Dual Advantage

Healthy Blue

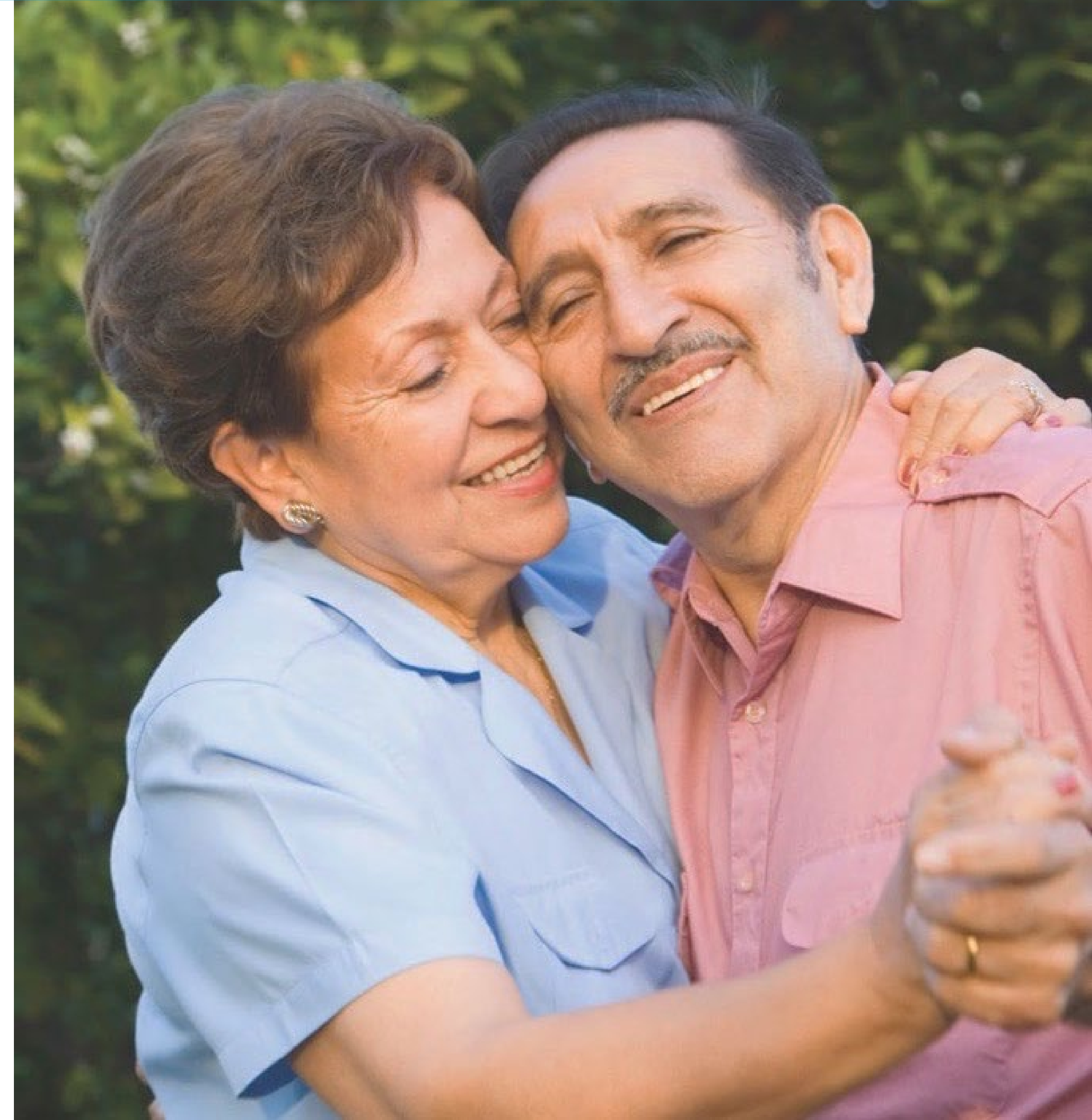
New provider orientation

Purpose, vision, and values

Our mission
Improving lives and communities. Simplifying healthcare. Expecting more.

Our vision
To be the most innovative, valuable, and inclusive partner

Our values:
- Leadership
- Community
- Integrity
- Agility
- Diversity



About Healthy Blue

- Began serving members in 2012
- Employs over 200 associates
- Has two locations: Baton Rouge and Monroe
- Serves over 330,000 members
- Contains over 22,000 care providers and over 200 hospitals in the provider network
- Processes claims quickly — less than five days
- Pays claims twice a week
- Provides innovative provider quality incentive programs

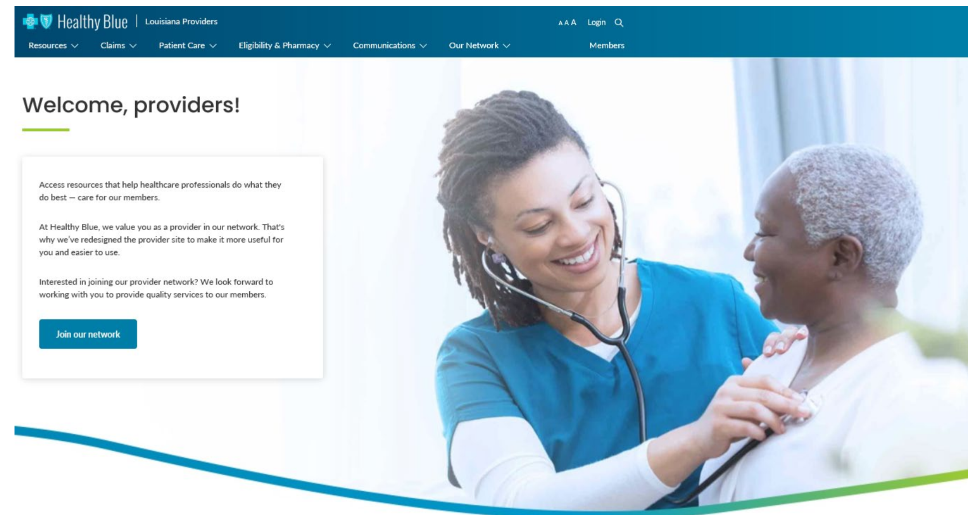
Agenda topics

- Provider website/registration
- Ongoing credentialing
- Cultural competency
- Fraud, waste, and abuse
- Translation services
- Member rights and responsibilities
- Authorization to release and/or obtain health information
- Member enrollment
- Availability standards
- Member eligibility
- Patient360
- Member value-added benefits
- Physical health (PH) and behavioral health (BH) integration
- Preapproval guidelines
- Healthy Blue Dual Advantage (HMO D-SNP)
- Integrated Practice Assessment Tool (IPAT)
- HEDIS® measures
- Nonemergency transportation services
- Laboratory and radiology services
- Pharmacy program
- Claim submission
- Grievances and appeals
- Provider Relationship Management representatives

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

Healthy Blue provider website

- The provider website, https://provider.healthybluela.com, is available to all care providers, regardless of participation status.
- The tools on the site allow you to perform key transactions.



Availity Essentials

Availity Essentials (https://availity.com), is an online multi-payer platform that gives physicians, hospitals, and other healthcare professionals access to multiple payer information with a single, secure login.

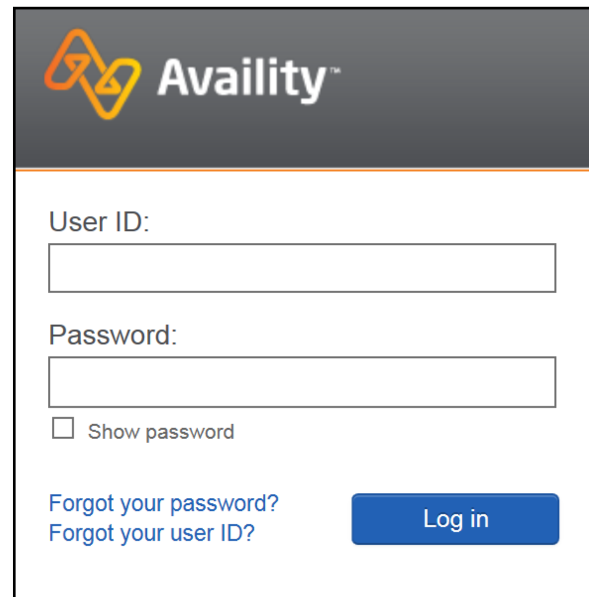
Availity services include:

- Eligibility and benefit inquiries.
- Claim submissions and status inquiries.
- A direct link to the Healthy Blue provider website for appeals, panel listings, and preapproval.

Detailed training on Availity is available.

Availity Essentials (cont.)

If you're navigating to the secure Healthy Blue provider website from https://availity.com, enter your Availity ID and password, then select **Log in**.



Ongoing credentialing

- Notify us immediately of any changes in licensure, demographics, or participation status by calling **504-836-8888** or emailing LAinterpr@healthybluela.com. This includes physician additions and deletions to your practice locations.
- Recredentialing occurs every three years or sooner, if required by state law.
- For contracting needs, email LANetworkDevelopment@healthybluela.com.

Cultural competency

- We expect care providers and staff to gain and continually increase their knowledge and sensitivity to diverse cultures.
- We believe that when care providers account for a patient’s values, reality conditions, and linguistic needs, it results in effective care and services.
- You can complete cultural competency training online through the provider website at https://provider.healthybluela.com > Resources > Training Academy Cultural competency resources > Cultural Competency Training.

Evidence-based, promising, and emerging best practices

Healthy Blue strongly encourages interventions that have shown consistent scientific evidence of producing preferred client outcomes.

Find evidence-based practices on the following websites:

- Substance use disorders:
  - National Institute on Drug Abuse: drugabuse.gov
  - National Institute on Alcohol Abuse and Alcoholism: niaaa.nih.gov
- Mental health and co-occurring disorders:
  - Substance Abuse and Mental Health Services Administration: samhsa.gov
  - National Institute of Mental Health: nimh.nih.gov

Fraud, waste, and abuse

Help us prevent fraud, waste, and abuse. And tell us if you suspect fraud!

- Steps you can take:
  - Verify each patient's identity.
  - Ensure services are medically necessary.
  - Document medical records completely.
  - Bill accurately.
- You can report your concerns by:
  - Visiting https://fighthealthcarefraud.com/report-fraud-form.
  - Calling Provider Services at **844-895-8160**.
  - Calling our Medicaid Fraud Hotline at **800-633-4227**.

Translation services

- Translation services are available 24/7 in over 170 languages.
- To obtain translation services, call Member Services at **844-521-6941**.

Member rights

Members have the right to:

- Receive information about the organization, its services, its practitioners and care providers, and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Participate with practitioners in making decisions about their health care.
- Candidly discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization’s member rights and responsibilities policy.

Member responsibility

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and care providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their care providers.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals (to the degree possible).

Member involvement in trainings

- Members and family members will be involved in the development and delivery of trainings through our member advisory council.
- This council promotes a collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allowing participation in providing feedback on policies and programs.

Authorization to release or obtain health information

https://provider.healthybluela.com > Resources > Forms > Other Forms > *Authorization to Release or Obtain Health Information*

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: ______

Mailing Address: ______

City, State, Zip Code: ______

Relationship: ______ Telephone Number: ______

☐ **RELEASE Information TO** or ☐ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: ______

Mailing Address: ______

City, State, Zip Code: ______

Relationship: ______ Telephone Number: ______

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action

☐ Changing Physicians ☐ Research related treatment

☐ Creating health information for disclosure to a third party.

☐ Other: (Specify) ______

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests

☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports

☐ X-ray Reports ☐ MR/DD Records ☐ Other: ______

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes

☐ Other ______

This authorization shall expire on ______ (date or event) and is needed for the period beginning ______ and ending ______.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

______ ______

Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	Title	Date
Telephone	**Fax**	**Email**

Availability standards

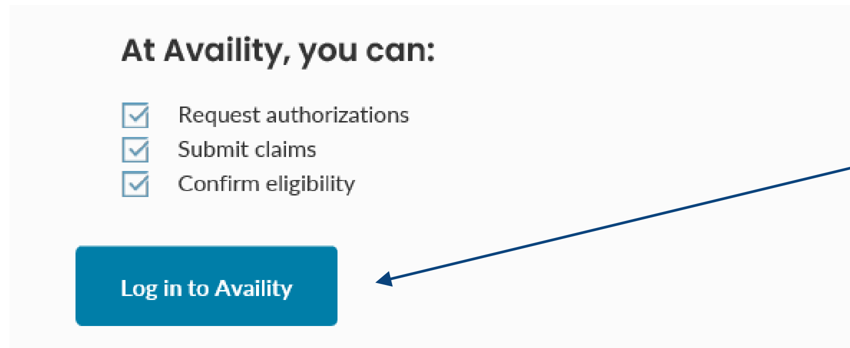
Our members must have access to primary care services for routine, urgent, and emergency services, as well as specialty services for complex or chronic care.

Appointment availability standards

Appointment type	Appointment standard
Emergency visits	Immediately
Urgent visits	Within 24 hours
Nonurgent sick visits	Within 72 hours
Medically necessary specialist visits	Same day (within 24 hours of referral)
Routine specialist visits	Within one month of referral
Lab referrals or X-rays — urgent care	Within 48 hours or as clinically indicated
Lab referrals or X-rays — regular	Not to exceed three weeks
Initial prenatal visit	For first trimester: 14 days For second trimester: seven days For third trimester: three days High risk: within three days or sooner if needed

Verifying eligibility

- To verify eligibility, log in at availity.com.



Patient360

Patient360 provides:

- Demographics.
- Care summaries details.
- Claims details.
- Authorization details.

To use Patient360:

Log in to Availity

Finding Patient360 on Availity:

1. From the Availity home page, select **Payer Spaces** from the top navigation.
2. Select the health plan.
3. From the Payer Spaces homepage, select the **Applications** tab.
4. Select the **Patient360** tile.

Member value-added benefits

- Adult dental care
- Adult vision care
- Healthy Rewards incentives
- Programs and incentives for pregnant women and new moms
- Healthy lifestyle and weight management programs
- Community outreach and support
- Online resources

Not all value-added benefits (VAB) apply to behavioral health (BH) only members. If the VAB is tied to a medical service that is not covered under BH, BH-only members are not eligible for that benefit.

Physical and behavioral health integration

- Healthy Blue provides both basic and specialized behavioral health (BH) services to Healthy Blue members.
- Basic BH services are provided in the primary care setting by a PCP.
- Specialized BH services are provided by a licensed mental health provider, psychiatrist, psychologist, medical psychologist, or psychiatric nurse practitioner.

BH-only services

Healthy Blue also provides specialized BH services through Carelon Behavioral Health, Inc.* to:

- Individuals living in nursing homes.
- Dual-eligible members not living in institutions.
- Members receiving home and community-based waivers.

Preapproval and notification

The provider website, as well as the provider manual, lists services requiring preapproval and/or notification.

Prior authorization requirements

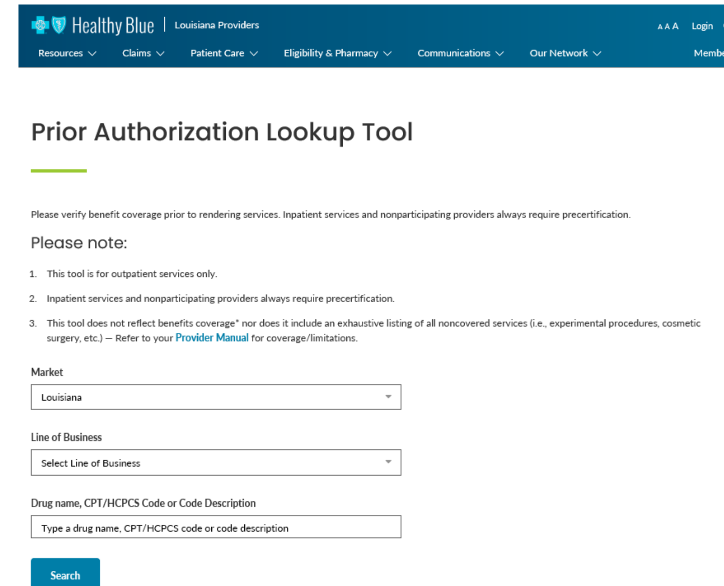
The preferred method to request or check the status of a prior authorization request or decision for a particular plan member is to access our Interactive Care Reviewer (ICR) tool via Availity. Once logged in, select **Patient Registration | Authorizations & Referrals**, then choose **Authorizations** or **Auth/Referral Inquiry** as appropriate.

Log in to Availity

Prior Authorization Lookup Tool

The Prior Authorization Lookup Tool on the provider website helps you search by market, member's product, and CPT® code.

Access the Prior Authorization Lookup Tool online.



Preapproval status

You can check the status of your preapproval request on the provider website or by contacting Provider Services Monday through Friday, from 7 a.m. to 7 p.m. Central time at **844-895-8160**.

Interactive care reviewer (ICR)

- Physicians and facilities who have a national provider identifier (NPI) can submit physical and behavioral health outpatient and inpatient prior authorization requests for Healthy Blue members via ICR, which is available on AvailityEssentials.
- Ordering and servicing physicians and facilities can use the inquiry feature to find information on any prior authorization affiliated with their tax or organizational ID.
- ICR is also available for preapproval requests previously submitted via phone, fax, ICR, or other online tools.
- ICR is available online 24/7.

BH preapproval requests

- Preapproval requests can be submitted through Availity (clinical information can be attached).
- While the preferred method of preapproval requests is submission through ICR via Availity, requests may also be submitted via fax and phone.
- Requests can be submitted by fax for different levels of care, such as:
  - Inpatient notification at **844-432-6027**.
  - Outpatient requests at **844-432-6028**.
- Requests can be completed on the phone with a care provider 24/7:*
  - Call **844-895-8160** and follow the BH prompting.
  - To determine if a code requires precertification, refer to the Prior Authorization Lookup Tool on the provider website.

** Only emergent/acute care requests are accepted via phone, not nonurgent/outpatient care requests.*

Precertification requests for all other service types

- Physical health precertification and inpatient notification can be done:
  - Online at https://provider.healthybluela.com (preferred method).
  - By phone at **844-895-8160**.
  - By fax at **877-269-5705**.
- Physical health concurrent inpatient clinical fax: **888-822-5595**
- Physical health outpatient fax: **888-822-5658**
- Outpatient DME fax: **844-528-3684**
- Find services managed Carelon Medical Benefits Management, Inc.*
  - Online at the ***Provider****Portal*SM https://providerportal.com.
  - By phone at **800-714-0040**.
- Carelon Medical Benefits Management manages precertification for the following modalities: computed tomography, magnetic resonance, positron emission tomography scans, nuclear cardiology (echocardiography, stress echo, resting transthoracic echo, transesophageal echo), radiation oncology, sleep medicine, and cardiology services.

Preapproval requests for all other service types (cont.)

- **Preapproval:** The act of authorizing specific services or activities before they are rendered or occur.
- **Notification:** Telephonic, fax, or electronic communication from care providers to inform Healthy Blue of their intent to render covered medical services to members.
- Care providers must provide notification prior to rendering services outlined in this document.
- For emergency or urgent services, notification is needed 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.
- For code-specific requirements for all services, visit our provider self-service website > Resources > Prior Authorization Requirements.
- The Prior Authorization Look Up Tool provides requirements for network care providers.
- In many cases, out-of-network care providers may be required to request precertification for services when network care providers do not.

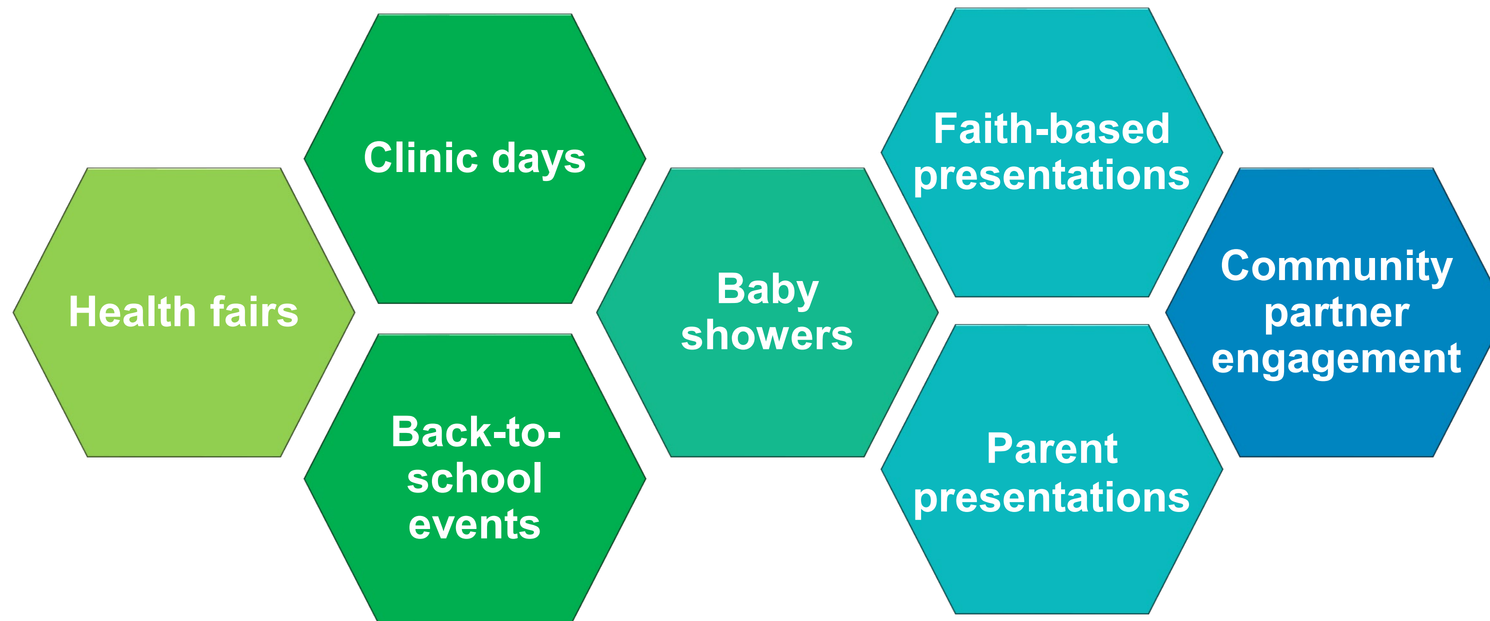
Screening of BH conditions and referral procedures

- Screening and identification of BH conditions begins in the PCP office.
- No referrals are required for basic BH services provided in a network PCP or medical office.
- No referrals are required for specialist visits including specialized BH consultations.
- For code-specific requirements for all services, you can access the Prior Authorization Look Up Tool on our provider self-service website.

Integrated Practice Assessment Tool

- Healthy Blue does annual assessments of practice integration using the publicly available Integrated Practice Assessment Tool (IPAT) on a statistically valid sampling of care providers.
- The types of care providers include (but are not limited to) BH care providers, PCPs, internists, family practitioners, pediatrics, OB/GYNs, and any other provider likely to interact with the BH population.
- For more information on IPAT, visit http://samhsa.gov and do a search for IPAT.

Collective strategies



HEDIS

What is HEDIS?

- It is a performance measurement tool coordinated and administered by the NCQA.
- It produces results used to measure performance, identify quality incentives, and aid with provider and member educational programs.

Your role in HEDIS includes:

- Promoting health to our members.
- Providing appropriate care to our members.
- Documenting all care in the patient's medical record.
- Responding to our requests for member records in a timely manner.
- Accurately coding all claims.

HEDIS (cont.)

When does record collection start and end?
Quality staff collects HEDIS data from medical records from February to May.

Data collection methods:
Fax, mail, on-site, and remote electronic medical record system access

Ways to improve scores for HEDIS measures:

- Use correct diagnosis and procedure codes.
- Submit claims in a timely manner.
- Ensure all components are included in medical record documentation.

HEDIS measures – P4P

1. ADHD Continuation
2. ADHD Initiation
3. Initial of Injectable Progesterone Therapy (17-P)
4. Ambulatory ED
5. Follow up After Hospitalization for Mental Illness Within 30 Days of Discharge
6. Well Child — 1st 15 months of life (H)
7. Well Child — 3 to 6 years of life (H)
8. Well Child — Adolescent (H)
9. Prenatal Care (H)
10. Postnatal Care (H)
11. Diabetes — Medical Attention for Nephropathy (H)
12. Diabetes — Eye Exam (H)
13. Diabetes — A1C Testing (H)
14. Controlling High Blood Pressure (H)
15. CAHPS Health Plan Rating — Adult
16. CAHPS Health Plan Rating — Child

* Hybrid measures denoted with H.

HEDIS measures – accreditation

1. Childhood Immunization — Combo 10
2. Immunizations for Adolescents — Combo 2
3. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
4. Breast Cancer Screening
5. Cervical Cancer Screening
6. Adult BMI
7. Chlamydia Screening in Women
8. Adult Flu Vaccinations
9. Asthma Medication Ration
10. Medication Management for People with Asthma
11. Diabetes — Blood Pressure Control
12. Diabetes — A1C Control
13. Statin Therapy for Patients with Diabetes — Received
14. Statin Therapy for Patients with Diabetes — Statin Adherence
15. Medical Assistance with Smoking and Tobacco Use Cessation
16. Antidepressant Medication Management — Continuation Phase

HEDIS measures – accreditation (cont.)

17. Follow up After Hospitalization for Mental Illness — 7 days
18. Follow Up After ER Visit for Mental Illness — 7 days
19. Follow Up After ER Visit for Alcohol and other Drug Abuse — 7 days
20. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence — Engagement
21. Diabetes Screening for Schizophrenia or Bipolar
22. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
23. Metabolic Monitoring for Children and Adolescents on Antipsychotics
24. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
25. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
26. Appropriate Testing for Pharyngitis
27. Use of Imaging Studies for Low Back Pain
28. Appropriate Treatment for Upper Respiratory Infection
29. Use of Opioids at High Dosage
30. Use of Opioids from Multiple care providers — Multiple Prescribers and Multiple Pharmacies
31. Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid
32. Pharmacotherapy Management of COPD Exacerbation — Bronchodilator

Performance Improvement Projects (PIP)

Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, and (3) Pharmacotherapy for Opioid Use Disorder

Rationale: Alcohol and drug misuse can lead to serious health, relationship, employment, and other social economic problems. Problematic alcohol or drug use can also lead to substance use disorders (SUD). Addiction services focused on helping individuals achieve recovery goals, addressing major lifestyle goals, and preventing reoccurrence/readmits to emergency facilities is essential to successful outcomes for improving rates of initiation and engagement of our SUD members.

Aim: Improve the rate of Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment and to improve the rates for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, as well as Pharmacotherapy for Opioid Use Disorder by implementing enhanced interventions to test the change concepts to achieve the following objectives:

PIP (cont.)

Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

Rationale: Hepatitis C (HCV) is a significant health problem in the U.S where millions of Americans are believed to be chronically infected. Louisiana has one of the highest rates of HCV in the country. Eradicating HCV in Louisiana and with our member population is critical to improve health inequities within our state.

Aim: Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives

PIP (cont.)

Improving Receipt of Global Developmental Screening in the First Three Years of Life

Rationale: *The American Academy of Pediatrics recommends developmental surveillance at most pediatric well-child visits, and formal developmental screening using a standardized screening tool at a minimum once during each of the 1st, 2nd, and 3rd years of life, to occur at pediatric well-child visits with appropriate follow-up for children with concerning screening results (Lipkin et al., 2020).*

Aim: Increase the percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second, or third birthday.

PIP (cont.)

Ensuring access to the COVID-19 vaccine among Healthy Louisiana vaccine-eligible enrollees: Persons 18 years of age or older (or 16 years and up for Pfizer vaccine only)

Rationale: The Advisory Committee on Immunization Practices (ACIP) issued interim recommendations on the use of available COVID-19 vaccines to prevent COVID-19 (Oliver et al., 2020b). The State of Louisiana COVID-19 Vaccination Playbook's rationale for prioritizing persons with these conditions is to protect the most vulnerable, and cites the current CDC guidelines (CDC, 2020). Effective Tuesday, March 9, 2021, the State of Louisiana expanded eligibility for COVID-19 vaccines to include people who have health conditions that may result in a higher risk of disease (https://ldh.la.gov/index.cfm/page/4137, 2021).

Aim: Ensure access to COVID-19 vaccination for Healthy Louisiana enrollees.

NEMT/NEAT

- Healthy Blue provides nonemergency medical transportation (NEMT)/nonemergency ambulance transportation (NEAT) services, including both ambulance and nonambulance, for members.
- NEMT/NEAT services are provided to and from all medically necessary services (including carved out services) for members who lack viable alternate means of transportation.

Laboratory services

Notification or precertification is not required if lab work is performed in a physician's office or participating hospital outpatient department (if applicable), or is done by one of our preferred lab vendors:

- LabCorp*
- Quest Diagnostics, Inc.*

Radiology services

- Computed tomography scans, echocardiograms, and magnetic resonance imaging are all approved through Carelon Medical Benefits Management:
  - Online: Online at the ***Provider****Portal*$_{SM}$ **https://providerportal.com**.
  - By phone at **800-714-0040**.
  - Note: Fax requests not accepted

Pharmacy program

The *Preferred Drug List* (*PDL*) and formulary are available on our website at https://provider.healthybluela.com.

A preapproval is required for:

- High-cost injectable and specialty drugs.
- Any other drugs identified on the *PDL* as needing prior authorization.

Pharmacy program (cont.)

- Requests for nonformulary or nonpreferred drugs will require preapproval from the Healthy Blue Pharmacy department:
  - Pharmacy prescription drug preapproval fax: **844-864-7865**.
  - Pharmacy medical injection preapproval fax: **844-487-9291**
- Pharmacy care providers who need to check pharmacy eligibility can call Provider Services at **844-895-8160**.
- Members can call Member Services at **844-521-6941**.
- CarelonRx, Inc. is a separate company that manages pharmacy services and benefits on behalf of health plan members.

Prescription Monitoring Program

- Network prescribers must use and conduct patient-specific queries in the Prescription Monitoring Program (PMP) for patients:
  - Upon first visit to that prescriber.
  - During subsequent visits on all BH patients as deemed necessary by the specific member’s medical history, diagnosis, and/or suspicious behavior.
- Additional PMP queries should be conducted at the prescriber’s discretion or at the request of Louisiana Department of Health (LDH).
- PMP is a Healthy Louisiana contractual requirement that is subject to chart review.

Submitting claims

Claims can be submitted:

- On the Healthy Blue provider website.
- Through an electronic data interchange (EDI) 837.
- Through a third-party clearinghouse.
- By mail.

EDI submissions:

- Healthy Blue can work with any vendor, clearinghouse, or claims billing service.
- Below is a list of payer IDs for frequently used clearinghouses:
  - Availity payer ID for Healthy Blue: 00661
  - Smart Data Solutions (SDS)* payer ID for Healthy Blue: 16730
  - Change Healthcare* payer ID for Healthy Blue: 58532

Additional questions about submitting claims through EDI can be answered by our E-Solutions team at **800-470-9630** or by contacting your clearinghouse directly.

Submitting claims (cont.)

Claims overview

Launch Availity | Prior Authorization | Claims & Disputes | Forms | Training Academy

Filing your claims should be simple. That's why Healthy Blue uses Availity, a secure and full-service web portal that offers a claims clearinghouse and real-time transactions at no charge to healthcare professionals. Use Availity to submit and check the status of all your claims and much more.

Log in to Availity

Find these tools on Availity:

Claims

To submit a claim:

1. From the Availity home page, choose **Claims & Payments** from the top navigation.
2. Select **Type of claim** from the drop-down menu.

Claims status inquiry

1. From the Availity home page, select **Claims & Payments** from the top navigation.
2. Select **Claim Status** from the drop-down menu.

Claims status inquiry and claim appeal

To check claims status or appeal a claim:

1. From the Availity home page, select **Claims & Payments** from the top navigation.
2. Select **Claim Status Inquiry** from the drop-down menu.
3. Submit an inquiry and review the *Claims Status Detail* page.
4. If the claim is denied or final, there will be an option to dispute the claim. Select **Dispute the Claim** to begin the process. You'll be redirected to the *Payer* site to complete the submission.

Clear Claims Connection

To use Clear Claims Connection:

1. From the Availity home page, select **Payer Spaces** from the top navigation.
2. Select the health plan.
3. From the *Payer Spaces* home page, select the **Applications** tab.
4. Select the **Clear Claims Connection** tile.

Electronic payment services

If you sign up for electronic remittance advice (ERA)/electronic funds transfer (EFT), you can:

- Start receiving ERAs and import the information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create your own custom reports within your office.
- Access reports 24/7.

Additional information:

- EDI hotline: **800-590-5745**
- Emdeon (by Change Healthcare) 27514, Capario (by Change Healthcare) 28804, Availity 2637

Clear Claim Connection™

The Clear Claim Connection tool is available on our website to help you determine if procedure codes and modifiers will likely pay for your patient's diagnosis.

Clear Claim Connection™

McKesson Edit Development Glossary About Help Logoff

Gender: Male Female

Date of Birth: / / (mm/dd/yyyy)

Click Grid to enter information:

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Date of Service
					/ /
					/ /
					/ /
					/ /
					/ /

Add More Procedures>>

Review Claim Audit Results Clear

Rejected versus denied claims

- Rejected claims do not enter the adjudication system due to missing/incorrect information.
- Denied claims go through the adjudication process but are denied for payment.

Routine claim inquiries

- Our provider experience program ensures care provider claim inquiries are handled efficiently and in a timely manner.
- Claim inquiry calls are handled by Provider Services by calling **844-895-8160**.

Grievances

- We track all care provider grievances until resolved.
- The provider manual details filing and escalation processes and contact information.

Payment disputes

Care providers can submit claim payment reconsiderations verbally, in writing, or electronically. We encourage care providers to submit claim reconsideration requests through Availity Essentials.

For you, this means an enhanced experience when:

- Filing a claim payment reconsideration.
- Sending supporting documentation.
- Checking the status of your claim payment reconsideration.
- Viewing your claim payment reconsideration history.

Payment disputes (cont.)

Availity functionality includes:

- Acknowledgement of submission at the time of submission.
- Email notification when a reconsideration has been finalized by Healthy Blue.
- A worklist of open submissions to check a reconsideration status.

Additionally, payment disputes may be submitted with a copy of the *Explanation of Payment*, supporting documentation, and a letter of explanation to:

Healthy Blue
Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

Medical appeals

- Separate and distinct appeal processes are in place for our members and care providers, depending on the services denied or terminated.
- Please refer to the denial letter issued to determine the correct appeals process.

Healthy Blue Dual Advantage

- New dual special needs plan (D-SNP) Healthy Blue Dual Advantage offered in 2020
- Serves dual-eligible members who are eligible for both Medicaid and Medicare
- Enrollment occurs quarterly throughout the year
- For more information:
  - Visit our provider website: https://provider.healthybluela.com
  - Call the number on the back of your patient's member ID care to contact Provider Services.

Note: Contacts for Healthy Blue Dual Advantage are not the same as the contacts for Medicaid offered by Healthy Blue.

Healthy Blue Dual Advantage (cont.)

Serves 27 parishes:

- Acadia
- Ascension
- Assumption
- Bossier
- Caddo
- De Soto
- East Baton Rouge
- East Feliciana
- Iberville
- Jefferson
- Lafayette
- Lafourche
- Livingston
- Orleans
- Pointe Coupee
- St Bernard
- St Charles
- St Helena
- St James
- St John Baptist
- St Martin
- St Mary
- St Tammany
- Terrebonne
- Washington
- West Baton Rouge
- West Feliciana

Provider Relationship Management contact info

- Provider Relationship Management inbox: LAinterPR@HealthyBlueLA.com
- Provider Relationship Management representatives’ territories and contact information.

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. LabCorp is an independent company providing laboratory services on behalf of the health plan. Quest Diagnostics, Inc. is an independent company providing laboratory services on behalf of the health plan. CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan. Smart Data Solutions is an independent company providing transportation services on claims billing services on behalf of the health plan. Change Healthcare is an independent company providing assessment and reporting services on behalf of the health plan.

https://provider.healthybluela.com

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