Provider Manual

Provider Participation, Product, Utilization Management

Truli for Health

truli for health

Contents

Welcome to the Truli for Health Provider Manual

Provider Participation, Product, Utilization Management

This manual is an important resource designed to help you work with us. We will share information about programs, tools and resources available to our providers.

If there is any inconsistency between information in this manual and the agreement(s) between you and Truli for Health (your "agreement"), the terms of your agreement(s) shall govern.

Who We Are

BeHealthy Florida, Inc., doing business as Truli for Health, is a new consumer-centric open-access commercial HMO health plan. Our care model is a purposeful collaborative model where like-minded health professionals work together to achieve the best outcomes for our members. Our network is a high-performing collaborative network that features health system and physician group partners in specific regions throughout the state. These partners will work collaboratively to deliver better member experiences and health outcomes. Our members must select a primary care physician (PCP) who will coordinate their care and wellness needs.

Product Effective Dates by Market

July 1, 2020

- Central Florida – Orange, Osceola and Seminole counties
- South Florida – Broward, Palm Beach, Martin, St. Lucie and Indian River counties

January 1, 2021

- West Florida – Hillsborough, Pinellas and Pasco counties

January 1, 2022

- Northwest Florida – Escambia and Santa Rosa counties
- Central Florida – Lake Expansion – Lake county

January 1, 2023

- Northeast Florida – Duval and St. Johns counties
- Central Florida – Sumter Expansion –Sumter county
- West Florida – Hernando Expansion – Hernando county

Our Health Care Partners

Truli is developed around a group of select integrated health systems and physician groups.

Central Florida

Primary Care	Sanitas Medical Center	https://www.mysanitas.com/
Urgent Care Center	GuideWell Emergency Doctors Operated by Crucial Care	https://www.guidewellemergency.com/
Health Systems	Orlando Health	https://www.orlandohealth.com/
Primary Care	UFHealth University of Florida Health	https://ufhealth.org/
Health Systems	UFHealth University of Florida Health	https://ufhealth.org/

Northeast Florida

Primary Care	UFHealth University of Florida Health	https://ufhealth.org/
	Flagler Health+	https://www.flaglerhealth.org/
Urgent Care Center	UFHealth University of Florida Health	https://ufhealth.org/
	Flagler Health+	https://www.flaglerhealth.org/
Health Systems	UFHealth University of Florida Health	https://ufhealth.org/
	Flagler Health+	https://www.flaglerhealth.org/

Northwest Florida

Primary Care	BAPTIST HEALTH CARE	https://www.ebaptisthealthcare.org/
Urgent Care Center	BAPTIST HEALTH CARE	https://www.ebaptisthealthcare.org/
Health Systems	BAPTIST HEALTH CARE	https://www.ebaptisthealthcare.org/

South Florida

Primary Care	Sanitas Medical Center	https://www.mysanitas.com/
	PEDIATRIC ASSOCIATES®	https://www.pediatricassociates.com/
Urgent Care Center	GUIDEWELL EMERGENCY DOCTORS Operated by CRUCIAL CARE	https://www.guidewellemergency.com/
Health Systems	Bethesda Hospital East BAPTIST HEALTH SOUTH FLORIDA	Bethesda Hospital East https://www.bethesdaweb.com/
	Bethesda Hospital West BAPTIST HEALTH SOUTH FLORIDA	Bethesda Hospital West https://www.bethesdawest.org/
	Boca Raton Regional Hospital BAPTIST HEALTH SOUTH FLORIDA	Boca Raton Regional Hospital https://www.brrh.com/
	Cleveland Clinic Florida	https://my.clevelandclinic.org/florida
	HolyCross Health A Member of Trinity Health	https://www.holy-cross.com/
	JUPITER MEDICAL CENTER	https://www.jupitermed.com/
	Wellington Regional Medical Center	https://www.wellingtonregional.com/

West Florida

Primary Care	DIAGNOSTIC CLINIC MEDICAL GROUP	http://dc-fl.com/
	Sanitas Medical Center	https://www.mysanitas.com/
	PEDIATRIC ASSOCIATES®	https://www.pediatricassociates.com/
Urgent Care Center	TGH URGENT CARE powered by FAST TRACK	https://www.fasttrackurgentcare.com/
	GUIDEWELL EMERGENCY DOCTORS Operated by CRUCIAL CARE	https://www.guidewellemergency.com/
Health Systems	TGH Tampa General Hospital	https://www.tgh.org/
Independent Diagnostic Testing Center	TOWER RADIOLOGY TGH Tampa General Hospital	https://www.towerradiologycenters.com/
Primary Care	HCA Florida Healthcare℠	https://www.hcafloridahealthcare.com/
Health Systems	HCA Florida Healthcare℠	https://www.hcafloridahealthcare.com/

Truli at-a-Glance

Health ID card

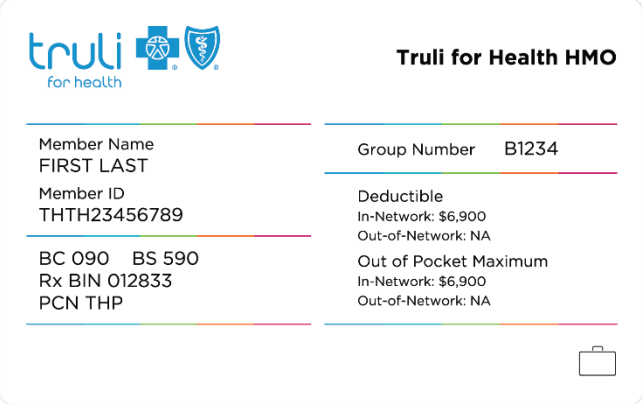
Each member has access to a paper ID card and digital card. The nine-digit ID number is listed on the card. Use this number to communicate with us about a member.

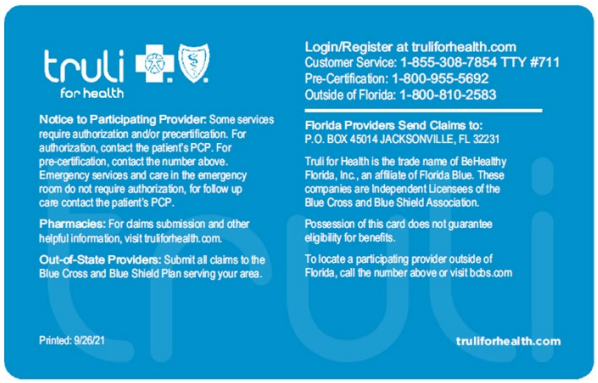
You can find the following member information on the card:

- Member's ID number
- Member's benefit plan
- Other important information, such as where to submit a claim and the group information

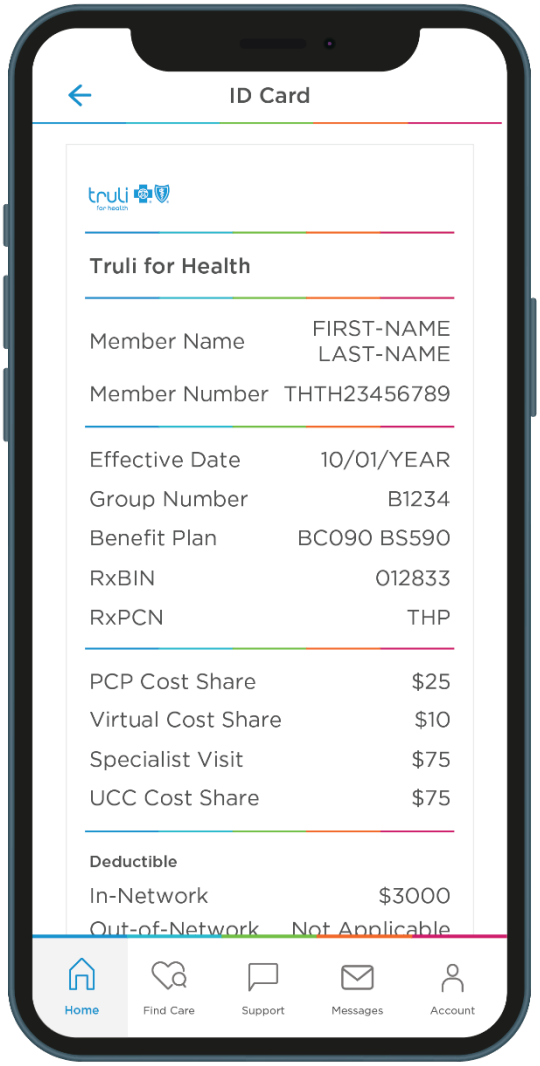
Note: Presenting an ID card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits.

Paper ID Card





Digital



Truli for Health HMO Network

The Truli collaborative network includes primary care physicians, specialists, facilities, ancillary providers, and related services within the same health system and select community providers[1].

Primary Care Physicians

All members are required to select a primary care physician (PCP). The PCP will manage and coordinate the member's care and services. We always support development of a strong personal relationship between members and their PCP, and we have designed our care and utilization management programs and processes to keep the PCP engaged with the member.

While our plans are open access, which allows our members to self-refer to participating specialists, our utilization management program requires specialists to submit prior notification for a member visit not initiated by a member's assigned PCP with a referral.

Truli will routinely evaluate continued participation in the PCP network to ensure PCPs maintain satisfactory quality, efficiency and member satisfaction results.

PCP Member Panel Status

Truli encourages its participating PCPs to maintain an open and active panel. However, in the event you must change your panel status, contact the Provider Contact Center at 833-238-8144.

Closed

A closed panel will prevent any member, whether an existing patient of the PCP or not, from selecting the physician as a PCP. Truli requires at least a 30-day advance notice to close or open a panel.

Closed to new patients

A Panel status of Closed to New Patients will also prevent members from selecting the physician as a PCP. This panel status requires the PCP to contact the plan to have members added to their panel.

Plan-initiated panel closure

Truli reserves the right to close a provider's panel. Truli will notify physicians in the event of a plan-initiated panel closure.

Panel age restrictions

Submit age restrictions in writing to Truli. Truli's standard restrictions are as follows:

- Children only: Newborn to 18 years
- Adolescent and adults: 12 and older
- Adults only: 18 years and older

[1] A local network of esteemed medical professionals collaborating to provide high-quality care while reducing healthcare costs and enhancing accessibility for members.

Member-initiated PCP Change

Members have a right to change their PCP.

The actual date of the PCP change is prospective. The date we receive the request will determine the effective date of the change.

PCP Change Request Received	PCP Change Effective
On or before the 5th day of the month	The same day as the request
After the 5th day of the month	The first day of the following month

The Plan may expedite a PCP change if it is determined to be in the best interest of the member or current PCP.

PCP-initiated Member Transfer

Truli will collaborate with the PCP and member to attempt to resolve an issue between a member and PCP before transferring a member to another PCP. Reasons for a PCP to request Truli to remove a member from their panel may include:

- Patient is consistently non-compliant with the PCP's medical advice
- Patient is consistently disruptive in the office
- Patient consistently misses scheduled appointments without cause or without notice to the office
- Irreconcilable differences between the physician and patient

PCPs should call the Provider Contact Center at 833-238-8144 to begin panel changes.

Specialist

Our specialty network is a high-performing network of practitioners who are always expected to collaborate with the member's assigned PCP on a member's planned and ongoing treatment. This collaboration is so important that we require our specialists to submit prior notification for scheduled member visits not initiated by a member's assigned PCP with a referral.

Truli will routinely evaluate continued participation in the specialty network to ensure that specialists maintain satisfactory quality, efficiency and member satisfaction results.

Specialist Visit Notification Requirement

Truli doesn't require a PCP referral for a specialist visit. However, if a PCP referral is not on file for a specialist visit, *the specialist must submit a notification* to Truli of a scheduled visit at least two (2) business days before a member's scheduled visit. *We will deny* specialist claims that have no PCP referral on file and no plan Specialist Notification on file.

Instructions for how to submit a Specialist Notification is listed in the Truli for Health Programs section of this manual.

Physician Extenders

Physician Extender is defined as: Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Nurse Specialist, Physician Assistant and Registered Nurse First Assistant. They are health care providers who practice in collaboration with or under the supervision of a physician.

Except for Physician Extenders directly contracted with Truli for Health (i.e., the Provider Agreement is between Truli and the Physician Extender or a group that consists solely of Physician Extenders), reimbursement for Covered Services rendered by Physician Extenders is subject to a fifteen percent reduction from the Provider's contract rate where a relative value unit exists.

Provider Directory

Providers who participate in the Truli for Health HMO network are listed in the Truli for health Provider Directory. Truli for Health Provider Directory

Provider Data and Demographics

Tell us immediately about any demographic changes so our members have access to accurate information. This is required by law, regulatory requirements and accrediting bodies, such as National Committee for Quality Assurance (NCQA). Maintaining an updated provider record will prevent operational process issues. (Example: Specialist Notification, referrals, authorizations)

Updating your information through Availity

Log into Availity > Navigate to Payer Space > Florida Blue > Select "View and Manage Your Records"

Providers must notify us 30 days prior to the effective date of any changes to ensure accurate information is displayed in the Provider Directory.

Note: Some changes may affect credentialing. Prompt notification of any credentialing related changes are required to avoid claim processing issues.

Third-Party Networks

The following vendors provide network and other services on behalf of Truli.

Type of Service	Provider	Service Area
Chiropractic	American Specialty Health	Statewide
Dental	FCL/LSV Dental Management	Statewide
Home Care Services (such as durable medical equipment and home health services)	CareCentrix®	Statewide
Lab (Clinical reference lab and pathology)	Quest Diagnostics℠ and Dermpath Diagnostics The preferred lab for anatomical pathology services in Florida is AmeriPath® Exact Science for Cologuard testing.	Statewide

Type Of Service	Provider	Service Area
Pharmacy (specialty drugs)	Caremark Specialty Pharmacy	Statewide
Vision	Davis Vision	Statewide
Pathology	IRL Pathology Services	Central Florida
Dermatology	Dermatology Network Solutions	South Florida
Ophthalmology	Eye Management Inc. Ophthalmology	South Florida
Podiatry	Podiatry Network Solutions	South Florida

The following is a partial list of provider types that are excluded from Truli for Health Participating Provider agreements. Services performed by the following provider types are excluded from reimbursement under Truli for Health Participating Provider agreements, unless explicitly included.

- Behavioral Health Practitioners
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Applied Behavioral Analyst
- Psychiatrist
- Psychologist
- Chiropractor

Electronic Self-Service Capabilities

Truli for Health Website

Our contracts require you to conduct business with us electronically. Using electronic transactions is fast, efficient and supports a paperless work environment. Our Truli for Health website guides you to tools and resources to support your billing, claim and administrative needs. On the site you can find helpful information about self-service tools, medical policies, news bulletins, member eligibility, claims, prior authorizations and notifications.

Availity

Electronic Self-Service Tools are available through Availity®[1]

Checking Availity first will ensure you receive the most current member information.

Here is list of some of the tools that are available via Availity:

- Check member eligibility and benefits
    - Using Availity for benefit information will provide you with an Availity transaction id (fast path code). This transaction ID will enable priority routing to a service representative service should you need to call us for assistance. Enter the code when prompted. Providers will not receive eligibility and benefits information telephonically without one.
- Submit claims for payment
- Check the status of a claim
- Clear Claim Connection
- Update provider data for the Online Provider Directory
- Submit Authorizations, Referrals & Specialist Notifications

Check eligibility and benefits

You can verify a member's eligibility and benefits by:

- Going to the Eligibility and Benefits application in Availity at availity.com.
- Using electronic data interchange (EDI) Eligibility & Benefit Inquiry and Response (270/271) transactions.
- *If the capability is not available,* you may call the Provider Contact Center at 833-238-8144.

Submitting Claims

Providers should submit electronic claims to us through Availity. You can:

- File claims to us through Availity at availity.com and submit them in real time. Within minutes, Availity confirms they received the claim and forwarded it for processing.
- Create claims in a billing system and send them using Availity's Electronic Data Interchange (EDI) batch submission. Within minutes, Availity replies with information about accepted or rejected claims. You must correct and resubmit any rejected claims.
- Work with a billing service or clearinghouse to send claims to us through Availity.

You will also manage claim corrections and edits through Availity.

For detailed information on the claim submission process, review the Claims and Reimbursement document.

Clear Claim Connection

Simulate likely procedure code editing rules for Truli for Health claims prior to submission or after receiving the remittance advice by using Clear Claim Connection; available through Availity®

This tool is intended for use as a simulation for general information and is not a guarantee of payment or a binding estimate of payment. Medical Policies (Medical Coverage Guidelines), member benefits, terms, limitations, and exclusions will prevail if there is a conflict with a payment edit.

Claims are adjudicated using claim processing rules for procedure code editing in effect at the time the claim is submitted. Procedure code edits are typically updated twice per year. Clear Claim Connection only returns current claim editing logic. Therefore, if your simulation results do not match how your claim processed, it is possible a version update may be the reason.

Claim editing rules are consistent for most Truli for Health claims.

How to Use Clear Claim Connection

From the Availity® home page, under the Claims Management Menu tab, click on Research Procedure Code Edits. Next, you must accept the Terms and Conditions of Use. On the next page displayed select the Clear Claim Connection Link which will take you to the Claim Entry Screen. On the Claim Entry screen, provide the data listed below and click on the Review Claim Audit Results button. The information returned is confidential and solely for the use of authorized provider.

- Patient's gender
- Patient's date of birth
- Procedure code
- Up to four diagnosis codes
- Place of service (system will default to the Office (11) Place of Service if nothing is entered
- Modifiers, if applicable (optional data field)
- Date of service (needed to determine active and non-active procedure codes)

This capability also provides source information and clinical rationale for editing rules, but only on procedure lines with a "Disallow" or "Review" response in the "Recommended" data field. To view this additional information, click on the line to highlight it, and then click the Review Clinical Edit Clarification button. You can also double click the line to review the related clinical edit clarification.

Note: For those using a popup block, this may need to be disabled to view the site. This tool cannot be used for outpatient institutional claims analysis.

Updating your information through Availity

Go to the Florida Blue Payer Space in Availity and select **View and Manage your Record**.

Note: Some changes may affect credentialing. You must tell us about changes to credentialing information promptly to avoid claim processing issues.

Health Information Exchange

Truli requires its contracted providers to keep written or electronic medical records that comply with industry standards and applicable federal, state, and local laws, rules and regulations.

Electronic medical records

Providers who use electronic medical records must have a system in place that complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act, and other federal and state laws.

Providers sharing medical records with us agree to allow us to share this information with other providers treating the member. The records will be shared via secured electronic means.

At our request, providers will direct their vendor(s) to work with us, on their behalf, to integrate this electronic technology into their system(s). Providers agree to integrate Clinical Information Exchange (CIE) capabilities with us.

[1]Availity, LLC is a multi-payer joint venture company. For more information or to register, visit www.availity.com.

Quality Performance Measures

Truli's goal is to create a best-in-class experience and ensure quality health care for our members. To do this, we use claims, encounter, and medical record data in our Quality Improvement (QI) programs. These programs address:

- Quality of care issues.
- Health management and wellness activities.
- Grievance and appeal resolution.
- Performance measures.

Your Participation and Feedback

As a participating provider, you may offer input on QI programs by QI Committee representation and through your Truli provider service advocate.

Quality performance indicators

We have designed a robust, Truli-administered quality program to align with HEDIS®[2] related measures from the Centers for Medicare & Medicaid Services guidance for commercial plans regarding its Quality Rating System. We've selected specific objective HEDIS[2] measures from the measure set—including

adult and pediatric measures—to assess “process of care” and “outcome of care” dimensions for each important aspect of care and service.

These measures help consumers and the public evaluate how well Truli’s delivery system meets customer needs in these areas. Providers can use these measures to evaluate and improve member care and service.

[2]Healthcare Effectiveness Data and Information Set

How we measure your performance

We will assess your performance based on your Truli members with diagnoses that align with associated measures. We will rate you against industry benchmarks and then compare your performance to your Truli neighborhood peers and other established regional providers.

To be included in a measure, you must have at least 25 members who meet the measure’s clinical criteria. On these qualified measures, you must achieve 90 percent of the regional average in at least 50 percent of the qualifying measures and achieve 60 percent of non-emergent services at Anchor Health Systems[2] to be eligible for a total cost of care reduction bonus.

How we review your results

Truli will review your performance results on a rolling, 12-month schedule using HEDIS-like measurements through our third-party vendor. We will develop your initial results three months after the end of your first contract year. Then, we will update the results quarterly.

Clinical Practice and Preventive Health Guidelines

Truli uses national, state and specialty clinical practice guidelines, preventive health guidelines and other internal criteria to offer direction and standards for preventive, acute and chronic health care services relevant to our members.

We review clinical practice guidelines against utilization management criteria and member education materials to ensure consistent and aligned communications. These guidelines include factual and appropriate medical recommendations. Local physician committees also recommend how we use these guidelines.

Quality of Care – Advanced Directives

Truli encourages providers to ask patients (18 years or older) if they have advanced directives or living wills in place and record their responses, yes or no, in their medical records, keeping a copy of the advance directive and/or living will in the patient’s medical file.

When we perform our annual medical record reviews to meet our regulatory responsibilities, this information is very important. During the review, we check to see if you have asked your patients about advance directives, including a living will, and if you have copies in their medical records.

[2] Truli for Health’s ‘anchor’ providers, comprised of key local hospital systems and physicians, are experts in working together to provide coordinated, value-based care.

Standard Reports and Information

Truli will provide reports to certain providers on a recurring basis. Following is a sample of the information we may share.

Contract Reconciliation Results	Premiums, expenses and all applicable credits and deductions. Recast views by month with totals by quarter and year
Contract Reconciliation Results – Quality Scorecard	Results for quality measures applicable to the contract for the reconciled period, delivered along with the contract reconciliation results
Membership Roster	Operational and analytical (recast) views of a PCP panel The operational views will have the necessary formats to identify new members each month, days since last visit, etc. Analytical views will have different data points for recast membership
Quality Measures	Results by quality measure
Quality Measures – Target List	Member-level reports, gaps in care, etc.
IP Census	Admits, discharges and transfers for a member panel
Medical Expenses – Cost Trends	Utilization trends with a cost-by-service category of breakdown and different views to identify high-cost members, admits in the context of PCP visit frequency, etc.

Compliance and Confidentiality

Confidentiality and Protected Health Information

Truli and its participating providers are “Covered Entities” under the privacy rule portion of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Covered Entities must follow applicable federal and state standards for Protected Health Information (PHI) use and disclosure.

Truli expects its providers to keep current office policies and procedures to prevent the unauthorized or inadvertent disclosure of confidential information. This may include, but is not limited to, administrative, physical and technical controls to protect a member’s PHI.

Fraud, Waste and Abuse

When providers, members, health plans and employees commit fraud, waste and abuse, it hurts everyone. Truli asks that you help us detect and eliminate fraud, waste and abuse. Let us know about any potential fraud, waste and abuse you find. We also ask that you cooperate with any fraud, waste or abuse review.

We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for our members.

Understanding fraud, waste and abuse

Fraud is any type of intentional deception or misrepresentation a person makes knowing that the deception could result in their or some other person receiving an unauthorized benefit. The attempt itself is fraud, regardless of whether it is successful.

Waste includes activities that cause unnecessary expenses and resource mismanagement, such as careless, poor or inefficient billing or treatment methods.

Abuse is any practice inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the program or in payment for services that are not medically necessary or don't meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the program.

Examples of fraud, waste and abuse

Provider

- Altering or falsifying medical records.
- Direct billing or balance billing Medicaid members.
- Billing for services they didn't give.
- Billing for medically unnecessary tests.
- Billing professional services untrained personnel performed.
- Misrepresenting diagnoses or services.
- Overutilization.
- Soliciting, offering or receiving kickbacks or bribes.
- Unbundling.
- Under-utilization.
- Billing more than once for the same service.
- Billing or charging the member for services Truli for Health paid.
- Dispensing generic drugs and billing for brand-name drugs.
- Performing and/or billing for inappropriate or unnecessary services.
- Trading prescription drugs for sexual favors.
- Offering a prescription or prescription drugs without seeing or treating the member.
- Offering gifts, a prescription, prescription drugs or money to members in exchange for receiving treatments or services.

Members

- Disruptive or threatening behavior.
- Frequent emergency room visits for non-emergent conditions.
- Forging, altering or selling prescriptions.
- Lying about the amount of money or resources the member has to get benefits.
- Lying about a medical condition to get medical treatment.
- Obtaining controlled substances from multiple providers.
- Using more than one provider to obtain similar treatments and/or drugs.

Reporting fraud, waste and abuse

You do not have to give proof, but if you suspect medical billing fraud, waste or abuse, you have a responsibility and a right to report it.

You can report suspected fraud, waste, or abuse by calling the Provider Contact Center at 833-238-8144 or send a message through the Availity message center.

Incident Reporting

Truli for Health complies with incident reporting as defined in Florida Statute § 641.55(1)(d), which requires provider assistance in obtaining the information to be reported. The state of Florida defines the type of incidents that must be reported in Florida Statute § 459.026(4). **Report such incidents to the Truli Provider Contact Center and request an incident report be submitted to the Quality Management Department.**

Truli for Health Programs

Our Medical Policies and Medical Coverage Guidelines

Truli processes claims based on a member's eligibility, their effective benefits and the evidence-based medical necessity of the services providers give. Our decision process includes using evidence-based medical policies and medical coverage guidelines (MCGs) and the medical necessity provisions found in the member's benefit agreement and certificate of coverage.

Find the latest policies and guidelines

You can find our medical policies and guidelines at the Truli for Health website under the **Medical Policies (Medical Coverage Guidelines)** section.

We will add any new information to the guidelines' "**What's New**" section.

Certificate of Medical Necessity forms

To hasten the medical review process for certain requests, Truli gives you Certificate of Medical Necessity (CMN) forms. We have matched each CMN form with one of our MCGs. Instead of sending required documentation to us, you can attest to information within the member's medical documentation.

Finding MCGs with CMNs

When an MCG has an associated CMN form, the Position Statement will provide instructions to locate the specific form needed.

Virtual visits

Virtual visits give members convenient access to care. If you are an in-network PCP or behavioral health specialist that offers virtual visits through two-way interactive video conferencing, you can bill services that we have defined on a pre-approved list of covered virtual codes. Providers must give these services through a mobile device, tablet, or computer and/or telephone. A virtual visit may include:

- Providing care, treatment, or services to a patient virtually instead of in person.
- Establishing initial and providing ongoing, clinical medical or behavioral health services.
- Giving online assessment and management services for an established patient.

Virtual visits must be reported with the appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code(s) that describes the virtual visit. Modifier -95 or -GT must be appended, indicating the use of interactive audio and video telecommunications technology. The service should also be reported using place of service code 02 or 10 to indicate the location where the member received the services through a telecommunication system. If more than one virtual visit is performed on the same date of service, the visits should be combined into a single evaluation and management (E/M) code. If a face-to-face visit is performed on the same day as a virtual visit, the visits should be combined into a single E/M code. If multiple E/M codes are reported by the same practitioner on the day for the same patient, only one E/M code will be allowed.

Truli covers only the following virtual visit codes:

Code	Description	Effective Date
90785	Psytx complex interactive	7/1/2020
90791	Psych diagnostic evaluation	7/1/2020
90792	Psych diag eval w/med srvcs	7/1/2020
90832	Psytx pt&/family 30 minutes	7/1/2020
90833	Psytx pt&/fam w/e&m 30 min	7/1/2020
90834	Psytx pt&/family 45 minutes	7/1/2020
90836	Psytx pt&/fam w/e&m 45 min	7/1/2020
90837	Psytx pt&/family 60 minutes	7/1/2020
90838	Psytx pt&/fam w/e&m 60 min	7/1/2020
90839	Psytx crisis initial 60 min	7/1/2020
90840	Psytx crisis ea addl 30 min	7/1/2020
90845	Psychoanalysis	7/1/2020
90846	Family psytx w/o patient	7/1/2020
90847	Family psytx w/patient	7/1/2020
90853	Group psychotherapy	3/31/2021
90951	Esrd serv 4 visits p mo <2yr	1/1/2021
90952	Esrd serv 2-3 vsts p mo <2yr	1/1/2021
90953	End-Stage Renal Disease Monthly Capitation Payment codes	3/31/2021
90954	Esrd serv 4 vsts p mo 2-11	1/1/2021
90955	Esrd srv 2-3 vsts p mo 2-11	1/1/2021
90956	End-Stage Renal Disease Monthly Capitation Payment codes	3/31/2021
90957	Esrd srv 4 vsts p mo 12-19	1/1/2021
90958	Esrd srv 2-3 vsts p mo 12-19	1/1/2021
90959	End-Stage Renal Disease Monthly Capitation Payment codes	3/31/2021
90960	Esrd srv 4 visits p mo 20+	1/1/2021
90961	Esrd srv 2-3 vsts p mo 20+	1/1/2021
90962	End-Stage Renal Disease Monthly Capitation Payment codes	3/31/2021
90963	Esrd home pt serv p mo <2yrs	1/1/2021
90964	Esrd home pt serv p mo 2-11	1/1/2021
90965	Esrd home pt serv p mo 12-19	1/1/2021
90966	Esrd home pt serv p mo 20+	1/1/2021
90967	Esrd home pt serv p day <2	1/1/2021
90968	Esrd home pt serv p day 2-11	1/1/2021

Code	Description	Effective Date
90969	Esrd home pt serv p day 12-19	1/1/2021
90970	Esrd home pt serv p day 20+	1/1/2021
92507	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
92508	Speech/Hearing Therapy	1/1/2024
92521	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
92522	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
92523	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
92524	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
92526	Oral Function Therapy	1/1/2024
93797	Cardiac rehab	1/1/2024
93798	Cardiac rehab/monitor	1/1/2024
94002	Vent mgmt inpat init day	1/1/2024
94003	Vent mgmt inpat subq day	1/1/2024
94004	Vent mgmt nf per day	1/1/2024
94005	Home vent mgmt supervision	1/1/2024
94625	Phy/qhp op pulm rhb w/o mntr	1/1/2024
94626	Phy/qhp op pulm rhb w/ mntr	1/1/2024
94664	Evaluate pt use of inhaler	1/1/2024
96105	Assessment of aphasia	1/1/2024
96112	Devel tst phys/qhp 1st hr	1/1/2024
96113	Devel tst phys/qhp ea addl	1/1/2024
96116	Neurobehavioral status exam	7/1/2020
96121	Psychological and Neuropsychol	3/31/2021
96125	Cognitive test by hc pro	1/1/2024
96127	Brief emotional/behav assmt	3/31/2021
96130	Psychological and Neuropsychological Testing	3/31/2021
96131	Psychological and Neuropsychological Testing	3/31/2021
96132	Psychological and Neuropsychological Testing	3/31/2021
96133	Psychological and Neuropsychological Testing	3/31/2021
96136	Psychological and Neuropsychological Testing	3/31/2021
96137	Psychological and Neuropsychological Testing	3/31/2021
96138	Psychological and Neuropsychological Testing	3/31/2021
96139	Psychological and Neuropsychological Testing	3/31/2021
96156	Hlth bhv assmt/reassessment	3/31/2021
96158	Hlth bhv ivntj indiv 1st 30	3/31/2021

Code	Description	Effective Date
96159	Hlth bhv ivntj indiv ea addl	3/31/2021
96160	Pt-focused hlth risk assmt	7/1/2020
96161	Caregiver health risk assmt	7/1/2020
96164	Hlth bhv ivntj grp 1st 30	3/31/2021
96165	Hlth bhv ivntj grp ea addl	3/31/2021
96167	Hlth bhv ivntj fam 1st 30	3/31/2021
96168	Hlth bhv ivntj fam ea addl	3/31/2021
97110	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97112	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97116	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97150	Group therapeutic procedures	1/1/2024
97151	Bhv id assmt by phys/qhp	3/31/2021
97152	Bhv id suprt assmt by 1 tech	3/31/2021
97153	Adaptive behavior tx by tech	3/31/2021
97154	Grp adapt bhv tx by tech	3/31/2021
97155	Adapt behavior tx phys/qhp	3/31/2021
97156	Fam adapt bhv tx gdn phy/qhp	3/31/2021
97157	Mult fam adapt bhv tx gdn	3/31/2021
97158	Grp adapt bhv tx by phy/qhp	3/31/2021
97161	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97162	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97163	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97164	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97165	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97166	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97167	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97168	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97535	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97755	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97760	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97761	Therapy Services, Physical and Occupational Therapy, All levels	3/31/2021
97763	Orthc/prostc mgmt sbsq enc	1/1/2024
97802	Medical nutrition indiv in	7/1/2020
97803	Med nutrition indiv subseq	7/1/2020
97804	Medical nutrition group	7/1/2020
98000	Synch Audio-Video New SF 15	1/1/2025

Code	Description	Effective Date
98001	Synch Audio-Video New Low 30	1/1/2025
98002	Synch Audio-Video New Mod 45	1/1/2025
98003	Synch Audio-Video New High 60	1/1/2025
98004	Synch Audio-Video Est SF 10	1/1/2025
98005	Synch Audio-Video Est Low 20	1/1/2025
98006	Synch Audio-Video Est Mod 30	1/1/2025
98007	Synch Audio-Video Est High 40	1/1/2025
98008	Synch Audio-Only Visit New Patient SF 15	1/1/2025
98009	Synch Audio-Only Visit New Patient Low 30	1/1/2025
98010	Synch Audio-Only Visit New Mod 45	1/1/2025
98011	Synch Audio-Only Visit New High 60	1/1/2025
98012	Synch Audio-Only Visit Est SF 10	1/1/2025
98013	Synch Audio-Only Visit Est Low 20	1/1/2025
98014	Synch Audio-Only Visit Est Mod 30	1/1/2025
98015	Synch Audio-Only Visit Est High 40	1/1/2025
98966	Hc pro phone call 5-10 min	1/1/2024
98967	Hc pro phone call 11-20 min	1/1/2024
98968	Hc pro phone call 21-30 min	1/1/2024
99202	Office/outpatient visit new	7/1/2020
99203	Office/outpatient visit new	7/1/2020
99204	Office/outpatient visit new	7/1/2020
99205	Office/outpatient visit new	7/1/2020
99211	Office/outpatient visit est	7/1/2020
99212	Office/outpatient visit est	7/1/2020
99213	Office/outpatient visit est	7/1/2020
99214	Office/outpatient visit est	7/1/2020
99215	Office/outpatient visit est	7/1/2020
99217	Subsequent Observation and Observation Discharge Day Management	3/31/2021
99221	Initial hospital care	1/1/2024
99222	Initial hospital care	1/1/2024
99223	Initial hospital care	1/1/2024
99224	Subsequent Observation and Observation Discharge Day Management	3/31/2021
99225	Subsequent Observation and Observation Discharge Day Management	3/31/2021
99226	Subsequent Observation and Observation Discharge Day Management	3/31/2021
99231	Subsequent hospital care	1/1/2021
99232	Subsequent hospital care	1/1/2021

Code	Description	Effective Date
99233	Subsequent hospital care	1/1/2021
99234	Observ/hosp same date	1/1/2024
99235	Observ/hosp same date	1/1/2024
99236	Observ/hosp same date	1/1/2024
99238	Hospital discharge day management	3/31/2021
99239	Hospital discharge day management	3/31/2021
99281	Emergency Department Visits, Levels 1-5	3/31/2021
99282	Emergency Department Visits, Levels 1-5	3/31/2021
99283	Emergency Department Visits, Levels 1-5	3/31/2021
99284	Emergency Department Visits, Levels 1-5	3/31/2021
99285	Emergency Department Visits, Levels 1-5	3/31/2021
99291	Critical Care Services	3/31/2021
99292	Critical Care Services	3/31/2021
99304	Nursing facility care init	1/1/2024
99305	Nursing facility care init	1/1/2024
99306	Nursing facility care init	1/1/2024
99307	Nursing fac care subseq	1/1/2021
99308	Nursing fac care subseq	1/1/2021
99309	Nursing fac care subseq	1/1/2021
99310	Nursing fac care subseq	1/1/2021
99315	Nursing facilities discharge day management	3/31/2021
99316	Nursing facilities discharge day management	3/31/2021
99341	Home visit new patient	1/1/2024
99342	Home visit new patient	1/1/2024
99344	Home visit new patient	1/1/2024
99345	Home visit new patient	1/1/2024
99347	Home Visits, Established Patient	3/31/2021
99348	Home Visits, Established Patient	3/31/2021
99349	Home Visits, Established Patient	3/31/2021
99350	Home Visits, Established Patient	3/31/2021
99354	Prolonged service office	7/1/2020
99355	Prolonged service office	7/1/2020
99356	Prolonged service inpatient	1/1/2021
99357	Prolonged service inpatient	1/1/2021

Code	Description	Effective Date
99402	Lactation consultant (initial visit)	7/1/2020
99404	Lactation Consultation (follow-up visit)	7/1/2020
99406	Behav chng smoking 3-10 min	7/1/2020
99407	Behav chng smoking > 10 min	7/1/2020
99446	Interprofessional Internet Consultation	1/1/2021
99447	Interprofessional Internet Consultation	1/1/2021
99448	Interprofessional Internet Consultation	1/1/2021
99449	Interprofessional Internet Consultation	1/1/2021
99451	Interprofessional Internet Consultation	1/1/2021
99452	Interprofessional Internet Consultation	1/1/2021
99468	Neonate crit care initial	1/1/2024
99469	Inpatient Neonatal and Pediatric Critical Care, Subsequent	3/31/2021
99471	Ped critical care initial	1/1/2024
99472	Inpatient Neonatal and Pediatric Critical Care, Subsequent	3/31/2021
99473	Self-meas bp pt educaj/train	1/1/2024
99475	Ped crit care age 2-5 init	1/1/2024
99476	Inpatient Neonatal and Pediatric Critical Care, Subsequent	3/31/2021
99477	Init day hosp neonate care	1/1/2024
99478	Continuing Neonatal Intensive Care Services	3/31/2021
99479	Continuing Neonatal Intensive Care Services	3/31/2021
99480	Continuing Neonatal Intensive Care Services	3/31/2021
99483	Cognitive Assessment and Care Planning Services	3/31/2021
99495	Trans care mgmt 14-day disch	7/1/2020
99496	Trans care mgmt 7-day disch	7/1/2020
99497	Advncd care plan 30 min	7/1/2020
99498	Advncd are plan addl 30 min	7/1/2020
G0108	Diab manage trn per indiv	7/1/2020
G0109	Diab manage trn ind/group	7/1/2020
G0270	Mnt subs tx for change dx	7/1/2020
G0296	Visit to determ ldct elig	7/1/2020
G0316	Prolonged hospital inpatient or observation care	1/1/2024
G0317	Prolonged nursing facility evaluation and management service	1/1/2024
G0318	Prolonged home or residence evaluation and management	1/1/2024
G0396	Alcohol/subs interv 15-30mn	7/1/2020
G0397	Alcohol/subs interv >30 min	7/1/2020

Code	Description	Effective Date
G0406	Inpt/tele follow up 15	1/1/2021
G0407	Inpt/tele follow up 25	1/1/2021
G0408	Inpt/tele follow up 35	1/1/2021
G0410	Grp psych partial hosp 45-50	1/1/2024
G0420	Ed svc ckd ind per session	1/1/2021
G0421	Ed svc ckd grp per session	1/1/2021
G0422	Intense cardiac rehab w/exercise	1/1/2024
G0423	Intense cardiac rehab no exercise	1/1/2024
G0425	Inpt/ed teleconsult30	1/1/2021
G0426	Inpt/ed teleconsult50	1/1/2021
G0427	Inpt/ed teleconsult70	1/1/2021
G0438	Ppps, initial visit	1/1/2021
G0439	Ppps, subseq visit	1/1/2021
G0442	Annual alcohol screen 15 min	7/1/2020
G0443	Brief alcohol misuse counsel	7/1/2020
G0444	Depression screen annual	7/1/2020
G0445	High inten beh couns std 30m	7/1/2020
G0446	Intens behave ther cardio dx	7/1/2020
G0447	Behavior counsel obesity 15m	7/1/2020
G0459	Telehealth inpt pharm mgmt.	7/1/2020
G0506	Comp asses care plan ccm svc	7/1/2020
G0508	Crit care telehea consult 60	1/1/2021
G0509	Crit care telehea consult 50	1/1/2021
G0513	Prolong prev svcs, first 30m	1/1/2021
G0514	Prolong prev svcs, addl 30m	1/1/2021
G2010	Remote Eval of Pre-Recorded Patient Info	1/1/2021
G2086	Off base opioid tx first m	1/1/2021
G2087	Off base opioid tx, sub m	1/1/2021
G2088	Off opioid tx month add 30	1/1/2021
G2211	Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M)	3/31/2021
G2212	Prolonged Services	3/31/2021
G3003	Addition 15m pain mang	1/1/2024
G9685	Acute nursing facility care	1/1/2024

Referral, Prior Authorization and Specialist Notification

The referral, specialist notification and prior authorization processes are separate of one another. All providers must follow referral, specialist notification and/or prior authorization requirements when providing a service that requires any of these.

If you do not follow these processes when required, it may result in a denial of your claim, and the service will not be billable to the member.

PCP Referrals

As an open access plan, referrals are not required for members to see a specialist. However, a member's assigned PCP is expected to manage their care. If their PCP determines the member should see a specialist in the network who is not part of the member's current PCP group (i.e. different TIN), then the member's PCP should submit a referral to Truli. Referrals are valid for the named specialist or any other providers billing under the same TIN.

How to submit a referral

You can quickly add a referral, submit a referral inquiry and check a referral status through Availity.

- Referrals must be submitted electronically.
- Referrals are effective immediately.
- They are viewable online within 48 hours.
- We do not accept referrals by phone, fax or paper, unless state law requires us to.
- We can backdate them up to five calendar days from the date of submission.
- Web users must have access to the Referral Submission role on their user profile to submit and verify referrals.
- Only the member's PCP or another PCP practicing under the same TIN can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

Specialist Notification Requirements

While Truli does not require a PCP referral for a specialist visit; specialists should verify if the member's assigned PCP has issued a referral. If a PCP referral is not on file, the specialist ***must*** submit a Specialist Notification to the plan at least two (2) business days prior to the scheduled visit (e.g., If the visit is scheduled for Thursday, notification must be submitted to the plan by the end of business the Monday prior.)

Truli will deny specialist claims that have no PCP referral on file and no prior Specialist Notification on file. Claims submitted for specialist visits will be denied and not billable to the member when submitted without a referral from the member's assigned PCP or a timely specialist notification on file.

Specialist Notifications are only required when a PCP referral is not on file for a specialist visit. You can quickly verify if a PCP referral was submitted through Availity®.

How to submit a referral

You can quickly add a referral, submit a referral inquiry and check a referral status through Availity.

- Referrals must be submitted electronically.
- Referrals are effective immediately.
- They are viewable online within 48 hours.
- We do not accept referrals by phone, fax or paper, unless state law requires us to.
- We can backdate them up to five calendar days from the date of submission.
- Web users must have access to the Referral Submission role on their user profile to submit and verify referrals.

- Only the member's PCP or another PCP practicing under the same TIN can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

Services that do not require a referral or notification

Referrals are not needed for the following services:

- Services from network physicians in the same TIN as the member's PCP
- Services rendered in any network urgent care center, network convenience care clinic or designated network online "virtual visits"
- Services billed as observation in the outpatient department of an acute care facility.
- Admitting physician services for emergency admissions
- Services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons in an acute or subacute care setting
- Services from a network pathologist, network radiologist or network anesthesia physician in an acute or subacute care setting

Utilization Management

Utilization management (UM) programs focus on optimizing our members' health and well-being. They are a collaborative effort between providers and Truli to make sure we coordinate our members' medically necessary services efficiently and timely. This helps our members to access health care services they need and assures providers are delivering medically appropriate care.

UM program activities

Registered nurses and clinicians perform retrospective, concurrent or prospective UM activities under medical director supervision.

Medical prior authorization (prospective review)

Truli requires prior authorization for certain covered services before you render them. If we require prior authorization for a service and you do not obtain it before you render the service, we may reduce or deny coverage.

The patient and their treating provider make decisions about the patient's health care and treatment. Truli's decisions about requested treatment or services simply reflect our determination of coverage.

Financial incentives are not a factor in coverage decisions

Truli for Health has a financial incentives policy in place that is designed to assist practitioners, providers, employees and supervisors involved in (or who supervise those involved in) making coverage and benefit utilization management or utilization review (UM/UR) decisions, where relevant. The policy states:

- UM/UR decision-making is based only on the factors set forth in Truli for Health's definition of medical necessity (for coverage and payment purposes) in accordance with Truli for Health's medical policy guidelines, then in effect, and the existence of coverage and benefits under a particular contract/policy/certificate of coverage. Truli for Health is solely responsible for determining whether expenses incurred, or to be incurred, or medical care are, or would be, covered or paid under a contract or policy. In fulfilling this responsibility, Truli for Health shall not be deemed to participate in or override the medical decisions of any Truli for Health member's practitioner or provider.
- Truli for Health payment policies are not designed to reward practitioners or other individuals conducting UM/UR for issuing denials of coverage or benefits.
- Financial incentives for UM/UR decision makers are not designed to encourage decisions that

result in underutilization. Rather, the intent is to minimize coverage and payment for unnecessary or inappropriate health care services, reduce waste in the application of medical resources, and to minimize inefficiencies that may lead to the artificial inflation of health care costs.

Service categories that require prior authorization

Truli requires prior authorization for the following service categories:

Service	How to Obtain Authorization
Behavioral Health Services Inpatient Admissions, Partial hospitalization, IOP and Substance Abuse Rehabilitation	Contact New Directions Behavioral Health • www.ndbh.com/providers • Call 855-888-5001
Cardiology Services (Non-Emergent)	Effective January 1, 2022 – Prior authorization not required
Chemotherapy Physician Administered Drugs	Refer to Physician Administered Drug section of this guide. If the drug is in the **PADP list**, submit the request to Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management • https://gatewaypa.com/ • Call 800-424-4947 If the drug is not in the PADP list, submit request for authorization electronically through Availity. • www.availity.com
Chiropractic	Chiropractic providers participating in the American Specialty Health (ASH) network should call 800-972- 4226.
Durable medical equipment	Submit authorization requests to CareCentrix: • www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
ECG, EEG, EKG, EMG, Electrophysiology	Effective January 1, 2022 – Prior authorization not required
End-Stage Renal Disease (ESRD) Dialysis Services Services for treating end-stage renal disease, including outpatient dialysis services	Submit authorization requests electronically through Availity
Home Health / Home Infusion	Submit authorization requests to CareCentrix: • www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Hospice	Submit authorization requests electronically through Availity
Hyperbaric Chamber Treatment Hyperbaric oxygen treatment (99183, A4575, C1300) requires authorization.	Submit authorization requests electronically through Availity

Service	How to Obtain Authorization
Injectable Medications A drug capable of being injected intravenously through an intravenous infusion, subcutaneously or intra-muscularly	Refer to Physician Administered Drug section of this guide If the drug is in the **PADP list**, submit request to Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management • https://gatewaypa.com/ • Call 800-424-4947 If drug is not in the **PADP list**, Submit authorization requests electronically through Availity • www.availity.com • Call Truli for Health at 800-955-5692
Insulin Pumps and Supplies	Submit authorization requests to CareCentrix: • www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Intensity Modulated Radiation Therapy (IMRT)	Submit authorization requests electronically through Availity
Inpatient - Acute and Long-Term Acute Care (LTAC) Newborn admissions require separate authorization from the mother if the baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Truli.	Submit authorization requests electronically through Availity In the event the newborn is not yet added to the policy, providers can submit requests: • via fax at 1-866-441-1569 • via telephone at 1-877-219-9448
Licensed Nurse Midwife	Submit authorization requests electronically through Availity
Oral Maxillofacial	Submit authorization requests electronically through Availity
Orthotic / Prosthetic	Submit authorization requests to CareCentrix • www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Outpatient Hospital Services (Includes 23-hour observations)	Submit authorization requests electronically through Availity All outpatient psychiatric and substance abuse admissions should be coordinated through New Directions Behavioral Health • www.ndbh.com/providers • Call 855-888-5001
Pain Management	Submit authorization requests electronically through Availity
Pharmacy Provider Administered Drugs	Refer to Physician Administered Drug section of this guide • If the drug is in the PADP list, call Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management at 800-424-4947 • If drug is not in the PADP list, call Truli for Health at 800-955-5692
Radiation Oncology	Effective January 1, 2022 – Prior authorization not required
Skilled Nursing Facility	Submit authorization requests electronically through Availity

Service	How to Obtain Authorization
Sleep Studies Laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders	Submit authorization requests to CareCentrix: • www.carecentrixportal.com/ProviderPortal • Call 855-243-3326
Surgical Procedures Outpatient Facility	Submit authorization requests electronically through Availity
Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation	Submit authorization requests electronically through Availity

For additional information or Current Procedural Terminology (CPT) Code level details, please access Availity > Select Payer Spaces > Truli for Health > Resources

How to submit prior authorization requests

To start the prior authorization process, providers should follow these steps:

1. Review the Prior Authorization List to determine if we require a prior authorization for the requested service.
2. Once authenticated in Availity, select the **Authorization** section
3. Select Truli for Health as the Payer
4. Complete the **Request Information** section
5. Complete the **Provider Performing Service** section
6. Complete the **Facility** section
7. Submit the form

Updating prior authorization requests

To check the status or update an authorization request, use the authorization section on Availity.

Authorization review timeline

Within 15 business days from the date, we receive your request, we will review the clinical information you submitted and decide on the outcome. We will process any authorization review requests you make after hours, on weekends or on holidays the following business day.

Provider Protocol Exemption Request

To prescribe a medication, medical procedure or course of treatment for a condition that is different from the step-therapy protocol developed by Florida Blue, complete the Provider Protocol Exemption Request Form. Additional information can be found in the Provider Protocol Exemption Instruction document.

Concurrent inpatient review

Truli conducts concurrent inpatient reviews to ensure services a member receives:

- Are medically necessary
- Meet Truli evidence-based criteria
- Are provided in the appropriate care setting

This review also uncovers any continuity of care gaps before discharge.

Truli performs focused retrospective reviews when certain factors suggest a review is warranted.

How we communicate UM decisions

Truli sends all UM decisions (approvals and denials) to the requesting provider in writing. When we deny a service, you will receive the decision in writing, including the clinical reasons for the decision and the supporting evidence-based criteria, including medical guidelines we used to determine medical necessity.

Physicians can review criteria

Physicians who treat Truli for Health members have the opportunity to discuss any adverse determination based on medical appropriateness or necessity with the physician reviewer making the decision. An explanation of this procedure is included with each written adverse benefit determination notice. Providers may request and receive, free of charge, an explanation of the scientific or clinical criteria Truli for Health relied upon in making benefit determinations by contacting our UM department at 800-955-5692 and choose option 2.

Standing Authorization

We have established various medical management (utilization management) programs for the review of service requests to determine benefit coverage provided under our policies. The medical management programs are a collaborative effort between Truli for Health, providers and physicians to provide members with information that will help them make more informed decisions about their health care and coverage.

Per your agreement with us, you are required to comply fully with medical management programs administered. Failure to obtain a prior authorization may result in the member and/or provider being held financially responsible for the procedure. There are however certain services that when performed in an office setting may not require a provider to obtain an authorization.

Authorization Guidelines

Note: Members should be referred to a participating provider to maximize benefits and to avoid higher out-of-pocket expenses.

Diagnostic Tests

Participating providers have standing authorizations for approval of the diagnostic tests below when performed in an in-network provider office or outpatient facility, including a free-standing location of service. This list contains the most commonly billed tests and is not all-inclusive.

Note: When a diagnostic test is performed as part of a treatment/service that requires an authorization, an authorization for the main service needs to be obtained. If not authorized, the entire claim may be denied.

The Diagnostic Tests listed in the following section, when performed in an office setting, may not require an authorization. Claims will process according to the coverage terms, limitations and exclusions of the

member's benefit plan at the time services are rendered. Final coverage determination is based on procedures included in the claim filed.

Note: Always refer to the current CPT coding manuals and guidelines for full description of all codes.

Diagnostic Tests	
Codes	**Description, Exception and/or Special Instruction**
Allergy	
95004	
95017 - 95071	
Cardiokymography	
Q0035	
Cardiovascular	
92978	Endoluminal Intravascular Ultrasound OCT C 1st
92979	Endoluminal Intravascular Ultrasound OCT C Each
93000 - 93024	
93224 - 93227	
93268 - 93272	
93303 - 93304	Transthoracic Echocardiograph (TTE)
93306 - 93308	TTE w/Doppler Complete; TTE w/o Doppler Complete; TTE Follow-up or Limited
93312 - 93317	Echo, Transesophageal
93320 - 93321	Doppler Echo Exam, Heart
93325	Doppler Color Flow, Add-on
93350 - 93352	Echocardiography
93354 - 93464	Coronary Angiography
93561 - 93568	
93569 - 93572	
93600 - 93642	
93662	Intracardiac ECG (ICE)
93724	Analyze Pacemaker System
93770	Measure Venous Pressure
93978 - 93979	Vascular Study
93880	Extracranial Study, Complete, Bilateral
93882	Extracranial Study, Unilateral or Limited
93922 - 93926	Lower Extremity Study
93930 - 93931	Upper Extremity Study
Gastroenterology	
43200	
91010 - 91013	
91037 - 91065	
91122	

Male Genital System	
54240	
54250	
Maternity	
59020	
59025	
Mobile Imaging	
Q0092	Portable X Ray
R0070 – R0076	Transport of Portable X Ray
Neurology and Neuromuscular	
95816	
95819	
95829	
95860 – 95875	
95907- 95913	
95921- 95937	
95954- 95962	
Non-Invasive Vascular	
93886 – 93895	
93950 – 93977	
93990	
Ophthalmology	
92060	
92081- 92083	
92136	
92235 – 92250	
Otorhinolaryngology	
92540 - 92546	
92562	
92564 - 92588	
92612 – 92617	
Pulmonary	
94010	
94772	
94060 - 94621	
94680 - 94750	
94770	
Radiological Guidance	
77011 – 77014	Computed Tomography
77021 & 77022	Magnetic Resonance
77065 - 77067	Breast Mammography
77071-77077 & 77080	Bone/Joint Studies
19081, 19281 & 19283	Other

Radiology Diagnostic Imaging	
70010 – 70332,70350 -	Head and Neck
71010 – 71130	Chest
72020-72120, 72170, 72190,72200-72270 and 72285 - 72295	Spine and Pelvis
73000 - 73140	Upper Extremities
73501- 73660	Lower Extremities
74000 – 74022, 74190	Abdomen
74210 – 74363	Gastrointestinal Tract
74400 – 74485	Urinary Tract
74710, 74740, 74775	Gynecological and Obstetrical
75600-75630, 75705-75774, 36223- 36227, 36251-36254, 36901 – 36906, 93556	Aorta and Arteries
75801 – 75893	Veins and Lymphatics
75894-75989, 34701 – 34711,0254T	Transcatheter Procedures
0234T–0238T	Transluminal Atherectomy
37225 – 37229, 37231-	Endovascular Revascularization with or without stent
76000 - 76140	Other
Radiology Nuclear Medicine	
78012-78075	Endocrine
78102-78195	Hematopoietic, etc.
78201-78291	Gastrointestinal
78300-78320, 78350, 78351	Musculoskeletal
78414-78445, 78456-78458	Cardiovascular
78579-78598	Respiratory
78600-78607, 78610-78645, 78650, 78660	Nervous
78700-78761	Genitourinary
78800-78807	Other

Radiology Ultrasound	
76700-76776	Abdomen and Retroperitoneum
76641-76642	Breast
76818-76872	Pelvis – OB, Non-OB, Genitalia
76881-76886	Extremities
76930-76964	Guidance Procedures
76970-76998	Other Procedures
76506-76513, 76516-76536	Head and Neck
76604, 76641, 77065-77067, 51725-51798	Chest
19296 - 19298	Placement of Radiotherapy
20555	Placement of Needles or Cath
31643	Bronchoscopy, Rigid or Flexible
41019	Placement of Needles, Catheters
43499	Esophagus Surgery Procedure
47999	Bile Tract Surgery Procedure
55860 (55862, 55865, 55875, 76873, G0458)	Surgical Exposure, Prostate
55899	Genital Surgery Procedure
55920	Placement of Needles or Catheter
57155 - 57156, 58346	Insertion of Radiation Source for Clinical Brachytherapy
61796 - 61799	Stereotactic Radiosurgery; Cranial
61800	Application of Stereotactic Radiosurgery; Cranial
63620 - 63621	Stereotactic Radiosurgery (Spinal) Procedures on the Spine and Spinal Cord
67218	Destruction of Localized Retinal Lesion
77261 - 77263	Clinical Radiation Treatment Planning
77280	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Single Area
77290	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Complex, 3 or more areas
77300	Basic Radiation Dosimetry Calculation
77301	Intensity Modulated Radiotherapy (IMRT)
77307	Teletherapy Isodose Plan
77316 - 77318	Brachytherapy Isodose Plan
77332	Radiation Treatment Simple Devices and Special Services
77334	Radiation Treatment Complex Devices and Special Services
77336	Continuing Medical Radiation Physics Consultation
77338	Multi-Leaf Collimator (MLC)
77370	Special Medical Radiation Physics Consultation
77371 - 77373 (G0339-G0340)	Radiation Treatment Delivery
77385 - 77386 (G6015 - G6016)	Intensity Modulated Radiation

Radiology Ultrasound	
77387 (G6001 - G6002, G6017, 77014)	Guidance for Localization of Target Volume
77402 (G6003 - G6014, 77407, 77412, 77295)	Radiation Treatment Delivery
77417	Radiology Port Image(s)
77427	Radiation Treatment Management (5 Treatments)
77432	Stereotactic Radiation Treatment
77435 (32701)	Stereotactic Body Radiation
77470	Special Radiation Treatment
77520 (77522-77523, 77525)	Proton Treatment, Simple, Without Complications
77761 (77762-77763, 76965, 77767-77768, 77771-77772, 77778,	Intracavity Radiation Source Application, Simple
77790	Supervision, Handling, Loading of Radiation Element
S8030	Scleral Application of Tantalum Ring(s)
C1717	Brachytherapy Source, Non-Standard, High Dose Rate Iridium – 192 Per Source
Q9958	High Osmolar Contrast Material, ≤ 149 mg/ml Iodine Concentration, per 1 ml

Radiation Oncology Treatments

Participating providers have standing authorizations for the radiation oncology treatments below when performed in a physician office, hospital outpatient or ambulatory surgical center. This list contains the most commonly billed treatments and is not all-inclusive.

Note: When a treatment is performed as part of a treatment/service that requires an authorization, an authorization for the main service needs to be obtained. If not authorized, the entire claim may be denied.

The Radiation Oncology treatments listed in the following section, when performed in an office setting, may not require an authorization. Claims will process according to the coverage terms, limitations, and exclusions of the member's benefit plan at the time services are rendered. Final coverage determination is based on procedures included in the claim filed.

Note: Always refer to the current CPT coding manuals and guidelines for full description of all codes.

Radiation Oncology	
Codes	**Description, Exception and/or Special Instruction**
19296 - 19298	Placement of Radiotherapy
20555	Placement of Needles or Cath
31643	Bronchoscopy, Rigid or Flexible
41019	Placement of Needles, Catheters
43499	Esophagus Surgery Procedure
47999	Bile Tract Surgery Procedure
55860 (55862, 55865, 55875, 76873, G0458)	Surgical Exposure, Prostate
55899	Genital Surgery Procedure

Radiation Oncology	
Codes	**Description, Exception and/or Special Instruction**
55920	Placement of Needles or Catheter
57155 - 57156, 58346	Insertion of Radiation Source for Clinical Brachytherapy
61796 - 61799	Stereotactic Radiosurgery; Cranial
61800	Application of Stereotactic Radiosurgery; Cranial
63620 - 63621	Stereotactic Radiosurgery (Spinal) Procedures on the Spine and Spinal Cord
67218	Destruction of Localized Retinal Lesion
77261 - 77263	Clinical Radiation Treatment Planning
77280	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Single Area
77290	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Complex, 3 or more areas
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77307	Teletherapy Isodose Plan
77316 - 77318	Brachytherapy Isodose Plan
77332	Radiation Treatment Simple Devices and Special Services
77334	Radiation Treatment Complex Devices and Special Services
77336	Continuing Medical Radiation Physics Consultation
77338	Multi-Leaf Collimator (MLC)
77370	Special Medical Radiation Physics Consultation
77371 - 77373 (G0339-G0340)	Radiation Treatment Delivery
77385 - 77386 (G6015 - G6016)	Intensity Modulated Radiation
77387 (G6001 - G6002, G6017, 77014)	Guidance for Localization of Target Volume
77402 (G6003 - G6014, 77407, 77412, 77295)	Radiation Treatment Delivery
77417	Radiology Port Image(s)
77427	Radiation Treatment Management (5 Treatments)
77432	Stereotactic Radiation Treatment
77435 (32701)	Stereotactic Body Radiation
77470	Special Radiation Treatment
77520 (77522-77523, 77525)	Proton Treatment, Simple, Without Complications
77761 (77762-77763, 76965, 77767-77768, 77771-77772, 77778,	Intracavity Radiation Source Application, Simple
77790	Supervision, Handling, Loading of Radiation Element
S8030	Scleral Application of Tantalum Ring(s)
C1717	Brachytherapy Source, Non-Standard, High Dose Rate Iridium – 192 Per Source
Q9958	High Osmolar Contrast Material, ≤ 149 mg/ml Iodine Concentration, per 1 ml

Pharmacy

Drug Lists

Truli offers three different drug list options to our members. The member's digital card will show which drug list applies to the member's coverage.

- Truli Rx Choice
- Truli Rx Flex
- Truli Rx Basic

Home Delivery for 90-Day Supply

Our convenient home delivery pharmacy service through Amazon Pharmacy can help members save time and money, increase adherence, and promote better health outcomes. Members can get up to a 90-day supply of their medication shipped to their preferred location when ordering through home delivery. Prescriptions can be easily sent to Amazon Pharmacy using your EMR systems by e-prescribing to Express Scripts Home Delivery Amazon Pharmacy 001.

Submit new prescriptions to Amazon Pharmacy using the following information:

Pharmacy Name	Address	Phone # / Fax #	ePrescribe Name
Amazon Pharmacy	4500 S Pleasant Valley Rd. Suite 201 Austin, TX 78744	Phone 855-206-3605 Fax 512-884-5981	AMAZON PHARMACY 001
Hours for Prescriber Line	8 a.m. – 10 p.m. weekdays 10 a.m. – 8 p.m. weekends		

Controlled Substances and Specialty Medications

Amazon Pharmacy does not dispense C-2 controlled substances or service specialty medications. Members should continue to use their local retail pharmacy for C-2 controlled substances and CVS/Caremark for their specialty medication needs.

Specialty Drugs

Specialty drugs are injectable, oral, inhaled or infused therapies used to treat complex medical conditions. Local pharmacies and provider offices may not carry or stock these drugs because they:

1. Require more complex handling than traditional drugs
2. Are high cost
3. May need frequent dosage adjustments

Specialty pharmacy network

Members must fill their specialty drugs at one of the following specialty pharmacies:

CVS/Caremark Specialty Pharmacy Services
All Products
Phone: 866-278-5108
Fax: 800-323-2445

CVS/Caremark Hemophilia Services
Hemophilia Products
Phone: 866-792-2731
Fax: 866-811-7450

Only the pharmacies listed above are in-network for specialty drugs. A pharmacy can be in-network for retail or home delivery drugs and still not be in-network for specialty drugs.

Ordering provider-administered specialty drugs

Provider offices that administer covered provider-administered specialty drugs in their office can obtain them two ways:

Options	Option Descriptions
Order the injectable drug from our Specialty Pharmacy Network	Specialty suppliers provide specialty medications for in-office administration using one of two service options: • **Just-in-time service** – Order drugs one to two weeks before the service date to allow for eligibility and coverage review and shipping time. • **Stock replacement service** – Order drugs within 30 days of the service date the provider administered the drug in-office. The specialty supplier will contact the provider's office to confirm medication delivery. **Billing** The specialty pharmacy will bill Truli directly for the drug. The provider should: • Bill applicable office visit procedure codes, including drug administration codes, as is customary, and follow standard billing practices for the service. • Collect the office visit cost share (copayment and deductible, as applicable) according to a member's benefit agreement.
Provide the drug from your own supply	The provider should • File a drug reimbursement claim ("buy and bill") directly to Truli. • Bill applicable office visit procedure codes, including drug administration codes, as customary, and follow standard billing practices for the service. • Collect the office visit cost share (copayment and deductible, as applicable) according to a member's benefit agreement.

Retail Pharmacy Authorization Guidelines

Truli requires certain prescription and injectable drugs to meet specific clinical criteria before our pharmacy programs cover them.

Retail pharmacy drugs that are subject to prior authorization review can be found in the Prior Authorization Program Information guide. To request authorization for a retail drug, providers should complete and submit an electronic Prior Authorization (ePA) request through CoverMyMeds®.

CoverMyMeds Determination Logic Guide
CoverMyMeds Reference Guide

Medical and Specialty Pharmacy Authorization Guidelines

Truli requires prior authorization through various utilization management programs for a wide range of drug services processed through the medical benefit. Prior authorization requests for medical and specialty pharmacy drugs are handled by different entities depending upon the circumstance.

Check the Medical Pharmacy Drugs Requiring PA list for help determining where an authorization request should be submitted and a current listing of drugs requiring prior authorization when processed through the member's medical benefit.

Provider Administered Drug Program (PADP)

Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management helps manage our PADP. This program uses clinically accepted standards to maximize patient care in the most appropriate and affordable manner.

A member's benefits determine which drugs we cover. Drugs we do not cover through PADP may still require prior authorization. Providers can obtain authorizations through Availity.

PADP exclusions

PADP guidelines do not apply in the following scenarios:

- Drugs a patient receives in an emergency room
- Drugs a patient receives in an observation unit
- Drugs a patient receives during an inpatient stay
- Drugs a provider or patient orders through Truli's Specialty Pharmacy Program, such as "Just-in-Time" or "Drug Replacement"

How to submit prior authorization requests for PADP

Review the **PADP list** to determine if Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management manages the drug.

If the drug is in the PADP list, submit requests electronically to Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management:

- https://gatewaypa.com/
- Call Medical Pharmacy Solutions (MPS) division of Prime Therapeutics Management at 800-424-4947

If the drug is not in the PADP list, submit authorization requests electronically through Availity:

- www.availity.com
- Call Truli for Health at 800-955-5692

Independent Clinical Laboratory

Providers should refer laboratory services to Quest Diagnostics℠ and Dermpath Diagnostics®. The preferred lab for anatomical pathology services in Florida is AmeriPath®.

Only the laboratory services listed below are eligible for payment when a participating Truli physician performs them in the office. Truli will deny payment for any other laboratory services a physician performs in the office, and the physician must not bill the member for these services. Draw fees are only eligible for payment when providers send lab services to Quest Diagnostics and Dermpath Diagnostics or another participating laboratory.

Codes	Descriptors
36415	Collection of venous blood by venipuncture
80076	Hepatic function panel (7)
80048	Basic metabolic panel
80051	Electrolyte panel (CO2, Cl, K, Na)
81000	Urinalysis, by dip stick or tablet reagent, non-automated with microscopy
81001	Urinalysis, by dip stick or tablet reagent, automated with microscopy
81002	Urinalysis, by dip stick or tablet reagent, non-automated without microscopy
81003	Urinalysis, by dip stick or tablet reagent, automated without microscopy
81005	Urinalysis, qualitative or semi quantitative, except immunoassays Add 24 hours for urine collection
81015	Urinalysis; microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82150	Amylase
82247	Bilirubin; total
82270	Consecutive collected specimens with single determination, for colorectal neoplasm screening
82272	1 to 3 simultaneous determinations, performed for other than colorectal neoplasm screening
82565	Creatinine; blood
82803	Gases, Blood, any combination of PH, PCO2, PO2, CO2, HCO3 (including calculated O2 saturation)
82946	Glucagon Tolerance Test
82947	Glucose; Quantitative, Blood (Except reagent strip)

Codes	Descriptors
82948	Glucose; blood, reagent strip
83036	Hemoglobin; Glycosylated (A1C)
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
84703	Gonadotropin, chorionic (HCG); qualitative
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (HCT)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85610	Prothrombin time partial thromboplastin time (PT), international normalized ratio (INR)
86308	Heterophile antibodies; screening
86580	Skin test, tuberculosis, intradermal
87210	Wet mount for infection agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87400	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method, Influenza A or B, each
87420	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; respiratory syncytial virus
87425	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; rotavirus
87430	Infectious agent antigen detection by enzyme immunoassay technique, Streptococcus, group A
87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique

Codes	Descriptors
87804	Infectious agent detection by immunoassay with direct optical observation; influenza
87807	RSV assay w/ optic
87809	Infectious agent detection by immunoassay with direct optical observation; adenovirus
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
88172	Cytopathology. Evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s).
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis.
89051	Cell count, miscellaneous body fluids, except blood; with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, or body fluid (except urine)
89190	Nasal smear for eosinophils
89300	Semen analysis; presence and/or motility of sperm including Huhner test

Internal Dispute Resolution

Provider Appeal Process

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals. Truli will conduct a one-time appeal review. There are no second level appeal rights for a post-service provider appeal.

Truli has a defined provider appeal process for providers who are dissatisfied with how a claim processed, paid or denied.

Provider appeal categories:

- Clinical appeals
- Non-clinical appeals (coding appeals)
- Administrative appeals, appeal appropriateness

Providers may send an appeal if there is financial liability for the provider or the provider is sending the appeal on behalf of a member (patient). Not all claim denials are eligible for a provider appeal. For example, services are not eligible for a provider appeal include but are not limited to:

- Office and outpatient evaluation and management codes for place of service 19 or 22
- Drug Screens

If the provider is sending a post-service appeal on behalf of a member, the Truli Appointment of Representation (AOR) form must be completed and accompany the appeal. The appeal will then process as a member appeal.

Member Appeals Exception process

The provider may submit the appeal request without an AOR form when the following conditions are met:

1. The provider is unable to reach the member to complete the AOR form.
2. A member refuses to submit payment to a provider for services rendered and a claim has been denied.
3. If one or both these conditions are met, the provider can submit the appeal and must:
   a. Describe the contact attempts to the member with dates.
   b. Describe interaction with the member with dates about payments as indicated in number 2.

Please note:

1. Clinical appeals/non-clinical appeals: Providers must not appeal again for decisions Truli has already processed as an appeal. Providers are required to submit ALL documentation at the time of the appeal submission.
2. Administrative appeals: For reconsiderations of administrative appeals please follow the process noted in the Administrative Appeals process below.
3. Claim reprocessing is not an appeal.
4. A physician or physician group must submit all documentation needed within reason to decide an internal appeal to Truli for Health's Provider Appeal and Dispute Department.

Participating providers must submit appeals within one year of the date that appears on the respective remittance advice. Truli for Health will not overturn claim denials based on a provider's failure to comply with required procedures and time frames.

Providers may not balance bill members for covered services, including disputed amounts.

If a Provider appeal is denied, a letter will be sent informing you of the decision. If approved, the claim will be forwarded for adjustment and/or payment.

Pre- and Post-service Appeals

Providers can request appeals for both pre-service and post-service adverse determinations by following the same rules as the general appeals process.

Clinical Appeals:

Clinical appeals encompass claims that require clinical review. Clinical appeal options (as referenced on the Provider Clinical Appeal Form) are:

- Utilization management appeals
- Adverse determination appeals (medical necessity or experimental / investigational appeal) non-clinical appeals

Providers have a right to appeal adverse determinations (denials) by submitting a request for reconsideration. Denials may be issued for several reasons that most commonly include:

Adverse determination appeals

A provider may file a written request for reconsideration when we have denied payment because a proposed or actual health care service or supply was:

- Not medically necessary.
- Experimental or investigational.
- Supportive of an experimental or investigational service.
- Supportive of a not medically necessary procedure (adverse determination appeal).

To request an adverse determination appeal for pre-service or post-service claims, the appeal must be in writing and a claim status request or telephone inquiry questioning how we applied benefits or allowed amounts.

Utilization management appeals

A utilization management (UM) appeal is a written request to review a claim that required an authorization, pre-service review or precertification.

UM appeals are not:

- Provider pre-service determination appeals (unless ERISA requires).
- Claims status requests, telephone inquiries or post-service claim reviews of how we applied benefits or allowed amounts.

Providers must file UM appeals within the lesser of the time frame contained in the provider's agreement or one year (365 days) from payment date. Truli will not overturn claim denials if the provider does not follow required procedures and timeframes.

How to request clinical appeals

Providers can request a clinical appeal two ways: electronically through Availity's automated appeals system or by mailing it to us.

Electronic Appeal submission (preferred method)

When a provider submits an appeal electronically, Availity includes all forms the provider must complete.

1. Go to Florida Blue Payer Space on Availity.
2. Complete all required forms.
3. Upload any supporting documentation, as necessary.
4. Submit the appeal to us through Availity.

Written appeal (alternate method)

When sending an appeal by mail, include the following:

- A completed Provider Appeals form.
  Note: Download and print the form from the Florida Blue Payer space on Availity.
- A copy of the EOP with the claim in question.
- A written explanation of the reconsideration.
- All supporting documentation.
- A completed <Truli for Health Appointment of Representation (AOR) form> if the provider is sending a post-service appeal on behalf of our member. We will process the appeal as a member appeal.

Send the appeal packet to the following address:

Truli for Health
Attn: Provider Disputes Department
P.O. Box 45014
Jacksonville, FL 32232

Questions? We are here to help.

How we communicate updates

This manual is not a complete compilation of provider polices or procedures. We will share vital information and updates about policies and programs we do not include in this manual on our website or in special publications, such as letters, bulletins, or newsletters. If we change a website's location, a benefit plan name, our branding or the customer identification card identifier, we will also share that information with you.

Contact us

You can find a helpful list of current phone numbers, operating hours, and more at truliforhealth.com *and select* **Contact**.

Call the Provider Contact Center:	833-238-8144
Hours of Operation:	Monday – Thursday, 8 a.m. to 6 p.m. Friday, 9 a.m. to 12 p.m. IVR Self-service Options 24/7/365