Managed Behavioral Health Provider & Facility Manual

March 2026

Lucet™

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Section 1: Introduction

Preface

Lucet takes pride in the collaborative relationships developed with network providers and facilities. Our members and your patients/clients gain when we work together to improve accessibility to the highest quality of care possible at the most affordable cost. Lucet encourages providers and facilities to give us feedback about programs, policies, and processes.

Please consider this provider and facility manual as a general guide to programs, policies, and processes. When updates to the Provider Manual are made, Lucet makes every effort to communicate these changes to providers and facilities through email, fax, our website, and our quarterly Provider Newsletter. The current version of the manual is available on our website at www.lucethealth.com

You are encouraged to contact the Network Operations (Provider Relations) department at providerrelations@lucethealth.com with questions and issues not covered here or to clarify any content. To notify Lucet of updates to your practice locations, demographics, and new areas of clinical specialization, please go to the Profile update form available on our website at www.lucethealth.com. To discuss other matters, please call 1-888-611-6285.

About Lucet

Philosophy

Lucet takes a population health, member-centric approach that meets members where they are and matches the level of intervention to the members' needs. All services are designed to ensure that members get the proper care at the right time with the right provider and are connected with needed community support.

Lucet recognizes that the success of delivering care to members and optimizing clinical outcomes relies on collaborative relationships with providers. Lucet is dedicated to working with our provider community to promote the delivery of high-quality care, that is member-specific, clinically necessary treatment in the least restrictive environment.

Expectations of Providers

We appreciate your hard work and dedication to empower members to live life to the fullest. Our goal in working with our provider community is to continuously improve the care delivery system within each of our networks from region to region. We strongly

believe that we can only do so through continuing to strengthen our collaborative working relationships with providers who use evidence-based practices with fidelity to the model and whose clinical outcomes for members support their recovery of health and life roles. The success of these efforts will be demonstrated by our ability to work with our network to achieve the Triple Aim of improved health, reduced cost, and better member experience.

This manual is a valuable resource that describes our commitment, expectations, and services to support your success in delivering care to members. Please refer to our delivery of care expectations below and our supportive resources described in the Clinical Program section.

Delivery of Care Expectations and Supportive Resources

1. Delivery of care in the least restrictive setting

   Providing the least restrictive setting is especially important when members are being evaluated for higher levels of treatment. The level of intensity of services will need to match the members' clinical needs. We prefer that members be treated as close to their homes as possible to help ensure community-based resources are in place to support better outcomes over a longer period.

2. Setting clear and measurable goals

   We believe more treatment does not necessarily mean better treatment. It is the provider's responsibility to establish key treatment milestones with clear and measurable goals to understand progress and objectively determine when a member has successfully completed treatment. Treatment must answer the questions, "Why is this level of care needed now?" "What measurable outcomes will be used to define success?"

3. Improved member engagement

   Make use of the Lucet Care Management team (see Section 6) to help members safely discharge to the community and have a comprehensive community-based treatment plan. We expect you to obtain a Release of Information (ROI) from the member before discharge, as it enables Lucet to coordinate care and facilitate access to other types of clinical resources, including support groups, self-management resources, and assistance in addressing barriers to care. The ROI is essential because it allows these resources to work directly with the patient and family members.

4. Discharge planning

   Discharge planning is a critical component of quality member care that begins on the day of admission. Quality discharge planning includes coordination and

linkage to applicable behavioral health, medical, legal, and social determinant follow-up resources. Lucet expects comprehensive discharge planning that integrates elements of IDEAL Discharge Planning as published by the Agency for Healthcare Research and Quality. Guidelines summarizing best practices of IDEAL Discharge Planning should be reviewed at www.ahrq.gov. A facility's performance is evaluated on the percentage of members attending follow-up visits, readmission rates, and other key indicators. Discharge planning is critical to that progress. All facility-based care providers are required to submit quality discharge plans to Lucet within **forty-eight hours of** discharge or change in service level.

Quality Discharge plans **must include** documentation of the following:

- A scheduled discharge appointment within seven days of discharge. For mental health admissions, follow-up appointments should meet the defined criteria for HEDIS.
- Member understanding of discharge plans, including knowledge of discharge appointments and aftercare goals
- Member involvement in discharge decision-making
- A current crisis/safety/relapse prevention plan

Lucet shall monitor and inform the facility of de-identified scorecard information to evaluate their performance of quality discharge metrics. Lucet shall provide you with the performance data and analysis and allow the opportunity to discuss findings. You are expected to review scorecard metrics and work cooperatively with Lucet to improve quality discharge performance. For more information on the specific form items, please visit the Clinical Discharge Form Flyer and Clinical Discharge Review Form.

5. A signed Authorized Designee / Authorization of Representation Form

If you wish to give access to your information to someone else (spouse, family member, your child's guardian, your employer, parent, etc.), you can complete the Authorized Delegate Form, which allows Lucet to share information about your healthcare account with whomever you designate. For more information on the specific form items, please visit our website

6. Scheduling a 7-day follow-up appointment after mental health inpatient discharge

   After an inpatient discharge, members should follow up with a licensed clinician within seven days. When coordinating 7-day follow-up appointments, providers must verify the patient's availability for the appointment. Lucet can assist in identifying providers who can offer appointments within seven (7) days. To request assistance in identifying a provider who can see a member within seven (7) days, contact Lucet at the phone number on the insurance card.

7. Community-based resources

   Utilize community-based resources to address social determinants of health

while providing longer-term stability and independence. Lucet can assist you with our sophisticated resource database to identify resources such as food

pantries, domestic abuse shelters, energy assistance, job training, and support groups, among many others.

8. Integration with physical health

   Coordinating care with the patient's primary care physician (PCP) will create a holistic care plan to address comorbidity and allow the PCP to communicate and receive valuable information about the member's physical and behavioral.

9. Provider Performance

   Lucet is committed to promoting a high-quality network of providers available to members. Consistent with the triple aim of healthcare, provider performance will be monitored to evaluate improved member health, reduced cost, and a better member experience. Measurements differ based on the level of care being provided, emphasizing metrics that promote quality outcomes such as readmission rate and timely access to treatment.

10. Clinical record documentation

    Documentation must be clear and support the claims billed and/or services that meet medical necessity criteria for ongoing treatment.

    The medical record must include documentation of the active participation of the member in treatment and progress toward goals achieved.

11. Measure outcomes

    Lucet may conduct provider profiling using claims-based analysis that enables us to understand network quality and cost performance at the individual provider and facility level. This allows us to guide members to top-performing providers who meet member needs in terms of service, cultural attributes, and accessibility factors.

12. Member Experience

    Lucet partners with providers to ensure members get the care they need at the right time with the right provider. We understand that members seeking services are often at their most vulnerable. Caring for them with dignity, respect, and a spirit of collaboration contributes to a positive outcome.

    Lucet expects you to:

    - Provide considerate, courteous care, treat members with respect, and recognize personal privacy, dignity, and confidentiality.

- Have a candid discussion of medically necessary and appropriate treatment options or services for each member's condition regardless of cost or benefit.
- Deliver information in clear and understandable terms.
- Provide culturally sensitive care, including respecting members' cultural, racial, ethnic, and linguistic needs.
- Engage members in treatment planning and treatment decisions and verify members understand the treatment plan.
- Discuss medical records with members and keep health records confidential except when disclosure is required or permitted by law.
- Communicate effectively by returning messages within 24 hours and setting clear expectations with members regarding appointment availability.
- Respond to questions concerning treatment sufficiently to address member's issues.
- Explain the cost of treatment fully when members inquire. Provide Lucet with accurate information regarding demographics, discipline, specialty, and office hours to ensure members have accurate information.
- Assist members needing services and care that cannot be accommodated by clearly redirecting back to Lucet for assistance.

Together is the way forward. By collaborating, we can achieve more on the patient's behalf. When you need additional support, Lucet offers innovative resources to help support your success, such as on-site care management, on-site care transitions, an enhanced network of outpatient providers who can see members within Seven (7) days of discharge, in-home behavioral health services, coordination of medication delivery on the day of discharge, and coordination of medication compliance follow-up, among other services (services are not available in all locales). Email Lucet Provider Relations at ProviderRelations@lucethealth.com to learn about the resources available in your area.

Provider Communications

Lucet updates the manual annually and as needed. The updated version is available online at www.lucethealth.com. Throughout the year, we convey policy changes and other pertinent information to Providers and Facilities through various channels:

- Newsletters
- Broadcast emails
- Office manager meetings
- Website at www.lucethealth.com
- Educational workshops and symposiums

Please ensure your email address, office location, and practice information is up-to-date by reviewing your provider directory information in the Provider Update Form or via the Provider Portal. Remember, as a participating provider in the Lucet network, **you are required to notify us within 72 hours if you have a change of address, phone number, fax number, or email.** Lucet will ask you to verify the accuracy of your provider directory information every 90 days. You are required to attest to its accuracy or update your profile to make it accurate.

Contacting Lucet

To contact the Lucet Service Center for utilization management, care management, care consultation, or administrative questions regarding eligibility, benefits, or claims, please refer to health and group plan-specific information in the appendix at the end of this manual.

Website

Lucet provides detailed and easy-to-use information about many programs and services at www.lucethealth.com. Updates occur frequently to provide current information about behavioral health care and services. The website includes the following:

- Lucet Provider and Facility Manual
- Documentation forms
- Medical Necessity Criteria for authorization of payment determinations
- Medical Policy for Transcranial Magnetic Stimulation (TMS)
- Medical Policy for Electroconvulsive Therapy (ECT)
- Medical Policy for Psychological/Neuropsychological Testing (PNT)
- Lucet Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy
- Clinical Practice Guidelines
- Provider WebPass (username and password are needed)
- Member eligibility information for many Lucet contracts
- Member benefit information for many Lucet contracts
- Notice of Privacy Practices for Lucet
- Member rights and responsibilities
- Information about our Quality and Care Management programs
- An Autism Resource Center for individuals with autism spectrum disorder and their families.
- A Substance Use Disorder Center to assist individuals and their families struggling with alcohol or substance use.

The website also includes a provider search feature, allowing our members to locate Providers by name, location, and specialization. Members can also filter their searches by gender, language, age group, ethnic origin, credential/discipline, and whether providers are accepting new patients.

"WebPass"

Lucet's "WebPass" system used to check member eligibility and benefits, request authorizations, and check the status of authorization requests. Before using the WebPass system, you must obtain a username and password from Lucet. Please click here to access the form to request a WebPass account.

Lucet expects you to learn and understand the WebPass system as the primary means to interface with Lucet. Please submit authorization requests and check the status of authorizations through WebPass. Please review the WebPass section under Section 2: Network Operations.

Network Surveys

Please be aware that you or your patients may be selected to complete a survey about their Lucet experience.

Lucet conducts several surveys to assess quality and direct quality improvement initiatives, including Member Satisfaction Surveys, Provider Satisfaction surveys, and surveys to evaluate geographical availability and access to appointments. In addition, Lucet may conduct spot surveys to assess specific tools or processes to gather provider input into significant changes under consideration.

Disclaimer

This Provider Manual is for informational purposes only and does not constitute a contract, guarantee of coverage, or promise of reimbursement. Policies and guidelines may change at any time without notice. If any information in this manual conflicts with applicable laws, regulations, payer policies, or the terms of a provider or facility agreement, those authorities control. Providers are responsible for knowing and complying with all applicable requirements.

Lucet makes no warranty as to the accuracy or completeness of this manual and is not liable for any errors, omissions, or outcomes resulting from its use. Providers should not rely solely on this manual when making clinical, billing, or administrative decisions.

Section 2: Network Operations Policies and Procedures

Pursuant to the terms of the Provider/Facility Agreement, providers and facilities must comply with Lucet policies and this manual. Certain policies may apply to only a designated line of business, type of benefit plan, or government-sponsored health benefits program. You may find select policies and procedures on the provider portal at https://providerportal.lucethealth.com/s/login/ or on our out-of-network resource page at https://lucethealth.com/providers/outside-network/

Change in Provider Demographics

You must notify Lucet of any changes to availability or demographics, including email addresses. Refer to the appendix below to determine the notification deadlines that apply to you. You must review and attest to the accuracy of the demographics every 90 days to ensure they are accurate, up-to-date, and in compliance with their obligations under The Consolidated Appropriations Act of 2021. Demographic changes can be made through the provider portal at https://providerportal.lucethealth.com/s/login/

Note: Any address or Tax ID number updates/changes require a current W-9 form. If you have questions, please get in touch with Provider Relations at 888-611-6285 or submit providerrelations@lucethealth.com a service ticket on the provider portal at https://providerportal.lucethealth.com/s/login.

Groups and Facilities must notify Lucet of any changes to employee rosters within 72 hours. Follow the link and directions provided above to submit these changes.

Credentialing Criteria

Lucet credentials and re-credentials providers and facilities in compliance with NCQA accreditation standards, applicable health plan policies, and applicable state and federal laws. The Lucet Credentialing Committee makes decisions regarding credentialing and re-credentialing.

Minimum criteria for consideration as a provider in the Lucet network must include:

- Current unrestricted state professional license(s) or registration(s) that authorizes the applicant to practice independently in the state(s) where services are provided
- For facilities, PHP, IOP, and CMHC programs, an active unrestricted license for the services seeking to be contracted
- Minimum practice of fifteen hours per week
- An acceptable level of professional liability insurance (preferred coverage is $1,000,000 occurrence/$3,000,000 aggregate but may vary according to state law or Plan requirements)
- Internet access

- Up-to-date mailing address and email address
- Have 24-hour phone coverage

M.D. and D.O. Eligibility Requirements

M.D. and D.O. applicants must meet eligibility requirements in one of the following ways:

1. The M.D. or D.O. applicant has obtained board certification through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in Psychiatry by the ABMS/AOA certifying Member Board
    a. Except, for those M.D. or D.O. applicants with recent completion of their psychiatry residency, those M.D. or D.O. applicants may apply to the network with the requirement they shall become board-certified within one of the next two (2) consecutive testing periods following the completion of their residency (e.g., residency completed June 2022, first testing period September 2022, second testing period September 2023, terminate November 2023 if not board certified). If board certification is not obtained during this time frame, the M.D. or D.O. credentials and, as a result, provider contract will terminate at the end of November of year following the second testing period; or

2. The M.D. or D.O. applicant has obtained Board Certification through the ABMS or AOA in Addiction Medicine by ABMS/AOA certifying Member Boards or a non-expired certification from the American Board of Addiction Medicine (ABAM) and intends to treat individuals with substance use disorders. In addition, this category of M.D. and D.O. applicants must be board-certified by the ABMS or the AOA in the area in which they completed their residency. This type of physician will be referred to as an Addiction Medicine Specialist.

Site Visits

Lucet may conduct a site visit of network provider facilities and/or offices.
Site visits may include a review of any or all of the following:

- Availability and access to services
- Physical plant safety & environment
- Adherence to HIPAA and confidentiality
- ADA Compliance
- Patient Rights and Responsibilities
- Treatment recordkeeping and maintenance practices
- Member record documentation
- Medication safety
- H.R. practices, including credential verification of licensed staff, training and hiring practices of direct care staff
- Quality of services provided to members
- Quality & Risk Management processes and improvement programs

- Member treatment program philosophy
- Other

Board Certified Behavior Analyst (BCBA)

Line Therapists are Registered Behavior Technicians (RBT) certified or Board-Certified Assistant Behavior Analysts (BCaBA) via the Behavior Analyst Certification Board (BACB). It is the duty and responsibility of the supervising Board Certified Behavior Analyst (BCBA) to ensure compliance with the following requirements in the line of therapists you supervise.

Line therapists you supervise must be made aware in writing that they must inform you within 72 hours if they are arrested, or criminal action is brought against them. If the arrest/criminal action involves violence, dishonesty, or sexual activity involving a minor, the line therapist will not be permitted to work with any member until either the charges brought against the individual are dropped or until a court of competent jurisdiction adjudicates the individual as not guilty of the charges underlying the arrest or the criminal action.

A national criminal background check must be conducted for all Line Therapists, containing a search of the National Sex Offender Registry. Line Therapists must also be covered under the Supervising BCBA and Employers professional liability insurance with at least $1,000,000 per occurrence and $3,000,000 aggregate.

Interns and Provisionally Licensed Professionals

Note: Intern and Provisionally Licensed Professional approval vary by Health Plan. See Section 12 Appendix to confirm if approved by the Health Plan.

Overview

- You may be reimbursed for behavioral health services rendered by Interns and Provisionally Licensed Professionals in accordance with the applicable responsibilities and requirements outlined below, health plan guidelines, applicable state law, and any applicable benefit plan coverage and/or exclusions.
- Lucet does not credential or contract directly with Interns and Provisionally Licensed Professionals.
- Supervisors must be credentialed by Lucet.
- Interns and Provisionally Licensed Professionals are not displayed in the provider directory.
- Licensing and supervision requirements are governed by applicable state law.

Interns and Provisionally Licensed Professionals Responsibilities

- Maintain professional state licensure or registration, as applicable, in good standing for the duration of the supervisory arrangement.
- Provide services in accordance with applicable state licensing board rules.
- Engage in clinical supervision with a Supervisor.
- Inform Members of the supervisory relationship, provide contact information for the Supervisor, and obtain consent to receive services from an Intern or Provisionally Licensed Professional, as applicable, before rendering services.
- Consult the Supervisor if a member's needs exceed the competence of the Interns and Provisionally Licensed Professional.
- Inform the Supervisor immediately of any change to the Intern's or Provisionally Licensed Professional's licensure and/or certification status.
- Remain under supervision with a Supervisor while practicing as an Intern or Provisionally Licensed Professional.
- Only use the term associated with your actual credential and refrain from making misleading, deceptive, untrue, or fraudulent representations as to licensure or registration.

Supervisors' Responsibilities

- Maintain Applicable Supervisor licensure status as mandated by applicable state law.
- Work for the same organization as the clinicians you are supervising.
- Provide clinical supervision in accordance with applicable state law.
- Through the course of Supervision and treatment the Supervisor continually assesses the Member needs and ensures a match with the Interns and Provisionally Licensed Professionals skills.
- Verify Members are informed of the supervisory relationship and consent to receive services from Interns and Provisionally Licensed Professionals, in accordance with applicable state law.
- Ensure availability at all times when Interns and Provisionally Licensed Professionals are providing services.
- Meet continuity of care requirements per Lucet provider manual to coordinate prompt transition of Member services to another in-network clinician in the event of disruption to the Intern's or Provisionally Licensed Professional's licensure status and/or the supervisory relationship.
- Supervisors must not accept payment from Interns and Provisionally Licensed Professionals in exchange for supervision.
- Supervisors and/or their employer must verify the Interns' and Provisionally Licensed Professionals' credentials, background, and suitability to provide

services within the scope of their competence and applicable professional licensure and/or certification.
- If your or your facility participate in federally funded health care programs are required to search the Office of Inspector General (OIG), List of Excluded Individuals/Entities (LEIE) at least monthly to identify workforce members who are excluded from receiving payment or providing services for federally funded health care programs.

Provider Rights and Responsibilities

Providers have the right to:

1. Access information contained in personal credentials files

2. Rectify erroneous information in personal credentials files

3. Be informed of their status in the credentialing/re-credentialing process

4. Request a hearing in accordance with the Fair Hearing Plan policy if an adverse recommendation by the Credentialing Committee regarding participation in the Lucet network is made

5. Be credentialed in accordance with the Provider Credentialing and Re-credentialing policy, which describes the processes for credentialing and re-credentialing, including:
   - Maintaining the confidentiality of the credentials files to the extent permitted under state or federal laws and Lucet policies
   - Credentialing and re-credentialing recommendations that are non-discriminatory
   - Right to be notified if information received during the credentialing/re-credentialing process is substantially different from information received from a Provider
   - Notification within ten (10) business days of initial credentialing and adverse re-credentialing decisions.

Providers have the responsibility to:

1. Use and disclose protected health information in accordance with federal and applicable state laws

2. Comply with Lucet and the applicable plan's credentialing, quality management, member grievance, care transitions, performance evaluation, disciplinary process, utilization review, care management, and disease management programs

3. Comply with Lucet and the applicable plan's claims submission and processing requirements

4. Maintain health information (treatment records); submit to reasonably requested audits; implement action plans as required; and participate in follow-up reviews of deficiencies

5. Obtain Release of Information (ROIs) and other consents required to enable coordination of care, care management, and claims resolution activities by Lucet and the member's plan

6. Communicate with primary care physicians and other providers about mutual members

7. Comply with billing rules and guidelines

8. Coordinate care with other in-network health care providers whenever possible and appropriate

9. Use the WebPass system to:
    - check member eligibility and benefits
    - request authorizations
    - Check authorization status (Authorization notices are mailed to providers)
    - Submit Discharge information within 48 hours of discharge

10. Review and update their provider demographics at least every 90 days

Provider WebPass

WebPass is used to check member eligibility and plan benefits, request authorizations, and review the status of authorization requests. You will find membership eligibility and plan benefits in the provider WebPass section.

Web-based online support via the Internet: Lucet's online WebPass system is a password-protected website that allows you to request and verify member authorizations 24/7/365, communicate discharge information, and submit care management referrals. The WebPass system provides you a safe and secure way to send protected health information to Lucet.

Getting Started with WebPass

To create a new WebPass account, go to Lucet's website to complete the support form. The email must include the Tax ID and the WebPass user's first name, last name, and email address.

For entities with multiple users under one Tax ID, the user may request an administrator role. The administrator will manage additional WebPass users with that Tax ID, including adding users, resetting passwords, and deleting users who are no longer authorized to access the WebPass account.

WebPass instructions are located on the WebPass Login Page

Authorization Forms are located on the Lucet website. Select your health plan and choose Authorizations and Referrals.

Troubleshooting & Common Issues with Logging in to a WebPass Account

If you need to reset your password, please go to **https://webpass.ndbh.com/** and click the "Forgot Password" link to generate a new temporary password. The temporary password is only active for **24 hours**. If 24 hours elapse without setting up a permanent password, a new temporary password must be requested by clicking the "Forgot Password" link again. If you continue to experience issues logging in to your account, please email us at prwebpass@ndbh.com

If your organization has multiple Tax IDs, you must have a separate account for each Tax ID.

You must log in every 180 days, or your WebPass account will be locked for security reasons.

You must update your demographic information with Lucet before it will be displayed in the WebPass system. Links to submit demographic changes are available on the WebPass login page.

If you experience problems with obtaining timely eligibility and benefits information, please get in touch with us by emailing prwebpass@ndbh.com

WebPass Reminders

- **Urgent care coverage review schedule** - Lucet will complete continued stay and step-down reviews for urgent care on the last covered day. Please submit continued stay and step-down review requests for inpatient and residential on the last authorized day.

  [Ex., Lucet authorizes urgent care coverage for 11/27-11/29. We will review continued or step-down requests on 11/28. Provider should, therefore, submit a review request on 11/28 because it is the last covered day. Remember that the day of discharge is not covered. In this example, 11/29 is the day of discharge.]

- **Timely submissions** – For inpatient or residential care members, please submit continued stay review requests and step-down review requests before 12:30 p.m. EST. Again, reviews should be submitted on the last covered day. Doing so enables Lucet to provide a timely and complete medical necessity determination, allowing for peer reviews if needed.

- **Diagnosis** – Please provide the most accurate diagnosis and update in each WebPass submission as reflected in the medical record.

- **Continued stay requests** – Updated clinical information is required to reflect the member's current status and progress on measurable goals, as listed on the member's individualized treatment plan.

- **Progress** – As indicated, please provide CIWA scores, vitals, and labs. Include the most recent results.

- **Medications** - Must be updated in each submission.

- **Discharge plan** – Please ensure a discharge plan is populated on the initial authorization request and updated with each concurrent authorization review request, including specific providers and appointments. All facility-based care providers are required to submit a WebPass Discharge Form to Lucet for all levels of care within 48 hours of discharge or change in service level. Members require follow-up appointments within seven (7) days of discharge. For mental health admissions, follow-up appointments should meet the defined criteria for HEDIS.

- **Forms** – Please submit all needed forms, including releases of information, member consent for referral to Behavioral Health Homes (BHH), consent for referral to other providers to coordinate care, and the Medicare Important Message Form.

- To View the WebPass request authorization decision:
    - Log in to WebPass
    - Complete a" Member Search"
    - Click "Member Authorizations Viewer" in the function menu
    - Click "Details" on the left side of the authorization. A new window will be generated that has authorization details, including the decision.

Section 3: Provider Accessibility Overview

Lucet is committed to assisting members to obtain timely access to services with appropriate network providers. When members contact Lucet and request assistance in finding a provider for a routine referral, Lucet attempts to directly schedule with the provider or provide the name and contact information for 3-5 providers. For members contacting Lucet with urgent needs, Lucet links the member with the provider and sets up the appointment.

Availability Standards

Lucet requests that providers make every effort to provide timely access to members according to their needs.

Urgent or Emergent Care

In an urgent or emergent situation, the member must be offered the opportunity to be seen in person immediately. If a member contacts your office with an urgent or emergent situation, and your office cannot provide an appointment within the timeframes below as appropriate based on the member's clinical situation, your office should refer the member to an emergency room.

- Immediately it is further defined as:
    - Life-Threatening Emergency: In a life-threatening emergency, the member should be seen as soon as possible, within an hour.
    - Non-life-Threatening Emergency: When there is a significant risk of serious deterioration, the member must be seen within 6 hours of the request.
    - Urgent: In an urgent situation, the member must be offered the opportunity to be seen within twenty-four (24) hours of the request.

Non-Urgent with Attention Required

If the member's needs are not urgent but delays in access to medical attention could be detrimental, the member must be offered the opportunity to be seen within seven (7) days of the request.

Routine Office Visit – Initial

For a member whose circumstances are non-urgent and do not require medical attention, the member must be offered an appointment within ten (10) days of request.

Routine Office Visit -Follow-Up

For a routine office visit that is considered a follow-up visit, the member must be offered the opportunity to be seen within thirty (30) days of the request.

Coordination of Care with Primary Care Physicians and other Providers

Lucet encourages all providers to coordinate and share information with their patients' primary care physicians (PCP) and other behavioral and medical specialists (e.g., neurologists, pain management, etc.) whenever appropriate. Lucet actively participates in these collaborative efforts. You may be contacted by a Lucet staff member to assist you in scheduling an appointment, verifying attendance, treatment planning, medication reconciliation, completing an authorization form, and other efforts to coordinate care. To facilitate care coordination, Lucet provides several authorization forms on our website for your use.

Members benefit when all healthcare providers share health information. Lucet recommends that network providers educate and explain to members the important reasons for sharing health information with their PCP and other health care providers in accordance with federal and state laws. Under the Health Information Portability and Accountability Act (HIPAA), providers can share protected health information (PHI) with other providers for treatment, case management, and care coordination without the patient's authorization. This sharing is permitted to ensure continuity of care, but providers must adhere to the "minimum necessary" standard; meaning providers should only share information that is essential for the purpose. Members can also request restrictions on the use or disclosure of their Protected Health Information (PHI) for treatment, payment or operations ("TPO") and providers must comply, if they agree with the request, documenting the agreement and honoring it unless required by law or in emergencies.

Member psychotherapy notes, HIV/AIDS information, and genetic information have heightened privacy restrictions requiring a member's written authorization for most disclosures, with some exceptions for situations like mandatory reporting or court orders. Psychotherapy notes are particularly protected because they are considered the personal notes of the treating provider and are not part of the standard medical record. HIV/AIDS and generic information have specific federal and state protections because of social and health-related risks from improper disclosure.

Strict confidentiality protections exist for substance use disorder (SUD) treatment records under 42 USC § 290dd-2 and 42 CFR Part 2 (together known as "Part 2"). Part 2 generally requires explicit written patient consent for use and disclosure of Part 2 records for TPO purposes. These added protections are intended to encourage SUD treatment by protecting patient identity, diagnosis, referrals, and treatment to ensure individuals are not disadvantaged for seeking help. A HIPAA covered entity or business associate that receives Part 2 records based on a single consent for all future uses or disclosures for TPO purposes is not required to segregate or segment such records and may redisclose them pursuant to HIPAA and Part 2 regulations. Disclosures must include a copy of the consent or explanation of its scope. SUD counseling notes require separate consent.

SUD treatment records from a non-Part 2 program are not protected under 42 CFR Part 2; although members may still have privacy rights under HIPAA and state law. Non-Part 2 treating providers are not restricted from documenting and maintaining SUD-related information in the medical record because Part 2 protections only apply to records created by Part 2 programs. Additional guidance on the confidentiality and disclosure of SUD treatment records can be found at: Disclosure of Substance Use Disorder Patient Records and Protecting Health Information | Focus:PHI

To promote better outcomes and whole-person treatment, you are encouraged to educate members on the benefits of coordinated care and request authorization to use or release information when applicable and appropriate. We encourage all providers to participate in these collaborative efforts to ensure the best possible outcomes for members.

Section 4: Member Safety and Quality of Care
Member and Client Rights and Responsibilities

Members/Clients have the right to:

1. Receive information about Lucet, its services, its network providers and affiliates, and their rights and responsibilities.
2. Be treated with respect and receive recognition of their dignity and right to privacy.
3. Receive communications in a language they understand.
4. Participate with network providers and affiliates in decisions about their health care.
5. Have a candid discussion of appropriate or medically necessary treatment options for their health conditions, regardless of cost or benefit coverage.
6. Voice complaints or appeals about Lucet or the services or care they receive either verbally or in writing and obtain prompt resolution.
7. Make recommendations regarding this Statement of Rights and Responsibilities for members and clients.
8. Expect confidentiality of their personal health information
9. Inspect and copy their personal health information.
10. Be ensured reasonable access to care without discrimination.
11. Include family/significant others in health care decision-making and treatment planning.
12. Treatment that is individualized and offers interventions and options that are customized, flexible, and adapted to meet member's unique needs.
13. Receive information and explanation about the guidelines and criteria used in making medical necessity decisions.
14. Expect Lucet to advocate on the member's behalf (if asked).
15. Be provided information regarding staff, network, or vendor qualifications of organizations contracted by Lucet to provide services.

16. Decline to participate in programs or services or to withdraw from programs or services at their will.

17. Be provided with information regarding the staff members that manage their services and how they can request to change services.

Members/Clients accept responsibility to:

1. Provide information (to the extent possible) that Lucet and its providers and affiliates need to support health care.

2. Follow the plans and the instructions for care and treatment agreed upon with plans, providers, and affiliates.

3. Understand their health conditions and participate in developing mutually agreed-upon treatment goals, to the extent possible

4. Inform their provider or Lucet of their decision to decline or withdraw from a care management program.

Quality Improvement

Lucet establishes and maintains the Quality Improvement (QI) Program, which is designed to continuously improve the quality of behavioral health care and service provided to our members. QI initiatives strive to achieve significant improvement in identified clinical and non-clinical service areas and are expected to have a positive impact on health outcomes, services received, and member and provider satisfaction over time.

Data collected for QI projects and activities are related to key indicators of clinical care and services that focus on high-volume and high-risk diagnoses, services, or populations. Goals are established, measured, and analyzed; many of which are based on those established by national accrediting organizations and best practices. The QI Program is intended to ensure that the structure and processes in place lead to desired outcomes for both members and providers.

The scope of the Lucet QI Program includes:

- Member safety
- Treatment services
- Treatment outcome
- Access and availability of care
- Continuity and coordination of care
- Cultural and linguistic needs
- Care Management services

- Complaints
- Member and provider satisfaction
- Confidentiality and privacy

Lucet evaluates its QI Program annually. Based on the results, a new work plan is created for the following year. Further information about the Quality Improvement Program is available on request by emailing QualityImprovement@lucethealth.com

Healthcare Effectiveness (HEDIS) Performance Measure

Monitoring HEDIS (Health Care Effectiveness Data and Information Set) measures are tools used to gauge performance on important dimensions of care and service. HEDIS is a widely used set of performance measures used in the health care industry that is developed and maintained by the National Committee for Quality Assurance (NCQA). Over 90% of Health Plans in the United Stated use HEDIS and submit data to establish performance benchmarks. HEDIS measures set parameters to evaluate plan and provider quality by setting benchmarks for specific indicators that allow health plans to compare themselves to each other as well as members to compare when selecting health plans for health coverage. The health plan data from these plans is analyzed for outcomes and inform annual HEDIS updates. HEDIS includes measures across 6 domains of care:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems

The following measures, monitored by Lucet, involve providers' implementation of best practices for members' behavioral health needs.

A. **Follow-Up after Hospitalization for Mental Illness (FUH) –** The HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure is designed to ensure that patients discharged from an acute inpatient stay for mental illness or intentional self-harm receive timely follow-up care, which is critical for their recovery and ongoing well-being. The FUH measure assesses the percentage of discharges for individuals aged six years and older who have a principal diagnosis of mental illness or intentional self-harm and who receive a follow-up outpatient, intensive outpatient, or partial hospitalization visit within 7 and 30 days after discharge. Visits can include appointments with mental health providers, primary care providers, peer support services, telehealth, or community mental health centers, but cannot occur on the same day as discharge. Timely follow-ups reduce the risk of readmission, improve continuity of care, and supports better mental health outcomes. Providers play a key role by

educating patients and caregivers about the importance of follow-up, coordinating care, and addressing barriers such as transportation or stigma. Completing a 7-day follow-up automatically counts toward the 30-day measure, and both rates are reported for quality monitoring and improvement. Providers can consistently apply the following strategies, to help ensure patients receive timely follow-up care after psychiatric hospitalization, improving FUH rates and supporting better patient outcomes:

1. **Proactive Discharge Planning:** Begin discharge planning as soon as the patient is admitted. Schedule the follow-up appointment with a mental health provider prior to discharge, ideally within seven days. Involve the patient and their family in all stages of planning to ensure understanding and buy-in.
2. **Care Coordination:** Ensure discharge paperwork is sent promptly to outpatient providers. Invite care coordinators to meet with patients before discharge to facilitate aftercare planning and smooth transitions.
3. **Patient and Caregiver Education:** Educate patients and caregivers about the importance of timely follow-up care to reduce the risk of readmission and support recovery. Use methods like the “Teach Back” technique to confirm understanding of discharge instructions and next steps.
4. **Outreach and Reminders:** Assign case managers or outreach staff to encourage patients to keep follow-up appointments or reschedule missed ones. Use reminder calls or messages prior to appointments and after missed visits to improve attendance.
5. **Address Barriers to Care**: Identify and attempt to alleviate barriers such as transportation, lack of support, or stigma before discharge. Ensure accurate contact information is collected and coordinate with community resources as needed. Be aware of factors such as housing, employment, and social support that may impact a patient’s ability to attend follow-up appointments, and address these as part of discharge planning.
6. **Accurate Coding and Documentation:** Use complete and precise billing codes for all behavioral health disorder diagnoses and treatment encounters. This helps ensure all services are captured for HEDIS reporting and reduces unnecessary medical record requests.

B. **Initiation and Engagement of Substance Use Disorder Treatment (IET)** – The IET measure assesses the quality of care for patients with substance use disorders by evaluating how quickly treatment begins after diagnosis and whether patients remain engaged in treatment over time. Early initiation and sustained engagement are linked to better health outcomes, reduced morbidity and mortality, and lower healthcare costs. Patients who start treatment within 14 days of diagnosis and receive at least two additional services in the following month are more likely to experience improved health and social outcomes. Timely and continuous care is essential for positive patient outcomes in substance use disorder treatment, and providers play a crucial role in supporting

recovery and long-term wellness. These interventions also help lower healthcare spending by reducing emergency visits, hospitalizations, and complications related to untreated SUD. Providers who proactively schedule follow-up appointments, educate patients about the importance of ongoing care, and use reminders or outreach strategies can help patients stay engaged, further improving their chances of recovery and long-term wellness. Implementing the following strategies can help providers deliver better, more timely care to patients with substance use disorders:

1. **Prompt Initiation of Treatment:** Ensure that patients diagnosed with alcohol or other drug dependence begin treatment within 14 days. This can include inpatient admission, outpatient visits, telehealth, or medication-assisted treatment (MAT).
2. **Engage Patients in Ongoing Care:** Schedule at least two follow-up treatment services within 34 days of the initial visit. Use reminders, direct outreach, and care coordination to keep patients engaged in their treatment plan.
3. **Proactive Patient Outreach:** Set up automated reminders via phone, text, or patient portals. Directly contact high-risk patients to schedule follow-ups and necessary care, tailoring outreach to patient preferences for better engagement.
4. **Leverage Technology and Data:** Use real-time dashboards to track care gaps and monitor patient progress. Automate reminders and documentation workflows to ensure timely follow-ups and accurate reporting.
5. **Screen Regularly and Early:** Conduct routine substance use screenings for all patients, especially during annual visits or after major life events. Use validated tools to identify substance use disorders early.
6. **Accurate Coding and Documentation:** Use complete and precise billing codes for all substance use disorder diagnoses and treatment encounters. This helps ensure all services are captured for HEDIS reporting and reduces unnecessary medical record requests.

C. **<u>Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)</u>** – The FUI measure is designed to assess the quality of care provided to patients aged 13 and older who have experienced an acute inpatient hospitalization, residential treatment, or detoxification visit for a substance use disorder (SUD). The measure tracks the percentage of these patients who receive a follow-up visit or service for SUD within 7 days and within 30 days after discharge. Timely follow-up is crucial, as individuals leaving high-intensity care are at increased risk for relapse, disengagement from the healthcare system, and other negative outcomes. By prioritizing prompt and coordinated follow-up, providers can help reduce relapse rates and improve long-term outcomes for patients with substance use disorders. By focusing on these strategies, providers can help ensure patients receive the necessary follow-up care, reduce relapse rates, and improve overall outcomes for individuals with substance use disorders.

1. **Educate Patients:** Clearly explain the importance of timely follow-up visits after discharge from high-intensity care for substance use disorder. Patients who understand the risks of relapse and the benefits of ongoing treatment are more likely to attend follow-up appointments.
2. **Schedule Promptly:** Arrange follow-up appointments as soon as possible, ideally before the patient leaves the facility. Prioritize appointment availability for patients recently discharged from inpatient, residential, or detoxification settings.
3. **Coordinate Care:** Facilitate communication and collaboration between behavioral health and primary care providers. Sharing progress notes and updates helps ensure continuity of care and supports adherence to treatment plans.
4. **Address Social Barriers:** Assist patients with challenges such as transportation, childcare, or housing that may prevent them from attending follow-up appointments. Partnering with case managers or community resources can help overcome these barriers.
5. **Proactive Outreach:** If a patient misses a scheduled follow-up, reach out within 24 hours to reschedule. Timely engagement can prevent loss to follow-up and improve compliance.
6. **Use Correct Coding and Documentation:** Ensure that all follow-up visits are accurately documented and coded with a principal diagnosis of substance use disorder. This is essential for the visit to count toward the HEDIS FUI measure.

D. **Follow-Up After Emergency Department Visit for Mental Illness (FUM) & Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** - The HEDIS FUM & FUA measure is designed to improve the quality of care for patients who visit the emergency department (ED) with a diagnosis of mental illness, intentional self-harm or substance use. These measures evaluate the percentage of ED visits for these conditions where the patient receives a follow-up visit with a mental health provider within 7 and 30 days after discharge. Timely follow-up is crucial because it helps ensure continuity of care, reduces the risk of relapses or readmission, and supports better long-term outcomes for individuals experiencing mental health crises. Providers play a key role by scheduling follow-up appointments before the patient leaves the ED, communicating the importance of follow-up care, and coordinating with outpatient mental health services. By adhering to the HEDIS FUM & FUA measure, providers can help close gaps in care and contribute to improved patient safety and well-being. By consistently applying these strategies, providers can help ensure patients receive the necessary follow-up care and improve their performance:

1. **Schedule Follow-Up Before Discharge:** Arrange the follow-up appointment with a mental health provider before the patient leaves the emergency

department. This increases the likelihood that the patient will attend the visit within the required 7- or 30-day window.
2. **Educate Patients and Caregivers:** Clearly explain the importance of timely follow-up care to patients and their families. Emphasize how follow-up visits can reduce the risk of relapse, readmission, and support ongoing recovery.
3. **Coordinate Care:** Ensure that discharge paperwork is sent to the appropriate outpatient provider within 24 hours. Effective communication between ED staff, behavioral health, and primary care providers helps facilitate timely follow-up.
4. **Use Correct Diagnosis Codes:** At the follow-up visit, use a principal diagnosis code for mental illness. Visits coded for non-mental illness diagnoses will not count toward the measure. Ensure all follow-up visits are properly documented and billed using the appropriate codes and settings (including telehealth, telephone, or virtual check-ins, when applicable).
5. **Outreach for Missed Appointments:** If a patient cancels or misses their follow-up, proactively reach out and assist them in rescheduling as soon as possible.
6. **Address Barriers:** Help patients overcome obstacles to attending follow-up, such as arranging transportation or offering telehealth options.

E. **<u>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</u>** - The APP measure evaluates whether a child or adolescent who is newly prescribed an antipsychotic also receives psychosocial care within a defined period (from 90 days before to 30 days after the prescription). The APP measure is designed to ensure that children and adolescents (ages 1–17) who are prescribed antipsychotic medications receive appropriate first-line psychosocial interventions. This measure is important because antipsychotic medications are often prescribed for nonpsychotic conditions, even though evidence-based guidelines recommend psychosocial therapies—such as behavioral interventions, psychological therapies, and skills training—as the initial treatment for many of these conditions. By embedding the following practices into workflows, providers can not only improve their APP scores but also deliver higher quality, more comprehensive care to their pediatric patients:

1. **Ensure Timely Psychosocial Interventions:** Make it standard practice to refer children and adolescents prescribed antipsychotics to evidence-based psychosocial care (such as therapy or behavioral interventions) within the required timeframe (90 days before to 30 days after the prescription). By ensuring that antipsychotic medications are part of a comprehensive, coordinated treatment plan that includes psychosocial care, documenting all interventions thoroughly, and periodically reviewing the ongoing need for medication. This approach supports safer, more effective care and aligns with best practices for pediatric behavioral health.
2. **Enhance Documentation:** Accurately document all psychosocial services provided, including referrals, therapy sessions, and patient engagement. Use

electronic health records (EHRs) to capture and track these interventions, ensuring that all relevant data is available for HEDIS reporting.

3. **Provider Education and Engagement:** Educate prescribers and clinical staff about the APP measure requirements and the importance of psychosocial care as a first-line treatment. Regularly review performance data with providers and recognize those who excel in meeting the measure. Hold regular team meetings to review progress, share best practices, and adjust workflows as needed.
4. **Close Care Gaps Proactively:** Use real-time dashboards and care gap reports to identify patients who are missing psychosocial interventions. Outreach teams can follow up with families to schedule and encourage participation in therapy.
5. **Leverage Technology:** Implement digital tools and automated reminders to prompt both providers and families about upcoming or overdue psychosocial appointments. Telehealth options can also increase access to care, especially for families facing transportation or scheduling barriers.
6. **Collaborate Across Teams:** Foster communication between prescribers, behavioral health providers, care coordinators, and administrative staff to ensure a seamless process for referrals and follow-up.

F. <u>Depression Screening and Follow-Up for Adolescents and Adults (DSF)</u> - DSF is a quality metric that assesses how well providers are screening for depression and ensuring appropriate follow-up care. This measure applies to patients aged 12 and older and evaluates two key components: (1) the percentage of members who are screened for clinical depression using a standardized instrument (such as PHQ-2, PHQ-9, or other validated tools), and (2) the percentage of those who screen positive and receive follow-up care within 30 days. Follow-up care can include an outpatient, telephone, e-visit, or virtual check-in with a diagnosis of depression or another behavioral health condition, a dispensed antidepressant medication, a documented depression case management encounter, or a full-length depression screening indicating no need for further follow-up. Providers should ensure proper documentation and coding for both the screening and any follow-up actions, as this impacts compliance with the measure and ultimately supports better patient outcomes. By adhering to the DSF measure, providers contribute to improved identification and management of depression, which is essential for overall patient health. Here are practical tips to help improve compliance:

1. **Use Standardized Screening Tools:** Always use validated instruments such as PHQ-2, PHQ-9, or other approved tools for depression screening. Ensure the tool is age-appropriate for the patient. All patients who are screened through the Lucet Navigate & Connect Scheduling Platform receive a depression screening.
2. **Document Thoroughly:** Record both the screening result and the instrument used in the patient's medical record. Documentation should clearly indicate the date, score, and outcome of the screening.

3. **Ensure Timely Follow-Up:** If a patient screens positive, arrange and document follow-up care within 30 days. This can include an outpatient visit, telehealth check-in, case management encounter, or dispensing of antidepressant medication.
4. **Use Correct Billing and Diagnosis Codes:** Apply the appropriate CPT, HCPCS, and ICD-10 codes for both the screening and follow-up visits. Accurate coding helps ensure compliance and reduces the need for additional record requests.
5. **Educate and Train Staff**: Regularly train clinical and administrative staff on DSF requirements, documentation standards, and coding practices. Use tip sheets and toolkits provided by Lucet and NCQA.
6. **Leverage Electronic Health Records (EHR):** Utilize EHR prompts and templates to remind providers about depression screening and follow-up requirements. Evaluate opportunities for EHRs to help track compliance and automate documentation.
7. **Review and Audit Performance:** Periodically audit charts to ensure screenings and follow-ups are being completed and documented correctly. Use feedback to improve workflows and address gaps.

G. Readmissions (PCR) – Discharge from an inpatient setting is a critical transition point in a member's care. Lucet, in conjunction with health plans, monitors the number of adult acute inpatient stays that were followed by acute readmission within 30 days. The measure is used in part to identify additional discharge planning needs for the member who readmits, to identify facility trends and identify potential gaps in discharge resources. Both behavioral health and medical admissions are considered in this annual HEDIS measure.

H. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) – For members with schizophrenia, lack of adherence to treatment with antipsychotics is common, and can be a significant cause of relapse. Lucet monitors the percentage of adult members with schizophrenia who were dispensed and remained on antipsychotic medication for at least 80 percent of their treatment period. Monitoring antipsychotic medication adherence may lead to a reduced rate of relapse and fewer hospitalizations.

Population Diversity and Health Equity

Lucet is focused on providing and coordinating care for the whole person. This whole person approach is inclusive of the individual and unique needs of the member. Understanding these factors improves communication to help better address challenges and quickly connect members to providers who can meet their needs.

Diversity and health equity factors and/or preferences include:

- Spoken language(s)
- Customs

- Beliefs
- Values
- Gender
- Ethnicity
- Racial
- Social
- Religious and Spiritual
- Disabilities such as hearing, vision, or mobility impairment

Lucet members voice their disparity concerns through member satisfaction surveys and the complaints or grievances processes. The information provides Lucet approach to strategically use cultural competencies as a valuable adjunct to the quality improvement process. This process identifies opportunities to assess network structure, recognize training and hiring needs, facilitate learning between providers and members and provide firsthand feedback to providers to improve health equity, resulting in enhanced member experience.

Lucet's influence on positive change is not only external to our members and providers, but internally with our own staff. Cultivating cultural behaviors internally helps with Lucet service delivery to our diverse member populations and enables staff to work effectively cross-culturally. An internal Diversity, Equity, and Inclusion Committee facilitates the following functions.

- Institutionalizing cultural knowledge
- Promoting education and collaboration on diverse viewpoints
- Supporting programs that strengthen and foster an inclusive work environment.

Integrating the knowledge of the member's cultural, language, and impairment needs into provider practices and applying it appropriately to meet the member's disparity needs will help build the bridge between the member and their provider.

Acknowledging members' cultural needs, preferences, beliefs, and values is recognizing their personal identity and key to establishing a trusting relationship and developing a suitable treatment plan. Since 1979, The U.S Department of Health and Human Services' Office of Disease Prevention and Health Promotion has set priorities for preventing disease and promoting the health of all Americans with Healthy People initiatives. The mission of "Healthy People 2030" is to promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people. Health disparities are differences in health outcomes and their causes among groups of people. Reducing health disparities creates better health for all Americans. With appropriate resources in place, members of diverse populations can be treated effectively. A provider's sensitivity to cultural factors may directly shape a member's experience and their ability to participate in their treatment. It can also enhance delivery of health care services for members with these special requirements.

How can you meet members' unique needs?

- Maintain current and complete information of your outward-facing demographics to assist in matching a member's preference for a provider. Doing this creates a better fit for you and the member. To update your demographics, please submit information via the Provider Update form or by contacting providerrelations@lucethealth.com
- In addition, ensure you and your staff are sensitive to cultural and linguistic aspects in your treatment services. The links below offer additional information from the Agency for Healthcare Research and Quality and the Health Resources and Services Administration websites.

Helpful Links

Healthy People 2030: https://odphp.health.gov/healthypeople

Address Language Differences
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool9.pdf

Religion, culture, beliefs, and ethnic customs
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool10.pdf

Utilization Management (UM) Services

The UM program promotes positive health outcomes by providing the structure and processes needed to provide care management for Managed Behavioral Health (MBH) members. Lucet's care and utilization management approach aims to align attention and resources to address:

- The care needs of members with clinical complexities, requiring high levels of health care services
- Needs of members in populations requiring specialty care
- The need for evidence-based care for all members, including newly diagnosed or first presenting
- Transitions of care, so that members experience continuity of care as they move through the behavioral health/substance use disorder continuum of services.
- The UM Program is a framework for making benefit determinations affecting the health care of members in a fair, impartial, and consistent manner. All UM services are provided by phone or through Lucet's website.

The UM staff is available 24/7 to provide information about UM processes and to address requests for benefit coverage. Members have direct access to all behavioral health providers and can self-refer to providers for assessment. Members who contact Lucet for assistance to find a provider and obtain an appointment are asked a series of questions. These questions enable UM staff to determine the type of services needed, the acuity of the member's condition, and the appropriate time frame for the appointment. In urgent and emergent situations, the member is assisted with access to services. The safety of the member is the primary concern. The staff facilitates peer clinical reviews, appeals and coordinates services with other departments.

Focus Areas

Our Quality Improvement program focuses on activities that support continuous improvement of member safety, experience, and outcomes. We identify opportunities for improvement, implement changes, and monitor processes and results. A sample of some of these key activities and provider tips include:

Member Safety - Lucet promotes the exchange of information between medical and behavioral health providers. Communication with providers about key elements associated with member care improves member safety, continuity of care and coordination of care.

Medication Safety - Identifying opportunities for medication reconciliation is one of the key elements of coordination of care activities. When members participate in our Care Management (CM) program, Lucet provides a list of the medications reported by the member or from facility discharge orders to their prescribing physicians. This enables the prescribing physicians to review the medication list and identify and reconcile any discrepancies. Lucet's care managers utilize our Coordination of Care fax form (COC Form) to communicate with medical and behavioral health providers to facilitate medication reconciliation. By informing ordering providers of the need for medication reconciliation, actions can be taken to reduce inconsistencies, decrease the potential for harm and provide a channel to communicate a list of members' prescribed medications to medical and behavioral health providers.

Medication Overdose – Studies show that suicide attempt by overdose is associated with a high rate of repeated admissions. Lucet designed a Medication Overdose Prevention Program to decrease the potential for recurrent prescribed medication overdose among members hospitalized for psychiatric and/or substance use treatment. Inpatient facilities should notify prescribers when they are treating a member at an inpatient facility. Lucet monitors the rate at which facilities indicate when the prescriber has been notified.

Quality of Care – Lucet strives to develop, maintain and promote best practices in behavioral health care. Our focus is on measuring and monitoring quality and implementing data driven interventions that drive positive member outcomes and enhance member safety.

Lucet screening programs are designed to provide early identification of potential disorders and assist providers as they direct members to appropriate assessments and levels of care to avoid complications of untreated conditions.

1. **The Behavioral Health Screening for Coexisting Depression and Substance Use** program aims to detect depression in members admitted to a higher level of care for substance use disorder. Lucet utilizes WebPass and telephonic utilization management contacts to collect information as to whether a depression screen was performed, and if the result was positive during all admissions for a substance use disorder. If left unidentified and untreated, the coexistence of substance use, and depression can complicate treatment of the member and can hinder providers' efforts to address the member's substance use disorder. This comorbidity places individuals at high risk for suicide and social and personal impairment.

2. **The Behavioral Health Screening for Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications** is a program based on scientific evidence that, in patients diagnosed with schizophrenia or bipolar disorder, a strong correlation exists between the prescription of antipsychotic medications and the occurrence of diabetes. Members with bipolar disorder or schizophrenia who are actively engaged in Lucet's Care Management programs and who are being treated with antipsychotics will be asked if they have had a fasting glucose or HbA1c test in the past calendar year. If not, they will be encouraged to speak with their prescriber to obtain this screening.

Adverse Event Reporting

An editable version of Adverse Event Reporting Form can be found on the Behavioral Health Plan Providers page of Lucet website. **Fax completed forms to 816-237-2374**.

Sentinel Event Reporting

Sentinel events must be reported by the facility or provider within one (1) business day from learning of the occurrence. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury may include loss of limb or function. The following are considered sentinel events:

a. **Homicide or Serious Homicide Attempt** – Any act of a member, who has received care from the facility or provider within three (3) calendar days prior to the incident, which results in the death of another individual, or which was a serious attempt to kill another individual.

b. **Serious Suicide Attempt** – Any act of self-harm by a member that results in stabilization in an intensive care unit. Consideration will be given to lethality of the attempt, intent of members and potential pattern of behavior.

c. **Sexual Assault** – Nonconsensual sexual contact involving a member, including oral, vaginal, or anal penetration or fondling of the member or another patient's sex organ(s).

d. **Unexpected Death/Completed Suicide** – Any unexpected death that occurs during treatment by the facility or provider; or a death that occurs within three (3) calendar days of the member receiving care from the facility or provider.

Incident Reporting

For incidents not meeting the definition of a sentinel event, but that could present a quality-of-care concern, the facility or provider must notify Lucet within two (2) business days from learning of the occurrence. Examples include but are not limited to:

a. Alleged or suspected abuse: verbal, physical, sexual, neglect
b. Altercation with injury or without injury
c. Elopement/unauthorized absence
d. Falls with or without injury
e. Medication error
f. Self-harming behavior or suicide attempt with or without injury

If you need to report a sentinel event or other adverse incident, please fill out and submit the Adverse Event Reporting Form. **Fax completed forms to 816-237-2374**.

Please report the incident as soon as possible, even if all information is not yet available. Final submission of all information is required within five business days of the event. Though Lucet recommends using our reporting form, we will accept the information in any form or format. Should you wish to submit the information without using our recommended form, please ensure to include all the information requested in the form.

Note: when there is secondary coverage or denied care, reporting is still required.
If you have questions, please contact: QMComplaints@lucethealth.com

Complaint Reporting

Lucet Health defines "Complaints" as an expression of dissatisfaction. There are several ways you may file a complaint or report dissatisfaction with Lucet Health. Should you desire to file a complaint regarding any aspect of your experience with Lucet Health please see the ways you can do this below.

Complaints may be sent by email: QMComplaints@lucethealth.com (No PHI, please)

Mailed to:
Lucet Health
Complaints
P.O. Box 6729
Leawood, KS 66206

Or sent by fax to:
816-237-2374

Section 5: Managing Utilization
Utilization Management Program

Lucet's Utilization Management Program is a framework for making benefit and medical necessity determinations fairly, impartially, and consistently. Lucet bases medical necessity decisions on the clinical necessity and appropriateness of health care services, procedures, or settings. Prior to completing medical necessity reviews, Utilization Managers determine if members are eligible to receive coverage for requested services based on guidelines set forth in the member's benefit plan description.

Lucet uses Placement Criteria, including LOCUS, CALOCUS, ASAM, ESCII and Medical Policies to determine the medical necessity of a requested health care service. Information about these criteria and guidelines can be found in the provider section of the Lucet website. A physical copy of the Medical Necessity Criteria can be requested by emailing Compliance at compliance@lucethealth.com,.

Utilization Management

Lucet manages behavioral health benefits requiring utilization management (UM) to ensure members have access to healthcare services that are timely, appropriate, and medically necessary. UM reviews are performed by licensed clinicians with appropriate behavioral health credentials. We coordinate care among the members' primary care physician, psychiatrist, and behavioral health therapist as appropriate.

Lucet UM staff are available 24/7/365. You can call Lucet or access our website portal (WebPass) to submit authorization requests. Please refer to the appendix in this manual for the appropriate plan and phone number to call to address questions about the UM process, send outbound communication regarding UM inquiries, connect providers with clinical peers, or initiate reviews with external or independent review organizations. Lucet staff will identify themselves by name, title, and organization when initiating or returning calls regarding UM issues. Lucet offers TDD/TYY and language assistance services for members, providers, and facilities to discuss UM issues.

Conducting Clinical Utilization Management (UM) Review

Utilization managers apply the applicable clinical review criteria to the clinical information submitted by the facility/provider when making a benefit determination for the requested treatment and/or level of care. Utilization Managers collect only the pertinent minimum information necessary to make a medical necessity determination and ensure the quality of care.

a) **Utilization** review determinations for pre-service, urgent, and concurrent reviews are based solely on the clinical information made available to Lucet at the time of the utilization review determination.

b) **Utilization** review determinations for post-service reviews are based solely on the health information submitted by the provider in the medical record at the time the care was provided.

If Utilization Managers do not have the pertinent minimum clinical information needed to make a medical necessity determination, you may be given an extension of time to supply additional clinical information. If you do not submit the additional clinical information needed after an extension, the case will be sent to a physician reviewer to complete a peer review of the information that was provided.

Lucet bases decisions about utilization of services only on eligibility, coverage, and appropriateness of the health care service. Lucet does not reward nor offer incentives to employees or personnel who perform utilization of review functions to make medically inappropriate review decisions. Lucet does not reward, hire, promote, or terminate individuals for issuing denials of coverage.

Members may contact Lucet at the phone number on their insurance card to obtain a referral to a network provider. Lucet will assist in identifying appropriate providers in the members' area and may offer additional assistance with making a timely appointment with the selected provider.

The plan fact sheets in the appendix include benefit information, eligibility, and any requirements for pre-notification or authorization for coverage specific to the plan.

Clinical Peers

Clinical reviewers and peers are available whenever a provider has concerns about access to services, authorization for services, a UM decision, a level of care recommendation, or other matters relevant to member care. A claim doesn't need to reach the formal denial or appeal process for such dialogue. External and independent review organizations are also available.

UM Process Limitations

Please also be aware that the Lucet UM process is designed to comply with the requirements set forth by federal and state statutes and regulations, accreditation standards, and plan requirements. In addition, Lucet, as well as providers and facilities, are required to abide by federal and state confidentiality laws regarding disclosing a member's information.

In compliance with confidentiality laws, Lucet will not conduct the UM process in any manner with third-party billing or management companies unless they provide written authorization using the applicable plan's Authorized Representative Form or attest to obtaining permission from the member via WebPass. This authorization is required even if the third-party billing or management company has entered a Qualified Service Organization Agreement with a provider or facility. Lucet will not accept clinical information from or disclose clinical information to these companies without such authorization.

Treatment Record Reviews

You must cooperate with treatment record reviews, audits, and requests conducted by Lucet or its designee, a payor, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services, a State Department of Insurance, the Center for Consumer Information and Insurer Oversight, the Comptroller General and all other governmental and accrediting agencies to which Lucet and a payor are subject. Lucet may conduct reviews and audits on an unplanned basis as part of continuous quality improvement and/or monitoring activities. Requirements pertaining to record reviews and access are summarized below and detailed in your Agreement with Lucet:

You will allow Lucet and payors access to data and information relating to professional and ancillary care provided to members to the extent permitted by and otherwise consistent with applicable laws. As appropriate, you will obtain all required approvals and consents to allow you to disclose such information to Lucet and its payors.

Cooperation and compliance include but are not limited to providing access to any medical records, governance documents, books, contracts, financial records, protected health information, and other documents, whether in electronic or paper format, which are relevant to:

- The services and Covered Services performed under the provider's Agreement;
- The determination that services performed are Covered Services;
- Reconciliation and coordination of benefit liabilities;
- Determination of amounts payable;
- Medical audit or review;
- Utilization management, quality improvement, care transitions, and other clinical program activities;
- Financial transactions associated with the provider's Agreement;
- Overpayment, underpayment, and documentation reviews; and
- Other relevant matters as required to conduct the audit, evaluation, or inspection deemed necessary.

Guidelines for Treatment Record Documentation

The following guidelines were developed for treatment records review and to promote orderliness, security, confidentiality, and adequate documentation. You may be asked to submit several medical records for audit per these guidelines. A passing score is considered 80 percent or higher.

1. **Confidentiality**: (a) Treatment records are securely stored, (b) treatment records are only accessible by authorized personnel, and (c) office staff receives periodic training in the confidentiality of patient information.

2. **Personal/Biographical Information**: Personal/biographical information is documented consistently in the treatment record. Information includes:

    - Name or ID number on each page
    - Date of birth
    - Home address
    - Home/work telephone numbers
    - Gender
    - Employer or school
    - Marital or legal status
    - Appropriate consent forms/guardianship information
    - Emergency contact information

3. **Comprehensive Treatment Record Organization**: A comprehensive medical record is defined as a single all-inclusive record of health information that is comprised of all clinical patient information available to the provider or facility. The internal information from the provider is integrated with external information.

    a. Practices with satellite offices must have at least one location that maintains a comprehensive treatment record.
    b. You must establish a separate record for each member. All contents of the paper or hard copy treatment record are in an established format and sequence, either in chronological or reverse chronological order.
    c. Each page in the treatment record contains the member's name or unique identifier. Each treatment record should include information regarding the member’s address, gender, DOB, employer or school name, relevant phone numbers, email addresses, emergency contacts, marital status, legal status, and guardianship, if applicable.
    d. An Electronic Medical Record (EMR) may encompass multiple applications to form a comprehensive record. For example, if demographic information such as home/work phone number is stored in one application, and follow-up visit information is stored separately from

the main EMR. All applications must be accessible to the clinical staff from an individual workstation.

4. **Allergies**: Documentation of medication allergies is clearly noted. If the patient has no known allergies, this is noted in the treatment record – typically as NKA (no known allergies) or NKDA (no known drug allergies). Physician and nurse practitioner records also clearly describe the reactions associated with allergies.

5. **Special Status Situations**: Special status situations include conditions where the patient is at imminent risk of harm, has suicidal or homicidal ideation with a plan, or is unable to conduct activities of daily living. Observations of these situations and prompt referral to the appropriate level of care are documented in the record. If the situation requires mandated reporting, please document the report in the medical record.

6. **Medication Management**: Records contain medication information. This information includes:
    - Medication prescribed, including quantity or documentation of no medication
    - Dosages and usage instructions of each medication (physician and nurse practitioner records)
    - Dates of initial prescription or refills (physician and nurse practitioner records)
    - Herbal medications or over-the-counter medications

7. **Informed consent**: Records must include evidence of informed consent, indicating that the patient or family member has been made aware of the proposed treatment modalities, the risks and benefits of such treatment, alternative treatments, and the risks of treatment and declining treatment.

8. **Alcohol, Tobacco, And Substance Use and/or Abuse**: Documentation includes past and present use of cigarettes, alcohol, and prescribed, illicit, and over-the-counter drugs, including frequency and quantity.

9. **Mental Status Evaluation**: The treatment record contains evidence of at least one mental status evaluation/examination (e.g., patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control).

10. **History**: A psychiatric and medical history was obtained and documented in the record, outlining the patient's past treatment and response (or lack thereof). The history consists of:
    - Relevant medical and psychiatric conditions
    - Previous treatment dates
    - Therapeutic interventions and responses

- Sources of clinical data (e.g., self, mother, spouse, past records)
- Relevant family information
- Consultation reports, if available/applicable (e.g., psychological testing)
- Lab test results, if applicable, in physician and nurse practitioner records (i.e., Lithium, Depakote, Tegretol levels)

11. **Minor Patients Treatment Records**: Records of minor patients (under 18 years of age) contain documentation of prenatal and parental events, complete developmental histories (physical, psychological, social, intellectual, and academic), and evidence of family involvement in care within 60 days of the initial visit. When a minor is prescribed psychotropic medication, documentation reflects parental consent and that the parent or legal guardian is informed about the medication, its purpose, side effects, risks, and treatment alternatives.

12. **Diagnostic Testing**: All diagnostic testing reports and their interpretations are present (e.g., psychological testing reports, neuropsychological testing reports, and laboratory reports).

13. **Treatment Plan**: Within the first three (3) visits, the treatment plan contains (a) specific, measurable goals, (b) documentation that the treatment plan and/or goals were discussed with the patient, (c) estimated time frames for goal attainment or problem resolution, and (d) documentation of the patient's strengths and limitations in achieving goals. Each member's personalized treatment plan should guide the overall treatment process.

14. **Diagnosis**: The treatment record documents a DSM-V or ICD-10 diagnosis or clinical impression within the first three visits. "Deferred" or "Rule out" diagnosis is acceptable but must be revised within three (3) visits. To reflect the member's appropriate Risk Adjustment Factor under the Affordable Care Act, the member's diagnosis must include all the diagnoses impacting the member, reflecting the severity of the patient's overall illness.

15. **Treatment Record Notes**: Each face-to-face encounter note contains all the following: (a) reason for the patient's visit, (b) objective and subjective documentation of the patient's presentation, (c) goal of the service, (d) summary of the intervention/service provided with the member response (e) an updated treatment plan, and (f) diagnosis being treated during service.

    Treatment Record Notes must support the medical necessity of the service provided and support the billed code. Documentation for each visit must stand alone and contain all required documentation elements in the encounter note. For example, a sign-in sheet for group therapy should not be needed in addition to the encounter note to support member's group attendance. Likewise, a copy of an appointment book should not be required in addition to an encounter note to support time.

- The treatment record reflects an individualized interaction with the member. Documentation is not repetitive or reflective of rote or cloned charting.

- Documented abnormalities in the assessment or exam (indicated by check mark or narrative) also include the provider addressing an intervention or rationale that reflects the documented abnormality.

16. **Group Notes:** Group documentation must be for each specific encounter for the date of service and each session attended, not a collective summary for multiple sessions or dates of service. Documentation must include:
    - Date, start/stop times, and duration of the group
    - Purpose of group
    - Objective and subjective documentation of the member's presentation during group (individualized to the member)
    - Summary of the intervention utilized
    - Member's response to the group
    - Provider of the group is documented and authenticated with a professional degree and/or professional credentials
    - Documentation must support medical necessity and be connected to the member's individualized treatment plan

17. **Doctors' Orders for Drug Screens**: Doctors' orders for drug screens must include rationale and the substance tested for. Orders for drug screens should not be standing orders.

18. **Legibility:** The medical record is legible to someone other than the writer for paper records and written notes. Documentation contains only those terms and abbreviations that should be understandable to other medical professionals.

19. **Author Identification, Authentication, and Date and Time of Entries:** All entries are dated, including the month, year, start and stop times, and/or duration the member was seen face-to-face by the rendering provider. Entries must also clearly identify the rendering provider and be authenticated (signed) by the individual providing the services with a professional degree (e.g., Ph.D., M.D./D.O., LCSW) and/or professional credentials.

    Only handwritten signatures and eligible EMR signatures qualify for authentication. An electronic signature must include a unique personal identifier such as a code, biometric, or password entered by the author. The signature must be adhered to the document when created and include the author's name, credentials, date of signature, and timestamp. For example, a typed signature that lacks the above-listed identifiers would not qualify as authentication.

20. **Date of Rendered Service:** Documentation reflects each service rendered for the day it was rendered. A summary of services for multiple dates of service or multiple members is unacceptable.

21. **Follow-up Appointments:** The medical record documents dates of follow-up appointments or, as appropriate, a discharge plan. Documentation of follow-up with the member has occurred if an appointment was missed.

22. **Continuity and Coordination of Care:** As applicable, the medical record reflects continuity and coordination of care as evidenced by communication with, or review of information from, other behavioral health providers, consultants, ancillary providers, and health care institutions.

23. **Coordinating Care with the PCP:** Medical records reflect contact with the member's primary care physician (PCP), as applicable, and follow-up contact as needed.

24. **Appropriate edits to documentation:** You should document the services rendered in the member's medical record at the time of service. At times, you may determine that the information entered into the medical record is not entirely accurate. If revisions need to be made to a medical record, amend and edit the record using the following steps:
    a. To remove information from the record, draw a single line through the words needing removal, ensuring the content is still readable.
    b. The individual amending or editing the record must sign and date the revision.

    Documentation should not be created or edited after receipt of a medical record request for a claim's payment audit to receive payment.

Non-Medicare Commercial Member and Provider Denial and Appeal Rights

We rely on providers to represent the level of care appropriately for each member in their requests. Retrospective modifications to authorization requests resulting in downcoded level of care are subject to further investigation and if deemed misrepresentative, may result in adverse actions, up to and including referral to law enforcement.

Non-Medicare Member and Provider Denial and Appeal Definitions

Adverse benefit determination

- A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or

failure to provide or make a payment that is based on a member's eligibility to participate in a plan;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate or
- Any cancellation or discontinuance of coverage that has a retroactive effect.

Appeal – A verbal or written request to contest an adverse benefit determination, such as services that have been denied, reduced, etc.

"Clinical Peer," "Peer Clinical Reviewer," or "Physician Reviewer" – A Board Certified Physician (MD or DO) or other Ph.D. behavioral health care professional who holds a current, unrestricted license or certificate in a state or territory of the United States to practice and is in the same or similar specialty as that which typically manages the health condition, procedures, or treatment under review. If required by the applicable state, the Clinical Peer is licensed in the state where services were rendered. Unless expressly allowed by state or federal law or regulation, the Clinical Peer is in a state or territory of the United States when conducting a peer clinical review or an appeals consideration. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the treating provider).

"Doc-to-Doc" or "Peer-to-Peer" Conversation - Synonymous terms, defined as a telephonic clinical discussion about the treatment of a member, conducted between a Clinical Peer Reviewer and the practitioner who is directing the care of the member, who is typically the attending physician for the member.

Expedited Appeal – Review of an adverse benefit determination of an urgent care request involving an admission, continued stay, or other health care service from which Member has not been discharged, and for which it has been determined that the member has a medical condition where the time frame for completing a standard appeal would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function.

Independent Review Organization (IRO) - An external review company that conducts independent, external reviews of behavioral health and substance use services to determine the appropriateness of care based on medical necessity criteria, level of care requested, and effectiveness of a requested service. IRO-employed Clinical Peers are board-certified and independently licensed. These reviewers are not affiliated with Lucet.

Initial Clinical Review – Clinical review conducted by appropriately licensed or certified health professionals. Initial clinical review staff may approve requests for

admissions, procedures, and services that meet clinical review criteria but may not make an adverse benefit determination.

Medical Necessity or Medically Necessary- Please refer to the controlling specific health plan and/or group documents for the definition of Medical Necessity.

Initial Peer Review - A Peer-to-Peer Conversation occurs when care management staff cannot approve the service request based on the available clinical information.

Post-Service Request (aka Retrospective Request) - A request for coverage of medical care or services after treatment at the requested level of care has concluded.

Clinical Peer Review Process

Initial Peer Review - When Care Management staff cannot approve the service request based on the available clinical information, the case is sent to a Clinical Peer for review. The Clinical Peer offers to conduct a peer-to-peer conversation with the Attending Physician or Practitioner directing the member's care in order to obtain or clarify the information to be used in the benefit determination. Attending providers may not delegate this responsibility, designate a representative, or use a third-party billing/management company to participate in the peer-to-peer conversation. If the discussion occurs and a decision is reached, this part of the process ends. The next step for the provider and/or member is to request an appeal (see the Appealing Adverse Benefit Determination section below).

For Inpatient and Residential services, peer-to-peer conversations are available only to the Attending provider directly involved with the member's care.
The member's primary provider/clinician may request and participate in peer-to-peer conversations for Partial Hospitalization, Intensive Outpatient, and Outpatient services.

Notification of Adverse Benefit Determination- If the Initial Peer Review results in an Adverse Benefit Determination of the requested service based on lack of medical necessity, the requesting provider and/or facility and the member are notified of the adverse benefit determination.

Notification of the adverse benefit determination is given verbally to the provider and/or facility by Care Management staff at Lucet. Written notification is also provided to the member, provider, and/or facility. The written notification includes pertinent information regarding the adverse benefit determination, including:

a. Information identifying the adverse benefit determination
b. Date(s) of the service
c. Name of provider/facility
d. The availability of the diagnosis and treatment codes and their corresponding meanings upon request

e. Discussion of the pertinent facts about the member's condition and the contractual or clinical reason and rationale for the adverse benefit determination and specific reference to the Clinical Review Criteria or benefit provision used in the decision
f. The qualifications and title of the Clinical Peer and the person making the adverse benefit determination
g. The benefit provision, guideline, standard, or criteria used in making the adverse benefit determination, which is available free of charge upon request
h. A statement that the requestor, provider, or facility is entitled to receive, upon request and free of charge, how to request copies of all documents, records, and other information relevant to the adverse benefit determination
i. A description of and how to pursue an internal appeal
j. A description of and how to pursue an external appeal
k. Contact information for an office of health insurance consumer assistance or ombudsman, if available; and
l. The telephone number to be called if there are any questions

Please note: Lucet follows URAC and NCQA standards regarding conducting peer-to-peer conversations. Prior to the initiation of the appeal process, Lucet offers attending physicians and treating practitioners the opportunity to have a clinical discussion with the clinical peer reviewer. Please refer to the respective Health Plan for specific requirements regarding peer-to-peer conversations.

Appealing Adverse Benefit Determinations

Lucet provides Members/Member representatives, Providers, and Facilities the right to appeal adverse benefit determinations when medical necessity criteria are unmet.

* Claim denials unrelated to medical necessity criteria (e.g., outside of timely filing, coding errors, contractual payment issues, etc.) have a different claims dispute process. Please refer to the Claims Dispute section below for more information about claims disputes.

*Medical necessity appeal inquiries for Medicare and Federal plans should contact the respective health plan.

Appeal rights and procedures can vary with each policy. Please refer to the initial denial letter for specific appeal rights, including but not limited to what, if any, appeal rights are available, who can request an appeal, where to send appeal requests, and time frames regarding appeal requests and responses. Lucet's role in appeals varies by plan and group. The information in this document is to be used as a general reference guide. Appeals can be requested telephonically or in writing. Written requests should include the following information:

- Member's name, certification/identification number, date of birth
- Date(s) of service and procedure/service that is being appealed

- Treating practitioner's name and contact information, including phone and fax number
- Specific reason(s)/rationale for the appeal request; an explanation of why Lucet should reevaluate the adverse benefit determination; and
- Any relevant clinical information that supports the appeal request, such as medical records or other supporting documentation

Dispute Type	Who Can Request	Submission and Timeframes
Expedited Appeal They are used when there is disagreement with an adverse benefit determination based on medical necessity criteria. The expedited appeal option is available when a medical necessity-based adverse benefit determination could seriously jeopardize the life or health of the Member. The Member must still receive treatment at the requested level of care, and urgency must be demonstrated.	Members/ authorized delegates, providers, facilities (In some instances, an Appointment of Representative (AOR) * form may be required)	**Submission** See Appendix **To Request** 180 days from the date of the denial (See appendix for policy-specific rules on timely filing and submission information) **LUCET Response** 72 hours
Standard Appeal They are used when disagreement with an adverse benefit determination based on medical necessity criteria. The standard appeal option is available for cases not meeting the requirements to expedite the appeals process.	Members/ authorized delegates, providers, facilities (In some instances, an AOR* form may be required)	**Submission** **Online:** https://webpass.ndbh.com/ **Phone:** See appendix **Fax:** 816-237-2382 **Mail:** LUCET – Attention Appeals PO Box 6729 Leawood, KS 66206-0729 **To Request** 180 days from the date of the denial (see appendix for policy-specific rules on timely filing) **LUCET Response** 30 calendar days

Post-Service Request A request for medical care coverage or services after treatment at the requested level of care has concluded. This is not a type of appeal.	Providers, facilities	**Submission** **Online:** https://webpass.ndbh.com/ **Phone:** See appendix **Fax:** 816-237-2382 **Mail:** LUCET – Attention Appeals PO Box 6729 Leawood, KS 66206-0729 **To Request** One (1) year from the date of discharge (see appendix for policy-specific rules on timely filing) **LUCET Response** 30 calendar days
Claims Dispute Used to dispute a claim denied for reasons other than not meeting medical necessity criteria. (e.g., contractual payment, coding, and timely filing issues)	Members/ authorized delegates, providers, facilities	Contact the respective Health Plan for Details

*AOR gives a provider/facility permission to request an appeal on a member's behalf.

Non-Medical Necessity Related Claims Dispute Resolution

Lucet recognizes there may be times when participating providers disagree with how a claim was adjudicated. If a claim issue cannot be resolved through an initial claim adjustment request, then a written claim dispute inquiry may be needed. This type of request is different than an appeal or grievance. Disputes are defined as a written request from a participating network provider questioning (or disputing) an adjusted claim that was based upon one of the following reasons:

- Reimbursement concerns (the allowed amount is different than a contracted fee schedule amount)
- Authorization penalties
- Maximum daily benefit denials
- Timely filing denials
- Claim bundling/unbundling
- Refund/recoupment of monies

Lucet is committed to providing health plan claim dispute guidance. See the appropriate tables noted below.

Blue Cross Blue Shield Alabama

BCBSAL Dispute Information (Excludes Medicare and FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: Facilities: 800-760-6852 Participating Providers: 877-231-7239 Online: https://providers.bcbsal.org Portal/Web/pa/resources/policies&guidelines/ Provider Appeals Mail: Blue Cross and Blue Shield of Alabama Appeals PO Box 10408 Birmingham, AL 35202-9562 Fax: 205-220-9562

Arkansas Blue Cross Blue Shield (ABCBS) Commercial HMO and PPO

ABCBS Dispute Information (Excludes Medicare and FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: 877-345-5976 Online: https://www.arkansasbluecross.com/providers Select View Forms, select Claim Reconsideration Request Form Mail: Arkansas Blue Cross and Blue Shield Attn: Medical Re-Review PO Box 3688 Little Rock, AR 72203-3688

Arkansas Blue Cross Blue Shield (ABCBS) Federal Employee Program (FEP) (including State of Arkansas Employees)

All claim dispute inquiries should be directed towards Arkansas Blue Cross Blue Shield FEP at 800-482-6655.

Arkansas Blue Cross Blue Shield (ABCBS) Medicare Advantage (MA)

All claim dispute inquiries should be directed towards Arkansas Blue Cross Blue Shield at 800-827-4814.

Walmart through Arkansas Blue Cross Blue Shield/Blue Advantage Administrators (BAA)

Walmart Dispute Information	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: 866-823-3790 Online: Blue Advantage of Arkansas Select Provider, select Email us (customer service link) Mail: Blue Advantage Administrators PO Box 1460 Little Rock, AR 72203

Florida Blue PPO, including Medicare Advantage

Florida Blue Dispute Information (Excludes Medicare and FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: 800-727-2227 Online: https://floridablue.com/providers/tools-resources/provider-manual Mail: Florida Blue Provider Disputes Department PO Box 43237 Jacksonville, FL 32203-3237

Florida Blue HMO, including Medicare Advantage and Blue Medicare Classic Plus HMO, is available in Hillsborough and Palm Beach Counties.

Florida Blue Dispute Information (Excludes Medicare and FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: 800-727-2227 Online: https://floridablue.com/providers/tools-resources/provider-manual Mail: Florida Blue Provider Disputes Department PO Box 43237 Jacksonville, FL 32203-3237

Please see the separate appendix section on Florida Blue Federal Employee Program policies.

Florida Blue Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Florida Blue at 800-333-2227 (https://fepblue.org).

Florida Blue Medicare Preferred HMO (Florida Blue and BeHealthy)

All claim dispute inquiries should be directed towards Florida Blue at 800-333-2227.

Blue Cross Blue Shield of Kansas (BCBSKS) PPO

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

Blue Cross Blue Shield of Kansas (BCBSKS) Solutions/EPO (Exclusive Provider Organization)

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

Blue Cross Blue Shield of Kansas (BCBSKS) Medicare Advantage

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO

Blue KC Dispute Information (Excludes FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. Note: Please refer to the separate appendix sections on Blue KC Medicare and Federal policies.	**How to Submit a Request** Provider Hotline: (816) 395-3929 Provider claim inquiry: (800) 432-3990 Online: https://providers.bluekc.com To efficiently handle a written request, please complete a Claim Inquiry form. An interactive PDF copy of the form is in the *Forms* section on our provider portal (see *Contact* | *Resource Directory*).

Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care, Preferred-Care Blue, BlueSelect & BlueSelect Plus PPO

Blue KC Dispute Information (Excludes FEP plans)	
Claim Dispute A written request from a provider for reconsideration of a claim payment, reduction of payment, or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.) Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual.	**How to Submit a Request** Provider Services: (816) 395-3929, opt 3 Online: https://providers.bluekc.com/ To efficiently handle a written request, please complete a Claim Inquiry form. An interactive PDF copy of the form is in the Forms section on our provider portal (see Contact | Resource Directory).

Inquiry disputes for Federal plans should be directed towards Blue KC. Please see the separate appendix sections on Blue KC Federal policies.

Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Blue KC at 800-221-2362.

Section 6: Clinical Programs Philosophy

Lucet care management philosophy is based on a member-driven approach where we seek to ensure the following:

- A member's needs are determined at the point of access, ensuring that members needing behavioral health services have access to the full continuum of care.
- Discharge planning begins at the time of admission to ensure clinically appropriate aftercare.
- Recovery is the single most important goal for the behavioral health service delivery system that requires providing member-specific, clinically necessary treatment in the least restrictive environment available.
- A member's treatment is always guided by an individualized treatment plan.
- Coordination of care that requires sharing relevant clinical information is done with appropriate respect for privacy, consistent with all Lucet policies and applicable laws governing member confidentiality.
- Timely outpatient treatment for behavioral health disorders contributes to symptom reduction and maintenance of treatment outcomes.

Care Management Program

Lucet Care Management program collaborates with providers and community health resources to assess, plan, facilitate services, and advocate for members. Such collaboration promotes optimal health outcomes. Our program incorporates member education, improves provider awareness, minimizes fragmentation of care within the healthcare delivery system, and addresses the members' physical and behavioral health needs.

By serving as a single point of contact, Care Managers use evidence-based practices to engage members and partner with providers to assist with treatment adherence and promote recovery. Care Management is a service with an emphasis on:

- Supporting members' efforts to take an active role in developing their treatment plans
- Using a member-centric holistic approach during transitions of levels of care
- Coordinating referrals to providers, community resources, and caregivers
- Improving member resiliency, self-management, and self-care
- Empowering members to adhere to their treatment plan
- Assisting members to achieve time-limited, individualized, attainable goals

Care Managers are licensed clinicians with expertise in care coordination who empower members to understand how to self-manage their health condition and support them in accessing high-quality health care.

As a Lucet provider, you may request Care Management services for a member. Please see the plan or group-specific contact information in the appendix at the back of this manual.

Care Transitions Activities

Readmissions often occur when members:

- Are not adequately prepared for self-management
- Do not know their discharge plans
- Cannot access providers when problems arise
- Receive minimal input regarding their treatment plans
- Experience medication errors
- Do not have adequate follow-up treatment

Lucet Care Transitions activities focus on providing a better member experience, improving populations' health, and reducing service costs by avoiding readmissions and improving the quality of service provided to the member.

Adequate Care Transition activities achieve multiple goals:

- Ensures that members and member support systems understand and are actively engaged in the member's individualized treatment plan
- Coordinates care with the member's outpatient behavioral and medical providers
- Addresses barriers to treatment adherence
- Verifies that follow-up care is timely and appropriate to the member's needs.

Lucet Care Transitions activities:

- Help providers and the member understand the importance of post-hospitalization aftercare
- Increase the scheduling of and attendance at post-discharge follow-up appointments within seven (7) days
- Increase member understanding, participation, and adherence to their treatment plan
- Assist members in identifying and resolving any barriers that may exist to attending aftercare appointments

Member Self-Management and Preventive Health Tools

Lucet offers self-management tools derived from scientific evidence that provide members with information in the areas of emotional well-being, relationships, and health, including:

- Smoking and tobacco use cessation
- Diet, fitness, and nutrition
- Healthy eating
- Managing stress
- Addiction
- Emotional health assessments
- Recovery and resiliency
- Treatment monitoring

These materials are available through the www.lucethealth.com website and have been evaluated for language that is easy to understand, taking members' unique needs into account. Self-management tools are reviewed every two years and are updated more frequently if new evidence is available.

Condition-specific preventive health and educational tools are also available to providers and members through www.lucethealth.com. Evidence-based information is available in the areas of depression, bipolar disorder, ADHD, Autism, and other common behavioral health conditions to help members navigate through diagnosis, treatment, questions, and concerns. If you want more information, please see the plan or group-specific contact information in the appendix at the back of this manual.

Specialty Programs

Child & Adolescent

- A dedicated team of CMs that specialize in helping youth and their families
- Strong knowledge of resources and treatment options specific to this population
- Works to avoid unnecessary admissions by connecting families with appropriate treatment and resources
- Specialized rounds with a board-certified child psychiatrist
- Monthly didactic meeting to continue CM's knowledge growth on a variety of topics and diagnoses

Eating Disorder

- Shift individual expertise to a dedicated team with specific knowledge of community specialists and resources
- Specialty team is comprised of UM, CM, and Psychiatry to increase support when navigating and identifying gaps in care
- Increased Collaboration with medical providers and health plan partners
- Specialized rounds with Lucet medical directors and eating disorder experts

SUD Hybrid

- High-risk SUD population assigned to a specific SUD specialist who serves as a single point of contact
- SUD specialist coordinates between providers, members, families, and outpatient providers
- Weekly rounds with internal Lucet Addictionologist
- SUD specialist leverages both UM and CM activities to provide a consistent and positive member and provider experience
- Specialized connection to local community SUD providers and resources

Autism Resource Program

Lucet's Autism Resource Program collaborates with providers and members to support and advocate for members with autism spectrum disorder (ASD). Such collaboration promotes optimal health and quality of life outcomes. Our program supports coordination of care, encourages adherence to clinical best practice guidelines, and offers a wide variety of referrals and education to promote optimal treatment outcomes.

Essential Components of ABA Treatment

- Training technicians to perform the following services:
    - Carry out treatment protocols accurately, frequently, and consistently;
    - Record data on treatment targets;
    - Record notes;
    - Summarize and graph data;
- Ongoing direction of technician.
- Ongoing, frequent review and analysis of direct observational data on treatment targets.
- Modification of treatment targets and protocols based on data.
- Training technicians, family members, and other caregivers to implement revised protocols.
- A complete medical record that consists of the following:
    - All assessments performed by the Behavior Analyst, using direct observation.
    - Preferred skills assessments must be developmentally and age-appropriate and include non-standardized curriculum assessments such as the ABLLS, VB-MAPP, or other developmental measurements employed during pre-treatment assessments. Only those portions of assessments that address core deficits of autism are medically necessary; this excludes assessments or portions of assessments that cover academic, speech, vocational skills, etc.
    - Individualized treatment plan with clinically significant and measurable goals that clearly address the member's active core deficits of ASD. Goals

should include the date of treatment introduction, measured baseline/present level of performance of the targeted goal, the objective present level of behavior, mastery criteria, estimated date of mastery, and a specific plan for generalization of skills.
    - Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated.
    - Documentation of treatment participants, procedures, and setting. Requested hours should reflect the provider's ability to provide treatment as well as the member's availability to participate.
    - Plan to coordinate care with member's other qualified healthcare professionals to communicate pertinent medical and/or behavioral health information.
- Transition and aftercare planning that includes the following:
    - Begin during the early phases of treatment
    - Focus on the skills and supports required for the member to transition toward their natural environment, as appropriate to their realistic developmental abilities.
    - Include systematic titration of treatment hours based on progress.
    - Identify appropriate services and supports for the period following ABA treatment.
    - Include a planning process and documentation with active involvement and collaboration with a multidisciplinary team to include caregivers.
    - Long-term outcomes must be developed specifically for the individual with ASD, be functional in nature, realistically attainable for the member's level of functioning, and focus on skills needed in current and future environments.
    - Realistic expectations should be set with current treatment plan goals connecting to long-term outcomes.
    - Transition and aftercare planning may change over time based on member progress, targeted behavior levels, and realistic outcomes of treatment.
- Training family members and other caregivers to implement selected aspects of the treatment plan. Caregiver participation is crucial to ABA treatment and should begin at the onset of services. Caregivers and providers should mutually agree upon the provider's clinical recommendations for the amount and type of caregiver training sessions.
    - Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, activities of daily living, skill acquisition, and behavior management, to include

observational measures for assurance of treatment integrity. Caregiver training is necessary to address the member's appropriate generalization of skills, including daily living activities, and potentially decrease familial stressors by increasing the member's independence.

- Caregiver training goals submitted for each authorization period must be specific to the member's identified needs. They should include goal mastery criteria, data collection, behavior management procedures, if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading, and shaping. Each caregiver goal should include the date of introduction, current performance level, and a specific plan for generalization. Goals should include measurable criteria for the acquisition of specific caregiving skills.
- It is recommended that one (1) hour of caregiver training occurs for the first ten (10) hours of direct line therapy, with an additional 0.5 hours for every additional ten (10) hours of scheduled direct line therapy unless contraindicated or caregiver declines. Caregiver training hours should increase to a higher ratio of total direct line therapy hours if member goals address activities of daily living, as the provider plans for transition to a lower level of care within the next six (6) months or, as the member comes within one (1) year of termination of benefits based on benefit coverage.
- If parents decline or are unable to participate in caregiver training, a generalization plan should be created to address members' skill generalization across environments and people.
- Caregiver training does not include training of teachers, other school staff, other health professionals, counselors, or trainers in ABA techniques. However, caregiver training can include teaching caregivers how to train other professionals or people involved in the member's life.

Diagnostic Instruments and Screening Assessments:

Screening Measures: These are brief assessments designed to identify children needing a comprehensive evaluation secondary to risks associated with delay, disorder, or disease that interfere with normal development. Screening measures differ from diagnostic measures in that they typically require less time and training to administer and have high rates of false positives. Screening measures' results indicate the risk level for disability as opposed to the provision of a diagnosis. Screening measures are not appropriate standalone support for an autism diagnosis and should be followed by in-depth assessments. Additional acceptable documentation includes autism-specific standardized assessments or a detailed clinical note based on a comprehensive review of DSM-5 signs and symptoms. Examples of screening measures include:

- Autism Spectrum Rating Scale (ASRS), short form
- Childhood Autism Rating Scale, second edition. (CARS-2)
- Childhood Autism Spectrum Test. (CAST)
- Social Communications Questionnaire (SCQ)
- Autism Behavior Checklist (ABC)
- Gillian Autism Rating Scale (GARS)
- Checklist for Autism in Toddlers (CHAT)
- MCHAT R F with follow-up questions (score 3-7)
- MCHAT R without follow-up questions (score 8-20)
- Social Responsiveness Scale, second edition (SRS-2)

Diagnostic assessments: These offer significant details concerning specific deficits and/or survey a broader swath of core behaviors in autism. The reliability and validity of the instrument are defined in depth. Reliability gauges the extent to which the instrument is free from measurement errors across time, across raters, and within the test. Validity is the degree to which other evidence supports inferences drawn from the scores yielded by the instrument. This is often grouped into content, construct, and criteria-related evidence. These assessments also provide a measure of the severity of illness. One of the following assessments is required to meet the diagnostic criteria outlined in the ABA Medical Policy:

- Autism Diagnostic Observation Schedule, second edition (ADOS-2)
- Autism Diagnostic Interview, revised (ADI-R)
- DSM-5 Checklist

Standardized Adaptive Assessment Instruments: Adaptive assessments are a type of psychological testing that is vetted, standardized, and norm referenced. These assessments provide a pathway to allow comparison of an individual member's score to a norm-referenced mean. One of the following is required within 90 days of pre-treatment assessment to establish baseline data:

- Vineland Adaptive Behavior Scale (VABS)
- Adaptive Behavior Assessment Scale (ABAS)
- Behavior Assessment System for Children (BASC)
- Pervasive Developmental Disorder Behavior Inventory (PDDBI)

Standardized Cognitive Assessments: One of the following is required within 90 days of pre-treatment assessment to establish baseline data:

- Ages & Stages Questionnaires (ASQ)
- Battelle Developmental Inventory, second edition (BDI-2)
- Developmental Assessment of Young Children 2 (DAYC-2)
- Developmental Profile-3 (DP-3 or DP-4)

- Differential Abilities Scale (DAS)
- Kaufman Brief Intelligence Test – Second Edition (KBIT-2)
- Reynolds Intellectual Assessment Scale
- Leiter International Performance Scale-R
- Mullen Scales of Early Learning
- Bayley Scales of Infant Development
- Kaufmann Assessment Battery for Children, second edition (K-ABC-II)
- Wechsler Preschool and Primary Scale of Intelligence, third edition (WPPSI-III)
- Wechsler Intelligence Scale for Children, fourth edition (WISC-IV)
- Test of Non-Verbal Intelligence, fourth edition (TONI-4)

Non-Standardized Curricular Assessments: These tools are developed to provide a curriculum-based individual assessment. They are criterion-referenced, as opposed to psychological testing, which is vetted, standardized, and norm-referenced. The latter offers a pathway to allow comparison of an individual member's score to a norm-referenced mean. These are not required but offer options to demonstrate progress in treatment. Examples include:

- Assessment of Basic Language and Learning Skills (ABLLS)
- Verbal Behavior Milestones Assessment and Placement Program (VBMAPP)
- PEAK
- Essentials For Living (EFL)
- Assessment of Functional Living Skills (AFLS)

Out of State claims coding:
ABA service providers who are in-network with their local Blue Cross and Blue Shield plan and contracted to utilize ABA service codes that are different from the approved list will be eligible for reimbursement for service codes equivalent to the covered ABA service codes listed here: Billing Codes | ABA Coding Coalition. Service codes not equal to the approved service codes do not qualify for reimbursement. Out-of-state ABA service providers should discuss approved service codes during the clinical review of requested services. For additional information about code usage, please review the ABA Coding Coalition Supplemental Guidance on Interpreting and Applying the 2019 CPT Codes for Adaptive Behavior Services.

ABA CPT Codes Requiring Face-to-Face Services

Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets and goals.

Codes 97153, 97154, 97155, 97158 require face-to-face services with the patient(s). Codes 97156 and 97157 require face-to-face services with the guardian(s)/caregiver(s) present. (REF pp 856-857 of CPT Handbook 2025).

Additional information:

- Applied Behavior Analysis (ABA) requires authorization. Lucet will assign an authorization reference number. (For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy under the Provider section of www.lucethealth.com.) Failure to obtain authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements. The authorization must be in the name of the BCBA who will be performing the services (e.g., 97151, 97155, 97156, 97157, 97158) or overseeing the technicians performing the services (e.g., 97152, 97153, 97154). Important Note: Some plans do not have a benefit for ABA services.
- All request forms are located on WebPass. For WebPass access, please contact autismadmin@lucethealth.com or prwebpass@lucethealth.com. Please include your name, email and group tax ID. The WebPass guide is located here: ABA WebPass Guide
- Please submit your request at least *two weeks* prior to authorization expiration to ensure ample time to review the request. Reviews of authorization requests may take up to 15 days. Authorization status can be viewed in WebPass.
- Prior to submitting a request, please verify that ABA is a covered benefit for the member's current diagnosis and if it requires prior authorization through Lucet.
- Changes to current authorizations can be completed using the ABA Amended Request form including provider changes, increase/decrease in hours, change of service location, additional code requests, or additional goals for review.
- Ensure all demographic information (service location address, last name, NPI, etc) is updated and accurate to prevent claims issues. This may be done through your provider portal, by contacting the health plan, or through contacting your provider representative depending on your state.
- For clinical questions, contact your Autism Care Manager or call 877-563-9347. For administrative questions, contact autismadmin@lucethealth.com.
- Single case agreements are not necessary if the member's policy covers the requested services. If the services to be rendered are not covered due to network or benefit limitations, and if the treatment is medically necessary, a single case agreement might be available if certain conditions are met. To determine if a single case agreement is an option, please contact Lucet by calling the number on the back of the member's insurance card.

Section 7: Clinical Practice Guidelines

Lucet adopts clinical practice guidelines that are meant to assist providers with screening, assessing, and treating common behavioral health and substance use disorders.

Section 8: Provider Resources

Lucet is committed to partnering with providers and facilities in their treatment of members with substance use and mental health disorders. This partnership ensures members have access to timely, appropriate treatment. One of our roles in this partnership is to provide up-to-date, evidence-based best practice provider resource tools and models. Best practice models are no substitute for sound clinical judgment but are intended to enhance compliance with current best practice treatments, focusing on positive member outcomes.

Click on the links in each section to access Lucet Clinical Best Practice Resources.

Lucet Toolkits:

Primary Care Provider Toolkit - Primary Care Physicians (PCP) help patients with their behavioral health needs. At times, patients will say that they have a behavioral health concern or diagnosis, but often, it is difficult to tell without appropriate screening and referrals. We believe that behavioral health is essential, not just because it affects a person's overall well-being but also because when it goes undetected and untreated, it often gets worse. Untreated or inappropriately treated mental health concerns negatively impact a person's quality of life, can interfere with proper management of cooccurring medical treatment, and can lead to increased utilization of the healthcare system, including frequent and often lengthy primary care visits. That's why we've created a PCP toolkit that identifies appropriate screening tools, referral processes, PCP Consult Line, and behavioral health support for members to connect members to care. Lucet encourages you to develop connections and coordinate care with primary care physicians to ensure effective delivery of service.

Healthcare Effectiveness Data Information Set (HEDIS®) Toolkit - HEDIS was developed by the National Committee for Quality Assurance (NCQA®). HEDIS is a set of performance measures used in the healthcare industry, is part of NCQA accreditation, and is an essential activity for Lucet to ensure members receive the highest quality care from providers. – HEDIS measures are tools used to gauge performance on important dimensions of care and service. HEDIS is a widely used set of performance measures used in the health care industry that is developed and maintained by the National Committee for Quality Assurance (NCQA). Over 90% of Health Plans in the United Stated use HEDIS and submit data to establish performance benchmarks. HEDIS measures set parameters to evaluate plan and provider quality by setting benchmarks for specific indicators that allow health plans to compare themselves to each other as well as members to compare when selecting health plans for health coverage. The health plan data from these plans is analyzed for outcomes and inform annual HEDIS updates. HEDIS includes measures across 6 domains of care:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.

- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems

This **Lucet HEDIS toolkit** aims to offer a better understanding of the current HEDIS behavioral health measures and to provide guidance to healthcare providers on how they can help improve the quality of care and performance of the HEDIS measures. Information on the following measures is included:

- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Use of Opioids at High Dosage (HDO)
- Use of Opioids from Multiple Providers (UOP)
- Risk of Continued Opioid Use (COU)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
- Initiation and Engagement of Substance Use Disorder Treatment (IET)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Emergency Department Toolkit - The purpose of this toolkit is to offer guidance and a better understanding of the Healthcare Effectiveness Data and Information Set (HEDIS®) behavioral health performance measures related to follow-up care for members after being seen in the emergency department (ED) for mental illness (FUM), substance use, or drug overdose (FUA). The FUA measure assesses ED visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit or a pharmacotherapy dispensing event for SUD, substance use, or drug overdose with any health care practitioner preferably within 7 days but no later than 30 days of the ED visit. The FUM measure assesses ED visits for adults and children 6 years of age and older with a principal diagnosis of mental illness or with a principal diagnosis of intentional self-harm plus a secondary diagnosis of a mental health disorder and who received a follow-up visit for mental illness with any health care practitioner preferably within 7 days but no later than 30 days of the ED visit.

Substance Use Toolkit – Approximately 22% of all patients in healthcare settings have a substance use condition, such as alcohol, opioid, or other drug abuse or dependence. Consequently, medical settings are important places to identify individuals with substance use disorders (SUD), engage them in treatment and begin providing them services (Urada et al, 2012). This toolkit was provided to assist in the identification of substance use disorders.

Mental Health Awareness Toolkit - With one in five American adults having a mental health condition, we are not alone in the behavioral health challenges we face. The Mental Health Awareness toolkit provides resources to better understand what it means to live with mental illness. We encourage you to distribute, share via social media and print the materials in this toolkit. Understand the facts to #MakeItMainstream.

Member Facing

Lucet Member Resources Library - Behavioral Health Services
The Lucet Resource Center contains vital information to help members start their journey to better mental health. Providers can access, print, and post or hand out posters and pamphlets for member education. Topics include:

Self-help tools	Screening tools
PTSD toolkit	Suicide Awareness
Stamp out Stigma	Autism Resource Center
Substance Use Disorder	Case Management

Members can also obtain information about Lucet programs provider services and print necessary forms such as consent to release information and health record requests.

Telehealth Standards

Telehealth Best Practices

Section 9: Fraud, Waste and Abuse

Lucet's Fraud, Waste, and Abuse (FWA) Program is based on regulations, recommendations, standards, and guidance from various payers, policies and law enforcement programs. We engage in a variety of activities to ensure compliance with these legal and ethical responsibilities. These activities include establishing policy & procedure, monitoring claims, conducting audits, participating in onsite investigations, managing prepayment review, and providing education on various program integrity topics.

Fraud, waste, and abuse divert critical funds from legitimate patient care, increases healthcare costs for everyone, and can expose individuals to unnecessary or harmful medical services. Lucet is committed to preventing, identifying, investigating, and reporting fraud, waste, and abuse. Lucet regularly monitors claims, audits claims, and reports all fraud and/or abuse cases to the appropriate health plan or governmental agency. We expect our Providers and Facilities to comply with all applicable state and federal laws pertaining to FWA in addition to applicable Lucet and health plan policies and procedures. Lucet will pursue and take appropriate action, up to and including criminal action, against anyone found in violation of FWA laws and regulations.

Lucet is here to answer any questions you may have regarding participating in our programs. Please visit our website or contact us at 888-611-6285

Definitions

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste is the overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to health care programs. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to health care programs, improper payment, payment for services that fail to meet professionally recognized standards of care or medically unnecessary services. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Examples of fraud, waste, and abuse include:

- Billing for services that have not been provided, including falsifying records to show delivery of such services

- Submitting false information about services performed or billing for services at a level of complexity higher than services provided or documented in the medical records
- Making a false statement or misrepresenting a material fact in any application for any benefit or payment
- Presenting a claim for services when the individual who furnished the service was not appropriately licensed
- Failing to return an overpayment within sixty (60) days after the later of either the date on which the overpayment was identified or the date any corresponding cost report was due
- Providing or ordering medically unnecessary services or tests
- Paying for referrals of Federal health care program beneficiaries
- Billing a health plan for appointments that patients did not attend
- Charging in excess of services or supplies

Audits

Lucet performs random post-payment audits of provider and facility claims and medical records to identify fraudulent billing practices. Other entities may also conduct audits, such as payors, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services, State Departments of Insurance, the Center for Consumer Information and Insurer Oversight, the Office of Inspector General (OIG) and other governmental and accrediting agencies to which Lucet and payors are subject. No specific intent to defraud is required to find that a violation of law occurred.

We expect our providers and facilities to fully cooperate and participate in all audit requests. This includes, but is not limited to, allowing Lucet access to member medical records and progress notes and permitting Lucet to conduct on-site audits or desk reviews.

Upon claims analysis and a review of member medical records, Lucet will provide a detailed letter to the provider or facility outlining any deficiencies pertaining to poor documentation or a lack of evidence to support paid services. Providers and facilities should provide a corrective action plan to remedy such deficiencies. A corrective action plan must include but is not limited to; the identified issue, corrective action to be taken, responsible parties, and the effective dates.

Claim Recoupment and Appeals

Upon the results of a claim audit analysis and/or Program Integrity medical record review, Lucet reserves the right to recommend recoupment of any claims that may have been paid incorrectly or paid pursuant to billing practices that did not adhere to Lucet's or the applicable plan's billing policies and procedures.

Post-payment audit appeals:

A. First-Level appeal: Services denied as a part of the post-pay audit process may be appealed in writing within forty-five (45) days of receipt of the findings or within the timeframe outlined in the findings letter. Written notification of appeal, specific claim lines being appealed, and any additional supporting documentation should be provided with the appeal. A member of Lucet's Program Integrity team will make the first level appeal determination. Documentation with edits or corrections will not be accepted as part of the appeal. Appeals are to be submitted as instructed in the findings letter.

B. Second-Level Appeal: A provider may request a second and final appeal in writing within 45 days of receipt of the first-level appeal determination or within the timeframe outlined in the appeal determination letter. Written notification of appeal, specific claim lines being appealed, and any additional supporting documentation should be provided with the appeal. The second and final appeal determination will be made by a Lucet Medical Director or Independent Review Organization (IRO) within 45 days of receipt of the appeal. Documentation with edits or corrections will not be accepted as part of the appeal. Second-level appeals are to be submitted as instructed in the letter containing the determination from the first-level appeal.

Excluded Persons

Under Section 1128 of the Social Security Act, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) has authority to exclude individuals from participating in Federal health care programs. Providers and facilities participating in federally funded health care programs must determine whether they or their employees and contractors are excluded from participation. It is considered fraud for a provider or facility that has been excluded from a federally funded health care program to submit a claim for services. HHS-OIG, maintains the List of Excluded Individuals/Entities (LEIE). This list may be accessed online here. Providers and facilities participating in federally funded health care programs must search this website at least monthly to identify workforce members who are excluded from receiving payment or providing services for federally funded health care programs. Excluded individuals must be promptly removed from work involving Federal and State health care programs.

Reporting Suspected Fraud, Waste or Abuse

Health care providers are essential to preserving the integrity of the health care system, protecting beneficiaries from harm, and preventing fraud, waste, and abuse. It's your responsibility to comply with program guidelines and existing laws. If you suspect healthcare fraud, waste or abuse, report it immediately. Lucet's fraud hotline is 1-855-580-4871 or you can email us at compliance@lucethealth.com.

Section 10: Billing Assistance

Billing and Missed Appointments

Lucet does not authorize payment to providers for missed appointments, nor may a member be billed unless they have agreed, in writing and prior to beginning treatment with the provider, to pay out of pocket for any missed appointments. You are not to charge members a fee for leaving their appointment early when the session length was booked for longer than 15 minutes. Please see the CPT Time Rule Table available below. Shortened sessions still qualify as a billable service. Per Lucet Agreements, providers are unable to charge members outside of their patient responsibility for billable services.

Psychiatric Diagnostic Evaluations

For psychiatric diagnostic evaluation with medical services, routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not considered medically necessary. A psychiatric diagnostic evaluation can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or if a significant change in mental status requires further assessment. An extended hiatus is generally defined as approximately six (6) months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

Medication-Assisted Treatment (MAT) Services

MAT services are only reimbursable in an outpatient setting. Facilities may not be reimbursed when the MAT services are conducted in a facility setting, such as Acute Inpatient, Residential, Partial Hospitalization, or Intensive Outpatient Services.

Maximum Visits per Day

Benefits will be authorized for only one (1) professional unit per day unless a plan specifies otherwise, except for the following combined services:

- Outpatient psychotherapy or group therapy with a non-psychiatrist provider plus medication management with a psychiatrist on the same day
- Outpatient psychotherapy or evaluation plus psychological testing on the same day. Please review the Center for Medicare and Medicaid Services (CMS) Medical Unlikely Edit (MUE) for specific procedure code limits.

Concurrent and Overlapping Services

You should not bill concurrent services, including two or more direct services being delivered at the same time to the same member. Additionally, you should not deliver overlapping services, meaning delivering non-group services to more than one Member at the same time.

Billing Submission

Ensure documentation supports the number of units and/or time-based coding billed.

- Services may only be billed in whole units. Partial units will not be accepted. For time-based codes, please refer to the CPT time rule below.
- Only the provider rendering the face-to-face session with a member can bill for that service. Unless present for the entire session, providers may not bill for services rendered by interns and provisionally licensed providers.
- Submissions for Inpatient residential services will be paid for the entire stay using the rate that is in effect on the date of admission.
- Applied Behavior Analysis (ABA) services documentation guidelines are provided within this section.

CPT Time Rule

Please refer to the most recent version of the CPT Manual for the latest information regarding billing codes. According to the CPT Manual, time is defined as the face-to-face time spent with the member. A unit of time is attained when the midpoint is passed. An hour is attained when 31 minutes have elapsed (more than midway between zero and sixty). A second hour is attained when 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. For example, to bill under Code 90832, you must work a minimum of 16 minutes. If you worked 16 - 37 minutes, you would use the 30-minute code (90832); for 38 - 52 minutes, you would use the 45-minute code (90834); and for 53+ minutes, you would use the 60-minute code (90837).

Coding Outpatient Psychotherapy Sessions Provided Without E/M Services

Actual length of session	**Code As**	**Code Description**
0-15 minutes	Not reported	-
16-37 minutes	90832	30 minutes
38-52 minutes	90834	45 minutes
53-89 minutes	90837	60 minutes

Common Billable CPT and Revenue Codes

Below is a list of commonly billed codes. Please refer to the most recent version of the CPT Manual and your fee schedule regarding qualified providers for each service.

Service Code	Treatment Description
Psychotherapy Service Codes	
+90785	Interactive complexity
90791	Psychiatric diagnostic evaluation (no medical services)
90792	Psychiatric diagnostic evaluation (with medical services)
90832	Psychotherapy, 30 minutes with a patient
+90833	Psychotherapy, 30 minutes with a patient with E/M Service
90834	Psychotherapy, 45 minutes with patient
+90836	Psychotherapy, 45 minutes with the patient when performed with E/M Service
90837	Psychotherapy, 60 minutes with patient
+90838	Psychotherapy, 60 minutes with the patient when performed with E/M Service
90839	Psychotherapy for crisis, first 60 minutes
+90840	Psychotherapy for crisis, each additional 30 minutes
90845	Psychoanalysis
90846	Family Psychotherapy without Patient Present, 50 minutes
90847	Family Psychotherapy with Patient Present, 50 minutes
90853	Group Psychotherapy

Psychological and Neuropsychological Testing Codes

Service Code	Treatment Description
96130	Psychological Testing Evaluation services by a physician or qualifying health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, and report and interactive feedback to the patient, family member (s), or caregiver (s), when performed, the first hour
+96131	Each additional hour (List separately in addition to code for primary procedure)
96132	Neuropsychological testing evaluation services by a physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, and report and interactive feedback to the patient, family member (s) or caregiver (s), when performed, first hour
+96133	Each additional hour (List separately in addition to code for primary procedure)

Test Administration and Scoring

96136	Psychological or neuropsychological test administration and scoring by a physician or other qualified health care professional, two or more tests, any method, first 30 minutes
+96137	Each additional 30 minutes (List separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
+96139	Each additional 30 minutes (List separately in addition to code for primary procedure)

Automated Testing and Result

96146	Psychological or neuropsychological test administration, with a single automated instrument via an electronic platform, with automated result only

Neurobehavioral Status Exam

96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
+96121	Each additional hour (List separately in addition to code for primary procedure)

"+" Indicates an Add-On Code to be reported with another code

E/M	
99202	Office or other outpatient visit for E/M with new patient which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes be met or exceeded.
99203	Office or other outpatient visit for E/M with new patient which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204	Office or other outpatient visit for E/M with new patient which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205	Office or other outpatient visit for E/M with new patient which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99211	Office or other outpatient visit for E/M with established patient (minimal)
99212	Office or other outpatient visit for E/M with established patient which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
99213	Office or other outpatient visit for E/M with established patient which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for E/M with established patient which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on

	the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for E/M with established patient which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99221	Initial inpatient/residential evaluation – detailed or comprehensive, low complexity
99222	Initial inpatient/residential evaluation – comprehensive, moderate complexity
99223	Initial inpatient/residential evaluation – comprehensive, high complexity
99231	Subsequent inpatient/residential visit – problem focused, straight forward or low complexity
99232	Subsequent inpatient/residential visit – problem focused, moderate complexity
99233	Subsequent inpatient/residential visit – detailed, high complexity
99238	Hospital discharge day management, 30 minutes or less
99251	Initial inpatient consultation (problem focused, straight forward)
99252	Initial inpatient consultation (expanded problem focus, straight forward)
99253	Initial inpatient consultation (detailed, low complexity)
99254	Initial inpatient consultation (comprehensive, moderate complexity)
99255	Initial inpatient consultation (comprehensive, high complexity)

CPT and REVENUE CODES IN NUMERICAL ORDER	
124	Inpatient Day – Mental Health
126	Inpatient Day – Substance Use
129	Sub-Acute/ Residential Rehabilitation
762	Observation Bed
901	Electroconvulsive Therapy-Facility Code
905	Intensive Outpatient (IOP) – Psychiatric
906	Intensive Outpatient (IOP) – Chemical Dependency
912	Partial Care (PHP) - Less Intensive

913	Partial Care (PHP) - Intensive
1001	Residential - Psychiatric
1002	Residential-Chemical Dependency

Reimbursement for services is subject to Plan guidelines.

Section 11: Compliance Program Overview

Lucet's Compliance Program is designed to prevent, detect, and resolve conduct that does not conform to local, state, and federal law. The Compliance Program is also formulated to meet the requirements for an effective compliance and ethics program as set forth by the U.S. Department of Health and Human Services Office of Inspector General ("OIG") General Compliance Program Guidance dated November 2023, the Medicare Managed Care Manual, 42 C.F.R. §422.503(b)(4)(vi), and the United States Department of Justice Sentencing Commission Guidelines §8B2.1.

Reporting Noncompliance

Lucet maintains a Compliance HelpLine for anonymous reporting of suspected noncompliance, fraud, abuse, and concerns about unethical conduct. To report a compliance concern, please contact Lucet's Compliance Department.

Phone	855-580-4871
Email	compliance@lucethealth.com
Online	Compliance and Ethics Concern Form
Mail	Lucet Compliance Department PO Box 6729 Leawood, KS 66206

Lucet will not retaliate against any person who, in good faith, reports suspected noncompliance, fraud, or abuse to Lucet, a health plan, federal or state governments, or any regulatory agency.

HIPAA Privacy and Security

To help inform members about the use and disclosure of their medical information, please refer to the Notice of Privacy Practices found at https://lucethealth.com/hipaa/. This document will explain member rights as they pertain to health information and how Lucet uses and discloses protected health information.

Lucet has implemented privacy and security measures, including the use of encrypted email, to prevent the unauthorized release of or access to personal information. As HIPAA Covered Entities, providers and facilities must also safeguard protected health information sent via email. **The confidentiality of any communication transmitted to or from Lucet via unsecured/unencrypted email cannot be guaranteed.** Please do not send medical or personal information via non-secure email.

Privacy Policy

Please refer to the Privacy Statement found at https://lucethealth.com/privacy-policy/. This statement explains how personal information is collected and used by Lucet and how this information may be disclosed to third parties.

When a visitor performs a search on www.lucethealth.com, Lucet may record information identifying the visitor and/or linking the visitor to the search performed. Lucet may also record limited information for every search request and use that information to solve technical problems with the service and to calculate overall usage statistics.

Artificial Intelligence and Machine Learning

Providers must ensure responsible use of artificial intelligence (AI) or machine learning for healthcare delivery through clear, transparent policies and oversight to guide the safe and effective use of AI and to protect patient information. AI-powered tools that automate and enhance administrative and clinical tasks for healthcare providers, rather than a single, universal manual approach, must ensure operational accountability, member safety, ethical responsibility and detections of bias in healthcare delivery. Providers shall ensure the human factor in its preparation and final review of all medical documentation, billing, coding, authorizations, and privacy releases prior to inclusion in computer systems. Providers must use tools that exhibit characteristics of trustworthy AI, such as those outlined by the National Institute of Standards and Technology (NIST), American Medical Association (AMA), or CMS AI Playbook.

Section 12: Appendix

Appendix for Blue Cross and Blue Shield Plans

(Fully insured, Federal Employee Program and Self-Funded accounts)

Note: Information in the appendix is specific to each plan (i.e., not a Lucet process). For terms and definitions, refer to the member's plan or call the Customer Service number on their ID card. Information may be subject to change. If you have questions, please direct them to the applicable plan.

Blue Cross Blue Shield of Alabama (including Southern Company)

Provider Network through Lucet

Outpatient Authorizations (Lucet)	Prior authorization is required for ABA therapy. All other outpatient services may be reviewed retrospectively. Please utilize WebPass
Precertification (Lucet)	Please call 855-339-9811
Benefits and Eligibility (Lucet)	Please call 855-339-8558 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Medical Necessity Appeals (Lucet)	Expedited Appeals 800-248-2342 Standard Appeals WebPass
Claims Inquiries (BCBSAL)	Please call 205-220-6899 or Ask-EDI@bcbsal.org See below for additional details.
Deaf or Hard of Hearing (Alabama Relay)	800-548-2546 (Voice) 800-548-2546 (TTY/HCO) 711 in your service area
Physician Help Line (Lucet)	Please call 855-339-9812
Interns & Provisionally Licensed Professionals	APPROVED

Primary Requirements

- Providers/Facilities must use an NPI number in billing.
- All Alabama providers MUST have a physical location in Alabama. Telehealth only providers must also have a physical address in AL for each TIN

Authorizations

- No authorization is required for most office-based outpatient services, including psychological or neuropsychological testing unless otherwise noted.
    - Southern Company requires authorization for Transcranial Magnetic Stimulation (TMS).
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- Precertification is required for all inpatient services.
- Precertification is required for residential treatment when covered by the Member's contract. Benefits should be verified prior to admission.
- Precertification is required for partial hospitalization and intensive outpatient services when required by the Member's contract.
- Some products require a referral from the Member's primary care physician prior to treatment.

Preferred Medical Laboratory

As of December 1, 2024, **LabCorp became the exclusive national laboratory and the only Preferred Medical Laboratory Plus (PMLP) provider in the PML network.**

This supports continued access to high-quality, low-cost lab services for members. While other contracted labs may remain in-network, American Esoteric Laboratories (AEL), BioReference, Quest Diagnostics and their affiliates are ***no longer included.***

Review the full list of laboratories that are no longer in network and access additional FAQs on the Preferred Medical Laboratory Network here.

Benefits

- Online eligibility and benefits information is available at https://providers.bcbsal.org/
    - WebPass is Lucet's online system that allows providers to access product eligibility and benefit information. Lucet WebPass system is accessible through Lucet's website, WebPass. To obtain a username and password to access the WebPass system, please follow the instructions listed on the website.
- If you have questions about Member benefits, please call Lucet Customer Service at 1-855-339-8558.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	Two (2) years after denial is rendered**	72 hours from receipt of request	Phone: 800-248-2342
Standard Appeal	Two (2) years after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 800-248-2342 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

**Excludes Medicare and FEP plans*
***Medical necessity appeal inquiries for Medicare and Federal plans should be directed to Blue Cross Blue Shield of Alabama at 800-248-2342.*
****Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Claims

Timely Filing
The timely filing of claims is 180 days.

All Blue Choice and EPS EDI Claims
Please work directly with your Practice Management System vendor or Clearinghouse to obtain information on enrolling or setting up your system to submit Blue Choice and all EPS claims to BCBSAL. Providers may work with their specific clearinghouse to set it up correctly in their practice management system. Alternatively, Providers may work directly with their practice management system vendor, even if they use a clearinghouse because the practice management system vendor will coordinate the setup for submitting Blue Choice and EPS claims to BCBSAL.

Please click the link for instructions about electronic funds transfers (EFT): Direct Deposit/EFT Registration - provider.bcbsal.org

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Supervised Interns Billing and Coding

Services provided by supervised interns must be billed under the Supervisor's NPI, in accordance with all other standard billing requirements. The following HCPCS modifiers shall be used as applicable:

- GC – Service has been performed in part by a resident under the direction of a

teaching physician

- HO – The rendering clinician or registered intern has the highest educational attainment of a master's degree.
- HP – The rendering clinician has the highest educational attainment of a doctoral degree.

Lucet Navigate and Connect Platform

In-network Alabama providers have the opportunity to participate at no cost in our best-in-class scheduling and measurement-based care technology program.

Our goal is to connect Alabama members to high quality mental health treatment in a timely fashion. Our technology platform allows our call center representatives and care managers to assist members by directly scheduling appointments with in-network providers.

As the program grows, we seek more providers to join this initiative. Participation in the program offers multiple benefits, including:

- Tailored referrals for patients, curated for your practice
- Hassle-free appointment scheduling, including appointment reminders, digital assessments that identify key issues in advance of treatment sessions and support measurement-based care

If you want to learn more and would like to speak with a Lucet team member, please fill out the Contact Us form.

Change in Demographics

Providers must review and attest to the accuracy of their demographics every 90 days on their Lucet Provider Portal account to ensure they are accurate, up-to-date, and in compliance with their obligations under The Consolidated Appropriations Act of 2021. Demographic changes can be made through the provider portal at https://providerportal.lucethealth.com/s/login/. If you have questions, please get in touch with Provider Relations at 888-611-6285 or Providersupport@Lucethealth.com. Accurate demographic information ensures timely referrals.

Medical Records

Medical records are to be provided upon request without charge.

Telemedicine

Telemedicine is a secure and HIPAA-compliant method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. The Member must have a covered mental health benefit that permits Telemedicine for Providers to receive payment for Telemedicine services.

Lucet considers telemedicine to aid in delivering behavioral health coverage using interactive telecommunications when the member and behavioral health provider are not in the same physical location. Telecommunications must be synchronous (live) telemedicine service rendered via a real-time audio and video telecommunications system. Effective 1/1/24, Alabama Providers can bill the telehealth audio-only codes 99441-99443. This must be reported when there is no visual component. See, for example, the Telehealth Billing Guide For Providers for additional guidance.

Behavioral Health Providers can provide telemedicine services at a Consulting provider site (distant site), a Referring provider site (originating site), or both.

- A Consulting provider site (distant site) is one at which services are provided to a member not physically present with the behavioral health provider. Providers will use the appropriate CPT codes for Telemedicine Behavioral Health.
- A Referring provider site (originating site) is one at which services are provided to a member in an office of a provider using the originating site's equipment to receive Telemedicine Behavioral Health services with a provider in another location. The originating site can bill BCBSAL claims for providing the equipment with the appropriate Q code but not for the behavioral health services.
- All Alabama providers MUST have a physical location in Alabama. Telehealth only providers must also have a physical address in AL for each TIN

Codes
All available fee schedule codes are appropriate for use by Behavioral Health Providers if the service provided through Telemedicine can be done with the same quality as the service provided in the office setting. Exceptions may apply during a Public Health Emergency.

When billing for behavioral health services delivered via Telemedicine, use the "**95**" or the "**GT**" modifier. Use Place of Service Code "**02**" or "**10**".

Provider's Responsibility:
Providers will choose a secure, HIPAA-compliant vendor and sign an attestation form agreeing to meet all necessary telemedicine requirements before conducting telemedicine services:

- Complete the Telemedicine Behavioral Health Services Provider Attestation form
- Meet the requirements outlined in the Telemedicine Behavioral Health Services Provider Attestation form, including the ability to provide all telemedicine sessions through secure, HIPAA-compliant technology.
- Carry Liability and malpractice insurance that covers telemedicine services.

Questions directed to your provider relations representative should be submitted through the provider portal support case form. Login and select Support to complete the support case.

Arkansas Blue Cross Blue Shield (ABCBS) Commercial HMO and PPO

Precertification (Lucet)	Please call 877-801-1159 or utilize WebPass
Organizational Determination Benefit Inquiry (Lucet)	Please call 877-801-1159 opt. 2 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 877-801-1159 opt. 1 or utilize WebPass
Medical Necessity Appeals (Lucet)	See chart below
Claims Inquiries (ABCBS)	To find the ABCBS phone number, please check the back of the member's ID card or visit https://www.arkansasbluecross.com/
Provider Relations (ABCBS)	To find the ABCBS phone number, please check the back of the member's ID card or visit https://www.arkansasbluecross.com/
Deaf or Hard of Hearing (Arkansas Relay)	800-285-1131 (Voice) 800-285-1131 (TTY) 711 in your service area
Interns & Provisionally Licensed Professionals	NOT APPROVED

** Applicable to Self-Funded groups*
***Applicable to Fully-Insured Commercial and Exchange (excludes Medicare Adv, FEP, and Self-Funded plans)*

Primary Requirements

- Providers/Facilities must use an NPI number in billing.
- Unless present for the entire session, providers may not bill for services rendered by interns and provisionally licensed providers.

Authorizations

- Authorization rules vary according to member benefits. Please call the number on the back of the member's ID card with questions.

Organizational Determinations/Benefit Inquiry

- For those services that don't require prior authorization, we encourage providers to submit an Organizational Determination/Benefit Inquiry instead. This form replaces any former courtesy reviews or formal benefit inquiries.
- An Organization Determination/Benefit Inquiry is an optional process to understand if a service meets medical necessity criteria.
- Arkansas Blue Cross will honor the decision(s) made on the Organizational Determination/Benefit Inquiry

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 877-801-1159.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	180 days after denial is rendered	72 hours from receipt of request	Phone: 800-248-2342
Standard Appeal	180 days after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 800-248-2342 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

**Excludes Medicare and FEP plans*

***Medical necessity appeal inquiries for Medicare and Federal plans should be directed to Arkansas Blue Cross Blue Shield. Please see the separate appendix sections on Arkansas Medicare and Federal policies.*

****Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Claims

- Claims must meet timely filing requirements.
- For claims inquiries, please check the back of the member's ID card or visit https://www.arkansasbluecross.com/
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – Paper claims should be mailed to:

  Arkansas Blue Cross and Blue Shield
  P.O. Box 2181
  Little Rock, AR 72203-2181

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Arkansas Blue Cross Blue Shield (ABCBS) Federal Employee Program (FEP) (including State of Arkansas Employees)

Precertification (Lucet)	Please call 877-801-1159 opt. 2 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 877-801-1159 opt. 1 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Arkansas Relay)	800-285-1131 (Voice) 800-285-1131 (TTY) 711 in your service area
Medical Necessity Appeals (Lucet)	Please call 800-367-0406
Medical Necessity Appeals (State of Arkansas)	Employee Appeals 800-484-8416 Appeals Fax 501-978-2916
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers/Facilities must use an NPI number in billing.

Authorizations

- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- No authorization is required for outpatient services, including partial hospitalization and intensive outpatient services.
- Precertification is required for all inpatient services, including residential.
- Prior authorization is required for residential services.
- No authorization is required for psychological or neuropsychological testing.

- State of Arkansas Employees: Authorization is required for ABA, inpatient, residential, partial hospitalization, intensive outpatient services, and Transcranial Magnetic Stimulation (TMS).

Timely Filing

- Timely filing of claims is 180 days.

Benefits

- ABCBS FEP department will quote benefits. If you have questions about member benefits, please call FEP customer service at 1-800-482-6655.

Claims

- Claims must meet FEP/ABCBS filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please call FEP customer service at 1-800-482-6655.
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
  Paper Claims – Paper claims should be mailed to:

  Arkansas Blue Cross Blue Shield FEP
  P.O. Box 2181
  Little Rock, AR 72203

- Arkansas Blue Cross FEP Customer Service: 1-800-482-6655
- Lucet Customer Service: Use Provider WebPass or call 800-367-0406
- All services must be billed in whole units. Partial units will not be paid.
- Paper Claims for Arkansas State Employees – Paper claims should be mailed to:

  Arkansas Blue Cross Blue Shield – Arkansas State Employees
  PO Box 8069
  Little Rock, AR 72203

- Electronic Claims for Arkansas State Employees– Providers interested in filing electronic claims should use payer ID – 00520
- To check the status of claims for Arkansas State Employees, call 1-800-482-8416

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate

for your provider type, which is available on our website at https://www.lucethealth.com/Providers. Select *Arkansas Blue Cross Blue Shield* under the *'Choose your health plan'* drop-down box, then click

the *Profile Updates* box. If you have questions, please contact provider relations at 888-611-6285. ARProviderRelations@LUCETHEALTH.com

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Arkansas Blue Cross Blue Shield (ABCBS) Medicare Advantage (MA)

Precertification (Lucet)	Please call 877-801-1159 opt. 2 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 877-801-1159 opt. 1 or utilize WebPass
Claims Inquiries (ABCBS)	Please call 800-287-4188
Provider Relations (ABCBS)	Please call 877-359-1441
Deaf or Hard of Hearing (Arkansas Relay)	800-285-1131 (Voice) 800-285-1131 (TTY) 711 in your service area
Medical Necessity Appeals (ABCBS)	Please call 501-378-2025
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers/Facilities must use an NPI number in billing.

Authorizations

- Precertification is required for inpatient, partial hospitalization, intensive outpatient services, and Transcranial Magnetic Stimulation (TMS).
- Residential is not a covered benefit for ABCBS MA.
- No authorization is required for outpatient care, psychological or neuropsychological testing.
- Applied Behavior Analysis (ABA) is a covered benefit for ABCBS MA. ABA does not require prior authorization for ABCBS MA.
- Out of Network authorization rules vary by group and plan.

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 877-891-5196.

Claims

- Claims must meet timely filing requirements.
- For claims inquiries, call 800-287-4188
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – Paper claims should be mailed to:

  Arkansas Blue Cross and Blue Shield
  P.O. Box 2181
  Little Rock, AR 72203-2181

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Walmart through Arkansas Blue Cross Blue Shield/Skai Blue Cross Blue Shield

Precertification (Lucet)	Please call 877-709-6822 opt. 2 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Arkansas Relay)	800-285-1131 (Voice) 800-285-1131 (TTY) 711 in your service area
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers/Facilities must use an NPI number in billing.

Authorizations

- Prior Authorization is required for partial hospitalization and intensive outpatient services.
- No prior authorization is required for routine outpatient services.
- Prior authorization is required for Inpatient and residential services.
- Prior authorization is required for Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- Failure to obtain prior authorization may result in denial of payment.

Timely Filing

- Timely filing of claims is 365 days.

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 1-877-709-6822 opt. 1.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	Six (6) months after denial is rendered	72 hours from receipt of request	Phone: 877-290-2623
Standard Appeal	Six (6) months after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 877-290-2623 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated.*

Claims

- Claims must meet ABCBS filing requirements.
- Clean claims will be processed within 10 to 30 days.
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – paper claims should be mailed to:

  Blue Advantage Administrators
  P.O. Box 1460
  Little Rock, AR 72203

- Lucet Customer Service: 1-877-709-6822
- All services must be billed in whole units. Partial units will not be paid.

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Florida Blue PPO, including Medicare Advantage

Authorizations for ABA Therapy (Lucet)	Fax to 816-237-2372 Attn: FL ABA Request
Precertification (Lucet)	Please call 866-730-5006 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 866-287-9569 or utilize WebPass
Claims Inquiries (Lucet)	Please call 877-801-1159 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Florida Relay)	800-955-8770 (Voice) 800-955-8771 (TTY) 711 in your service area
Medical Necessity Appeals Expedited and Member (FLBCBS)	Please call 877-842- 9118
Medical Necessity Appeals Standard (Lucet)	Please call 877-801-1159
Interns & Provisionally Licensed Professionals	APPROVED (excludes Medicare Advantage)

Authorizations

- Applied Behavior Analysis (ABA) requires authorization. Lucet will assign an authorization reference number.
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity.
- For further information regarding Psychological/Neuropsychological testing coverage, please see Florida Blue - Behavioral Health Provider Network | Lucet (lucethealth.com)
- Transcranial Magnetic Stimulation (TMS) & Electroconvulsive Therapy (ECT) require authorization. Please locate the request forms on Lucet's website or via WebPass Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.

Claims

- Please be advised: Florida Blue requires providers to utilize a type 2 NPI number. If you are billing using **a Tax ID number**, you must register for a type 2 NPI number. You will NOT have to register for a Type 2 NPI number if you are billing using your Social Security number.
    - To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
    - **Using your new group/type 2 NPI number in the billing process**
- The group/type 2 NPI number will be used as the "billing provider" on a claim
- The individual NPI number will be used as the "rendering provider" on a claim
- Claims must be filed within 180 days from the date of service to meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity.
- Claims must be submitted electronically using payer ID – 00590.
- If no method is available for submitting an electronic claim, Lucet may waive the electronic submission requirement.
- In-state and Out-of-state (BlueCard) claims review requests must be submitted through the Availity secure provider portal.
- All services must be billed in whole units. Partial units will not be paid.
- All higher levels of care must be billed based on the number of days authorized for proper benefit and claim adjudication. See Florida Blue billing guidelines on the floridablue.com website provider resources.

Inactive Providers

Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Supervised Interns Billing and Coding

Services provided by supervised interns must be billed under the Supervisor's NPI, in

accordance with all other standard billing requirements. The following HCPCS modifiers shall be used as applicable:

- GC – Service has been performed in part by a resident under the direction of a teaching physician
- HO – The rendering clinician or registered intern has the highest educational attainment of a master's degree.
- HP – The rendering clinician has the highest educational attainment of a doctoral degree.

Lucet Navigate and Connect Platform

In-network FLB providers have the opportunity to participate at no cost in our best-in-class scheduling and measurement-based care technology program.

Every year, Lucet receives thousands of calls from Florida Blue members seeking referrals to behavioral health providers. Our goal is to connect these members to high-quality mental health treatment in a timely fashion. Our technology platform, Lucet, allows our call center representatives and care managers to assist members by directly scheduling appointments with in-network providers.

As the program grows, **we seek more providers to join this initiative**. Participation in the program offers multiple benefits, including:

- Tailored referrals for patients, curated for your practice
- Hassle-free appointment scheduling, including appointment reminders
  Digital assessments that identify key issues in advance of treatment sessions and support measurement-based care

If you want to learn more and would like to speak with a Lucet team member, please fill out the Contact Us form.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	180 days after denial is rendered	72 hours from receipt of request	Phone (FLBCBS): 877-842-9118
Standard Appeal	180 days after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 800-248-2342 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

** Medical necessity appeal inquiries for federal plans should be directed to Florida Blue. Please see the separate appendix section on Florida Blue Federal Employee Program policies. Medical necessity appeal inquiries for Medicare Advantage Plans should be directed to Florida Blue at 877-842-9118.*

***Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Notifications/Certification

- Notification/Certification is required for all Inpatient, Residential, Partial Hospitalization, and Intensive Outpatient Services. Some self-funded Plans may not have this requirement. Important Note: Medicare Advantage has no benefit for Residential Services.

Benefits

- Benefits vary by group and plan. For Behavioral Health and Substance use benefit validation, providers are encouraged to contact the Lucet Contact Center at 866-287-9569.

Change in Demographics

- Changes must be submitted within 72 hours of a change related to addresses, phone numbers, fax numbers, or email; however, please provide 45 days' notice of any planned availability or demographic changes when possible.

- To submit changes, please complete the electronic update form appropriate for your provider type, which is available on our website at https://www.lucethealth.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop-down box, then click the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or Providersupport@Lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Florida Blue HMO, including Medicare Advantage and BlueMedicare Classic Plus HMO, available in Hillsborough and Palm Beach Counties,

Authorizations for ABA Therapy (Lucet)	Fax to 816-237-2372 Attn: FL ABA Request
Precertification (Lucet)	Please call 866-730-5006 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 866-287-9569 or utilize WebPass
Claims Inquiries (Lucet)	Please call 877-801-1159 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Florida Relay)	800-955-8770 (Voice) 800-955-8771 (TTY) 711 in your service area
Medical Necessity Appeals Expedited and Member (FLBCBS)	Please call 877-842- 9118
Medical Necessity Appeals Standard (Lucet)	Please call 877-801-1159
Interns & Provisionally Licensed Professionals	APPROVED (excludes Medicare Advantage & BlueMedicare Classic Plus HMO)

Authorizations

- ABA requires prior authorization from the first visit. Lucet will assign an authorization reference number. (For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the provider section of www.lucethealth.com) Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements. Note: Medicare Advantage has no benefit for Autism services.
- Authorization is required for all Inpatient, Residential, Partial Hospitalization, and Intensive Outpatient services (including ABA therapy).
    - Note: some self-funded plans may not have this requirement.
    - Note: Medicare Advantage has no benefit for Residential Services.
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity.
- For further information regarding Psychological/Neuropsychological testing coverage, please see Florida Blue - Behavioral Health Provider Network.
- Transcranial Magnetic Stimulation (TMS) and Electroconvulsive Therapy (ECT) require authorization from the first visit. Please locate the request forms on http://www.lucethealth.com or via WebPass. Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	180 days after denial is rendered	72 hours from receipt of request	Phone (FLBCBS): 877-842-9118
Standard Appeal	180 days after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 800-248-2342 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

** Medical necessity appeal inquiries for federal plans should be directed to Florida Blue. Please see the separate appendix section on Florida Blue Federal Employee Program policies. Medical necessity appeal inquiries for Medicare Advantage Plans should be directed to Florida Blue at 877-842-9118.*

***Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Claims

- Please be advised: Florida Blue requires providers to utilize a type 2 NPI number. If you are billing using **a Tax ID number**, you must register for a type 2 NPI number. You will NOT have to register for a Type 2 NPI number if you are billing using your Social Security number.
    - To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
    - **Use your new group/type 2 NPI number in the billing process**
- The group/type 2 NPI number will be used as the "billing provider" on a claim
- The individual NPI number will be used as the "rendering provider" on a claim
- Claims must be filed within 180 days from the date of service to meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity
- Claims must be submitted electronically using payer ID – 00590.
- If no method is available to submit an electronic claim, Lucet may waive the electronic submission requirement.
- In-state and Out-of-state (BlueCard) claims review requests must be submitted through the Availity secure provider portal.
- All services must be billed in whole units. Partial units will not be paid.
- All higher levels of care must be billed based on the number of days authorized for proper benefit and claim adjudication. See Florida Blue billing guidelines on the floridablue.com website, which provides resources

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Supervised Interns Billing and Coding

Services provided by supervised interns must be billed under the Supervisor's NPI, in accordance with all other standard billing requirements. The following HCPCS modifiers shall be used as applicable:

- GC – Service has been performed in part by a resident under the direction of a teaching physician
- HO – The rendering clinician or registered intern has the highest educational attainment of a master's degree.
- HP – The rendering clinician has the highest educational attainment of a doctoral degree.

Benefits

- Varies by group
- No out-of-network benefit unless a group has a Point of Service (POS) Rider
- For Behavioral Health and Substance use benefit validation, providers are encouraged to contact 866-287-9569.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type, which is available on our website at https://www.lucethealth.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop-down box, then click the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or Providersupport@Lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Florida Blue Federal Employee Program (FEP)

Authorizations for ABA Therapy (Lucet)	Fax to 816-237-2372 Attn: FL ABA Request
Precertification (Lucet)	Please call 866-730-5006 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 866-287-9569 or utilize WebPass
Claims Inquiries (Lucet)	Please call 877-801-1159 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Florida Relay)	800-955-8770 (Voice) 800-955-8771 (TTY) 711 in your service area
Reconsideration/ Inquiries (FLBCBS)	Please call 877-842- 9118
Interns & Provisionally Licensed Professionals	NOT APPROVED

Claims

- Please be advised: Florida Blue requires providers to utilize a type 2 NPI number. If you are billing using **a Tax ID number**, you must register for a type 2 NPI number. You will NOT have to register for a Type 2 NPI number if you are billing using your Social Security number.
    - To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
    - **Use your new group/type 2 NPI number in the billing process**
- The group/type 2 NPI number will be used as the "billing provider" on a claim
- The individual NPI number will be used as the "rendering provider" on a claim
- Claims must be filed within 180 days from the date of service to meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity
- Claims must be submitted electronically using payer ID – 00590.
- If no method is available for submitting an electronic claim, Lucet may waive the electronic submission requirement.
- In-state and Out-of-state (BlueCard) claims review requests must be submitted through the Availity secure provider portal.
- All services must be billed in whole units. Partial units will not be paid.
- All higher levels of care must be billed based on the number of days authorized for proper benefit and claim adjudication. See Florida Blue billing guidelines on the floridablue.com website, which provides resources

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Authorizations

- Prior authorization is required for Applied Behavior Analysis (ABA).
- No certification is required for outpatient services.
    - Exception: FEP Focus policy requires authorization for IOP/PHP when the setting is a Residential facility
- Certification is required for all Inpatient services.
- Precertification is required for Residential Treatment.
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity.
- For further information regarding Psychological/Neuropsychological testing coverage, please see Florida Blue - Behavioral Health Provider Network.
- Transcranial Magnetic Stimulation (TMS) and Electroconvulsive Therapy (ECT) require authorization from the first visit. Please locate the request forms on www.lucethealth.com or via WebPass. Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and

authorization requirements.

Benefits

- For Behavioral Health and Substance use benefit validation, providers must contact the Lucet Contact Center at 866-287-9569.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type, which is available on our website at http://www.lucethealth.com/providers. Select *Florida Blue* under the *'Choose your health plan'* drop-down box, then click the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or Providersupport@Lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Teladoc is the telehealth vendor for FEP members. Providers must be contracted with Teladoc to render telehealth services.
- Florida Blue Virtual Visits are available to FEP members at the office cost share rate and must be billed by participating providers.

Florida Blue Medicare Preferred HMO

Outpatient Authorizations (Lucet)	No authorization is required. Outpatient services may be reviewed retrospectively.
Precertification (Lucet)	Please call 866-730-5006 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 866-287-9569 or utilize WebPass
Claims Inquiries (Lucet)	Please call 877-801-1159 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Florida Relay)	800-955-8770 (Voice) 800-955-8771 (TTY) 711 in your service area
Medical Necessity Appeal (FLBCBS)	Please call 877-842-9118
Interns & Provisionally Licensed Professionals	NOT APPROVED

Authorizations

- No authorization is required for outpatient services
- Authorization is required for all inpatient, partial hospitalization, and intensive outpatient services. Authorization is required for Transcranial Magnetic Stimulation (TMS) and Electroconvulsive Therapy (ECT). Please locate the form on Florida Blue - Behavioral Health Provider Network | Lucet (lucethealth.com) or via WebPass.

- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity.
    - For further information regarding Psychological/Neuropsychological testing coverage, please see Florida Blue - Behavioral Health Provider Network .

Benefits

- Contact Lucet toll-free at 1-866-287-9569
- Benefits vary by group and plan
- Residential services are not covered

Claims

- Please be advised: Florida Blue requires providers to utilize a type 2 NPI number. If you are billing using **a Tax ID number**, you must register for a type 2 NPI number. You will NOT have to register for a Type 2 NPI number if you are billing using your Social Security number.
    - To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
    - **Use your new group/type 2 NPI number in the billing process**
- The group/type 2 NPI number will be used as the “billing provider” on a claim
- The individual NPI number will be used as the “rendering provider” on a claim
- Claims must be filed within 180 days from the date of service to meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity
- Claims must be submitted electronically using payer ID – 00590.
- If no method is available for submitting an electronic claim, Lucet may waive the electronic submission requirement.
- In-state and Out-of-state (BlueCard) claims review requests must be submitted through the Availity secure provider portal.
- All services must be billed in whole units. Partial units will not be paid.
- All higher levels of care must be billed based on the number of days authorized for proper benefit and claim adjudication. See Florida Blue billing guidelines on the Florida Blue website.

Inactive Providers

Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider’s contract upon written notice, as permitted under the terms of the applicable participation agreement.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for

your provider type, which is available on our website at https://www.lucethealth.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop-down box, then click the *Profile Updates* box. If you have

questions, please contact Provider Relations at 888-611-6285 or Providersupport@Lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Imperial Health

Behavioral Health Authorizations (Imperial)	Please call (833-838-8200)
Benefits and Eligibility (Lucet)	Please call (833-838-8200)
BH Claims Inquiries (Imperial)	Please call 800-778-9302
Provider Relations (Imperial)	Please call 800-830-3901
Deaf or Hard of Hearing (Imperial)	TTY By dialing 711
Medical Necessity Appeal Expedited (Imperial)	Please call 800-838-8271 Fax: 626-380-9049
Medical Necessity Appeal (Imperial)	Please call 800-838-8271 Fax: 626-380-9049
EDI Clearinghouse (Imperial)	Please call Office Ally (866) 575-4120
Interns & Provisionally Licensed Professionals	NOT APPROVED

Authorizations

Imperial requires prior authorization for the following behavioral health services:
Inpatient Hospital (including detox)

- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA)
- Psychological and Neuropsychological Testing (PNT) for some ASO groups

- Outpatient Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) for some ASO groups

Lucet Navigate and Connect Platform

Imperial Behavioral Health Providers have the opportunity to participate in our best-in-class scheduling and measurement-based care technology program.

Every year, Lucet receives thousands of calls seeking referrals to behavioral health providers. Our goal is to connect these members to high-quality mental health treatment in a timely fashion.

Our technology platform allows our call center representatives and care managers to assist members by directly scheduling appointments with in-network providers.

To truly understand this service's benefits to members and providers, watch this short video, which spotlights the impact of the direct scheduling program.

As the program grows, we seek more providers to join this initiative. Participation in the program offers multiple benefits, including:

- Tailored referrals for patients, curated for your practice
- Hassle-free appointment scheduling, including appointment reminders Digital assessments that identify key issues in advance of treatment sessions and support measurement-based care

If you want to learn more and would like to speak with a Lucet team member, please email learnmore@lucethealth.com.

Medical Necessity Appeals

For a Standard Appeal:

Mailing Address:	Imperial Health Plan Attention: Appeals & Grievances PO Box 60874 Pasadena, CA 91116
Phone:	English & Spanish: 800-838-8271 TTY: 711
Fax:	626-380-9049
Website:	www.imperialhealthplan.com

For a Fast Appeal:

Phone:	English & Spanish: 800-838-8271 TTY: 711
Fax:	626-380-9049

Claims

Imperial Health Plan of California, Inc.
Claims Department
PO Box 60874
Pasadena, CA 91116-6874

Imperial Health Holdings Medical Group, Inc.
Claims Department
PO Box 60075
Pasadena CA 91116

Electronic Claims
Providers can sign up on the Office Ally website at www.officeally.com or by calling (866) 575-4120.
Imperial Health Plan of California Office Ally payer code is: IHP01
Imperial Health Holdings Medical Group Office Ally payer code is: IHHMG

Change in Demographics

To update your address, contact information and W9, complete Imperials provider information change request form and email completed form to: pdm@imperialhealthholdings.com

Medical Records

Medical records are to be provided upon request without charge, as agreed to in your Imperial provider contract.

Telehealth

Reimbursement for telehealth services is subject to plan guidelines.

Complaints

For assistance with provider complaints, the Provider Network Management Department is available Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST). Our contact information is as follows:
Phone: (800) 830-3901
Email: pnm@imperialhealthholdings.com

Blue Cross Blue Shield of Kansas

Additional provider information can be found at the following links on the BCBSKS website, or you may contact your BCBSKS Provider Representative.

Plan Name	BCBSKS PPO	BCBSKS EPO	BCBSKS SOK	BCBSKS FEP	BCBSKS Medicare
Prior Authorization Inpatient Precertification Requests	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-952-5906 or or electronically on WebPass
Prior authorization RTC	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-952-5906 or electronically on WebPass	Lucet 800-9525906 or electronically on WebPass	Lucet completes enrollment in CM (preferred but not required). Submit directly to BCBSKS	N/A
Prior AuthorizationrTMS	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	No authorization required
Prior authorization ABA	Lucet Fax 816-237-2372 or Phone 877-563-9347 or electronically on WebPass	Lucet Fax 816-237-2372 or Phone 877-563-9347 or electronically on WebPass	Lucet Fax 816-237-2372 or Phone 877-563-9347 or electronically on WebPass	Lucet Fax 816-237-2372 or Phone 877-563-9347 or electronically on WebPass	N/A
Prior authorization of any other OP service	No authorization required	No authorization required	No authorization required	No authorization required	No authorization required
Benefits, Eligibility, Claims Inquiries	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990
Other inquiries	Lucet 800-952-5906	Lucet 800-952-5906	Lucet 800-952-5906	Lucet 800-952-5906	Lucet 800-589-1635
Provider relations	BCBSKS 800-432-3587	BCBSKS 800-432-3587	BCBSKS 800-432-3587	BCBSKS 800-432-3587	BCBSKS 800-432-3587
Deaf/Hard of Hearing	Kansas Relay Services 800-766-3777	Kansas Relay Services 800-766-3777	Kansas Relay Services 800-766-3777	Kansas Relay Services 800-766-3777	Kansas Relay Services 800-766-3777
Member or Provider Appeals	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990	BCBSKS 800-432-3990

Additional provider information can be found at the following links on the BCBSKS website, or you may contact your BCBSKS Provider Representative.

Professional Provider Manuals

- https://www.bcbsks.com/providers/professional/publications/manuals

Institutional Provider Manuals

- https://www.bcbsks.com/providers/institutional/resources
- Note: To access the Institutional Provider Manual, follow the offsite link and log in to your secured Blue Access portal.

Medicare Advantage Provider Policies and Procedures

- https://www.bcbsks.com/providers/medicare-advantage

Claims

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO

Prior Authorizations (Lucet)	Please call 800-528-5763 or utilize WebPass
Precertification (Lucet)	Please call 800-528-5763 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 833-302-6463 or utilize WebPass
Claims Inquiries (Lucet)	Please call 833-964-6338 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Kansas Relay)	800-766-3777 (Voice) 800-766-3777 (TTY) 711 in your service area
Deaf or Hard of Hearing (Missouri Relay)	800-735-0135 (Voice) 800-735-2966 (TTY) 711 in your service area
Medical Necessity Appeals Expedited (Lucet)	Please call 800-528-5763
Medical Necessity Appeals Standard (Lucet)	Please utilize WebPass
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers must have a Blue KC Provider number. This is assigned after credentialing is complete. If you do not already have an 8-digit Blue KC Provider ID, please get in touch with customer service at 833-964-6338. The services rendered by interns or provisionally licensed providers may bill as themselves as out of network.
- Providers/Facilities must use a NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered, regardless of whether that is an office, home, or other location.

Authorizations

- Prior authorization is required for all inpatient, residential, Transcranial Magnetic Stimulation (TMS), Electroconvulsive Therapy (ECT), and Applied Behavioral Analysis (ABA) services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Outpatient professional services do not require authorization.
- No authorization is required for partial hospitalization (PHP), intensive outpatient services (IOP) and psychological/neuropsychological testing (PNT). These services may be reviewed retrospectively to ensure they meet the criteria for medical necessity.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions. For authorizations related to autism services, please refer to the policy entitled "Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy," located under the provider section of www.lucethealth.com
- For authorizations related to TMS, please refer to instructions on the initial and continuation treatment request forms and see our medical policy for this therapy. TMS form

Timely Filing

- Timely filing of claims is 180 days.
- Claim adjustments and corrected claims must be submitted within 12 months of the original paid date for claims previously processed by Blue KC.

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 833-302-6463.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number, the member's ID number, and date of birth. The phone number for Blue Touch is 816-395-3929. Online eligibility and benefits information is available at http://www.bluekc.com/. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

Medical Necessity Appeals

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	180 days after denial is rendered	72 hours from receipt of request	Phone: 877-290-2623
Standard Appeal	180 days after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 877-290-2623 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

**Excludes FEP plans.*
***Medical necessity appeal inquiries for Federal plans should be directed towards Blue KC. Please see the separate appendix sections on Blue KC Federal policies.*
****Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Claims

- Blue KC will only accept claims via electronic billing. Use payer ID - 47171
- Blue KC Customer Service: 1-800-456-3759
- Lucet Customer Service: 800-528-5763
- All services must be billed in whole units. Partial units will not be paid.

Inactive Providers
Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of

changes to address, phone number, fax number, or email.

- To submit this update, please log in to the provider portal, navigate to *Accounts*, and then select *Roster*. To terminate a roster member who is no longer employed with your organization, enter the appropriate Termination Date and select *Save*. If you have questions, please get in touch with Provider Relations at 888-611-6285 or mailto:Providersupport@lucethealth.com.

at https://www.lucethealth.com/Providers. Select *Blue KC* under the *'Choose your health plan'* drop-down box, then click the *Profile Updates* box. If you have questions, please get in touch with Provider Relations at 888-611-6285 or KCProviderRelations@lucethealth.com

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines

Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care, Preferred-Care Blue, BlueSelect & BlueSelect Plus PPO, Affordable Care Act

Prior Authorizations (Lucet)	Please call 800-528-5763 or utilize WebPass
Precertification (Lucet)	Please call 800-528-5763 or utilize WebPass
Benefits and Eligibility (Blue KC)	Please call 833-302-6463
Claims Inquiries (Lucet)	Please call 833-964-6338 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Kansas Relay)	800-766-3777 (Voice) 800-766-3777 (TTY) 711 in your service area
Deaf or Hard of Hearing (Missouri Relay)	800-735-0135 (Voice) 800-735-2966 (TTY) 711 in your service area
Medical Necessity Appeals (Lucet)	Please call 800-528-5763 or utilize WebPass
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers must have a Blue KC Provider number. This is assigned after credentialing is complete. If you do not already have an 8-digit Blue KC Provider ID, please get in touch with customer service at 1-800-456-3759. The services rendered by interns or provisionally licensed providers may bill as themselves as out-of-network
- Providers/Facilities must use a NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered, regardless of whether that is an office, home, or other location.

Authorizations

- Prior authorization is required for all inpatient, residential, Transcranial Magnetic Stimulation (TMS), Electroconvulsive Therapy (ECT), and Applied Behavior Analysis (ABA) services.
  - Failure to obtain prior authorization may result in denial of payment.
  - Refer to the member's plan for specific benefits and authorization requirements.
- Outpatient professional services do not require authorization.
- No authorization is required for partial hospitalization (PHP), intensive outpatient services (IOP) and psychological/neuropsychological testing (PNT) except as indicated below. These services may be reviewed retrospectively to ensure they meet the criteria for medical necessity.
- The following plans require prior authorization for the specified services:
  - ACA: Individual members require prior authorization for PHP and IOP services.
  - You can identify ACA Individual members by their member ID, which begins with the prefix YBD, YBG, YJJ, YBS, or YJT.
  - Preferred Care Blue JAA: Individual members may require prior authorization for partial hospitalization (PHP), intensive outpatient services (IOP), and/or psychological/neuropsychological testing (PNT).
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions." For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the provider section of www.lucethealth.com
- For authorizations related to psychological/neuropsychological testing (PNT), please refer to instructions on the psychological/neuropsychological testing request PNT form.
- Transcranial Magnetic Stimulation (TMS) requires prior authorization. For authorizations related to TMS, please refer to the instructions on the initial and continuation treatment request forms and see our medical policy for this therapy. TMS form

Timely Filing

- Timely filing of claims is 180 days.
- Claim adjustments and corrected claims must be submitted within 12 months of the original paid date for claims previously processed by Blue KC.

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 833-302-6463.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number, the member's ID number, and date of birth. The phone number for Blue Touch is 816-395-3929.
- Online eligibility and benefits information is available at www.bluekc.com. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

Medical Necessity Appeals

(Excludes FEP plans) *

Appeal Type	Timely Filing	Lucet Turn Around Time	How to Submit a Request
Expedited Appeal	180 days after denial is rendered	72 hours from receipt of request	Phone: 877-290-2623
Standard Appeal	180 days after denial is rendered	30 calendar days from receipt of the request	Online: WebPass Phone: 877-290-2623 Fax: 816-237-2382 Mail: LUCET HEALTH Attn: Appeals PO Box 6729 Leawood, KS 66206-0729

**Medical necessity appeal inquiries for Federal plans should be directed to Blue KC. Please see the separate appendix sections on Blue KC Federal policies.*
***Member must currently be in treatment at the requested level of care, and urgency must be demonstrated*

Claims

- Blue KC will only accept claims via electronic billing. Use payer ID - 47171
- Blue KC Customer Service:1-800-456-3759
- Lucet Customer Service: 800-528-5763
- All services must be billed in whole units. Partial units will not be paid.

Inactive Providers

Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit this update, please log in to the provider portal, navigate to *Accounts*, and then select *Roster*. To terminate a roster member who is no longer employed with your organization, enter the appropriate Termination Date and select *Save*. If you have questions, please get in touch with Provider Relations at 888-611-6285 or Providersupport@lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP) and Blue Cross Blue Shield of Kansas City (Blue KC) Postal Service Health Benefits (PSHB)

Prior Authorizations (Lucet)	Please call 800-528-5763 or utilize WebPass
Precertification (Lucet)	Please call 800-528-5763 or utilize WebPass
Benefits and Eligibility (Lucet)	Please call 800-892-6048 for FEP Please call 833-467-2140 for PSHB or utilize WebPass
Claims Inquiries (Lucet)	Please call 800-528-5763 or utilize WebPass
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to Login (lucethealth.com), or email Providersupport@Lucethealth.com.
Deaf or Hard of Hearing (Kansas Relay)	800-766-3777 (Voice) 800-766-3777 (TTY) 711 in your service area
Deaf or Hard of Hearing (Missouri Relay)	800-735-0135 (Voice) 800-735-2966 (TTY) 711 in your service area
Medical Necessity Appeals (Blue KC)	Please call 800-221-2362
Interns & Provisionally Licensed Professionals	NOT APPROVED

Primary Requirements

- Providers must have a Blue KC Provider ID number. Blue KC will assign a provider ID number after credentialing is complete. To obtain a Blue KC Provider ID number, please get in touch with Blue KC customer service at 1-816-395-3678. The services rendered by interns or provisionally licensed providers may bill as themselves as out-of-network
- Providers/Facilities must use a NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered, regardless of whether that is an office, home, or other location.

Authorizations

- Precertification is required for inpatient services.
- Prior authorization is required for residential services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- No authorization is required for partial hospitalization, intensive outpatient, psychological/neuropsychological testing, or Transcranial Magnetic Stimulation (TMS) services. These services may be reviewed retrospectively to ensure medical necessity.
- Prior authorization is required for Applied Behavior Analysis (ABA).

Timely Filing

- Timely filing of claims is 180 days.
- Claim adjustments and corrected claims must be submitted within 12 months of the original paid date for claims previously processed by Blue KC

Benefits

- If you have questions about member benefits, please use provider WebPass or call Lucet Customer Service at 833-302-6463.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number, the member's ID number, and date of birth. The phone number for Blue Touch is 816-395-3929. Online eligibility and benefits information is available at www.BlueKC.com. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

Claims

- Blue KC will only accept claims via electronic billing. Use payer ID – 47171
- Blue KC Customer Service: 1-816-395-3678
- Lucet Customer Service: 1-800-528-5763
- All services must be billed in whole units. Partial units will not be paid.

Inactive Providers

Providers must submit at least one claim for covered services within any consecutive twelve (12)-month period. Failure to meet this minimum activity requirement may result in termination of the provider's contract upon written notice, as permitted under the terms of the applicable participation agreement.

Change in Demographics

- Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to address, phone number, fax number, or email.
- To submit this update, please log in to the provider portal, navigate to *Accounts*, and then select *Roster*. To terminate a roster member who is no longer employed with your organization, enter the appropriate Termination Date and select *Save*. If you have questions, please get in touch with Provider Relations at 888-611-6285 or Providersupport@lucethealth.com.

Medical Records

- Medical records are to be provided upon request without charge.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

SCAN

Precertification (SCAN)	• Fax: 800-411-0671 • Email: UMCCMDEPARTMENT@scanhealthplan.com
Benefits and Eligibility (SCAN)	• Fax: 800-411-0671 • Email: UMCCMDEPARTMENT@scanhealthplan.com
Provider Relations (Lucet)	Please call 888-611-6285, submit a support case to log in or email Providersupport@Lucethealth.com.
Medical Necessity Appeals (SCAN)	To initiate an appeal, you will need to contact the appropriate SCAN number: Members – 855-844-7226 Providers – 877-778-7226
Claims Inquiries	Please call 888-540-7226 or log into SCAN's Provider Portal and navigate to *Availity Essentials*, selecting *Claims & Payments* then *Claim Status*.
Deaf or Hard of Hearing (Relay)	Dial 711 to identify the correct toll-free number for your location.
Prescription Questions (SCAN)	Please call 855-844-7226
Medical Case Management (SCAN)	Please call 855-844-7226
Behavioral Health Case Management Fees	None

ID Card (SCAN)	Please call 855-844-7226
Pharmacy Vendor (SCAN)	Please call 855-844-7226
Telehealth Provider (Lucet)	Please call 888-611-6285, submit a support case to log in or email Providersupport@Lucethealth.com.
Telehealth Members (SCAN)	If a member has questions about urgent medical needs, please refer to SCAN's telehealth provider at the following website: www.doctorsondemand.com/scan
Specialty Benefit Template: RX program (SCAN)	Please call 855-844-7226
Transportation Benefit (SafeRide)	Please call 844-714-2218. Please see below for additional details.
Interns & Provisionally Licensed Professionals	NOT APPROVED

Managed Plans

1. SCAN Balance HMO
2. SCAN Classic HMO
3. SCAN Heart Health HMO
4. SCAN Venture HMO

Authorizations

Refer to SCAN Member Services.

Prescription Questions

- For questions about coverage, costs, or prior authorization, advise the caller that SCAN Member Services can assist and refer to the toll-free number in the chart
- For prior authorizations, the member may seek assistance or status from the provider to support a request already under review. Please confirm with the caller if a prior authorization was submitted and what support is needed to determine if the call should be directed to Member Services or the provider.
- Refer to SCAN Member Services to submit a new prior authorization, check the status of an existing one, or dispute a decision.

Services

Non-Covered Services

- Medical Marijuana
- ABA
- IOP
- Residential Substance Abuse Treatment
- Sub-Acute Detox for Substance
- Halfway House

Non-covered Providers

- Licensed Mental Health Counselor (LMHC)
- Board Certified Behavioral Analyst (BCBA)

Claims

Submit Claims

Two ways to submit a claim:

1. **EDI 873 (preferred)**
   Providers should submit all claims electronically using the EDI 837 Transaction

   Getting started

   - If you're already using a vendor, contact them to add SCAN's payer ID, or
   - Enroll with Office Ally at cms.officeally.com or (360) 975-7000 Option 1
   - Use the following payer IDs for SCAN:
   - Claims: SCAN1
   - Encounters: SCANE

2. **Paper Submission**

   If unable to submit electronically, mail a paper UB-04 or HCA 1500 to:
   SCAN Health Plan
   PO Box 21543
   Eagan, MN 55121

Check claims status:

• Portal: Log in to Availity Essentials > select Claims & Payments > Claim Status
• Phone: Call SCAN at (888) 540-7226 (note: allow for 30 days for status to reflect on portal prior to calling)

Questions about a processed claim?

• Review payment details and request copy of RA or check tracer at ECHO Health
• Review the Processed Claim Inquiry Messaging Instructions on SCAN Payer Space on Availity Essentials
• If you still have questions, call Provider Services at (888) 540-7226

Claims Disputes and Appeals

To challenge the determination of a claim, providers may submit a dispute.

Please include the appropriate form below:
• Reopening Request Form to correct a coding error or omission
• Provider Dispute Resolution (PDR) Form for non-contracted provider disputes Submit the dispute form via fax to 562-997-1835.

If unable to fax, mail it to: SCAN Health Plan Attn: SCAN Claims Provider Disputes P.O. Box 21543 Eagan, MN 55121

Benefits

Benefits vary by group and plan. For Behavioral Health and Substance use benefit validation, providers are encouraged to refer members to SCAN Member Services at 855-844-7226

Transportation Benefit

Scan members have covered transportation benefits—warm transfer members to Safe Ride: 1-844-714-2218. SafeRide has an interpreter line for bilingual callers.

Transportation Benefits:

- For Classic HMO, it's 54 one-way trips
- For Balance HMO-SNP, it's 54 one-way trips, of which 28 can be non-medical
- For Heart First HMO-SNP, it's 54 one-way trips, of which 28 can be non-medical
- For Venture HMO, it's eight (8) one-way trips

Members can schedule weekly rides for mental health appointments. SafeRide can schedule these rides! The member would call SafeRide to schedule those rides.

List of what information the member needs to have ready to request/schedule a ride:

- Date of appointment.
- Appointment time.
- Pick up location.
- Drop-off location.
- What type of appointment are they going to.
- Doctor's phone number.

They will also need to verify HIPAA.

Change in Demographics

Please provide 45 days advance notice of any planned availability or demographic changes when possible. Contractually, you must notify us within 72 hours of changes to your address, phone number, fax number, or email.

To submit changes, please complete the electronic update form appropriate for your provider type, available on our website at https://www.lucethealth.com/Providers. Select SCAN under the 'Choose your health plan' drop-down box, then click the Profile Updates box. If you have questions, please contact Provider Relations at 888-611-6285 or Provider relations@lucethealth.com.

Medical Records

Medical records requested by Lucet, SCAN, or a regulatory entity such as HHS are to be provided within a reasonable timeframe and free of charge.

Members may request a copy of their Lucet medical record by submitting a written request to Compliance@lucethealth.com.

Appendix A: Blue Plan Groups

Note: Information in the appendix is specific to each plan (i.e., not a Lucet process). It may be subject to change. If you have questions, please direct them to the applicable plan.

Appendix A.1: Tampa General Hospital

Customer Service	Please call 1-844-594-6012
PPO Provider Locator	Please call 1-800-810-2583
Preadmission Certification	Please call 1-855-288-8357
Provider Benefits/Eligibility	Please call 1-855-630-6825
Pharmacist Help Line	Please call 1-800-545-8349
EAP	Please call 1-800-624-5544
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Timely filing of claims is 180 days.

Claims

- Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.
- Claims submitted electronically using payer ID– 00590.
- Members file claims to:

  Birmingham Service Center
  PO Box 10527
  Birmingham, AL 35202-0500

Appendix A.2: Polk County Public Schools

Customer Service	Please call 1-855-630-6824
PPO Provider Locator	Please call 1-800-810-2583
Preadmission Certification	Please call 1-855-288-8357
Provider Benefits/Eligibility	Please call 1-855-630-6825
Pharmacist Help Line	Please call 1-800-545-8349
EAP	Please call 1-800-272-7252
PCSB Employee Clinic (Contracts separately with group)	Please call 1-863-419-3322
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Timely filing of claims is 180 days.

Claims

- Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.
- Claims submitted electronically using payer ID– 00590.
- Members file claims to:

  Birmingham Service Center
  PO Box 10527
  Birmingham, AL 35202-0500

Appendix B: Medicare Advantage Plans contracted with Lucet

Note: Information in the appendix is specific to each plan (i.e., not a Lucet process). It may be subject to change. If you have questions, please direct them to the applicable plan.

Appendix B.1: BayCare Select Health Plan

Benefits & Eligibility (BayCare Select Health Plan)	See the Customer Service Phone number on the Member's ID card for benefits/eligibility or call 866-509-5396
Provider Relations/ Operations (BayCare Select Health Plan)	866-509-5396
Claims Inquiries (BayCare Select Health Plan)	866-509-5396
Deaf or Hard of Hearing (Relay)	Relay services Dial 711 for the state relay service toll-free number.
Provider Appeals (BayCare Select Health Plan)	www.baycareplus.org appeals@baycarehealthplans.org 866-509-5396 DNIS 3827
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- BayCare Select Health Plan claims must be filed according to your contract:
  - Twelve (12) months from the date of service or date of discharge; or
  - Six (6) months from the date of service; or
  - 90 days from the date of discharge
- Non-contracted providers must file within twelve (12) months from the date of service or date of discharge.
- Claims received after twelve (12) months from the date of service or date of discharge or after the length of time stated in the member's contract will be denied. In such an event, the member and BayCare Health Plan will be held harmless for these amounts.

Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 81079.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services are not a covered benefit for BayCare Select Health Plan

Appendix B.2: Mutual of Omaha Medicare Advantage Company

Benefits & Eligibility	See the Customer Service Phone number on the Member's ID card for benefits/eligibility or call. Cincinnati, OH (KY) – 1-877-603-0785 San Antonio, TX – 1-866-488-0249
Provider Relations/ Operations	Cincinnati, OH (KY) – 1-877-603-0785 San Antonio, TX – 1-866-488-0249
Claims Inquiries	Cincinnati, OH (KY) – 1-877-603-0785 San Antonio, TX – 1-866-488-0249
Deaf or Hard of Hearing (Relay)	Relay services Dial 711 for the state relay service toll-free number.
Provider Appeals	www.mutualofomahacareadvantage.com appeals@mutualmedicareadvantage.com Cincinnati, OH (KY) - 877-603-0785 DNIS 3802 San Antonio, TX - 866-488-0249 DNIS 4859
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Mutual of Omaha Medicare Advantage Company claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or the length of time stated in the member's contract, will be denied. In such an event, the member and Mutual of Omaha Medicare Advantage Company will be held harmless for these amounts.

Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 82275.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services are not a covered benefit for Mutual of Omaha Medicare Advantage Company.

Appendix B.3: Medicare Advantage Insurance Company of Omaha

Benefits & Eligibility	See the Customer Service Phone number on the Member's ID card for benefits/eligibility or call. Dallas, TX – 1-844-335-3776 El Paso, TX – 1-844-335-2918 Denver, CO – 1-844-335-4178
Provider Relations / Operations	Dallas, TX – 1-844-335-3776 El Paso, TX – 1-844-335-2918 Denver, CO – 1-844-335-4178
Claims Inquiries	Dallas, TX – 1-844-335-3776 El Paso, TX – 1-844-335-2918 Denver, CO – 1-844-335-4178
Deaf or Hard of Hearing	Relay services Dial 711 for the state relay service toll-free number
Provider Appeals	Dallas, TX – 1-844-335-3776 El Paso, TX – 1-844-335-2918 Denver, CO – 1-844-335-4178
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Medicare Advantage Insurance Company of Omaha claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or the length of time stated in the member's contract, will be denied. In such an event, the member and Medicare Advantage Insurance Company of Omaha will be held harmless for these amounts.

Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 82275.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services are not a covered benefit for Medicare Advantage Insurance Company of Omaha.

Appendix B.4: Physicians Health Plan (PHP) Medicare

Benefits & Eligibility	See the Customer Service Phone number on the Member's ID card for benefits/eligibility or call PHP Sparrow & Sparrow Advantage: 1-844-529-3757 PHP Covenant & Covenant Advantage: 1-844-329-9247 PHP Advantage: 1-855-229-2172
Provider Relations / Operations	PHP Sparrow & Sparrow Advantage: 1-844-529-3757 PHP Covenant & Covenant Advantage: 1-844-329-9247 PHP Advantage: 1-855-229-2172
Claims Inquiries	PHP Sparrow & Sparrow Advantage: 1-844-529-3757 PHP Covenant & Covenant Advantage: 1-844-329-9247 PHP Advantage: 1-855-229-2172
Deaf or Hard of Hearing	Relay services Dial 711 for the state relay service toll-free number
Provider Appeals	PHP Sparrow & Sparrow Advantage: 1-844-529-3757 PHP Covenant & Covenant Advantage: 1-844-329-9247 PHP Advantage: 1-855-229-2172
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Physician Health Plan (PHP) Medicare claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or the length of time stated in the member's contract, will be denied. In such an event, the member and Physician Health Plan (PHP) Medicare will be held harmless for these amounts.

Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 83276.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Medicare for Physician Health Plan (PHP) does not cover Telehealth services.

Appendix B.5: Mary Washington Health Plan

Benefits & Eligibility	See the Customer Service Phone number on the Member's ID card for benefits/eligibility or call. Mary Washington: 1-844-529-3760
Provider Relations / Operations	Mary Washington: 1-844-529-3760
Claims Inquiries	Mary Washington: 1-844-529-3760
Deaf or Hard of Hearing	Relay services Dial 711 for the state relay service toll-free number
Provider Appeals	Mary Washington: 1-844-529-3760
Interns & Provisionally Licensed Professionals	NOT APPROVED

Timely Filing

- Mary Washington Health Plan claims must be filed within 180 days from the date of service or discharge.
- Claims received after 180 days, or the length of time stated in the member's contract, will be denied. The member and Mary Washington Health Plan will be held harmless for these amounts in such an event.

Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 83269.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services are not a covered benefit of the Mary Washington Health Plan