ACA StandardHealth with Health Choice 2024 End of Year Provider **Forums**

October 9, 2024 - Flagstaff November 13, 2024 - Mohave Pima - Canceled

Zoom Recording: https://azblue.zoom.us/rec/share/ZngfVxe_F1qMb3hkLzJdNz_lr9WS2a6aQ8-f2KlE8Qqc0_iKU9LCFHVHsObF_hqd.rDr-z4gmNbr-a8sJ?startTime=1728498491000



Health Choice

Agenda



1. Welcome
Charlotte Whitmore, VP Network Services

2 minutes

2. ACA StandardHealth with Health Choice (ACA SH HC) Contracting 10 minutes Aimee Perez, Director Contracting

3. Clinical and Integrated Health Updates
Integrated Care Management
Jennifer DeMaris, Manager Integrated Care Management

15 minutes

4. Provider Resources 20 minutes

ACA SH HC Plan

Member Benefits

Reimbursement Services

Prior Authorization, Inpatient Notification, Radiology

Additional Provider Resources

Jadelyn Fields, Manager Network Operations & Provider Educator

5. Q and A 10 minutes



ACA StandardHealth with Health Choice Contracting



Contracting Key Points

Your contract includes Participation in all Health Benefit Plans offered by Health Choice:

- ✓ Arizona Medicaid Programs as awarded
- ✓ Medicare Advantage-Special Needs Plan
- ✓ Affordable Care Act (ACA) Plan "ACA StandardHealth with Health Choice" Effective January 1, 2024

Key Things To Know!

- Continuing Care Period minimum of 90-days
 following the end date or earlier date that the Member
 no longer qualifies as a Continuing Care Patient
- Regulatory Requirement 42 USC 300gg-138

Together we make a network!

We Value Your Partnership!

- This ACA Plan is attractive to Individuals subject to Medicaid Redetermination
- ❖ Affordable, Low-Cost Premiums for Individuals who were accustomed to a Medicaid health plan
- ❖ Familiar to former Health Choice and other AHCCCS health plan members

Important timeframes

- Provide written notice by March 1st, to end on January 1st of following year
- prior to October 1st, through the end of the calendar year
- after October 1st, through the end of the first quarter of the following calendar year





Health Choice

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Integrated Care Management

Presented by: Jennifer DeMaris



Introduction and Overview

- Integrated Care Management (ICM): collaborative process designed to promote health, preventative wellness and continuity of care by assessing, planning, implementing, coordinating, monitoring, and evaluating care options and services available to our members through plan and community resources.
- Support members from birth to death for physical and mental health. Our team of Integrated Care Managers ensure members receive the necessary care and services to achieve optimal health outcomes for members
- The goal is to meet individuals' health care needs while promoting quality, cost-effective outcomes.
- We do this through direct member contact, collaboration with internal and external partners and community resources





Helping Members Stay Healthy



We explain all the benefits available under the plan.



We provide education regarding new or chronic conditions; preventative measures members can take and how to prepare for getting older



We can remind about scheduling annual visits or completing preventative screenings.



We can connect to community resources that can help with food, utilities, lodging, housing and employment





Care Management Can Help



Collaborative Approach:

 Your care manager will work closely with you, your family or loved one, your provider(s) and community supports

Services Provided:

- Comprehensive Care Coordination
- oCollaborate with your providers (physical/behavioral) providers to ensure seamless communication and continuity of care
- Care Plan or Treatment Plan Collaboration
- Gain clarity on your treatment options and make an informed decision
- Resource Identification
- OHelp in finding resources tailored to your specific needs (e.g., food, housing, and clothing)
- Support and Education
- o Increase your knowledge and access to tools for managing your health
- Feel more confident in getting assistance from medical, behavioral and community providers
- Personalized Advocacy
- •Ensure your voice is heard and your unique needs are met
- Medication Teaching
- Assistance in understanding your medication(s)



Relationships (Internal/External)

Care

Management

Connecting Members to SDOH
Supports

Community Cares

*211Community Based

Organizations Collaborating with C

Partners

Primary Care
Specialists
Pharmacy
Internal (Medical Directors, UM,

Ensuring Members Needs

Are Met

Vendor Relationships:

DME/Preferred

Aveanna

Partnerships

Community Health Fairs

Member Engagement Events

Provider Forums



Collaborative Coordination with Specialized Teams

TOC
Transition of
Care

ED Diversion

Crisis



Transitions of Care (TOC)

Provided to all members who have been admitted to a hospital/acute level of care

- Does NOT include Observation stays, ED/Urgent Care or Short Stay
- Program length: 30 days from date of discharge
- Goal: Connect to member as quickly as possible to prevent readmissions, ED or negative health outcomes
- Process:
 - Telephonic outreach attempt is done as within 24 hours from discharge
 - Confirm post discharge appointments
 - o PCP/BH provider within 7 days of discharge
 - Identify and address any gaps in knowledge/care, service needs, and barriers:
 - > DME
 - Caregiver/home assistance
 - > Transportation
 - Medication
- Provide information back to PCP/BH provider such as:
 - DC Summary
 - Medication Reconciliation
 - o Care Plan
- Refer to Care Management for any ongoing issues or extended support needed



ED Diversion Team

Identifying Causes and Reducing Repetitive ED Utilization

- Member Criteria: Individuals with 4 or more ED visits within 6 months
 - HIE ED Alerts
 - CPR (Maricopa County)
 - Provider
- Program length: 6 months to a year
- Goal: Identify root cause for ED utilization and provide an alternative
 - Lack of or Unavailable PCP
 - o Telehealth
 - Extended Hours
 - o Mobile Providers
 - Unmet needs
 - o SDOH
 - o Specialist Referral
 - o Identify and address any gaps in knowledge/care, service needs, and barriers:
 - > Transportation
 - Medication
 - > Partnership with available programs if applicable (such as Monogram, Helper Bees, Continuity Med for Pathway members)
- Provide information back to PCP/BH provider such as:
 - o Barriers
 - Upcoming appointments
 - o Care Plan (if appropriate)
- Refer to Care Management for any ongoing issues or extended support needed



Crisis Team

Individuals with Crisis Involvement

- Member Criteria: Involvement with Crisis Support
 - Community Stabilization referral from Mobile Team
 - ED
 - Specialty Care/Crisis Stabilization Unit
- Program length: 7 days from date of event
- Goal: Connect to member as quickly as possible to behavioral health services
 - o Telephonic outreach attempt is done within 24 hours from discharge
 - o If not previously receiving BH services coordinate intake or provide options to member
 - o If receiving BH services, confirm post discharge appointments
 - o PCP/BH provider within 7 days of discharge
 - o Identify and address any gaps in knowledge/care, service needs, and barriers:
 - > Transportation
 - Medication
- Provide information back to PCP/BH provider such as:
 - Crisis Summary (sent by Solari)
 - Upcoming appointments
 - Any referral to CM
- Refer to Care Management for any ongoing issues or extended support needed



Provider Resources Jadelyn Fields, Manager Network Operations & Provider Educator



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Health Choice

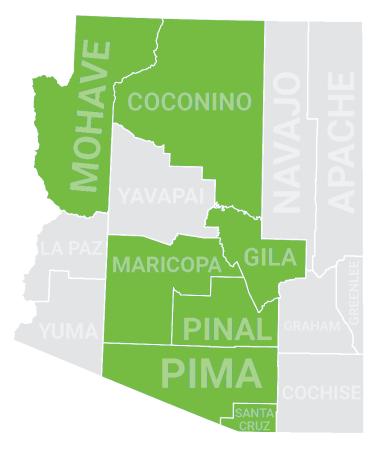
ACA StandardHealth with Health Choice Plan



2025 ACA StandardHealth with Health Choice plan

We paired our StandardHealth HMO plan with our Health Choice network to offer a unique plan in the market.

- Offering plan in 7 counties expanding to Mohave County
- Deliver a lower premium plan
- Attract Health Choice members who are no longer eligible for Medicaid





2025 ACA StandardHealth with Health Choice plan

This plan is ideal for those who:

- Are transitioning from a Health Choice plan and want to keep their same doctors
- Want added support and resources for chronic health conditions
- Prefer fixed costs for doctor and specialist visits and prescription drugs
- Need help coordinating care across multiple providers

	ACA StandardHealth with Health Choice	ACA Standard	Health with Heal	th Choice CSR
	Silver	Silver 4	Silver 5	Silver 6
Deductible	\$5,000	\$3,000	\$500	\$0
Out-of-Pocket Maximum	\$8,000	\$6,400	\$3,000	\$2,000
Assignde PCP Required	Yes	Yes	Yes	Yes
Specialist Referral Required	Yes	Yes	Yes	Yes
Primary Care (PCP) Visit	\$40	\$40	\$20	\$0
Specialist Visit	\$80	\$80	\$40	\$10
Rx Tier 1 (Generic)	\$20	\$20	\$10	\$0



Cost-Share Reduction Plan Options

(with financial help from the federal government)

2025 ACA StandardHealth with Health Choice Key Overview - FAQ

Key Overview: ACA StandardHealth with He	ealth Chaica	
Rey Overview. ACA Standard Heatti With Hi	eattii Choice —	
Plan Name	ACA StandardHealth with Health Choice	
Network	ACA Health Choice Network	
Member Prefix	IAZ (letters at the beginning of the member's ID)	
Plan Type	This is a PCP-HMO ACA plan	
Open-Access Plan	No	
PCP Required	Yes	
PCP Assignment Notification	Yes, member must be notified of PCP assignment and any changes to their assignment	
Specialist Referrals Required	Yes, the referral information must be included on the specialist claim. Approvals for t	
	referrals are not required. If the referral is not included on the claim the claim will be	
	denied.	
Types of Specialist Services Needing Referrals	Referrals are required for all non-emergency/urgent professional services provided in an	
.,,	office setting, except as noted in the member benefit book, including:	
	•Cardiac and pulmonary rehabilitative and habilitative services	
	•©hiropractic services	
	•Dbstetrics or gynecology services	
	•Dutpatient behavioral health services	
	Pediatric dental and vision services	
	■Physical, occupational, speech, or cognitive therapy ■ Physical the speech that the speech	
	•Telehealth services provided by BlueCare Anywhere SM	
	· · · · · · · · · · · · · · · · · · ·	
Specialist Referral Term	 • Drgent care/walk-in services For services that require prior auth, the time frame for the referral will correspond with the services of the referral will correspond with the services. 	
Specialist Referrat ferm		
	the time frame of the prior authorization. Other referrals are not restricted to a particular	
Drawider Cavering Cassislist Deferred	Any provider in the same group and speciality (under the same tax ID) may perform	
Provider Covering Specialist Referral	7. 7. 7.	
Eligible PCPs for Assigned PCP Requirement	services. Eligible PCPs include providers (M.D., D.O., N.P., P.A., or an OB-GYN provider during	
Eligible PCPS for Assigned PCP Requirement		
	pregnancy) actively practicing in the specialties of family medicine, internal medicine,	
	general practice, general pediatrics, or obstetrics and gynecology (for members during	
Check Eligibility, Benefits and Claims Status	pregnancy). healthchoiceaz.com/providers/provider-portal	
Medical Policies including Prior Authroization Requirements Prior Authorization Forms	healthchoiceaz.com/providers/pa-guidelines healthchoiceaz.com/providers/forms	
	Call 1-800-322-8670, fax at 1-877-422-8120 or submit online at	
Request Prior Authorization	healthchoiceaz.com/providers/provider-portal	
Claim Submission	Use EDI RP105 to submit claims to Health Choice for this plan. If you are unable to submit	
Ctaini Subinission	claims electronically, you can mail them to:	
	ACA Standard Health with Health Choice	
	P.O. BOX 52033	
Service Reimbursement	PHOENIX, AZ 85072-2033 Health Choice will reimburse you in the same way they currently reimburse you for other	
Service Reminursement		
	plans. Access remit statements through the Health Choice provider portal at	
Cubmit Annada and Cristonas	healthchoiceaz.com/providers/provider-portal	
Submit Appeals and Grievances	healthchoiceaz.com/providers/provider-portal	
Plan Administrator	AZ Blue Health Choice	
Contact Number	800-322-8670	

Please note: Credentialing and Network Contracting are two separate processes. There must be an executed agreement as well as a completed credentialing event before a practitioner or facility can provide services to BCBSAZ Health Choice Members. Our credentialing department sends initial approval letters informing you of each practitioner or facility credentialed with Health Choice.

Member Benefits



2025 Network Flyer & Open Enrollment Shoppers Guide



2025 ACA StandardHealth with Health Choice HMO



Plan Benefit Options



2025 ACA dHealth with Heal

2024/2025 Benefit Plan Changes

Adobe Acrobat
Document



2025
Individual and Family
Affordable Care Act Health Plans



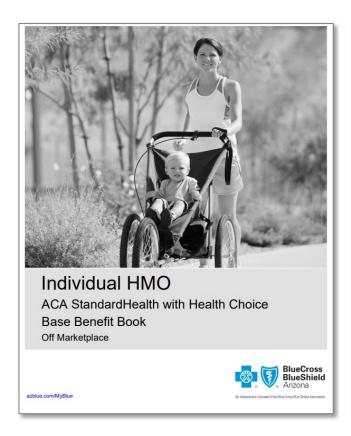
Open Enrollment/Shoppers Guide

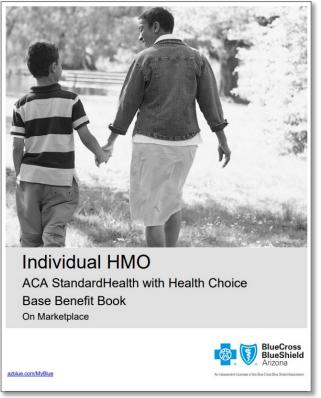


2025 Open Enrollment Guide



Benefit Books







Member Benefit Book Differences

	On Exchange	Off Exchange
Description	Plans sold on the Federally Facilitated Marketplace	Plans sold direct by BCBSAZ
Eligibility of Benefits	Provisions will vary if administered by the FFM Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) available	Provisions will vary if administered by BCBSAZ Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) not available
Terms to Know	Includes subsidy terms	Doesn't include subsidy terms
Other Health Plan Details (Premium Due Date)	The 3-month grace period for premium payment applies only for On-FFM plans for persons getting APTC. For Off-FFM plans, and On-FFM plans with no APTC, BCBSAZ allows only a 31-day grace period.	For Off-FFM plans BCBSAZ allows only a 31-day grace period.



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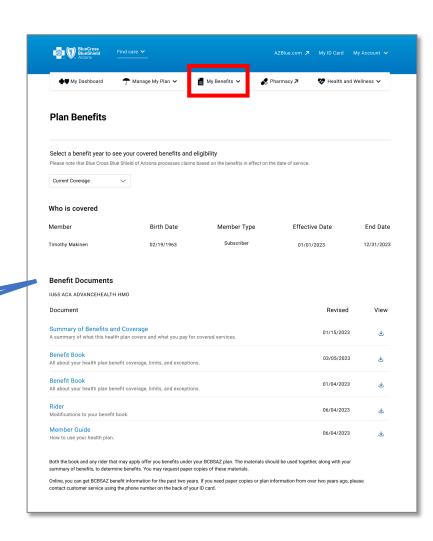
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Member Portal

Benefit documents





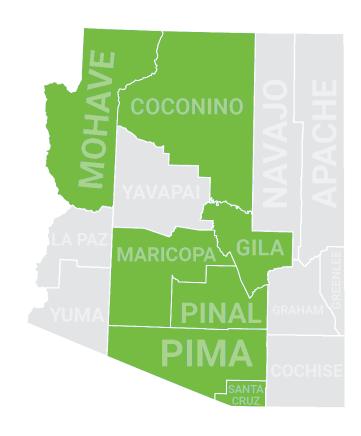


Reimbursement Services



Claims Adjudication Highlights

- Preventative Services
- Cost Share (Copay)
- Out of Network Benefits, NSA (No Surprises Act)
 The "No Surprises Act" (NSA) is part of the federal Consolidated Appropriations Act (CAA) signed into law in 2020. The NSA includes patient billing protections effective January 1, 2022. For requirements and additional information regarding NSA please visit: Claims & Remits | No Surprises Act | BCBSAZ
- Interest ARS 44-1201 and ARS 20-3102
- Grace Period Rules
- Medical Claims Review
- Coordination of Benefits
- Reconsideration/Dispute/Provider Portal







Grace Period Rules

Individuals under age 65 and their families can qualify for federal financial help to buy their health insurance coverage through the federal Health Insurance Marketplace (the Exchange). Individuals who fall below certain income levels and buy coverage through the Exchange can qualify for advance payments of a premium tax credit (APTC) to help pay their premium.

Generally, if these subsidized members become delinquent on their monthly premium payments, health insurers must follow certain federal rules before terminating their coverage. As long as these individuals pay their share of the first month of premium, insurers cannot later terminate their coverage without first giving them a three-month grace period to catch up on payments. These rules directly affect provider payments for services and may impact practice operations.

Insurers have to pay claims for services rendered during the first month of the grace period. Claims for services rendered in the second and third months of the grace period may be pended, but the member is still considered eligible. If the member doesn't pay the full amount due by the end of the grace period, the insurer must terminate the member's coverage, retroactive to the last day of the first month of the grace period. When a member defaults on the premium payment, Blue Cross® Blue Shield® of Arizona (BCBSAZ) will deny any claims for services rendered in the second and third months.

Grace Period Rules

Below is a summary of how we apply the federal requirements and implement the grace period :

- The three-month grace period applies *only* to individuals who meet all of these criteria:
 - Are enrolled in an individual qualified health plan through the Exchange
 - Are receiving a federal subsidy (APTC)
 - Have paid at least one full month's premium
- If a member meets the criteria above, we must give the member a three-month grace period to cure any default in premium payments.
- During the grace period, we cannot terminate coverage for nonpayment of premium. The member will show as "eligible" for electronic and phone inquiries about eligibility.
- We send notification letters to providers who submit claims for services for individuals who are in the second and third months of a grace period.

The notification letter indicates:

- That the claim has been pended because the subsidized member is in his or her second or third month of the three-month grace period
- That claims may be denied if the subsidized member exhausts the three-month grace period without paying all outstanding premiums
- The member's paid-through date
- We process prior authorization requests in normal timelines but notify providers, as described above, when members are in a grace period.
- We pay all appropriate claims for covered services rendered to a member during the first month of the grace period;
- We pend all non-pharmacy claims for services rendered to a member in the second and third months of the grace period.
- We are allowed to, and do, deny pharmacy claims during the second and third months of the grace period. The pharmacy receives a point-of-service denial message stating that the member does not have coverage.
- If the member cures the premium default, we process the medical claims in accordance with the member's benefit plan and all normal claim-handling procedures. Additionally, upon request, we reimburse individuals who paid for covered prescriptions during the second and third months of the grace period.

Note: No interest will be applied to these pended claims.

- If the member does not cure the default by the end of the grace period, we terminate the member's coverage (retroactive to the last day of the first month of the grace period) and deny all claims for services rendered in the second and third months.
- We process grievances and appeals as required by law. Consequently, we may request medical records for cases for members who ultimately aren't eligible. We work with providers to try to minimize unnecessary work and records requests.

Federal regulation references: 45 C.F.R. § 156.270(d)





Prior Authorization, Inpatient Notification, Radiology Benefits



Prior Authorization, Inpatient Notification, Radiology

PA Guidelines | AZBlue

Prior Authorization Grids and Dental Code List is located by visiting our website (link above).

- Medical Prior Authorization requests can be submitted:
 - o Via the secure Provider Portal:
 - o Log in Health Choice Provider Portal (healthchoiceaz.com)
 - o Dedicated ACA SH HC Fax Line: 602-864-5308
- Dental Prior Authorization requests can be submitted:
 - o Via the secure Provider Portal:
 - o Log in Health Choice Provider Portal (healthchoiceaz.com
 - o <u>Email: HCHDentalDeptHCA@azblue.com</u>
 - Mail: ACA StandardHealth with Health Choice Attn: Dental Prior Authorizations 8220 N. 23rd Ave., Phoenix, AZ 85021
- Check Prior Authorization status:
 - o On the Provider Portal
 - o By calling 800-322-8670
- EviCore is the Radiology Benefit Manager
 - ACA StandardHealth with Health Choice is partnered with eviCore for radiology benefits management of select MRI, CT, PET, ultrasound and cardiac imaging studies. To submit a new request for imaging services and select cardiac testing/procedures, contact EviCore by: Phone: 888-693-3211, Fax: 888-693-3210, or website.
- Notify us of an admission to a facility within one day: physical, behavioral, LTACH, SNF
 - o Fax: 480-760-4732





Health Choice Member Information

24/7 Member Help

Extreme heat temperatures may adversely impact patients on specific medications. Please refer to our notice Heat and Medications Information Sheet for Health Care Providers alerting healthcare providers of the impact that ambient heat may have on patients taking.

Home > ACA StandardHealth Health Choice



AZ Blue is offering a new Affordable Care Act (ACA) health plan called ACA StandardHealth with Health



For Members

benefits, your member ID card, health tips, claims, and more!

Login to your account ()

status. Visit our resource center for information about prior authorization, forms, and more

Provider Portal () Resource Center ()

BCBSAZ Health **Choice Websites** & Provider **Manuals**

Our Provider Manuals are designed to provide basic information about the administration of the BCBSAZ Health Choice Arizona, BCBSAZ Health Choice Pathway and ACA StandardHealth with Health Choice programs.

Details within our manuals are intended to furnish providers and their staff with information, covered services, claim and/or encounter submission requirements.

The Health Choice Arizona provider manual is an extension of the Health Choice Arizona Subcontractor Agreement, executed by the participating provider. The participating provider agrees to abide by all terms and conditions set forth within our Provider Manuals. The Provider Manual is incorporated into the contract each provider holds with Health Choice.

Please take advantage of additional resources available online on the 'For Providers' tab of our websites or from the 'Home' screen of your secure online provider portal.

BCBSAZ Health Choice Arizona: https://www.azblue.com/health-choice-az

BCBSAZ Health Choice Pathway: https://www.azblue.com/health-choice-pathway

ACA StandardHealth with Health Choice: https://www.azblue.com/aca-standardhealth-health-

Claim Submissions

KEEP YOUR RECORDS UP TO DATE!

By not keeping your information current, you may experience claim rejections, non-payments, or returned check payments.

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

BCBSAZ Health Choice (AHCCCS)

Health Choice **Arizona Payer ID# 62179**

P.O. BOX 52033, PHOENIX, AZ 85072-2033

BCBSAZ Health Choice Pathway (Medicare Advantage D-SNP)

Health Choice Pathway Payer ID# 62180

P.O. BOX 52033, PHOENIX, AZ 85072-2033

ACA StandardHealth with Health Choice (ACA IU65 - 1/1/2024)

ACA StandardHealth with Health Choice Payer ID# RP105

P.O. BOX 52033, PHOENIX, AZ 85072-2033

Claim Submissions: Solutions for Providers - Provider Portal

In response to the ongoing Change Healthcare system outage, BCBSAZ Health Choice has developed temporary, alternative solutions via our Provider Portal to allow providers to directly submit claims without the need for a clearinghouse, and to allow downloading and printing of remittance advices.

Electronic 837 Claims Submissions

Please follow the instructions outlined below in lieu of submission to Change Healthcare to $\underline{\textit{UPLOAD}}$ electronic claims submission.

- Log into the secure Provider Portal as normal and navigate to the 'Documents' section
- Navigate to 'Upload files' in the upper right corner
- Select appropriate 'EDI File Types', 'Line of Business', and 'Choose File' from your network to upload
- The portal will validate the file uploaded matches the file type selected before accepting for processing
- · Files accepted for processing will be updated with a status of 'File Sent to Claim System'

Electronic 835 Remittance Advices Please follow the instructions outlined below to <u>DOWNLOAD</u> electronic remits.

Printable Paper Remittance Advices

Please follow the instructions outlined below to <u>PRINT</u> paper remits.

- Log into the secure Provider Portal as normal and navigate to the 'Documents' section
- Select '835-Electronic Remittance Advice' under 'File Types'.
- Select 'Line of Business' (not required)
- Click 'Apply Filters'
- Under 'Filename' identify 835 file to download
- Click on the file hyperlink under 'Filename' to download to your network system, then open.
- Select 'RA-Paper Remittance Advice' under 'File Types'
- Select 'Line of Business' (not required)
- Click 'Apply Filters'
- Under 'Filename' identify RA file to download
- Click on the file hyperlink under 'Filename' to download to your network system
- Open the RA file from the downloaded location on your network
- Print PDF file as you would any other document

Claim Submissions: Solutions for Providers - iEDI

On March 19, 2024, BCBSAZ Health Choice added an alternative solution to support electronic claims submissions.

Providers can submit electronic 837 claims to Optum iEDI, a clearinghouse that was developed outside the Change Healthcare environment. iEDI was not impacted by the cybersecurity incident.

Provider's requiring support with the iEDI Clearinghouse should contact their dedicated Optum Account Manager.

If you do not have an Optum Account Manager, you can submit an inquiry to Optum via their general form located here: https://www.unitedhealthgroup.com/ns/changehealthcare/iedi.html.

Payer ID	Payer Name	Transactions
62179	BCBSAZ Health Choice Arizona	837 Institutional, Professional and Dental
62180	BCBSAZ Health Choice Pathway	837 Institutional and Professional
RP105	BCBSAZ ACA Standard Health With Health Choice	837 Institutional, Professional and Dental

To avoid duplicate claim denials, please ensure that you are submitting claims through only one of the available options. If you submitted claims to a clearinghouse that works with iEDI and you received a 'submitted' response, you do not need to resubmit through iEDI. Providers can contact their clearinghouse directly to confirm responses.

For more information on the Change Healthcare (now a subsidiary of Optum) cybersecurity incident: Optum Solutions Status – Update: Some applications are experiencing connectivity issues. (changehealthcare.com)

Claim Submission Reminders

KEEP YOUR RECORDS UP TO DATE!

By not keeping your information current, you may experience claim rejections, non-payments, or returned payments.

No Staple Required

Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim and <u>each page of documentation should indicate the claim number.</u>

Prior Authorization Number

Submit claims with the full and complete Prior Authorization number reported, <u>including leading zeros</u>.

Sending Correspondence to a specific department?

Help us stay efficient in getting your mail to the correct department, please <u>indicate which department</u> your mail should be directed to.

Physical/Correspondence

BCBSAZ Health Choice, BCBSAZ Health Choice Pathway OR ACA StandardHealth with Health Choice

Attention: SPECIFIC DEPARTMENT

8220 N. 23rd Ave

Phoenix, AZ 85021



Claim Submissions Outside of Arizona

As a reminder, Arizona providers and contracted providers located in contiguous counties to Arizona will submit claims to Health Choice directly.

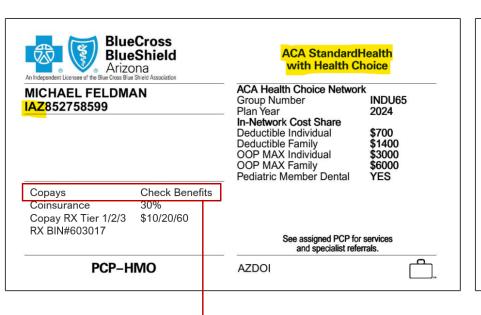
As a Blue Cross Blue Shield of Arizona plan, we align with Blue billing requirements. This change only affects billing for services rendered to a Health Choice members outside of Arizona. Providers rendering services outside of Arizona will submit claims directly to the Blue plan within that state.

EXCEPTION: Health Choice contracted providers located in contiguous (bordering) counties to Arizona will submit claims directly to Health Choice.

Below is a current listing of contiguous counties (subject to change upon county boundary changes by each state).

- California: San Bernardino County
- Nevada: Clark County and Lincoln County
- Utah: Kane County and Washington County
- Colorado: Montezuma County
- New Mexico: San Juan County, McKinley County, Cibola County, Catron County, Grant County, and Hidalgo County

ACA StandardHealth with Health Choice – Member ID Card Example





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Possession of this card does not guarantee eligibility for benefits. Prior authorization required for certain benefits. Certain benefits require a PCP referral to be covered. Except for emergencies, benefits must be provided by network providers to be covered.

Emergency services available inside and outside Arizona from non-network providers. Urgent care available outside Arizona from BlueCard Traditional providers.

File claims with the local BCBS plan, except file with Medicare when Medicare is primary and file AZ chiropractic claims with the Chiropractic Benefits Administrator. Contact BCBSAZ for air ambulance and ancillary claim filing instructions.

azblue.com/member

Customer Service: 602-864-4115 855-801-4635

 Urgent Care Outside AZ
 1 (800) 810-2583

 Provider Service
 1 (800) 322-8670

 Pharmacy Benefits
 1 (866) 325-1794

 24/7 Nurseline
 1 (888) 267-9037

 Chiropractic Benefits
 1 (800) 678-9133

BlueCross BlueShield Arizona P.O. Box 52003 Phoenix, AZ 85072-2033

Removing copays for 2025. Providers will need to look up benefits.

BCBSAZ Health Choice (Medicaid) Member ID Card Example



Health Choice



An Independent Licenses of the Disc Error Disc Shield Association

Member: John Q Sample ID #: HCIA12345678

Health Plan Name: BCBSAZ Health Choice

Member Services: 1-800-322-8670 RxBIN: 004336 RxPCN: MCAIDADV RxGRP: RX3898

Crisis Hotline: 1-844-534-4673

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM



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Arizona providers send medical claims to: BCBSAZ Health Choice PO Box 52033 Phoenix, AZ 85072-2033

Providers outside of Arizona should file all claims to the local Blue Cross and Blue Shield Plan in whose service area the member received services.

Health Choice

HealthChoiceAZ.com Member Services: 1-800-322-8670 24/7 Nurse Advice Line: 1-888-267-9037 Pharmacists Call: 1-800-364-6331

Benefits are limited to emergent care outside of Arizona.

BCBSAZ Health Choice Pathway – Member ID Card Example



Health Choice

Member: John Q Sample ID #: MZHHC1234567

Health Plan Name: BCBSAZ Health Choice Pathway (HMO D-SNP)

RxBIN: 004336 RxPCN: MEDDADV RxGRP: RX8749

Health Plan: (80840) Plan ID: H5587-002





Arizona providers send medical claims to: BCBSAZ Health Choice Pathway PO Box 52033 Phoenix, AZ 85072-2033

Providers outside of Arizona should file all claims to the local Blue Cross and Blue Shield Plan in whose service area the member received services.

Health Choice

HealthChoicePathway.com Member Services: 1-800-656-8991, TTY 711 24/7 Nurse Advice Line: 1-888-267-9037 Pharmacy Help Desk: 1-866-693-4620 Pharmacy Prior Auth and Appeals Fax: 1-877-424-5690 Crisis Hotline: 1-844-534-4673

Benefits are limited to emergent care outside of Arizona.

Health Choice Dual – Member ID Card Example



Health Choice



An Independent Liversee of the Blue Errors Blue Shield Association

Member: John Q Sample HCP ID #: MZHHC1234567 AHCCCS ID #: HCIA12345678

Health Plan Name: BCBSAZ Health Choice Pathway (HMO D-SNP) BCBSAZ Health Choice Arizona RXBIN: 004336 RXPCN: MEDDADV RXGRP: RX8748 Health Plan: (80840) Plan ID: H5587-002

Member Services: 1-800-656-8991 Crisis Hotline: 1-844-534-4673

Medicare R

MEDICARE HMO



Arizona providers send medical claims to: BCBSAZ Health Choice Pathway PO Box 52033 Phoenix, AZ 85072-2033

Health

Choice

Providers outside of Arizona should file all claims to the local Blue Cross and Blue Shield Plan in whose service area the member received services.

HealthChoicePathway.com Member Services: 1-800-656-8991, TTY 711 24/7 Nurse Advice Line: 1-888-267-9037 Pharmacy Help Desk: 1-866-693-4620 Pharmacy Prior Auth and

Appeals Fax: 1-877-424-5690

Benefits are limited to emergent care outside of Arizona.

PROVIDER PORTAL

Are you registered for the Provider Portal?

Sign-up today!

Get access to secure member eligibility, claim status/reconsideration, submit medical, dental and pharmacy prior authorization requests and much more.

COMING SOON

Quality Gaps in Care Reporting

PDM and AzAHP Credentialing Enhancements to the Summary Page Member Benefit Accumulator (Deductible Balance – ACA SH HC)

Our portal is available under the 'Login/Register' button at the top of each of our plan websites:

Health Choice AZ | AZBlue

Health Choice Pathway | AZBlue

ACA StandardHealth Health Choice | AZBlue

Easy to follow portal training video(s) on our websites 'For Providers' tab -> 'Provider Education'

Secure Provider Portal: Home Screen





HOME ELIGIBILITY CLAIMS HEMBER ROSTER QUALITY PRIOR AUTHORIZATIONS DOCUMENTS LOG OFF

DECESAZ Health Choice has developed temporary, alternative solutions via our Provider Portal to allow providers to directly submit claims without the need for a clearinghouse, and to allow downloading and printing of remittance advices.

© BCBSAZ Health Choice added an alternative solution to support electronic claims submissions on March 19, 2024. Providers can now submit electronic 837 claims to Optum iEDI, a clearinghouse that was developed outside the Change Healthcare environment. Please refer to the provider notices for additional instructions. Change Healthcare Incident Solutions and Response

Welcome to Health Choice Provider Portal

New & Upcoming Enhancements

- 🛕 You can now submit Dental Prior Authorization and Dental Specialty Referral requests directly through your secure portal.
- 1) Dental Claims History now provides member benefit balance.
- (i) Medical Review Documents (reserved ONLY for approved Hospital Tax ID): Update process for file upload directly to a claim only. Pardon our dust as we continue maintenance on this feature.

Provider Reminders

- A AHCCCS Medicaid Redeterminations are underway! Our BCBSAZ Health Choice assistors can help members Monday through Friday, 8 a.m. to 5 p.m. at 1-844-390-8935. Members can also visit HealthEArizonaPlus.gov to update their AHCCCS information.
- ① Member ID prefixes and EDI Payor ID#s: Health Choice Arizona is HCI (e.g. HCIA12345678); EDI Claim Payor #62179. Health Choice Pathway is MZH (e.g. MZHHC1234567); EDI Claim Payor ID #62180. ACA StandardHealth with Health Choice is IAZ (e.g. IAZ987654321); EDI Payor ID#RP105.
- ① Paper Claim Submission Address for all lines of business: P.O. BOX 52033, PHOENIX, AZ 85072-2033
- ♠ Recent Member Admissions and/or Discharges
- $ilde{\Omega}$ Providers can submit credentialing requests via our Provider Portal. Forms will automatically be routed to our Credentialing or Contracting department for processing with an accessible PDF form for your records. Click the Provider Demographic Request/AzAHP E-Apply Practitioner Data Form link under Provider Tools.
- ① Opportunity for Practitioner Input ① Health Choice values our network of providers and is interested in your input regarding Utilization Management (UM) Guidelines. If you have interest in assisting with development or review of UM criteria and technology, please send your contact information along with your field of practice to: HCHComments@azblue.com

Member Eligibility:

Click here to view eligibility and coordination of benefit details for a member

Authorizations Provider Tools Use one of our convenient tools to learn more about our services. Need information regarding authorizations? Choose one of the following options below. Use one of our convenient tools to manage your account or look up answers in our document · Claims Lookup · View Your Medical Prior Authorization Status · Dental History / Benefits · Provider Member Roster · View Your Dental Prior Authorization Status · Vision History / Benefits · Health Choice & Health Choice Pathway - Pharmacy Prior Authorization Request Provider Resources Health Choice Arizona - Prior Authorization Grid • Health Choice Integrated Care Provider Portal Health Choice Pathway - Prior Authorization Grid (Arizona) • Provider Demographic Request/Electronic Credentialing – AzAHP Practitioner Data form

· ACA StandardHealth with Health Choice - Prior Authorization Grid

Drivoev Notice

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Contact Us

Provider Portal View: Provider Resources



Provider Resources

Please note that user Account passwords should NOT be shared between employees. Sharing password

visit us online under our "For Providers" tab for content specific to education-related material.

BCBSAZ Health Choice (Medicaid)

BCBSAZ Health Choice Pathway (Dual SNP HMO Medicare Advantage)

Provider Manuals

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- · ACA StandardHealth with Health Choice

Provider Notices

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- · ACA StandardHealth with Health Choice

Prior Authorization Guidelines

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- ACA StandardHealth with Health Choice

Provider Forms

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- · ACA StandardHealth with Health Choice

Provider Education (POLT List, Portal Training Videos, Newsletters, Quality Coding)

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- ACA StandardHealth with Health Choice

Dental Matrix and Clinical Review Criteria

- BCBSAZ Health Choice Dental Benefits Matrices
- · BCBSAZ Health Choice Pathway Supplemental Benefits
- ACA StandardHealth with Health Choice

BCBSAZ Health Choice Pathway Model of Care

BCBSAZ Health Choice Pathway

Prescription Drugs and Formulary

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- · ACA StandardHealth with Health Choice

Cultural Competency

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway
- · ACA StandardHealth with Health Choice

Clinical Guidelines

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway

Quality & Performance Measures

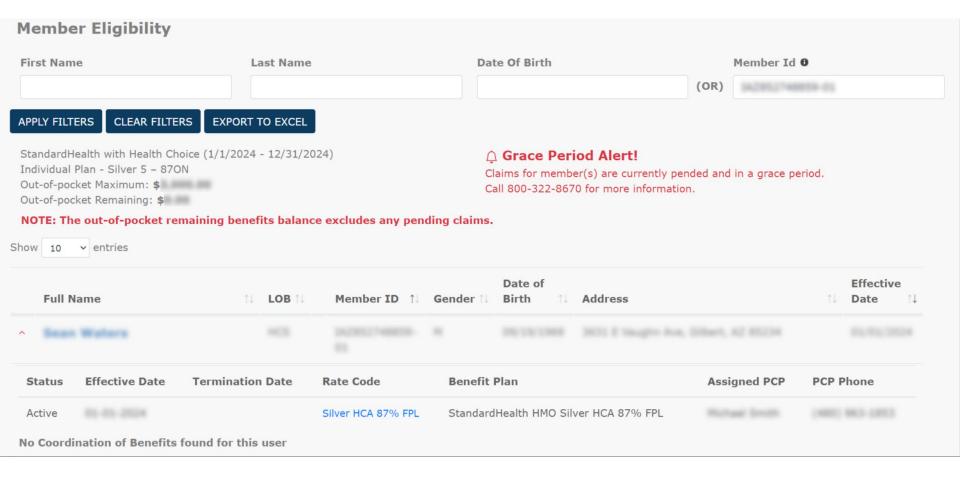
BCBSAZ Health Choice

Medical Management

- BCBSAZ Health Choice
- BCBSAZ Health Choice Pathway

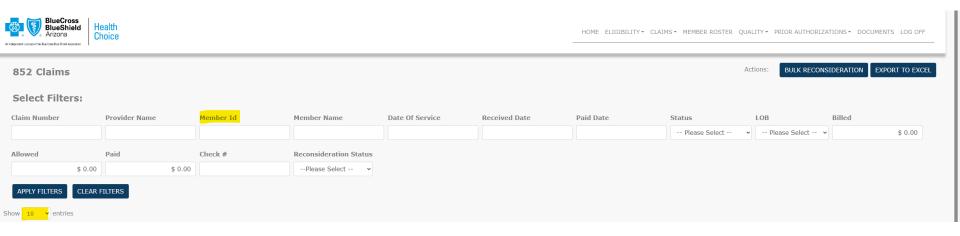
Behavioral Health Resources

Secure Provider Portal: Eligibility



Secure Provider Portal: Claims

When searching for a claim(s) you must include the dependent number as part of the member ID # = IAZ852758599 - 01 (02, 03, 04).



Q&A



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Health Choice



Health Choice

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