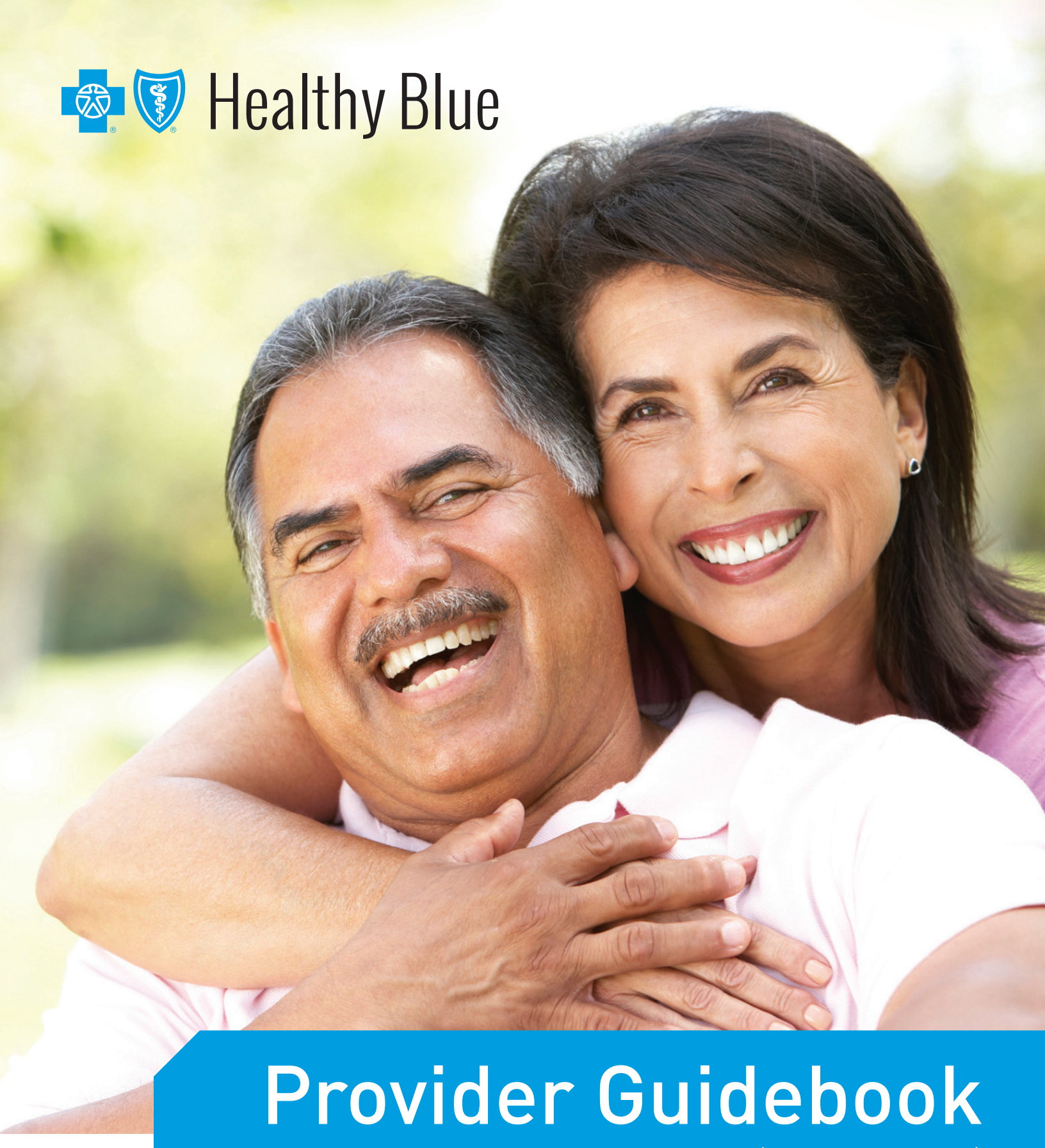
Healthy Blue



Provider Guidebook

Healthy Blue Dual Advantage (HMO D-SNP)

https://providers.healthybluela.com

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BLACRPM-0008-20 515722MUPENMUB December 2020

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1 MEDICARE OVERVIEW

1.1 Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers over 40 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

1.2 Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible member or spouse has worked at least 10 years in Medicare-covered government employment, is age 65, and is a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium-free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80% of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

1.3 Part B

Medicare Part B pays for many medical services and supplies, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received at home, in the doctor's office, in a clinic, in a nursing home or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services.
- X-rays and laboratory tests.
- Certain ambulance services.
- DME.
- Services of certain specially qualified, nonphysician practitioners.
- Physical and occupational therapy.
- Speech/language pathology services.
- Partial hospitalization for mental health care.
- Mammograms and Pap tests.
- Home Health care if a beneficiary does not have Part A.

1.4 Medicare Advantage Plans

The Balanced Budget Act of 1997 (*BBA*) established Medicare Part C also referred to as Medicare Advantage (MA). Prior to January 1, 1999, Medicare Health Maintenance Organizations (HMOs) existed as Medicare Risk or Medicare Cost plans. The *Balanced Budget Act of 1997* was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

1.5 Medicare HMO

Blue Advantage contracts with a network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals to provide services to our members. Healthy Blue Dual Advantage (HMO D-SNP) members must select a primary care physician (PCP) from those that are part of the plan's network. The PCP is responsible for managing the member's medical care, including admissions to a hospital. The member's PCP is also responsible for referring the member to a specialist. PCPs should refer the member to an in-network specialist and note the referral in the member's chart. PCPs are not required to notify the plan of the referral.

Medicare HMOs have "lock-in" requirements. This means that in order to access benefits, a member is locked into receiving all covered care from doctors, hospitals and other health care providers who are contracted with the plan. In most cases, if a member goes outside the plan for services, neither the plan nor Original Medicare will pay. The member will be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which a member may receive anywhere in the world; for urgently needed care, which members may receive while temporarily away from the plan's service area; for out-of-area renal dialysis services; and if the service is prior authorized by the plan. Urgent care is also covered inside the service area if the plan's delivery system is temporarily unavailable or inaccessible. When possible, providers should refer HMO members to providers within the network.

1.6 Managed Care Plan Enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums.
- Live in the plan's service area.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7, each year, with a January 1 plan effective date.

Special Election Period

CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, there is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Medicaid program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g., QMB-only, SLMB-only, etc.) and individuals who qualify for low income subsidy, but who do not receive Medicaid benefits.

This SEP begins the month the individual becomes dually-eligible and exists as long as he or she receives Medicaid benefits; however, there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

- January – March,
- April – June, and
- July – September.

It may not be used in the 4th quarter of the year (October – December).

1.7 Medicare Dual Eligible Special Needs Plans

Dual Eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs are open to beneficiaries in all Medicaid eligibility categories including: Qualified Medicare Beneficiary without other Medicaid (QMB only), QMB+, Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only), SLMB+, Qualifying Individual (QI), other full benefit dual eligible (FBDE) and Qualified Disabled and Working Individual (QDWI).

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare zero cost-sharing D-SNPs
- Medicare non-zero cost-sharing D-SNPs

1.8 Healthy Blue Dual Advantage Medicare Advantage Plans

Links to the Healthy Blue Dual Advantage *Summary of Benefits* (*SOB*), *Evidence of Coverage* (*EOC*) and formulary are in the table below. If the product you are searching for is not on the list below, please call the number on the back of the member's ID card for *EOC*, *SOB* and formulary information or see the benefits page at https://providers.healthybluela.com/la/pages/medicare-advantage.aspx

EOC	https://providers.healthybluela.com/Documents/LALA_CAID_EvidenceofCoverage.pdf
SOB	https://providers.healthybluela.com/Documents/LALA_CAID_SummaryofBenefits.pdf
Formulary	https://providers.healthybluela.com/Documents/LALA_CAID_ComprehensiveFormulary.pdf

Supplemental Benefits

Our Healthy Blue Dual Advantage plans include supplemental benefits. Supplemental benefits are items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the plan in addition to what Medicare covers. Please refer to each plan's benefit materials to locate any supplemental benefit coverage. Most supplemental benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit or they are considered noncovered benefits.

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly. Providers **not contracted with the vendor network** to render such a benefit, please note you will only be reimbursed or able to bill a member for noncovered services if:

- For an HMO member, you have provided the member with advanced notice of noncoverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's MA plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. Per the *Healthy Blue Dual Advantage Provider Guidebook,* CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll-free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

1.9 Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, Healthy Blue Dual Advantage is not responsible for any services under Medicare Part A during the inpatient stay. This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility.

Healthy Blue Dual Advantage is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A are covered by the Medicare Advantage plan beginning on the effective date of enrollment.

If the member's Medicare Advantage coverage terminates while the members is hospitalized, Healthy Blue Dual Advantage is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

1.10 Hospice Election for Medicare Advantage (MA) Members

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a Medicare Advantage (MA) member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services rendered during the election period. The Medicare Advantage plan is responsible for supplemental services covered under the member's MA plan and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of Hospice Election.

The following are submission guidelines for Hospice claims:

Hospice-related Services

- Submit the claim directly to CMS

Nonhospice-related Services

- For Part A services not related to the member's terminal condition, submit the claim to the Medicare Fiscal Intermediary using the condition code 07.
- For Part B services not related to the member's terminal condition, submit the claim to the Medicare Carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by an attending physician that is not employed or paid by the hospice provider, submit the claim to the Fiscal Intermediary/Medicare Carrier with a "GV" modifier.

Coordination of Member Cost-Share Amount and Supplemental Benefits

- Submit the claim to the Medicare Advantage Plan with the original Medicare EOMB.

Note: The Healthy Blue Dual Advantage plan will coordinate based on the EOMB in the situation where the MA plan liability if the member cost sharing is less than the MA plan cost-share amount. Please submit the claim with the EOMB for consideration.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 — Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for members who have elected hospice coverage. The Medicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and beneficiary Protections Sections 10.22 – 10.4 and the CMS Change Request 8727 dated May 1, 2014, all-outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: **http://cms.gov**.

2 PROVIDER PARTICIPATION IN HEALTHY BLUE PLANS

2.1 Participation Procedures for Physicians and Physician Group(s)

Healthy Blue plans must provide for the participation of individual health care professionals through reasonable procedures that include:

a. Written notice of rules of participation
b. Written notice of material changes in participation rules before they become effective
c. Written notice of adverse participation changes, and
d. Process for appealing adverse physician participation decisions

(These requirements also apply to physicians that are part of a subcontracted network.)

Provider agrees that in no event, including but not limited to nonpayment by plan, insolvency of plan or breach of the Agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered individual or persons other than plan acting on their behalf for covered services provided pursuant to the Agreement. This section does not prohibit the collection of supplemental charges or cost shares on plan's behalf made in accordance with the terms of the covered individual's health benefit plan or amounts due for services that have been correctly identified in advance as a noncovered service, subject to medical coverage criteria, with appropriate disclosure to the covered individual of their financial obligation. This advance notice must satisfy the CMS regulations for Medicare Advantage organizations, which currently requires a provider to provide to covered individuals a coverage determination that includes CMS-mandated appeal rights. Both parties agree that failure to follow the CMS regulations will result in a provider's financial liability.

A provider further agrees that for covered individuals who are dual eligible enrollees for Medicare and Medicaid, that a provider will ensure they will not bill the covered individual for cost sharing that is not the covered individual's responsibility and such covered individuals will not be held liable for Medicare Parts A and B cost sharing when the state is liable for the cost sharing. In addition, provider agrees to accept the plan payment as payment in full or by billing the appropriate state source.

CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Providers are encouraged to call the toll-free customer service number with any questions around services that may or may not be covered.

See also **Section 2.12 Billing Members and Balance Billing**.

2.2 Terminating Participation with Medicare Advantage Plans from Healthy Blue

In the event a provider wishes to terminate his/her participation in the Medicare networks or Healthy Blue terminates a provider for reasons other than cause, a mandatory 60-day notification is required for the termination by either party. Please refer to your contract for specific termination requirements.

Any provider requesting termination of his/her participation should send written notification to the Blue Advantage Network Management Department in his/her region. Upon receipt of the termination request, Blue Advantage will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

2.3 Termination of a Provider Contract with Cause

A Medicare Advantage organization that suspends or terminates an agreement under which the health care professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- Reason for the action
- Standards and the profiling data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable
- Affected health care professional's right to appeal the action as well as the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

2.4 Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should contact Healthy Blue Dual Advantage provider contracting at network.development@bcbsla.com or **1-800-716-2299, option 1**.
Upon receipt of the termination request, Healthy Blue Dual Advantage will send a written CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination.

2.5 Provider Anti-discrimination Rules

Plans are prohibited from discriminating with respect to reimbursement, participation or indemnification solely on the basis of a provider's licensure or certification as long as the provider is acting within the scope of such licensure or certification. This prohibition does not preclude any of the following:

- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of enrollees; a Medicare Advantage (MA) plan may choose to contract with a doctor of medicine that meets the needs of enrollees and does not need to contract with another practitioner who can provide only a discrete subset of physician services.
- Use of different reimbursement amounts for different specialties or within the same specialty
- Implementation of measures designed to maintain quality and control costs consistent with the MA organization's responsibilities.

2.6 Compliance with Medicare Laws, Audits and Record Retention Requirements

Medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee.
- Maintain such records and information in a manner that is accurate and timely.
- Identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Medicare Advantage member, Healthy Blue Dual Advantage and providers are obligated to abide by all federal and

state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)). First tier and downstream providers must also agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested **and** must maintain records for a minimum of 10 years.

For the purposes specified in this section, providers must agree to make available its premises, physical facilities and equipment, records relating to the MA Organization's members, including access to provider's computer and electronic system and any additional relevant information that CMS may require.

Providers acknowledge that failure to allow the Department of Health and Human Services, the Comptroller General or their designees the right to timely access as addressed in this section may result in a $15,000 noncompliance penalty.

Denying claims by excluded and precluded providers

Healthy Blue monitors appropriate sanction resource lists to identify providers for whom claims should be denied for its Medicare businesses. For pharmacy providers, the PBM shall be primarily responsible for reviewing the OIG and General Services Administration (GSA) sanction lists in their entirety to ensure no excluded providers are in the pharmacy network. Monthly updates to the sanctions lists are monitored to ensure pharmacies new to the list are not included in the network. For medical providers, Healthy Blue Medicare Claims monitors the OIG website on a monthly basis to identify sanctioned providers both to prevent payment for medical claims to ineligible providers, and to support correct claim determination complying with Medicare regulations. Further, Healthy Blue Provider Data Management monitors the CMS website on a monthly basis to identify precluded providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries both to prevent payment and to support correct claims determination complying with Medicare regulations.

2.7 Encounter Data

Each Medicare Advantage organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Provider services must be submitted by the Medicare Advantage organization for all the services provided by the network and nonnetwork physicians and nonphysician practitioners.

Encounter data shall conform with and include all information necessary for the Medicare Advantage Organization to submit data to CMS in accordance with applicable CMS and federal requirements, including but not limited to all HIPAA requirements that may be imposed upon a Medicare Advantage organization and provider.

If the provider fails to submit encounter data accurately, completely and truthfully, in the format described in 42 CFR 422.257, then this will result in denials and/or delays in payment of the provider's claims.

In addition, the provider has contractually agreed to certify the accuracy, completeness and truthfulness of the provider's generated encounter data that the Medicare Advantage Organization is obligated to submit

to CMS. No later than 30 days after the beginning of every fiscal year while the Medicare Advantage participation is in effect, the provider agrees to certify the accuracy, completeness, and truthfulness of the provider's encounter data submitted during the specific period. This certification shall be provided in writing and in the specified format at the request of the Medicare Advantage Organization.

2.8 Encounter Data for Risk Adjustment Purposes

Risk Adjustment and Data Submission

Risk adjustment is the process used by CMS to adjust the payment made to the Medicare Advantage Organization based on the health status of the Medicare Advantage Organization's Medicare Advantage members. Risk adjustment was implemented to pay Medicare Advantage Plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. As an MA organization, diagnosis data collected from encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Medicare Advantage Organizations submit "all ICD-10 codes for each beneficiary", Healthy Blue Dual Advantage also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the Medicare Advantage Organization is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform a RADV audit in order to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a RADV audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-10-CM Codes

CMS requires that physicians currently use the ICD-10-CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with the guidelines, it is important for physicians to code all conditions that coexist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

Medical Record Documentation Requirements (Risk Adjustment)

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code is assigned;
- They are used to validate diagnosis data that was previously provided to CMS by the Medicare Advantage Organization.

Because of this, the provider plays an extremely important role in ensuring that the best documentation practices are established.

CMS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.
- Patient's condition(s) should be clearly documented in record.

- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
- The documentation describing the condition and MEAT must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician's signature, credentials and date must appear on record and must be legible.

2.9 Medical Record Review Process

Healthy Blue Dual Advantage medical record standards require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. Healthy Blue Dual Advantage performs medical record reviews to assess network PCPs in relation to current medical record standards. Healthy Blue Dual Advantage recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires practitioners to comply with the plans' standards for medical record documentation.

Medical record audits/reviews are performed annually on a sample of randomly chosen PCPs contracted for the plans' managed care products for Medicare Advantage networks. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process. See *Medical Record Criteria* listed below.

Medical Record Criteria

The medical record will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.
2. Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
4. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
6. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
7. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or noncompliance to care plan).
8. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other, non-MA members.)
9. Continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.

10. Age appropriate routine preventive services/risk screenings are consistently noted, (in other words, childhood immunizations, adult immunizations, mammograms, Pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

2.10 Federal Funds

Healthy Blue Dual Advantage has a contract with CMS to perform activities as a Medicare Advantage organization. In performing its duties as an Medicare Advantage organization, Healthy Blue Dual Advantage receives federal payments and, as such, Healthy Blue Dual Advantage agrees to comply, and must ensure that all related entities, contractors, and subcontractors paid by Healthy Blue Dual Advantage to fulfill the Healthy Blue Dual Advantage obligations under its Medicare Advantage contract with CMS agree to comply, with all federal laws applicable to those entities receiving federal funds. The payments you receive from Healthy Blue Dual Advantage under this agreement for services rendered to the Healthy Blue Dual Advantage covered individuals are, in whole or in part, from federal funds. Thus, you, as a recipient of said federal funds, agree to comply with the following:

- Title VI of the *Civil Rights Act of 1964* as implemented by regulations at 45 CFR part 84
- The *Age Discrimination Act of 1975* as implemented by regulations at 45 CFR part 91
- *The Americans with Disabilities Act*
- *Rehabilitation Act of 1973*
- Other laws applicable to recipients to federal funds, and
- All other applicable laws and rules.

2.11 Prompt Payment by Medicare Advantage (MA) Organization

Receipt of claims by noncontracted providers will be considered a “clean claim” if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The MA organization is bound to adhere to the following prompt payment provisions for noncontracted providers:

- Pay 95% of clean claims within 30 days of receipt
- Pay interest on clean claims not paid within 30 days
- All other claims must be approved or denied with 60 calendar days from date of receipt

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider. Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified time frame, the claim will be closed and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a physician or other practitioner who has opted out of the Medicare program by filing with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at **https://www.cms.gov**. You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

If you are a contracting provider, please refer to you contract for the prompt payment terms applicable to you.

2.12 Billing Members and Balance Billing

Cost Sharing

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Cost-Sharing Responsibility for Special Needs Plan Members

Members that are dually eligible for Medicare and for full Medicaid coverage of their Medicare Part A and Part B premiums and other cost sharing (such as deductibles, coinsurance, and copayments) through a Medicare Savings Program are protected from liability for payment of Medicare premiums, deductible, coinsurance and copayment amounts. Some Medicare Savings Programs cover some but not all of these premium and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as *private pay* in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Healthy Blue Dual Advantage processes the claim for reimbursement when Healthy Blue Dual Advantage has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Healthy Blue Dual Advantage does not have an arrangement with the state Medicaid agency. In states where Healthy Blue Dual Advantage pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Healthy Blue Dual Advantage does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Healthy Blue Dual Advantage. Please check your *EOP* upon claims adjudication.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS 1500* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of MA plan, noncontracting and Original-Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider
The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copayment amount, if the MAO uses a copayment for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
    - The copayment amount, if the MAO uses a copayment for its cost-sharing; or
    - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to nonnetwork providers may be found in the *MA Payment Guide for Out-of-Network Payments*, at **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf**.

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid Coverage for Special Needs Plan Members
Healthy Blue Dual Advantage D-SNP (Dual Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services

Recovery Look-Back Period
To align with CMS guidelines, 42 CFR § 405.980, 405.986, Healthy Blue Dual Advantage recovers Medicare Advantage claim overpayments within four years of the claim payment date.
In addition, CMS' Medicare Integrity Program employs Recovery Audit Contractors to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

2.13 Recoupment/Offset/Adjustment for Overpayments of Contracting Providers

Healthy Blue Dual Advantage shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Healthy Blue Dual Advantage to a provider against any payments due and payable by Healthy Blue Dual Advantage to a provider under the *Participating Provider Agreement*. The provider shall voluntarily refund all duplicate or erroneous claim payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, noncompliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Healthy Blue Dual Advantage that any recoupment, improper payment, or overpayment is due from a provider, provider must refund the amount to Healthy Blue Dual Advantage within 60 days of when Healthy Blue Dual Advantage notifies a provider. If such reimbursement is not received by Healthy Blue Dual Advantage within the 60 days following the date of such notice, Healthy Blue Dual Advantage shall be entitled to offset such overpayment against other amounts due and payable by Healthy Blue Dual Advantage to a provider in accordance with regulatory requirements. Healthy Blue Dual Advantage reserves the right to employ a third-party collection agency in the event of nonpayment.

2.14 Contracted Provider Assistance with Medicare Advantage Material

As part of the Healthy Blue Dual Advantage goal to improve the health of the senior community, we are committed to providing them with the facts about our Medicare Advantage health care plans that help seniors make more informed decisions about their health care and coverage needs. To assist with meeting the goal to keep Medicare beneficiaries more informed, we need your help. Healthy Blue Dual Advantage would like to make Medicare Advantage materials available to beneficiaries through our contracted providers. We are asking your permission to display Medicare Advantage materials in your offices. Our sales representatives will be contacting you and other contracted providers to work with Healthy Blue Dual Advantage to provide this information to beneficiaries.

Your participation with this request is strictly voluntary; however, as with all provider-based activities, CMS has certain requirements for both the Medicare Advantage sponsor of these materials and the contracted providers (and any subcontractors, including providers or agents) who display the materials in their offices.

CMS Guidelines

Providers contracted with Medicare Advantage (and their contractors) are permitted to:

- Provide the names of Medicare Advantage sponsors with which they contract and/or participate to beneficiaries.
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials; rather, if providers agree to make available and/or distribute plan marketing materials for some of their contracted plans, providers should do so knowing they must accept future requests from other plans with which they participate.

To that end, providers are permitted to:

- Provide objective information on Medicare Advantage sponsors' specific plan formularies, based on a particular patient's medications and health care needs.

- Provide objective information regarding Medicare Advantage sponsors, including information such as covered benefits, cost sharing and utilization management tools.
- Make available and/or distribute plan marketing materials including Prescription drug plan (PDP) enrollment applications, but not Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD enrollment applications for all plans with which the provider participates.
- To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
- Refer their patients to other sources of information, such as State Health Insurance Plan SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at **http://www.medicare.gov** or **1-800-MEDICARE (1-800-633-4227**).
- Print out and share information with patients from CMS' website.
- **Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all.**

The *Medicare & You Handbook* or Medicare Options Compare (from **http://www.medicare.gov**), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by Medicare Advantage sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Medicare Advantage sponsors should advise contracted providers of the provision, based on a particular patient's medications and health care needs.

2.15 Delegation

Delegated Activities

If Blue Advantage has delegated activities to the provider, then Blue Advantage will provide the following information to the provider and the provider shall provide such information to any of its subcontracted entities:

- A list of delegated activities and reporting responsibilities;
- Arrangements for the revocation of delegated activities;
- Notification that the performance of the contracted and subcontracted entities will be monitored by the plan
- Notification that the credentialing process must be approved and monitored by the plan; and
- Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

Delegation of Provider Selection

In addition to the responsibilities as set forth above, to the extent that the plan has delegated selection of the providers, contractors, or subcontractor to the provider, the plan retains the right to approve, suspend, or terminate any such arrangement.

2.16 Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from Healthy Blue Dual Advantage to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or

safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services at **1-844-895-8160** or the number on the back of the member ID card to report receipt of misrouted PHI.

3 Summary of Provider Credentialing Program

Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers.

This process consists of two parts:

- Credentialing
- Recredentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. Our credentialing program consists of a full initial review of a provider's credentials at the time of application to our networks. The appropriate credentialing packet and provider agreement are forwarded to the provider upon receipt of the request for participation in our networks. The credentialing packets and criteria are available on the provider page at **www.BCBSLA.com/providers** >Provider Networks >Join Our Network.

When a fully completed credentialing packet, agreement and required supporting documentation are received, the credentialing process can take up to 90 days. Our credentialing staff verify the provider's credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to our policies and procedures and Utilization Review Accreditation Committee (URAC) standards. We return incomplete or incorrect credentialing applications and stop the application process. The process starts over once all completed documents are received.

Providers will remain non-participating in our network(s) until the application has been approved by the Credentialing Committee.

3.1 Credentialing Committee

Healthy Blue Dual Advantage and the Credentialing Committee review the provider's credentials to ascertain compliance with the following criteria. All participating providers must maintain these criteria (as applicable for provider type) on an ongoing basis:

- Unrestricted license to practice medicine in Louisiana as required by state law
- Agreement to participate in the Healthy Blue Dual Advantage network
- Professional/malpractice liability insurance that meets required amounts
- Malpractice claims history that is not suggestive of a significant quality of care problem
- Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours
- Absence of patterns of behavior to suggest quality of care concerns
- Utilization review pattern consistent with peers and congruent with needs of managed care
- No sanctions by either Medicaid or Medicare
- No disciplinary actions
- No convictions of a felony or instances where a provider committed acts of moral turpitude
- No current drug or alcohol abuse

Based upon compliance with this criteria, Healthy Blue Dual Advantage will recommend to the Credentialing Committee that a provider be approved or denied participation in our network(s). The Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's application. The Credentialing Committee approves credentialing twice per month.

3.2 Facility Credentialing

Facilities requesting network participation must complete the initial facility credentialing application packet, which includes a checklist of required documents as well as the Health Delivery Organization (HDO) Information Form. Select facility types must also complete an HDO attachment:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
- HDO Attachment D: Urgent Care Clinic / Walk-in Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

Healthy Blue Dual Advantage also has specific credentialing requirements for certain facility types:

3.2.1 Freestanding Diagnostic Imaging Facilities

Healthy Blue Dual Advantage requires that all freestanding diagnostic imaging facilities and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a facility performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from the Healthy Blue Dual Advantage network in which they participate. Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear cardiology

An an ***Opti****Net*® score of 80% or more for each modality is required. Healthy Blue Dual Advantage reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Healthy Blue Dual Advantage within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Healthy Blue Dual Advantage's credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging facility no longer performs a modality that requires accreditation or performs another modality that does not require accreditation. This policy applies for freestanding (not hospital-based) diagnostic imaging facilities only.

3.2.2 Medical staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Psychologist can be set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital per diem and/or DRG case rates and will not be set up independently under the hospital agreement.

3.2.3 Subcontracted providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to, EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all hospital services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Healthy Blue Dual Advantage or the member for such services.

For those instances when Member Providers may need to send a member to another facility when the member is inpatient, the Member Provider should bill Blue Advantage for that service. The other facility should not bill Healthy Blue Dual Advantage for the services rendered.

For example, a member, who is an inpatient at Main Street Hospital, needs hyperbaric oxygen therapy, but Main Street Hospital does not have the necessary equipment. Therefore, Main Street Hospital sends the member to Metropolitan Medical Center. Once the procedure is completed, the member returns to Main Street Hospital. In this case, Main Street Hospital should bill Healthy Blue Dual Advantage for the hyperbaric oxygen therapy and reimburse Metropolitan Medical Center accordingly. Metropolitan Medical Center should not bill Healthy Blue Dual Advantage or the member.

At least annually, Member Providers should furnish Healthy Blue Dual Advantage with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement.

3.2.4 Urgent care centers

For an urgent care center to participate in the Healthy Blue Dual Advantage networks, it must be open at least until 8 p.m., Monday through Friday and open for a minimum of eight hours on either Saturday or Sunday. If a facility does not meet these requirements, please contact the Network Development Representative for the area to discuss further.

3.2.5 Professional Credentialing

Professional providers requesting Healthy Blue Dual Advantage network participation must complete the initial professional credentialing application packet, which includes a checklist of required documents as well as the Louisiana Standardized Credentialing Application (LSCA). All providers, regardless of network participation, must include their NPI(s) on the application.

Reimbursement During Credentialing (for professional providers only)
Louisiana law allows certain healthcare provider types the option to be reimbursed for claims at network allowable changes and member benefit options during the credentialing process and the claims are paid directly to the provider. To qualify for this provision, the professional provider must meet the following criteria:

- You must be applying for network participation to join a provider group that already has an executed group agreement on file with Healthy Blue Dual Advantage. This provision does not apply for solo practitioners.
- You must have admitting privileges to a network hospital. PCPs can have an arrangement with a hospitalist group to admit their patients.
- Your initial credentialing application for network participation must include a written letter of request asking Healthy Blue Dual Advantage to reimburse you at the group contract rate and an agreement to hold our members harmless for payments above the allowable amount.

View our *How to Request Reimbursement During Credentialing* guide for more information on the process. It is available on the provider page at **www.BCBSLA.com/providers** >Provider Networks >Join Our Network.

3.3 CLIA Certification Required

Professional providers who perform laboratory testing procedures in the office are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

3.4 Recredentialing

After the initial credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by the Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

If a provider's network participation has been terminated, that provider may be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

3.5 Status Changes

A provider is required to report changes in their credentialing criteria to Healthy Blue Dual Advantage within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

3.6 Utilization Management Medicare Advantage Plans

Components of utilization management for Healthy Blue Dual Advantage plans:

- Application of Clinical Criteria Guidelines
- Referral management
- Referring out-of-network
- Providing *Advanced Beneficiary Notice of Noncoverage* (*ABN*)
- Prior authorization
- Concurrent review
- Denials
- Emergency care/urgent care
- Case management
- Under and over utilization

Application of Clinical Criteria Guidelines

Healthy Blue Dual Advantage uses Medicare coverage guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the criteria. Medical necessity decision making includes assessing the needs of the individual patient and characteristics of the local delivery system.

Healthy Blue Dual Advantage uses the following utilization management criteria for its MA plans:

- **Medicare Coverage Directives** are the primary criteria used in making decisions regarding coverage for the Healthy Blue Dual Advantage plans. Medicare Advantage plans are required to provide its Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers.
- **Healthy Blue Dual Advantage Medical Policy** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request.

- **Medically Necessary (or Medical Necessity)** means services, treatments, diagnostic procedures, or supplies provided to members that are medically required and appropriate to diagnose and/or treat a member's physical or mental condition. Also, such services, treatments, diagnostic procedures, or supplies must: 1) meet widely accepted evidence-based criteria and professionally recognized standards of health care; 2) not be used primarily for the comfort or convenience of the member, the member's family or caregiver, or the member's treating physician; 3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis and/or treatment of the member's physical or mental condition; and 4) not be provided to the member as an inpatient when the services or supplies could be safely and appropriately provided to the member in an outpatient setting.

Guidelines are also developed for disease management and preventive services. These guidelines are available upon request or at **https://providers.healthybluela.com/la/pages/medicare-advantage.aspx**. CMS National and Local Coverage Determinations or other Medicare guidance, (for example, *Medicare Policy Benefit Manual*, *Medicare Managed Care Manual*, *Medicare Claims Processing Manual*, Medicare Learning Network.

3.7 Use of Clinical Guidelines

Application of criteria must be reviewed in the context of the individual member and consider age, co-morbidities, extenuating circumstances and/or complications, response to treatment, psychosocial issues, support network, and home environment. In the application of decision criteria for specific consumers, relevant characteristics of the local delivery system are considered, including, but not limited to, the availability of certain types of facilities or services within the service area and the capability of facilities or other providers to offer needed services.

The hierarchy for UM criteria application will be applied to all medical necessity determinations for coverage for services provided to members eligible for benefits under Medicare Advantage products. CMS national and local coverage guidelines are referenced first for all medical necessity reviews.

If there is no guidance or criteria available in CMS, the Healthy Blue Dual Advantage Corporate Medical Policies followed by evidence-based guidelines, such as MCG Guidelines criteria, Compendia, NCCN (*National Comprehensive Cancer Network Clinical Practice Guidelines*) may be used.

Healthy Blue Dual Advantage Corporate Medical Policy

Healthy Blue Dual Advantage decision criteria incorporate nationally recognized standards of care and practice, current professional literature, and cumulative professional expertise and experience. The decision criteria used by senior business clinical reviewers are evidence based and consensus-driven. Criteria are updated as standards of practice or technology change. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the review criteria. An annual review and approval is performed by the Medical Policy and Technology Assessment Committee (MPTAC) or when applicable for certain specialty areas, another national clinical committee that utilizes comparable procedures for development of decision criteria. The criteria are reviewed annually for approval and adoption by Healthy Blue Dual Advantage.

3.8 Referral Management

Members are required to select a PCP who serves as the coordinator of care to ensure access to appropriate medically necessary specialty care. When referring a member to a specialist, selecting a participating provider within the Healthy Blue Dual Advantage network will maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider,

please call Provider Services or if you believe you must refer to a provider outside of our network, you must contact Healthy Blue Dual Advantage in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories. However, it does not include urgent, emergent or out-of-area renal dialysis services.

3.9 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening and preventive women's health services, such as Pap tests)
- Case Management services

Healthy Blue Dual Advantage members must obtain all routine services within the Healthy Blue Dual Advantage provider network, unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan. Healthy Blue Dual Advantage members have limited out-of-network coverage for routine services. All services not covered under the Point of Service (POS) benefit must be obtained within the Healthy Blue Dual Advantage provider network, unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan.

3.10 Referral Guidelines

PCPs may only refer members to Healthy Blue Dual Advantage Medicare contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Healthy Blue Dual Advantage directly for prior authorization. Referring a Medicare member out-of-network who does not have the benefit will result in the claim denying with member liability unless urgent, emergent, out-of-area renal dialysis or if prior authorization was received by the plan. Contact Healthy Blue Dual Advantage directly for prior authorization.

3.11 Providing Noncovered Services Advanced Notification

For services that require prior authorization or are noncovered by the plan (in other words statutory exclusion), it becomes extremely important that Healthy Blue Dual Advantage authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow Healthy Blue Dual Advantage authorization protocols, Healthy Blue Dual Advantage may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS issued guidance concerning the Advanced Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-for-Service document and cannot be used for Medicare Advantage denials or notifications. Per the ***CMS Medicare Claims Processing Manual*** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This ensures the member will receive a denial of payment and accompanying appeal rights. If you

have any doubt about whether a service is not covered, please seek a coverage determination from the plan.

3.12 Access to Care and Services

Healthy Blue Dual Advantage may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability, except as it relates to end-stage renal disease.

Healthy Blue Dual Advantage plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare. The Medicare Advantage organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24/7.

Healthy Blue Dual Advantage has established performance measures to assist in developing and maintaining adequate providers and practitioners in all our Medicare Advantage networks. Performance is monitored at least annually and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for Healthy Blue Dual Advantage members when providers and practitioners are not available or accessible in the members' geographic locations. In those instances, the in-network provider should collaborate with our utilization management area to obtain authorization for out-of-network services. In certain circumstances, the member may only be responsible for the in-network cost sharing.

Providers and suppliers must be located throughout the service area. Services are generally considered accessible if they reflect usual practice and travel patterns in the local area. Generally, hospital and PCP services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care services exceed 30 minutes as in some rural areas.

Appointment access standards for primary care services are:

Service	Access Requirement
Emergency	Immediate 24 hours a day/seven days a week access available — for emergent diagnoses. Behavioral health providers must be available to assess a patient experiencing an emergent situation within 6 hours.
Urgent	Within 48 hours — including behavioral health urgent services.
Routine	Within 10 business days — including behavioral health routine services.

Organizations and providers who contract with the Healthy Blue Dual Advantage network are required to establish and implement appropriate treatment plans for a member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty providers. Treatment plans must be time-specific and updated by the PCP.

The Healthy Blue Dual Advantage medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a

referral to another participating provider of that like specialty. Plans may select the providers through whom services are provided as long as:

- The plan makes services available and accessible within the service area with reasonable promptness and in a manner, which ensures continuity.
- The plan provides access to appropriate providers, including credentialed specialists, for medically necessary care; and if a network provider is unavailable or inaccessible then the MA organization must arrange for services outside of the network.
- Coverage is provided for emergency services without regard to prior authorization or whether the provider was a participating provider.
- The plan maintains and monitors a network of appropriate providers.
- The plan gives women enrollees direct access to women's health specialists within the network for women's routine and preventive health care services.
- The plan establishes written standards for timeliness of access to care and customer service that meet or exceed standards established by CMS and continuously monitors to ensure continuous compliance with standards.
- The plan ensures services are provided in a culturally competent manner.
- The plan ensures services are available 24/7 when medically necessary.
- The MA organization ensures continuity of care and integration of services and makes a "best effort" attempt to conduct an initial assessment of an enrollee's health care needs within 90 days of enrollment.

** Not all contracting providers have to be located within the service area, but CMS must determine that all services covered under the plan are accessible from the service area.*

3.13 Direct Access to Preventive/Routine Gynecological and Mammography Services

Women enrollees may choose direct access to a women's health specialist within the network for routine and preventive health care services provided under the plan as basic benefits. These services include annual Pap testing and mammography exams. No referrals are required for routine gynecological exams or mammography services provided by a network provider. Please refer to the most recent Medicare Advantage provider directory for the mammography center and OB/GYN specialty provider listings.

3.14 Direct Access to Influenza and Pneumococcal Immunizations with no Cost Sharing

Healthy Blue Dual Advantage strongly encourages all members to receive influenza and pneumococcal immunizations. No referral or copayment for the immunization is required.

3.15 Prior authorization

Healthy Blue Dual Advantage must be notified as early as possible before all planned inpatient admissions and no later than one business day after an unplanned inpatient admission. For services including but not limited to: selected diagnostic, outpatient and inpatient procedures, prior authorization must be requested at a minimum of 72 hours in advance. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results, medical records and attempts at conservative treatment (when appropriate) in order to complete the prior authorization process.

CMS defines an expedited/urgent request as 'a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in seriously

jeopardy.' Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request. Providers are required to provide notification in advance of services to allow Healthy Blue Dual Advantage to meet CMS processing timeframes:

Medical:

- Standard — 14 calendar days
- Expedited — 72 hours

Pharmacy (including Part B medical injectables):

- Standard — 72 hours
- Expedited — 24 hours

NOTE: Healthy Blue Dual Advantage requires notification within one business day for all ER admissions.

3.16 Interactive Care Reviewer (ICR)

Interactive Care Reviewer is the preferred method for the submission of preauthorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (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.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access ICR under *Authorizations and Referrals* via the Availity Portal (**https://www.availity.com**).

To register for an ICR webinar use the attached link: **https://bit.ly/2z394yL.**

For an optimal experience with ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari. The Healthy Blue Dual Advantage ICR is not currently available for the following:

- Transplant services
- Some vendor services

A Healthy Blue Dual Advantage Clinician will review each request for admission, procedures or services. If evidence-based criteria are met, the review clinician will document clinical data and authorize the requested service. Approval letters are mailed to the member, the PCP, the hospital and the attending physician within one business day of the decision. If the review nurse determines that the criteria are not met, or there is insufficient information to complete a review, the request for service is referred to a medical director for review. Only physicians, or other appropriate healthcare professionals, as defined by CMS, are able to render medical necessity denials. If a denial decision is indicated, the notification includes information regarding the appeal process, availability of a physician to discuss the case, and the reason for the denial including the specific clinical criteria or benefits provision.

Appropriately, licensed and trained professionals make UM decisions according to established criteria. Nonclinical associates, under the supervision of a licensed professional, may collect nonclinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Again, only physicians, or other appropriate healthcare professionals, as defined by CMS, are able to render denials. Practitioners from appropriate specialty areas are used as needed for medical necessity reviews and appeals.

3.17 How to submit prior authorizations

Failure to submit a prior authorization for an admission or provide notice of emergent inpatient admission will result in administrative denial. Please notify Healthy Blue Dual Advantage as early as possible before a planned admission and no later than within one business day after an unplanned inpatient admission.

If the required prior authorization is not obtained within the specified time frame, the claim will be administratively denied due to failure to notify Healthy Blue Dual Advantage of the admission. The provider will not receive payment for the service. Providers cannot bill the member for these denied services.

If you do not notify us within the required time frame, you may file a plea indicating the reason for the failure to provide timely notification as per above. **Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.** When submitting a response to a denial for failure to notify, the reason for the failure to provide proper notification should be presented. If your justification is accepted, the case will be sent for initial review and any adverse determination for medical necessity will be provided with subsequent appeal rights. Note, Healthy Blue Dual Advantage will not request information to justify the reason for late or no notification, nor if the notification requirement is waived will Healthy Blue Dual Advantage request medical records for any subsequent review.

To obtain authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Prior authorizations, Observation and Timely Notification Reminders for Medicare Advantage Members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely requests for service and communication is essential.

Please be aware of the following considerations and requirements to help ensure effective coordination of care for Medicare Advantage members and ensure consistent application of the Centers for Medicare and Medicaid Services guidelines and /or nationally recognized evidence based medical necessity guidelines) for pre- and post-service medical necessity and site of service reviews.

Emergent Acute Medical Admissions

Hospitals are required to notify and/or obtain an authorization as early as possible, but no later than within one business day of admission. The process for decision making is fastest when all supporting clinical information is submitted and includes test results (as applicable) and member's response to emergency treatment.

Planned Inpatient Admissions
Prior authorization is required for all planned inpatient admissions. The request for prior authorization for a planned inpatient stay should occur as soon as the provider determines the need for the inpatient admission. Providers should submit prior authorization requests in advance of the inpatient admission to allow for CMS processing timeframes. CMS standard processing timeframe is 14 calendar days, expedited processing timeframe is 72 hours. Services may not be reimbursable if the prior authorization is not obtained.

Hospital observation, in-patient admission and timely notification
Please notify us as soon as possible following admission but no later than within one business day of admission.

If we don't receive notification of admission, a retrospective review for medical necessity and site of service per the above hierarchy of review, will be conducted when the claim is submitted.

3.18 Inpatient Acute Concurrent Review
Healthy Blue Dual Advantage performs concurrent review for Medicare Advantage members at contracted in-area hospitals. The purpose of this review is to continuously improve medical care by:
- Determining the need for continued stay.
- Initiating discharge planning and case management.

3.19 Skilled Nursing Facility
Prior authorization for admission to skilled nursing facilities
According to CMS guidelines, patients should be admitted to a skilled nursing facility when "… as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF."*

Skilled nursing, acute rehabilitation and long-term care facilities are required to obtain prior authorization for Medicare Advantage members before that member can be admitted. For the member to receive maximum benefits, the health plan must authorize the admission. To ensure payment according to contract, before a Medicare Advantage member is transferred to the receiving facility, the facility must notify the plan and receive prior authorization for that transfer.

Please note:
- Prior authorization includes a review of both the service and the setting.
- Please present the request for admission to a skilled nursing facility, acute rehabilitation facility, and/or long-term acute care facility prior to admission.
- Please provide all supporting documentation with the request for prior authorization at the time of the request for admission.
- If the required prior authorization is not obtained prior to the service, the claim may be administratively denied for all days accrued prior to receiving an approval for admission, in accordance with your provider contract.
- To obtain prior authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Please refer to your provider agreement, this provider manual, and the Medicare Advantage *Precertification Guidelines* found at the Medical Policy, UM Guidelines and Prior authorization

Requirements link on the Healthy Blue provider home page at **https://providers.healthybluela.com/la/pages/medicare-advantage.aspx.**

To obtain authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Please share this information with clinical staff and others involved with facility authorization and admissions.

We look forward to working with you and your colleagues to ensure our members are discharged at the right time clinically, to the right place and achieve the best clinical outcome.

Healthy Blue Dual Advantage will coordinate skilled nursing facility (SNF) benefits for our Medicare Advantage members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. Healthy Blue Dual Advantage plans waive the Original Medicare requirement for the three-day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a member into a SNF from various sites, including the office, home or from an observation stay. Care in a SNF is covered if **ALL** of the following three factors are met:

1. The patient requires skilled nursing services or skilled rehabilitation services, in other words, services that must be performed by or under the supervision of professional or technical personnel.
2. The patient requires these skilled services on a daily basis.
3. The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained and members will be assessed the applicable copays. A benefit period is used to determine coverage under the Healthy Blue Dual Advantage plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

* *Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 155, 04-20-12)*

Inpatient stays solely to provide custodial care are not covered under Healthy Blue Dual Advantage Medicare Advantage plans. Custodial care is defined as care furnished for the purpose of meeting nonmedically necessary personal needs that could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Healthy Blue Dual Advantage Medicare Advantage plans or Original Medicare does not cover custodial care unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

The obligation on the provider to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare, SNF and inpatient hospital services to enrollees of Medicare Advantage organizations. This obligation applies to all SNFs and applies to both teaching and nonteaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code, 04). It is also the provider's obligation to keep an audit trail on these claims.

3.20 Home Health Services

For a member to qualify for home health benefits, the member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service. Under the Healthy Blue Dual Advantage Medicare Advantage plans, the member does not have to be bedridden to be considered confined to home. The condition of the member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the member leaves the home, the member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration or to receive medical treatment. Home care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- DME
- Portable X-rays and EKGs
- Laboratory tests

3.21 Denials

Pre-Service Denials and Lack of Information

Lack of information denials may not be issued to Healthy Blue Dual Advantage Medicare Advantage (MA) members. CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested service requiring utilization management review, further attempts must be made to collect the missing information. If sufficient information is not received, the pre-service request will be referred to the medical director or physician consultant for medical necessity determination.

Denials for emergent inpatient admissions, discontinuation of coverage

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. Physician review decisions are made within one working day. Plan providers are also entitled to a physician-to-physician review. Hospitals must notify Medicare Beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to: **http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

Notice of Medicare Noncoverage Requirements

CMS requires 100% compliance of providers to deliver a *Notice of Medicare Non-Coverage* (*NOMNC*) to every Medicare beneficiary at least two days prior to the end of their skilled nursing facility, home health or comprehensive outpatient rehabilitation facility (CORF) care. Additionally, CMS requires Medicare inpatients to receive written information about their discharge rights. CMS has defined how this "Important Message from Medicare" (IM) is to be delivered by hospital facilities to Medicare beneficiaries.

Healthy Blue Dual Advantage has established policies and procedures that require skilled nursing facilities, home health agencies, and CORFs to comply with the CMS mandatory requirement for all Medicare beneficiaries enrolled in Medicare Advantage Plans to receive a valid *Notice of Medicare Non-*

Coverage (*NOMNC*), in a timely manner at the termination of care by a skilled nursing facility (SNF), home health agency, or CORF to allow the member the opportunity to appeal to the Quality Improvement Organization (QIO), in the event they disagree with the termination of services.

Healthy Blue Dual Advantage responsibility and liability for SNF termination of services
When Healthy Blue Dual Advantage makes a decision to terminate coverage of a member's services in a SNF, a valid *NOMNC* is sent to the SNF for the member to receive the *NOMNC* at least two calendar days in advance of the services ending, even if the member agrees with services ending, in compliance with CMS regulation.

Healthy Blue Dual Advantage is extending the notice period up to 8 p.m. (in the time zone the facility is located), with the next two calendar days following the date of the denial notice to be considered the required two-day notice.

Below is an outline of determining the last approved day after the decision has been rendered to end services:

If denial notice (*NOMNC*) issued with confirmation of verbal notification and appeal information provided to the member, on the below day and time in the time zone the facility is located	Then last approved day (LAD) will be on	Members' discharge will occur or member financial responsibility will begin on
Monday (12 a.m. to 8 p.m.)	Wednesday	Thursday
Tuesday (12 a.m. to 8 p.m.)	Thursday	Friday
Wednesday (12 a.m. to 8 p.m.)	Friday	Saturday
Thursday (12 a.m. to 8 p.m.)	Saturday	Sunday
Friday (12 a.m. to 8 p.m.)	Sunday	Monday
Saturday (12 a.m. to 8 p.m.)	Monday	Tuesday
Sunday (12 a.m. to 8 p.m.)	Tuesday	Wednesday

The Healthy Blue Dual Advantage verbal notification to the member and/or verbal or fax receipt confirmation of the delivery of the *NOMNC* submitted prior to 8:01 p.m. (in the time zone the facility is located), will be considered a valid delivery date/time to the facility.

Healthy Blue Dual Advantage Contracted SNF Provider Responsibility and Liability
The SNF providers are responsible for delivering the *NOMNC* on behalf of Healthy Blue Dual Advantage, to the member or representative **and** for obtaining signature(s) the same day received by Healthy Blue Dual Advantage, but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the *NOMNC* and obtain signature(s) the same day Healthy Blue Dual Advantage issues the *NOMNC*, the SNF provider is responsible for reissuing a *NOMNC* with the appropriate LAD to allow the member at least two calendar days in advance of the services ending.

In the event the member is in need of an authorized representative to acknowledge/sign the *NOMNC*, and the SNF is unable to deliver it to the authorized representative the same day Healthy Blue Dual Advantage issues it, the SNF should telephone the representative the same day the *NOMNC* is issued, to advise him/her when the beneficiary's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the person initiating the contact, the name of the member representative contacted by telephone, the date and time of the

telephone contact, and the telephone number called. The annotated *NOMNC* must be mailed on the same day. The SNF must retain a copy of the annotated NOMNC in the member's medical record.

The SNF provider is also responsible to issue a *NOMNC* (created by the SNF provider) for members who services are expected to be fewer than two days duration or when a guaranteed discharge date is in place.

Liability will remain with the SNF in the event the acknowledgement of receipt and delivery of the *NOMNC* to the member or member's representative is not completed within the same day received. The authorization through the last approved day (LAD) will remain the same for the facility. The member may receive a new *NOMNC* with a new LAD to extend the covered services, with no liability to the member or Healthy Blue Dual Advantage, in order to allow the member the adequate days/time to appeal to the QIO, should the member disagree with the termination of services.

Healthy Blue Dual Advantage Medicare Advantage Member Responsibility and Liability
The member or representative is responsible for acknowledging receipt of the *NOMNC* by signing the document. The member or representative is also responsible for contacting the QIO (no later than noon of the first day after receiving the *NOMNC*), if he or she wishes to appeal the termination and obtain an expedited review. The member may also make an expedited pre-service appeal request to the Healthy Blue Dual Advantage Medicare Complaints, Appeals, and Grievances Department should they miss their time frame for appealing to the QIO and are still in the facility.

Liability for the member will begin the day following the last approved day as specified on the *NOMNC*, should the member choose not to appeal the termination of services.

Note: QIOs must be available to receive a member's appeal request 24 hours a day, seven days a week.

Refer to the Provider and Member liability section of the provider contract with Healthy Blue Dual Advantage for further details.

3.22 Preservice denials

When a contracted provider is denied a pre-service request for a member, federal regulations require the Medicare Advantage organization to issue a written notice of the denial (a *Notice of Denial of Medical Coverage* (*NDMC*) also known as the Integrated Denial Notice (IDN)) informing the member of his/her appeal rights. Therefore, a physician or practitioner is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan..

3.23 Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care, and Ambulance Services

The Healthy Blue Dual Advantage MA plans are financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The pan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health. A Medicare Advantage organization is required to cover emergency services for its MA members regardless of whether the services were preauthorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity 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
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Urgently needed services are not emergency services as defined above, but are covered services that are medically necessary and immediately required as a result of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- An enrollee is temporarily absent from the MA plan's service area.
- When the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

Post-stabilization care is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and under specific circumstances includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the purposes of this requirement, post-stabilization care and maintenance care are used synonymously. The plan's financial responsibility for post-stabilization care services includes:

- Any service administered, even though not preapproved by the plan or its representative, during the one-hour period following the request to the MA organization for preapproval of further post-stabilization care.
- Services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for preapproval within one hour.
- The MA organization's representative and the treating physician cannot reach an agreement concerning care decisions and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
    - A plan physician assumes care through transfer.
    - The MA organization's representative and the treating physician reach an agreement on the member's care.
    - The member is discharged.

3.24 Case Management

Case management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes. Identification involves proactive processes to identify eligible members who are likely to benefit from case management services and meet referral criteria. The program utilizes proprietary predictive models to identify members with a variety of complex conditions who may potentially benefit from case management. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, and sales staff.

- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other health care providers, members or their families.
- Healthy Blue Dual Advantage discharge planners collaborate with all pertinent parties in the development of the discharge plan (in other words, PCP, specialist, Medical Director) to ensure the member's needs are met before leaving the hospital setting. Healthy Blue Dual Advantage has designed a platform that provides a single point of contact to providers and facilities to ensure effective and collaborative discharge planning, which streamlines the process for our providers while providing a more proactive, informative, and comprehensive transition for the member and their care partner to fully understand the care plan (in other words, ensuring ancillary needs are met [DME received before member returns home, home infusion training is required, etc.]). Additional intensified discharge planning efforts also include:
    - Performing medication reconciliation
    - Referring members to high-risk condition management programs, where applicable
    - Managing palliative care needs and refer to hospice when appropriate
    - Integrate psych and social workers where necessary

In addition, case referrals can be generated prospectively from the UM system during the prior authorization process and retrospectively from the claims system through claims data analysis and data review activities. Case referrals may also be triggered by the results of *Senior Health Risk Assessment* surveys and/or internal disease management registries, as appropriate. The *Senior Health Risk Assessment* is a risk appraisal, which evaluates health and wellness factors such as member's self-perception of health, presence of chronic or serious conditions, functional limitations, prior health care utilization and availability of social support. These factors are potentially predictive of future health care needs and we make a best-effort attempt to conduct this initial assessment of each enrollee's health benefit needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment. Essential functions of a Healthy Blue Dual Advantage case manager include the following:

Assessment: The case manager collects and analyzes data about actual and potential member needs. This may involve gathering data in relation to the member's medical issues, cognitive status, and functional status. After the data is analyzed, there is the planning, implementing and evaluation of the case management plan.

Planning: The case manager develops a member centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best way possible. This means identifying both short and long-term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

Linking/coordination: The case manager helps ensure continuity of care and integration of benefits across a variety of settings. Coordination is achieved through communication with the member, family and providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual member to help promote continuity of care.

Monitoring/evaluation: Case management will monitor interventions, based upon benefits, to help make sure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met then the case manager should work with the member to modify the plan for the member.

Advocacy: The case manager should incorporate the member's needs and goals in the plan. Case managers should gather input from all relevant parties to help ensure continuity of benefits so that the

member will achieve optimal results. Case managers are required to help protect the privacy and confidentiality of members at all times. Case managers should also present their limitations due to potential conflicts of interest between the member and Healthy Blue Dual Advantage.

3.25 Stars Outbound Call (OBC) Program

The Medicare Advantage Stars Outbound Call (OBC) Program plays a key role in addressing the Healthy Blue Dual Advantage approach for Medicare Advantage members in improving their healthy by getting the quality of care they need at the right time and in the right setting through conducting an outbound call to members and or providers to communicate the importance of obtaining preventive services such as colorectal screening, mammograms, annual wellness visits, and retinal eye exams.

By closing members gaps in care, this will help improve member health outcomes. Focused questioning by our Patient Education Coordinators (PEC), pharmacists, and technicians address key clinical measures to ensure our members receive the right care at the right time.

This program allows members to be proactively involved in their own care by notifying them of preventive screenings that can detect and help prevent chronic illness and highlighting the potential benefit of the proactive behavior. Focused scripting and call messaging allows for barrier assessment and provides actionable messaging aligned with behavior change. Members with barriers to care are offered assistance with transportation coordination, financial needs, or provided access to community resources within their respective area. Care coordination is offered along with referrals to a pharmacist, nurse, or social worker to address any issues or to receive assistance with scheduling recommended care.

3.26 Under and Over Utilization

Healthy Blue Dual Advantage has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

Healthy Blue Dual Advantage does not compensate, reward or give incentives, financially or otherwise, its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision-making for Healthy Blue Dual Advantage is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

3.27 Readmission Review Process

Readmission

For all services reimbursed by a DRG Rate or Case Rate, a readmission within 30 days of the discharge of the first admission for a related diagnosis or procedure, a complication arising out of the first admission, a readmission for services that should have been rendered during the previous admission, or a premature discharge is considered part of the original admission for reimbursement.

The specific situations for which the readmission payment may be considered part of the original admission for reimbursement are:

- Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.
- Member is discharged without discharge criteria being met, including the clinical and level of care criteria.

- Member is discharged from the hospital after surgery, but is readmitted within 30 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.
- Member discharged from the hospital with a documented plan to readmit within 30 days for additional services (doctor requested, member requested).
- Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.
- Member is discharged meeting discharge criteria but nonclinical factors have not been addressed, and member has had previous 30-day admits. Member has issues or barriers that require discharge plans beyond the typical.

If a subsequent admission is reimbursed at a methodology other than a DRG or Case Rate (in other words, Per Diem Rate or percentage Rate), then Healthy Blue Dual Advantage shall only reimburse the facility for the DRG or Case Rate of the original admission. None of these scenarios shall be combined to qualify for outlier reimbursement, if applicable If facility is an acute care hospital and is part of a hospital system operating under the same *Facility Agreement*, and/or if the facility shares the same tax identification number with one or more acute care hospitals, then a readmission during the same 30 day period to another acute care hospital within the system, and/or another acute care hospital operating under the same tax identification number as the facility, shall be subject to this readmission provision.

4 SPECIAL NEEDS PLAN (SNP) MEMBERS ONLY

4.1 Model of Care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. The SNP model of care is designed to improve the care of our members in all of the following areas:
    - Improving access and affordability of the healthcare needs of the population
    - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP) and interdisciplinary care team (ICT).
    - Enhanced care transitions across all health care settings and providers
    - Ensuring appropriate utilization of services for preventive health and chronic conditions.
    - Goals specific to the population may be defined as part of our model of care.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an assigned care coordinator, as well as an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.
3. We work to complete a telephonic HRA on each member. For new members the goal is to complete the initial HRA within 90 days of eligibility and annually before the anniversary of the last HRA. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental topics and serves as the basis for the member's individualized care plan (ICP). Providers have access to the HRA results and the ICP through the provider portal.
4. Based on the results of the health risk assessment, an ICP will be developed by the case manager working directly with the member, and the interdisciplinary care team (ICT) to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care
5. An ICT is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs, and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs

that have been identified during the care planning process. You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.

8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include the following measures:
    - HEDIS — used to measure performance on dimensions of care and service
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
    - Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
    - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
    - Medication therapy measurement measures
    - Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual Program Evaluation

Each year an evaluation of the model of care occurs to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we periodically review our program to assist us in early identification of any potential issues that may require actions. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that may not be trending toward our benchmarks. We do a comparison of our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets we are meeting or exceeding in many areas. We are also showing an upward trend when we compare the year over year results. We continue to work on ways to improve our outreach to our members and improving our completion rates for completion of the health risk assessments, the creation of an individualized care plan and establishing an interdisciplinary care team for each of our special needs plan members. We manage utilization of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post discharge management continue to improve in most markets. Preventive care goals are established for our programs and managed as part of the Healthcare Effectiveness Data and Information Set (HEDIS®) program.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

4.2 Healthy Blue Dual Advantage Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and includes changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition.

Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are some protocols when managing transitions:

- Participate in the interdisciplinary care team meetings.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our

providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.
- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer to external or internal programs.
- Coordinate care with behavioral health.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

5 Healthy Blue Dual Advantage Medicare Advantage Provider Payment Disputes, Administrative Pleas, and Standard Appeals

5.1 Distinguishing between Provider and Medicare Advantage Member Appeals

Healthy Blue Dual Advantage has separate and distinct processes for requests to reconsider a Healthy Blue Dual Advantage decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare Member liability denials are subject to the Medicare Complaint, Appeal and Grievance (MCAG) process as outlined in the *Medicare Member Appeals* and *Medicare Member Grievances* sections of this Provider Manual. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare Member follow the Healthy Blue Dual Advantage participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with Healthy Blue Dual Advantage and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly to allow Healthy Blue Dual Advantage to make an expedited decision. Your participation in and the member's election of the Medicare Advantage plan are an indication of consent to release those records as part of health care operations.

Medicare Member Liability

Healthy Blue Dual Advantage has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare member cost share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with subsequent review by the Independent Review Entity (IRE).
- The *Notice of Denial of Medicare Prescription Drug Coverage* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- *Notice of Medicare Non-Coverage* (*NOMNC*) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits (EOB)* indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability

If Healthy Blue Dual Advantage has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment, the participating provider is prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
Healthy Blue Dual Advantage has determined that the nonparticipating provider has failed to follow Medicare requirements unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

5.2 Provider Claim Payment Disputes and Administrative Plea Processes

Provider Claim Payment Dispute process
If you disagree with the outcome of a claim, you may begin the provider payment dispute process. Provider Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute**: The claim has been finalized but you disagree with the amount that you were paid;
- **Provider Administrative Plea**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.
    - Claims that were denied for lack of medical necessity should follow the existing provider post-service appeal process. An example of a post-service medical necessity appeal scenario would be as follows: On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied. For more information on each of these, please refer to the appropriate section in this provider manual.

Please be aware, there are two 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.
- **Claims Correspondence:** When Healthy Blue Dual Advantage 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 are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Healthy Blue decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:
- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.

The Healthy Blue Dual Advantage provider payment dispute process consists of two internal steps. 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 first step in the 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:** The second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

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

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

*Timely filing issues: Healthy Blue Dual Advantage will consider reimbursement of a claim which 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.

5.3 Claim Payment Reconsideration

The first step in the Healthy Blue Dual Advantage claim payment dispute process is called the reconsideration. It 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 web portal within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will considered to be 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.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan 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 when upholding our decision, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan 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 63 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 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. Overturned decisions will result in an adjustment and EPOs.

5.4 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 60 calendar days of the date on the reconsideration determination letter. Claim payment appeals received more than 60 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be 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 professionals.

The plan 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.

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

5.5 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services.
- **Web Portal (Reconsideration and Claim Payment Appeal)**: The plan can receive reconsiderations and claim payment appeals via the secure Availity Payment Appeal Tool at **https://www.availity.com.** Supporting documentation can be uploaded on the Portal. You will receive immediate acknowledgement of your web submission.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  - Provider Payment Disputes
    P.O. Box 61599
    Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

The health plan 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 Medicaid or Medicare ID number.
- A listing of disputed claims, which should include the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but 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.

Our Provider Experience program helps you with claim inquiries. Call Provider Services and select the Claims prompt within our voice portal. We will connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, Healthy Blue Dual Advantage 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 Dual Advantage will use it to finalize the claim.

The following table provides examples 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)	Use the **EDI Hotline** at **1-800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
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 to: Claims Correspondence P.O. Box 61010 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61010 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 to: Claims Correspondence P.O. Box 61010 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 365 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 Dual Advantage 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 to: Claims Correspondence P.O. Box 61010 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61010 Virginia Beach, VA 23466-1599

6 Healthy Blue Dual Advantage Participating Provider Standard Appeals

6.1 Participating Provider Appeals

Healthy Blue Dual Advantage participating providers may initiate provider appeals under the provider appeal procedures. Healthy Blue Dual Advantage typically determines provider appeals within 60 days when sufficient information is received to make a decision.

6.2 Medicare Participating Provider Standard Appeal

A formal request for review of a previous Healthy Blue Dual Advantage decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the Healthy Blue Dual Advantage decision letter date.*
- Include a cover letter with:
    - Member identifiable information
    - Date(s) of service in question
    - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Healthy Blue Dual Advantage's original decision
- Include necessary attachments:
    - Copy of the original Healthy Blue Dual Advantage decision
    - All applicable medical records

N**ote**: Healthy Blue Dual Advantage will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Healthy Blue Dual Advantage Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirement

7 HEALTHY BLUE DUAL ADVANTAGE NONPARTICIPATING PROVIDER PAYMENT DISPUTES AND APPEALS

7.1 Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process. For more information regarding the disputes process, please see the **Claims Dispute** section.

7.2 Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability Statement* must be included. To obtain this form, visit **https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip.**

The purpose of the *Waiver of Liability Statement* is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address.

Medicare Complaints, Appeals & Grievances
Mailstop: OH205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

8 HEALTHY BLUE DUAL ADVANTAGE MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

8.1 Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and the Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Therefore, it is important for the physician to be aware of the difference between appeals and grievances.

8.2 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Healthy Blue Dual Advantage to reconsider and change an initial coverage/organization determination (by Healthy Blue Dual Advantage or a provider) about what services, benefits or prescription drugs are necessary or covered or whether Healthy Blue Dual Advantage will reimburse for a service, a benefit or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Healthy Blue Dual Advantage denies it, the member has the right to appeal. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Healthy Blue Dual Advantage or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Healthy Blue Dual Advantage concerning reimbursement for a health care service
- An adverse initial organization determination by Healthy Blue Dual Advantage concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Healthy Blue Dual Advantage or a provider concerning authorization or payment for prescription drugs

Appeals should be sent to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Appeals
Mailstop: OH205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

8.3 Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; However, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at **https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html**.
- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended where good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe.
    - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeals may be submitted orally or in writing. Such appeals are resolved within 72 hours, unless it is in the member's interest to extend this time period.
    - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
    - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
    - Part D payment appeals must be resolved within 14 days from the date the request was received.
    - Part D appeals timeframes cannot be extended.

8.4 Further Appeal Rights

If Healthy Blue Dual Advantage is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Healthy Blue Dual Advantage will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
    - Within 72 hours if expedited
    - Within 30 days if the appeal is related to authorization for health care that is not a Part B drug.
    - Within 7 days if the appeal is related to authorization of a Part B drug.
    - Within 60 days if the appeal involves reimbursement for care

    - Part D prescription drug appeals are not forwarded to the IRO by Healthy Blue Dual Advantage but may be requested by the member or representative; information will be provided on this process during the Healthy Blue Dual Advantage Medicare member appeals process
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ)
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court

Hospital discharge appeals and QIO review process
Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Healthy Blue Dual Advantage continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

8.5 Medicare Member Grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Healthy Blue Dual Advantage or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Healthy Blue Dual Advantage must accept grievances from members orally or in writing within 60 days of the event. Healthy Blue Dual Advantage must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Healthy Blue Dual Advantage has 24 hours to respond. An expedited grievance can only be initiated if Healthy Blue Dual Advantage refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Healthy Blue Dual Advantage can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

8.6 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Healthy Blue Dual Advantage, the Medicare Advantage plan, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

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 a member's Healthy Blue Dual Advantage benefit plan. Please see reimbursement policies at **https://providers.healthybluela.com/la/pages/medicare-advantage.aspx**. 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 claim 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; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue Dual Advantage may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

Healthy Blue Dual Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue Dual Advantage strives to minimize these variations.

9.1 Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. 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, authorization requirements or stipulations within a Reimbursement Policy. Neither payment rates nor methodology are considered to be conditions of payments.

9.2 Review Schedules and Updates

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 policy on the provider website at the link above.

9.3 Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Healthy Blue Dual Advantage. 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

9.4 Reimbursement by Code Definition

Healthy Blue Dual Advantage allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluations 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

9.5 Healthy Blue Dual Advantage Coordination of Benefits

Healthy Blue Dual Advantage and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Healthy Blue Dual Advantage is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Healthy Blue Dual Advantage does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Healthy Blue Dual Advantage will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Healthy Blue Dual Advantage will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Healthy Blue Dual Advantage handles the filing of liens and settlement negotiations both internally and externally via its vendors.

The information contained in this handbook should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for Healthy Blue Dual Advantage members and enrollees are the responsibility of providers and practitioners. Please encourage the patient to review his/her Policy or Evidence of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment, as this Handbook does not supersede the Policy or Evidence of Coverage and Schedule of Benefits. The information in this Handbook may change from time to time.

10 PROVIDER DIGITAL ENGAGEMENT

10.1 Purpose

The purpose of this provider digital engagement chapter is to establish the standards to increase utilization of secure digital provider tools and applications that are accessible to participating and non-participating providers to improve efficiencies for providers and Healthy Blue. This chapter is applicable medical, dental and vision services.

In support of this digital supplement, the following efficiencies have been documented as industry averages per the annual CAQH CORE Efficiency Index study:

Table 10: Average, Minimum, and Maximum Time Spent by Providers Conducting Manual, Partial and Electronic Transactions, Medical, 2019 CAQH Index					
Transaction	**Method**	**Average Time Providers Spend per Transaction (minutes)**	**Min Time Providers Spend per Transaction (minutes)**	**Max Time Providers Spend per Transaction (minutes)**	**Potential Average Time Saving (minutes)**
Eligibility and Benefit Verification	Manual	10	3	30	8
	Partial	5	1	15	3
	Electronic	2	<1	10	
Prior Authorization	Manual	21	3	45	17
	Partial	8	1	20	4
	Electronic	4	<1	18	
Claim Submission	Manual	6	1	25	4
	Electronic	2	<1	6	
Attachments	Manual	11	1	30	6
	Electronic	5	1	10	
Claim Status Inquiry	Manual	12	1	20	8
	Partial	4	1	10	0
	Electronic	4	<1	11	
Claim Payment	Manual	5	<1	11	2
	Electronic	3	<1	10	
Remittance Advice	Manual	7	<1	19	5
	Partial	4	<1	10	2
	Electronic	2	<1	10	
Total Potential Time Savings (Manual)					**50**
Total Potential Time Savings (Partial)					**9**

10.2 Supplement Statement

This Supplement outlines the digital tools Healthy Blue has available to providers who serve its members, whether par or non-par. It is Healthy Blue's expectation that providers will utilize these digital tools unless mandated by law or other legal requirement no later than January 1, 2021. The electronic tools and applications include the secure Provider Portal, Electronic Data Interchange (EDI) Transaction

Gateway and available Business-to-Business Application Programming Interfaces (B2B APIs) - all hosted via Availity. This Supplement addresses the following processes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, attachments and authorization status
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred, that in markets where these tools are currently available, these digital alternatives are used:

- Disputes
- Grievances and Appeals
- Demographic updates
- Pharmacy Prior Authorization drug requests
- Services through Healthy Blue affiliates, AIM and Beacon
- Provider Enrollment

Healthy Blue expects that all providers seeking any functions and processes above will use available electronic self-service tools including EDI X12 transactions, the secure Provider Portal or direct desktop integration via B2B APIs in lieu of manual channels (paper, mail, fax, call, etc.). Availity provides access to all Healthy Blue self-service tools across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all Healthy Blue digital tools and capabilities is available on the secure Provider Portal via **https://www.availity.com**. Please access Availity to learn more about available EDI, Portal and B2B API options. Administration Simplification standard transaction requirements: **https://www.hhs.gov/hipaa/for-professionals/other-administration-simplification-rules/index.html**

NOTE: As a mandatory requirement, all trading partners who currently transmit directly to an Healthy Blue EDI Gateway must transition to the Availity EDI Gateway and have an active Availity Trading Partner Agreement in place.

10.3 Acceptance of Digital ID Cards

As Healthy Blue's members transition to using electronic member identification cards, providers may need to implement changes in their processes to accept this new format. Healthy Blue expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card. If providers require a copy of a physical member identification card, mmembers can fax or email a copy of the electronic member identification card from their phone/app, or providers can access it directly from the secure Provider Portal through Availity.

10.4 Eligibility and benefit inquiry and response

Providers may leverage any of the following Availity-hosted channels for electronic Eligibility & Benefit inquiry and response:

- EDI Transaction: X12 270/271 Eligibility Inquiry and Response (version 5010)
    - Healthy Blue supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Secure Provider Portal via Availity

    - Eligibility and Benefit verification utility – This utility allows a provider to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Healthy Blue has also enabled real-time access to Eligibility and Benefit verification APIs, that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration opportunities at **https://www.availity.com/Healthcare-APIs**.

10.5 Authorizations

Prior Authorization Submission, Attachment and Status
Providers may leverage any of the following channels for Prior Authorization submission, status inquiries and submission of electronic attachments (solicited or unsolicited) on the secure Provider Portal via Availity:

- EDI Transaction: X12 278 Prior Authorization and Referral (version 5010)
    - Healthy Blue supports the industry standard X12 278 transaction for prior auth submission and status inquiry as mandated per HIPAA.
- EDI Transaction: X12 275 Patient Information including HL7 payload (version 5010) for authorization attachments
    - Healthy Blue supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Secure Provider Portal via Availity
    - Interactive Care Reviewer (ICR) – The authorization ICR utility allows a provider to key a prior authorization request including an attachment or status inquiry directly into an online form.
    - Additionally, providers can use ICR to make inquiries on previously submitted requests regardless of how the original prior authorization was submitted (phone, fax, eReview, secure email, etc.).
- Provider desktop integration via B2B APIs
    - Healthy Blue has also enabled real-time access to Prior Authorization APIs, that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at **https://www.availity.com/Healthcare-APIs**.

10.6 Claims: Submissions, Attachments and Status

Claim Submissions, Attachment and Status
Providers may leverage any of the following channels for electronic Claim submisssion, attachments (for both pre and post payment) and status on the secure Provider Portal via Availity:

- EDI Transaction: X12 837 Professional, Institutional and Dental Claim submission (version 5010)
    - Healthy Blue supports the industry standard X12 837 transactions for all Fee-For-Service and Encounter billing as mandated per HIPAA.
- EDI Transaction: X12 275 Patient Information including HL7 payload attachment (version 5010)
    - Healthy Blue supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- EDI Transaction: X12 276/277 Claim status Inquiry and Response (version 5010)
    - Healthy Blue supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.

    - Secure Provider Portal via Availity: Direct Data Entry (DDE) – The claim DDE utility provider allows a provider to key a claim directly into an online claim form and also upload supporting documentation for a defined claim (solicited or unsolicited)
    - 837 Claim batch upload – The claim batch upload utility allows a provider to upload an entire batch/file of claims (must be in X12 837 standard format).
    - Claim Status Inquiry utility – This utility allows a provider to key an inquiry directly into an online claim status form with real-time responses.
- Provider desktop integration via B2B APIs –
    - Healthy Blue has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at **https://www.availity.com/Healthcare-APIs**.

10.7 Remittances & Payments Electronic Funds Transfer (EFT)

Like the payroll direct deposit service that most businesses offer their employees, Electronic Funds Transfer (EFT) uses the Automated Clearing House (ACH) Network to transmit health care payments from a health plan to a health care provider's bank account. Health plans can use a provider's banking informaton only to deposit funds, not to withdraw funds. Healthy Blue expects providers to accept payment via Electronic Funds Transfer (EFT) in lieu of paper checks. Providers can register or manage account changes for EFT via the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called **EnrollHub**. This tool will help eliminate the need for paper registration, reduce administrative time and costs and allows physicians and facilities to register with multiple payers at one time. EFT payments are deposited faster and are generally the lowest cost payment method.

To facilitate quicker reimbursement for providers who have not enrolled for EFT, Healthy Blue may move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Using the same Trace Identifier Segment (TRN) helps to match the payment to the correct remittance advice, a process called reassociation. Health plans are required to input the X12 835 TRN Segment into Field 3 of the Addenda Record of the CCD+Addenda. The TRN Segment in the Addenda Record of the CCD+Addenda should be the same as the TRN Segment in the associated ERA that describes the payment.

Electronic Remittance Advice (ERA)
Providers may leverage any of the following channels for Electronic Remittance Advice on the secure Provider Portal via Availity:

- EDI Transaction: X12 835 Electronic Remittance Advice (version 5010)
    - Healthy Blue supports the Tindustry standard X12 835 transaction as mandated per HIPAA.
- Secure Provider Portal via Availity - Remittance Inquiry:
    - The Remittance Inquiry application provides a digital version (PDF) of paper payment remittance that can be downloaded.

11 FORMS

Provider Authorization to Adjust Claims and Create Claim Offsets

Submit this completed *Authorization Form* with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name	
Provider NPI	
Provider tax identification number	
Provider contact information	
Cost Containment project number (if applicable)	
Document identification number (if applicable)	
Total recoupment dollar amount	

Please list claim information below if the *Cost Containment Letter* or other supporting claim/member detail is not provided with this request.

Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**

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Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			

If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at the number on the back of the member's ID card.

I authorize Healthy Blue to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____

Print name Signature

Mail this form to:
Attn: Cost Containment – Disputes
Healthy Blue Dual Advantage

P. O. Box 62427
Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Refund Notification Form* on the provider website. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments
Healthy Blue Dual Advantage
P.O. Box 933657
Atlanta, GA 31193-3657

Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is a Healthy Blue check, please include a completed form specifying the reason for the check return.

Provider name/contact	
Contact number	
Provider ID	
Provider tax ID	
Subscriber ID	
DCN number (Displayed on CCU Letter)	
Member name	
Member account number	
Date of service	
Total billed charges	

Total check amount:
$_____

Claim number(s):

Reason for refund or check return:

☐ Health plan letter
☐ Contract rate change
☐ Duplicate payment
☐ Incorrect member
☐ Incorrect provider
☐ Negative balance
☐ Other health insurance/third-party liability
☐ Payment error
☐ Billed in error/adjusted charge
☐ Other: _____

All refund checks should be mailed with a copy of this form to:
Healthy Blue
P.O. Box 933657
Atlanta, GA 31193-3657

https://providers.healthybluela.com

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Once the Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.

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