decisions on Requests for Authorization

The following are guidelines around the timeliness of decisions on authorization requests for physical health services.

Type of Request	Decision	Extension
Urgent Concurrent Hospitalization	72 hours	14 calendar days
Routine/Non-Urgent/Standard Pre-Service	14 calendar days	14 calendar days
Urgent / Expedited	72 hours	14 calendar days
Retrospective	30 calendar days	14 calendar days

- For cases in which a provider indicates that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Healthy Blue must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service.
- Healthy Blue may extend the time period by up to 14 calendar days if the member requests an extension or if Healthy Blue justifies a need for additional information and the reason(s) why the extension is in the member's interest.

5.2 Preauthorization for Inpatient Elective Admissions

We require preauthorization of **all inpatient elective admissions**. The referring PCP or specialist is responsible for preauthorization. The referring physician identifies the need to schedule a hospital admission; to do so, you can either:

- Submit your request through our Interactive Care Reviewer our online authorization tool at **Availity.com (Select Patient Registration>Authorizations & Referrals)**
- Fax the request to **800-964-3627**
- Call Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

Requests for preauthorization with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of preauthorization or failure by the provider to submit clinical when requested.
Appeals for administrative denials must address the reason for the denial (that is, why preauthorization was not obtained or why clinical was not submitted.)

If Healthy Blue overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

This will allow us to verify benefits and process the preauthorization request. For services that require preauthorization, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a preauthorization is on file by:

- Visiting our provider website at **https://provider.healthybluene.com**
- Calling Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

If coverage of an admission has not been approved, the facility should call Provider Services. We will contact the referring physician directly to resolve the issue.

We are available 24/7 to accept preauthorization requests. When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the preauthorization nurse.

Our preauthorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our preauthorization nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue a Healthy Blue reference number to

the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for admission are not met on the initial review, the requesting provider can discuss the case with the Healthy Blue medical director prior to the determination.

If the preauthorization documentation is incomplete or inadequate, the preauthorization nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal and fair hearing rights) will be mailed to the requesting provider, member's PCP and member.

Retrospective Authorization Process

Healthy Blue will not routinely perform retrospective authorization reviews, but will consider under the following qualifying circumstances:

- Member was granted retro eligibility by DHHS MLTC; or
- Dates of service are during a member's transition between two Heritage Health MCOs; or
- Member is incapacitated at admission and unable to provide insurance information.

If one of the above qualifying circumstances is met, providers should follow the steps below:

1. Provider submits a retro-authorization request through the standard authorization request channels (phone, fax, portal).
2. Provider must clearly indicate that they are making a retro-authorization request. If member was incapacitated at the time of admission, indicate this along with the clinical submission.

Upon receipt, Healthy Blue Utilization Management staff will review the request to

1. Determine if the retrospective authorization request meets a qualifying circumstance.
2. Determine if the request has been made within 30 days of Healthy Blue being notified of the member's eligibility by DHHS MLTC.
   a. a. If the retrospective authorization request is not received within the identified time frame, an administrative non-authorization will be issued. .

3. In cases where a member was incapacitated and unable to provide insurance information, providers have 30 days from date of admission to request for retrospective authorization.
   a. If the retrospective authorization request is not received within the identified time frame, an administrative non-authorization will be issued.
4. If HBN UM determines that items 1, 2, and 3 above are met, HBN UM staff will review the retrospective authorization request against the appropriate medical necessity criteria.
5. An authorization determination will be made and communicated to the provider.

For retro-authorizations that are not approved upon review, standard Healthy Blue appeal rights apply.

5.3 Emergent Admission Notification Requirements

Network hospitals must notify us within 24 hours or the next business day of an emergent admission. Network hospitals can notify us by calling Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8**

p.m. CT (available 24/7), by fax at **800-964-3627** or through the secure Availity Portal at **https://provider.healthybluene.com**.

Failure to comply with notification rules will result in an administrative denial.

Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions based on medical necessity.

Providers must submit clinical documentation to support medical necessity. We will reach out to the provider if the clinical information is insufficient and additional documentation is necessary.

If our medical director denies coverage, the attending or treating provider acting on behalf of the member will have an opportunity to discuss the case with him or her. We will mail the adverse determination letter to the provider and member and include the member's appeal and state fair hearing rights and process.

5.4 Nonemergent Outpatient and Ancillary Services — Preauthorization and Notification Requirements

We require preauthorization for coverage of certain nonemergent outpatient and ancillary services (see the **Preauthorization/Notification Coverage Guidelines section**). To ensure timeliness, you must include:

- Member name and ID.
- Name, phone number and fax number of the physician providing the service.
- Name of the facility and phone number where the service will be performed.
- Name of servicing provider and telephone number.
- Date of service.
- Diagnosis with ICD-10-CM code.
- Name of elective procedure with CPT code.
- Medical information to support the request including:
  - Signs and symptoms.
  - Past and current treatment plans, along with the provider who provided the surgery.
  - Response to treatment plans.
  - Medications, along with frequency and dosage.

For the most up-to-date preauthorization/notification requirements, go to **https://provider.healthybluene.com.** For the latest preauthorization forms, go to **https://provider.healthybluene.com.**

5.5 Prenatal Ultrasound Coverage Guidelines

The following are frequently asked questions and answers about our prenatal ultrasound policies.

What are the requirements for preauthorization for total obstetric care?	For obstetric care, we do not require preauthorization; we only require **notification** to our Provider Services team.
In which trimester of a woman's pregnancy is she determined to be an obstetric patient?	A member is considered to be an obstetric patient once pregnancy is verified.

Are there preauthorization requirements for prenatal ultrasound?	There are no preauthorization requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.
Is there a medical policy covering prenatal ultrasound procedures?	Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy, go to **https://provider.healthybluene.com.** The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.
Why was the policy created?	The policy was created to ensure members receive the most appropriate ultrasound for the diagnosis or condition(s) being evaluated.
Does the policy describe limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?	The policy covers two **routine** ultrasound per pregnancy. 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. Not all diagnosis codes are acceptable and appropriate for all ultrasounds. When submitted incorrectly, a claim will be denied.
Which ultrasound procedures are covered under this policy?	The policy does not apply to ultrasound studies with CPT codes not specifically listed in the policy, such as nuchal translucency screening, biophysical profile and fetal echocardiography. **For CPT codes 76801 (+76802) and 76805 (+76810),** one routine ultrasound study is covered per pregnancy. **For CPT codes 76811 (+76812), 76815, 76816 and 76817,** additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT code 76811 (and +76812) is only reimbursable to maternal fetal medicine specialists.
Are there exceptions to this policy?	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.

5.6 Preauthorization/Notification Coverage Guidelines

For code-specific preauthorization requirements, visit **https://provider.healthybluene.com**.

Air Ambulance Services	Preauthorization is required for air ambulance services. The provider has **30 calendar days** from the date of the initial air transport to seek prior authorization for services.
ABA	Preauthorization is required for all ABA services.
Behavioral Health/Substance Abuse Services	All facility-based behavioral health and substance use services require preauthorization. All services provided by non-participating providers require preauthorization. To obtain more information about preauthorization requirements for behavioral health services, please visit the provider website at **https://provider.healthybluene.com**. For information or to make referrals, call **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** Please visit **https://provider.healthybluene.com** to provide notification or request prior authorization for behavioral health services.
Chemotherapy	Preauthorization is required for inpatient chemotherapy as part of the elective inpatient admission and for oncology drugs and adjunctive agents. However, preauthorization is not required for procedures performed in the following outpatient settings: • Office • Outpatient hospital • Ambulatory surgery center Review additional information about chemotherapy drug coverage in the **Pharmacy Services section** of this manual.
Circumcision	Routine circumcisions are covered within the first 30 days of life, and medically necessary circumcisions are covered with no age limit.
Dermatology	No preauthorization is required for a network provider for: • Evaluation and Management (E&M). • Testing. • Procedures. Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic Testing	No preauthorization is required for a network provider for routine diagnostic testing.
	
	Preauthorization is required for the following:
	• MRA
	• MRI
	• CAT scan
	• Nuclear cardiac
	• Video EEG
	• PET imaging
	
	Carelon Medical Benefits Management manages preauthorization 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 Clinical Appropriateness Guidelines and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **www.providerportal.com**.

Durable Medical Equipment (DME)	No preauthorization is required for a network provider for: • Nebulizers. • Standard walkers. • Orthotics for arch support. • Heels, lifts, shoe inserts and wedges. • Bedside commodes. • Canes and crutches. • Diabetic shoes. Preauthorization is required for: • All routine rentals and purchased DME equipment other than what is included above. • Breast feeding pumps. • Certain prosthetics, orthotics and DME. • Heavy-duty walkers. • Specialized wheelchairs. • Oxygen concentrators.

	• Insulin pumps and supplies. • Hospital beds. • Ventilators. • CPAP, BIPAP and APAP. • Enteral and parenteral nutrition. • Lymphedema pumps. • Hoyer lifts. • Support surfaces. • Power operated vehicles and motorized wheelchairs. • Osteogenesis stimulators. • Seat lift mechanisms. • Apnea monitors. • Wound care supplies. • Standing frames. • Incontinence products. • Hearing aids. • Chest wall oscillation devices. • Suction pumps. • Tracheostomy supplies. • IV therapy and supplies. • Humidifiers. • Cochlear implants. • Dialysis and end stage renal disease equipment. • Gradient pressure stockings. • Light therapy/bili lights for jaundice babies. • Sphygmomanometers. For code-specific preauthorization requirements, visit **https://provider.healthybluene.com.** Enter codes to determine authorization requirements. To request preauthorization, submit a physician's order supporting documentation and fill out our preauthorization form, which can be found on **https://provider.healthybluene.com.** We must agree on HCPCS and/or 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 12 continuous/consecutive months. Oxygen equipment is reimbursed on a continuous rental basis. For additional questions regarding rent to purchase items, please contact Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Visit	Self-referral; Use the EPSDT schedule and document visits. Note: Vaccine serum is received under the Vaccines for Children (VFC) program.
Educational Consultation	No preauthorization is required.
Elective Termination of Pregnancy	Preauthorization 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 preauthorization is required for a network provider. We must be **notified within 24 hours or the next business day** if an ER encounter results in an inpatient admission.
ENT Services (Otolaryngology)	No preauthorization is required for a network provider for: • E&M. • Testing. • Certain procedures. Preauthorization is required for: • Tonsillectomy and/or adenoidectomy. • Nasal/sinus surgery. • Cochlear implant surgery and services.
Family Planning/Sexually Transmitted Infection (STI) Care	Members may self-refer to any in-network or out-of-network provider. Please encourage your patients to receive family planning services -in network to ensure continuity of service.
Gastroenterology Services	No preauthorization is required for a network provider for: • E&M. • Testing. • Certain procedures. Preauthorization is required for: • Bariatric surgery. • Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. • Upper endoscopy.
Gynecology	No preauthorization is required for a network provider for: • E&M. • Testing. • Certain procedures.
Hearing Aids	Preauthorization is required for digital hearing aids.

Hearing Screening	No preauthorization is required for a network provider for: • Diagnostic and screening tests. • Hearing aid evaluations. • Counseling.
Home Healthcare and Home IV Infusion	Preauthorization is required for: • Skilled nursing. • Extended home health services. • IV infusion services. • Home health aide. • Physical, occupational and speech therapy services. • Physician-ordered supplies. • IV medications for in home therapy. Note: Drugs and DME require separate preauthorization.
Hospice	Preauthorization is required for hospice.
Hospital Admission	Preauthorization is required for: • Elective admissions. • Some same day/ambulatory surgeries. We must be notified **within 24 hours or the next business day** if an ER encounter results in an inpatient admission. 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. We do not cover: • Rest cures. • Personal comfort and convenience items. • Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.). **We request notification of inpatient emergency admissions within one business day of admission**. Failure of admission notification after one business day may result in claim denial. Non-business days include the weekend, New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving Day and Christmas Day.
Laboratory Services (Outpatient)	Preauthorization is required for: • Genetic testing. Request prior authorization by visiting www.providerportal.com or by calling **855-574-6478 Monday through Friday from 8 a.m. to 6 p.m. CT**. • *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at www.providerportal.com.

	• All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition
Medical Supplies	No preauthorization is required for a network provider for disposable medical supplies.
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.
Neurology	No preauthorization is required for a network provider for: • E&M. • Testing. • Certain other procedures. Preauthorization is required for: • Neurosurgery. • Spinal fusion. • Artificial intervertebral disc surgery.
Observation	No preauthorization is required for observation up to 48 hours; observation beyond 48 hours requires authorization. In addition, if your observation extends beyond 48 hours or results in an admission, you must notify us within 24 hours or the next business day.
Obstetrical Care	No preauthorization is required for a network provider for: • Obstetrical services and diagnostic testing. • Obstetrical visits. • Certain diagnostic tests and lab services by a participating provider. • Prenatal ultrasounds. • Normal vaginal and cesarean deliveries. Notification requirements are as follows: • Notify Provider Services of the first prenatal visit. • For obstetric care, we require notification; we do not require preauthorization. • All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries. • 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 us of the mother's discharge date. 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 cesarean delivery, the hospital is required to notify Provider Services and provide clinical. Following

	notification, clinical updates can be faxed directly to the local health plan at **800-964-3627**. • Healthy Blue is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an obstetrical admission exceeding 48 hours after a vaginal delivery and 96 hours after a cesarean section. • If a member is admitted for an induction or labor and fails to deliver by day two of the admission, the hospital is required to submit clinical for the first two days of admission for medical necessity review. Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit birth information to us. Fax newborn delivery notifications to **800-964-3627**; providers may use standard reporting forms specific to their hospital as long as the following required information is included: o Indicate whether a live birth o Newborn's birth weight o Gestational age at birth o Apgar scores o Disposition at birth o Type of delivery (vaginal or cesarean); if a cesarean, the reason the cesarean was required o Date of birth o Gender o Single/multi birth o Gravida/para/ab for mother o EDC and if NICU admission was required If a newborn requires admission to the NICU, the hospital must notify Provider Services and submit clinical and updates. **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. Provider Services phone: **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** Provider Services notification fax: **800-964-3627** Local health plan inpatient clinical fax: **844-886-2757** OB care management programs are available for all high--risk women.
Ophthalmology	No preauthorization is required for a network provider for: • E&M. • Testing.

	• Certain procedures. Preauthorization is required for repair of eyelid defects. We do not cover services that are considered cosmetic.
Oral Maxillofacial	See Plastic/Cosmetic/Reconstructive Surgery.
Out-of-Area/ Out--of--Network (OON) Care	Preauthorization is required for all OON services except for emergency care, EPSDT screening, family planning and OB care. Note: Preauthorization is not required for EPSDT screening for both in-network and out-of-area network providers.
Outpatient/Ambulatory Surgery	Our preauthorization requirement is based on the procedure performed; visit our provider website for more details.
Pain Management/ Physiatry/Physical Medicine and Rehabilitation	Preauthorization is required for non-E&M-level services. Pain management services are not a covered benefit.
Pediatric Day Healthcare (PDHC)	Preauthorization is required.
Personal Care Services (PCS)	Preauthorization is required. PCS are covered for members ages 0 to 20 and excluded for members over 21 years of age.
Pharmacy Services	The pharmacy benefit covers medically necessary prescription and over-the-counter drugs prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/*PDL*. Refer to the *PDL* for the preferred products within therapeutic categories as well as requirements around generics, prior authorization, step therapy, quantity edits and the prior authorization process. Quantity and day supply limits apply. Preauthorization is required for certain chemotherapy drugs. Preauthorization is required for all nonformulary drugs.
Plastic/Cosmetic/ Reconstructive Surgery (Including Oral Maxillofacial Services)	No preauthorization is required for a network provider for: • E&M services. • Oral maxillofacial E&M services. Preauthorization is required for: • All other services. • Trauma to the teeth. • Oral maxillofacial medical and surgical conditions. • TMJ. We do not cover: • Services considered cosmetic in nature. • Services related to previous cosmetic procedures. Reduction mammoplasty requires review by our medical director.

Podiatry	No preauthorization is required for a network provider for: • E&M. • Testing. • Most procedures.
Radiology	See Diagnostic Testing.
Rehabilitation Therapy (Short-Term):	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 **1-800-964-3627** within one business the initial evaluation • Visits exceeding 12 visits will need to be prior authorized by UM by fax **1-800-964-3627.** • medical records and subsequent medical justification directly to the local health plan by fax at **1-800-964-3627.**
Musculoskeletal Programs	Carelon Medical Benefits Management manages preauthorization for the following modalities: • Joint Surgery • Spine Surgery • Interventional Pain Management Request prior authorization by visiting **www.providerportal.com** or by calling **855-574-6478 Monday through Friday 7 a.m. to 7 p.m.** *Carelon Clinical Appropriateness Guidelines* and *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at **www.providerportal.com**.
Skilled Nursing Facility	Preauthorization is required.
Sterilization	No preauthorization is required for a network provider for: • Sterilization. • Tubal ligation. • Vasectomy. We require a sterilization consent form for claims submissions. We do **not** cover reversal of sterilization.
Non-emergent Transportation	No preauthorization is required. For nonemergency transportation, members can call ModivCare at **844-531-3783 Monday through Friday 8 a.m. to 7 p.m. CT** to set up a ride or visit the ModivCare website: https://www.mymodivcare.com/. Providers and Facilities assisting with scheduling transportation can call 866-333-4918 Monday through Friday 8 a.m. to 7 p.m. CT or visit the website: **tripcare.modivcare.com**
Urgent Care Center	No preauthorization is required for a participating facility.
Well-Woman Exam	No preauthorization is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network GYN. The visit includes: • Examination

	• Routine lab work • STI screening • Mammograms for members 35 and older • Pap smears (Routine Pap smears are allowed once every three years per ACOG guidelines.) Members can receive family planning services without preauthorization at any qualified provider. Please encourage your patients to receive family planning services from an in-network provider to ensure continuity of service.
Revenue (RV) Codes	Preauthorization is required for services billed by facilities with RV codes for: • Inpatient • OB • Home healthcare • Hospice • CT, PET and nuclear cardiology • Chemotherapeutic agents • Pain management • Rehabilitation (physical/occupational/respiratory therapy) • Rehabilitation short-term (speech therapy) • Specialty pharmacy agents For a complete list of specific RV codes and code specific preauthorization requirements, visit **https://provider.healthybluene.com.**

We have clinical staff available 24/7 to accept preauthorization requests. When a medical request is received, we:

- Verify our members' eligibility and benefits.
- Determine the appropriateness of the request.
- Issue you a reference number.

For nonurgent preauthorization requests, we provide our decision no later than 14 calendar days following receipt of the request. For urgent or stat requests, we provide our decision within 72 hours. If documentation is not complete, we will ask you for the additional necessary documentation. UM decision making is based only on appropriateness of care and service and existence of coverage.

5.7 Hospital Admission Reviews

Observation

We allow up to 48 hours of outpatient observation without notification or preauthorization. If your observation care results in an inpatient admission, you must notify us within 24 hours or the next business day. Observation services beyond 48 hours require authorization. Some members may require a second day of outpatient observation services. A maximum of 48 hours of observation may be reimbursed.

Inpatient Admission Review
Notification of admission to the health plan is your essential first step in the authorization process. We review all inpatient hospital admissions and urgent/emergent admissions. We determine the member's medical status through:

- Telephonic, electronic or onsite review.
- Communication with the hospital's Utilization Review department.

We document the appropriateness of stay and refer specific diagnoses to our Care Management staff for care coordination or care management based on our integrated rounds.

Inpatient Concurrent Review
To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record.

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

The clinical submission deadline for Healthy Blue is 3 p.m. Central time, and we have a 10-minute grace period to alleviate time discrepancies on fax machines. Submissions of clinical information after 3:10 p.m. Central time may result in a denial of authorization.

We will communicate approved days and bed-level coverage to the hospital for any continued stay.

Preauthorization/Admission Notification: Preauthorization request and notification of intent to render covered inpatient and outpatient medical services	Fax: **800-964-3627** Call: **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT** Web: Log in at **Availity.com**
Inpatient Utilization Management: Emergent inpatient admissions require clinical information be submitted for medical necessity review	Fax: **844-886-2757** Call: **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT** **Availity.com**
Behavioral Health Inpatient Utilization Management: Psychiatric and substance use inpatient admissions require clinical information be submitted for medical necessity review	Call: **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT** **Availity.com**

5.8 Discharge Planning

Our Utilization Management clinicians coordinate our members' discharge planning needs with:

- The hospital's Utilization Review and/or Care Management staff
- The attending physician

We review discharge plans daily. As part of discharge planning, clinicians will try to meet with the member and family when necessary to:

- Discuss any discharge planning needs

- Verify the member's PCP, address and phone number.

The attending physician is responsible for coordinating follow-up care with the member's PCP.

For ongoing care, we work with the provider to plan the discharge to an appropriate setting, such as a:

- Hospice facility
- Physical rehabilitation facility
- Home healthcare program (for example, home IV antibiotics)
- Long-term acute care
- Skilled nursing facility

Pre-authorizations for post-admissions include but are not limited to:

- Home health
- DME
- Pharmacy
- Outpatient medical injectables
- Follow-up visits to certain practitioners
- Outpatient procedures
- Outpatient rehabilitation

5.9 Confidentiality of Information and Misrouted Protected Health Information

The following ensure members' protected health information (PHI) is kept confidential:

- Utilization management
- Care management
- DM
- Discharge planning
- Quality management
- Claims payment
- Pharmacy

PHI is shared only with those individuals who need access to it to conduct utilization management.

Providers and facilities are required to review all member information received from the state to ensure no misrouted PHI is included. Misrouted PHI includes information about members who a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, they should call our Provider Services team at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT** for instructions on what to do with it.

5.10 Emergency Services

Emergency services, including those for specialized behavioral health, don't require preauthorization. Healthy Blue covers and pays for emergency services, regardless of whether the provider that furnishes the emergency services is contracted with us. Healthy Blue will not deny payment for treatment obtained when a member had

an emergency medical condition, as defined in *42 CFR §438.114(a)*, nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms. We do not deny or discourage our members from using 911 or accessing emergency services. As a matter of course, we grant authorizations for these services immediately.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

The attending emergency physician or the provider treating the member will determine when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Healthy Blue for coverage and payment. If there is a disagreement between a hospital or other treating facility and Healthy Blue concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on Healthy Blue. This does not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized. If the emergency department cannot stabilize and release our member, we will help coordinate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

5.11 Urgent Care and After-Hours Care

We strongly encourage our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer them to one of our participating urgent care centers or another provider who offers after-hours care. Preauthorization is not required.

We strongly encourage PCPs to provide evening and weekend appointment access to members. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturday. To learn more about participating in the after-hours care program, call your local Provider Relations representative.

6 QUALITY MANAGEMENT

6.1 Quality Management Program

We have a comprehensive Quality Management (QM) program to monitor the demographic and epidemiologic needs of the population served. We evaluate the needs of the health plan's specific population annually, including:

- Age/sex distribution.
- Inpatient, emergent/urgent care.
- Office visits by type, cost and volume.

In this way, we can define high-volume, high-risk and problem-prone conditions.
To contact the QM department about quality concerns or to make recommendations for areas of improvement, call **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**

6.2 Quality of Care

We evaluate all physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards.
- External regulatory and accrediting agencies' requirements.
- Contractual compliance.

We share these reviews to enable you to increase individual and collaborative rates for members. Our quality program includes a review of quality-of-care issues for all care settings using:

- Member complaints.
- Reported adverse events.
- Other information.

The results are submitted to our QM department and incorporated into a profile.

6.3 Quality Management Committee

The quality management committee (QMC) responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structures that ensure National Committee for Quality Assurance (NCQA) and state compliance.
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Coordinate communication of QM activities.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual QM program description.
- Review and approve the annual work plan for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Analyze member and provider satisfaction survey responses.
- Monitor the health plan's operational indicators through the plan's senior staff.

6.4 Use of Performance Data

Practitioners and providers must allow Healthy Blue to use performance data in cooperation with our quality improvement program and activities.

6.5 Medical Review Criteria

Our medical policies, which are publicly accessible from our website, are the primary plan policies for determining whether services are considered to be:

- Iinvestigational/experimental.
- Medically necessary.
- Cosmetic or reconstructive.

MCG Care Guidelines criteria will be used when no specific Healthy Blue medical policies exist. In the absence of licensed MCG Care Guidelines criteria, we may use our *Clinical Utilization Management (UM) Guidelines*. A list of the specific *Clinical UM Guidelines* used will be posted and maintained on our website and can be obtained in hard copy by written request. The policies described above will support preauthorization requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both MCG Care Guidelines and our medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

6.6 Clinical Criteria

Healthy Blue utilization reviewers currently use MCG Care Guidelines criteria for inpatient concurrent clinical decision support for medical management coverage decisions and for discharge planning. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based on clinical appropriateness. Criteria include:

- Acute care.
- Long-term acute care.
- Rehabilitation.
- Subacute and skilled nursing facility.

You can obtain copies of the criteria used in a case to make a clinical determination by calling Provider Services or your local Healthy Blue office. You may also submit your request in writing to:
10040 Regency Circle, Suite 100, Omaha, NE 68114

Carelon Medical Benefits Management manages preauthorization 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
- Sleep Studies
- Cardiology services
- Genetic Testing
- Musculoskeletal Programs
- Spinal therapy

Carelon Clinical Appropriateness Guidelines and *Medical Policies* will be used. will be used. Carelon Medical Benefits Management guidelines are available online at **www.providerportal.com**.

The program includes outpatient hospitals and office settings only. Included settings are hospital – outpatient only, freestanding imaging centers and physician offices. Excluded settings are inpatient hospital, emergency room, 23-hour observation and ambulatory surgery centers.

You can contact Carelon Medical Benefits Management at **855-574-6478 Monday through Friday 7 a.m. to 7 p.m. (Central time)** or visit **www.providerportal.com** to submit a request.

6.7 Informal Reconsideration/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. Central time

Additional guidelines regarding peer-to-peer (P2P) discussions are below:

- A provider, acting on behalf of the member, must submit the member's written consent to be eligible for P2P participation within 5 business days of the adverse benefit determination.
- Requests for P2Ps will be handled within one working day of the receipt of the request.
- If the P2P discussion is not completed within 5 business days, 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 the provider at the provider's specified contact number. If the provider fails to respond, the request for a P2P will be closed, and the provider's next course of action will be to follow the formal appeal process.

6.8 Clinical Advisory Committee

We have established a clinical advisory committee (CAC) to:

- Facilitate regular consultation with experts who are familiar with standards and practices of treatment to include network providers who care for children, adolescents and adults.
- Review and provide input into all policies, procedures, and practices associated with CM, DM, and UM functions to include clinical and practice guidelines and UM criteria
- Review and approve initial practice guidelines and any significant changes in guidelines prior to adoption by the Health Plan

6.9 Utilization Management Staff

Healthy Blue, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Healthy Blue does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

UM staff are available as follows:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

6.10 Medical Advisory Committee

We have a Medical Advisory Committee (MAC) to provide relevant UM information to the QM program for quality improvement activities. This includes identifying quality of care concerns, disproportionate utilization trends, duplicative services, adverse access patterns, and lack of continuity and coordination of care processes.

The MAC achieves its goals and objectives by working collaboratively with participating network practitioners.

The MAC is responsible for providing oversight of UM activities at the plan, provider and membership levels. The MAC convenes no less than quarterly but will meet on an -ad Hoc basis as needed. Meeting minutes will be taken at each MAC meeting.

The committee responsibilities include but are not limited to the following:

- Conduct oversight of clinical service delivery trends
- Review utilization data to facilitate appropriate and efficient allocation of the Plan’s resources and services
- Approval of changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines

- Conduct a peer review process that provides a systematic approach for monitoring of quality and appropriateness of care
- Provide guidance and feedback regarding technology assessment
- Review grievance and appeals related to UM activities to determine if any needed policy changes
- Provide oversight of Population Health Management Strategy
- Review of identified UM operations system gaps
- Review results from internal UM audits

6.11 Provider Advisory Group

Healthy Blue established a provider advisory group (PAG) to obtain feedback from major provider organizations in the State, as well as individual providers, including behavioral health and pharmacy providers as well as providers who serve individuals with disabilities.

The PAG responsibilities include but are not limited to the following:

- Provide input on planning and delivery of services
- Review and provide input on provider training and provider concerns
- Enhance provider communication strategies
- Review and provide input on provider education material

6.11 Credentialing

Healthy Blue's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Healthy Blue's discretion in any way to amend, change or suspend any aspect of Healthy Blue's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Healthy Blue further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Healthy Blue
   - An independent relationship exists when Healthy Blue directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Healthy Blue's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of Healthy Blue's primary Network and include Healthy Blue Members who reside in the rental network area.

- That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and

4. Telemedicine.

Healthy Blue credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
  Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Healthy Blue credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes

  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Abuse
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Abuse Clinics
  - Partial Hospitalization – Mental Health and/or Substance Abuse
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
  End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Healthy Blue's networks or plan programs is conducted by a peer review body, known as Healthy Blue's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Healthy Blue affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Healthy Blue medical director designee and the vice-chair must be a lead medical officer or an Healthy Blue medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine);

surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Healthy Blue's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Healthy Blue may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Healthy Blue will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Healthy Blue will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Healthy Blue will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Healthy Blue will take appropriate action to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Healthy Blue when applying for initial participation in one or more of Healthy Blue's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Healthy Blue will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180 calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Healthy Blue will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history

Verification Element
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Healthy Blue credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Healthy Blue for review. If the candidate meets Healthy Blue screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Healthy Blue Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Healthy Blue has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Healthy Blue departments
- Any other information received from sources deemed reliable by Healthy Blue.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Healthy Blue has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Healthy Blue's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Healthy Blue may wish to terminate practitioners or HDOs. Healthy Blue also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Healthy Blue's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Healthy Blue will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Healthy Blue's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Healthy Blue's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Healthy Blue's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction,

debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Healthy Blue takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Healthy Blue may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Healthy Blue Credentialing Program Standards

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
D. Meet the education, training and certification criteria as required by Healthy Blue.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
   ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
   iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Healthy Blue's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Healthy Blue education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Healthy Blue review and approval. Reports submitted by delegates to Healthy Blue must contain sufficient documentation to support the above alternatives, as determined by Healthy Blue.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

F. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.

4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant arranged for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA/CDS registration.
    d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day timeframe will result in termination from the Network.

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Healthy Blue's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

    a. It can be verified that the applicant's application is pending; and
    b. The applicant has arranged for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA registration; and
    d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources; and
    e. The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.

    Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:
    a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and

b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current alcohol use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six (months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Healthy Blue's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work.
   b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, master's in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   d. Licensure to practice independently or in states without licensure or certification:
      i. Marriage & Family Therapists with a master's degree or higher: Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

3. Pastoral Counselors:
   a. Master's or doctoral degree in a mental health discipline.
   b. Licensed as another recognized behavioral health provider type (e.g. MD/DO, PsyD, SW,RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur, OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
   c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the

appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
   c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Healthy Blue Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.

Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non-Physician) Credentialing.

1. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
   e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
      i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
      ii. American Academy of Nurse Practitioners – Certification Program;
      iii. National Certification Corporation;
      iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
      v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
      vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

   If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
   f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
   g. The NP applicant will undergo the standard credentialing processes outlined in Healthy Blue's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for

failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. NPs will be clearly identified:
   i. On the credentialing file;
   ii. At presentation to the CC; and
   iii. Upon notification to network services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
   a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
   b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Healthy Blue procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All CNM applicants will be certified by either:
      i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
      ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides

only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

i. The CNM applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

j. Upon completion of the credentialing process, the CNM may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

k. CNMs will be clearly identified:
   i. On the credentialing file;
   ii. At presentation to the CC; and
   iii. Upon notification to network services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Healthy Blue Health Plan and submitted for individual review by the CC.
   f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
   g. The PA applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing

Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the PA may be listed in Healthy Blue provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Healthy Blue's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcohol use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;

14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Healthy Blue standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Healthy Blue may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Healthy Blue standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Healthy Blue standards.

A. General Criteria for HDOs:
    1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
    2. Valid and current Medicare certification.
    3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Healthy Blue's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for

participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.

4. Liability insurance acceptable to Healthy Blue.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Healthy Blue's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND HEALTHY BLUE APPROVED ACCREDITING AGENT(S)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC

Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA,

Delegated Credentialing
Provider groups with strong credentialing programs that meet our credentialing standards may be evaluated for delegation. As part of this process, we will conduct a predelegation assessment of a group's credentialing policy and program as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90% compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA -certified for all credentialing and recredentialing elements.

We are responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

6.12 Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:
- Participate in the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director. The medical director:
- Assigns a level of severity to the grievance.
- Invites the cooperation of the physician.

- Consults with and informs the MAC and peer review committee.
- Informs the physician of the ccommittee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken.

Note: The MAC is a recommending body to the regional Credentials Committee if the step involves a review of a provider's participation.

We report outcomes to the appropriate internal and external entities, including the quality management committee.

The peer review process is a major component of the MAC's monthly agenda. The peer review policy is available upon request.

7 PROVIDER DISPUTE PROCEDURES

7.1 Provider as Member Representative

A provider may act as the member's representative to file an appeal or grievance. To act as a member's representative, the provider must have the written consent signed by the member and follow the time frames and processes for member grievances and appeals (see the **Member Grievances Section**).

7.2 Provider Grievances

Providers can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.
Grievances can be submitted via:

- Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**
- Your local Provider Relations representative.

Submit written grievances to:
P.O. Box 61010
Virginia Beach, VA 23466-1010

- Fax at **866-387-2968**

If the outcome of our review is adverse to you, we will provide a written notice of adverse action. You can also appear in person at the address above to submit a complaint.

7.3 Avoiding an Administrative Adverse Decision

Most administrative adverse decisions result from nonadherence to, or a misunderstanding of, utilization management policies. Familiarizing yourself and your staff with notification and preauthorization policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits. Such information is readily available by calling **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidence-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers.
Peer-to-peer conversations (between a medical director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-to peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process.

7.4 Provider Claim Payment Disputes

If you disagree with the outcome of a claim, you may begin the Healthy Blue provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.
In cases where your claim is denied, the consent of a Member who received the services is not required in order for you to dispute the denial of the claim. You may pursue a claim dispute on the basis of non-payment for rendered services under the terms and conditions outlined in your contract with Healthy Blue. The Member who received the services is not required to sign an authorized representative form, or provide other forms of written consent, for you to dispute the denied claim for payment.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Please be aware, there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim, but not a request to change a claim payment (see the **Claim Inquiry section** for more information).
- **Claims correspondence:** When Healthy Blue requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials is in the **Claim Correspondence** section of this provider manual.
- **Medical necessity appeal:** A preservice appeal for a denied service. For these, a claim has not yet been submitted (see the **Medical Necessity Appeals** section for more information).

The Healthy Blue provider payment dispute process consists of two internal steps. Additionally, there are two external options. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Healthy Blue provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

2. **Claim payment appeal:** This is the second step in the Healthy Blue provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Binding arbitration:** The state of Nebraska supports an external arbitrator review process if you have exhausted all steps in the Healthy Blue payment dispute process but still disagree with the outcome.

7.5 Claim Payment Reconsideration

The first step in the Healthy Blue claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider website within 90 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 90 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Healthy Blue intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Healthy Blue claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately.

7.6 Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 30 calendar days from the date on the reconsideration determination letter.

Claim payment appeals received beyond 30 calendar days will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claims payment appeal request.
2. Date of initial filings of concern.
3. A statement of what action Healthy Blue intends to take or has taken.
4. The reason for the action.
5. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

7.7 How to Submit a Claim Payment Dispute

You can submit your verbal or written payment disputes within 90 calendar days of the date of the *EOP*. Complete the *Claim Payment Reconsideration or Claim Payment Appeal Submissions Form* located on our website and note the following submission methods:

- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**
- **Online (reconsideration and claim payment appeal)**: Healthy Blue can receive reconsiderations and claim payment appeals via the secure Availity Portal at **https://www.availity.com**. Select Claims & Payments > Appeals. You can upload supporting documentation, and you will receive immediate acknowledgement of your submission.
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the appropriate form, to:

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

Submission forms are available on the Healthy Blue provider website in the *Forms* section.

7.8 Required Documentation for Claims Payment Disputes

Healthy Blue requires the following information when submitting a claim payment dispute, reconsideration or claim payment appeal:

- Your name, address, phone number, email, and either your NPI or TIN
- The member’s name and their Healthy Blue or Medicaid ID number
- A listing of disputed claims, which should include the Healthy Blue claim number and the date(s) of service(s)
- All supporting statements and documentation, including a copy of the *EOP* and a copy of the claim

7.9 Binding Arbitration

After all internal dispute levels have been exhausted, either party may request binding arbitration, except to the extent the parties have agreed in the *Provider Agreement* to use an alternate means of binding dispute resolution. The parties will select an arbitrator who has experience and expertise in the healthcare field, in accordance with the rules of the American Arbitration Association. The arbitrator will conduct a hearing and issue a final ruling. Any arbitration fees and expenses will be paid equally by Healthy Blue and the other party or parties within 30 calendar days of receipt of the bill or in a time frame otherwise required under the arbitration rules. Each party will be responsible for its own attorney's fees arising out of or related to the arbitration.

8 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

8.1 Claims Submission

You have the option of submitting claims electronically or by mail. We encourage you to submit claims electronically, as you will be able to:

- Submit claims either through a clearinghouse or directly to Healthy Blue.
- Receive payments quickly.
- Eliminate paper.
- Save money.

Electronic Data Interchange (EDI)

Electronic Claim Submission

Healthy Blue uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Register with Availity

- Choose administrator to register your organization
- When the admin is ready to register, choose the ***register button*** on the top of the page
- Select your organization type and complete the registration process
- Admin should check email to verify account
- Once account is verified, admin will agree to the disclaimer, set up your security questions, and change password and setup authorized users.

Advantages of Electronic Data Interchange (EDI)

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity EDI Gateway

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

Availity EDI Payer IDs
https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Contact Availity
Contact Availity Client Services with any questions at **800-AVAILITY** (**282-4548**).

Useful EDI documentation
Availity *EDI Connection Service Startup Guide*
This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide
This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page
Availity register page for users new to Availity.

Washington Publishing Company
X12 code descriptions used on EDI transactions.

Paper Claims Submission
You must submit a properly completed *CMS-1450* or *CMS-1500 (02-12)* claim form:

- Within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; EPSDT screening claims should be filed as soon as possible within the timely filing period.
- On the original claim form with “drop out” red ink.
- Computer-printed or typed.
- In a large, dark font.

Submit paper claims to:
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466-1010

There are exceptions to the timely filing requirements. They include the following:

- For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date of the primary carrier's *Explanation of Benefits* or within 365 days from the service date even if the Third-Party Resources are outstanding.

Claim forms must include the following information (*HIPAA*-compliant where applicable):

- Member's ID number
- Member's name
- Member's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- Coordination of benefits/other insurance information
- Preauthorization number or copy of preauthorization
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data

We cannot accept claims with alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.

CMS-1500 and *CMS-1450* forms are available from the Centers for Medicare and Medicaid Services at **www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html.**

8.2 International Classification of Diseases, 10th Revision (ICD-10)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

What is ICD-10?
International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) is used for diagnosis coding.
- ICD-10-PCS (Procedure Coding System) is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

8.3 Encounter Data

If you are reimbursed by capitation, you must send us encounter data for each member encounter.

You must submit encounter data no later than 365 calendar days from the date of service through:
- EDI submission methods.
- A *CMS-1500* (*12*) claim form.
- Other arrangements that are approved by Healthy Blue.

EPSDT screening claims should be filed as soon as possible within the timely filing period.

Include the following:
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Healthy Blue provider ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports to the quality management committee on a quarterly basis. Lack of compliance will result in:
- Training.
- Follow-up audits.
- Corrective action up to and including termination.

8.4 Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
Use EnrollSafe **(https://enrollsafe.payeehub.org/)** to register and manage EFT account changes.

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to **Availity** https://apps.availity.com/availity/web/public.elegant.login
- Select My Providers
- Click on Enrollment Center and select Transaction Enrollment

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Contact Availity
Contact Availity Client Services with any questions at **800-AVAILITY** (**282-4548**).

8.5 Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

Exceptions:

- Claims submitted involving coordination of benefits or subrogation when pursuing payment from a third-party benefit, should not be denied for untimely filing, which is based on the third party's resolution date.
- If an error is made by MLTC or its subcontractors, the Plan must not deny claims for failure to meet timely filing.
- If a provider files erroneously with another MCO but produced documentation verifying that the initial filing of the claim occurred timely, the Plan must not deny claims for failure to meet timely filing.

You must use *HIPAA*-compliant billing codes when billing Healthy Blue electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of incidental to or inclusive of the primary procedure.

Whether you submit claims through EDI or on paper, use our claims guide charts in **Appendix A** to ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:

- Submit claims within 180 calendar days:
    - From the date of service (including in cases of other insurance)
    - From the date of discharge for inpatient claims filed by a hospital
- Submit claims for EPSDT services as soon as possible within the timely filing period

8.6 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time.
- Is accurate.

- Is submitted on a *HIPAA*-compliant standard claim form (*CMS-1500* or *CMS-1450* or successor forms).
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse.
- Is not a claim under review for medical necessity.

We will adjudicate clean claims to a paid or denied status within 15 business days of receipt. If we do not pay the claim within 60 calendar days, we will pay all applicable interest as required by law.

We produce and mail an *Explanation of Payment* (*EOP*). It shows the status of each claim that has been adjudicated during the previous claim cycle.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

8.7 Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.
If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

8.8 Claim Correspondence

Claim correspondence is different from a claim payment dispute. Correspondence is when Healthy Blue requires more information to finalize a claim. Typically, Healthy Blue makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Healthy Blue will use it to finalize the claim.

The following table provides examples of the most common correspondence issues, along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Contact Availity at **800-282-4548 between 7 am to 7 pm CT.**
***EOP* Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)**	• Submit a *Claim Correspondence* form, a copy of your *EOP* and the supporting documentation: • 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.**

Type of Issue	What Do I Need to Do?
	• In writing – Mail all required documents to: Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599
***EOP* Requests for Medical Records**	• Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records: • 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
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit a *Claim Correspondence* form and your corrected claim: • 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 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 180 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Healthy Blue to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a *Claim Correspondence* form, a copy of your *EOP* and the COB/TPL information: • 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
Emergency Room Payment Review	Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records:

Type of Issue	What Do I Need to Do?
	• 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

8.9 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by the member's Healthy Blue benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines including using industry standard compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider, state, federal or CMS contracts and/or requirements. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however Healthy Blue strives to minimize these variations.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Healthy Blue business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through Healthy Blue. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Healthy Blue allows reimbursement for covered services based on their procedure code definitions or descriptor, unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

8.10 Outlier Reimbursement - Audit And Review Process

Added Requirements and Policies
This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products
Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel

employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges
The reimbursement of charges for specimen are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:
The use of the operating room
The services of qualified professional and technical personnel

Personal Care Items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.
Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation
Operating Room ("OR") –Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.

Hospital/ Technical Anesthesia - Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's

notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.

Recovery Room – The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.

Post Recovery Room – Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.
The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	• Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) • Thawing/Pooling Fees
0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment • Oxygen • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heal/Elbow Protector • Burrs

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by RN • Intubation/Extubation • CPR
410	Respiratory Functions: • Oximetry reading by nurse or respiratory • Respiratory assessment/vent management • Medication Administration via Nebs, Metered dose (MDI), etc. • Charges Postural Drainage • Suctioning Procedure • Respiratory care performed by RN
0940 – 0945	Education/Training

8.11 Coordination of Benefits and Third-Party Liability

Healthy Blue follows state-specific guidelines when coordination of benefits procedures is necessary. Healthy Blue uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

When third-party resources and third-party liability (TPL) resources are available to cover the costs of trauma -related claims and medical services provided to Medicaid members, we will reject the claim and redirect the provider to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if we do not become aware of the resource until after payment for the service was rendered, we will pursue post payment recovery of the expenditure. The provider must **not** seek recovery in excess of the Medicaid -payable amount.

Healthy Blue may pay-and-chase the full amount allowed under the payment schedule for the claim and then seek reimbursement from the TPL insurer within 60 days after the end of the month in which the payment was made, for any liable TPL of legal liability if:

- The claim is for prenatal care for pregnant women.
- The claim is for preventive pediatric services (including EPSDT and well-baby screenings).
- The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

Healthy Blue will cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed, except for the pay-and-chase circumstances as outlined above.

Claims for labor and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees.

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

Coordination of Benefits Claim Examples

Scenario 1: Professional Claim

Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (copay, coinsurance and/or deductible). The Medicaid allowed amount minus the TPL paid amount is **less** than the patient responsibility; thus, the Medicaid allowed amount is the payment. Healthy Blue is responsible up to the Medicaid allowable amount.

Scenario 2: Outpatient Claim

Medicaid “zero pays” the claim; when cost-compared, the private insurance paid more than the Medicaid -allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment **and** the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.

Scenario 3: Inpatient Claim

The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.

Billing for Specialized Behavioral Health Services for Dual -Eligibles
For dual-eligible members (Medicare and Medicaid), Healthy Blue will be the secondary payer on hospital and professional claims for specialized mental health and substance use services.

If you have any questions regarding paid, denied or pended claims, please call Provider Services at **833-388-1406 Monday through Friday 7 a.m. to 8 p.m. CT**

8.12 Billing Members

Before rendering a service that is not covered by Healthy Blue, inform our member that we do not cover the cost of the service; he or she will have to pay for the service. If you choose to provide services that we do not cover:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the Client Acknowledgment Statement, specifying the member will be held responsible for payment of services (see the **Client Acknowledgement Statement** section).
- Understand you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

You cannot balance bill for the amount above that which we pay for covered services.

In addition, you may **not** bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Healthy Blue
- Failure to submit a claim to Healthy Blue for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by the provider in claims preparation, claims submission or the appeal/dispute process

8.13 Client Acknowledgment Statement

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true**:

- The member requests the specific service or item.
- You notify the member of the financial liability in advance of the service.

- You obtain and keep a written acknowledgment statement signed by you and by the member **prior to the service being rendered**, stating the following:

> "I understand my doctor, [insert provider's name], or Healthy Blue has said the services or items I have asked for on [insert dates of services] are not covered under my Healthy Blue plan. Healthy Blue will not pay for these services. Healthy Blue has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Healthy Blue decides they are not medically necessary or are not a covered benefit. I understand I am liable for payment if I sign an agreement with my provider prior to the services being rendered."
>
> Signature: _____
>
> Date: _____

8.14 Overpayment Process

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.

Once an overpayment has been identified by Healthy Blue, Healthy Blue will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **https://provider.healthybluene.com**. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, call Provider Services at **833-388-1406 Monday to Friday 7 a.m. to 8 p.m. CT**

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. If the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *Healthcare Reform Act*. The provision directly links the retention of overpayments to false claim liability. The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act*, including treble damages. To avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the *PPACA*.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at *42 U.S.C.A. § 1320a-7k*, clarifies the uncertainty left by the 2009 *Fraud Enforcement and Recovery Act*. This provision of the *Healthcare Reform Act* applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Balance Billing

Providers shall accept payment from Healthy Blue for covered services provided to Healthy Blue members in accordance with the reimbursement terms outlined in the provider agreement. Payment made to providers constitutes payment in full by Healthy Blue for covered benefits, with the exception of member expenses. For covered services, providers shall not balance bill members any amount in excess of the contracted amount in the provider agreement. An adjustment in payment as a result of claims policies and/or procedures does not indicate that the service provided is a noncovered service, and members are to be held harmless for covered services. For more information on balance billing, refer to the Nebraska contract. Additionally, providers shall not charge Healthy Blue members for missed appointments.

APPENDIX A: CLAIMS GUIDE CHARTS

CMS-1500

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Type	N	Check appropriate box	X
1a	Insured ID	Y	Healthy Blue Member ID	123456789
2	Patient Name	Y	Last name, First name, Middle initial	Doe, John, E
3	Patient Date of Birth	Y	MM/DD/YY	07 04 99
3	Patient Sex	Y	Check M box for Male, F box for Female	X
4	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E
5	Patient's Address	Y	Number and Street	123 Somewhere St
5	Patient's City	Y	City	Anytown
5	Patient's State	Y	State abbreviation	VA
5	Patient's ZIP Code	Y	US Postal ZIP code	12345-0001
5	Patient Phone	N	Area code plus phone number (10 digits)	757-123-4567
6	Patient Relationship to Insured	N	Check appropriate box	X
7	Insured Street	S	Number and Street	123 Somewhere St
7	Insured City	S	City	Anytown
7	Insured State	S	State abbreviation	VA
7	Insured ZIP Code	S	US Postal ZIP code	12345-0001
7	Insured Phone	N	Area code plus phone number (10 digits)	757-123-4567
8	Patient Status	S	Check appropriate box	X
9	Other Insured Name	S	Last name, First name, Middle initial	Doe, Mary, D
9a	Other Insured Policy or Group Number	S	Other Insured Member ID	555666777888
9b	Other Insured Date of Birth	S	MM/DD/YY	03 15 87
9b	Other Insured Sex	S	Check M box for Male, F box for Female	X
9c	Other Employer/School	S	Name of employer or school	Some Bank Name Inc.
9d	Other Insurance Name	S	Name of other insurance	For All Commercial Insurance
10a	Work Related Condition	S	Check appropriate box	X
10b	Auto Related Condition	S	Check appropriate box	X
10b	Accident Place State	S	State abbreviation	VA

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
10c	Other	S	Check appropriate box	X
10d	Local Use	N		N/A
11	Insured Policy Group or FECA Number	S	Insured Group Number	FAC111222B
11a	Insured Date of Birth	S	MM/DD/YY	07 04 99
11a	Insured Sex	S	Check M box for Male, F box for Female	X
11b	Insured Employer/School	S	Enter employer or school name	NONE
11c	Insured Plan Name	S	Insurance plan name	Medicaid
11d	Other Benefit Indicator	S	Check appropriate box	X
12	Patient/Authorized Signature	N		N/A
12	Patient/Authorized Date	N		N/A
13	Insured/Authorized Signature	N		N/A
14	Illness/Injury Date	S	MM/DD/YY	02 09 08
15	Similar Illness Date	S	MM/DD/YY	12 16 07
16	Disability Date — From	S	MM/DD/YY	02 05 08
16	Disability Date — To	S	MM/DD/YY	02 11 08
17	Referring Physician Name	S	Name of physician who referred patient for services	Jane A Smith
17a	Referring Physician ID Qualifier	S	Use corresponding qualifier for ID number submitted in 17a — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
17a	Referring Physician ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207QA0000X
17b	NPI	S	Valid 10-digit NPI number	9876543210
18	Hospitalization Date — From	S	MM/DD/YY	02 08 08
18	Hospitalization Date — To	S	MM/DD/YY	02 09 08
19	Local Use	N		N/A
20	Outside Lab	S	Check appropriate box	X

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
20	Lab Charges	S	Dollar amount from outside lab	60 00
21 1.	Diagnosis Code	Y	Valid primary diagnosis code	821.3
21 2.	Diagnosis Code	S	Valid secondary diagnosis code	N/A
21 3.	Diagnosis Code	S	Valid tertiary diagnosis code	N/A
21 4.	Diagnosis Code	S	Valid fourth diagnosis code	N/A
22	Medicaid Resubmission Code	N		123
22	Medicaid Original Reference	N	Original claim number	ABC123456789
23	Prior Authorization Number	S	If authorization for services was obtained, enter the Healthy Blue authorization number. If the services reported on the claim require a CLIA certificate number, the CLIA number should be reported in place of the authorization number.	1234AUTH5678 or 12D4567890
24	Shaded Area Data	S	Free-form text and/or NDC information	N400186115102 ML 1
24a	From Date	Y	MM/DD/YY	02 10 08
24a	To Date	Y	MM/DD/YY	02 10 08
24b	Place of Service	Y	2-digit place of service code	11
24c	EMG	N	Emergency Indicator "Y" or Blank = assumed "N"	Y
24d	Procedure Code	Y	Valid CPT/HCPCS code	99212
24d	Procedure Modifier 1	S	Valid 2-digit modifier	TN
24d	Procedure Modifier 2	S	Valid 2-digit modifier	TC
24d	Procedure Modifier 3	S	Valid 2-digit modifier	50
24d	Procedure Modifier 4	S	Valid 2-digit modifier	51
24e	Diagnosis Code Pointer	Y	Indicate which diagnosis code correlates to the line	1
24f	Charges	Y	Charges for line	$150.00
24g	Days or Units	Y	Appropriate number for days or units	1

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
24h	EPSDT	Y	Y = if EPSDT service or N = if not an EPSDT service	N
24i — shaded	ID Qualifier	S	Use corresponding qualifier for ID number submitted in 24j — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
24j — shaded	Rendering Provider ID #	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207XP3100X
24j — not shaded	Rendering Provider NPI	S	Valid 10-digit NPI number	1234567890
25	Federal Tax ID	Y	Valid 9-digit Tax ID or SSN	111223333
25	Federal Tax ID (SSN/EIN)	Y	Check SSN if social was used; check EIN if Tax ID was used	X
26	Patient Account Number	S	Patient account number with provider	123ACCT456
27	Accept Assignment	S	Check appropriate box	X
28	Submitted Total Charge	Y	Total charges on claim	$250.00
29	Patient Amount Paid	S	Amount patient paid	$0.00
30	Balance Due	S	Amount still due on claim	$250.00
31	Signature of Physician/ Physician Name	Y	Rendering provider's name	Jack T Specialist
31	Performing Provider Date	N	MMDDYY	2/10/2008
32	Service Facility Location Name	S	Name of facility where services were rendered	ABC Memorial Hospital
32	Service Facility Location Street	S	Number and Street	987 Somewhere St.
32	Service Facility Location City	S	City	Anytown
32	Service Facility Location State	S	State abbreviation	VA
32	Service Facility Location ZIP Code	S	US Postal ZIP code	12345-0001
32a	NPI	S	Valid 10-digit NPI number	9871234567

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
32b	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	ZZ282NC2000X
33	Billing Provider Group Name	Y	Name of billing group or provider	JTS Orthopedic Specialists
33	Billing Provider Street	Y	Number and Street	222 Somewhere St
33	Billing Provider City	Y	City	Anytown
33	Billing Provider First State	Y	State abbreviation	VA
33	Billing Provider First ZIP Code	Y	US Postal ZIP code	12345-0001
33	Phone Number	N	Billing provider phone number	757-555-4444
33a	NPI	Y	Valid 10-digit NPI number	9874561230
33b	Other ID	Y	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	ZZ207X00000X

UB-04

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Billing Provider Name	Y	Facility Name (Please ensure the name submitted matches the name used in the Healthy Blue processing system)	ABC Memorial Hospital
1	Billing Provider Street Address	Y	Number and Street	987 Somewhere St.
1	Billing Provider Address — City	Y	City	Anytown
1	Billing Provider Address — State	Y	State abbreviation	VA
1	Billing Provider Address — ZIP Code	Y	US Postal ZIP code	12345-0001
1	Billing Provider Telephone	O	Area code plus phone number (10 digits)	757-555-4444
1	Billing Provider Fax	O	Area code plus fax number (10 digits)	757-444-5555

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Billing Country Code	N		N/A
2	Provider Info/Pay-to Name	S	Facility Name	123 Hospital System
2	Provider Info/Pay-to Street	S	Number and Street	111 Somewhere St.
2	Provider Info/Pay-to City	S	City	Anytown
2	Provider Info/Pay-to State	S	State abbreviation	NC
2	Provider Info/Pay-to ZIP Code	S	US Postal ZIP code	53211-0001
2	Provider Info/Pay-to Phone Number	O	Area code plus phone number (10 digits)	N/A
3a	Patient Control Number	S	Provider's control number for patient	123CNTL456
3b	Medical Record Number	S	Provider's medical record number for patient	123REC456
4	Type of Bill	Y	Enter appropriate three-digit code for type of bill	111
5	Federal Tax Number	Y	Valid 9-digit Tax ID or SSN	999887777
6	Statement Period From	Y	MMDDYY	021108
6	Statement Period To	Y	MMDDYY	021908
7	Local Use	N		N/A
8a	Patient ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
8b	Patient Name	Y	Last name, First name, Middle initial	Doe, John E.
9a	Patient Street	Y	Number and Street	123 Somewhere St
9b	Patient City	Y	City	Anytown
9c	Patient State	Y	State abbreviation	VA
9d	Patient ZIP Code	Y	US Postal ZIP code	12345
9e	ZIP Code+4	S		0001
10	Birth Date	Y	MMDDYY	070499
11	Sex	Y	F=Female, M=Male	M
12	Admission Date	S	MMDDYY	021108

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
13	Admission Hour	S	Enter admission hour	13
14	Admission Type	S	Enter valid admission type	01
15	Admission Source Code	S	Enter valid admission source code	07
16	Discharge Hour	S	Enter discharge hour	12
17	Status	S	Enter valid discharge status	01
18	Condition Code	S	Enter valid condition code	A9
19	Condition Code	S	Enter valid condition code	04
20	Condition Code	S	Enter valid condition code	M0
21	Condition Code	S	Enter valid condition code	N/A
22	Condition Code	S	Enter valid condition code	N/A
23	Condition Code	S	Enter valid condition code	N/A
24	Condition Code	S	Enter valid condition code	N/A
25	Condition Code	S	Enter valid condition code	N/A
26	Condition Code	S	Enter valid condition code	N/A
27	Condition Code	S	Enter valid condition code	N/A
28	Condition Code	S	Enter valid condition code	N/A
29	Accident State	S	State abbreviation	VA
30	Local Use	N		N/A
31a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 01 021108 b. 04 021108
32a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 06 021108
33a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	N/A

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
34a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	N/A
35a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	a. 72 021108 021108
36a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	N/A
37	Local Use	N		N/A
38	Payer Name and Address	S	Enter the claims submission address	Healthy Blue P.O. Box 11111-1111 Virginia Beach, VA 23462
39a	Value Code/Amount	S	Enter valid value code and amount*	73 20 00
39b	Value Code/Amount	S	Enter valid value code and amount*	D3 45 00
39c	Value Code/Amount	S	Enter valid value code and amount*	54 30
39d	Value Code/Amount	S	Enter valid value code and amount*	N/A
40a	Value Code/Amount	S	Enter valid value code and amount*	N/A
40b	Value Code/Amount	S	Enter valid value code and amount*	N/A
40c	Value Code/Amount	S	Enter valid value code and amount*	N/A
40d	Value Code/Amount	S	Enter valid value code and amount*	N/A
41a	Value Code/Amount	S	Enter valid value code and amount*	N/A
41b	Value Code/Amount	S	Enter valid value code and amount*	N/A
41c	Value Code/Amount	S	Enter valid value code and amount*	N/A
41d	Value Code/Amount	S	Enter valid value code and amount*	N/A
42	Revenue Code	Y	Enter valid revenue code	0450
43	Description	O		N/A
	*Note: All newborn claims should contain a value code of 54 — Newborn birth weight in grams, along with the birth weight of the baby.			

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
44	HCPCS/Rates	S	Enter valid HCPCS/Rate/HIPPS code	99284
45	Service Date	S	MMDDYY	021108
46	Service Units	Y	Enter number of units	1
47	Total Charges	Y	Enter total charges for line	500 00
48	Non-Covered Charges	N		N/A
49	Local Use	N		N/A
42–23	PAGE _ OF _	O	Enter page counts	1 OF 1
42–23	CREATION DATE	O	Enter date claim was created	21208
42–23	TOTALS →	O	Enter total charges for the claim	N/A
50a	Payer Name	Y	Enter the primary payer name	Healthy Blue
50b	Payer Name	S	Enter the secondary payer name	For All Commercial Ins
50c	Payer Name	S	Enter the tertiary payer name	N/A
51a	Health Plan ID	N		N/A
51b	Health Plan ID	N		N/A
51c	Health Plan ID	N		N/A
52a	Rel Info	Y	Indicate Release of Information statement on file	Y
52b	Rel Info	S		N/A
52c	Rel Info	S		N/A
53a	Assign Benefits	N		N/A
53b	Assign Benefits	N		N/A
53c	Assign Benefits	N		N/A
54a	Prior Payments	S	Enter any prior payments	300 00
54b	Prior Payments	S	Enter any prior payments	N/A
54c	Prior Payments	S	Enter any prior payments	N/A
55a	Est. Amount Due	S	Enter estimate amount due from patient	15 00

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
55b	Est. Amount Due	S		N/A
55c	Est. Amount Due	S		N/A
56	NPI	Y	Valid 10-digit NPI number	9871234567
57a	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Taxonomy	ZZ282NC2000X
57b	Other Provider ID	S	Appropriate and valid qualifier and provider id number: Medicaid	1D 345678
57c	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Healthy Blue ID	N/A
58a	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E.
58b	Insured's Name	S	Last name, First name, Middle initial	N/A
58c	Insured's Name	S	Last name, First name, Middle initial	N/A
59a	Patient Relationship	R	Enter a valid patient relationship code	19
59b	Patient Relationship	R	Enter a valid patient relationship code	18
59c	Patient Relationship	R	Enter a valid patient relationship code	N/A
60a	Insured's Unique ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
	Insured's Unique ID	S	Insured unique Identification number	23234545
60c	Insured's Unique ID	S		N/A
61a	Group Name	S	Enter group name	Medicaid
61b	Group Name	S	Enter group name	For All Commercial Ins
61c	Group Name	S	Enter group name	N/A
62a	Insurance Group Number	S	Enter group number	N/A
62b	Insurance Group Number	S	Enter group number	F32415G
62c	Insurance Group Number	S	Enter group number	N/A

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
63a	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	1234AUTH5678
63b	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	N/A
63c	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	N/A
64a	Document Control Number	N		N/A
64b	Document Control Number	N		N/A
64c	Document Control Number	N		N/A
65a	Employer Name	S	Enter employer name	Some Bank Name Inc
65b	Employer Name	S	Enter employer name	N/A
65c	Employer Name	S	Enter employer name	N/A
66	DX Indicator	N	Enter diagnosis qualifier	9
67	Principle Diagnosis Code	Y	Enter valid diagnosis code	821.3
67a	Other diagnosis code A	S	Enter valid diagnosis code	733.93
67b	Other diagnosis code B	S	Enter valid diagnosis code	531
67c	Other diagnosis code C	S	Enter valid diagnosis code	N/A
67d	Other diagnosis code D	S	Enter valid diagnosis code	N/A
67e	Other diagnosis code E	S	Enter valid diagnosis code	N/A
67f	Other diagnosis code F	S	Enter valid diagnosis code	N/A
67g	Other diagnosis code G	S	Enter valid diagnosis code	N/A
67h	Other diagnosis code H	S	Enter valid diagnosis code	N/A
67i	Other diagnosis code I	S	Enter valid diagnosis code	N/A
67j	Other diagnosis code J	S	Enter valid diagnosis code	N/A

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
67k	Other diagnosis code K	S	Enter valid diagnosis code	N/A
67l	Other diagnosis code L	S	Enter valid diagnosis code	N/A
67m	Other diagnosis code M	S	Enter valid diagnosis code	N/A
67n	Other diagnosis code N	S	Enter valid diagnosis code	N/A
67o	Other diagnosis code O	S	Enter valid diagnosis code	N/A
67p	Other diagnosis code P	S	Enter valid diagnosis code	N/A
67q	Other diagnosis code Q	S	Enter valid diagnosis code	N/A
68	Local Use	N		N/A
69	Admit Diagnosis Code	Y	Enter valid diagnosis code	733.93
70a	Patient Reason DX A	S	Enter valid diagnosis code	346.2
70b	Patient Reason DX B	S	Enter valid diagnosis code	N/A
70c	Patient Reason DX C	S	Enter valid diagnosis code	N/A
71	PPS Code	S	Enter valid DRG code	123
72a	ECI A	S	Enter valid external code of injury	E812
72b	ECI B	S	Enter valid external code of injury	N/A
72c	ECI C	S	Enter valid external code of injury	N/A
73	Local Use	N		N/A
74	Principal Procedure Code	S	Enter valid procedure code	0032
74	Principal Procedure Date	S	MMDDYY	021108
74a	Other Procedure Code	S	Enter valid procedure code	N/A
74a	Other Procedure Date	S	MMDDYY	N/A
74b	Other Procedure Code	S	Enter valid procedure code	N/A
74b	Other Procedure Date	S	MMDDYY	N/A

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
74c	Other Procedure Code	S	Enter valid procedure code	N/A
74c	Other Procedure Date	S	MMDDYY	N/A
74d	Other Procedure Code	S	Enter valid procedure code	N/A
74d	Other Procedure Date	S	MMDDYY	N/A
74e	Other Procedure Code	S	Enter valid procedure code	N/A
74e	Other Procedure Date	S	MMDDYY	N/A
75	Local Use	N		N/A
76	Attending NPI	S	Valid 10-digit NPI number	2323232323
76	Attending Qualifier	S	Use corresponding qualifier for ID number submitted in 76: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
76	Attending ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	444556666
76	Attending Last Name	S	Attending physician's last name	Doe
76	Attending First Name	S	Attending physician's first name	Robert
77	Operating NPI	S	Valid 10-digit NPI number	2121212121
77	Operating Qualifier	S	Use corresponding qualifier for ID number submitted in 77: G2= Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
77	Operating ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	123456789
77	Operating Last Name	S	Operating physician's last name	Smith
77	Operating First Name	S	Operating physician's first name	Jane

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
78	Other (Space)	S	Enter qualifier for the provider reported: DN — Referring, ZZ — Other Operating Physician or 82 — Rendering Provider	82
78	Other NPI	S	Valid 10-digit NPI number	1112223334
78	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 78: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
78	Other ID	S	Appropriate and valid provider ID; Medicaid, Healthy Blue, Tax ID or SSN	987654321
78	Other Last Name	S	Physician's last name	Jones
78	Other First Name	S	Physician's first name	Jack
79	Other NPI	S	Valid 10-digit NPI number	N/A
79	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 79: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	N/A
79	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	N/A
79	Other Last Name	S	Physician's last name	N/A
79	Other First Name	S	Physician's first name	N/A
80	Remarks	S	Enter any free form remarks	Sample claim — Not Valid
81a	CC	N		N/A
81b	CC	N		N/A
81c	CC	N		N/A
81d	CC	N		N/A