Provider Quick Reference Card

Healthy Louisiana and LaCHIP

Provider Services
For general provider inquiries:
Phone: **844-521-6942**
Fax: **800-964-3627**

Healthy Blue

https://providers.healthybluela.com

Healthy Blue Prior Authorization/ Notification Coverage Guidelines

Easy access to prior authorization/notification requirements and other important information

For more information about requirements, benefits and services, visit https://providers.healthybluela.com for the most recent version of our provider manual.

If you have questions about this document or recommendations to improve it, call your local Provider Relations representative at **504-836-8888** or email lainterpr@healthybluela.com.

Prior authorization/notification instructions and definitions

Prior authorizations — physical health:

- Use our preferred method online at **https://provider.healthybluela.com**.
- By phone: **844-521-6942**
- Prior authorization requests and inpatient notification fax: **877-269-5705**
- Concurrent inpatient clinical fax: **888-822-5595**
- Outpatient fax: **888-822-5658**
- Outpatient DME fax: **844-528-3684**

Prior authorizations — behavioral health

- Use our preferred method online at **https://provider.healthybluela.com**.
- Phone: **844-521-6942**
- Inpatient fax: **844-432-6027**
- Outpatient fax: **844-432-6028**

AIM Specialty Health® (AIM) phone: **833-342-1254** (services managed by AIM are detailed below)

Prior authorizations — pharmacy:

- Fax: **844-864-7865**
- Fax — medical injectables: **844-487-9291**

Prior authorization — The act of authorizing specific services or activities before they are rendered or occur

Notification — Telephonic, fax or electronic communication from a provider to inform us of your intent to render covered medical services to a member

- Provide notification prior to rendering services outlined in this document.
- For emergency or urgent services, provide notification within 24 hours or the next business day.
- There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.
- It is our policy to cover two routine prenatal ultrasounds for fetal anatomic survey per member per pregnancy (CPT® codes 76801, 76802, 76805 and 76810). For CPT codes 76811, 76812, 76815, 76816 and 76817, additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT codes 76811 and 76812 are only reimbursable to maternal fetal medicine specialists.

The policy does not apply to the following specialists:

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

The policy also does not apply to ultrasounds performed in place of service code 23 — emergency department.

For code-specific requirements for all services, visit our provider self-service website and select **Prior Authorization & Claims** then **Prior Authorization Lookup Tool**.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request prior authorization for services when network providers do not.

Air ambulance services

Authorization is required for all services. Providers have 30 days from the date of transportation to provide medical necessity documentation and request authorization of services.

Applied Behavioral Analysis (ABA)

Prior authorization is required for all ABA services.

Behavioral health/substance abuse services

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

Precertification is required for the following specialty behavioral health services:

- Anesthesia for electroconvulsive therapy
- Inpatient psychiatric subacute
- Electroconvulsive therapy
- Psychological testing with interpret face-to-face
- Psychological testing with interpret technician
- Psychological testing with interpret computer
- Neurobehavioral status examination
- Initial hospital inpatient care, low complexity
- Initial hospital inpatient care, moderate complexity
- Initial hospital inpatient care, high complexity
- Subsequent hospital inpatient care, low
- Subsequent hospital inpatient care, moderate
- Subsequent hospital inpatient care, high
- Hospital discharge day management
- Hospital discharge day
- Alcohol and/or drug services — intensive outpatient II.1 level individual
- Alcohol and/or drug services — intensive outpatient II.1 group, ages 0 to 20
- Alcohol and/or drug services — intensive outpatient II.1 group, ages 21+
- Therapeutic group home per diem, ages 0 to 20
- Community psychiatric supportive treatment — individual office
- Community psychiatric supportive treatment — individual community
- Community psychiatric supportive treatment — homebuilders, ages 0 to 20
- Community psychiatric supportive treatment — functional family therapy, ages 0 to 20
- Community psychiatric supportive treatment — PSH individual office
- Community psychiatric supportive treatment individual — PSH individual community
- Assertive community treatment — nonphysician per diem, ages 18 to 20
- Assertive community treatment — physician per diem, ages 18 to 20
- Assertive community treatment — first month, if enrolled first to 10th day of month, ages 21+
- Assertive community treatment — first month, if enrolled 11th to 20th day of month, ages 21+
- Assertive community treatment — first month, if enrolled 21st to 31st day of month, ages 21+
- Assertive community treatment — subsequent months*, ages 21+
- Psychiatric health facility service per diem — PRTF, ages 0 to 20
- Psychosocial rehabilitation — individual office
- Psychosocial rehabilitation — individual community
- Psychosocial rehabilitation — group office, ages 0 to 20
- Psychosocial rehabilitation — group community, ages 0 to 20
- Psychosocial rehabilitation — group office, ages 21+
- Psychosocial rehabilitation — group community, ages 21+
- Multisystemic therapy — 12 to 17 years old target population, ages 0 to 20
- Applied Behavioral Analysis

Chemotherapy

- Prior authorization is required for inpatient chemotherapy as part of inpatient admission and for oncology drugs and adjunctive agents.
- Precertification is required for outpatient chemotherapy drugs.
- Prior authorization is not required for procedures performed in the following outpatient settings:
  - Office
  - Outpatient hospital
  - Ambulatory surgery center

For information on coverage and prior authorization requirements on chemotherapy drugs, please refer to the Prior Authorization Lookup Tool on our provider website. Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

- Routine circumcisions are covered within the first 30 days of life.
- Medically necessary circumcisions are covered with no age limit.

Dermatology

- No prior authorization is required for a network provider for evaluation and management (E&M), testing, and procedures.
- Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic imaging

- No prior authorization is required for routine diagnostic testing.
- Prior authorization is required for magnetic resonance angiograms (MRAs), MRIs, CT scans, nuclear cardiology, video electroencephalograms (EEGs) and positron emission tomography (PET) imaging.
- AIM manages precertification for the following modalities:
  - Computed tomography (CT/CTA)
  - Magnetic resonance (MRI/MRA)
  - Positron emission tomography (PET) scans
  - Nuclear cardiology
    - Echocardiography
    - Stress echo
    - Resting transthoracic echo
    - Transesophageal echo
  - Radiation oncology
  - Sleep medicine
  - Cardiology services
- AIM *Clinical Appropriateness Guidelines* and our *Medical Policies* will be used. AIM guidelines are available online at **www.aimspecialtyhealth.com**.
- Contact AIM by phone at **833-342-1254.**

Durable medical equipment (DME)

No prior authorization is required for:

- Electric breast pump:
  - All DME providers are required to obtain the Electric Breast Pump Request Form signed by the patient at the point of sale: **https://www.lamedicaid.com/provweb1/Forms/Electric_Breast_Pump_Request_Form_and_Instructions.pdf**

For DME code-specific prior authorization requirements, visit our provider self-service website at **https://provider.healthybluela.com.** Select **Prior Authorization & Claims** and then choose **Prior Authorization Lookup Tool**. Enter codes to determine authorization requirement.

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

We must agree on the Healthcare Common Procedure Coding System (HCPCS) and other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).

Our policy for rent-to-purchase on most items is limited to 10 continuous/consecutive months. For additional questions regarding rent-to-purchase items, please contact **844-521-6942**.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit

- Members may self-refer for EPSDT visits.
- Use the EPSDT schedule and document visits.

Note: Vaccine serum is received under the Vaccines for Children (VFC) program. For questions about the VFC program, call **504-568-2600**.

Educational consultation

No prior authorization is required.

Elective termination of pregnancy

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

- A woman suffers from a physical disorder, physical injury or physical illness — including a life-endangering physical condition caused by or arising from the pregnancy itself — that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of an act of rape or incest.

Emergency room

No prior authorization is required. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the ER.

Ear, nose and throat (ENT) services (otolaryngology)

- No prior authorization is required for a network provider for E&M, testing, and certain procedures.
- Prior authorization is required for:
  - Nasal or sinus surgery.
  - Cochlear implant surgery and services.

Family planning and sexually transmitted infection care

Members may self-refer to any in-network or out-of-network provider. Encourage patients to receive family planning services in-network to ensure continuity of service.

Gastroenterology services

No prior authorization is required for a network provider for E&M, testing, and certain procedures.

Precertification is required for:

- Bariatric surgery.
- Insertion, removal or replacement of adjustable gastric-restrictive devices and subcutaneous port components.
- Upper endoscopy.

Gynecology

No prior authorization is required for a network provider for E&M, testing, and certain procedures.

Hearing aids

Prior authorization is required for digital hearing aids.

Hearing screening

No prior authorization is required for:

- Diagnostic and screening tests.
- Hearing aid evaluations.
- Counseling.

Home health care and home IV infusion

Prior authorization is required for:

- Skilled nursing.
- Private duty nursing.
- Extended home health services.
- IV infusion services.
- Home health aide. physical, occupational and speech therapy services.
- Physician-ordered supplies.

Prior authorization is required for (cont.)

- IV medications for in-home therapy.

Notes:

- Drugs and DME require separate precertification.

Hospice care

A recipient must be terminally ill to receive hospice care. An individual is considered terminally ill if he or she has a physician-certified medical prognosis that the individual's life expectancy is six months or less if the illness runs its normal course.

Prior authorization is required.

Hospital admission

- Prior authorization is required for elective and non-emergent admissions and some same-day or ambulatory surgeries.
- Notification is required within 24 hours or the next business day if a member is admitted into the hospital through the ER. This includes normal vaginal and cesarean deliveries.
  Pre-admission testing must be performed by a Healthy Blue preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing.
- Notification of inpatient emergency admissions is requested within one business day of admission. Failure of admission notification after one business day may result in claim denial.
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.) are not covered.

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital.
- By telephone or fax.

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

The clinical submission deadline for Healthy Blue is 3 p.m. Central time. We will implement a 10-minute grace period to alleviate time discrepancies on fax machines. A fax confirmation for the transmittal of documentation prior to a specified time will be accepted by the plan as meeting the deadline.

Hospital admission (cont.)

If the clinical information is not submitted within the required time frame, the case will be administratively denied — reason: lack of timely submission of clinical information. The receipt of an administrative denial is based on the timely notification and submission of clinical information and is not based on medical necessity.

Administrative denials are not subject to our informal reconsideration or peer-to-peer process.

We will communicate to hospitals all approved days, denied days and bed-level coverage for any continued stay.

Your utilization management resources: Hospital prior authorization/admission notification: Prior authorization request and notification of intent to render covered medical services

- Fax: **877-269-5705**
- Call: **844-521-6942**
- Web: **https://provider.healthybluela.com**

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

- Fax: **888-822-5595**
- Call: **844-521-6942**

Hyperbaric oxygen and supervision of hyperbaric oxygen therapy

Prior authorization is required for the following:

- G0277 — Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval
- 99183 — Physician attendance and supervision of hyperbaric oxygen therapy, per session

To request PA, you may use one of the following methods:

- Web: **https://www.availity.com***
- Fax:
  - **888-822-5595** (inpatient)
  - **888-822-5658** (outpatient)
- Phone: **844-521-6942**

Laboratory services (outpatient)

Prior authorization is required for:

- Genetic testing.
- All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition.

Quest Diagnostics* and LabCorp* are the preferred lab providers for all Healthy Blue members. Contact Quest Diagnostics or LabCorp at the numbers below to receive a Quest or LabCorp specimen drop box.

- For more information about testing solutions and services or to set up an account, contact:
  - Quest Diagnostics: **866-MY-QUEST (866-697-8378)**
  - LabCorp: **800-345-4363**

Medical injectables

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

Some medical injectables require prior authorization when covered under the medical benefit and administered in the physician's office. Some specialty drugs under the pharmacy benefit may also require prior authorization per the **Louisiana Medicaid *Preferred Drug List***.

Musculoskeletal

Request prior authorization by submitting complete clinical information as follows:

- AIM Specialty Health
  - Phone: **833-342-1254**
  - Web: **www.aimspecialtyhealth.com/goweb**

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

Neurology

- No prior authorization is required for a network provider for E&M, testing, and certain other procedures.
- Prior authorization is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

Non-emergency medical transportation (NEMT)/ Non-emergency ambulance transportation (NEAT)

No prior authorization is required.

For nonemergency transportation, members can call MediTrans* at **866-430-1101** to set up a ride. There is also a dedicated Provider call-in line: **844-349-4324**.

Observation

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

Obstetrical (OB) care

No prior authorization is required for:

- OB services and diagnostic testing.
- OB visits.
- Certain diagnostic tests and lab services by a participating provider.
- Prenatal ultrasounds (clinical guideline for medical necessity applies).

Normal vaginal and cesarean deliveries. Notification requirements are as follows:

- Notify Provider Services of the first prenatal visit.
- For obstetric care, we require notification; we do not require prior authorization.
- All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries.

Baby delivery

- Healthy Blue will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal cesarean delivery. The hospital is required to notify Healthy Blue of the discharge date of the mother. Please fax maternal discharge notifications to **888-822-5595** within one business day of discharge.
- For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for a cesarean delivery, the hospital is required to provide:
  - Notification to our Provider Services team by phone at **844-521-6942** or fax at **877-269-5705**.
  - Initial hospital medical records and subsequent medical justification directly to the local health plan by fax at **888-822-5595**.
- The health plan is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an OB admission exceeding 48 hours after a vaginal delivery and 96 hours after a cesarean section. In these cases, the health plan is allowed to deny only the portion of the claim related to the inpatient stay.
- If a member is admitted for an induction of labor and fails to deliver by day two of the admission, the hospital is required to submit inpatient medical records via fax for the first two days of admission for medical necessity review.

Birth notification

- Hospitals are required to report the births of newborns within 24 hours of birth for enrolled members using Louisiana Department of Health's web-based Facility Notification System.
- Within 24 hours of the birth (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax newborn delivery notification to **877-269-5705**.
- The clinical information required is outlined as follows:
  - Whether it is a live birth
  - Newborn's birth weight
  - Gestational age at birth
  - Apgar scores
  - Disposition at birth
  - Type of delivery (vaginal or Cesarean[1])
  - Date of birth
  - Gender
  - Single or multiple birth
  - Gravida, para, abortus for mother
  - Estimated date of confinement (EDC) and if neonatal intensive care unit (NICU) admission was required
- You may use the standard reporting form specific to your hospital as long as the required information outlined above is included.
- Providers are required to register all births through LEERS (Louisiana Electronic Event Registration System), which is administered by LDH/Vital Records Registry. LEERS information and training materials are available at **http://new.dhh.louisiana.gov/index.cfm/page/669.**
- If a newborn requires admission to the NICU, the hospital must provide notification to our Provider Services team and send initial inpatient medical records directly to the local health plan by fax at **888-822-5595**.
- Well babies are covered under the mother's hospitalization authorization. If a newborn requires hospitalization as a boarder baby beyond the mother's discharge date, the hospital must provide notification as directed for NICU admissions.
- OB case management programs are available for all women with high-risk pregnancies.

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

Ophthalmology:

- No prior authorization is required for a network provider for E&M, testing, and certain other procedures.
- Prior authorization is required for repair of eyelid defects.
- We do not cover services that are considered cosmetic.

Oral maxillofacial

See Plastic, cosmetic or reconstructive surgery.

Out-of-area or out-of-network care

Prior authorization is required for all out-of-network services except for emergency care, EPSDT screening, family planning and OB care.

Outpatient or ambulatory surgery

Prior authorization is required based on the procedure performed; visit our provider website for more details.

Pain management, physiatric medicine, physical medicine and rehabilitation

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

Pediatric day health care

Prior authorization is required for the following services and codes:

- T1025
- T1026
- T2002

Personal care services

- Provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing and personal hygiene. Does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters.
- Covered for members aged 0 to 20 and excluded for members ages 21 and older.
- Requires prior authorization.

Pharmacy services

- The pharmacy benefit covers medically necessary prescription and over-the-counter drugs prescribed by a licensed provider. Please refer to the Louisiana Department of Health (LDH) *Preferred Drug List* (*PDL*) for the preferred products within therapeutic categories, as well as requirements for prior authorization, prior use therapy, quantity edits and age edits. Note that some medications require a diagnosis code to be submitted on the prescription.
- Requests for nonformulary or nonpreferred drugs will require prior authorization by calling the Healthy Blue pharmacy department at **844-521-6942** or by faxing a request to **844-864-7865**.
- Pharmacy providers who need to check pharmacy eligibility can call Provider Services at **844-521-6942**.
- Members can call Member Services at **844-521-6941**.
- A link to the LDH *PDL* and PA criteria are available on our provider self-service website.

Plastic, cosmetic or reconstructive surgery (including oral maxillofacial services)

- No prior authorization is required for E&M services, including oral maxillofacial E&M services.
- Prior authorization is required for:
  - All other services.
  - Trauma to the teeth.
  - Oral maxillofacial medical and surgical conditions.
  - Temporomandibular joint and muscle disorders.
- We do not cover services considered cosmetic in nature or related to previous cosmetic procedures.
- Reduction mammoplasty requires our medical director's review.

Podiatry

No prior authorization is required for E&M, testing, and most procedures.

Radiology

See Diagnostic Testing.

Rehabilitation therapy (short-term): speech, physical and occupational therapy

Request prior authorization by submitting complete clinical information as follows:

- AIM Specialty Health
  - Phone: **800-714-0040**
  - Website: **www.aimspecialtyhealth.com/goweb**

Requests submitted with incomplete clinical information may result in a denial. Initial outpatient therapy evaluations and re-evaluations do not require precertification. Appropriate therapy evaluations must be completed and submitted with precertification requests.

Musculoskeletal

Request prior authorization by submitting complete clinical information as follows:

- AIM Specialty Health:
  - Phone: **800-714-0040**
  - Website: **www.aimspecialtyhealth.com**

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

Skilled nursing facility

Prior authorization is required.

Sterilization

- No prior authorization is required for sterilization, tubal ligation or vasectomy.
- We require a sterilization consent form for claims submissions. We do not cover reversal of sterilization.

Telemedicine

Healthy Blue offers telemedicine through LiveHealth Online (LHO)* for our members. LHO is a mobile app and website (**https://startlivehealthonline.com**) that provides members with a convenient way to have live video visits with board-certified doctors, psychologists or psychiatrists. This service is available through mobile devices or computers from anywhere for nonemergency health conditions.

Additionally, our behavioral health members may obtain telemedicine mental health services through One TeleMed,* a telemedicine company that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers.

To make a referral to One TeleMed for a member, call **337-565-0843** and select **option 2**. Healthy Blue case management can also assist with care coordination for a member and can be reached at **877-440-4065, ext. 106-103-5145**.

Urgent care center

No prior authorization is required for a participating facility.

Well-woman exam

No precertification is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network gynecologist. The visit includes:

- Examination.
- Routine lab work.
- Sexually transmitted infections screening.
- Mammograms for members 35 and older.
- Pap smears (One routine Pap test is allowed every three years per American College of Obstetrics and Gynecology [ACOG] guidelines).

Members can receive family planning services from any qualified provider without precertification. Encourage patients to receive family planning services from an in-network provider to ensure continuity of service.

Revenue (RV) codes

Prior authorization is required for services billed by facilities with RV codes for:

- Inpatient.
- OB.
- Home health care.
- Hospice.
- CT and PET scans and nuclear cardiology.
- Chemotherapeutic agents.
- Pain management.
- Rehabilitation (physical/occupational/respiratory therapy).
- Rehabilitation, short-term (e.g., speech therapy).
- Specialty pharmacy agents.

Refer to our provider self-service website for code-specific precertification requirements and a complete list of specific RV codes.

Our service partners

LabCorp (lab services and diagnostic testing)	**800-345-4363**
Quest Diagnostics (lab services and diagnostic testing)	**866-MY-QUEST (866-697-8378)**
MediTrans (nonemergency medical transportation (NEMT)/nonemergency ambulance transportation (NEAT)	Member service line: **866-430-1101** Provider service line: **844-349-4324**
Superior Vision* (vision services)	**866-819-4298**
Adult Dental Services (21 and older) — DentaQuest	**800-508-6785**
Children's Dental Benefit Program Manager (under age 21)	Members under age 21 may receive dental services through MCNA Dental: **855-702-6262** DentaQuest: **800-685-0143**
AIM Specialty Health • Diagnostic or imaging services • Muskuloskeletal (Spine therapy) • Radiation oncology • Cardiology services • Sleep medicine	**833-342-1254**

Provider experience program

Our Provider Services team offers prior authorization, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call **844-521-6942**, Monday through Friday from 7 a.m. to 7 p.m. Central time.

Local Provider Relations

We also offer local Provider Relations representatives who will help your office with ongoing education, contract and fee issues, procedural issues, and more. Your office has a designated representative. If you have any questions, please call **504-836-8888** or email LAinterPR@HealthyBlueLA.com.

Provider website and interactive voice response available 24/7. To verify eligibility, check claims and referral authorization status, and look up prior authorization/notification requirements, visit our provider self-service website.

Can't access the internet? Call Provider Services and simply say your national provider ID when prompted by the recorded voice. The recording guides you through our menu of options; just select the information or materials you need when you hear it.

Claims services

Timely filing is within 365 calendar days from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility.

Because of the importance of EPSDT screenings and the collection of data related to these services, we encourage you to submit EPSDT claims as soon as possible within the timely filing period. For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date the third-party documents the resolution of the claim. In situations of enrollment in Healthy Blue with a retroactive eligibility date, the time frame for filing a claim will begin on the date we receive notification from the enrollment broker of the member's eligibility/enrollment.

Electronic data interchange (EDI)

Call our EDI hotline at **800-470-9630** to get started. If you use a different clearinghouse, contact your clearinghouse for instruction.

Paper claims

Submit claims on original claim forms (*CMS-1500* or *CMS-1450*) printed with dropout red ink or typed (not handwritten) in large, dark font. AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail to:
Healthy Blue
Claims Department
P.O. Box 61010
Virginia Beach, VA 23466-1010

Payment disputes

Claims payment disputes must be filed within 180 days of the adjudication date on your explanations of payment. Forms for provider appeals are available on our provider self-service website.

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

Changes or errors on claims, responses to itemized bill requests and submission of coordination of benefits/third-party liability information are not considered payment disputes. These should be resubmitted with a notation of corrected claim or claim correspondence to:

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

Peer-to-peer discussion

If our medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or servicing physician, and the member.

As a provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Health Care Management department at **877-440-4065, ext. 106-103-5145**.

Peer-to-peer (P2P) discussion guidelines:

- The member, or provider/agent on behalf of a member, may request a P2P within 10 business days from the notification of a medical necessity denial.
- A provider, acting on behalf of a member, must submit the member's written consent in order to be eligible to participate in a P2P discussion concerning a prospective service (proposed admission, procedure, or service not yet rendered).
- Consent of the member who received a service is not required for a provider to act regarding a concurrent or post-service denial.
- Requests for P2Ps will be handled within one working day of the request.
- If the P2P discussion is not completed within the specified time frame, the formal appeal process will need to be followed.
- We will not complete P2P discussions on retrospective-eligible, post-discharge hospitalizations. For retrospective-eligible, post-discharge adverse determinations, follow the formal appeal process.

The medical director will make two attempts to connect with you at your specified contact number. If you fail to contact the health plan medical director, the request for a P2P will be closed, and your next course of action will be to follow the formal medical necessity appeal process.

Medical appeals

Medical appeals, or medical administrative reviews, can be initiated by members or providers on behalf of the member with the member's written consent and must be submitted within 60 calendar days from the date of the notice of proposed action.

A provider submitting on behalf of a member can write a letter, call, fax or use the provider appeals form on our provider self-service website. Submit in writing to:
Healthy Blue
Central Appeals and Grievance Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

Call Provider Services: **844-521-6942**
Fax to Appeals department: **888-873-7038**

Health services

Case Management (CM) services:
844-521-6942

We offer care management services to members who are likely to have extensive health care needs. Our nurse case managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Disease Management (DM) services:
888-830-4300

DM services include educational information like local community support agencies and events in your local area. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, major depressive disorder, schizophrenia and substance use disorder.

Health services (cont.)

Quality Management (QM) program:
844-521-6942

We have a comprehensive QM program to monitor the demographic and epidemiological needs of the populations we serve. We evaluate the needs of our Louisiana member populations annually, includingage/sex distribution and inpatient,emergent/urgent care and office visits by type, cost and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

You have opportunities to make recommendations for areas of improvement. To contact the QM department about quality concerns or to make recommendations, please call **844-521-6942**.

24/7 NurseLine:
866-864-2544 (Spanish: **866-864-2545**)

24/7 NurseLine is a telephonic, 24-hour triage service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed whether after-hours or on weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.
- Obtain a virtual physician visit directly with a Louisiana-licensed online physician through LiveHealth Online at **www.livehealthonline.com**.

We encourage you to tell your Healthy Blue patients about this service and share with them the advantages of avoiding the ER when a trip there isn't necessary or the best alternative. Members can call our 24/7 NurseLine for health advice 24 hours a day, 7 days a week, 365 days a year.

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

Member services:
844-521-6941

Behavioral Health services:
844-227-8350

Pharmacy services:
844-521-6942

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue. LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Healthy Blue. Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue. One TeleMed is an independent company providing telehealth services on behalf of Healthy Blue. LabCorp and Quest Diagnostics are independent companies providing lab services on behalf of Healthy Blue. MediTrans is an independent company providing transportation services on behalf of Healthy Blue. Superior Vision is an independent company providing routine and medical optometry services on behalf of Healthy Blue.

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