

Provider Manual

Highmark Health Options Duals (HMO SNP)

Highmark Health Options Duals Select (HMO SNP)



Provider Services Inquiries

Highmark Health Options Duals:

1-855-401-8251

Highmark Health Options Duals Select:

1-844-722-5837

highmark.com/hhoduals/de

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QUICK REFERENCE

Important Phone Numbers for Highmark Health Options Duals

<u>Call to Inquire about:</u> Call Type	Department/Area	Contact Information	Hours of Operation
Claims Inquiry	Provider Services	Health Options Duals 1-855-401-8251 Health Options Duals Select 1-844-722-5837	7:00 am to 5:00 pm Monday – Friday
Authorization Medical and Behavioral Health	Utilization Management	1-844-401-8251	8:30 am to 4:30 pm Monday – Friday Calls received during non-business hours are referred to: 1-844-401-8251
Requests for admissions to inpatient rehab (IRF), Long-Term Acute Care (LTAC) or Skilled Nursing Facilities (SNF)	Home and Community Services	For urgent/emergent requests call 1-855-960-6116 Providers can submit authorization requests via toll-free fax: General Prospective Review 1-844-496-7226 Continued stay review for SNF/IRF/LTAC 1-855-796-7177 Therapy treatments/visits submitted to Home and Community Services 1-888-242-3495	8:00 am to 5:00 pm Monday – Friday

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<u>Call to Inquire about:</u> Call Type	Department/Area	Contact Information	Hours of Operation
Authorizations for cardiology, physical, occupational and speech therapy, musculoskeletal surgery, interventional pain management procedures, and advanced outpatient imaging, which includes: CT/CTA, MRI/MRA/MRS, PET scans, myocardial perfusion imaging, and stress echocardiography	HealthHelp	<p>Ordering providers can request an authorization using one of the following methods:</p> <p>Web: http://www.healthhelp.com/HighmarkHealthOptionsDE</p> <p>Fax: 1-877-637-6934</p> <p>Fax Expedited: 1-877-637-6935</p> <p>Phone: 1-877-761-1444</p>	<p>8:00 am to 8:00 pm Monday – Friday</p> <p>HealthHelp is available 24 hours a day 7 days a week</p>
Requests for sleep studies, select cardiology procedures, and radiation oncology services	HealthHelp	<p>Ordering providers can request an authorization using one of the following methods:</p> <p>Web: http://www.healthhelp.com/HighmarkHealthOptionsDE</p> <p>Fax: 1-877-637-6934</p> <p>Fax Expedited: 1-877-637-6935</p> <p>Phone: 1-877-761-1444</p>	<p>8:00 am to 6:00 pm Monday – Friday</p> <p>After-hour requests may be submitted by fax or via web portal.</p>

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<u>Call to Inquire about:</u> Call Type	Department/Area	Contact Information	Hours of Operation
Requests for oncology medications	HealthHelp	<p>Ordering providers can request an authorization using one of the following methods:</p> <p>Web: http://www.healthhelp.com/HighmarkHealthOptionsDE</p> <p>Fax: 1-877-637-6934</p> <p>Fax Expedited: 1-877-637-6935</p> <p>Phone: 1-877-761-1444</p>	<p>8:00 am to 8:00 pm Monday – Friday</p>
Member Eligibility	Interactive Voice Response System (IVR) Member Eligibility Line	1-855-401-8251	<p>24 hours a day 7 days a week</p>
Requests for Non-Formulary Drugs and Prior Authorizations	Pharmacy Services	<p>1-855-401-8251 Fax: 1-855-476-4158</p> <p>Electronic prior authorizations at CoverMyMeds.com</p> <p>Our searchable drug formulary and prior authorization forms are available at https://client.formularynavigator.com/Search.aspx?siteTestID=32237</p>	<p>8:00 am to 8:00 pm Monday – Friday</p> <p>Voicemail inbox is monitored 24 hours a day, 7 days a week for afterhours requests.</p>
Expedited Redetermination	Part D Prescriber Appeals	1-800-213-7083	<p>Voicemail inbox is monitored 24 hours a day, 7 days a week for requests and status of redetermination requests</p>

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<u>Call to Inquire about:</u> Call Type	Department/Area	Contact Information	Hours of Operation
Care Coordination	Care Coordination	1-855-401-8251	8:00am to 5:00 pm Monday – Friday
Healthy Weight Management and Diabetes Prevention	Wellness Programs	1-855-401-8251	8:00 am to 5:00 pm Monday – Friday
Member Outreach	Preventive Health	1-855-401-8251 Fax: 1-888-225-2360	8:00 am to 5:00 pm Monday – Friday
Member Complaints/Concerns/Inquiries	Member Services	1-855-401-8251	8:00 am to 8:00 pm Monday – Friday (April through September) 8:00 am to 8:00 pm 7 days/week (October through March)
Fraud, Waste and Abuse Concerns/Inquiries	Fraud, Waste and Abuse	1-844-325-6256	24 hours a day 7 days a week
Integrity and Compliance Concerns	Compliance	1-800-985-1056 or email integrity@highmarkhealth.org	24 hours a day 7 days a week
General Privacy/Legal Concerns	Privacy	privacy@highmarkhealth.org	24 hours a day 7 days a week
Report Suspected Privacy Breaches	Integrated Risk and Privacy Operations (IRO)	integratedriskandprivacyops@highmarkhealth.org	24 hours a day 7 days a week

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Helpful Telephone Numbers

<u>Call to Inquire about:</u>		
Call Type	Contact Information	Hours of Operation
Highmark Health Options Duals TTY/TDD Provides assistance with hearing impaired	1-800-232-5460 or TTY: 711	8:00 am to 8:00 pm Monday – Friday
Practice Change Information	Fax: 1-855-451-6680	24 hours a day 7 days a week
VSP Provider Servicing	1-800-615-1883	9:00 a.m. to 8:00 p.m. Monday – Saturday
United Concordia Government Business Operations (Provider Services)	1-866-568-5933	8:00 am to 5:00 pm Monday – Friday
TruHearing Provider Support	1-855-286-0550	8:00 am to 8:00 pm Monday – Friday
Fitness	1-833-423-4632	8:00 am to 8:00 pm Monday – Friday
Nurse Line Members can contact the nurse line if they are unable to reach their doctor	1-855-401-8251	24 hours a day 7 days a week

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<u>Call to Inquire about:</u>		
Call Type	Contact Information	Hours of Operation
Members can reach out to the Care Coordination team for assistance with scheduling appointments, coordinating care, arranging transportation, and completing their Health Risk Assessment	1-855-401-8251	8:00 am to 5:00 pm Monday – Friday
Flex Card – Healthy Food, OTC, Bathroom/Home Safety Devices and Utilities (and Pay-at-the-Pump Gasoline for Full Duals)	1-833-623-2619	8:00 am to 8:00 pm Monday – Friday

Important Addresses

HIGHMARK HEALTH OPTIONS DUALS MAILING ADDRESS LIST	
<p>IMPORTANT NOTE:</p> <p>To ensure your correspondence reaches the intended department all mailing addresses MUST include the appropriate Delivery Code (if applicable) and Attention Line.</p>	
<p>Corporate Office:</p> <p>Delivery Code Attention Highmark Health Options Duals 800 Delaware Avenue, Suite 900 Wilmington, DE 19801</p>	<p>FedEx & UPS Packages:</p> <p>All FedEx & UPS packages must be sent to the Corporate Office address along with the appropriate Delivery Code (if applicable) and Attention line.</p>
Reason for Mailing:	Mailing Address:
<p>Claims – Medicaid Medical</p>	<p>Attention: Claims Department Highmark Health Options PO Box 21771 Eagan, MN 55121</p> <p>When submitting claims please note the Delaware Payer ID Number is 47181. Any claim submitted to the wrong address or with an incorrect Payer ID Number will be denied.</p>
<p>Claims –Highmark Health Options Duals Medical and Behavioral Health</p>	<p>Attention: Claims Processing Department Highmark Health Options Duals PO Box 21215 Eagan, MN 55121</p> <p>Attention: Claims Processing Department Highmark Health Options Duals Select PO Box 21215 Eagan, MN 55121</p> <p>When submitting claims please note the Payer ID Number is 47183. Any claim submitted to the wrong address or with an incorrect Payer ID Number will be denied.</p>

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Reason for Mailing:	Mailing Address:
Administrative Claims Reviews Fax to 1-833-623-2577– Preferred submission method.	Attention: Claims Review Highmark Health Options Duals PO Box 890414 Camp Hill, PA 17089-0414 Attention: Claims Review Highmark Health Options Duals Select PO Box 890414 Camp Hill, PA 17089-0402
Clinical Provider Appeals Fax to 1-833-560-1828	Attention: Provider Appeals Highmark Health Options Duals PO Box 890416 Camp Hill, PA 17089-0416
Credentialing	Delivery Code: WC-CRED Attention: Credentialing Highmark Health Options Duals PO Box 535191 Pittsburgh, PA 15253-5191
Dental Claims	Attention: Claims United Concordia PO Box 69455 Harrisburg, PA 17110-9455
Member Appeals & Grievances	Attention: Appeals & Grievances Highmark Health Options Duals PO Box 890416 Camp Hill, PA 17089-0416
Member Enrollment/Disenrollment	Attention: Enrollment Highmark Health Options Duals DE PO Box 890032 Camp Hill, PA 17089-0032

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Reason for Mailing:	Mailing Address:
Overpayments Self-Audit/Overpayment Form can be submitted through the Provider Portal via Navinet	Highmark Health Options Duals HHOFRAUD 120 Fifth Avenue Pittsburgh, PA 15222 Highmark Health Options Duals Select HHOFRAUD 120 Fifth Avenue Pittsburgh, PA 15222
Pharmacy and Therapeutics (P & T) Committee	Delivery Code: WC-PHARM Attention: Pharmacy Services Highmark Health Options Duals PO Box 22158 Pittsburgh, PA 15222
Practice Change Information Fax to 1-855-451-6680- Preferred submission method.	Delivery Code: WC-PDM Attention: Provider Data Management Highmark Health Options Duals PO Box 535191 Pittsburgh, PA 15253-5191
Prescription Drug Claims	Delivery Code: WC-PHARM Highmark Health Options Duals Pharmacy Services PO Box 890419 Camp Hill, PA 17089-0419
Retrospective Authorization Reviews	Attention: Retrospective Reviews Highmark Health Options Duals PO Box 106004 Pittsburgh PA 15230
Subrogation (COB)	Attention: Enrollment Highmark Health Options Duals DE PO Box 890032 Camp Hill, PA 17089-0032

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Reason for Mailing:	Mailing Address:
Vision Claims	In-Network Claims VSP PO Box 495907 Cincinnati, OH 45249-5907 Out-of-Network Claims or Special arrangement providers VSP PO Box 495918 Cincinnati, OH 45249-5918

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Plan Co-Payments

This plan provides coverage for eligible medical services, with no out-of-pocket expenses or cost sharing required from the member. For more benefit information, please refer to the Evidence of Coverage booklet for each healthcare option located on our website at <https://www.highmarkhealthoptions.com/providers/>.

Dual Eligible Special Needs Plan (D-SNP)	Co-payment		
	PCP	SPECIALIST	ER
Health Options Duals (HMO SNP)	\$0	\$0	\$0*
Health Options Duals Select (HMO SNP)	20% coinsurance		\$115*

*Not covered outside the U.S. except under limited circumstances.

Duals Select copay will be waived if member is admitted within 24 hours for the same condition.

Please note: All members enrolled in Highmark Health Options Duals also have Medicaid (Medical Assistance) or receive some assistance from the State. Members will be eligible for Medicaid coverage to pay for cost sharing (deductibles, copayments, and coinsurance). They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility. Please follow Medicaid coverage and claims processing guidelines. Please contact Highmark Health Options Duals Provider Services for member specific information.

QMB members enrolled in the Duals Select plan (not QMB+ members) will have their medical cost share covered by their corresponding Medicaid plan.

Highmark Health Options Duals members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency.

Providers further agree that upon payment from our company under Highmark Health Options Duals line of business, providers will accept our plan payment as payment in full; or bill the appropriate State source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by Federal law.

INTRODUCTION

About This Manual

Our successes, measured by member and provider satisfaction and assessments by the Centers for Medicare and Medicaid Services (CMS), are dependent upon a strong understanding of Highmark Health Options Duals' policies and procedures. The entire Highmark Health Options Duals team is committed to providing accurate, up-to-date and comprehensive information to our member and provider communities through prompt and dedicated service. This Provider Manual is one way of sharing information with participating practitioner offices, hospitals and ancillary providers and is considered part of your contractual agreement with us. This manual is a reference and is designed to be updated as needed. Please retain all updates with your manual.

This manual and any updates are available in the Providers section of our website at <https://www.highmarkhealthoptions.com/providers/>.

Overview of Highmark Health Options

About Us

A national blended health organization, Highmark Health and our leading businesses support millions of customers with products, services, and solutions closely aligned to our mission of creating remarkable health experiences, freeing people to be their best.

Headquartered in Pittsburgh, we are regionally focused in Pennsylvania, Delaware, West Virginia, and eastern and northwestern New York with customers in 50 states and the District of Columbia. We passionately serve individual consumers and fellow businesses alike.

Highmark Health Options Duals offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal. Every year, Medicare evaluates plans based on a 5-star rating system. Highmark Health Options Duals complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Philosophy and Social Determinants of Health

Our legacy of addressing social determinants of health (SDoH), which refers to the conditions in which people are born, grow, live, work and age, can be traced back to the start of the organization.

We offer a wide variety of programs and demonstrations that addresses SDoH for our members. Many of these initiatives are available by member referral through our Care Coordination Program.

Highmark Health Options helps members find free or reduced-cost services in their community. Members can search for local support resources to access food, housing, transportation, utility assistance, medical care, job training and more.

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The Highmark Health Options Duals Community Support Tool, a free support resource tool supported by the “Find Help” platform, is a way to quickly and easily search for community support resources online. Users can find food, housing, and transportation resources. They can also search for employment and mental health support programs.

<https://hmhealthoptions.findhelp.com/>

History

Highmark Inc. (“Highmark”) was created in 1996 by the consolidation of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania. Highmark and its health insurance subsidiaries and affiliates are one of America’s largest health insurance organizations and operates health insurance plans in Pennsylvania, Delaware, West Virginia, and New York. Highmark currently serves 6 million members. In 2011, Highmark Health, the parent company of Highmark, became one of the first health insurance companies to evolve to an integrated health and wellness company with a patient-centered care delivery system.

Since 2006, we have also offered a Medicare product geared toward the unique needs of individuals eligible for both Medicare and Medicaid. Highmark Health Options Duals is a Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract and a contract with the state Medicaid program.

As of 2026, Highmark Health Options Duals operates in all three (3) Delaware counties (Kent, New Castle, and Sussex).



For individuals who qualify, there is no, or a low, monthly premium (depending on their level of Medicaid eligibility). Qualifying members receive healthcare coverage, plus prescription drug coverage, dental, transportation, vision, hearing services, fitness center membership and much more – all from ONE plan!

Mission

To create a remarkable health experience, freeing people to be their best.

Products

We offer two Dual-Eligible Special Needs Plans (D-SNP), serving those with Medicare Parts A and B, among other qualifying factors.

These plans are:

Highmark Health Options Duals - for those with full Medical Assistance such as FBDE, QMB+ or SLMB+.

- Our full dual members in Delaware have coverage from Highmark for both DSNP and Medicaid plans. This results in simplified access for members and providers to member and provider services as well as internal coordination for care management/coordination functions. Members of Highmark Health Options Duals Select are not considered full Medicaid members and therefore do not have alignment between the DSNP and any other payors. For additional information regarding benefit categories, please see the “Member” section on page 36.

Highmark Health Options Duals Select - for those with some level of assistance from the state such as SLMB, QI, or QMB.

Highmark Health Options Duals offers a variety of benefits to members:

1. All the benefits of Original Medicare
2. Flex card with a combined allowance and over-the-counter (OTC) products and home and bathroom safety items. SSBCI eligible members will receive an additional allowance for healthy food, utilities, and pay at the pump gasoline. Pay at the pump gasoline is not available for Duals Select members. Prescription drug coverage including Step Therapy
3. Hearing exams and hearing aids
4. Preventative and comprehensive dental services, including dentures
5. Vision exams and eyewear
6. A fitness program to help members stay active (including options for home-bound members)
7. Mental health services
8. Post discharge meals
9. Routine chiropractic care

Enhanced Benefits for 2026

Flex Card

Duals Members

- SSBCI Qualified Members receive \$250 per month combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), Pay-at-the-Pump Gas (SSBCI). Members can use the \$250 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least \$50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply.

- Non-SSBCI Members receive \$50 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the \$50 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.

Duals Select Members

- SSBCI Qualified Members receive \$250 per quarter combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI). Members can use the \$250 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply.
- Non-SSBCI Members receive \$50 per quarter combined allowance for OTC and Home/Bathroom Safety. Members can use the \$50 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply.

Duals Members

Dental Benefits:

- \$3,000 in combined allowance for Preventative & Comprehensive services
- Any combination of routine prophylaxis and periodontal maintenance, including perioprophylaxis, totaling 4 treatments per year
- 2 Endodontic services per year
- Crowns limited to 2 per year, 1 crown in 5 years per tooth
- Dentures are covered, one per arch every year including a full or partial denture or an immediate denture and repairs.

Vision Benefit (VSP):

- \$400 per year for eye glass frames or contact lenses
- 1 pair of lenses and frames or contact lenses each year
- Lens types covered in full: single vision, lined bifocals, lined trifocals and lenticular
- The following lens upgrades are covered: Scratch coating, oversized lenses, Tints, Standard progressives, Photochromic lenses, UV coating, and Polycarbonate lenses.

Duals Select Members

Dental Benefits:

- \$1,500 allowance for Comprehensive services
- Any combination of routine prophylaxis and periodontal maintenance, including perioprophylaxis, totaling 4 treatments per year
- 1 Endodontic services per year
- Crowns limited to 1 per year, 1 crown in 5 years per tooth

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- Dentures are covered one per arch every 5 years, including a full denture, a partial denture or an immediate denture and are not applied to the comprehensive maximum plan coverage amount.

Vision Benefit (VSP):

- \$150 per year for eye glass frames or contact lenses
- 1 pair of lenses and frames or contact lenses each year
- Lens types covered in full: single vision, lined bifocals, lined trifocals and lenticular

Duals and Duals Select Members

Hearing Aid Benefit (TruHearing):

- One (1) TruHearing-branded hearing aid per ear, every 3 years
- One year of follow-up visits for fitting and adjustments included
- Limited to TruHearing's advanced and Premium hearing aids, a rechargeable option is available.
- 80 batteries per aid for non-rechargeable models

To learn more, members can call 1-855-401-8251 (TTY users call 711), Monday through Friday, 8:30 am to 5:00 pm ET.

Highmark Health Options Duals is dedicated to providing benefits to the Medicare and Medicaid populations to meet their medical and social needs. The specific needs of our membership have led to the development of wellness, education and outreach programs. These programs identify needs and provide effective case management for members with chronic conditions such as asthma, COPD, diabetes, and cardiovascular conditions.

Continuing Quality Care

Healthcare is an ever-changing field, and we strive to stay on top of the members' needs. We are committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by the Highmark Health Options Duals' Quality Improvement/Utilization Management Committee, made up of experts in a wide variety of medical fields. The QI/UM Committee evaluates our ongoing efforts as well as new protocols and quality initiatives in order to improve service and care for members.

Wellness & Disease Management

Highmark Health Options Duals is dedicated to enhancing the lives of its members by promoting wellness, illness prevention, and health education through various initiatives:

Preventive Health Care

- Annual flu vaccination (Age 18 and older)
- Annual wellness (Age 18 and older)
- Breast cancer screening (Women ages 40 to 74 years)
- Colorectal Cancer Screening (Ages 45 to 75 years)
- Diabetes test as needed, including HbA1c, dilated retinal eye exams, and

- microalbumin for members with diabetes
- COVID-19 Vaccination (For eligible population)
- Tobacco cessation education and benefits
- Reminders for pediatric and adult immunizations

The Clinical Practice and Preventative Guidelines are listed within the provider portal at <https://www.highmarkhealthoptions.com/providers/>.

Health Care Disparities

Highmark Health Options Duals understands that to help improve our members' quality of life, we must consider racial, ethnic, cultural, and linguistic differences as well as sexual orientation and gender identity. For this reason, addressing disparities in health care is high on our leadership's agenda. Highmark Health Options Duals has a Health Equity Program whose activities are overseen by the Health Equity Committee (HEC). The HEC's primary objective is to address health care disparities for its diverse membership and ensure that services are accessible and provided in a culturally, linguistically, and inclusively competent manner. Highmark's commitment is demonstrated by designing the Health Equity Program to follow NCQA's Best Practice framework, which is a voluntary process where organizations commit to providing impartial care to all patients, regardless of their race, ethnicity, socioeconomic status, or other factors by focusing on identifying and addressing healthcare disparities through data collection, cultural competency, and targeted interventions. We believe a strong patient-provider relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural, language, geographic and/or personal identity barriers.

In an effort to develop a strong patient provider relationship we ask, via the company's Cultural Competency Data Form, our providers to share their race, ethnicity, and language information. Disclosing this information is strictly voluntary and will not be used for credentialing, contracting, or for any discriminatory purposes. The availability of this information allows us to connect members with the appropriate practitioners, to fit their needs and preferences. This allows our providers to foster better provider-patient communication, and improve patients' health, wellness, and safety.

Additionally, we are encouraging all providers to take cultural competency training and to inform us about the various trainings taken by providers and their office staff throughout the year. Providers can access the Cultural Competency Data Form on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

We also have Highmark Health Options cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our associates, members, and providers. A provider cultural toolkit is available on our website at <https://www.highmarkhealthoptions.com/providers/>.

The cultural toolkit includes facts about health care disparities from the Institute of Medicine, tips on how to better communicate with patients, tools to evaluate how well the practice is delivering quality care to culturally diverse populations, information about communication regulations and resources from the Title VI of the Civil Rights Act of 1964, facts about various

cultures to enable the advocacy of high-quality, culturally competent services to multi-ethnic populations, web-based modules for physicians to practice responding to situations where culturally competent care is needed, and more.

Lastly, Highmark Health Options Duals assesses our member populations' language profile at least every three years and makes the Population Assessment Language Profile report available to practitioners through updates to provider newsletters.

Community Involvement

Highmark Health Options Duals is an active partner in the community through:

- Participation in community events and sponsorships.
- Assisting community and social services agencies that serve high-risk populations.
- Developing outreach programs at no cost to the community for adults and children to educate them about health, wellness and safety issues.
- Promoting its health literacy initiative with individuals and organizations in the communities we serve. The goal of this initiative is to help people better understand and navigate the healthcare system.

Benefits of Highmark Health Options Duals

Highmark Health Options Duals is a “win-win” situation for all involved. Members receive improved access to primary medical care and, health and wellness programs. Providers receive timely payments, simplified administrative procedures and dedicated provider servicing. We fulfill our mission and ensure the availability of high-quality medical care for the dual eligible population to positively affect the personal health of individuals.

How Does Highmark Health Options Duals Work?

Highmark Health Options Duals Medicare Provider Network

We contract directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Our provider network includes more than 4,300 primary care and specialist practitioners, over 400 behavioral health providers, 19 hospital locations, over 100 ancillary locations, a network of pharmacies, home healthcare agencies and other related healthcare providers. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participating practitioners treat our members in their offices the same as they treat patients from any other health plan and agree not to discriminate in the treatment of or in the quality of services delivered to our members on the basis of race, sex, age, religion, place of residence, or health status. Because of the cultural diversity of our membership, participating providers must be culturally sensitive to the needs of our members. Participation in no way precludes participation in any other program with which the provider may be affiliated.

Provider Self-Service

NaviNet is a web-based solution securely linking providers nationwide through a single website. This service is available at no cost to our participating providers. NaviNet is the preferred tool for inquiring about member information.

We encourage our participating providers to access the NaviNet secure Provider Portal to utilize the self-service tools available, including:

- Secure Messaging and Document Exchange for direct and secure bi-directional communication and submission of documentation
- Batch claims search which allows the user to view all claims for a specific provider office
- Authorizations requests
- Submit Provider Post-Service Appeals
- Submit Claims and Payment Disputes

Provider Relations Role

Highmark Health Options Duals uses dedicated, highly trained Provider Account Liaisons (PALs) and Strategic Provider Account Liaisons. We are keenly aware that it is essential our providers and their staff have a solid understanding of the members' needs, our contract requirements, protocols, and Federal and/or State regulations in order to provide exceptional access and quality health care to our members. PALs will provide an initial training orientation to providers and their office staff within thirty (30) calendar days of successfully gaining approval to participate in our network. During that training the Provider Manual is reviewed. The training familiarizes new providers and their staff with our company policies and procedures.

Each participating primary care practice, specialty care practice, and hospital is assigned a Provider Account Liaison who is responsible for ongoing education. As a follow-up to the initial orientation, each assigned Provider Account Liaison regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

Primary Care Practitioner's Role

The definition of a primary care practitioner (PCP) is a specific practitioner, practitioner group or a certified registered nurse practitioner (CRNP) operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating, and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a member. The PCP is responsible for the coordination of a member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP. By focusing all of a member's medical decisions through the PCP, members are given comprehensive and high-quality care in a cost-effective manner. One of our goals is to work together with a dedicated group of practitioners to make a positive impact on the health of our membership and truly make a difference.

Contracts/No Gag Clause

Highmark Health Options Duals allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of our contracts with practitioners and providers include an affirmative statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options regardless of benefit coverage limitations. There is no language in our contracts that prohibits open clinical dialogue between practitioner and patient.

Quality Improvement

Purpose of the Quality Improvement Program

The purpose of the Quality Improvement (QI) Program is to ensure that members have access to and receive safe, appropriate, timely, and equitable quality medical and behavioral health care services. The QI Program monitors and evaluates the quality and appropriateness of care provided by Highmark Health Options Duals' provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement methodologies and industry-accepted quality measurement tools, Highmark Health Options Duals evaluates its performance outcomes to:

- Provide oversight and governance of SNP Model of Care (MOC)
- Identify opportunities to improve the provision and delivery of health care and health plan services
- Identify opportunities to improve member and provider satisfaction with care delivery and services
- Achieve optimum member health outcomes

The QI Program centers on these key areas:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- Health Equity

The QI Program strives to improve member adherence to preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.

The QI Program also strives to improve patient safety through:

- Education of members and providers regarding safe practices
- Assessment and identification of opportunities to improve patient safety throughout the provider network
- Communication to members and providers of safety activities and provisions that may be in place throughout the network

To ensure that these efforts impact all members equally, the QI Program aspires to continually identify opportunities to positively impact health outcomes and address any healthcare disparities as well as language barriers.

In addition, the QI Department maintains a catalog of policies and procedures that guide the execution of the QI Program. QI policies and procedures are reviewed and updated annually to reflect changes in requirements, government regulations, and the needs of the membership and provider network.

Goals of the Quality Improvement Program

The goal of the QI Program is to ensure the provision and delivery of high-quality medical and behavioral health care, pharmaceutical and other covered health care services, and quality health plan services.

The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Highmark Health Options Duals provider network and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, Highmark Health Options Duals focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving optimum member health outcomes.

By considering population demographics, health risks, utilization of health care resources, and financial analysis, the organization ensures that the major population groups are represented in QI activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical reports, health risk appraisal data, disease management and care management data, satisfaction survey information, and other utilization reports, will be used to identify members with special needs and/or chronic conditions and develop programs to assist in managing their conditions.

The QI program includes a focus on members who are considered the most vulnerable and receive coordinated care as defined in the MOC. Highmark Health Options Duals developed five focused plan level goals which are:

1. Improve access and affordability of the healthcare needs of the population.
2. Improvements made in the coordination of care and appropriate delivery of services.
3. Enhance care transitions across settings and providers.
4. Ensure the appropriate utilization of services for preventive health and chronic conditions.
5. Improve member experience.

Objectives of the Quality Improvement Program

The objectives of the QI Program are consistent with Highmark Health Options Duals mission, which is a commitment to both effective uses of healthcare resources and to continuous quality improvement in order to positively affect the member's whole care and their Health-related social needs (HSRN) and social determinants of health (SDoH).

Quintuple Aim methodology is utilized to make sure programs focus on patient experience, population health, provider well-being and engagement to reduce costs, improve patient outcomes, and enhance care team collaboration. A core component of the Quintuple Aim is

health equity which improves the overall health of the member population, patient experiences, promotes provider well-being, and focuses on all members having equal opportunities to access high quality healthcare services.

Highmark Health Options Duals utilizes the Plan, Do, Study, Act methodology to implement the QI Program. The QI team creates an annual program strategy and description (Plan) that is reviewed and accepted through the QI Committee structure. The goals, programs, and objectives outlined in the strategy are tracked through a quarterly QI Program Work Plan (Do). The Work Plan includes performance metrics such as HEDIS measures, survey outcomes, meeting minutes and other departmental reports. Programs at risk are taken through the QI Committee structure for mitigation and/or root cause analysis. Annually, the QI Program, including those items within the MOC are evaluated through the QI Program Evaluation (Study). The evaluation allows the business areas to identify barriers, mitigations, and opportunities for the upcoming year. Program level changes are made based on the evaluation outcomes (Act).

The objectives of the QI Program are outlined below:

1. Development and Implementation of an annual QI work plan to assure completion of planned activities. Current “whole care” needs of the population are evaluated. Programs are implemented to ensure continuous quality improvement. The work plan is updated quarterly and annually to determine the effectiveness, to identify opportunities for improvement, and to ensure completion of planned QI activities for each year.
2. The Provision of Appropriate, Timely, and Quality Health Care Services
3. Develop Guidelines which Address the Member Population
4. Assess Practitioner Performance

Scope of the Quality Improvement Program

The success of the Quality Improvement Program is directly related to the collaboration of all Highmark Health Options Duals employees in support of the Highmark Health Options Duals mission. The responsibility of implementing the QI Program is a Highmark Health Options Duals corporate responsibility, not only that of the Quality Improvement Department. Implementation and evaluation of the QI Program are embedded into the Highmark Health Options Duals daily operations. The scope of the QI Program focuses on the following areas:

Quality of Clinical Care

The QI Program focuses on delivering to members clinical services that are safe, appropriate, and meet professional standards. This is ensured through the monitoring of key indicators including, but not limited to, HEDIS measures, Star measures, Preventive and Clinical Practice Guidelines and a review of Quality-of-Care concerns such as Preventable Serious Adverse Events (PSAE) and Never Events. Identification of the most prevalent chronic disease/conditions to establish goals with positive health outcomes is conducted with the promotion of the Chronic Care Improvement Program (CCIP). The Chronic Care Improvement Program (CCIP) initiative establishes goals with positive health outcomes by identifying the most prevalent chronic diseases/conditions. Initiatives are designed and implemented to prioritize indicators that have not been achieved or are negatively deviating from goals.

Quality of Service

The QI Program focuses on delivering customer service to the members that is professional, equitable, accessible, available, and meaningful. This is ensured through the monitoring of key indicators including, but not limited to, the demographics of the population, including ethnic and racial disparities in healthcare and language barriers, the annual CAHPS Member Satisfaction Survey, Member Complaints and Grievances, Provider Appeals, and Member and Provider Call Center Statistics. Initiatives are designed and implemented to address any indicators that have not been achieved or are negatively deviating from goals.

Safety of Clinical Care

The QI Program works to improve patient safety by monitoring for member and practitioner education regarding safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network, and by ensuring that members and practitioners have been informed about safety activities and provisions which may be in place throughout the network. An additional method for monitoring safe practices and identifying opportunities involves collaboration with the Fraud Waste and Abuse department, auditing providers prescribing patterns, and reviewing clinical data related to safe prescribing methods and following clinical practice guidelines.

Member Experience

The QI Program focuses on creating and maintaining a positive member experience through initiatives based on the results of the annual CAHPS and Health Outcomes Surveys (HOS), Care Management satisfaction survey, and the trending of member inquiries, complaints, appeals and grievances to identify areas of opportunity.

Member Experience is also monitored through the quality and availability of provider services. This is ensured through the monitoring of network primary care physician (PCP) and specialist availability and accessibility, medical record reviews, including documentation standards, the assessment of continuity and coordination of care, and the conduction of an annual Member and Provider Satisfaction Survey.

Model of Care

The Model of Care (MOC) is a vital quality improvement tool and an integral component for ensuring that the unique needs of each beneficiary enrolled in a Medicare Special Needs Plan (SNP) are identified and addressed. The Patient Protection and Affordable Care Act (ACA) reinforces the importance of the MOC as a fundamental component of SNP quality improvement. The National Committee for Quality Assurance (NCQA) executes the review and approval of SNP MOCs based on standards and scoring criteria established by the Centers for Medicare & Medicaid Services (CMS).

Model of Care standards are comprised of four clinical and non-clinical elements:

1) Description of the SNP Population (General Population) 2) Care Coordination 3) Provider Network and 4) MOC Quality Performance Improvement Plan. Activities falling within the scope of the Highmark Health Options Duals SNP Model of Care are overseen and governed by the Quality Improvement Department by way of updates to the QI Work Plan, the MOC Workgroup, and standup meetings as needed. Quality Improvement is responsible to ensure the goals are set within the MOC and the standards are approved and met by CMS.

Additional activities to fulfill the scope:

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- Health Equity program identifies and assesses factors that potentially impact the members health, including demographics (e.g., age, sex at birth, ethnicity), gender and sexual identity, and other health disparities (e.g., access to and availability of medical facilities and services, variations in disease occurrences, mortality, language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs or barriers that may interfere with conventional provision of health care or services, caregiver considerations, or other concerns).
- Highmark monitors the Network Availability of primary care and specialty practitioners to ensure an adequate network of practitioners is maintained. Also, practitioners are assessed to ensure the cultural and linguistic needs of its members are met.
- Review of activities falling within the scope of the Highmark Health Options Duals Utilization Management department including monitoring criteria and processes to ensure that appropriate utilization decisions are made as outlined in the Model of Care.
- Oversight to ensure proper credentialing of new practitioners as well as the recredentialing of participating providers, non-physician practitioners, and therapy providers.
- Monitoring and evaluation of the Case Coordination program, which includes Preventative Health, Disease, and Case Management programs.
- Monitoring of activities falling within the scope of the Pharmacy Department and the Pharmacy and Therapeutics (P & T) Committee.
- Evaluation of Patient Safety.
- Monitoring of activities falling within the scope of the behavioral healthcare program.
- Collaboration with advanced data analytics and other reporting teams to evaluate the population and determine opportunities for improvement.
- Monitoring of activities by Population Health Management (PHM).

To request a copy of the Quality Improvement Program Description, Work Plan or Annual Evaluation, please contact the Provider Services Department at 1-855-401-8251.

Clinical Practice Guidelines

The Clinical Practice Guidelines are designed as a resource to assist practitioners in caring for our members. The clinical practice and preventive guidelines have been developed using either evidence-based clinical guidelines from recognized sources, or through the involvement of board-certified practitioners from appropriate specialties. The guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases, conditions or relevance to our members, as well as applicable regulatory and accrediting body requirements. The use of guidelines permits Highmark Health Options Duals to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical practice and preventive guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. Information on the following guidelines may be found on the website at <https://www.highmarkhealthoptions.com/providers/>.

- Asthma Management
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease
- Diabetes

- Healthy Weight Management
- Human Immunodeficiency Virus (HIV)
- Hypertension
- Major Depression
- Opioid Prescribing for Chronic Pain
- Palliative Care
- Prenatal Care- Routine and High-Risk
- Preventative Care (Adult: 19 years and over)
- Schizophrenia
- Substance Use Disorders

A paper copy of the individual guidelines is available upon request.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Healthcare errors can occur at any point in the healthcare delivery system; they can be costly in terms of human life, function, and health care dollars. Then there are the indirect costs of healthcare errors, such as a loss of trust and patient/practitioner dissatisfaction.

There are ways practitioners can develop a culture of patient safety in their practice. Clear communication is key to safe care. Collaboration between members of the interdisciplinary care team, hospitals, other patient care facilities, and the patient is critical. Safe practices include, but are not limited to, providing instructions to patients in terms they can easily understand, writing legibly when documenting orders or prescribing, and avoiding abbreviations that can be misinterpreted.

Read all communications from specialists and send documentation to other providers, as necessary, to assure continuity and coordination of care. When calling in orders over the telephone, have the person on the other end repeat the information back to you.

Collaborate with hospitals and support their safety culture. Bring patient safety issues to the committees you attend. Report errors to your practice or facility's risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask our Quality Improvement Department how you can support compliance with our safety initiatives.

We also work to ensure patient safety by monitoring and addressing quality of care issues identified through several internal and external sources such as: pharmacy, care management, and utilization data, continuity and coordination of care standards, sentinel/adverse event data, disease management program follow-up, fraud waste and abuse investigations, practitioner/provider, delegates, State and/or Federal agencies, and member complaints.

If you would like to learn more about patient safety, visit these web sites:

- Institute of Medicine Report: To Err is Human-Building a Safer Health Care System:
<https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system>

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- The Joint Commission National Patient Safety Goals: <https://www.jointcommission.org/>
- Institute for Healthcare Improvement: <https://www.ihl.org/PatientSafety>
- The Leapfrog Group for Patient Safety: <http://www.leapfroggroup.org/>
- Agency for Healthcare Research and Quality: <https://www.ahrq.gov/>

Reportable Conditions

Highmark Health Options Duals practitioners are contractually required to follow our QI programs, including, but not limited to, reporting certain diseases, infections, or conditions in accordance with Title 16 - Chapter 5 of the Delaware State Code. Highmark Health Options Duals' Reportable Conditions Policy, MBU-QI DE POL-302, has been established to detail this requirement, and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions Policy, please contact our Provider Services Department at 1-855-401-8251.

Medical Record Reviews

From time to time, we will submit an ad hoc request for medical records. It is imperative that providers in our participating network respond to these requests within fourteen (14) business days, with the exception of Quality-of-Care cases which require a response within three (3) business days, as dictated per contractual obligations.

If we request medical records, the provider must provide copies of those records at no cost. This includes notifying any third party who may maintain medical records of this stipulation as well as the time constraints. These requests are made to comply with regulatory requirements, requests, audits, or for operational purposes (e.g., to investigate quality of care issues, complaints/grievances, or Serious Adverse Event cases).

In addition to providing medical records upon request, providers are required to transfer member medical records, or copies of records, to newly designated PCPs, specialists, or treatment facilities within fourteen (14) business days from receipt of the request from DMMA, its agent, the member, or the member's new treating practitioner without charging the member.

The QI team for Highmark Health Options Duals also annually conducts a review of our providers' medical records to ensure compliance with criteria as specified in the Medical Record Review Standards. The standards, which incorporate a core set of critical factors, were developed and approved by our Quality Improvement/Utilization Management Committee.

These standards can be provided upon request or via the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

A score of 80% is required to pass the medical record review. Providers whose medical records do not comply may undergo remediation in the form of education and additional reviews. Continued non-compliance could result in possible provider sanctioning. Consistent and complete medical records documentation is an essential critical component of ensuring

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members quality to care. Accurate and concise documentation supports provider communication enhancing the continuity and coordination of care.

Potential Preventable Serious Adverse Events/Hospital Acquired Conditions and Never Events

Quality of Care concerns (including Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events) are identified by several internal and external mechanisms such as, but not limited to case management review, credentialing and recredentialing activities, claims payment retrospective review, utilization management case review, complaint and grievance review, fraud and abuse investigations, practitioner/providers, delegates, and state and/or federal agencies. Once a potential event has been identified an extensive review is conducted by our company's Quality Improvement and Medical Management Departments. The process includes, when necessary, a medical record review and possible telephonic or mail communication with the practitioner/provider. Once it has been determined if an actual event has been discovered, we will, when necessary, verify if payment denial or retraction needs to take place, and notify the practitioner/provider by mail if that is required. Should you have any questions, please contact the company's Provider Services Department at 1-844-325-6251.

Critical Incidents

A critical incident is when a health care provider suspects the person in their care has been harmed through abuse, neglect, mistreatment (inappropriate or unprofessional behavior), theft, injury, fall, or unexpected medical issue, non-lethal overdose or poisoning, unsafe behavior such as suicide attempt, or self-neglect, financial exploitation, or unexpected death.

Here's how to help.

- For elderly adults, refer to the Elder Abuse Suspicion Index (EASI) when you suspect abuse or neglect has occurred.
- Be an advocate.
- Be honest, open, up-front, and supportive.
- Find a private place to talk.
- Listen to the patient.
- Remain calm.
- Report the situation immediately.

See a critical incident? Report it.

If you observe or have knowledge of a critical incident, you are responsible for reporting it the same day by reporting it to the Division of Medicaid and Medical Assistance (DMMA) through their reporting website at

<https://hssdedhssprod.wellsky.com/humanservices/Pages/Login.aspx?ReturnUrl=%2Fhuman%2Fservices%2F>.

A report should also be made to the appropriate investigative state agency:

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Department of Services for Children, Youth and Their Families (DSCYF)

Division of Family Services (DFS, Child Protection)	1-302-633-2657
24-hour Child Abuse and Neglect Hotline	1-800-292-9582

Delaware Health and Social Services (DHSS)

Adult Protective Services	<i>For suspected abuse, neglect, disruptive behavior, or exploitation.</i>	1-302-424-7310
Division of Health Care Quality (DHCQ)	<i>For adult members in a long-term facility and for child members in a pediatric nursing facility.</i>	1-877-453-0012
Long-Term Care Office of the State Ombudsman (OSO)	<i>For residents in long-term care facilities who have a complaint about their rights.</i>	1-800-223-9074
Office of Health Facilities and Certification (OHFLC)	<i>For residents in long-term facilities who have a complaint about their rights.</i>	1-302-292-3930 or 1-800-942-7373
Division of Substance Abuse and Mental Health (DSAMH)	<i>For members with substance abuse disorders or mental health conditions or for members in rehab or mental health facility.</i>	1-855-649-7944
Division of Developmental Disabilities Services (DDDS)	<i>For DDDS members who reside in a DDDS group home setting.</i>	1-302-836-2154 (New Castle County) 1-302-933-3451 (Kent or Sussex County)
Division of Prevention and Behavioral Health (DPBH)	<i>For pediatric members with substance abuse disorder or a mental health condition or for pediatric members in a rehab or mental health facility.</i>	1-302-633-2600
Division of Professional Regulation	<i>For inappropriate conduct by a provider.</i>	Delpros.Delaware.gov 1-302-744-4500

Living Will Declaration Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a new law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991. The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds.

The primary purpose of the act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested.

While there is no specific governmentally mandated form, you can request a copy of a “Living Will” form from our Provider Services Department by calling 1-855-401-8251, or by visiting our website at <https://www.highmarkhealthoptions.com/providers/>.

A copy of the “Living Will” form should be maintained in the member’s medical record. Medical Record Review Standards state that providers should ask members, age 21 and older, whether they have executed an advance directive and document the member’s response in their medical records. Providers will receive educational materials regarding a member’s right to advance directives upon entering the practitioner network.

Member Outreach

Providers can request additional assistance from Highmark Health Options Duals Care Coordination to offer further health information and education to members. This support includes explaining the importance of keeping scheduled appointments, living with chronic conditions, adhering to treatment plans, and understanding benefits, services, and available resources.

To refer a member for this educational support, complete the Member Outreach Form available on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

A Highmark Health Options Duals representative will contact the member and follow-up with the practitioner as requested or needed. For more information or to request member outreach, please call our Care Coordination Department. You can also fax or email the completed Member Outreach form (Fax# and Email address are listed on the form).

Highmark Health Options Duals Practitioner Excellence (HHOPE) Program

Highmark Health Options Duals values the role practitioners play in serving our members and improving their health. The Highmark Health Options Duals Practitioner Excellence (HHOPE) program recognizes and rewards performance that demonstrates high quality, accessible, and efficient healthcare. Practice resources, such as the Highmark Health Options Duals Practitioner Excellence Incentive Program Guide, are provided to educate providers on the program. For more information about the HHOPE program, eligibility, how to participate, visit the Highmark Health Options Duals website

<https://www.highmarkhealthoptions.com/providers/hhope-program>.

Highmark Health Options Duals Practitioner Excellence Provider Performance Reporting

Highmark Health Options Duals Practitioner Excellence (HHOPE) Provider Performance Reporting is available to providers monthly through the Highmark Health Options Duals Care Gap Management Application (CGMA).

Within the CGMA, providers can:

- View member care gaps
- Submit evidence for care gap closure
- View their progress towards closing member care gaps

The CGMA allows providers to view member-specific numerator compliance for each care gap along with the member-specific opportunities for gaps yet to be closed. The provider reporting allows providers to gauge how they are performing.

Please contact the Provider Engagement Team with questions, to request a demo, or to set up a new user. Mail to: DePet@Hlghmark.com

Provider Engagement Team (PET)

The Provider Engagement Team is a dedicated team of Clinical Transformation Consultants who partner with our Delaware Medicare Providers to improve the overall outcomes of our members. The PET team provides information regarding best practices in quality improvement programs and information regarding performance compared to national benchmarks and peers. PET is a strategic partner with our providers in achieving their quality goals. For more information, contact DePet@Hlghmark.com.

MEMBER

Enrollment Eligibility

Our Medicare plans are designed to provide more than healthcare for those who qualify. Highmark Health Options Duals offers medical and prescription drug coverage, and all the benefits of Original Medicare, PLUS more benefits.

Healthcare Options

Dual Eligible Special Needs Plan

Highmark Health Options Duals (HMO SNP) and Highmark Health Options Duals Select are Dual Eligible Special Needs Plans, (D-SNP); serving those who have BOTH Medicare Parts A and B and Medicaid (Medical Assistance) and live within the Delaware service area. Highmark Health Options Duals is also considered a HIDE (Highly Integrated SNP) D-SNP plan which means an individual who has full dual Medicaid eligibility categorized as FBDE, QMB+, or SLMB+, and has Medicare Parts A and B, and chooses to enroll in Highmark Health Options Duals plan, will receive their Medicaid coverage through the same parent company-Highmark.

Refer to the chart below for eligibility criteria.

Enrollment Criteria	Health Options Duals	Health Options Duals Select
Must be entitled to Medicare Part A	Yes	Yes
Must be enrolled in Medicare Part B	Yes	Yes
Medicare eligibility may be due to either disability or age	Yes	Yes
Must be eligible for either: full Medicaid FBDE/ QMB+/ SLMB+	Yes	No
Must receive the following level of assistance from the state: QI/QMB ONLY/SLMB	No	Yes

Dual Eligible Categories

- **Medicaid only (“Full Dual”)** - Individual who is eligible for full Medicaid benefits.
Medicaid does not pay out-of-pocket costs for Part D cost-share.
- **Full Benefit Dual Eligible (FBDE)** - An FBDE individual is eligible for Medicaid either categorically or through optional coverage groups, such as medically needy or special income levels for institutionalized or home and community-based waivers.
- **QI (Qualifying Individual)**- An individual eligible for Medicare Part A. Individual is eligible for Medicaid payment of Medicare Part B premium only.
- **SLMB only** Medicaid pays Medicare Part B premiums only. These individuals do not qualify for additional Medicaid benefits.
- **QMB only (Qualified Medicare Beneficiary)** - Individual who is eligible for Medicaid payment of Medicare Cost-Share (i.e., Medicare Part A and/or Part B coinsurance,

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deductible, premium).

- **QMB+ (Qualified Medicare Beneficiary)** - Individual eligible for full Medicaid benefits and Medicaid payment of Medicare cost-share (i.e., Medicare Part A and/or Part B coinsurance, deductible, premium).
- **SLMB+ (Special Low-Income Medicare Beneficiary)** - An Individual eligible for full Medicaid benefits and Medicaid payment of Medicare Part B premium only.

The Enrollment/Disenrollment Process

The Centers for Medicare and Medicaid Services (CMS) has periods when beneficiaries can enroll or dis-enroll with/from Medicare. These times are known as election periods. Please contact or direct the member to contact Highmark Health Options Duals for additional information about election periods. Members can enroll in our plan by using any of these methods:

- Mailing in a paper enrollment form
- Enrolling on-line through Medicare's website
- Enrolling on-line through Highmark Health Options Duals' website at <https://medicare.highmark.com/dsnp/view-plans>
- Downloading an enrollment form from the Highmark Health Options Duals website at <https://medicare.highmark.com/dsnp/view-plans>. Under 2026 Enrollment Forms, click on the appropriate state link to open the enrollment form, Download and mail completed forms.

For the mailing address, please refer to **Member Enrollment/Disenrollment** under the "Important Addresses" section on page 13.

- By calling Highmark Health Options Duals at 1-855-401-8251 (TTY users should call 711 or 1-800-232-5460).
- Working with their sales agent Members of Special Needs Plans must meet specific eligibility requirements. Highmark Health Options Duals confirms the beneficiary's eligibility during the enrollment process.

Members can disenroll from our plan by:

- Sending Highmark Health Options Duals, a written request to disenroll.
- Contacting Highmark Health Options Duals and requesting a disenrollment form be sent to them.
- Contacting Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048 or www.medicare.com.
- By enrolling in a new Medicare health plan.

For additional information, Members should call Highmark Health Options Duals at 1-855-401-8251 (TTY users should call 711 or 1-800-232-5460).

Member enrollments are made effective the first day of the calendar month, and member disenrollment's are through the end of the calendar month.

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Member ID Cards

Each Highmark Health Options Duals member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic, PCP or plan change.

ID Cards are good for as long as the person is a member of Highmark Health Options Duals.

(Sample Member ID cards)

		Highmark Health Options Duals (HMO SNP) Highmark Health Options	
Member Name SAMPLE NAME		Effective 01/01/2026	
Member ID Primary: HXM123456789001 Secondary: XHD987654321001		Copoly PCP \$0 Specialist \$0	
Primary Care Provider SAMPLE PROVIDER, MD		ISSUER 80840 BIN 4336 PCN MEDDADV GROUP RX2343	
Phone 302-555-1212		Primary	
CMS-H7710 001		MedicareRx Prescription Drug Coverage	



Prior authorization is required for all out-of-network and out-of-state nonemergency services.

File out-of-area claims with local Blue Cross and/or Blue Shield Plan.

Highmark BCBS Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield.

HighmarkHealthOptions.com/Duals

Member Services, Behavioral Health,
24 Hour Nurse Line: **1-855-401-8251**

TTY: **711** or **1-800-232-5460**

Provider Services, Eligibility, Precertification:
1-855-401-8251

Pharmacy Help Desk: **1-800-364-6331**

BlueCard: **1-800-676-BLUE (2583)**

Claims Administrator

Primary	Secondary
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Payer ID: 47183	47181
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Address: PO Box 21215 Eagan, MN 55121	PO Box 21771 Eagan, MN 55121
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		Highmark Health Options Duals Select (HMO SNP)	
Member Name SAMPLE NAME		Effective 01/01/2026	
Member ID HXM123456789001		Copoly PCP \$0 Specialist \$0	
Primary Care Provider SAMPLE PROVIDER, MD		RxBIN 004336 Issuer 80840 RxPCN MEDDADV RxGrp RX2343	
Phone 302-555-1212		Primary	
CMS-H7710-002		MedicareRx Prescription Drug Coverage	



Prior authorization is required for all out-of-network and out-of-state nonemergency services.

Highmark BCBS Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield.

HighmarkHealthOptions.com/Duals

Member Services: **1-844-722-5837**

TTY: **711** or **1-800-232-5460**

24-Hour Nurse Line: **1-844-722-5837**

Behavioral Health: **1-844-722-5837**

Provider Services: **1-844-722-5837**

Eligibility: **1-844-722-5837**

Precertification: **1-844-722-5837**

Pharmacy Helpdesk: **1-800-364-6331**

BlueCard®: **1-800-676-BLUE (2583)**

Claims Administrator

P.O. Box 21215	Payer ID: 47183
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Eagan, MN 55121	NaviNet.net
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File out-of-area claims with local Blue Cross and/or Blue Shield Plan.

Highmark Health Options Duals members age 21 and over residing in Delaware will need to use their Highmark Health Options Duals ID card and keep their Medicaid member ID card to use for services covered under Medicaid and to cover Medicare deductibles and coinsurance, as long as the provider also participates with Medicaid.

Members under the age of 21 will use their Highmark Health Options Duals ID card and their Medicaid member ID card. These members will need to keep their Medicaid member ID card for non-medical assistance services, such as public transportation through Dart, Uber, etc. or cash assistance.

Determining Eligibility

Because of frequent changes in a member's eligibility, each participating practitioner is responsible to verify a member's eligibility with Highmark Health Options Duals BEFORE providing services. Verifying a member's eligibility along with requesting the applicable referral or authorization will ensure proper reimbursement for services. To verify a member's eligibility, the following methods are available to all practitioners:

1. **Highmark Health Options Duals Identification Card**
The card itself does NOT guarantee that a person is currently enrolled in Highmark Health Options Duals. Members are only issued an ID card once upon enrollment, unless the member changes their primary care practitioner, requests a new card or card is reissued due to plan changes such as copayments. Members are NOT required to return their identification cards when they are no longer eligible.
2. **NaviNet**
Participating providers can verify eligibility/benefits and check claim status via NaviNet. Participating providers also have the capability to submit certain authorization requests electronically via NaviNet.
3. **The Interactive Voice Response System (IVR)** is available twenty-four (24) hours a day, seven (7) days a week at 1-855-401-8251.
4. To verify member eligibility at each visit, practitioners may contact the plan directly at 1-855-401-8251.

NOTE: In an effort to better service our providers, please have your 10-digit NPI or 9-digit tax identification number available.

Primary Care Practitioner's Role in Determining Eligibility

Primary care practitioners verify eligibility by consulting their panel listing in order to confirm that the member is a part of the practitioner's panel. The panel list is distributed on or about the first of every month. The primary care practitioner should check the panel list each time a member is seen in the office. If a member's name is on the panel list, the member is eligible with Highmark Health Options Duals for that month. If a member insists that they are effective, but do not appear on the panel list, the provider should call the Provider Services Department for help in determining eligibility at 1-855-401-8251.

Benefits

Medical Benefits

Highmark Health Options Duals members are eligible for all the benefits covered under the Original (Fee- for-service) Medicare Program. In addition, Highmark Health Options Duals offers additional benefits for dental, vision, hearing and health and wellness services (plan benefits vary by plan). For a complete list of covered benefits, please refer to the Evidence of Coverage booklet. A complete copy of the Evidence of Coverage booklet for each healthcare option is located on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/duals/>. Members obtain most of their healthcare services either directly from their primary care practitioner or upon prior authorization (approval in advance) by an in-network specialist/ancillary provider; except for services available on a self-referral basis, such as OB/GYN services and routine vision services. The primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Evidence of Coverage

The covered services listed in the Evidence of Coverage booklet are covered only when all requirements listed below are met:

- Medicare covered services must be provided according to the coverage guidelines established by CMS.
- Services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of the medical condition and meet accepted standards of medical practice.
- Care is received from a network provider. In most cases, care received from an out-of-network provider will not be covered. Chapter 3 of the Evidence of Coverage booklets provides more information about requirements for using network providers and the situations when Highmark Health Options Duals will cover services from an out-of-network provider.
- A primary care provider (PCP) is providing and overseeing care.

In addition, some services listed in the Benefits Chart (Chapter 4 of Evidence of Coverage booklet) are covered only if the network provider gets approval in advance (sometimes called "prior authorization") from our company. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk.

Care Management Programs

Highmark Health Options Duals is committed to supporting our members' health and wellbeing. Highmark Health Options Duals strives to help members stay healthy, lead active lives, and improve their quality of life through dedicated programs for complex conditions such as heart disease, diabetes, chronic obstructive pulmonary disease, inflammatory bowel disease, kidney disease, and weight management.

Highmark Health Options Duals also offers health education and wellness for pregnant members and those seeking smoking cessation support. Our Care Management staff helps with resources, educational information, and self-management planning (specific qualifications apply).

General Medicare Exclusions

In addition to any exclusions or limitations described in the Evidence of Coverage, the following items and services are not covered except as indicated by Highmark Health Options Duals as described under Product offerings:

- Services considered not reasonable and necessary, according to the standards of Original Medicare.
- Experimental medical and surgical procedures, equipment and medications.
- Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community. (May be covered by Original Medicare under a Medicare-approved clinical research study or by Highmark Health Options Duals.)
- Private room in a hospital. (Covered only when medically necessary)
- Personal items in a member's rooms at a hospital or skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in a member's homes.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when a member does not require skilled medical care or skilled nursing care.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by a member's immediate relatives or household members.
- Cosmetic surgery or procedures. (Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.)
- Routine dental care, such as fillings or dentures (Routine cleanings may be covered).
- Non-routine dental care. (Dental care required to treat illness or injury may be covered as inpatient or outpatient care.)
- Routine chiropractic care. (Manual manipulation of the spine to correct a subluxation is covered.)
- Orthopedic shoes. (Unless shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.)
- Supportive devices for the feet. (Except for orthopedic or therapeutic shoes for people

with diabetic foot disease.)

- Routine hearing exams, hearing aids or exams to fit hearing aids. (Exams to diagnose and treat hearing and balance issues may be covered)
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. (Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.)
- Reversal of sterilization procedures and or non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. (However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under Highmark Health Options Duals, we will reimburse veterans for the difference. Members are still responsible for Highmark Health Options Duals cost-sharing amount.)
- Surgical treatment for morbid obesity. (Unless it is considered medically necessary and covered under Original Medicare.)
- Private duty nurses.
- Meals delivered to members' homes. Some plans offer meals as a supplemental benefit.
- Elective or voluntary enhancement procedures, services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance). (Except when medically necessary.) Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility.

At any time during the year, the Medicare program can change its national coverage. Since the plan covers what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease benefits, depending on the Medicare program change.

Prescription Drug Benefits

Prescription drug benefits are available to all members. Prescriptions must be filled by a participating pharmacy in order to be covered by the plan. When a member travels outside of the plan service area a national network of pharmacies is available via our Pharmacy Benefit Manager (PBM) network. If a member must use an out-of-network pharmacy, the member will generally have to pay the full cost of the prescription. The member may then request to be reimbursed for the cost covered by the plan. The plan contracts with CVS Health to develop a network or chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to plan members. A list of participating pharmacies can be obtained by contacting the plan's Pharmacy Department at 1-855-401-8251 or TTY: 711. Prescriptions are available to members who are eligible for pharmacy coverage when written by a plan practitioner. Prescription coverage and cost varies by plan.

Prescription Drug Coverage Formulary

Visit the below website for the most recent version of the formulary.

<https://client.formularynavigator.com/Search.aspx?siteTestID=32237>

Co-payments/Co-insurance

Member cost sharing for medications varies by plan, drug type and the amount of extra help, if any, that the member may receive. Members should contact Member Services or refer to the Evidence of Coverage to learn more about their specific coverage.

Please Note: The plan may place limits on the amount of medication a member may receive. Members can receive up to a 100-day supply of medication for prescriptions filled at an in-network pharmacy or up to a 100-day supply of medication for prescriptions filled at an in-network 100-day retail pharmacy. A 100-day mail order benefit is available for select plans.

Prescription Benefit Design

Some medications such as non-extended day supply drugs may be limited to a 30-day supply. We utilize a closed formulary. Practitioners are requested to prescribe medications included in the formulary whenever possible.

Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits, or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Medicare Request for Drug Coverage Form located on the Highmark Health Options Duals website at [HHO-Duals-Provider-Request-For-Drug-Coverage-Form.pdf](#).

Please refer to the Referrals and Authorizations Section of this manual for information regarding requesting non-formulary drugs.

Drugs Covered

- Legend drugs listed in the closed formulary
- Non-formulary drugs which have been granted a formulary exception for an individual member
- Insulin/disposable syringes/needles
- Compounded medication of which at least one ingredient is a covered Part D prescription drug
- Contraceptives

The plan places a limit on the amount of medication a member can receive at the pharmacy. Many prescriptions can be refilled up to 12 months from the original prescription date as authorized by the practitioner and as allowed by law.

Drug Exclusions

- A Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan cannot cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug

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Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our health plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.”

These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Covered outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of erectile dysfunction

Members' Rights and Responsibilities

Highmark Health Options Duals maintains a Members' Rights and Responsibilities statement for all of its Highmark Health Options Duals products. The Members' Rights and Responsibilities statement is reviewed and revised annually, or as needed, and is distributed to new and existing members and practitioners. We do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. We monitor compliance related to members' rights and responsibilities, including those rights and responsibilities as defined by Section 1557 of the Affordable Care Act of 2010.

Members can locate their Rights and Responsibilities in the Evidence of Coverage for the company's Highmark Health Options Duals Members under Chapter 8, “Your rights and responsibilities,” or on our website at the following web address:

<https://www.highmarkhealthoptions.com/>.

The company's Highmark Health Options Duals members have the right and responsibility to:

Member Rights

- Receive information from Highmark in a way that works for them (in languages other than English, in Braille, in large print, or other alternative formats, etc.)
- Be treated with respect and dignity.
- Receive timely access to covered services and drugs.
- Have their personal health information kept private and confidential.
- Receive information from Highmark about the Plan, its network of providers, their covered services, as well as member rights and responsibilities.
- Have Highmark support their right to participate with practitioners in making decisions about their care.
- Understand their treatment options and participate in decisions for their health care
- To give instructions about what is to be done if they are not able to make medical decisions for themselves.
- To file a complaint and/or to ask Highmark to reconsider decisions the Plan has made by filing an appeal, including complaints about the quality of care.
- To receive more information about their rights.
- To make recommendations regarding the organization's Member Rights and Responsibilities policy.
- Members' choice to exercise these rights will not adversely affect the way Highmark, its providers, or any state or federal agency will treat them.
- To request and/or participate in a scheduled Interdisciplinary Care Team (ICT) meeting which may include your assigned Case Manager, your PCP, caregiver, and any other pertinent personnel directly included in your care.
- To access and have direct input into your individualized care plan (ICP). Your care plan is available on your portal page or can be mailed to you upon request.

Member Responsibilities

- Get familiar with their covered services and the rules they must follow to get these covered services.
- Inform Highmark if they have any other health insurance coverage or prescription drug coverage in addition to our plan's coverage.
- Tell their doctor and other health care providers that they are enrolled in our plan.
- Help their doctors and other practitioners who care for them by providing needed information, asking questions, and following through on their care.
- To respect the rights of other patients and to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Pay Medicare premiums, and any applicable copayments or late enrollment penalties.
- Notify Highmark if they move, regardless of whether it is outside or inside of the Highmark service area.
- Call the Service Center for help if they have questions or concerns.

Member Satisfaction

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®¹) measures member satisfaction annually through a national survey. The Centers for Medicare and Medicaid (CMS) requires health plans to use a certified Survey Vendor to conduct the survey, which is utilized by health plans to capture information about consumer-reported experiences with healthcare, and to identify areas to improve or maintain performance. Results are compared nationally across all Medicare Advantage Plans, are reported to regulatory entities, and count towards a health plan's CMS Medicare Star Rating. Each year, the survey is administered to a sample of members 18 or older following CMS CAHPS survey protocol, and reveals members' experiences with their health plan, healthcare providers, and services over the 6 months prior.

Types of questions asked of members include, but are not limited to:

- Getting needed care
- Getting appointments and care quickly
- Health Plan customer service
- Care coordination
- Rating of Health Plan
- Rating of health care
- Getting needed prescription drugs
- Rating of drug plan
- Getting needed screens, tests and vaccines

¹"CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)"

COVERAGE ARRANGEMENTS

All participating practitioners must ensure 24-hour, 7 days-a-week coverage for members. Coverage arrangements should be made with another Plan participating practitioner or practitioners who have otherwise been approved by the Plan. All encounters must be billed under the name of the rendering practitioner, not the member's assigned primary care practitioner. Reimbursement will be paid directly to the participating covering primary care practitioner.

Covering practitioners, whether participating or not, must adhere to all of the Plan's administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member's primary care practitioner. To request approval of a non-participating covering practitioner, a non-participating authorization would need to be requested by the PCP through the UM Department. All encounters must be billed under the name of the rendering practitioner and all reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners.

Primary care practitioners agree that, in their absence, timely scheduling of appointments for members shall be maintained.

PRIMARY CARE PRACTITIONER

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available, 24 hours a day, 7 days a week. The Eligibility verification phone line can be reached at 1-855-401-8251.

Primary Care Practitioner (PCP) Selection

Each member in a family has the freedom to choose any participating primary care practitioner, and a member may change to another primary care practitioner should a satisfactory patient-practitioner relationship not develop. A primary care practitioner agrees to accept a minimum number of Highmark Health Options Duals members, as specified by their practitioner agreement, to their patient panel at each authorized office location without regard to the health status or healthcare needs of such members and without regard to their status as a new or existing patient to that practice or location.

Encounters

Primary care practitioners are required to report all services they provide for Highmark Health Options Duals members by submitting complete and accurate claims. All providers are contractually required to submit encounters for all member visits and all charted diagnoses that the member may suffer from.

Accurate Submission of Encounter Data

Encounter data provides the basis for many key medical management and financial activities at Highmark Health Options Duals:

- Quality of care assessments and studies
- Access and availability of service evaluation
- Program identification and evaluation
- Utilization pattern evaluation
- Operational policy development and evaluation
- Financial analysis and projection.

To effectively and efficiently manage member's health services, encounter submissions must be comprehensive and accurately coded. All providers are contractually required to submit encounters for all member visits.

Underreporting of encounters can negatively impact all stakeholders. For primary care practitioners, encounter data is essential as many of our Quality indicators are based on this information.

It is very important that all diagnosis codes that are applicable to the member be submitted on every claim, especially chronic conditions. It is also important for the capturing of all quality

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performance measures that the use of CPTII codes be submitted on every claim when applicable. The expected rate of submission for encounters is 100%.

Highmark Health Options Duals provides support and education to practices as indicated by their encounter submission rates.

CMS uses the Hierarchical Condition Categories (HCC) model to assign a risk score to each Medicare beneficiary. Accurate and complete reporting of diagnosis codes on encounters is essential to the HCC model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

Transfer of Non-Compliant Members

Primary care practitioners agree not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Highmark Health Options Duals members on the basis of race, sex, age, religion, place of residence, health status or source of payment; and to observe, protect and promote the rights of members as patients. Primary care practitioners shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the practitioner's panel. The Plan's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

Should an incidence of inappropriate behavior occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member's name and Highmark Health Options Duals ID Number to the Medicare Enrollment Department.

For the mailing address, please refer to Member Enrollment/Disenrollment under the "Important Addresses" section on page 13.

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services. Primary care practitioners are required to provide emergency care for any Highmark Health Options Duals member dismissed from their practice until the member transfer has been completed.

Transfer of Medical Records

Primary care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within fourteen (14) business days from receipt of the request from the member or the member's new primary care practitioner, without charging the member. Primary care practitioners are required to transfer member medical record or copies of records to newly designated Managed Care Organizations within fourteen (14) business days from receipt of the request from the Centers for Medicare and Medicaid Services or its agent.

Telehealth

Members have the option of receiving the below services either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with “CMS Guidance on Medicare Marketing Activities section”.

Telehealth services offered by the plan include:

Primary care physician (PCP) services

Physician specialist services

Individual sessions for mental health specialty services

Individual sessions for psychiatric services

Prior authorization/plan approval required: No

SPECIALTY CARE PRACTITIONER

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available, 24 hours a day, 7 days a week. The Eligibility verification phone line can be reached at 1-855-401-8251.

Coordination of Care

The primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by specialists. Therefore, all members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. The specialist is responsible for providing written correspondence to the member's primary care practitioner for continuity and coordination of care.

Emergency Services

Federal and state regulations prevent us from requiring members to contact a primary care practitioner, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. Per CMS guidelines: "An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition.

All Highmark Health Options Duals members are informed that they must contact their primary care practitioner for authorization prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Highmark Health Options Duals realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition, such as an OB/GYN during pregnancy, and the member may contact the specialist for instructions. If a specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the primary care practitioner of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider.

Transfer of Medical Records

Specialty care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within fourteen (14) business days from receipt of the request from the member or the member's new primary care practitioner, without charging the member. Specialty care practitioners are required to transfer member medical records or copies of records to newly designated Managed Care Organizations within fourteen (14) business days from receipt of the request from the Centers for Medicare and Medicaid Services or its agent.

Telehealth

Members have the option of receiving the below services either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with "CMS Guidance on Medicare Marketing Activities section".

Telehealth services offered by the plan include:

Primary care physician (PCP) services

Physician specialist services

Individual sessions for mental health specialty services

Individual sessions for psychiatric services

Prior authorization/plan approval required: No

OB/GYN SERVICES

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available, 24 hours a day, 7 days a week. The Eligibility verification phone line can be reached at 1-855-401-8251.

General Information

To eliminate any perceived barrier to accessing OB/GYN services, Highmark Health Options Duals allows all female members to self-refer to any participating OB/GYN for any OB/GYN-related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN's office is required to contact Highmark Health Options Duals to verify eligibility of the member. Highmark Health Options Duals permits its primary care practitioners to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office. As you care for our members, and you feel additional support or assistance is needed, please refer members to the Care Management Department for ongoing Case Management and support. To refer to the Care Management Department, please call 1-855-401-8251.

Diagnostic Testing

Fetal Non-stress Tests and Ultrasounds can be performed in the OB/GYN's office or at a hospital without an authorization from Highmark Health Options Duals.

Telehealth

Members have the option of receiving the below services either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized.

Telehealth services offered by the plan include:

Primary care physician (PCP) services

Physician specialist services

Individual sessions for mental health specialty services

Individual sessions for psychiatric services

Prior authorization/plan approval required: No

BEHAVIORAL HEALTH SERVICES

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available 24 hours a day, 7 days a week. The Eligibility verification phone line can be reached at 1-855-401-8251.

Authorizations and Referrals

Inpatient Services

All inpatient Mental Health and Substance Use Disorder services require a prior authorization. In the case of an emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues and discharge planning. Highmark Health Options Duals will perform concurrent inpatient level of care reviews to establish medical necessity if inpatient request is received within 4 calendar days of discharge. Admission requests made outside this timeframe must be submitted through retrospective review.

Outpatient Services

- Highmark Health Options Duals does not require participating providers to obtain a referral or authorization for most outpatient mental health or substance use disorders covered by Medicare.
- Outpatient Behavioral Health services requiring authorization for medical necessity include:
 - Partial Hospitalization (PHP)
 - Intensive Outpatient (IOP)
 - Electroconvulsive Therapy (ECT)
 - Transcranial Magnetic Stimulation (TMS)
 - Neuropsychological / Psychological Testing
 - Services provided by a non-participating provider
 - In the event services are needed urgently or emergently, outpatient authorizations must be requested within 1 business day. Authorization requests made outside of this this timeframe must be submitted through retrospective review.

Substance Use Disorder (SUD) Services

- Authorization is required for the below:
 - ASAM level of care 4 WM: Medically Managed Intensive Inpatient Withdrawal Management
 - ASAM level of care 4: Medically Managed Intensive Inpatient Services
- The current medical necessity criteria being used for SUD requests is American Society of Addiction Medicine (ASAM)

Failure to obtain a timely authorization may result in a denial of payment.

Authorization request can be submitted telephonically, by fax or via the provider portal. Contact information: Phone-1-855-401-8251 or fax to 1-833-560-1820. For services not covered by Medicare; the services may be covered by the member's county –specific behavioral health plan.

Medical Necessity

If the behavior status does not meet the medical necessity for the proposed level of care, the request is referred to the Behavior Health Medical Director, a board-certified Psychiatrist, for review and determination. The current medical necessity criteria being used for behavioral health services are Change Healthcare InterQual., Centers for Medicaid and Medicare Services National Coverage Determinations, Local Coverage Determinations, and the American Society of Addiction Medicine. Members may seek emergent care for behavioral health and/or substance use. A mental health crisis may or may not be a life-threatening situation in which a person is exhibiting extreme emotional or behavior disturbance and a comprised ability to function, which could result in suicidal or homicidal thoughts or actions.

Emergency services are covered for inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergent behavioral health crisis.

Crisis Resources

Mental Health, Drug, and Alcohol Crisis Services

- Northern Delaware (New Castle County and greater Smyrna), 1-800-652-2929 or 1-302-577-2484.
- Southern Delaware (Sussex County and Kent County south of Smyrna), 1-800-345-6785 or 1-302-424-5550.
- For children and teens under age 18, members can call the Division of Prevention and Behavioral Health Services 24-Hour Mobile Response and Stabilization Services, 1-800-969-4357 or 1-800-969-HELP.

Crisis Intervention Services are located throughout the state. Members can call or go to:

- Crisis Intervention Service Centers.
- Recovery Response Centers.
- Hospital Emergency Departments.

Crisis Intervention Service staff are available 24 hours a day to help people with severe personal, family, or marital problems. These problems may include depression; major life changes, such as unemployment or loss of an important relationship; anxiety; feelings of hopelessness; thoughts of suicide; delusions; paranoia; and substance use disorder.

Crisis Intervention Services

Ellendale

Mobile Crisis Intervention Services

700 Main St. (rear entrance)

Ellendale, DE 19941

1-302-424-5550

Recovery Innovations Recovery Response Center

700 Main St.

Ellendale, DE 19941

1-302-424-5660

New Castle

Mobile Crisis Intervention Services

Fernhook Building

14 Central Ave.

New Castle, DE 19720

1-302-577-2484

Newark

Psychiatric Emergency Services:

Christiana Hospital

4755 Ogletown-Stanton Road

Newark, DE 19718

1-302-320-2118

Recovery Innovations Recovery Response Center

659 East Chestnut Hill Rd. Newark, DE 19711

1-302-318-6070

Wilmington

Psychiatric Crisis Team, Wilmington Hospital

501 W. 14th St.

Wilmington, DE 19801

1-302-320-2118

Helplines: Local and National

Delaware Coalition Against Domestic Violence

100 W. 10th St., Suite 903

Wilmington, DE 19801

1-302-658-2958

Hotline: 1-800-701-0456

Contact Lifeline

1-800-262-9800

(Crisis helpline, 24/7)

Disaster Distress Helpline

1-800-985-5990 (Immediate crisis counseling related to disasters, 24/7)

National Domestic Violence Hotline

1-800-799-SAFE (7233)

TTY: 1-800-787-3224

Text: SAFE to 88788

National Suicide Prevention Lifeline

- The National Suicide Prevention Lifeline, where compassionate, accessible care and support is available for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.
- The existing number for the National Suicide Prevention Lifeline (1-800-273-8255) is still active. Using either number will get people to the same services.
- The Lifeline is free, confidential, available 24/7, and can be reached by both phone call (multiple languages) and text (English only). The Lifeline currently serves TTY users either through their preferred relay service or by dialing 711, then 1-800-273-8255.
- Additionally, the Lifeline is available through chat by visiting <https://suicidepreventionlifeline.org/chat>.

National Helpline 1-800-662-4357 (Treatment referral and information, 24/7)

Veterans Crisis Line

1-800-273-8255, Press 1

(24/7, free and confidential support for any service member or veteran or someone concerned about one)

Telehealth

Members have the option of receiving the below services either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with “CMS Guidance on Medicare Marketing Activities section”.

Telehealth services offered by the plan include:

Primary care physician (PCP) services

Physician specialist services

Individual sessions for mental health specialty services

Individual sessions for psychiatric services

Prior authorization/plan approval required: No

HOSPITAL SERVICES

Inpatient Admissions

In order for Highmark Health Options Duals to monitor the quality of care and utilization of services by our members, all practitioners are required to obtain an authorization number for all hospital admissions by contacting the Utilization Management Department at 1-855-401-8251. In the event services are needed urgently or emergently, authorizations must be requested within (4) calendar days of discharge. Admission requests made outside of this timeframe must be submitted through retrospective review.

Failure to obtain a timely authorization for scheduled care may result in the administrative denial of your claim without regard to medical necessity. Claims submitted for non-emergent care without prior authorization will be denied.

Highmark Health Options Duals will accept an inpatient authorization request from the primary care practitioner, ordering practitioner, the attending practitioner or the hospital's Utilization Review Department for both emergent and non-emergent hospital care; however, no party should assume the other has obtained authorization.

The Utilization Management Representative refers to a Highmark Health Options Duals Medical Director if criteria or established guidelines and/or policies are not met for a determination.

In the case of an emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital or member is encouraged to notify the Highmark Health Options Duals Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues and discharge planning. Highmark Health Options Duals will perform concurrent inpatient level of care reviews to establish medical necessity. Authorization requests made after the care has been completed (post service/post discharge) must be submitted as an appeal once a claim denial has been received. Post service authorization requests will not be accepted by Utilization Management.

During the discharge planning process, if Highmark Health Options Duals is notified by the Quality Improvement Organization (QIO) that the member disagrees with the attending physician's discharge, a written detailed notice of discharge will be provided to the member through a process agreed upon by the hospital and Highmark Health Options Duals and will be provided to the member within the timeframes established by CMS.

Emergency Room

Members are informed through the Evidence of Coverage how and when to utilize emergency services. Emergency services do not require prior authorization. If a member is unsure whether to go to the emergency room, the member is instructed to call his/her primary care practitioner for advice.

Ambulance Services

Emergent ambulance transport does not require prior authorization. Non-emergent ground ambulance transport by a participating provider does require prior authorization; as well as for non-emergent ground ambulance transport by a non-participating provider except as noted below. Highmark Health Options Duals considers non-emergent transportation as transportation for a patient that does not require immediate access to medical or behavioral health care and/or if not provided would not result in a medical or a behavioral health crisis.

Non-emergent transportation may include the following scenarios:

- Ambulance transports from one facility to another when the member is expected to remain at the receiving facility, which may include the following:
 - Hospital to Skilled Nursing Facility (SNF)
 - SNF to Hospital (non-emergent)
 - Hospital to Rehabilitation Facility
 - Rehabilitation Facility to Hospital (non-emergent)
- Ambulance transport to home upon discharge (if medically necessary).

Highmark Health Options Duals considers emergent transportation as transportation that allows immediate access to medical or behavioral health care and without such access could precipitate a medical or a behavioral health crisis for the patient. Either a participating or non-participating ambulance provider may render 911 transportation or transport to a psychiatric facility for a member under a psychiatric commitment order without an authorization from Highmark Health Options Duals.

Highmark Health Options Duals also considers the following situations emergent, and thus does not require authorization when rendered by a Highmark Health Options Duals participating ambulance provider:

- ER to ER
- ER to Acute Care or Behavioral Health Facility
- Acute Care to Acute Care or Behavioral Health Facility
- Hospital-to-Hospital, when a patient is being discharged from one hospital and being admitted to another
- *End Stage Renal Dialysis Center

Providers should bill the above types of transports with the appropriate non-emergent, basic life support code and the modifier HH.

*Ambulance transportation by non-participating providers to End Stage Renal Dialysis Centers does not require authorization. Although there is no pre-authorization required for participating or non-participating ambulance transport for a member with ESRD for dialysis services, the ambulance transport must meet Medicare's medical necessity program coverage criteria in order for payment to be made.

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Authorization for non-emergent air ambulance transportation is required by Highmark Health Options Duals' Utilization Management Department. A Highmark Health Options Duals participating Ambulance provider should be contacted to render non-emergent transportation when possible. Ambulance transportation from one facility to another for diagnostic testing or services not available at the current facility, with the expectation of the member returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization from Highmark Health Options Duals. The originating facility should assume the cost for this type of transport even if for unforeseen circumstances, the member remains at the receiving facility. The originating facility may contact any ambulance service of their choosing to provide transport in this scenario only.

DRG Post-Payment Audits

Our Company or a designated delegate conducts monthly post-payment reviews of inpatient claims to verify the accuracy of DRG payments.

For reviews conducted by a designated delegate, you should expect the following:

- You will receive a letter requesting records for specific paid claims.
- You will have thirty (30) calendar days to provide the requested medical records for review.
- Failure to submit the requested records may result in an administrative denial by our company and recoupment of the original payment.
- You will receive a determination letter from the delegate describing the outcome of the medical records and claim review.
- You will have thirty (30) calendar days to either accept the delegate's findings or request a reevaluation by providing supporting information for the paid claims to the delegate.
- If you disagree with the delegate's reevaluation, our Medical Director can review your supporting information to make a final determination.
- If you do not respond to these notifications, we will proceed with a payment adjustment.

Questions should be directed to our Fraud, Waste and Abuse Hotline by calling 1-844-325-6256.

Technical Denials

Technical Denial determinations are not subject to reconsideration and further appeals but may be subject to re-review/reopening. These types of denials include:

- Medical record not being submitted timely (42 CFR 476.90(b)); and
- Billing errors including cost outlier denials due to duplicative billing for services or for services not actually furnished or not ordered by the physician.

You will receive correspondence from us indicating the specific claims and required documents required for review. If you do not respond to these notifications, we will proceed with a payment adjustment.

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Questions regarding Technical Denials should be directed to Highmark Health Options Duals' Financial Investigations and Provider Review Team by calling the Fraud, Waste and Abuse Hotline at 1-844-325-6256.

Accessibility to Care (Appointment Standards)

Highmark Health Options Duals maintains accessibility to care standards and processes for ongoing monitoring of access to health care. Providers are contractually required to conform to these standards to ensure that health care services are provided to our members in a timely manner.

PROVIDER TYPE	APPOINTMENT TYPE	ACCESS STANDARD
Primary Care (PCP) Behavioral Health (BH)	Emergent Care	Immediately seen or referred to an emergency facility Practice sites will be able to schedule an appointment immediately or refer the member to an emergency facility.
Primary Care (PCP) Behavioral Health (BH)	Urgent Care	Immediately seen or scheduled within 24 hours Practice sites will be able to schedule an appointment either immediately or within 24 hours of being contacted by member.
Primary Care (PCP) Behavioral Health (BH)	Non-Urgent, but in need of medical attention	Within 7 business days Practice sites will be able to schedule an appointment within 7 business days of being contacted by member.
Primary Care (PCP) Behavioral Health (BH)	Routine or Preventative Care	Within 30 business days Practice sites will be able to schedule an appointment within 30 business days of being contacted by member.

The above appointment standards and other accessibility resources are located on our provider website at <https://www.highmarkhealthoptions.com/providers/provider-resources/accessibility-to-care-standards/>.

POLICIES AND PROCEDURES

Highmark Health Options Duals has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable Practitioner Agreement, policies and procedures, or accepted Utilization Management Standards and Quality Improvement Guidelines.

Policy Changes

In order for Highmark Health Options Duals to be in compliance with federal and state laws, regulations and regulatory bulletins governing the Medicare and Medicaid Programs in the course of providing services, providers and their staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs. Additionally, providers need to be aware that no regulatory order or requirement of the Centers for Medicaid and Medicare, Departments of Insurance, Health or Human Services shall be subject to arbitration with the Plan.

Practitioner Education and Sanctioning

Highmark Health Options Duals practitioners will be monitored for compliance with administrative procedures, guidelines, trends of inappropriate resource utilization, potential quality of care concerns and compliance with medical record review standards. Practitioner education is provided through Provider Engagement staff, Provider Account Liaisons and our Medical Directors. The company follows a tiered approach of education and sanctioning prior to implementing termination procedures. Network practitioners who do not improve through the provider education process will be referred to the Quality Improvement/Utilization Management Committee for evaluation and recommendations. Recommendations may include remediation or practitioner sanctioning.

Examples of repeated practitioner conduct that may be further reviewed for education and remediation include, but are not limited to:

- Member complaints
- Reported occurrences of excluding or denying health care services to a member based on his or her race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency or age
- Failure to obtain prior authorization for a referral to a non-participating practitioner
- Failure to obtain prior authorization for those services requiring such
- Utilization management trends exceeding the peer group
- Quality indicator outcomes below the peer group
- Identification of Severe Quality of Care concerns
- Failure to cooperate with administrative aspects of the QI/UM Program
- Failure to provide adequate practitioner coverage
- Failure to be accessible to members via telephone or answering services
- Repeated failure to be compliant with the established accessibility standards
- Repeated failure to comply with Environmental Assessment standards

Highmark Health Options Duals conducts ongoing monitoring of Medicaid and Medicare sanction information by utilizing the OIG report, CMS Preclusion Listing, and the DMMR Medichex Sanctions report. If a participating provider is found on the reports, the provider's file is pulled for further investigation and presented to the QI/UM Committee for a decision. Upon notification from DMMR that a provider has been terminated due to loss of licensure and/or criminal convictions, Highmark Health Options Duals will immediately move forward with terminating the provider from its network. The effective date of termination will be the same date utilized by DMMA.

Practitioner Due Process

We have established a policy and procedure to define the situations when due process procedures are afforded to practitioners, and to specify the due process procedures available in accordance with federal and state regulations, in particular the Health Care Quality Improvement Act of 1986. The Practitioner Due Process Policy will be updated in accordance with federal and state regulations, and will indicate the appropriate procedures to notify new applicants and participating practitioners whenever:

- Credentialing or recredentialing applications are denied.
- Adverse determinations are made regarding participation.
- Action to suspend or terminate an agreement occur.
- A participating physician or healthcare practitioner is being terminated due to quality-of-care concerns or other conduct.

A physician or healthcare practitioner has the right to request a hearing in the event he or she receives a proposed Professional Review Action as recommended by the Plan's Quality Improvement/Utilization Management Committee.

Title VI of the Civil Rights Act Of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title VI of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Section 1557 of the Affordable Care Act Of 2010

Providers are expected to comply with the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the basis of race, color, national origin, religious creed, sex, sexual orientation, gender identity, English proficiency, age of a disability in certain health programs and activities.

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Highmark Health Options Duals will assist practitioners in locating resources upon request. The Plan offers the Member Handbook and other information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at 1-855-401-8251 to ask for these other formats. Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

For interpreter services, please contact a qualified medical interpretation service or Language Line Services. Practitioner offices can contact the AT&T Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients at 711 or 1-800-232-5460 for patients with hearing impairments.

Confidentiality

Through contractual agreements, all practitioners and providers have agreed to abide by all policies and procedures regarding member confidentiality. The performance goal for confidentiality is for practitioners to secure patient records from unauthorized access.

Under these policies, the practitioner or provider must meet the following:

- Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations. This includes implementing policies and procedures for managing access to and use of race, ethnicity, preferred language, sexual orientation and gender identity/preference data.
- Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
- Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment or healthcare operations (TPO), is released to Highmark Health Options Duals without seeking the consent of a member, unless federal or state laws require express written consent. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, and disease management. We follow the requirements of HIPAA and limit our requests to the amount of PHI that is minimally necessary to meet the payment, treatment, or operational function. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations.
- Environmental security of confidential information is conducted by all providers and practitioners treating our members. This includes both internal and external monitoring of practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment standards that require that patient records be protected from public access.

Fraud, Waste and Abuse (FWA)

We have a comprehensive policy for handling the prevention, detection and reporting of fraud, waste and abuse (FWA). It is our policy to investigate any actions by members, employees or practitioners that affects the integrity of the Plan and/or the Medicare Program. We enforce all industry standard claim coding requirements including those from NCCI, AMA CPT, ICD-10-CM, NCDs LCDs, and HCPCS.

Providers are responsible for knowing the following FWA definitions as applicable to Medicaid and Medicare:

- **Fraud:**
An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a health plan, a subcontractor, a provider, a state employee, or a member among others.
- **Waste:**
Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.
 - Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse:**
Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Medicaid contracts, Medicare manuals, and the requirements of state or federal regulations) for health care in a managed care setting.
 - Abuse can be committed by the health plan, subcontractor, provider, state employee, or a member, among others. Abuse also includes member practices that result in unnecessary cost to the Medicaid/Medicare Programs, the health plan, a subcontractor, or provider.
- **False Claims Act:**
The False Claims Act (FCA) provides that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approvals (among other activities) is liable to the United States Government for a civil penalty of \$5,000 to \$10,000 plus three times the amount of damages the Government sustains because of the act of that person (as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990). The FCA includes a qui tam provision, where individuals can bring claims on behalf of the Government in exchange for a percentage of any recovery.

- **Compliance Program:**
To ensure compliance with FWA requirements of Medicaid contracts and Medicare Manuals, the Plan and providers will have:
 - Written policies, procedures, and standards of conduct readily available for all employees which outlines our commitment to an FWA program,
 - Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors,
 - Mechanisms to report compliance issues or FWA,
 - Enforcement standards through publicized disciplinary guidelines,
 - Provisions for internal monitoring and auditing, and
 - Provisions to promptly take action to detected offenses and develop corrective action initiatives.
- **Financial Investigations and Provider Review (“FIPR”):**
A multi-faceted unit within the Plan that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance with recipient benefits and provider contracts.

As a participating practitioner with us, the contract that is signed requires compliance with our policies and procedures for the detection and prevention of FWA. Such compliance may include, but not limited to:

- referral of information regarding suspected or confirmed FWA to us;
- submission of statistical and narrative reports regarding FWA activities;
- submission of medical record requests for pre-payment and post-payment review;
- participation in interviews and audits; and
- completion of provider compliance assessment.

Providers can find FWA trainings created by the Plan’s FIPR Team on our website at <https://www.highmarkhealthoptions.com/providers/>. All providers are required to have a representative review the Provider FWA Training upon contracting with us and annually thereafter. The provider representative will be responsible for communicating the information obtained from the Provider FWA Training to the entire staff of the provider. It is the provider’s responsibility to either attend the annual Provider FWA Training or independently review the required materials. Providers will be expected to submit proof of their completion of the training when requested by the Plan. Further information and updates concerning the Provider FWA Training can be found on the Plan’s website.

Our policies and procedures follow the guidelines set forth by CMS, where applicable. For further information on Fraud, Waste and Abuse, Providers should refer to the CMS website [Reporting Fraud | CMS](#).

It is our policy to discharge any employee, terminate any practitioner or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified as being involved in FWA activities.

If FWA is suspected, whether it is by a member, employee or practitioner, it is your responsibility to immediately notify us by calling the Fraud, Waste and Abuse Hotline at 1-844-325-6256.

Some common examples of provider fraud, waste and abuse are:

- Billing for services not rendered
- Billing for services that the clinician or facility is not appropriately licensed
- Billing for supplies not being purchased or used
- Billing separately for services in lieu of an available combination code
- Billing more than once for the same service
- Up-coding
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Some common examples of member fraud, waste and abuse are:

- Loaning or using another person's ID
- Changing or forging an order or prescription
- Stealing provider's prescription pads
- "Doctor shopping" for prescriptions

Fraud, Waste and Abuse Recovery Requirements:

Our Company has FWA functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits and medical record reviews
- Retrospective claims edits and medical record reviews
- Provider education
- FWA investigations and audits
- Provider compliance assessments
- Provider overpayment determinations and extrapolations

Our FWA functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (NCQA), and state Medicaid regulations & bulletins. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes ICD-10-CM, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

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Our Company will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. We will recover claims payments that are contrary to national and industry standards. We will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews.

If any of the FWA recovery efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments,
- We may determine provider recoveries based on audit results and extrapolation methodologies,
- We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days,
- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics; and
- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from the Plan's provider network.

We may deny payment or pursue overpayments for the following reasons (but is not limited to):

NCCI Procedure to Procedure (PTP) edits
NCCI Medically Unlikely (MUE) edits
NCCI Add-On Code edits
Retrospective coordination of benefits
Retrospective termed member eligibility
Retrospective rate adjustments
Incorrect fee schedule applied to claim
Provider excluded
Provider license terminated or expired
Provider does not meet the requirements to render services
Different rendering provider
No authorization or invalid authorization
Inaccurate claim information
Duplicate claims
Non-covered service
Outpatient services while member was inpatient
Overlapping services
Patient different than member
Per diem services billed as separate or duplicate charges
Services provided outside of practice standards
Group size exceeds limitations
No services provided including no-shows and cancellations
Missing records
Missing physician orders
Missing medication records
Missing laboratory results

Invalid code or modifier
Invalid code combinations
Diagnosis codes that do not support the diagnosis or procedure
Add-on codes reported without a primary procedure code
Clinical documentation issues
Claims documentation issues
Insufficient documentation
Potentially fraudulent activities
Excessive services
Altered/forged records
Inpatient readmissions (up to 10 days)

Fraud, Waste and Abuse Audits

At times, FIPR will conduct audits regarding FWA. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted by the Plan, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond. Overpayment letters issued through administrative reviews will be sent at the discretion of FIPR management.

Additionally, we partner with multiple vendors to conduct various pre-payment and post-payment audits or reviews. Such audits or reviews could include:

- Retrospective data mining reviews.
- Subrogation.
- Inpatient and outpatient chart reviews.
- Pre-payment clinical validation and claims pattern reviews.

Vendor specific questions should be directed to the Plan's Provider Services by calling 1-855-401-8251(Full Plan) or 1-844-722-5837 (Partial Plan).

Overpayments

The Plan, its providers, and its members are responsible for the identification and return, regardless of fault, of overpayments. In the event that we make an overpayment to a provider, we must recover the full amount of that overpayment. Additionally, if a provider identifies an overpayment from us, the provider is responsible for returning the overpayment in full at the time of discovery.

Provider Self-Audit (Self-Identified Overpayment)

Federal and State regulations require providers to routinely audit claims for overpayments. We have a process in place for our network providers to report the receipt of a self-identified overpayment. Providers must notify us in writing of the reason for the self-identified overpayment and should provide payment within sixty (60) calendar days in accordance with 42 U.S.C. §1320a7k(d). If the claim is over two (2) years old a check is preferred. If the

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claim(s) are less than 2 years old, retraction is preferred. For claims retractions, providers can submit the Provider Self-Audit form that is located on the provider portal. It is imperative that Providers include the explanation of the Self-Audit and the claims they represent. If a listing of claims is not provided, we cannot guarantee that the claims will not be included in separate audits, for the same reason. Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form which is located on our website at <https://www.highmarkhealthoptions.com/providers/>.

Conversely, if providers use an extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with your submission.

Deposit of a Provider check, or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. FIPR may contact the provider to discuss self-audit results as necessary.

The overpayment letter and check (if applicable) should be sent directly to Highmark Health Options Duals.

For the mailing address, please refer to **Overpayments** under the “Important Addresses” section on page 14.

Additionally, for more information on self-audits, see the “Self-Audit” e-bulletin posted by CMS at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-self-audit.pdf>

When submitting information for an identified overpayment, please include the following:

- Provider Information (i.e., Name, NPI, TIN, Contact information, etc.)
- Self-Audit / Overpayment Information
- Period of claims
 - For claims more than 2 years old, please provide a check
 - For claims less than 2 years old, retraction of claims is preferred
- List of affected claims and/or extrapolation calculation used to determine overpayment amount
- Other information (as required)

TRENDSsubmit: Provider Self-Reporting Process

Providers can electronically submit overpayments via TRENDSsubmit. This secure, online process allows providers to be notified of claim retractions in real-time and eliminates the manual paper process. The TRENDSsubmit team provides user training resources and ongoing support. Providers can contact Jennifer Baron via email at jbaron@trendhealthpartners.com in order to initiate TRENDSsubmit access.

Medical Record Requests and Standards

We may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If we request medical records, the provider must provide copies of those records at no cost to the Plan.

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This includes notifying any third party who may maintain medical records of this stipulation. In addition, the provider must provide access to any medical, financial or administrative records related to the services provided to our members within thirty (30) calendar days of our request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

We require providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under Federal and State regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within sixty (60) days of identification.
- Providers must have member records that include all Medicaid and/or Medicare requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. (No clone or copying and pasting of medical records)

Consent to Treatment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by clinician
	Lists the types of services and/or treatments
	Includes the benefits and any potential risks
	Includes alternative services and/or treatments
	Must be easy to read and legible

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Release of Information for Payment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Lists the types of services and/or treatments
	Must be easy to read and legible

Privacy Practices	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Must be easy to read and legible

Medical Information	Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
	Allergies and adverse reactions
	Significant illnesses and medical conditions
	Medical history, such as family history, psychosocial history, medical surgical history, baseline physicals, and periodic updates
	High risk behaviors (Tobacco/cigarette, alcohol, substance misuse, HIV/STD, nutrition, social and emotional risks, etc.)
	Laboratory and other studies ordered
	Continuity of care is documented
	Immunizations and dates
	Must be easy to read and legible

Treatment Plan	Valid for dates of service
	Identifies the patient
	Signed and dated by clinician (witness or author's identification)
	Documents that member or guardian reviewed or participated with the development of the treatment plan
	Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice
	Identifies the diagnosis
	Identifies interventions and goals of treatment
	Documents necessity for treatment
	Reviews are completed timely as applicable
	Must be easy to read and legible

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Progress/ Clinical Entry Note	Dates of Service
	Identifies the patient
	Signed, dated, and credentialed by author/clinician
	Start and stop times for time-based services
	Units of service
	Place of service
	Note is missing narrative/description of services
	Note does not identify the treatment goals and objectives
	Note does not list symptoms and behaviors
	Note does not identify follow-up or next steps in treatment
	Corresponding encounter or timesheets as applicable
	Must be easy to read and legible

Medication List	Medication prescribed
	Signed and dated by clinician
	Lists dosages, dates, and refills
	References the side effect and symptoms
	Must be easy to read and legible

Environmental Assessment Standards

We have established specific guidelines for conducting Environmental Assessment Site Visits, including medical record-keeping standards for all practitioner types, including primary care practitioners, specialty care practitioners, and dental providers. An Environmental Assessment will be conducted on an ongoing basis through monitoring of complaints. Our subcontracted vendor conducts all site visits for contracted dental providers. The purpose of the site visit is to assure that practitioners are in compliance with our Environmental Assessment Standards.

When an environmental assessment is required, a Provider Account Liaison will conduct an Environmental Assessment. The Environmental Assessment must be conducted with the Office Manager or with a practitioner of the practice. The Provider Account Liaison will complete the Environmental Assessment Form and physically or virtually tour the office as well as interview staff and examine the appointment schedule. The Provider Account Liaison will assess the office for evidence of compliance with the Environmental Assessment Standards.

Upon completion of the review, the Provider Account Liaison will conduct an exit interview with the Office Manager and/or practitioner. The results of the Environmental Assessment will be reviewed. Non-compliance issues must be addressed with a corrective action plan within thirty (30) days of receipt for non-compliant standards.

The Provider Account Liaison will conduct a follow-up visit within ninety (90) days or until the office site is compliant. If any of the standards are not met, the Medical Director will assess the potential impact of the discrepancy to patient care and evaluate the corrective action plan. If the plan is not acceptable, the Medical Director may suggest a different corrective action plan. If the office is not agreeable to correcting the identified problem, the information will be presented to the Quality Improvement/Utilization Management Committee for review. Special

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circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The Provider Account Liaison will communicate the final results to the practitioners.

Provider Account Liaisons conduct site visits that include compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by the Department of Public Welfare.

The Environmental Assessment Standards are listed on pages 75-76.

Environmental Assessment Standards

PHYSICAL ACCESSIBILITY AND APPEARANCE
Parking
<ul style="list-style-type: none">• Parking lot should have adequate parking available near the physician office.• Parking lot should have one handicap accessible space per every 25 parking spaces.• Accessible parking spaces are clearly marked for people with disabilities.
Exterior Path of Travel
<ul style="list-style-type: none">• Persons using a mobility aid (e.g. walker, scooter, or wheelchair) can get from the accessible parking space to the office door.
Curb Ramps
<ul style="list-style-type: none">• The curb ramps are at least 36" wide leading to the office.
Ramps
<ul style="list-style-type: none">• There are railings present if the ramp is longer than 6 ft.
Building Entrance
<ul style="list-style-type: none">• The patient entrance and exit are clearly marked and unobstructed.
Elevators
<ul style="list-style-type: none">• There is an elevator present when the office is not located on the first or ground floor.
Hallway Doors
<ul style="list-style-type: none">• The hallways entrance/exits are handicapped accessible.
Provider Interior Path
<ul style="list-style-type: none">• Pathways through the provider's office are wide enough for a person to maneuver a wheelchair.• The office, waiting room, restroom, and at least one exam room is wheelchair accessible.
Bathroom Facilities
<ul style="list-style-type: none">• Support rail(s) are present in bathroom facilities.
Waiting Area
<ul style="list-style-type: none">• The office hours are displayed.• Patient areas are clearly marked as non-smoking.

MEDICAL RECORD KEEPING

- All providers must maintain current and comprehensive medical records which conform to standard medical practices.
- Patient records must be secure from public access at all times.
- The office must have a written confidentiality policy that applies to all staff.
- Records are documented legibly.
- Office must have an organized filing system to insure prompt retrieval of patient records. (Alphabetically, social security numbers)
- There must be a single chart for each patient. If family records are kept, individual records must be clearly delineated.
- Records must identify the member on each page.
- All medically related patient phone calls documented in the medical record.
- Office recalls missed appointments and makes documentation in the medical record.
- Chart Documentation:
 - Allergy or NKA visible in the same place on every record.
 - Patient medical history in each record. Is there a medical history in each patient record?
 - Treatment/progress notes in each patient record.
 - Problem List in the medical record. (PCPs and PCP Specialists Only)
 - Standard place in the medical record for preventive care/immunizations (PCPs and Specialists only).

****IF PROVIDER RELATIONS HAS QUESTIONS OR CHART DOES NOT MEET THE STANDARD THEN A COPY OF ONE RECORD NEEDS TO BE GIVEN TO QI FOR REVIEW.**

Provider Changes

To ensure our members have up-to-date and accurate information about Highmark Health Options Duals' network providers while accessing our provider directory, it is imperative that providers notify us of any of the following:

- Address Changes
- Phone & Fax number changes
- Changes of hours of operation
- Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only)
- Practitioner participation status (additions & terminations)
- Mergers and acquisitions

The physician agreement indicates that participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty (60) days' notice required if you plan to close your practice to new patients and thirty (30) days' notice required for a practice location change. Please refer to the Practice /Provider Change Request Form which is located on our provider website at

<https://www.highmarkhealthoptions.com/providers/>.

FQHC Provider Changes Process

The Highmark Health Options Duals physician agreement indicates that participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty (60) days' notice required if you plan to close your practice to new patients and thirty (30) days' notice required for a practice location change.

Whenever an FQHC has New Adds (physician or group), Demographic changes and/or Terminations that occur within an FQHC practice location(s), the FQHC Provider Change Form must be completed and sent to the plan within the timeframes indicated above.

Please refer to the FQHC Provider Change Form which is located on our website at:
<https://www.highmarkhealthoptions.com/providers/>.

CMS Guidance on Medicare Marketing Activities

Below is the CMS guidance on provider marketing activities as detailed at 42 CFR § 422.2266.

Activities with healthcare providers or within a healthcare setting.

(a) **Where marketing is prohibited.** The requirements in [paragraphs \(c\)](#) through [\(e\)](#) of this section apply to activities in the health care setting. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:

- (1) Exam rooms.
- (2) Hospital patient rooms.
- (3) Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).
- (4) Pharmacy counter areas.

(b) **Where marketing is permitted.** Marketing activities and materials are permitted in common areas within a health care setting, including the following:

- (1) Common entryways.
- (2) Vestibules.
- (3) Waiting rooms.
- (4) Hospital or nursing home cafeterias.
- (5) Community, recreational, or conference rooms.

(c) **Provider-initiated activities.** Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Provider-initiated activities that meet the definition in this [paragraph \(c\)](#) fall outside of the definition of marketing in [§ 422.2260](#). Permissible provider-initiated activities include:

- (1) Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from www.medicare.gov), including in areas where care is delivered.
- (2) Providing the names of MA organizations with which they contract or participate or both.

(3) Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.

(4) Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, the CMS' website at www.medicare.gov, or 1-800-MEDICARE.

(5) Referring patients to MA plan marketing materials available in common areas.

(6) Providing information and assistance in applying for the LIS.

(7) Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

(d) ***Plan-initiated provider activities.*** Plan-initiated provider activities are those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements.

(1) During plan-initiated provider activities, MA organizations must ensure that the provider does not:

(i) Accept or collect Scope of Appointment forms.

(ii) Accept Medicare enrollment applications.

(iii) Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.

(iv) Mail marketing materials on behalf of the MA organization.

(v) Offer inducements to persuade patients to enroll in a particular MA plan or organization.

(vi) Conduct health screenings as a marketing activity.

(vii) Distribute marketing materials or enrollment forms in areas where care is being delivered.

(viii) Offer anything of value to induce enrollees to select the provider.

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e) **MA organization activities in the health care setting.** MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in [paragraphs \(a\)](#) and [\(b\)](#) of this section. However, during MA organization activities, the following is permitted:

(1) Accepting and collect Scope of Appointment forms.

(2) Accepting enrollment forms.

(3) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

Provider Complaints

We have created a Provider Complaint system for participating and non-participating providers to raise issues with Highmark Health Options Duals policies, procedures and administrative functions. Complaints will be investigated, and the details of the findings and disposition will be communicated back in writing to the provider within thirty (30) days of receipt. If additional time is needed to resolve Highmark Health Options Duals will provide status updates to the provider as applicable.

Any misdirected submissions, including but not limited to Administrative Reviews or Clinical Appeals, into the Provider complaint system will be routed to the appropriate department. The provider will be advised of the redirection and educated on proper handling and contact details of the appropriate department for future reference.

All network providers are required to be NaviNet enabled. Providers are expected to use this tool to access the Provider Complaint Messaging Center. All non-participating providers will be directed to complete the Highmark Health Options Duals Non Participating Provider Complaint Form which is located on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

The form may be submitted to <https://www.highmarkhealthoptions.com/providers/> or faxed to 1-888-778-8121.

Continuity and Coordination of Care

Specialists, Hospitals & Skilled Nursing facilities must ensure compliance with the Continuity and Coordination of Care requirements, by ensuring that all discharge summaries and progress reports are reported back to the member's PCP. Continuity and Coordination of Care across settings is a regulatory requirement. Care across settings, such as between Primary Care Physicians (PCPs) and Specialists, presents many challenges to the continuity of information, relationships and treatment.

Much of the Plan's membership is made up of the most vulnerable individuals. Some of whom suffer from severe or chronic illnesses. Enhanced communication is imperative across all the touchpoints within these patients' care in order to make the informed decisions which will ensure their well-being. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications and concerns identified by providers across treatment settings. For additional continuity of care concerns or assistance, please contact your Provider Account Liaison.

REFERRALS AND AUTHORIZATIONS

Referrals

The Highmark Health Options Duals plan (D-SNP) is designed for dual-eligible members who qualify for both Medicare and Medicaid. This D-SNP plan is highly integrated where Medicare and Medicaid cash flows together. When services like tests, treatments, or specialist referrals are ordered. A prior authorization may be needed to confirm that it is medically necessary. You may submit the request through our online portal which is the preferred method. Fax in or by phone.

Out of Plan Referrals

Occasionally, a member may need to see a healthcare professional outside of Highmark Health Options Duals' provider network. When the need for out-of-plan services arises, the primary care practitioner must contact our Utilization Management Department to obtain an authorization. The Utilization Management Department will review the request and make arrangements for the member to receive the necessary medical services with a specialty care practitioner in collaboration with the recommendations of the primary care practitioner. Every effort will be made to locate a healthcare professional within an accessible distance to the member.

Referrals for Second Opinions

Second opinions from a qualified health care professional may be requested by a member. When requesting a second opinion consultation, Highmark Health Options Duals recommends that you issue a referral to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact our Utilization Management Department to assist in arranging and obtaining an authorization for the second opinion of an out-of-network provider at no additional cost to the member than an in-network referral.

Self-Referral

All Highmark Health Options Duals members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. Members may refer themselves for the following types of care:

- Routine Women's Health Care
- Pap Smears
- Pelvic Exams
- Mammograms
- Flu Shots
- Pneumonia Vaccinations
- Specialists Visits
- Prostate Screening
- Colorectal Screening

- Bone Mass Measurements
- Diabetes Monitoring Training
- Dialysis
- Behavioral Health Services
- Substance Use Services
- Vision Exams*
- Hearing Exams*

*Benefit coverage varies by product.

Authorizations

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who may benefit from case management or disease management. Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by calling the Highmark Health Options Duals Utilization Management Department prior to services being rendered. (Refer to the section listed as the Process for Requesting Prior Authorization.) The Utilization Management Department assesses the medical appropriateness of services using nationally recognized criteria, such as Change Health Care InterQual® Criteria, the American Society of Addiction Medicine (ASAM) Guidelines, the Centers for Medicare and Medicaid Services (CMS)-definition of medical necessity, CMS National and Local Coverage Determinations, and our company's medical policies when authorizing the delivery of healthcare services to plan members.

The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member. It refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the doctor.

Effective January 1, 2026, Highmark Health Options Duals will operate as an aligned HIDE plan, necessitating an integrated authorization decision for both benefit types. An aligned member is a member who has both D-SNP Medicare and Medicaid through HHO. To facilitate integrated authorizations, the HHO Utilization Management (UM) team will complete two authorizations, one for Medicare and one for Medicaid. Provider only need to submit an authorization request under the Medicare benefit; HHO UM will automatically review the authorization request using both the Medicare and Medicaid benefit, decisioning appropriately based on medical necessity.

The Highmark Health Options Duals Select is exclusively a Medicare plan, and the authorization process specifically addresses only Medicare-covered benefits. Members HHO Duals Select are not classified as full Medicaid members and there is no alignment between their Dual Special Needs Plan (DSNP) and other payers. Provider needs to submit an authorization request under the Medicare benefit and HHO UM will review the authorization request using the Medicare benefits only, decisioning appropriately based on medical necessity.

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Prior authorization must continue to be obtained for Highmark Health Options Duals members through Home and Community Care Services for admissions and concurrent stays to a Skilled Nursing Facility, a Long-Term Acute Care Hospital and an Inpatient Rehabilitation Facility.

The following services require a prior authorization from Highmark Health Options Duals or have a payment policy applied:

- Acute Inpatient Admission and Continued Stays
- Notification of Discharge (Acute IP Discharge)
- Behavior Health Admission/Continued Stay Review Psych
- Behavior Health Substance Use/Misuse Admission/Continued Stay Review
- Behavior Health Discharge
- Behavior Health Outpatient Requests
- Chiropractic Visits
- Durable Medical Equipment (DME) Requests

Note: A comprehensive list of items requiring authorization can be found on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>, under the provider section. Remember to check for medical or payment policies that may apply.

Note: Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained. In the event services are needed urgently or emergently, authorizations must be requested within 4 calendar days of discharge for inpatient services and within 1 business day for outpatient services. Authorization requests made outside of this timeframe must be submitted through retrospective review.

Along with the authorization the provider must submit justification as to why an authorization was not requested such as the member was incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records to Highmark Health Options Duals.

For the mailing address, please refer to **Retrospective Authorization Reviews** under the “Important Addresses” section on page 14 or fax to 1-855-501-3904.

Note: You will be able to initiate authorization requests by selecting Highmark Health Options Duals under My Health Plans after logging in to naviNet. Next, you will select Authorization Submission from the Authorization Submission fly-out menu. Complete the Selection Form by filling in the patient's information and selecting the appropriate category.

A training guide that includes detailed instructions is located on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

Process for Requesting Prior Authorizations

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to Highmark Health Options Duals members. The Utilization Management Department can be contacted between the hours of 8:30 am and 4:30 pm, Monday through Friday, at 1-844-401-8251.

When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message, and a Utilization Management Representative will return the call the next business day. Urgent requests or questions are directed to call 1-844-401-8251.

If faxing information, speak with a Utilization Management Representative first and when requested, fax the information to the Utilization Management Representative's attention. The Representative will inform you of the name and fax number.

Highmark Health Options Duals providers can submit authorization requests electronically via NaviNet for all UM related requests, including but not limited to, the following services:

- Inpatient Maternity
- Inpatient Services
- Durable Medical Equipment
- Select Surgical Procedures
- Diagnostic Testing
- Genetic Testing

In the case of an emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital, or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues and discharge planning.

Highmark Health Options Duals will perform concurrent inpatient level of care reviews to establish medical necessity. In the event services are needed urgently or emergently, authorizations must be requested within (4) calendar days of discharge. Admission requests made outside of this timeframe must be submitted through retrospective review.

Authorization requests made after the care has been completed (post service/post discharge) must be submitted as an appeal once a claim denial has been received. Post service authorization requests will not be accepted by Utilization Management.

When requesting authorization of planned procedures, we recommend calling the Utilization Management Department as soon as possible, but within a minimum of two (2) working days in advance when possible.

When a call is received, the information given will be reviewed, and the members' eligibility verified. However, since a member's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

The following information may be needed to authorize a service. Please have this information available before placing a call to the Utilization Management Department:

- Member Name and Birthdate
- Member ID Number
- Procedure Code, if applicable (CPT4, HCPCS)
- Durable Medical Equipment (DME) Codes and Cost of Item(s), when applicable
- Date of Service
- Name of Admitting/Treating Practitioner
- Name of the Practitioner requesting the Service
- NPI number
- Any other pertinent clinical information such as:
 - Diagnoses/Co-morbidities
 - Age
 - Complications
 - Progress of treatment
 - Medical history
 - Previous test results
 - Current medications
 - Psychosocial situation
 - Home environment/social situation, when applicable.

When Home and Community Care Services has authorized services provided by a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) and it has been determined that coverage for the services will end, the Home and Community Care Services staff will coordinate with the SNF, HHA, or CORF through a process agreed upon by the facility/agency and Home and Community Care Transitions to deliver the appropriate notification (Notice of Medicare Non-Coverage) to the member. The notification will inform the member of the discontinuation of the service and will be provided to the member within the timeframes established by CMS.

Note: Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained.

Along with the authorization the provider must submit justification as to why an authorization was not requested such as the member was incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records. The information must be sent directly to Highmark Health Options Duals.

For the mailing address, please refer to Retrospective Authorization Reviews under the “Important Addresses” section on page 14 or fax to 1-855-501-3904.
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Outpatient Therapy Services

All Outpatient Therapy treatment services including physical therapy, occupational therapy, and speech therapy require a prior authorization. Outpatient therapy services will request prior authorization through the HealthHelp Portal at

<http://www.healthhelp.com/HighmarkHealthOptionsDE> or by calling into the dedicated toll-free phone number, Monday through Friday 8:00 AM to 8:00 PM at 1-877-761-1444. A separate authorization number is required for each procedure ordered. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

In keeping with our commitment of promoting continuous quality improvement for services provided to our members, we entered into an agreement with HealthHelp in 2024 to implement a Musculoskeletal (MSK) Management Program. This program includes prior authorization for non-emergent MSK procedures including outpatient, interventional spine pain management services (IPM), inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries; you would call HealthHelp at the same number above.

Durable Medical Equipment

For DME, medical supplies and orthotics and prosthetics the following information is needed when requesting authorization:

- Name of requested equipment or medical supply, appropriate code (HCPCS), cost
- Rental vs. purchase request
- Amount of items requested
- Clinical Information to support the medically necessary service request

Services Requiring Authorization

Utilization Management prior authorization is required on the following services:

- Elective Inpatient Admissions, including behavioral health and substance misuse (inpatient rehabilitation, skilled nursing facility, and long-term acute care hospital admissions are managed v via Home and Community Care Services.
- Genetic Testing
- Hyperbaric Oxygen Therapy
- Non-Invasive Positive Pressure Ventilation
- Readmissions within 30 Days
- Durable Medical Equipment (DME), Orthotics, Prosthetics, Medical Supplies or monthly rentals
- Cardiology Procedures including Peripheral Revascularization, Cardiac Devices, Ablation/EPS (HealthHelp)
- Complex outpatient imaging services (HealthHelp).
- Chiropractic Services (Chiropractic services are covered to correct a subluxation by means of manual manipulation of the spine)
- Outpatient Psychiatric Partial Hospitalization
- Outpatient Rehab (physical therapy, occupational therapy, speech therapy, including therapy performed in the home are managed through (HealthHelp).
- Experimental/Investigational Services
- Plastic Surgery/Cosmetic Procedures
- Non-participating provider services (exception: emergency room, dialysis, emergency ambulance transport)
- Outpatient surgical procedures as follows:

- Bariatric Surgery/Stapling
- Blepharoplasty
- Breast Reduction
- Carpal Tunnel Surgery
- Genital Reconstruction
- Hyperbaric Oxygen Therapy
- Hysterectomy
- Implants
- Musculoskeletal Surgeries (HealthHelp)
- Pain Management Interventions, including spinal procedures (Through HealthHelp).
- Panniculectomy
- Radiation Oncology (via Health Help)
- Removal of Breast Implant
- Rhinoplasty
- Sleep Studies, PAP Therapy, Oral Appliances (via Health Help)
- Spinal Neuro Stimulator Services
- TMJ Surgery
- Transplants
- Tubal Ligations
- Varicose Vein Surgeries performed at a Short Procedure Unit or Ambulatory Care Center

Note: A comprehensive list of items requiring authorization is located on our website at <https://www.highmarkhealthoptions.com/providers/>. In addition, participating providers can access our provider portal, via NaviNet to determine if a code requires prior authorization.

In the case of urgent/emergent admissions, the Highmark Health Options Duals admitting physician, hospital, or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Organ transplants require prior authorization and must be performed at a Medicare- approved transplant center, per CMS requirements. The following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multi-visceral, and stem cell.

Prior Authorization Decision Timeframes and Notification

Standard Decisions:

For standard precertification requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than seven (7) calendar days from the receipt of the request. Verbal notification of either decision will be made to the provider on behalf of the member. Notification will be sent to the requesting provider and member in writing on all initial authorization determinations no later than seven (7) calendar days from the receipt of the request.

For standard concurrent requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the

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member's health condition requires, but no later than 72 hours from the receipt of the request. Verbal notification of the decision will be made to the provider on behalf of the member. Notification will be sent to the requesting provider and member in writing on all authorization determinations. Written notification will occur within 72 hours of receiving the request.

Expedited Decisions:

For expedited requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request. The Utilization Management Department will notify the requesting provider and the member telephonically on all expedited determinations. Written notification to the member and provider will occur within 72 hours from receipt of the request.

Home Infusion

Nursing visits and supplies related to home infusion services do not require authorization. Refer to Pharmacy regarding authorization requirements for infusion drugs.

Pharmacy Services

Highmark Health Options Duals utilizes a closed formulary. Practitioners are encouraged to prescribe formulary medications when medically appropriate. Some formulary medications may have additional coverage restrictions, such as a quantity limit or step therapy.

If changing to a formulary medication is not medically advisable for an enrollee, or if an exception is needed for a formulary medication that has coverage restrictions, a practitioner must initiate a request for drug coverage by one of the following methods: submitting an electronic prior authorization via CoverMyMeds.com, faxing the Request for Drug Coverage Form to 1-855-476-4158, or calling Pharmacy Services at 1-855-401-8251. Practitioners should ensure that all information on the form is available when calling or submitting as failure to provide this may result in an adverse coverage determination.

We encourage practitioners to utilize the Request for Drug Coverage Form is located on the Highmark Health Options Duals website at [HHO-Duals-Provider-Request-For-Drug-Coverage-Form.pdf](#). The forms may be photocopied, or you can also request a copy by calling Pharmacy Services.

All standard requests for Part B or Part D drugs submitted with the necessary clinical information will be reviewed and a decision made as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request by Pharmacy Services; all expedited requests within 24 hours after the receipt of the request. In certain cases, the plan will automatically authorize a temporary supply of a non-formulary drug to allow sufficient time to transition the enrollee to a formulary alternative or request an exception. Enrollees and practitioners are notified in writing and/or telephonically of decisions in accordance with CMS guidance.

Managing Care Transitions

Highmark Health Options Duals teams (i.e., Utilization Management and Care Coordination) prioritize seamless coordination of care during member transitions, especially when moving from an acute care setting to another setting. Inadequate transitions can result in poor quality of care, gaps in necessary services, and increased patient safety risks. These issues can contribute to costly and unnecessary hospital readmission(s), preventable adverse events, and medication (i.e., drug-related) errors.

Highmark Health Options Duals facilitates effective transition of care coordination throughout the authorization process by collaborating closely with practitioners and providers. For both planned and unplanned transitions, the health care provider (or organization) transitioning the member must provide a patient care plan to the receiving health care provider (or organization) within one business day of the transition notice. This timely sharing of a comprehensive care plan enhances continuity and coordination of care, reducing patient risks.

A patient care plan includes essential, patient-specific information relevant to the patient's clinical condition and health status. It should encompass both medical and non-medical details, such as a current problem list, allergies/sensitivities, medication regimen, contact information for the patient and health care providers, baseline physical and cognitive functioning, and advance directives.

The transitioning health care provider (or organization) often includes this care plan in patient documents such as discharge summaries, transfer summaries, or patient instructions. Additionally, any changes to the member's health care status or care plan should be communicated to the member and/or their responsible caregiver within one business day.

To facilitate and ensure safe transitions, Highmark Health Options Duals identifies scheduled and unscheduled care transitions, establishes a single point of contact for member support throughout the process, and maintains communication with the member, their responsible party, primary care provider, and other treating health care professionals and providers.

New Technology

Any new technology or new use of existing technology identified during the Utilization Management review process, and requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, professionals (who have expertise in the technology), and other major payers/state agencies and opinions of professional societies and/or utilize the contracted services of Hayes, Inc. for information related to the new technology. The technology will also be investigated through CMS National and Local Coverage Determinations. If the technology has not been reviewed by appropriate governmental regulatory bodies, the Medical Director will discuss the need for the specifically requested technology with the primary care practitioner and may consult with a participating specialist from the Highmark Health Options Duals expert panel regarding the use of the new technology. The new technology review will be presented to the Highmark Health Options Duals QI/UM Committee. If it is determined that no other approved technology is available

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and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given. Highmark Health Options Duals will consider those specific medical items, services, treatment procedures or technologies not specifically identified as non-covered or non-reimbursable by Medicare as defined within National Coverage Determinations.

CLAIMS AND BILLING

Member Billing Policy

Highmark Health Options Duals offers one Dual-eligible Special Needs Plans (D-SNP) which is designed for those eligible for BOTH Medicare (PART A and B) and Medicaid (Medical Assistance) or assistance from the State. Individuals who qualify for both are commonly referred to as Duals. Because our members are enrolled in a Medicare Advantage Plan, there is a limit to how much a member will have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B.

A member's out-of-pocket expense or cost sharing will vary depending upon the level of assistance they may be receiving from the State or Medicare. Maximum Out of Pocket (MOOP) is a cost sharing limit that once reached triggers a Medicare Advantage plan to pay 100% of the allowed costs for covered Part A and Part B services. MOOP is accumulated as claims for Part A and Part B services are received, and finalized by, a health plan.

Beginning January 1, 2023, per the CY 2023 Medicare Advantage Final Rule, Medicare Advantage Plans must calculate MOOP based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost-sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid. In order to be compliant with the CY 2023 MA Final Rule, we will begin tracking MOOP accumulations for Highmark Health Options Duals members, as noted above.

As a reminder, our Dual-Eligible Highmark Health Options Duals members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

Providers further agree that upon payment from Highmark Health Options Duals, providers will accept the plan payment as payment in full or bill the appropriate State source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by Federal law.

Claims

General Information

Procedures for Highmark Health Options Duals are as follows:

Effective January 1, 2026, Highmark will operate as an aligned HIDE plan, necessitating an integrated claims decision across both benefit types. An aligned member is a member who has both D-SNP Medicare and Medicaid through HHO. To facilitate integrated claims processing, changes have been made to the current claim submission procedures. Effective January 1, 2026: To process claims for **aligned members**, providers need only submit a **single claim** to the D-SNP Medicare Payer ID (47183), including the D-SNP Medicare ID number. Highmark will automatically process claims under both Medicare and Medicaid benefits, eliminating the need for providers to submit separate claims. Provider should submit all service to the D-SNP payer ID first even if a service that is not typically covered by

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Medicare (this includes LTSS and HBCS). Please ensure you bill all codes required to receive payment under both benefits. If corrected claim is submitted to D-SNP Medicare: The corrected claim will automatically be sent to Medicaid as well. If corrected submitted to Medicaid: The correction will only apply to the Medicaid claim.

- Important: Date of Service Matters:
 - **Institutional Inpatient:** Only claims with an admittance date 1/1/2026 or after will be processed under both eligibilities. If admittance date is prior to 1/1/2026, provider is to follow standard process of submitting claim to D-SNP Medicare and then billing Medicaid with EOB.
 - **Institutional Outpatient & Professional:** Claims will only process under D-SNP Medicare and Medicaid eligibilities if all lines of claims have a date of service 1/1/2026 or after. If there are any claim lines that are prior to 1/1/2026 DOS provider is to follow standard process and bill Medicare and then bill Medicaid with EOB.

Note: Rejected claims and claims that cannot be processed under D-SNP Medicare for invalid member id or member unable to be located with information billed will not be processed under Medicaid. These claims will require a corrected claim under D-SNP Medicare.

Providers will continue to receive two separate payments and remittance advises (835s) – one for the Medicare claim and one for the Medicaid claim.

- All claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes International Classification of Diseases (ICD-10-CM), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) with modifiers where appropriate, National Drug Codes (NDC).
- The Center for Medicare and Medicaid Services (CMS) place of service codes are the only place of service codes accepted for processing claims.
- New codes will be added to the Highmark Health Options Duals respective fee schedules effective the first of the month upon receipt of notification from CMS. The new fees/rates will be loaded into the Claims system for payment within thirty days (30) from the notification. If a provider would like the new rate considered, it is the provider's responsibility to resubmit a corrected claim with the appropriate coding within the timely allowance. Retroactive payments are not made to the provider.
- Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format.
- Paper and EDI claims without the required National Provider Identifier (NPI) numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form. Paper claims will be handled just like rejected EDI claims and will not be loaded in the claims system. Providers will be held to timely filing policies in regard to submission of the initial and corrected claims.
- Handwritten claims are not accepted. Correct/current member information, including the member ID number, must be entered on all claims. The member ID number or MBI (Medicare Beneficiary Identifier) in alpha and numeric format will be accepted on

electronic claims. The member ID number is preferred to assure that the claim is processed under the correct individual.

- The billing provider address submitted on claims must be a physical address. Claims submitted via will be rejected if a P.O. Box number is submitted as the billing address.
- Please allow four (4) to six (6) weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- Claims are accepted and facilities and providers are encouraged to submit initial bills within 180 days from the date of service, however any initial claim not submitted within 180 days must be submitted within 365 days from the date of service. Initial bills submitted after 365 days will be denied as untimely.
- Corrected claims or requests for review are considered if information is received within 365 days from the date of service on the claim.
- When Highmark Health Options Duals is secondary to any commercial plan, claims must be submitted within timely filing guidelines.
- Inpatient hospital claims must be submitted with an MS-DRG Code.
- Providers of obstetric services are reimbursed on a global basis for deliveries. Individual visits are not reimbursed and should not be billed.
- In the case of a claims overpayment, we will produce a negative remittance advice. The negative remittance advice will capture the overpayment and the impacted claims. Overpayments will be deducted from future claim payments until the Providers account returns to a positive status. Providers also have the capacity to submit a reimbursement to balance the account.

Timely Filing

Providers are encouraged to submit initial claims within one hundred and eighty (180) calendar days after the date of service. However, any initial claim not submitted within 180 days must be submitted within 365 days from the date of service. Initial bills submitted after 365 days will be denied as untimely. We prefer to receive claims electronically, but we do accept claims submitted on paper. If you bill on paper, we will only accept paper claims on a CMS-1500 or a UB-04 Form. No other billing forms will be accepted. For more information visit the Medicare Website at:

https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.

UB-04 and a CMS-1500 Claim Forms can be found on the provider website at

<https://www.highmarkhealthoptions.com/providers/>.

Providers must bill within three hundred sixty-five (365) calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Highmark Health Options Duals is secondary. An original bill along with a copy of the EOB is required to process the claim. All claims submitted after the 365-day period following receipt of the EOB or after the 365 days from the date of service will be denied. Claims submitted with primary carrier EOBs that do not list the adjudication or remit date will be denied.

Any claim that has been submitted to Highmark Health Options Duals but does not appear on a remittance advice within sixty (60) days following submission should be researched by calling our Provider Services Department at to inquire whether the claim was received and/or processed.

Electronic Claims Submission

Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format. The EDI 837 Health Care Claim transaction is the electronic transaction for claims submissions.

Highmark Health Options Duals accepts claims electronically in data file transmissions through electronic claim files sent directly to Highmark Health Options Duals are permitted only in the HIPAA standard format. Providers are encouraged to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

For submission of professional or institutional electronic claims, please refer to the following grid for:

PAYER NAME	PAYER ID	CLAIM TYPE
Highmark Health Options Duals	47183	Professional
Highmark Health Options Duals	47183	Institutional
Highmark Health Options Duals Select	47183	Professional
Highmark Health Options Duals Select	47183	Institutional

Requirements for Submitting Claims to Highmark Health Options Duals through a Clearinghouse

When submitting claims please note the Payer ID Number is 47183. Any claim submitted with the incorrect Payer ID Number will be denied.

The billing provider address submitted on claims must be a physical address. Claims will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

We have a health plan specific edit through for electronic claims that differ from the standard electronic submission format criteria.

The edit requires:

- The assigned member identification number. For providers who do not know the member's identification number it is acceptable to submit the member's Medicare Beneficiary Identifier (MBI) on electronic claims.

In addition to edits that may be received from, we have a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to, but if the codes are not currently valid, they will be rejected.

Providers must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by our company. Edits applied when claims are received will appear on an EDI Report within the initial acceptance report or Claims Acknowledgment Report. The NPI (National Provider Identifier) number is required, and the Member's. When care is coordinated, the referring provider's name and NPI are also required. A claim will be rejected if it does not include required NPI(s) and current procedure and diagnosis codes.

To ensure that claims have been accepted via EDI, providers should receive and review the following reports on a daily basis:

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. Highmark Health Options Duals will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 claims forms. However, services billed by report cannot be submitted as attachments along with electronic claims.

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required in order to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer)

Our company has engaged PNC Healthcare to migrate to a new claims payment platform, Claim Payments & Remittances (CPR) service, powered by Echo Health. This platform allows our company to make payments based on provider's preferences, maximizing electronic payment options and simplifying adoption.

Providers may register to receive payments electronically. The new CPR service enables providers to log into a web-based portal to manage their payment preferences and access their detailed explanation of payment (EOP) for each claim payment.

Outlined below are new payment options:

1. **Virtual Card Payments** – If you are not currently registered to accept payments electronically, you will receive virtual credit card payments with your EOP.
2. **Electronic Funds Transfer (EFT) Payments** – If you are interested in a more automated method of receiving payments, EFT is a fast and reliable payment method.

You can also choose to automate the associated remittance information via an 835 Electronic Remittance Advice (ERA) sent directly to your organization or your clearinghouse.

- To sign up to receive EFT payments only or 835 and EFT from our company, visit <https://enrollments.echohealthinc.com/EFTERAdirect/HighmarkDuals>
- To sign up to receive EFT payments only or 835 and EFT from our company and from all Echo payers, visit <https://view.echohealthinc.com/EFTERA/efterainvitation.aspx>

3. **Medical Payment Exchange (MPX)** –provides the option to direct print an in-office check at no cost, receive virtual card payment or enroll for EFT.
4. **Paper Checks** – To receive paper checks and paper EOPs, you must contact CPR Customer Service to elect to opt out of virtual card payments or remove your EFT enrollment.

Claims Review Process

We will review for reconsideration any claim that a provider feels was denied or paid incorrectly. These are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, refunded claim payments due to incorrect payment, or coordination of benefit issues. Administrative claim reviews can be initiated by the provider through a written request, by contacting our Provider Services Department or via fax. A plan participating provider can also submit a request through the Provider Portal via NaviNet. To help us resolve the dispute, please forward documents that support your position including Claim ID Number, Member ID Number, date of service and clear rationale. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within three hundred sixty-five (365) calendar days of the date of service on the claim. Claims inquiries for administrative reviews should be sent directly to Highmark Health Options Duals.

For the mailing address, please refer to **Administrative Claims Reviews** under the “Important Addresses” section on page 13 or fax to 1-833-623-2577.

Cotiviti Claims Pattern Review (CPR)

Highmark Health Options Duals utilizes Cotiviti Claims Pattern Review (CPR) to enhance the accuracy, integrity and timeliness of our claims processing. CPR has enabled efficient Payment Policy Management and allows for the review of claims using “real time” analytics, including the ability to pause claims processing and enabling Cotiviti CPR experts to review claims for proper validation prior to payment.

Cotiviti Claims Pattern Review Appeals Process

Providers have the right to submit for review any claim they feel was denied or paid incorrectly. Providers have three options to send in Cotiviti CPR Appeals:

1. Direct upload to the [Secure Portal](#). Simply click on the “Submit Records” button and enter your password high90CCVC.
2. Secure faxing to 800-409-0499.
3. Mailing the records directly to Cotiviti. Please mark the envelope “Confidential” and send to:

C/O Cotiviti-6150
10701 S Riverfront Pkwy,
Box 12017
South Jordan, Utah 84095

Coordination of Benefits

Coordination of Benefits (COB) is the process of establishing financial responsibility for a claim and coordinating benefit payments between two or more insurance plans. It allows another insurance plan to pay the provider first as a primary payment. Once it has been determined what the first insurer (primary carrier) has paid, it is necessary to determine if there are any benefits remaining to be paid.

Some of our members have other insurance coverage. Highmark Health Options Duals follows Medicare coordination of benefits rules. We will not deny or delay approval of otherwise covered treatment or services unless the probable existence of third-party liability is identified in our records for the member at the time the claims are submitted.

Please note the following criteria applies and designates when Highmark Health Options Duals is not the primary plan for Medicare covered members:

- Enrollee is 65+ years and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.
- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits (EOB), the practitioner should submit a claim to Highmark Health Options Duals.

The practitioner must:

- Follow all authorization and billing procedures.
- File all claims within timely filing limits as required by the primary insurance carrier.
- Submit a copy of the primary carrier's EOB with the claim to our company within 365 days of the date of the primary carrier's EOB.
- The amount billed must match the amount billed to the primary carrier. We will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Members seeking care, regardless of primary insurer, are required to contact their primary care practitioner and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

Highmark Health Options Duals accepts electronic COB transactions via 837 processing in accordance with the implementation guides for both 837 Professional and Institutional

processing. Submitting COB claims electronically will save providers time and eliminates the need for paper claims with copies of the other payer's explanation of benefits (EOB) attached. This will increase quality, consistency and speed of payment.

Please consult with your software vendor to insure they have electronic COB submission capability and work with your EDI vendor to review the HIPAA implementation guide and submission requirements.

Claim Coding Software

Highmark Health Options Duals uses HIPAA compliant automated coding software to improve accuracy and efficiency in claims processing, payment and reporting and to verify the clinical accuracy of professional and outpatient claims in accordance with clinical editing criteria.

This coding software will review claims against sets of rules that correspond to Current Procedural Terminology (CPT-4), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases -version 10 (ICD-10), Revenue Codes, American Medical Association (AMA), and the Centers for Medicare and Medicaid Services (CMS) guidelines as well as industry standards, medical policy and literature and academic affiliations.

The software used is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, practitioner and practitioner-specialty level.

Our company payment policies focus on areas such as, but not limited to:

- National billing edits including the Correct Coding Initiative (CCI)
- Modifier usage
- Global Surgery period
- Add On code usage
- Age appropriateness
- State Guidelines
- CMS' National Coverage Determinations (NCD's)
- CMS' Local Coverage Determinations (LCD's)

Billing

Billing Procedures

A “clean claim” as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered “clean” if the appropriate authorization has been obtained in compliance with our company’s Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 claim forms (or their replacement with CMS designations, as applicable) or an acceptable electronic format through our contracted clearinghouse. We may pend or deny a claim if you do not list:

- Patient name, address, date of birth and ID number.
- Patient medical plan identifier.
- Date of service for each covered service.
- Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, with modifiers where appropriate, current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity--inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code.
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure and NDC units dispensed.
- Name of practitioners/providers and applicable/required National Provider Identifier (NPI) numbers.
- The billing provider address submitted on claims be a physical address.
- Provider Tax Identification Number (TIN).
- Valid CMS place of service code(s).
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
- Billed charge amount for each covered service.
- Primary carrier Explanation of Benefits (EOB) when patient has other insurance
- MS-DRG code for inpatient hospital claims.

The billing provider address submitted on claims must be a physical address. Claims will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Highmark Health Options Duals processes medical expenses upon receipt of a correctly completed CMS-1500 Form and hospital expenses upon receipt of a correctly completed UB-04 form. Sample copies of a UB-04 and a CMS-1500 claim forms can be found on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

NPI

As mandated in the Affordable Care Act (ACA), all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) are required to include their NPI on all claims for payment submitted under the Medicare and Medicaid programs.

Below please find a few highlights of the ACA requirements and company policies and procedures to support these requirements.

- NPIs for billing, rendering, ordering and attending providers are required to be reported on paper claims in addition to electronic claims.
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper claims and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in our claims system. Providers will be held to timely filing policies in regard to submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

CMS-1500 The following fields are to be reported as indicated:	
Field 17b	NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health) (required)
Field 24J	NPI of Rendering Provider (required)
Field 32a	NPI of Service Facility (if applicable)
Field 33a	NPI of Billing Provider (required)

UB-04 The following fields are to be reported as indicated	
Field 56	NPI of Billing Provider (required)
Field 76	NPI of Attending Physician (required)
Field 77	NPI of Operating Physician (if applicable)
Field 78	NPI of Other Physician (if applicable)
Field 79	NPI of Other Physician (if applicable)

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires but does not include the fourth or fifth-digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete.

For the mailing address, please refer to **Claims-Highmark Health Options Duals** under the “Important Addresses” section on page 12.

Any questions concerning billing procedures or claim payments can be directed to our Provider Services Department at 1-855-401-8251.

Surgical Procedure Services

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient in the same operative session or on the same day for which separate payment may be allowed. Our company determines reimbursement of surgical procedures upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the subsequent procedures. Reimbursement for more than 5 procedures requires medical record documentation. Pre- and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria.

Anesthesia Services

Highmark Health Options Duals processes anesthesia services based on anesthesia procedure codes only. Anesthesia services should be billed with the correct American Society of Anesthesiologists (ASA) code in the range of 00100-01999, which are included in the CPT manual and reimbursed as time-based anesthesia. All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or more: round up; less than 30 seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in field 24G on the CMS-1500 claim form for all providers who bill in paper format. All anesthesia services should be billed with the appropriate anesthesia modifier.

Hospital Services

Hospital claims are submitted on UB-04 claim forms. To assure that claims are processed for the correct member, the member's identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the remittance advice.

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for electronic claims submissions.

Field #	Description	Requirements
1	Provider Name, Address, City, State, Zip Telephone, Fax, Country Code	Required Facility Name and Physical Address where services were rendered (P.O. Box #s is not acceptable here)
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birthdate	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	Maybe Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	Maybe Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used

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38	Responsible Party Name and Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPSC/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Health Plan Practitioner Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Health Plan Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable

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66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name and Identifiers (Including NPI)	Maybe Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	Maybe Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	Maybe Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	Maybe Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

CMS-1500 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for electronic claims submissions.

Field#	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Health Plan Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Reserved for NUCC Use	Not Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Reserved for NUCC Use	Not Required
9c	Reserved for NUCC	Not Required
9d	Insurance Plan Name or Program Name	Required, If Applicable
10a,b,c	Is Patient Condition Related to: a) Employment b) Auto Accident c) Other Accident	Required, If Applicable
10d	Claim Codes (Designated by NUCC)	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Other Claim ID	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	Other Date	Not Required

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16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a	Other Identification Number of Referring Practitioner	Required, If Applicable
17b	National Provider Identifier (NPI)	Required
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Additional Claim Information (Designated by NUCC)	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Required, If Applicable
21	Diagnosis or Nature of Illness or Injury. (Relate To 24E)	Required
22	Resubmission Code and/or Original Ref. No	Required, If Applicable
23	Prior Authorization Number	Required, If Applicable
24A	Date(s) of Service	Required
24B	Place of Service	Required
24C	EMG	Required, If Applicable
24D	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24E	Diagnosis Code Pointer	Required
24F	Charges	Required
24G	Days or Units	Required
24H	EPSDT Family Plan	Required, If Applicable
24I	ID Qualifier	Required, if applicable
24J	Rendering Provider ID	Required
25	Federal Tax Identification Number, SSN/EIN	Required
26	Patient Account Number	Required
27	Accept Assignment	Required
28	Total Charge	Required
29	Amount Paid (Required when another carrier is primary payer)	Required, If Applicable
30	Reserved for NUCC Use	Not Required

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31	Signature of Physician or Supplier including degrees or credentials/date	Required Health Plan Individual Practitioner Name and Date Required
32	Service Facility Location Information	Required. Facility Name and Physical Address where Services were Rendered Required (P.O. Box #s are not acceptable here.
32a	Name and Address of Facility Where Services Were Rendered (If other than Home or Office)	Required
32b	Other ID#	Required, If Applicable
33	Billing Provider Info and Phone #	Required Facility Name and Physical Address where services were rendered (P.O. Box #s is not acceptable here)
33a	NPI number	Required
33b	Other ID#	Required. If Applicable

Federally Qualified Health Centers (FQHC)

Overview

In accordance with the Centers for Medicare and Medicaid Services (CMS) Highmark Health Options Duals requires FQHCs to submit qualified visits using established specific payment codes. The FQHC Highmark Health Options Duals Billing Guide is ONLY applicable to those practices who are contracted under an Ancillary Services Agreement. FQHCs contracted under an Ancillary Services Agreement are reimbursed at the CMS Prospective Payment System (PPS) rate.

Encounter Definition

Rates are charged for each Encounter. An eligible Encounter is defined as:

Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Family planning encounters and obstetrical encounters are a subset of medical encounters.

Eligible Providers include:

1. Physician (including Podiatrists)
2. Mid-level Practitioners:
 - CRNP (midwife or a licensed nurse practitioner)
 - Licensed Physician Assistant
 - Speech, Physical & Occupational Therapist
 - Audiologist
 - Case Manager
 - Nutritionists

Prospective Payment System (PPS) Methodology for Medicare

Refer to the MLN Matters® Articles for the FQHC to determine the appropriate encounter code that drives the PPS rate payment:

- Article titled MLN Matters Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)
 - MLN Matters® Number: MM8743

For more information visit the FQHC resources webpage at

<https://www.highmarkhealthoptions.com/providers/> and review the FQHC/RHC Annual Training Provider Orientation PowerPoint.

Multiple Encounter Submission

Encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute a single encounter. The following two conditions are recognized for payment of more than one encounter rate on the same day:

1. After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment; and
2. The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.
 - The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters.
 - Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.
 - Include only one encounter per claim. Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, submit one claim for each encounter. On each claim, to indicate it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in field 19 on the CMS-1500 Claim Form or in the Comments field when billing electronically.
 - Documentation for all encounters must be kept in the members’ file.

All participating FQHCs/RHCs providers are required to bill with the following Place of Service Code.

50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
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For services rendered at an FQHC facility, please do not bill with POS 11.

All claims must be billed with the appropriate FQHC qualified encounter code for Medicare. Total charges for the encounter should be billed with appropriately approved qualified procedure code(s) from the current Medicare Fee Schedule. Claims submitted with just the encounter code will not be paid.

All practitioners must come over on the FQHC Provider Change Form or Roster Template and be set up with the plan’s credentialing/claims system prior to rendering services. All FQHCs must have a collaborative agreement on file between the physicians, and extender(s) on staff. For more information on the FQHC Provider Process refer to the Policies and Procedures section of the manual.

Timely Filing

Providers are encouraged to submit initial claims within one hundred and eighty (180) calendar days after the date of service. However, any initial claim not submitted within 180 days must be submitted within three hundred sixty-five (365) days from the date of service. Initial bills submitted after 365 days will be denied as untimely. We prefer to receive claims electronically, but we do accept claims submitted on paper. If you bill on paper, we will only accept paper claims on a UB-04 claim form. No other billing forms will be accepted.

For more information visit the Medicare Website at:

https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.

The UB-04 Claim Form can be found on the provider website at

<https://www.highmarkhealthoptions.com/providers/>.

For more Claims and Billing information, refer to the Claims and Billing Sections:

- Member Billing Policy
- General Information
- Electronic Claims Submission
- Requirements for Submitting Claims to Highmark Health Options Duals through HIPAA 5010
- Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer)
- Claims Review Process
- Coordination of Benefits
- Claim Coding Software
- Billing Procedures
- UB-04 Data Elements for Submission of Paper Claim Forms
- CMS-1500 Data Elements for Submission of Paper Claim Forms

Any claim that has been submitted to our company but does not appear on a remittance advice within sixty (60) days following submission should be researched by calling the Provider Services Department to inquire whether the claim was received and/or processed.

INTEGRATED APPEALS AND GRIEVANCES - Applicable Integrated Plan (AIP)

Introduction

Highmark Health Options Duals encourages its members to let us know right away if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to contact Member Services for assistance.

This section provides an outline of rules for making complaints in different types of situations. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

What Are Integrated Appeals and Integrated Grievances?

Since Highmark Health Options Duals is an integrated plan, meaning it provides both Medicare and Medicaid benefits, appeals and grievances are classified as integrated. Please note that integrated appeals only pertain to medical benefits.

Members have the right to make a complaint if he or she has concerns or problems related to coverage or care. "Integrated appeals" and "integrated grievances" are the two different types of complaints that can be made about the Medicare and/or Medicaid benefits.

An "integrated appeal" can be filed if a member asks Highmark Health Options Duals to reconsider and change a decision we have made about what services or benefits are covered or what we will pay for a service or benefit. A member may file an integrated appeal under these circumstances:

- If we do not cover or pay for services a member thinks we should cover
- If we or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- If a member believes that we are stopping coverage of a service or benefit too soon

A "integrated grievance" is the type of complaint that can be made if a member has any other type of problem with Highmark Health Options Duals or one of our plan providers. For example, grievances may be filed if a member is experiencing a problem regarding the following situations:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior or the behavior of the provider's office staff
- Not being able to reach someone by phone or get the information needed, or
- The cleanliness or condition of a provider's facilities

Generally, grievances should be filed directly with Highmark Health Options Duals, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). The QIO in Delaware is Commence Health. QIO quality of care reviews are discussed on page 124.

Acting as an Authorized Representative

Highmark Health Options Duals will accept integrated appeals or grievances made by the member and/or his/her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his/her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form (AOR) which is located on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/> or an equivalent document.

The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is also valid for any subsequent levels of integrated appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. We will require submission of appropriate documentation, such as a durable power of attorney.

A physician who provides treatment to a member (upon providing notice to the member) may request an integrated appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the integrated appeal; however, the provider may not charge the member a fee for representation. Providers who do not have a contract with Highmark Health Options Duals must sign a "Waiver of Liability" statement that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the integrated appeal. The "Waiver of Liability" can be found on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

It is important to note that the integrated appeals process will not commence until Highmark Health Options Duals receives a properly executed AOR or for payment integrated appeals from non-participating providers, a properly executed Waiver of Liability statement.

AIP Plan Integrated Appeals for Coverage of Other Medical Services

Expedited Integrated Appeals Process and Timeline

An expedited review is available when the member's health or life is at immediate risk or when delays could impair the member's ability to attain, maintain, or regain maximum function

Expedited appeals must be filed within sixty-five (65) calendar days from the date of the adverse benefit notice, unless a written request with a valid reason extends this timeframe. Appeals can be submitted verbally, in writing, via fax, or through the member or provider portal.

We will review expedited appeals promptly and aim to resolve them within 72 hours of receipt, in accordance with the members' health needs.

Standard Integrated Appeals Process and Timeline

Standard appeals must be filed within sixty-five (65) calendar days of the adverse benefit notice, unless an extension is justified with written cause. Appeals may be submitted verbally, in writing, fax or by portal. Participating and non-participating providers can request pre-service standard appeals; non-participating providers with a valid waiver of liability may request post-service payment appeals.

We will make a decision within 30 calendar days for medical or payment issues, and within 7 days for Part B drug appeals, following receipt of a valid appeal.

The review period may be extended by up to 14 calendar days for medical services if requested by the member or if the plan determines an extension is in the member's best interest.

If the appeal is denied, members will receive a written notification detailing the decision and reasons. For cases involving both Medicare and Medicaid, the letter will also inform members of a second-level review with the Independent Review Entity (IRE) and their rights to a State Fair Hearing through Delaware. If the appeal involves Medicare only, the letter will specify that the case has been forwarded to the IRE for a second-level review. For Medicaid-only cases, the letter will explain the members' Fair Hearing rights through the Delaware State Fair Hearing process.

Continuation of Benefits

While the appeal is under review, members may continue receiving care for previously authorized services if they request continuation within 10 days of the adverse notice or before the scheduled change in services. If continuation of benefits is requested by the provider written consent must be obtained from the member. If the final decision upholds the denial, the member may be responsible for costs of services provided during the appeal process. If the final decision favors the member and services were not continued, they will be reinstated within 72 hours for both expedited and standard appeals.

State Fair Hearing Process

Members, their authorized representatives, or providers on behalf of the member have the right to appeal Highmark Health Options Duals' adverse determinations through the State Fair Hearing process. Completion of the internal appeal process through Highmark is a prerequisite. Members may also request a Fair Hearing if Highmark fails to adhere to the required timeline.

To file a State Fair Hearing, the appeal must be submitted in writing within 65 days of the date of the adverse decision notice. Members may request continuation of benefits during this process by submitting a request within 10 days of the adverse notice or before the scheduled change.

If the final decision from the Fair Hearing is not in the member's favor, they may be liable for services already rendered; if the decision is favorable, services will be reinstated within 72 hours.

Members needing assistance with filing a Fair Hearing may contact Highmark Health Options Duals at 1-855-401-8251 (TTY/TDD: 711). To request a Fair Hearing, contact the Delaware Division of Medicaid & Medical Assistance:

Division of Medicaid & Medical Assistance
Fair Hearing Officer
901 North DuPont Highway
P.O. Box 906, Lewis Building
New Castle, DE 19720
Phone: 302-255-9500 or toll-free at 1-800-372-2022
Fax: 1-302-255-9614

Highmark Health Options Duals will participate in the hearing process by presenting and defending our decisions in person or by phone. If the Fair Hearing results in overturning a denial, Highmark will authorize the disputed services within 72 hours of receiving the notice of the decision.

This concludes the final level of appeal for Medicaid benefits. For Medicare appeals at second through fifth levels, procedures are outlined separately

Select Plan: Appeals for Coverage of Other Medical Services

After Highmark Health Options Duals has issued an organization determination, a member or authorized representative may file an appeal. If we deny all or part of a request for coverage of services or payment for services, a member may ask for us to reconsider our decision. This is called a request for reconsideration. A member or authorized representative may call Member Services or file a reconsideration or get assistance in filing. We can also accept written requests for appeal which can be forwarded to the address below or fax to the Appeals Department at 1-833-560-1828. All appeals must be filed within sixty-five (65) calendar days of any initial denial notice. Additional time may be granted for good cause. Any requests for good cause extensions must be completed in writing.

The first step of the appeal process is referred to as a request for reconsideration. If the member's medical condition warrants it, an expedited appeal may be requested. Highmark Health Options Duals' staff will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the initial coverage determination will review the appeal. Members also have the right to obtain and provide additional information as part of the appeal. Additional information in support of the members' appeal may be provided in writing.

For the mailing address, please refer to **Member Appeals & Grievances** under the "Important Addresses" section on page 13.

Information may also be provided by fax at 1-833-560-1828 or by calling Member Services at 1-855-401-8251 to submit a verbal appeal or schedule to submit in person.

Members or authorized representatives also have the right to ask us for a copy of the information that pertains to their appeal. Members may call Member Services at the number listed above in order to make such a request.

For a decision about payment for care already received, the appeal must be finalized by Highmark Health Options Duals within sixty (60) days, which includes payment for the services or forward the appeal to the Independent Review Entity (IRE) for review. For a standard review about medical care not yet provided, we must finalize the appeal within thirty (30) days or sooner if the member's health condition warrants. If the request is for a Medicare Part B prescription drug not yet received, we must finalize the appeal within seven (7) calendar days of receipt of an appeal.

For expedited appeals regarding medical care or Part B drugs, Highmark Health Options Duals has up to 72 hours to make a decision but will make it expeditiously as the enrollee's health condition requires. All adverse reconsideration decisions are automatically forwarded to the IRE for review. Also, if we do not issue a decision within the standard or expedited timeframes as outlined above, the appeal will be automatically forwarded to the IRE for review. The IRE has a contract with CMS and is not part of Highmark Health Options Duals.

When the appeal is for services that have not been received, if the member requests an extension, or

- The extension is justified and in the enrollee's interest due to the need for additional medical evidence from a non-contract provider that may change an MA plan's decision to uphold a denial; or
- The extension is justified due to extraordinary, exigent, or other non-routine circumstances.

We cannot take extra time when the appeal is for a Part B prescription drug.

Upon completion of the reconsideration, all parties to the appeal will be notified of the outcome. If the decision is a denial, the member or authorized representative will be verbally notified that their appeal has been forwarded to the IRE.

Both AIP and Select Medicare Appeals

Highmark Health Options Duals will automatically forward all adverse reconsideration decisions to the IRE. The member may request a copy of the file that is provided to the IRE for review. The IRE will notify the member of the receipt of the appeal, review the request and make a decision about whether we must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision, if the appeal is for a Part B prescription drug or part D drug the IRE must decide within seven (7) calendar days. For expedited appeals regarding medical care, the IRE has up to 72 hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the members' best interest. The IRE cannot take an extension if the appeal is for a Part B prescription or Part D drug.

The IRE will issue its decision in writing to the member or authorized representative and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge (ALJ).

IRE Review

Highmark Health Options Duals will automatically forward all adverse reconsideration decisions to the IRE. The member may request a copy of the file that is provided to the IRE for review. The IRE will notify the member of the receipt of the appeal, review the request and make a decision about whether we must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision, if the appeal is for a Part B prescription drug or part D drug the IRE must decide within seven (7) calendar days. For expedited appeals regarding medical care, the IRE has up to 72 hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the members' best interest. The IRE cannot take an extension if the appeal is for a Part B prescription or Part D drug.

The IRE will issue its decision in writing to the member or authorized representative and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge (ALJ).

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Appeals Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Highmark Health Options Duals coverage of a hospital stay is ending too soon, the member or his or her authorized representative can file an integrated appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS). The QIO for the state of Delaware is Commence Health. The QIOs are groups of health professionals that are paid to handle this type of integrated appeal from Medicare patients. When such an integrated appeal is filed on time, the stay may be covered during the integrated appeal review. One must act very quickly to make this type of integrated appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his/her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the integrated appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than midnight of discharge date and before leaving the hospital. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one (1) calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no

financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or authorized representative asks us for an expedited integrated appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited integrated appeal decision. If the expedited integrated appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited integrated appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an Independent Review Entity (IRE) review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can file an integrated appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the integrated appeal review if filed on time.

If Highmark Health Options Duals and/or the care provider decide to end coverage for SNF, HHA or CORF a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two (2) calendar days before coverage ends or the second to the last day of service if care is not being provided daily (such as HHA). The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an integrated appeal of a termination of coverage. As will be explained in the notice referenced above, the member or his or her authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Highmark Health Options Duals provides to the QIO. It is very important that the provider immediately faxes all of the

members' medical records to the QIO for their review. Highmark Health Options Duals will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one (1) full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, Highmark Health Options Duals will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor Highmark Health Options Duals will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his/her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited integrated appeal. It is important to note that if the member or authorized representative requests an expedited integrated appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Highmark Health Options Duals staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Appeals for Coverage of Part D Drugs

Highmark Health Options Duals encourages its members to contact us through Member Services with any questions, concerns, or problems related to prescription drug coverage. As with medical services, we also have processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feel that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling 1-800-213-7083. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

An "appeal" is any part of the procedures that deal with the review of an unfavorable coverage determination. A member or his/her authorized representative may file an appeal if he/she wants us to reconsider and change the decision we have made about what Part D prescription drug benefits are covered or what we will pay for a prescription drug. This is called a redetermination.

It is important to note that if Highmark Health Options Duals approves a member's exception request for a non-formulary drug, the member may not request an exception to the copayment that applies to that drug.

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Problems getting a Part D prescription drug that may be addressed by an appeal are as follows:

- If the member is not able to get a prescription drug that may be covered.
- If a member has received a Part D prescription drug that may be covered but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- If a member disagrees with the copayment amount.
- If coverage of a drug is being reduced or stopped.
- If there is a requirement to try other drugs before the prescribed drug is covered
- If there is a limit on the quantity or dose of the drug.

There are several steps that members may use to request care or payment from Highmark Health Options Duals. At each step, qualified personnel evaluate the request, and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options available.

After Highmark Health Options Duals has issued a coverage determination, a member or authorized representative or prescribing physician or other prescribers may file an appeal, also commonly referred to as a request for redetermination. All appeals must be filed within sixty-five (65) calendar days from the date of the coverage determination. If the member's life, health, or ability to regain maximum function is in jeopardy, an expedited appeal may be requested. Our associates will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the members' appeal may be provided in writing.

For the mailing address, please refer to Member Appeals & Grievances under the "Important Addresses" section on page 13.

Information may also be provided by fax 1-833-560-1828 OR call Member Services at 1-855-401-8251 to submit a verbal appeal or schedule to submit in person.

Members also have the right to ask us for a copy of the information that pertains to their appeal. Members or Providers may reach the Member Services as indicated above in order to make such a request.

Upon completion of the redetermination, the member and parties to the appeal will be notified of the decision. For a standard pre-service decision about a Part D drug, we have up to seven (7) calendar days to issue a decision and authorize the drug in question. If the member's health condition requires it, the decision will be issued sooner. If we do not issue a decision within seven (7) calendar days, the request will automatically be forwarded to the Independent Review Entity (IRE) for review.

If the request is for reimbursement for a Part D Drug that has already been decided, then we must authorize payment for the benefit within 14 calendar days from the date it receives the

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request and make payment (i.e., mail the payment) no later than thirty (30) calendar days after the date we received the request.

For an expedited appeal regarding Part D drugs that have not been provided, we have up to seventy-two (72) hours to issue a decision and authorize the requested medication. However, the plan will make the decision as expeditiously as the enrollee's health condition requires. If an expedited appeal was requested and Highmark Health Options Duals does not comply with the seventy-two (72) hour timeframe, the case will automatically be forwarded to the IRE for review.

If the redetermination does not result in the approval of the drug under review, the member may ask for review by an IRE. It is important to note that IRE review of Part D drug denials is not automatic as it is for medical services. The IRE has a contract with the federal government and is not part of Highmark Health Options Duals.

See above for information on the IRE, ALJ, MAC, and Judicial Review process

Amount in Controversy, Federal Minimum Requirements for Filing

Integrated appeal Level	Calendar Year 2025	Calendar Year 2026
ALJ Hearing	\$190	\$190
Judicial Review	\$1,900	\$1,900

Member Integrated Grievances

An integrated grievance is different from an integrated appeal in that it usually does not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the integrated appeals processes. The grievance process is only available to members or their representatives. The member integrated grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- The cleanliness or condition of a network pharmacy.
- If a member disagrees with our decision not to expedite a request for coverage determination.
- If Highmark Health Options Duals does not provide a decision within the required timeframe.
- If Highmark Health Options Duals does not forward a case to an IRE if we do not comply with required timeframes for reconsideration.
- If Highmark Health Options Duals does not provide the member with required notices.

Members also have the opportunity to file expedited grievances under certain conditions-see page 123.

Members are encouraged to contact our Member Services first in order to be provided with immediate assistance. Our associates will try to resolve any complaint over the telephone. If a written response is requested, one will be provided. If our Member Services staff is not able to

resolve the telephone complaint, we will provide a written response to the member. Highmark Health Options Duals employs a formal, multi-disciplinary process to review member grievances. Members may file an integrated grievance by calling our Member Services Department or by writing to Highmark Health Options Duals.

For the mailing address, please refer **Member Appeals & Grievances** under the “Important Addresses” section on page 13.

Information may also be provided by fax at 1-833-560-1828 or by telephone at 1-855-401-8251.

If the member would like to have someone else file an integrated grievance on their behalf, an Appointment of Representative Form (AOR) must be completed. The form is located on the Highmark Health Options Duals website at <https://www.highmarkhealthoptions.com/providers/>.

Upon receipt of any standard grievance, we will send the member an acknowledgement letter. The acknowledgement letter will include details of the member’s grievance, explain the integrated grievance process and inform the member of their rights during the integrated grievance process.

Standard Integrated Grievances

The member or the authorized representative will have the opportunity to submit any information, documentation or evidence regarding the grievance. Highmark Health Options Duals will conduct a full and thorough investigation of the substance of the complaint including any aspect of clinical care involved. The member or the member’s representative will be notified orally or sent a written response as quickly as the case requires based on the member’s health status, but no later than thirty (30) calendar days after receiving the grievance. We may extend the timeframe by up to fourteen (14) calendar days if the member requests the extension or if we justify a need for additional information and the delay is in the member’s best interest.

Expedited Integrated Grievances

Highmark Health Options Duals also has a process in place when it may be necessary to expedite the review of an integrated grievance because the member’s life, health, or ability to regain maximum function is in jeopardy. Members may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a Reconsideration.
- When we have refused to grant a member’s request for an expedited Organization Determination.
- When we have refused to grant a member’s request for an expedited Reconsideration (Integrated appeal).

The circumstances outlined above are the only times that an expedited integrated grievance review is available. When an expedited integrated grievance is filed, we will take prompt, appropriate action, including a full investigation within 24 hours of receiving the request. The member or representative will be notified of the decision by telephone within 24 hours of filing the Expedited Grievance, and a letter explaining the decision will follow within two (2) days.

Quality Improvement Organization Review

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by Highmark Health Options Duals under the internal integrated grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's integrated grievance process. For any complaint filed with the QIO, Highmark Health Options Duals must cooperate with the QIO in resolving the complaint this includes directing providers to respond to QIO requests for information within fourteen (14) calendar days.

How to File a Quality-of-Care Complaint with the QIO

QIOs are assigned regionally by CMS. For members who reside in Delaware, quality of care complaints filed with the QIO must be made in writing to the following addresses:

BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450
Phone: 1-888-396-4646
Fax: 1-855-236-2423
TTY: 888-985-2660

Member Grievances for Select Plan

The Highmark Health Options Duals Select is a Medicare plan only. The grievance process pertains only to the Medicare covered benefits, but the process will be the same as above with the following exceptions:

- The grievance must be received within 60 days of the incident that prompted the complaint
- For the expedited grievances Highmark Health Options Duals Select will send written responses within three (3) days of the oral notification.

Clinical Provider Integrated appeals

All providers participating with our health plan may file a formal provider integrated appeal to request the review of any post-service denial for payment denied due to medical necessity or for lack of prior authorization. This process is intended to afford providers with the opportunity to address issues regarding payment only. Integrated appeals for services that have not yet been provided must follow the Member Reconsideration or Redetermination processes above. The formal Provider Integrated appeal Process must be initiated by the provider through a written request for an integrated appeal.

For the mailing address, please refer to **Clinical Provider Integrated appeals** under the “Important Addresses” section on page 13 or fax to 1-833-560-1828.

Providers who are non-contracted with Highmark Health Options Duals may also file an integrated appeal; however non-contracted providers must follow the member integrated appeals process for reconsiderations as outlined above.

Clinical Provider Integrated Appeal Process

First Level Provider Integrated appeal

1. To request a provider integrated appeal, providers must make a written request for integrated appeal which must be received by the plan within:
 - a. Sixty (60) calendar days of the date of their denial notice denying an authorization unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
 - b. One hundred and eighty (180) calendar days of the date of their denial notice denying a post- service claim unless otherwise negotiated by contract. When an authorization has been denied, provider must adhere to the sixty (60) calendar-day time frame, the one hundred and eighty (180) calendar days once the claim has denied does not apply.
2. When submitting a written request for an integrated appeal, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the integrated appeal, and the member’s medical records containing all pertinent information regarding the services rendered by the provider.
3. All first level provider integrated appeal reviews will be completed within sixty (60) calendar days of the date the written request was received.
4. The provider will be informed of the decision in writing by mailing/faxing notification within sixty (60) calendar days from receipt. This notification will include additional integrated appeal rights as applicable (i.e., Second Level Provider Integrated appeal- see below). If the integrated appeal is approved, payment will be issued within sixty (60) calendar days of notification.

Second Level Provider Integrated appeal

1. If the provider is not in agreement with the first level provider integrated appeal committee's decision, the provider may seek a second level provider integrated appeal. A request for a second level provider integrated appeal must be submitted to the plan in writing within sixty (60) calendar days of the date on the first level provider integrated appeal decision letter, or as otherwise indicated via contract. All second level provider integrated appeal requests must include specific reasons as to why the provider does not agree with the plans' first level provider integrated appeal committee's decision along with any additional supporting documentation.
2. All second level provider integrated appeal reviews will be completed within sixty (60) calendar days from the date the second level provider integrated appeal request was received.
3. The second level integrated appeal committee will inform the provider of its decision in a written/fax decision notice within sixty (60) calendar days. This is the final level of integrated appeal, and the decision is binding, unless otherwise governed per contract.

MODEL OF CARE

Website location: <https://www.highmarkhealthoptions.com/providers/>

Overview

As a Special Needs Plan (SNP), Highmark Health Options Duals is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC) Plan. In accordance with CMS guidelines, Highmark Health Options Duals' SNP MOC Plan is the basis of design for our care management policies, procedures and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals.

Highmark Health Options Duals has a MOC that has goals and objectives for the targeted populations, a specialized provider network, uses nationally recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and adds services for the most vulnerable beneficiaries including, but not limited to, those beneficiaries who are frail, disabled, or near the end-of-life.

The SNP MOC includes four main sections: Description of the SNP population (General Population), Care Coordination, Provider Network, and MOC Quality Measurement and Performance Improvement. This SNP Provider Network section explains what Highmark Health Options Duals expects from their providers.

Provider Network

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP provider networks.

This MOC section contains three Elements:

- Specialized Expertise
- Use of Clinical Practice Guidelines and Care Transition Protocols
- MOC Training for the Provider Network

Within the above elements, Highmark Health Options Duals' expectations of providers are explained in detail. The below is a summary of Highmark Health Options Duals' provider network composition and responsibilities.

1. Highmark Health Options Duals expects all network practicing providers to utilize the most current up to date clinical practice guidelines when providing care to members to ensure the right care is being provided at the right time, as well as to reduce inter-practitioner variation in diagnosis and treatment.
2. Highmark Health Options Duals encourages practitioners to follow the adopted clinical practice guidelines but allows the practitioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed utilizing national clinical criteria.

3. During a care transition, it is expected that the transferring facility will provide a discharge summary and care plan information to the receiving facility **within one business day**. Members who are transitioning home should receive a copy of their discharge summary and care plan at the time of discharge. A copy should be sent to the primary care physician (PCP) **within one business day**.
4. Highmark Health Options Duals expects all network practicing providers to receive and [attest](#) to MOC training annually. If there is a trend of continued non-attestation, those providers found to be non-compliant with the Model of Care may be targeted for potential clinical review. For those non-compliant providers, individual results such as, but not limited to, utilization patterns, hospital admissions, readmissions and HEDIS performance outcomes may be reviewed. If there are issues identified, a Corrective Action Plan may be requested.
5. Highmark Health Options Duals conducts medical record reviews at least annually and expects all network providers to respond to record requests timely. Reviews are conducted on PCPs, Specialty Care Practitioners, Behavioral Health Practitioners, and Ancillary providers. Results from the review are communicated to providers and include opportunities for improvement and education as needed.
6. Highmark Health Options Duals encourages providers to participate in Interdisciplinary Care Team (ICT) meetings. As a provider, you are an important part of the member's ICT. The ICT members conduct a clinical analysis of the member's identified level of risk, needs, and barriers to care to develop an Individualized Care Plan (ICP), which will be reviewed with the member. The ICT analyzes, modifies, updates, and discusses new ICP information with the member and providers as a team, when appropriate. Providers can request an ICT meeting for their members by calling 1-855-401-8251 (TTY: 711).
7. Highmark Health Options Duals provides multiple ways for providers to receive information about Highmark Health Options Duals updates. Provider manuals and newsletters are located on the Highmark Health Options Duals provider portal and webpage. Newsletters are updated quarterly and provide information regarding any new clinical programs or updates that would affect the provider's communication with their direct pod or ICT. Provider manuals are updated annually and provided during annual trainings. The manuals are also available on our provider website.
8. The following are functionalities available via the Provider Portal:
 - Automated ICT communications.
 - Care Plans generated or updated by the ICT
 - Discharge reports
 - Quarterly Performance dashboards that show gaps in care and chronic conditions
 - Secure messaging is also available to have open dialog between providers and internal staff who are part of the member's ICT.

9. Highmark Health Options Duals expects provider directories to be continuously updated such as changes to the office address, phone numbers, office hours, hospital affiliations, and acceptance of new patients.

Common MOC Terms and Definitions:

Members may ask you about the following information that is routinely discussed with their care manager.

Health Risk Assessment (HRA) Survey: Highmark Health Options Duals uses the HRA to provide each Medicare member a means to assess their health status and needs as well as priorities to improve their health by promoting positive behaviors. The HRA is also used by the care managers to provide an assessment of risk that can generate referrals for clinical programs. Newly enrolled members identified by the Centers for Medicare and Medicaid Services (CMS) on a monthly enrollment file are requested to complete an initial HRA within ninety (90) days of their effective date as required by CMS Model of Care standards. Existing members are required to complete an HRA within 12 months of the last completed HRA or the member's enrollment date if there is no completed HRA on record.

Individualized Care Plan (ICP): Highmark Health Options Duals utilizes the information collected from the HRA as well as other available clinical data, such as claims and encounters, to create a care plan that is individualized to each member's needs and priorities. The ICP will be created in conjunction with the member and/or caregiver to ensure it includes consideration of the member's personal care preferences, self-management goals and objectives. At a minimum, a completed ICP will contain:

- Services and interventions specifically tailored to the member's Health-related social needs (HRSN) and Social Determinants of Health (SDoH) needs
- Documentation of the member's personal healthcare preferences (as appropriate)
- Member self-management goals and objectives (as appropriate)
- Clearly defined goals with measurable outcomes
- Progress and action toward the goals
- Whether the goals have been "met" or "not met"
- Appropriate alternative actions if "not met"

Interdisciplinary Care Team (ICT): Member care routinely demands a combination of efforts from physicians of various disciplines, registered nurses, and licensed social workers, as well as other pertinent skilled health care professionals and paraprofessionals. Comprehensive patient care planning involves coordination, collaboration and communication between this ICT and the member. Highmark D-SNP Provider Portal should be utilized frequently for any communications regarding members, their ICP, or ICT.

Other Important Information about Our Model of Care

All Members have an assigned Care Manager. If you need to reach them about care plans, request additional support for your member, or schedule a formal ICT meeting, Care Coordination can be reached at the following number: 1-855-401-8251 (TTY: 711). Specific questions regarding the Model of Care Plan should be addressed with your Highmark Health Options Duals' Provider Representative.

***Action Required** – Please go to <https://www.highmarkhealthoptions.com/providers/model-of-care> Fill out the provider information at the bottom of the page after reviewing the MOC training. Click agree to acknowledge you have reviewed and understand Highmark Health Options Duals' Model of Care Information and submit your attestation.

PREVENTIVE HEALTH, DISEASE, AND CARE MANAGEMENT

Highmark Health Options Duals Preventive Health, Disease, and Care Management Programs are designed to promote early identification, intervention, and ongoing support for members across the continuum of care.

These programs focus on preventing disease progression, improving health outcomes, and enhancing quality of life through proactive outreach, education, and coordinated care.

All programs are developed and administered in alignment with federal, state, and accreditation standards, ensuring consistency, quality, and compliance across all participating populations and lines of business.

Preventive Health

Highmark Health Options Duals focuses on the importance of health screening and early detection of diseases. Key interventions include:

- Reminders for Preventive Health screenings
- Telephonic outreach to assist members in scheduling mammograms when needed.
- Notifications to physicians about members overdue for mammograms and/or Papanicolaou test (i.e., PAP smears)
- In-home A1c and colorectal cancer screening kits for members
- Member newsletters with articles focusing on the importance of Preventive Health
- Health screening information on the Highmark Health Options Duals website

Disease Management

Highmark Health Options Duals Disease Management Program offers comprehensive support to providers in managing members with chronic conditions and those at risk of developing them.

This program promotes evidence-based care, aiming to improve member health outcomes and enhance their overall quality of life. Participating members gain access to a variety of clinically validated resources, including guidelines, educational materials, and tools that facilitate care coordination and provider collaboration. The program specifically targets key areas:

- Cardiovascular
- Gastrointestinal
- Pulmonary
- Metabolic
- Renal

Through education, proactive outreach, and coordinated care, it supports the management of both acute and chronic conditions. By emphasizing individualized, member-centered care, Highmark Health Options Duals Disease Management Program seeks to improve clinical outcomes, reduce avoidable hospitalizations, and strengthen continuity of care.

It fosters collaboration among providers, members, and interdisciplinary care teams to ensure a coordinated approach to managing complex needs, preventing complications, and promoting sustained patient wellness.

Care Management

The goal of Care Management, i.e. Care Coordination, is to address medically or socially complex conditions by enhancing the integration of services to improve health outcomes and prevent disease.

The Care Coordination team consists of licensed nurses and social workers with expertise in various areas such as special needs members (pediatric and adults), human immunodeficiency virus/acquired immunodeficiency syndrome, substance use, chronic physical/behavioral conditions, health and wellness. Their diverse backgrounds enable them to provide comprehensive support tailored to the specific needs of individuals.

Care Coordination is a multifaceted process that plays a crucial role in ensuring members receive comprehensive and effective care. By integrating assessment, planning, coordination, and advocacy, Highmark Health Options Duals healthcare professionals tailor interventions to meet individual needs, improve outcomes, and prevent complications. Early intervention is key to expanding treatment options and managing conditions proactively, which can significantly enhance an individual's quality of life and overall health.

Core Components of Care Coordination

- **Assessment:** Evaluating member needs and resources.
- **Planning:** Developing a care plan tailored to the members' needs.
- **Intervention:** Implementing the care plan and facilitating linkage to necessary services that promote comprehensive coordination of benefits for optimal member experience and outcome.
- **Quality Monitoring:** Tracking the effectiveness of interventions and services.
- **Evaluation/Reassessment:** Reviewing and adjusting the care plan as needed based on patient progress and changing needs.

Responsibilities of Care Coordination

- **Liaison Activities:** Coordinating with healthcare practitioners, social service agencies, advocacy groups, and other relevant organizations.
- **Complex Case Management:** Managing the care of individuals with complex conditions/diseases or serious needs.
- **Service Coordination:** Ensuring seamless integration of services across various care providers, including primary, specialty, ancillary, and behavioral health services.
- **Social Service Access:** Helping members navigate city, county, and state agencies for ongoing social services affecting medical access.
- **Transitions:** Managing the transition of care from hospital to home, ensuring continuity and support.

Referrals to Care Coordination

Referrals to Care Coordination are appropriate for individuals facing:

- **Serious and complex medical needs:** Adults or children with multiple or severe medical conditions requiring comprehensive management.
- **Behavioral Health or Substance Use Issues:** Individuals struggling with behavioral health disorders or substance use that necessitate integrated care and support.
- **Health-Related Social Needs/Social Determinants of Health Concerns:** Problems such as social isolation, food insecurity, inadequate housing, transportation issues, or exposure to domestic violence that impact their overall well-being and access to care.

These criteria help members who would benefit from coordinated efforts to address their complex needs and improve their health outcomes.

Transitions from Hospital to Home

The transition from hospital to home can be challenging. Highmark Health Options Duals goal is to minimize confusion and support members effectively during this critical period. To facilitate a smooth transition, Highmark Health Options Duals Care Coordination initiates contact with the patient while they are still in the acute care setting and focuses on these key areas:

- **Follow-Up Appointments:** Ensuring members make and keep follow-up appointments with their healthcare providers.
- **Home Health Care Needs:** Assessing and arranging medically necessary home health services to support recovery.
- **Durable Medical Equipment:** Coordinating the acquisition of any needed medical equipment for home use.
- **Transportation:** Discussing and arranging transportation options for follow-up appointments.
- **Gaps in Care and Preventive Screenings:** Identifying and addressing any gaps in care, including coordinating preventive screenings.

Highmark Health Options Duals Care Coordination team is dedicated to comprehensive patient support, focusing on essential aspects such as medication adherence, appointment management, and ensuring transportation needs are met.

Wellness Programs

Highmark Health Options Duals offers key wellness programs through Care Coordination: the Healthy Weight Program and the Diabetes Prevention Program. By referring eligible Highmark Health Options Duals members to Care Coordination, you can connect them with valuable resources and personalized support to help them achieve their health goals and prevent chronic conditions.

Healthy Weight Program

The Healthy Weight Program provides comprehensive support for members in achieving and maintaining a healthy weight. The program offers personalized guidance, nutritional education, and resources, so members can effectively manage their weight, make informed

decisions, and improve their overall well-being. This program empowers members to take an active role in their weight management journey.

Diabetes Prevention Program

The Diabetes Prevention Program equips at-risk members with the tools they need to prevent or delay the onset of type 2 diabetes. They'll connect with trained lifestyle coaches and a supportive community where they'll learn strategies for healthy eating, physical activity, and stress management. This program complements your clinical care by providing the lifestyle support necessary for members to achieve lasting health improvements.

Provider Referrals to Disease, Care Management, and Wellness Programs

Providers can refer members to Highmark Health Options Duals Disease, Care Management, and Wellness Programs (specific qualifications apply) for assistance in managing their healthcare needs.

Care Coordination staff are available Monday through Friday, from 8:00 AM to 5:00 PM, at 1-855-401-8251 to provide care coordination and support. Participation is voluntary, and members can opt out at any time by contacting Highmark Health Options Duals.

For assistance outside of business hours or on holidays, please call Provider Services at 1-855-401-8251 or refer to the Quick Reference section in this manual.

INTRODUCTION TO CREDENTIALING

Who is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), master's level and Doctor of Psychology (Ph.D.), Doctor of Philosophy (Ph.D.) and Clinical Social Workers and other medical practitioners and behavioral healthcare specialists as deemed appropriate. (This listing is subject to change.)

Extenders: Physician Assistant (PA), a Certified Nurse Midwife (CNM), a Certified Registered Nurse Practitioner (CRNP), Master level Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Hospice, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, FQHCs, Rural Health Clinics (RHC) and Facilities providing mental health and substance misuse services. (This listing is subject to change.)

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, but not limited to, malpractice histories, quality of care concerns and licensure status. Our company prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Credentialing Standards

Highmark Health Options Duals has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DMMR, and NCQA standards. Highmark Health Options Duals adherences to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.

All information must be current and up to date to begin the credentialing process. Therefore, it is important to provide us with your CAQH ID on a completed Provider Data Form and submit all attachments in a timely manner with the most current information available. We will obtain your most current application through the CAQH database.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Highmark Health Options Duals participating supervising practitioner. This agreement must adhere by state specific regulations for collaborative/written agreements for extenders. Any time there is a change in the extender's supervising physician, the extender will be required to submit a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter.

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Where applicable, the submittal of the collaborative/written agreement must include a copy of the letter of approval from the State and if applicable per the collaborative/written agreement, a DEA is required.

Highmark Health Options Duals standards include, but are not limited to the following:

- A current, unrestricted license.
- Fully completed and attested CAQH application
- National Provider Identifier (NPI) number
- Curriculum Vitae and/or Work History to include month and year
- Copy of current, unencumbered DEA certificate, if applicable
- Acceptable malpractice history as subject to decision by our company's Medical Directors and Legal Counsel
- Unexpired professional liability coverage as mandated by state law, of no less than \$500,000 per occurrence, \$1,500,000 per aggregate and coverage provided by the Medical Care Availability and Reduction of Error Fund (Mcare) or Federal Tort Coverage
- Active participation in the Medicare and/or Medical Assistance Programs; free of sanctions
- Foreign graduates must submit an ECFMG certificate
- Other items as deemed appropriate

The credentialing/recredentialing process involves primary sourced verification of practitioner credentials.

The Credentialing Department will notify practitioners, in writing, within forty-five (45) calendar days of receiving any information obtained during the credentialing or recredentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of our company's notification to submit written corrections and supporting documentation to the Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application, or a copy of the credentialing criteria. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by Certified Mail, overnight mail or carrier to the practitioner within ten (10) business days from the date that the Credentialing Department received the request.

All practitioners must be recredentialed at least every three (3) years in order to continue participation within our company. This helps to ensure continued compliance with National Committee for Quality Assurance (NCQA), Center for Medicare and Medicaid Services (CMS) and the Department of Health (DOH), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

We are committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in our Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and Performance Monitoring

Our company's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt-out Listing (CMS), CMS Preclusion Listing, and applicable state disciplinary reports. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB)/Healthcare Integrity Practitioner Data Bank (HIPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a participating practitioner is found on the OIG, Medicare Opt-Out List, Medicare/Medicaid sanction/exclusion listing or applicable state disciplinary action report, the practitioner's file is immediately pulled for further investigation. Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

The credentialing department monitors member complaints as part of the recredentialing process on a monthly basis. The credentialing department receives complaint reports, which reveals member complaints filed against practitioners as well as trends in those complaints. If the complaint is deemed viable by the reporting area, it is documented in the reports. Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Our recredentialing process includes a comprehensive review of a practitioner's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Practitioner Absences

Highmark Health Options Duals continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify us in writing that the practitioner is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Credentialing Department will not terminate the practitioner called to active duty, on maternity leave or on an approved sabbatical, if appropriate coverage is in place. Practitioner/practitioner's office should notify us of the practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Credentialing Department will

determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, it must be completed within sixty (60) calendar days of the practitioner resuming practice.

Denial and Termination

In accordance with Highmark Health Options Duals' business practices, the inclusion of a practitioner in our Provider Network is within the sole discretion of our company.

We conduct credentialing in a non-discriminating manner and do not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. We understand and abide by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner does not meet our baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for recredentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Highmark Health Options Duals' Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Practitioners who want to request a review of a termination, other than for quality-of-care concerns, must submit a written request for the review along with any supporting documentation to us within thirty (30) calendar days of the date of the certified notification.

Delegated Credentialing

Delegation is the formal process by which Highmark Health Options Duals has given other entities the authority to perform credentialing functions on our behalf. We may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets our program requirements. The delegated entity has authority to conduct specific activities on behalf of our company. We have the ultimate accountability for the quality of work performed and retain the right to approve, suspend, or terminate the practitioners and site. Any further sub-delegation shall occur only with our approval and shall be monitored and reported back to us.

NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Health Options Duals such as routine eligibility, benefits and claims status inquiries.

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology for Highmark Health Options Duals.

VSP is a separate company that administers the vision benefit(s) for Highmark Health Options Duals.

United Concordia Dental is a separate company that administers the dental benefit(s) for Highmark Health Options Duals.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is a separate company that administers the hearing aid benefit(s) for Highmark Health Options Duals.

Findhelp is a separate company that gathers community-based organization resources for Highmark Health Options Duals.

Home and Community Services is a separate company that administers prior authorization for certain services for Highmark Health Options Duals.

Change Healthcare is a separate company that administers E&M audits, education and probe audit expansion for Highmark Health Options Duals.



800 Delaware Avenue, Suite 900
Wilmington, DE 19801

How to Contact Highmark Health Options Duals
1-855-401-8251 (TTY: 711) or 1-800-232-5460

**How to Contact Highmark Health Options
Duals Select**
1-844-722-5837 (TTY: 711) or 1-800-232-5460

Provider Services Hours of Operation
Monday–Friday, 8 a.m.–8 p.m.

**How to Find Participating Providers
or Pharmacies**
highmark.com/hhoduals/de

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