Welcome

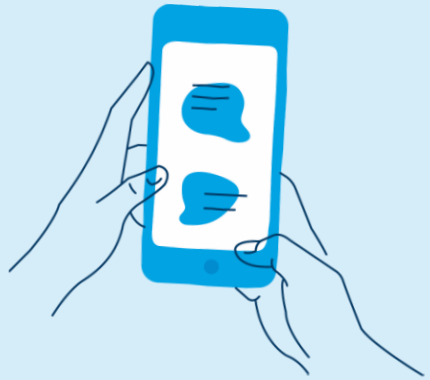
21st Century Cures Act

All Delaware network providers must be enrolled in the Delaware Medical Assistance Program (DMAP).

This applies to all Highmark Health Options (HHO) network providers who furnish, order, refer, or prescribe items or services to Delaware Medicaid members.

Providers should have received a notice from DMAP to attest or complete a new Provider Enrollment Application.

- If you have not received a letter or responded to the request, please reach out to Gainwell Technologies.
- Failure to timely fulfill this requirement will result in termination and/or non-payment of claims.



Contact Gainwell Provider Services with questions about DMAP enrollment applications on the Provider Portal.

1-800-999-3371

Option **0**, then Option **4**.

or

DelawarePret@GainwellTechnologies.com

Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.

Appeals and Grievances Provider Forum

HIGHMARK HEALTH OPTIONS

Agenda

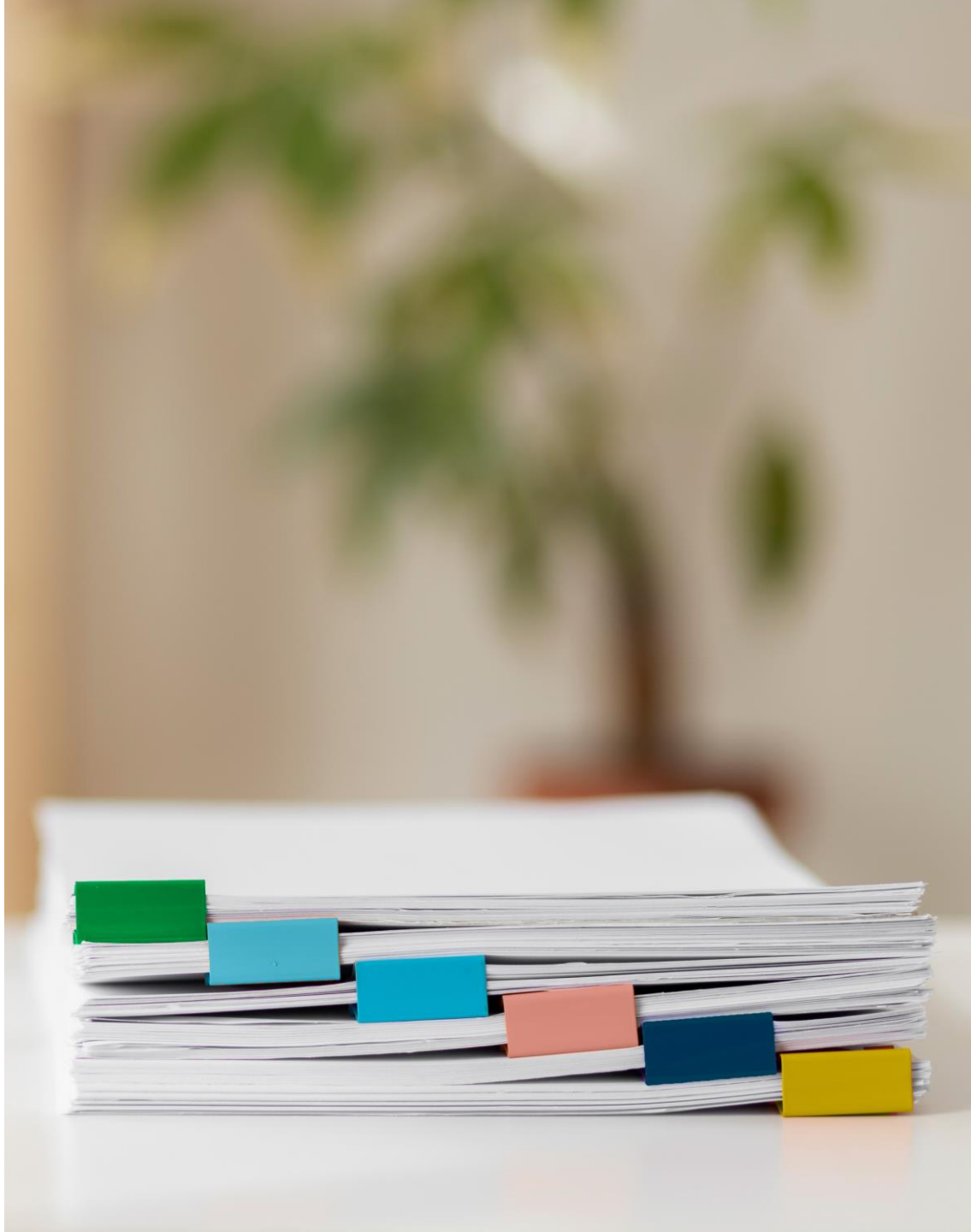
- Member Appeals
- Provider Appeals
- Quantity Limits
- Genetic Testing
- Prior Authorization – Claim Mismatches
- Submitting Clinical Documentation
- Balance Billing
- Written Consent for Appeal
- QOC Grievances & Critical Incidents

Member Appeals

HIGHMARK HEALTH OPTIONS

Member Appeal

A member appeal is the review of an adverse benefit determination.



Adverse benefit determination

The denial or limited authorization of a requested service including determinations based on the type or level of services.

Member Appeal

- Appeals for services or items that have not yet been provided or are considered concurrent must follow the Member Appeal process.
- Must be filed within **60 calendar days** from the date on the initial denial letter.

Member Appeal

Standard member appeals:

- Processed within **30 calendar days.**

Expedited member appeals:

- Processed within **72 hours.**

Member Appeal: Signed Consent

Every member appeal must have a consent for the provider to file on the member's behalf.

HHO cannot begin the appeal process until a member has signed a consent form allowing you to file an appeal on the member's behalf.

Member Appeal

Member Appeal requests can be submitted via:

Fax: 833-841-8074

Mail: Highmark Health Options
Attn: Member Appeals
P.O. Box 106004
Pittsburgh, PA 15230

Consent form must be included with appeal information.

Provider Appeals

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Provider Appeal

- A provider appeal is typically submitted for the denial of payment for services rendered for various reasons, such as:
  - Services determined to be medically unnecessary.
  - Improper billing procedures.
- All provider appeals are post service (service has already been rendered).
- Providers may file an appeal to request the review of **a denied claim or service**.
  - This process is for Medicaid participating and non-participating providers.

Provider Appeals

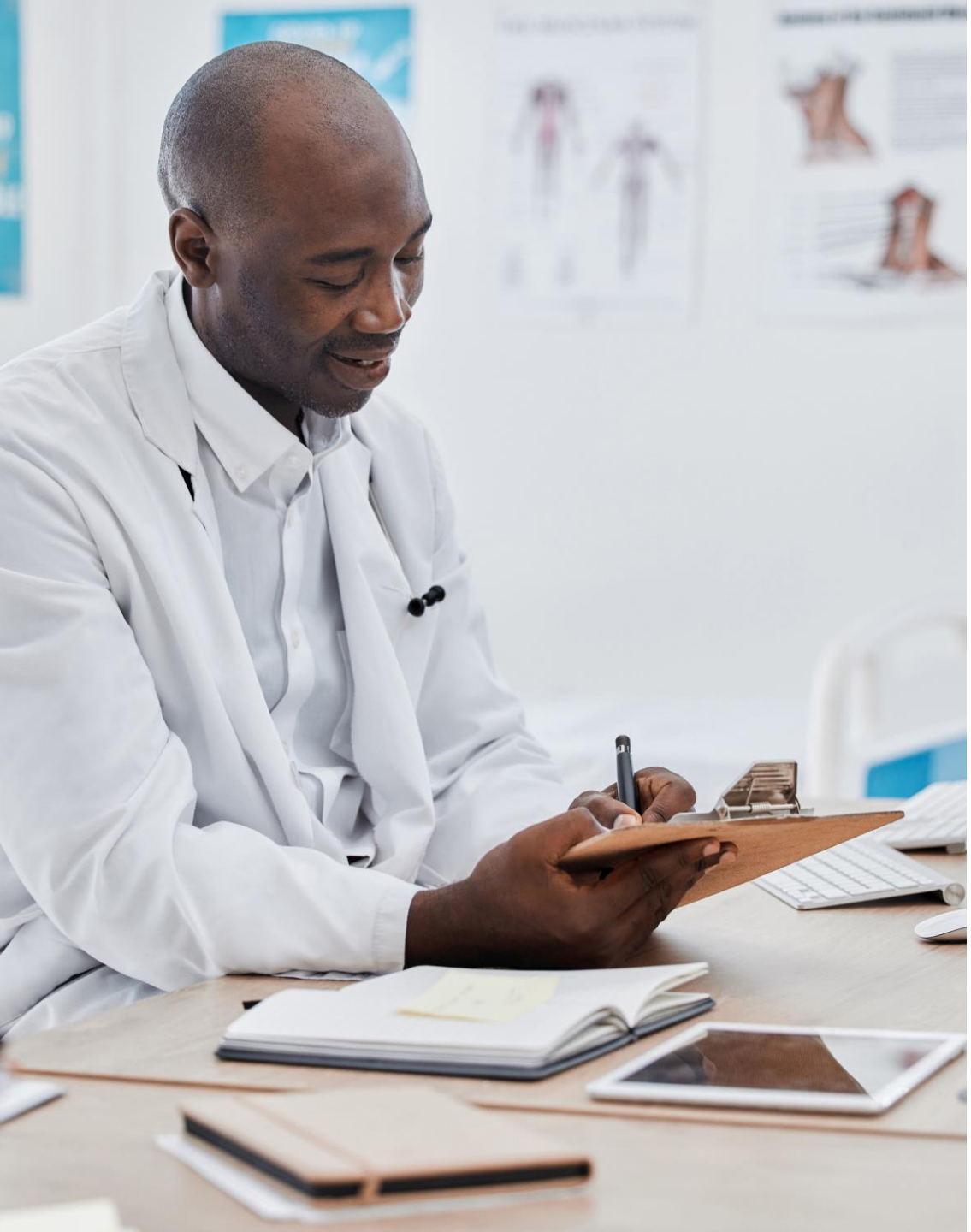
Provider appeal filing timeframe:

- Denied authorization: **60 calendar days**
- Denied claim: **180 calendar days**

Appeals and Grievances processing timeframe:

- **60 calendar days**

A claim must be submitted and a denial received before a provider appeal can be submitted and processed. Submitting an appeal prior to receiving a claim denial will result in an administrative denial.



Provider Appeals

- A claim must be submitted, and a denial received, before a provider appeal can be submitted and processed.
- Submitting an appeal prior to receiving a claim denial will result in an administrative denial.

Provider Appeals

The Provider Appeal's process **must** be initiated by the provider through a **written request** for an appeal.

Provider Appeal requests can be submitted via:

Fax: 833-841-8075

Mail: Highmark Health Options
Attn: Provider Appeals
P.O. Box 106004
Pittsburgh, PA 15230

Replies are sent via mail. When submitting a provider appeal, include a cover letter with return address and contact for written correspondence.

Guidance

HIGHMARK HEALTH OPTIONS

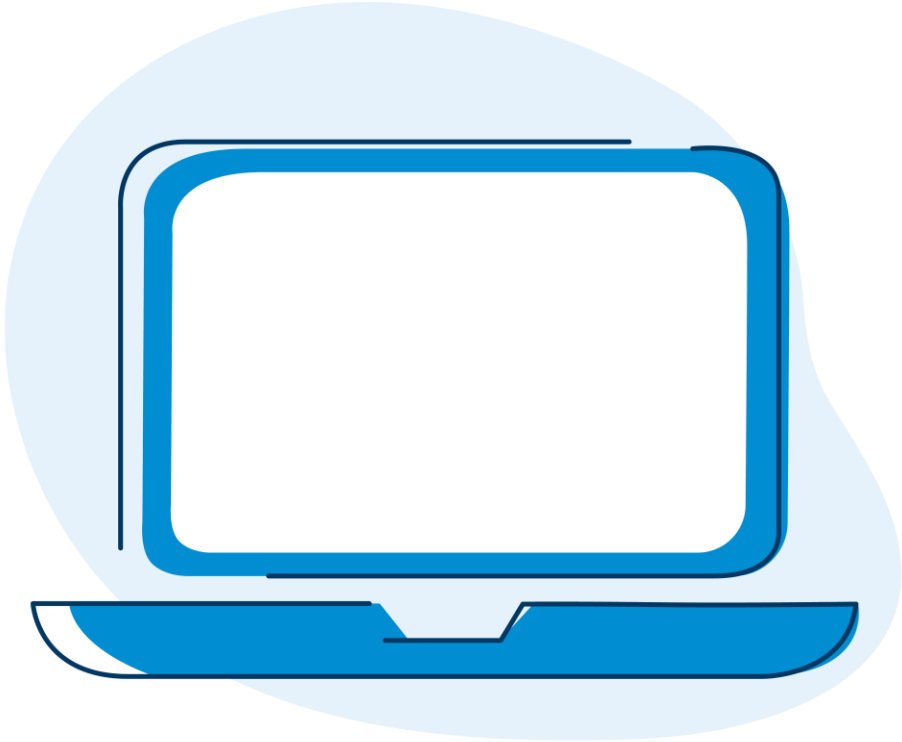
HHO website

Provider Manual

- Services Requiring Authorization section

Medical Policies

- Prior authorization requirement
- Clinical criteria
- Coding coverage
  - CPT, HCPCS, **and** diagnosis code requirements (ex: authorization required for both a bioengineered skin replacement code **and** the application code)
- Must meet all coverage criteria



Delaware Medicaid guidelines

Visit: https://medicaid.dhss.delaware.gov/

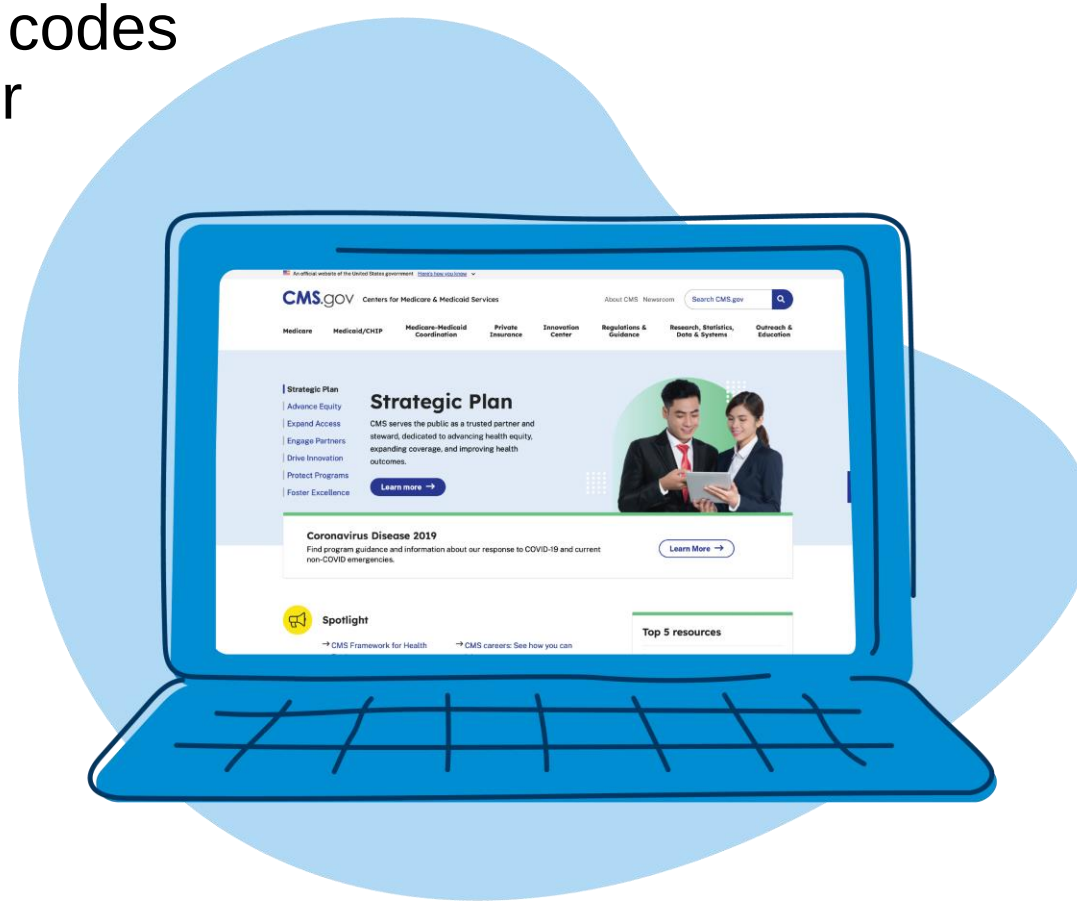
DHSS DME Provider Specific Policy Manual.

Appendix A states the following:

- “The 3-month limits established below for supply codes represent maximum usage for very ill patients and must not be billed routinely for all patients. The DME provider must limit billing to those items prescribed and dispensed as medically necessary.”
- Refer to Appendix A for medical and surgical supply limits.

CMS.gov

- Medically Unlikely Edits(MUE) for HCPCS/CPT codes are the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
  - CMS publishes most MUE values on its website; however, some MUE values are confidential and are not releasable.
- CMS Local Coverage Determinations (LCD), Local Coverage Articles (LCA) and National Coverage Determinations (NCD).
- Internet-Only Manuals (ex: Claims Processing Manual).



FDA-approved prescribing information

Inappropriate for age:

- Example: safety and effectiveness of quadrivalent influenza virus vaccine (RIV4) has not been established for patients under age 18.

Laboratory test required prior to administration:

- Example: neutrophil count required on same date of service or within previous 20 days of administration of Abraxane.

Recommended frequency exceeded:

- Example: Nyvepria administered once per chemotherapy cycle.

Diagnosis

- Example: immune globulin billed with diagnosis Z00.01 Encounter for general adult exam w/abnormal findings rather than D80.2 Selective deficiency of immunoglobulin A [IgA].

Quantity Limits

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Quantity Limits

The physician order must specify the:

- Item(s) requested and any related accessories or supplies
- Quantity needed, frequency of change, and the duration of need.

The DME provider must maintain documentation of the written order, **and** the face-to-face encounter documentation detailing medical need.

- The fact that a physician ordered or advised a supply does not in itself make the request a covered service.

Quantity Limits

- Limits established represent usage for very ill patients and must not be billed routinely for all patients.
  - Providers must limit billing to those items prescribed and dispensed as medically necessary.
- The order must be reviewed for continued medical need at least yearly.
- It is the provider's responsibility to verify that the member is not receiving the same item from another provider.
  - Failing to do so may result in denial of claims due to exceeding the maximum units allowed.
  - Call Provider Services to check quantity limits.

Genetic Testing

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Genetic Testing

Authorization is required for genetic tests (See Provider Manual – Prior Authorization List).

- Multiple policies exist for various genetic testing which are available on the HHO website:

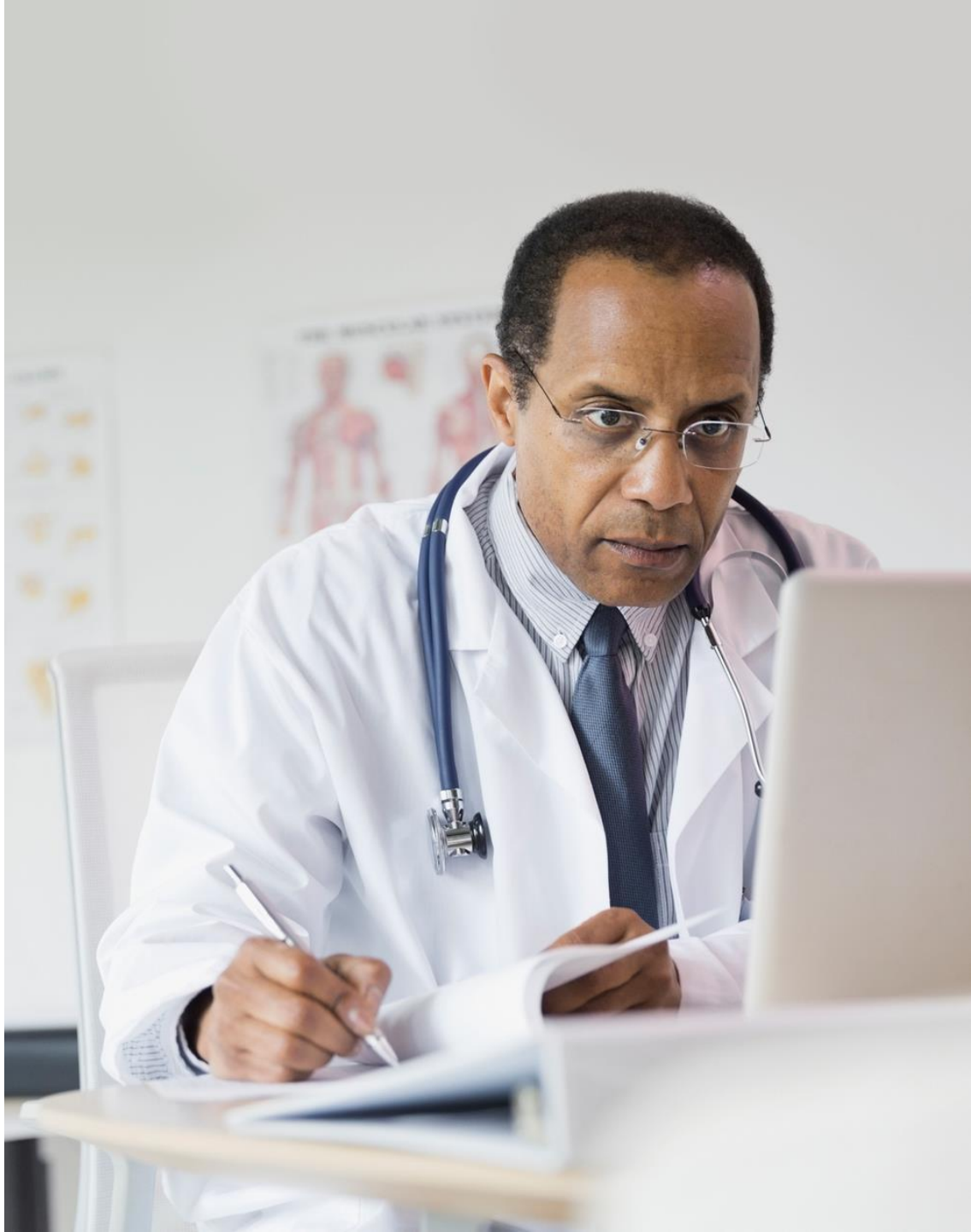
Policy #	Policy Name
MP-1250	BRCA1 & BRCA2 Genetic Mutation Testing
MP-1209	Chromosomal Microarray Analysis: CGH & SNP
MP-1211	Gene Expression Profiling
MP-1012	Whole Exome & Whole Genome Sequencing
MP-1207	Genetic Testing for Colorectal Cancer Susceptibility
MP-1011	Congenital Abnormality Testing

Policy #	Policy Name
MP-1204	Cystic Fibrosis Testing
MP-1205	Genetic Disease Testing
MP-1208	Fetal Aneuploidy Testing
MP-1210	Oncologic Testing Panels
MP-1041	Molecular Markers for Fine Needle Aspirates of Thyroid Nodules (authorization not required for covered codes only)

Genetic Testing

Failure to follow the prior authorization procedure may result in the administrative denial of your claim, regardless of medical necessity.

- When circumstances for obtaining a prior authorization were outside of your control, a retrospective authorization may be requested.
- This request must be submitted with supporting clinical documentation, as well as justification as to why a timely request for authorization was not made.



Genetic Testing: Example

A request for prior authorization was attempted; however, HHO staff indicated authorization was not required and the request was voided.

- Submit a letter of explanation which includes the date and time of your call, the name of the person you spoke to, the call reference number, and the voided authorization (if provided).
- Include the supporting clinical documentation.

  Note: a physician order and test results are not sufficient to establish medical need.

Prior Authorization – Claim Mismatches

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Prior Authorization – Claim Mismatches

To avoid issues, obtain authorizations which accurately reflect the:

- Service/item (CPT/HCPCS code) provided
- Reason (diagnosis code)
- Quantity
- Date(s) of service
- Provider/facility

Prior Authorization – Claim Mismatches

MISMATCH EXAMPLES:

Authorization obtained for A4353 (Intermittent urinary catheter, with insertion supplies) with diagnosis R33.9 (Retention of urine, unspec).

- Claim is submitted for A4353 with diagnosis E11.9 (Diabetes mellitus type 2, unspec complications) (item was not approved for diagnosis reported).

Authorization obtained for inpatient admission for procedure 15830 (panniculectomy) for dates of service 04/16 – 04/18/23.

- Claim is submitted for inpatient admission for 15830 for dates of service 04/15 – 04/18/23 (authorization not approved for billed dates of service beginning 04/15/23).

Prior Authorization – Claim Mismatches

MISMATCH EXAMPLES:

Authorization for 77470 (Special treatment procedure) approved due to concurrent chemotherapy during radiation treatment.

- Claim submitted with all matching information; however, an additional claim for the chemotherapy has not been received (must submit medication administration record for chemotherapy agent).

Authorization for J1300 X100 (Inj, Soliris/eculizumab, 10mg) approved for diagnosis N05.8 for dos 02/02/2022.

- Claim submitted with primary diagnoses N18.4, secondary diagnosis R33.9, tertiary diagnosis Z94.0, other diagnosis N05.8 (approved diagnosis not in primary diagnosis position).

Submitting Clinical Documentation

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Submitting Clinical Documentation

- For a claim to be paid or for a service or item to be reviewed for possible approval, there must be sufficient supporting documentation in the provider's records to verify that the services performed are/were medically necessary.
  - Incomplete or illegible records can result in denial of payment or service/item.
- Make sure all clinical documentation is submitted during initial review to avoid the need to file an appeal on behalf of the member.

Supporting Documents

- Records provided should substantiate the service provided as well as the level of care.
- Information should be legible, clear, concise and reflect the patient's condition/ need on the date written.
- Duration of services must be documented for all time-based services.
- Quantities and measurements documented must be specific.

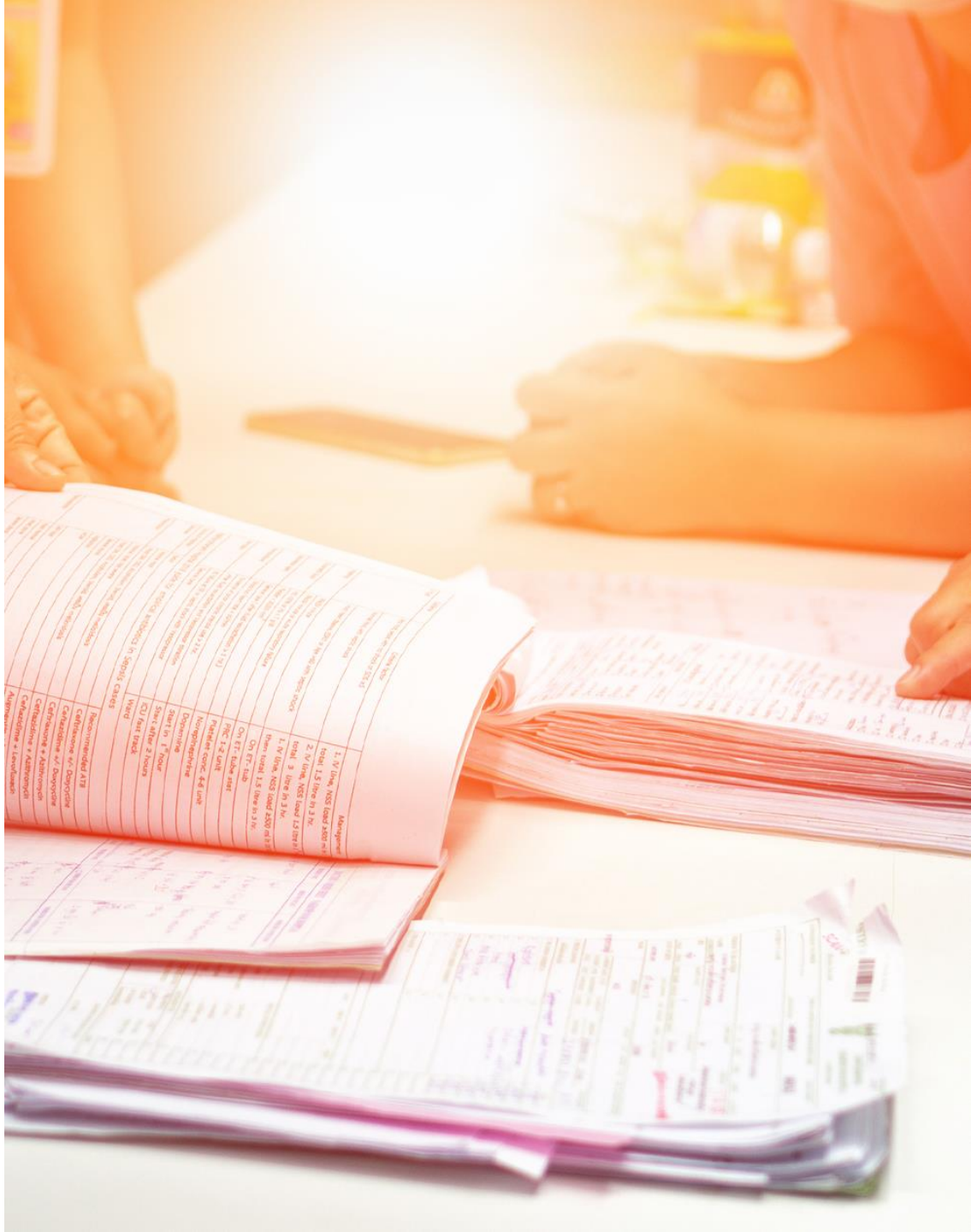
Supporting Documents

It is okay to draw attention to relevant information in the medical records as long as information is not altered!

- This includes underlines, arrows, notations in margins, and placing that documentation at the beginning of the medical record submission.

Common Documentation Submission Issues

- Illegible documentation.
- Submitting a letter without supporting clinical.
- Invalid orders – illegible, altered, missing information, description not specific/no HCPCS codes.
- Documentation is not patient-specific (ex: providing generic description of a particular laboratory test).



Common Documentation Submission Issues

- Documentation is inconsistent:
  - LOMN indicates ambulance transport required due to pt is non-ambulatory while ambulance documentation indicates on arrival to destination pt ambulates independently up stairs and into home.
- Submitting only patient discharge instructions and miscellaneous summary sheets.

Common Documentation Submission Issues

- Submitting the physician order or a letter indicating “the MD ordered it, so it is medically necessary.”
- Submitting the same documents in response to a request for additional information letter.

Items Not Considered Part of Medical Record

- Notes on a fax cover sheet.
- Cover letter in lieu of clinical records.
- Appeal forms/letters.

Balance Billing

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Balance Billing

Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

Balance Billing

- Members file grievances regarding bills received from providers.
- Outreach performed by grievance analysts and/or provider relations representative.

Written Consent for Appeal

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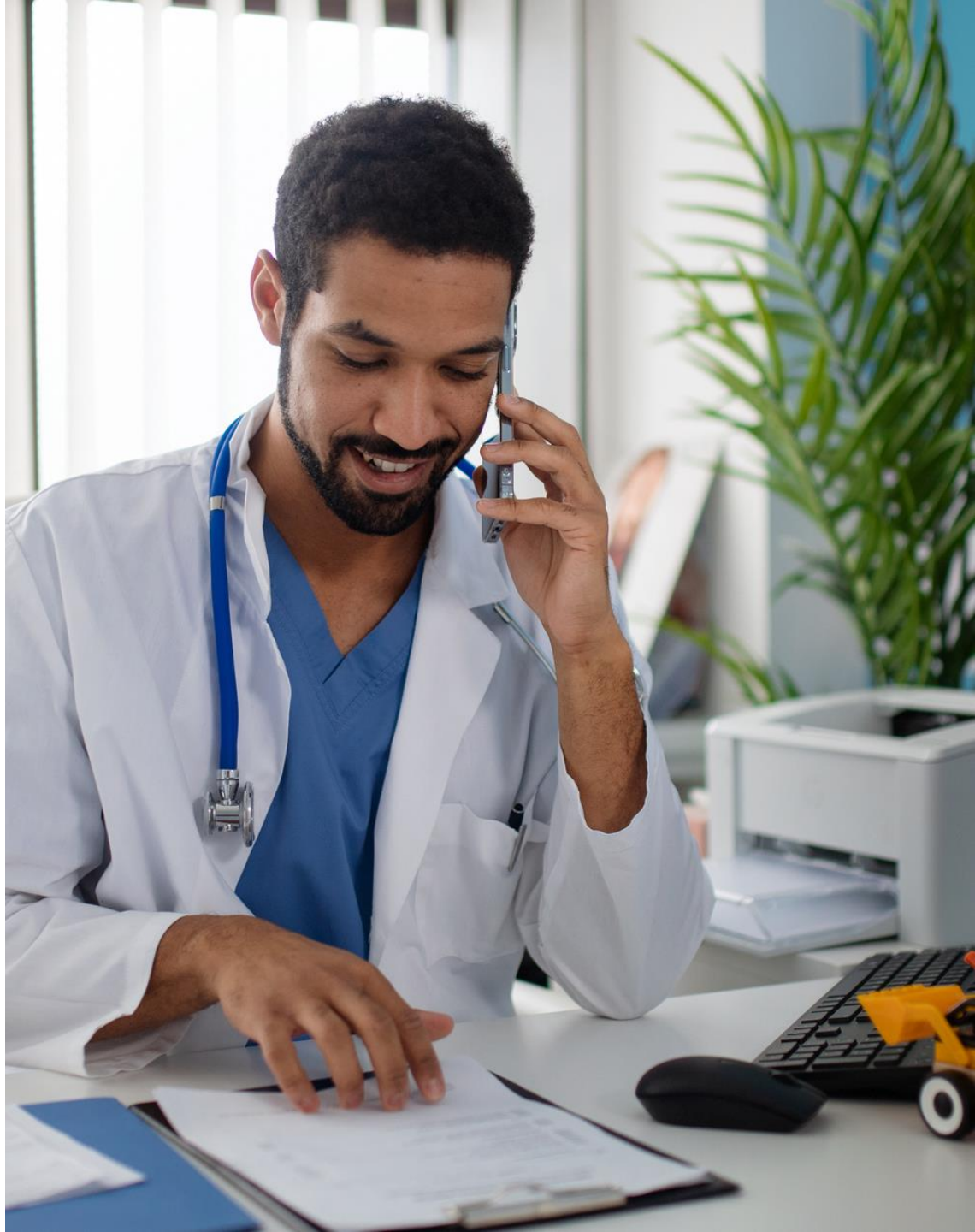
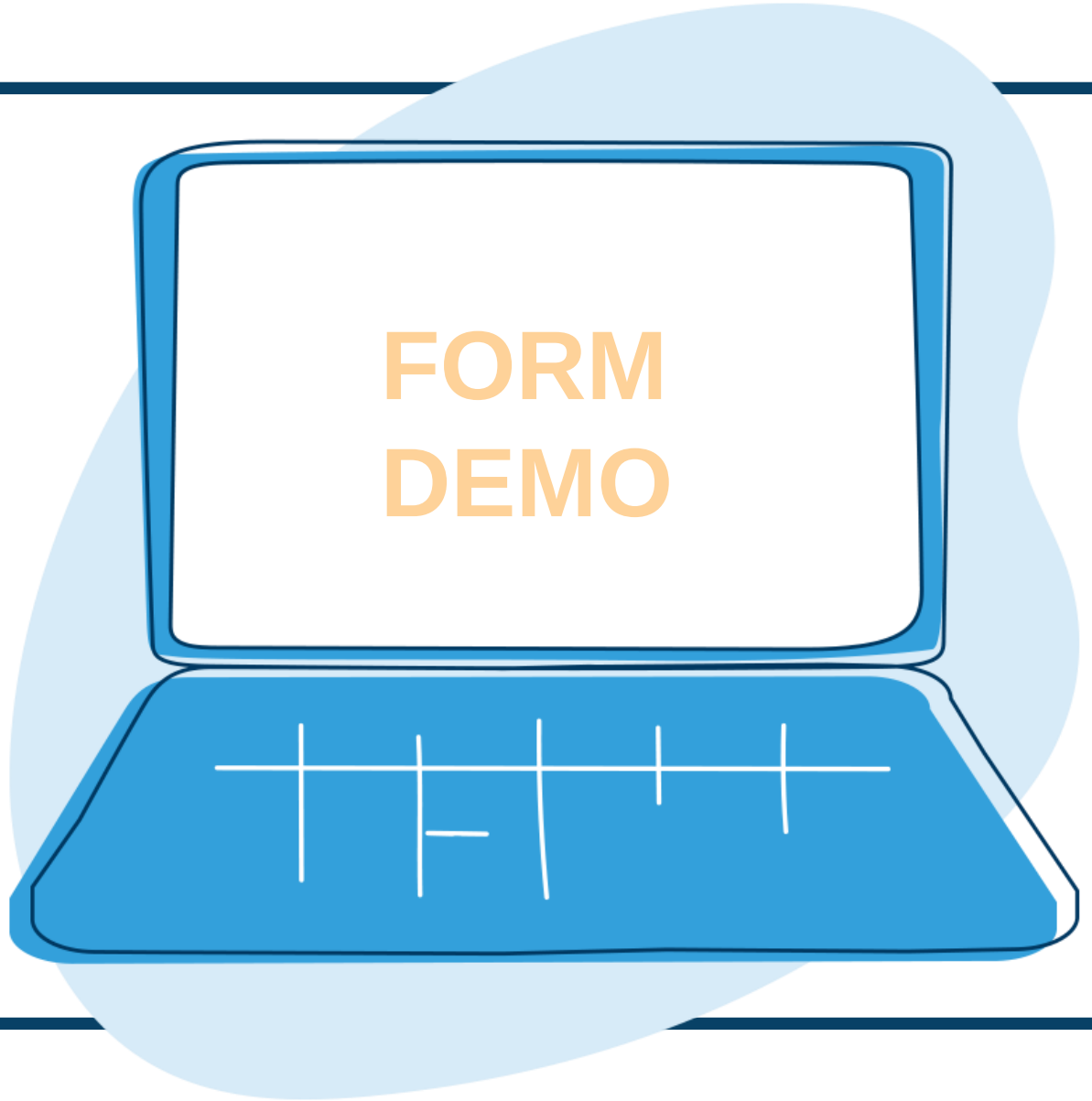
Written Consent

- If you are requesting a pre-service appeal for the denial of a service or item, know that the appeal **must** contain consent from the member allowing you to file on the member's behalf.
- Processing of the appeal will not continue until a consent form is received.
- This includes expedited appeals and standard appeals.



Written Consent

Please see demo of form:



QOC Grievances & Critical Incidents

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What is a Quality-of-Care Grievance?

- Any issue that impacts the quality of the health care that a member receives and may have resulted in the member's care not achieving the desired health outcome potentially due to care that was not consistent with current professional knowledge.
- The member's health or life may have been placed in jeopardy due to the action or lack of action taken by a practitioner.

Who performs QOC investigations?

- Quality of Care (QOC) Team includes QOC RNs and Medical Directors.
  - They work together following the processes to investigate and review all QOC Grievances routed to the Quality Improvement department.
  - The team works in collaboration with Grievance Analysts, Providers, and Medical Directors to ensure that investigations and determinations are performed appropriately and in a timely manner.
- Medical records are essential for these investigations.
  - Do your part in providing records in a timely manner.

Resolution of Quality-of-Care Investigations

HARM SCORES

1. Death
2. Severe Permanent Harm
3. Permanent Harm

4. Temporary Harm
5. Additional Treatment
6. Emotional Distress/ inconvenience
7. No Harm

8. No QOC, No Harm Score

- Corrective Action Plans
  - Are usually sent out when **harm scores reach 1-3**.
  - They must be responded to **within 10 business days**.
- Provisional Harm Letters
  - Are sent out when medical records are not received in a timely fashion.
  - Any harm level can be assigned.

What is a Critical Incident?

- Critical Incidents (CIs) are defined by Division of Medicaid and Medical Assistance (DMMA). They include, but are not limited to:
  - Unexpected death of a member.
  - Suspected physical, mental, or sexual abuse and/or neglect/exploitation of a member.
  - Suspected theft or financial exploitation of a member.
  - Severe injury sustained by a member.
  - Inappropriate or unprofessional conduct by a provider involving a member.
  - Medication Error

Who can report a Critical Incident?

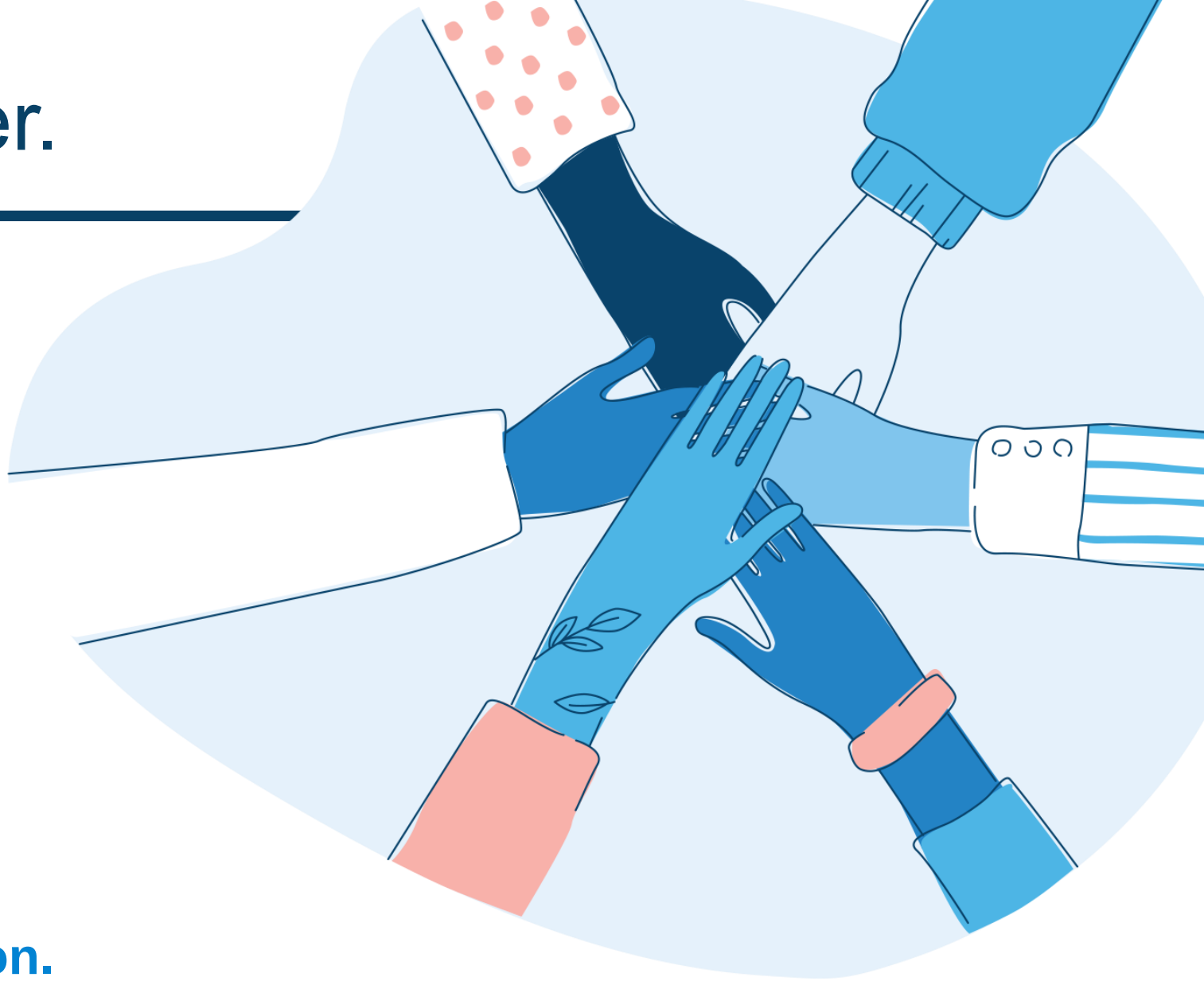
Anyone can report.

- Immediately report the incident to the appropriate state agency.
- Report the incident to Highmark Health Options through Member Services at **1-844-325-6251**.

Identification and Notification

Report CIs the same business day of the CI to:	
Adult Protective Services (APS) **1-302-424-7310** • For suspected abuse, neglect, disruptive behavior, or exploitation	**Delaware Health and Social Services (DHSS) Long-Term Care Office of the State Ombudsman (OSO)** **1-800-223-9074** • For residents in long-term care facilities, who have a complaint about their rights
Division of Health Care Quality (DHCQ) **1-877-453-0012** • For members in a long-term care facility • For child members in a pediatric nursing facility	**Office of Health Facilities and Licensing and Certification (OHFLC)** **1-302-292-3930 *or* 1-800-942-7373** • Acute care and outpatient healthcare facilities and agencies throughout Delaware
The Division of Family Services (DFS) **1-800-292-9582** • For children living in the community • Note: This phone number is also the 24-hour Child Abuse and Neglect Reporting Hotline.	**Police** **911** • Any criminal activity such as theft, rape, or child abuse
Division of Substance Abuse and Mental Health (DSAMH) **1-855-649-7944** • For members with substance use disorder or a mental health condition or for members in a rehab or mental health facility	**Division of Prevention and Behavioral Health (DPBH)** **1-302-633-2600** • For pediatric members with substance use disorder or a mental health condition or for members in a rehab or mental health facility
For DDDS members, please make sure CI is reported to DDDS https://fw1.harmonyis.net/de-live-assessments/?WebIntake=0325A0FC-B62D-4B4D-80C4-AA4D7F84FA71 https://dhss.delaware.gov/dhss/ddds/reportabuse.html	

We’re in this together.



Putting our members and their safety first is a responsibility we all share.

We must ensure that critical incidents are:

- **Identified**
- **Reported**
- **Managed appropriately**

This is a vital step in our mission.