



# Provider quick reference guide

## Healthy Louisiana and LaCHIP

### Provider Services

For general provider inquiries:

Phone: **844-521-6942**

Fax: **800-964-3627**

For Behavioral Health Crisis Hub  
Need Immediate Help?

If you or someone you know is in need of help,  
please reach out to the Louisiana Crisis Hub.

Call for Help: **855-24CARE5 (855-242-2735)**



# Healthy Blue

<https://provider.healthybluelouisiana.com>

# Prior authorization and notification coverage guidelines

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



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

## Prior authorization/notification instructions and definitions

### Prior authorizations — physical health:

- Use our preferred method online at <https://provider.healthybluela.com>.
- 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**

Carelon Medical Benefits Management, Inc. phone: **833-342-1254** (services managed by Carelon Medical Benefits Management are detailed below).

### Prior authorizations — pharmacy through CarelonRx, Inc.:

- Use our preferred method online at <https://provider.healthybluela.com>
- Phone: **800-424-1664**
- Fax: **800-424-7402**

**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 use 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
- 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

### Behavioral health/substance use services (cont.)

- 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.
- Prior authorization 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.
- Carelon Medical Benefits Management 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
- Carelon Medical Benefits Management Clinical Appropriateness Guidelines and our *Medical Policies* will be used. Carelon Medical Benefits Management guidelines are available online at [guidelines.carelonmedicalbenefitsmanagement.com](#)
- Contact Carelon Medical Benefits Management by phone at **833-342-1254**.

## Durable medical equipment (DME)

No prior authorization is required for:

- Electric breast pump:

## DME (cont.)

- All DME providers are required to obtain the *Electric Breast Pump Request Form* signed by the patient at the point of sale: <https://tinyurl.com/uudap7jr>

For DME code-specific prior authorization requirements, visit our provider self-service website at <https://provider.healthybluelua.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.healthybluelua.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. If you have questions about the VFC program, please 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. If a member is admitted into the hospital through the ER, we must be notified within 24 hours or the next business day.

## 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. To ensure continuity of service, encourage patients to receive family planning services in-network.

## 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

Hearing aids are covered for members under 21 years of age.

## Hearing screening

No prior authorization is required for:

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

## Home healthcare and home IV infusion

Prior authorization is required for:

- Skilled nursing.
- Extended home health services.

## Home healthcare and home IV infusion (cont.)

- IV infusion services.
- Home health aide.
- Physical, occupational, and speech therapy services.
- Physician-ordered supplies.
- IV medications for in-home therapy.

Note: Drugs and DME require separate precertification.

## Hospice care

A recipient must be terminally ill to receive hospice care. An individual is considered terminally ill if they have 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 not required. Providers should bill with appropriate Revenue Codes. Authorization is required for Service Intensity Add-On (SIA).

## Hospital admission

- Prior authorization is required for elective and non-emergent admissions and some same-day or ambulatory surgeries.
- Notification is required by 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 one of our preferred lab vendors or network facility outpatient department. Please see our provider directory for a complete listing.
- Notification of a NICU/boarder baby admission is required within 48 hours of a vaginal delivery and within 96 hours of caesarean section.
- 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) are not covered.

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record by telephone, fax, or Electronic Medical Record (EMR).

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.

### Hospital admission (cont.)

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.

If the clinical information is not submitted within the required time frame, the case will be administratively denied. 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.healthybluel.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://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 of our 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

Some medical injectables require prior authorization when covered under the medical benefit and administered in an outpatient clinical setting.

- Use our preferred method online at **<https://provider.healthybluel.com>**
- Phone: **844-521-6942**
- Fax: **844-487-9291**

### Musculoskeletal

Request prior authorization by submitting complete clinical information to:

- Carelon Medical Benefits Management:
  - Phone: **833-342-1254**
  - Web: **[providerportal.com](http://providerportal.com)**

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 by 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

- We will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal Cesarean delivery. The hospital is required to notify us of the 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**.

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

- If a newborn requires admission to the NICU, the hospital must provide notification within 48 hours of a vaginal delivery and within 96 hours of caesarean section. Notification should be made to our Provider Services team. Initial inpatient medical records may be sent 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.
- 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 the Louisiana Department of Health's web-based Facility Notification System.
- The hospital is required to submit clinical birth information to the health plan within 24 hours of the birth (or within one business day of delivery). 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\*)
  - Date of birth
  - Gender
  - Single or multiple births
  - Gravida, para, abortus for mother
  - Estimated date of confinement (EDC) and if neonatal intensive care unit (NICU) admission was required

### OB care (cont.)

- 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>.
- OB case management programs are available for all women with high-risk pregnancies.

\* 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, psychiatric medicine, physical medicine and rehabilitation

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

### Pediatric day healthcare

Prior authorization is required for the following services and codes:

- T1025
- T1026
- T2002

### Personal care services

Personal care services BH: Personal care services (PCS) support individuals with mental illness in performing routine tasks independently at home. These services include minimal assistance, supervision, or prompting for activities like eating, bathing, grooming, dressing, transferring, ambulation, and toileting. Medicaid-eligible members, ages 21 and older, may qualify for PCS if they meet medical necessity criteria and have been recommended by a licensed mental health professional or physician. Eligible members must have transitioned from or avoided nursing facility care through the My Choice Louisiana program, be medically stable, and not be enrolled in any Medicaid program offering similar services. These services must also align with the scope and limitations of PCS. Requires prior authorization.

- 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.
- Requires prior authorization.

### Pharmacy services

CarelonRx provides the pharmacy benefit for our members. For questions, call **844-521-6942**. Our provider self-service website has a link to the Louisiana Department of Health (LDH) Preferred Drug List (PDL) and PA criteria.

### 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:

- Fax requests to us at **888-822-5658**.

Requests submitted with incomplete clinical information may result in a denial. Initial outpatient therapy evaluations and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be completed and submitted with prior authorization requests. Services must be prescribed by a physician, nurse practitioner, or physician assistant.

### Specialty Pharmacy

Most specialty drugs are covered 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.

### 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

We offer telemedicine through LiveHealth Online (LHO) for our members. LHO is a mobile app and website ([startlivehealthonline.com](http://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 uses information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. To make a referral to One TeleMed for a member, call **337-565-0843** and select **option 2**. Our 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 healthcare.
- Hospice.
- CT and PET scans and nuclear cardiology.
- Chemotherapeutic agents.
- Pain management.
- Rehabilitation (physical/occupational/respiratory therapy).
- Rehabilitation, short-term (for example speech therapy).
- Specialty pharmacy agents.

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

### Our service partners

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

### 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 Health Care Networks

We also offer local provider relationship management representatives who will help your office with ongoing education, contract and fee issues, procedural issues, and more. Your office has a designated representative:

- New Orleans and Metairie: **504-834-1271**
- Baton Rouge: **225-819-4893**
- Monroe: **318-795-2130**

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 verbally attest to having 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 occur within one business day of the request. Healthy Blue works with the requestor to accommodate and schedule the P2P.
- 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 P2P will be conducted between the provider rendering the service and Healthy Blue's physician.

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

### Medical appeals

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

A provider submitting on behalf of a member can write a letter, call, fax or use the provider appeals form on our provider self-service website. Submit in writing to:

Central Appeals and Grievance Processing  
Healthy Blue  
P.O. Box 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 healthcare 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.

#### Condition Care (formerly disease management) services:

**888-830-4300**

Condition Care services include educational information and offering resources on local community support agencies. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, adult major depressive disorder, child and adolescent major depressive disorder, schizophrenia, and substance use disorder. Condition Care also offers Concierge Care digital programs for CHF, T2D, and BH (depression and anxiety).

## 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, including age/sex distribution and inpatient, emergent/urgent care and office visits by type, cost and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

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



### 24/7 NurseLine:

**866-864-2544** (Spanish: **866-864-2545**)

24/7 NurseLine is a telephonic, 24-hour triage service your 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 **livehealthonline.com**.

We encourage you to tell your 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:

**800-424-1664**

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross Blue Shield Association.

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