

# 2020 Provider Manual



# TABLE OF CONTENTS

Chapter/Unit	TOPIC	See Page
<b>CHAPTER 1</b>	<b>GENERAL INFORMATION AND CONTACT INFORMATION</b>	
<b>1.1</b>	<b>Highmark Health Options Overview</b>	
	• Introduction	11
	• General Information	11
	• Purpose of This Manual	11
<b>1.2</b>	<b>Quick Reference Directory</b>	
	• Highmark Health Options Contact Information	13
	• Highmark Health Options Website	13
	• Telephone Numbers and Hours of Availability	13
	• NaviNet	14
	• Highmark Health Options Provider Services	14
	• Pharmacy Services	15
	• State of Delaware Contact Information	16
<b>CHAPTER 2</b>	<b>MEMBER INFORMATION</b>	
<b>2.1</b>	<b>Enrollment and Eligibility</b>	
	• Enrollment and Eligibility Determination	18
	• Enrollment and Eligibility Determination	18
	• Role of the Health Benefit Manager (HBM)	18
	• Member Resources	19
	• Member Handbook	19
	• Member Advocates	19
	• Member Services	19
	• Verifying Eligibility	20
	• Health Options Interactive Voice Highmark Response (IVR) System	20
	• PCP's Role in Verifying Eligibility	21
	• Member Identification Cards	22
	• SAMPLE ID CARD: Diamond State Health Plan (DSHP)	22
	• SAMPLE ID CARD: Diamond State Health Plan – Plus (DSHP Plus)	23
	• SAMPLE ID CARD: Diamond State Health Plan – Plus Long-Term Services and Support (DSHP Plus LTSS)	24

*Continued on next page*

Chapter/Unit	TOPIC	See Page
<b>2.2</b>	<b>Member Rights</b>	
	• Member Rights and Responsibilities	26
	• Member Rights	26
	• Member Responsibilities	28
	• Critical Incidents	29
	• What are Critical Incidents?	29
	• Reporting Critical Incidents	29
	• Reporting Suspected Abuse or Neglect	29
	• Second Opinions	30
	• Interpretation Services	31
	• Billing for Missed Scheduled Appointments Prohibited	32
<b>CHAPTER 3</b>	<b>COVERED BENEFITS AND SERVICES</b>	
<b>3.1</b>	<b>Member Benefits</b>	
	• Covered Services	34
	• Overview	34
	• Basic Benefits	34
	• Prescription Drugs	39
	• Overview	39
	• Prior Authorization and Exceptions	39
	• When Prescription Medications are Covered	41
	• Over-the-Counter (OTC)	41
	• Non-Covered Pharmacy Services	41
	• Delaware Prescription Monitoring Program	42
	• Pharmacy and PCP Lock-In	42
	• Urgent and Emergent Services	43
	• Emergency Services	43
	• Situations When Emergency Care is Typically Not Needed	43
	• Hospital Guidelines Followed for Triage	44
	• Follow-Up Care After Emergency Room Visit	44
	• Urgent Care	44
	• Chiropractic Services	45
	• Non-Covered Services	47
<b>3.2</b>	<b>Behavioral Health Services</b>	
	• Overview	50
	• Introduction	50
	• Referring Members	50
	• Benefits and Services	51
	• Limitation of Benefit	51
	• Verifying Eligibility	51

Continued on next page

Chapter/Unit	TOPIC	See Page
(Ch3.2 cont'd)	<ul style="list-style-type: none"> <li>• Provider Appointment Standards</li> </ul>	51
	<ul style="list-style-type: none"> <li>• In-Office Wait Time</li> </ul>	51
	<ul style="list-style-type: none"> <li>• Coordination Between Physical Health and Behavioral Health</li> </ul>	52
	<ul style="list-style-type: none"> <li>• Crisis Intervention Services</li> </ul>	53
	<ul style="list-style-type: none"> <li>• Statewide Service Locations</li> </ul>	54
	<ul style="list-style-type: none"> <li>• Northern Delaware</li> </ul>	54
	<ul style="list-style-type: none"> <li>• Southern Delaware</li> </ul>	55
	<ul style="list-style-type: none"> <li>• Behavioral Health Authorizations</li> </ul>	56
	<ul style="list-style-type: none"> <li>• Services Requiring Authorization</li> </ul>	56
	<ul style="list-style-type: none"> <li>• Requesting Precertification</li> </ul>	56
	<ul style="list-style-type: none"> <li>• Requesting Ongoing (Concurrent) Authorization</li> </ul>	57
	<ul style="list-style-type: none"> <li>• Discharge Notification Form</li> </ul>	57
	<ul style="list-style-type: none"> <li>• Substance Abuse Treatment Authorizations</li> </ul>	58
	<ul style="list-style-type: none"> <li>• Services Requiring Authorization</li> </ul>	58
	<ul style="list-style-type: none"> <li>• Requesting Authorization</li> </ul>	58
<b>3.3</b>	<b>Additional Services</b>	
	<ul style="list-style-type: none"> <li>• Dental and Vision Services</li> </ul>	60
	<ul style="list-style-type: none"> <li>• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)</li> </ul>	61
	<ul style="list-style-type: none"> <li>• Primary Care Practitioner Responsibilities</li> </ul>	61
	<ul style="list-style-type: none"> <li>• Required Screenings Schedule</li> </ul>	61
	<ul style="list-style-type: none"> <li>• Initial Assessments</li> </ul>	63
	<ul style="list-style-type: none"> <li>• Coordinating Services</li> </ul>	63
	<ul style="list-style-type: none"> <li>• Reporting Services</li> </ul>	63
	<ul style="list-style-type: none"> <li>• Referrals</li> </ul>	64
	<ul style="list-style-type: none"> <li>• Member Outreach Form</li> </ul>	64
	<ul style="list-style-type: none"> <li>• Transplant Services</li> </ul>	65
	<ul style="list-style-type: none"> <li>• Covered Transplant Services</li> </ul>	65
	<ul style="list-style-type: none"> <li>• Eligibility Requirements</li> </ul>	65
<b>CHAPTER 4</b>	<b>PROVIDER PARTICIPATION AND RESPONSIBILITIES</b>	
<b>4.1</b>	<b>Highmark Health Options Provider Network Participation</b>	
	<ul style="list-style-type: none"> <li>• Introduction to Network Participation</li> </ul>	67
	<ul style="list-style-type: none"> <li>• Eligible Professional Providers</li> </ul>	67
	<ul style="list-style-type: none"> <li>• Provider Disclosure Statement</li> </ul>	68
	<ul style="list-style-type: none"> <li>• National Provider Identifier (NPI)</li> </ul>	68
	<ul style="list-style-type: none"> <li>• Registering as a Non-Participating Provider</li> </ul>	68
	<ul style="list-style-type: none"> <li>• Mutual Roles and Obligations for Network Participating Providers and Highmark Health Options</li> </ul>	69
	<ul style="list-style-type: none"> <li>• How to Participate in Highmark Health Options Credentialed Networks</li> </ul>	70
	<ul style="list-style-type: none"> <li>• For CAQH Participating Practitioners</li> </ul>	70

Continued on next page

Chapter/Unit	TOPIC	See Page
(Ch4.1 cont'd)	• If You Are Not Yet Registered with CAQH	71
	• Notification of Application Status	71
	• How to Resign from Network Participation	71
	• Assignment Accounts	72
	• Eligible Entities and Arrangements	72
	• How to Establish an Assignment Account	73
	• Electronic Transactions Required	73
	• Keeping Assignment Account Information Up to Date	74
	• Notification of New or Departing Practitioners	74
	• Restrictions	74
	• How to Make Changes to an Existing Assignment Account	75
	• Changes to ACH Direct Deposit Account	75
	• Provider Tax Identification Numbers	76
	• Electronic Transaction Requirements	77
	• Non-Network Provider Payment Guidelines	78
	• Facility and Ancillary Provider Networks	79
<b>4.2</b>	<b>Highmark Health Options Credentialing and Recredentialing</b>	
	• Introduction to Credentialing	82
	• Highmark Health Options Network Credentialing Policy	84
	• Practitioners' Credentialing Rights	89
	• The Credentialing Process	92
	• If You Already Have a CAQH ID	92
	• If You Are Not Yet Registered with CAQH	93
	• Steps in the Initial Credentialing Process	93
	• The Recredentialing Process	96
	• Assessment of Clinical Quality	96
	• Assessment of Data Completeness	97
	• Office Site Reviews	98
	• Step-by-Step Process	98
	• Credentialing Requirements for Facility-Based Providers	99
	• Facility-Based Practitioner Credentialing Policy	99
	• PARE Attestation	99
	• Credentialing Requirements for Behavioral Health Care Providers	100
	• Dual Credentialing and Recredentialing as Both PCP and Specialist	102
	• Practitioner Quality and Board Certification	103
	• Malpractice Insurance Requirement	105
	• Termination from the Networks	106
	• Reconsiderations and Appeals	109

Continued on next page

Chapter/Unit	TOPIC	See Page
<b>4.3</b>	<b>Policies and Procedures for Providers</b>	
	• Maintaining Medical and Financial Records	112
	• Medical Records Maintenance and Retention	112
	• Financial Records Maintenance and Retention	124
	• Confidentiality and HIPAA Requirements	124
	• Availability and Accessibility	127
	• Availability and Accessibility Standards	127
	• Office Wait Times	127
	• Cultural Competence	128
	• What is Cultural Competence?	128
	• The CLAS Standards	128
	• Language Interpretation Standards	128
	• Second Opinions	129
	• Advance Directives	130
	• Member Non-Compliance	131
	• Fraud and Abuse	132
	• Overpayments	133
	• Prohibited Marketing Activities	134
<b>4.4</b>	<b>Primary Care Providers</b>	
	• Primary Care Practitioner Assignments	136
	• PCP Assignment Changes	136
	• Highmark Health Options Member No-Show Policy	137
	• Written Transfer Requests	137
	• Primary Care Practitioner Responsibilities	138
	• Delivery of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	139
	• Primary Care Practitioner Responsibilities	139
	• Required Screens Schedule	139
	• Initial Assessments for SSI Members Under Age 21	140
	• Obstetrics and Gynecology	141
	• Maternity Care Providers	142
	• Intake Visit	142
	• Perinatal Care and Risk Assessment Form	142
	• Obstetrics Billing	143

*Continued on next page*

Chapter/Unit	TOPIC	See Page
<b>4.5</b>	<b>Specialty, Ancillary, and Facility Providers</b>	
	• Specialty Care Practitioners	145
	• Verifying Eligibility	145
	• Billing Members for Covered Services Prohibited	145
	• Specialists Functioning as Primary Care Practitioners	145
	• Continuity and Coordination of Care Requirements	145
	• Ancillary Providers	146
	• Ambulance Services	146
	• Durable Medical Equipment	147
	• Imaging Services	147
	• Hospital/Facility Services	148
	• Authorization Requirements	148
	• Authorization Requests	148
	• Transmission of Laboratory Data	148
	• Procedures in a Hospital's SPU or ASU	148
	• Emergency Services	149
	• Continuity and Coordination of Care Requirements	150
	• On-Site Care Coordinators	151
<b>CHAPTER 5</b>	<b>HEALTH CARE MANAGEMENT</b>	
<b>5.1</b>	<b>Medical Management</b>	
	• Medical Necessity Criteria	153
	• Medical Necessity Defined	153
	• Prior Authorization	155
	• Requesting Prior Authorization	155
	• Services Requiring Authorization	156
	• Authorization Process	158
	• Procedures Specific to Durable Medical Equipment	159
	• Skilled Nursing Facility (SNF)	161
	• Outpatient Therapy Services	161
	• Acute Inpatient Rehabilitation Facility	161
	• Home Infusion	161
	• Hospice Services	162
	• Behavioral Health Services	162
	• Pharmacy Services	162
	• Home Health Care	163
	• Private Duty Nursing Services	165
	• Transitions from Hospital to Home	166
	• Medical Claims Review	167

*Continued on next page*

Chapter/Unit	TOPIC	See Page
<b>5.2</b>	<b>Case Management and Care Management</b>	
	• Highmark Health Options Lifestyle Management & Wellness	169
	• Asthma Program	171
	• Diabetes Program	172
	• Cardiac Program	173
	• Chronic Obstructive Pulmonary Disease (COPD) Program	174
	• MOM Options Program	175
	• Highmark Health Options Care Management Program	176
	• Complex Care Management Program	177
<b>5.3</b>	<b>Complaints, Grievances, and Appeals</b>	
	• Provider Complaint Procedures	179
	• Registering a Formal Complaint	181
	• Complaints About Claim Payments	181
	• Registering a First Level Appeal (Informal Appeal)	182
	• Registering a Second Level Appeal (Formal Appeal)	182
	• Filing Grievances and Appeals on Behalf of a Member	182
	• Grievances	183
	• Appeals	185
	• State Fair Hearings	190
	• Dispute Resolution	192
<b>5.4</b>	<b>Quality Management</b>	
	• Quality Improvement/Utilization Management Program Overview	194
	• Program Purpose	194
	• Program Goal	194
	• Program Objectives	195
	• Program Scope	196
	• Clinical Quality	198
	• Practitioner Office/Facility Site Quality and Medical/Treatment Evaluations	199
	• Environmental Assessment Standards	200
	• Risk Adjustment	204
	• Service Quality	
<b>CHAPTER 6</b>	<b>LONG-TERM SERVICES AND SUPPORT (LTSS)</b>	
<b>6.1</b>	<b>General Information and Covered Services</b>	
	• Overview	206
	• Goals of the DSHP Plus LTSS Program	206
	• Eligibility and Enrollment	207
	• Long-Term Services and Support (LTSS) Benefits	208
	• Covered Services	208

Continued on next page



Chapter/Unit	TOPIC	See Page
(Ch6.1 cont'd)	• At-Risk Members	208
	• Self-Directed Attendant Care Services	208
	• Long-Term Services and Support (LTSS) Billing and Reimbursement	210
	• Additional LTSS Program Information	210
	• Background Checks	210
	• Critical Incident Reporting	210
<b>6.2</b>	<b>Case Management for Long-Term Services and Support (LTSS)</b>	
	• Plan of Care	215
	• Long-Term Services and Support (LTSS) Providers	217
	• Long -Term Services and Support (LTSS) Case Managers	218
<b>6.3</b>	<b>Long-Term Services and Support (LTSS) Provider Contracting and Credentialing</b>	
	• LTSS Credentialing Process	222
	• LTSS Credentialing Criteria	226
	• Attachment A	229
<b>CHAPTER 7</b>	<b>CLAIMS, BILLING, AND REIMBURSEMENT</b>	
<b>7.1</b>	<b>Highmark Health Options Claim Submission and Reimbursement</b>	
	• General Information	231
	• Reporting Practitioner Identification Number	231
	• Diagnosis Coding	232
	• Hospital Services	233
	• Claims Mailing Address	233
	• Claim Submission Procedures	233
	• Claim Coding Software	236
	• Coordination of Benefits	237
	• Submission of Highmark Health Options Secondary Payer Claims	237
	• Auto and Casualty Claims	237
	• Clean Claims	239
	• Timely Filing Guidelines	240
	• Electronic Claim Submission	241
	• Electronic Remittance Advice (ERA)	243
	• EPSDT Claim Format Requirements	244
	• Claim Adjustments, Reconsiderations, and Appeals	246
	• Highmark Health Options Reimbursement	247

Continued on next page

Chapter/Unit	TOPIC	See Page
(Ch7.1 cont'd)	• CMS-1500 Data Elements for Paper Claim Submission	248
	• UB-04 Data Elements for Paper Claim Submission	250
<b>7.2</b>	<b>Highmark Health Options Specific Billing</b>	
	• Specialty/Fee-For-Service Providers	253
	• Highmark Health Options Members with Medicare	254
	• Subrogation	256
	• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	257
	• Obstetrical Care Services	258
	• Surgical Procedure Services	259
	• Anesthesia Services	260

# CHAPTER 1: GENERAL INFORMATION AND CONTACT INFORMATION

## UNIT 1: HIGHMARK HEALTH OPTIONS OVERVIEW

### IN THIS UNIT

### TOPIC

Introduction  
General Information  
Purpose of This Manual

# 1.1 HIGHMARK HEALTH OPTIONS OVERVIEW

---

## Introduction

The Highmark Health Options Provider Manual contains an integrated set of procedures and policies that apply to network participating provider offices. This manual was designed to be your primary reference guide to Highmark Health Options.

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## General Information

Highmark Health Options is a Highmark Blue Cross Blue Shield Delaware (“Highmark Delaware”) owned and administered managed care organization contracted with the State of Delaware’s Department of Health and Social Services (DHSS) to provide health services to eligible individuals.

Highmark Inc. (“Highmark”) was created in 1996 by the consolidation of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania. In recent years, Highmark has acquired BlueCross BlueShield of Delaware and Mountain State Blue Cross Blue Shield. Highmark currently serves 5.2 million members.

In 2011, Highmark Health became one of the first in the nation to take steps to evolve from a traditional health insurance company to an integrated health and wellness company with a patient-centered care delivery system. Highmark Health is the parent company of Highmark Inc.

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## Purpose of this Manual

This manual is designed to give you access to information such as claims filing, researching patient benefits, and joining the network. It also includes important information on how to communicate with Highmark Health Options through automated and electronic systems whichever is the efficient and convenient method for you and your staff.

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# CHAPTER 1: GENERAL INFORMATION AND CONTACT INFORMATION

## UNIT 2: QUICK REFERENCE DIRECTORY

### IN THIS UNIT

### TOPIC

Highmark Health Options Contact Information

- Highmark Health Options Website
- Telephone Numbers and Hours of Availability
- NaviNet
- Highmark Health Options Provider Services

Pharmacy Services

State of Delaware Contact Information

## 1.2 HIGHMARK HEALTH OPTIONS CONTACT INFORMATION

### Highmark Health Options Website

Our website, [highmarkhealthoptions.com](http://highmarkhealthoptions.com), provides up-to-date information.

### Important Addresses

	ADDRESS
<b>OFFICE LOCATION</b>	Highmark Health Options 800 Delaware Avenue Wilmington, DE 19801
<b>MEMBER CORRESPONDENCE</b>	Highmark Health Options – Member Mail P.O. Box 22188 Pittsburgh, PA 15222-0188
<b>PROVIDER CORRESPONDENCE</b>	Highmark Health Options – Provider Mail P.O. Box 890419 Camp Hill, PA 17089-0419
<b>PRIVACY OFFICE CORRESPONDENCE</b>	Highmark Health Options P.O. Box 1991 Wilmington, DE 19889-8835

### Telephone Numbers and Hours of Availability

DEPARTMENT	CONTACT NUMBER	HOURS
Provider Services	1-844-325-6251	Mon.–Fri. 8 a.m. to 5 p.m.
Member Services	1-844-325-6251	Mon.–Fri. 8 a.m. to 8 p.m.
Member Services (DSHP Plus)	1-855-401-8251	Mon.–Fri. 8 a.m. to 8 p.m.
Pharmacy Services	1-844-325-6251 Request for Medicaid Drug Exception Form Faxed to 1-888-245-2049	Mon.–Fri. 8 a.m. to 5 p.m.
Authorizations	1-844-325-6251	Mon.–Fri. 8 a.m. to 5 p.m. (24/7 secure voicemail for inpatient admissions notification)
Care Management/Long-Term Services and Support (LTSS)	1-844-325-6251	Mon.–Fri. 8 a.m. to 5 p.m. (after hours support accessible through the Nurse Advice Line)
Member Eligibility Check (IVR)	1-844-325-6161	24/7
Behavioral Health	1-844-325-6251	Mon.–Fri. 8 a.m. to 5 p.m.

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## 1.2 HIGHMARK HEALTH OPTIONS CONTACT INFORMATION, Continued

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### NaviNet®

Participating providers can access NaviNet® 24 hours a day, seven (7) days a week. NaviNet can be used for eligibility and benefits inquiries, claim status inquiries, authorization requests and inquiries, provider/facility directory searches, and provider information updates. Providers can access NaviNet at: [www.navinet.net](http://www.navinet.net).

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### Highmark Health Options Provider Services

Immediate answers to most inquiries can be found by using NaviNet – the preferred method for benefit and claim inquiries. For more complex issues or if NaviNet is unavailable, Provider Service Representatives are available to answer questions and provide information about the program.

#### Provider Services Information:

- Phone: 1-844-325-6251
- Hours of Operation: Mon.–Fri. 8 a.m. to 5 p.m.

When placing a call to Provider Services, please have the following information available:

- Patient's name and Member ID
  - Type of service and date of service, if available
  - Claim number, if applicable
  - Provider's name and provider number
-

## 1.2 PHARMACY SERVICES

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### **Pharmacy Network**

Highmark Health Options pharmacy network includes national chains and many local independent pharmacies.

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### **Preferred Drug List (PDL) and Supplemental Formulary**

Highmark Health Options offers coverage for drugs listed on the State of Delaware's Department of Health and Social Services (DHSS) Preferred Drug List (PDL) and offers an additional Supplemental Formulary consisting of drug classes not covered by the PDL.

Any revisions to the PDL are owned by DHSS and the Delaware Medicaid Pharmaceutical and Therapeutics Committee.

The Highmark Health Options Pharmacy and Therapeutics Committee (P&T) approves revisions to the Supplemental Formulary on an as-needed basis and updates are posted to the provider section of the Highmark Health Options website at: [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

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## 1.2 STATE OF DELAWARE CONTACT INFORMATION

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### Claims Information

#### Claims information for Delaware Medical Assistance Program:

**Address:** **DXC Technology**  
P.O. Box 909  
Manor Branch  
New Castle, DE 19720-0909

**Telephone:** 1-800-999-3371

**Fax:** 1-302-454-7603

**Provider Portal:** <https://medicaid.dhss.delaware.gov>

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### Dental Services

**Telephone:** 1-800-372-2022

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### For More Information

Additional information regarding the Delaware Medical Assistance Program can be found at the following website: <https://medicaid.dhss.delaware.gov/>.

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# CHAPTER 2: MEMBER INFORMATION

## UNIT 1: ENROLLMENT AND ELIGIBILITY

### IN THIS UNIT

### TOPIC

#### Enrollment and Eligibility Determination

- Enrollment and Eligibility Determination
- Role of the Health Benefit Manager (HBM)

#### Member Resources

- Member Handbook
- Member Advocates
- Member Services

#### Verifying Eligibility

- Highmark Health Options Identification Card
- Highmark Health Options Interactive Voice Response (IVR) System
- PCP's Role in Verifying Eligibility

#### Member Identification Cards

- Sample ID Card: Diamond State Health Plan (DSHP)
- Sample ID Card: Diamond State Health Plan Plus (DSHP Plus)
- Sample ID Card: Diamond State Health Plan – Plus Long-Term Services and Support (DSHP Plus LTSS)

## 2.1 ENROLLMENT AND ELIGIBILITY DETERMINATION

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### **Enrollment and Eligibility Determination**

Highmark Health Options is offered to those recipients who are enrolled in the State of Delaware's Medical Assistance Program and who are eligible for enrollment into a Managed Care Program. The Department of Health & Social Services (DHSS) determines recipient eligibility.

### **Role of the Health Benefit Manager (HBM)**

DHSS employs a Health Benefit Manager (HBM) who performs Outreach, Education, Enrollment, Transfer, and Disenrollment of clients/members. The HBM explains the benefits offered by Highmark Health Options and other Managed Care Organizations (MCOs) and helps recipients choose an MCO that meets their needs. Potential members are encouraged to select a primary care practitioner from a list of participating practitioners.

Potential clients submit enrollment applications to the State Service Centers or online via the ASSIST website. DHSS electronically notifies Highmark Health Options that a recipient will be enrolled in Highmark Health Options. Recipients approved by DHSS are added to Highmark Health Options' information system with the effective date assigned by the State. Newly enrolled members receive a new Member Handbook and a Highmark Health Options identification card.

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## 2.1 MEMBER RESOURCES

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### **Member Handbook**

The Member Handbook explains the benefits and services available to our members and the health care services paid for by Highmark Health Options. It also explains what to do in the event of an emergency or urgent medical situation.

Enrolled Highmark Health Options members are notified annually of any changes made to the Member Handbook and may request a copy of the handbook at any time.

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### **Member Advocates**

Highmark Health Options has employed Member Advocates who are responsible for working with members, providers, and the member's case managers to assist members in obtaining care, including scheduling appointments, to assist members in navigating the grievances and appeals process, and to identify resources necessary to assist those members with limited English proficiency or communication barriers.

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Members can call the Highmark Health Options Member Services line to be connected to a Member Advocate.

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### **Member Services**

Members should be directed to call Highmark Health Options Member Services with any questions about their benefits and Highmark Health Options services. DSHP members should call 1-844-325-6251; DSHP Plus members should call 1-855-401-8251.

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## 2.1 VERIFYING ELIGIBILITY

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### Overview

Because of frequent changes in a member's eligibility, each participating practitioner is responsible to verify a member's eligibility with Highmark Health Options **BEFORE** providing services. Verifying a member's eligibility along with any applicable authorization will help ensure proper reimbursement for services.

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### Verifying Eligibility

To verify a member's eligibility, the following methods are available to all practitioners:

#### Highmark Health Options Identification Card

The card itself does **not** guarantee that a person is currently enrolled in Highmark Health Options. Members are only issued an ID Card once upon enrollment. However, the member will receive new ID Cards if they change their primary care practitioner or request a new one. Members are **not** required to return their identification cards when they are no longer eligible for Highmark Health Options.

#### Highmark Health Options Interactive Voice Response (IVR) System

Available 24 hours a day, seven (7) days a week at **1-844-325-6161**. To verify member eligibility at each visit, practitioners follow a few simple steps, which are listed below:

- Using your telephone keypad, enter the member's 12-digit Highmark Health Options ID followed by the pound key (#). If you make a mistake, press star (\*) to start over. To return to the main menu, press #.
- To verify coverage or PCP assignment for today's date of service, press 1.
- To enter a different date, press 2. Please enter the 8-digit date of service using the 2-digit month, 2-digit day, and 4-digit year (e.g., **01012015**).

If you make a mistake, press \* to start over. If you need help, press #.

#### ADDITIONAL INSTRUCTIONS

- For more information, press 1
  - To have verification faxed to you, press 2
  - To check another date, press 3
  - To check another member, press 4
  - If you would like to return to the main menu, press #
  - If you are completed with your call, you may hang up
- 

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## 2.1 VERIFYING ELIGIBILITY, Continued

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### **PCP's Role in Verifying Eligibility**

Primary care practitioners verify eligibility by consulting their panel listing in order to confirm that the member is 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 for that month.

If members insist they are effective but do not appear on the list, the practitioner should call the Highmark Health Options Provider Services Department at 1-844-325-6251 for help in determining eligibility.


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## 2.1 MEMBER IDENTIFICATION CARDS

### Overview

Recipients approved by the Department of Health & Social Services (DHSS) are added to Highmark Health Options information system with the effective date assigned by DHSS. Newly enrolled members receive a new Member Handbook and a Highmark Health Options Identification Card (See sample Highmark Health Options ID cards below.)

### Sample ID Card: Diamond State Health Plan (DSHP)


		<b>Diamond State Health Plan</b>	
<b>MEMBER NAME</b> <b>FIRSTNAME MI</b> <b>LASTNAME</b>		<b>PCP INFORMATION</b> <b>PCPNAME PCPNAME</b> <b>XXX-XXX-XXXX</b>	
<b>MEMBER ID #</b> <b>XHD123456789001</b>		<b>DOB</b> <b>01-01-1900</b>	
<b>MEDICAID ID</b> <b>12345678910</b> <b>RxBIN</b> <b>004336</b> <b>RxPCN</b> <b>ADV</b> <b>RxGrp</b> <b>RX2339</b>	<b>Electronic Payer ID</b> <b>47181</b>		


		<a href="http://www.highmarkhealthoptions.com">www.highmarkhealthoptions.com</a>	
<p>24 Hour Nurse Line: 24 hour access to nurses who provide health education and support.</p> <p>Call the Behavioral Health number to get help obtaining services. If your medical condition is very serious or life or death, go to the nearest emergency room (ER). In an emergency dial 911.</p> <p>Always carry your ID card. Be sure to give your Highmark Health Options card, your state Medicaid ID card and any other insurance ID cards to your provider.</p>		<p>Member Service    1-844-325-6251          TTY Hearing Svc    Dial 711 or                                       1-800-232-5460          24 Hr. Nurse Line    1-844-325-6251          Behavioral Health    1-844-325-6251  <b>For Providers:</b>          Eligibility IVR        1-844-325-6251          Pre-Certification    1-844-325-6251          Pharmacy             1-800-364-6331          Help Desk*</p> <p>File claims to:          Highmark Health Options Claims Dept          P.O. Box 890402          Camp Hill, PA 17089-0402</p> <p>Highmark Blue Cross Blue Shield Delaware and Highmark Health Options are Independent Licensees of the Blue Cross and Blue Shield Association.</p>	
		<small>*Pharmacy Benefits Administrator</small>	

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## 2.1 MEMBER IDENTIFICATION CARDS, Continued

Sample  
ID Card:  
Diamond  
State Health  
Plan – Plus  
(DSHP Plus)

		Diamond State Health Plan–Plus	
MEMBER NAME <b>FIRSTNAME MI</b> <b>LASTNAME</b> MEMBER ID # <b>XHD123456789001</b>		PCP INFORMATION <b>PCPNAME PCPNAME</b> <b>XXX-XXX-XXXX</b> DOB <b>01-01-1900</b>	
MEDICAID ID RxBIN RxPCN RxGrp	<b>12345678910</b> <b>004336</b> <b>ADV</b> <b>RX2339</b>	Electronic Payer ID <b>47181</b>	

		<a href="http://www.highmarkhealthoptions.com">www.highmarkhealthoptions.com</a>	
24 Hour Nurse Line: 24 hour access to nurses who provide health education and support.		Member Service <b>1-855-401-8251</b> TTY Hearing Svc <b>Dial 711 or</b> <b>1-800-232-5460</b> 24 Hr. Nurse Line <b>1-844-325-6251</b> Behavioral Health <b>1-844-325-6251</b>	
Call the Behavioral Health number to get help obtaining services. If your medical condition is very serious or life or death, go to the nearest emergency room (ER). In an emergency dial 911.		<b>For Providers:</b> Eligibility IVR <b>1-844-325-6251</b> Pre-Certification <b>1-844-325-6251</b> Pharmacy <b>1-800-364-6331</b> Help Desk*	
Always carry your ID card. Be sure to give your Highmark Health Options card, your state Medicaid ID card and any other insurance ID cards to your provider.		File claims to: Highmark Health Options Claims Dept P.O. Box 890402 Camp Hill, PA 17089-0402	
		Highmark Blue Cross Blue Shield Delaware and Highmark Health Options are Independent Licensees of the Blue Cross and Blue Shield Association. <small>*Pharmacy Benefits Administrator</small>	


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## 2.1

### MEMBER IDENTIFICATION CARDS, Continued

**Sample  
ID Card:  
Diamond  
State Health  
Plan – Plus  
Long-Term  
Services and  
Support  
(DSHP Plus  
LTSS)**

		Diamond State Health Plan – Plus Long Term Services and Support (LTSS)	
MEMBER NAME <b>FIRSTNAME MI</b> <b>LASTNAME</b>		PCP INFORMATION <b>PCPNAME PCPNAME</b> <b>XXX-XXX-XXXX</b>	
MEMBER ID # <b>XHD123456789001</b>		DOB <b>01-01-1900</b>	
MEDICAID ID RxBIN RxPCN RxGrp	<b>12345678910</b> <b>004336</b> <b>ADV</b> <b>RX2339</b>	Electronic Payer ID <b>47181</b>	

		<a href="http://www.highmarkhealthoptions.com">www.highmarkhealthoptions.com</a>	
24 Hour Nurse Line: 24 hour access to nurses who provide health education and support.		Member Service <b>1-855-401-8251</b> TTY Hearing Svc <b>Dial 711 or</b> <b>1-800-232-5460</b>	
Call the Behavioral Health number to get help obtaining services. If your medical condition is very serious or life or death, go to the nearest emergency room (ER). In an emergency dial 911.		24 Hr. Nurse Line <b>1-844-325-6251</b> Behavioral Health <b>1-844-325-6251</b>	
Always carry your ID card. Be sure to give your Highmark Health Options card, your state Medicaid ID card and any other insurance ID cards to your provider.		<b>For Providers:</b> Eligibility IVR <b>1-844-325-6251</b> Pre-Certification <b>1-844-325-6251</b> Pharmacy <b>1-800-364-6331</b> Help Desk*	
<b>Diamond State Health Plan - Plus Long Term Services and Support (LTSS)</b>		File claims to: Highmark Health Options Claims Dept P.O. Box 890402 Camp Hill, PA 17089-0402	
		Highmark Blue Cross Blue Shield Delaware and Highmark Health Options are Independent Licensees of the Blue Cross and Blue Shield Association.	
		<small>*Pharmacy Benefits Administrator</small>	

# CHAPTER 2: MEMBER INFORMATION

## UNIT 2: MEMBER RIGHTS

### IN THIS UNIT

### TOPIC

Member Rights and Responsibilities

- Member Rights
- Member Responsibilities

Critical Incidents

- What are Critical Incidents?
- Reporting Critical Incidents
- Reporting Suspected Abuse or Neglect

Second Opinions

Interpretation Services

Billing for Missed Scheduled Appointments Prohibited

## 2.2 MEMBER RIGHTS AND RESPONSIBILITIES

### Overview

All Highmark Health Options members have rights and responsibilities. The following is the Highmark Health Options Members' Rights and Responsibilities Statement.

### Member Rights

Highmark Health Options members have a right to:

- Learn about their rights and responsibilities
- Get the help they need to understand the Member Handbook
- Learn about Highmark Health Options, our services, doctors, and other health care providers
- See their medical records as allowed by law.
- Have their medical records kept private unless they tell us in writing that it is okay for us to share them or it is allowed by law
- Complete facts from their doctor of any information relating to their medical condition, treatment plan, or ability to inspect and offer corrections to their own medical records
- Be part of honest talks about their health care needs and treatment options no matter the cost and whether their benefits cover them
- Be part of decisions that are made by their doctors and other providers about their health care needs
- Be told about other treatment choices or plans for care in a way that fits their condition
- Get news about how doctors are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Be treated with respect, dignity, and the right to privacy all the time
- Know that we, their doctors, and their other health care providers cannot treat them in a different way because of their age, sex, race, national origin, language needs, or degree of illness or health condition
- Talk to their doctor about private things
- Have problems taken care of fast, including things they think are wrong, as well as issues about their coverage, getting an approval from us, or payment of service
- Be treated the same as others
- Get care that should be done for medical reasons
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Choose their PCP from the PCPs in our Provider Directory that are taking new patients

## 2.2 MEMBER RIGHTS AND RESPONSIBILITIES, Continued

### Member Rights (continued)

- Use providers who are in our network
- Get medical care in a timely manner
- Get services from providers outside our network in an emergency
- Refuse care from their PCP or other caregivers
- Be able to make choices about their health care
- Make an Advance Directive (also called a living will)
- Tell us their concerns about Highmark Health Options and the health care services they get
- Question a decision we make about coverage for care they got from their doctor
- File a complaint or an appeal about Highmark Health Options, any care they get, or if their language needs are not met
- Ask how many grievances and appeals have been filed and why
- Tell us what they think about their rights and responsibilities and suggest changes.
- Ask us about our Quality Improvement Program and tell us how they would like to see changes made
- Ask us about our utilization review process and give us ideas on how to change it
- Know that we only cover health care services that are a part of their plan
- Know that we can make changes to their health plan benefits as long as we tell them about those changes in writing
- Ask for the Evidence of Coverage and other member materials in other formats such as other languages, large print, audio CD, or Braille at no charge to them
- Ask for an oral interpreter and translation services at no cost to them
- Use interpreters who are not their family members or friends
- Know that they are not liable if their health plan becomes bankrupt (insolvent)
- Know their provider can challenge the denial of service with their approval
- Know that they can request a copy of the Member Handbook at any time; they will be notified annually of their right to request a handbook
- Know how they can get a list of providers in the network, including the names and education level of all network providers, and how they may choose providers within Highmark Health Options

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## 2.2 MEMBER RIGHTS AND RESPONSIBILITIES, Continued

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### Member Responsibilities

To receive the best care, members must do their part. Members have the responsibility to:

- Tell us, their doctors, and their health care providers what they need to know to treat them
- Ask us to correct their health and claims records if they feel they are incorrect or incomplete
  - We may say “no” to their request but we will provide the member a written explanation within 60 calendar days
  - The member may also request to have a statement of their disagreement added to their personal medical information
- Members who would like to make a request are advised to contact Member Services at 1-844-325-6251
- Learn as much as they can about their health issue and work with their doctor to set up treatment goals they agree on with their doctor
- Ask questions about any medical issue and make sure they understand what their doctor tells them
- Follow the care plan and instructions that they have agreed on with their doctors or other health care professionals
- Do the things that keep them from getting sick
- Make and keep medical appointments and tell their doctor at least 24 hours in advance when they cannot make it
- Always show their Member ID card when they get health care services
- Use the emergency room only in cases of an emergency or as their doctor tells them
- If they owe a copay to their pharmacies, pay at the time the services are received.
- Tell us right away if they get a bill that they should not have gotten or if they have a complaint
- Treat all Highmark Health Options staff and doctors with respect and courtesy
- Know and follow the rules of their health plan
- Know that laws guide their health plan and the services they get
- Know that we do not take the place of workers' compensation insurance
- Tell the Delaware Division of Social Services (DSS) Change Report Center and us when they change their address, family status, or other health care coverage; to report changes to the DSS Change Report Center, the member should call 1-866-843-7212

If a minor becomes emancipated (over the age of sixteen), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

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## 2.2 CRITICAL INCIDENTS

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### What Are Critical Incidents?

- Critical incidents shall include, but are not limited to, the following:
- Unexpected death of a member, including deaths occurring in suspiciously, unusually, or suddenly when the deceased was not attended by a physician;
  - Suspected physical, mental, or sexual mistreatment, abuse, and/or neglect of a member;
  - Suspected theft or financial exploitation of a member;
  - Severe injury sustained by a member;
  - Medication error involving a member; or
  - Inappropriate/unprofessional conduct by a provider involving a member
- 

### Reporting Critical Incidents

Providers must report critical incidents to Highmark Health Options by calling the Highmark Health Options Care Management Department at: 1-844-3256251.

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### Reporting Suspected Abuse or Neglect

Highmark Health Options identifies and tracks critical incidents and reviews and analyzes critical incidents to identify and address potential and actual quality of care and/or health and safety issues. In addition, Highmark Health Options identifies, develops, and implements strategies to reduce the occurrence of incidents and improve the quality of care.

To report suspected abuse or neglect, please contact Highmark Health Options at 1-844-325-6251.

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## 2.2 SECOND OPINIONS

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### **Second Opinions**

Highmark Health Options ensures member access to second opinions. Second opinions may be requested by Highmark Health Options, the member, the member's caregiver, or the primary care practitioner. Highmark Health Options will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network at no cost to the member.

The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider of Highmark Health Options. Second opinions from out-of-network providers must be authorized when no participating provider is accessible to the member or when no participating provider can meet the member's needs.

### **Second Surgical Opinions**

Second surgical opinions may be requested by Highmark Health Options, the member, member's caregiver, or the primary care practitioner. When requesting a second surgical opinion, Highmark Health Options recommends that you issue a referral to a consulting practitioner who is in a practice other than that of the attending practitioner or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner.

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## 2.2 INTERPRETATION SERVICES

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### **Translation Services**

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color, or national origin discrimination in programs receiving federal funds. Practitioners 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.

Practitioner offices are expected to address the need for interpreter services in accordance with the American with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Highmark Health Options will assist practitioners in locating resources upon request.

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### **Interpreter Services for Members Who are Hearing Impaired**

Highmark Health Options offers the Member Handbook and other Highmark Health Options 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 1-844-325-6251 to ask for these 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.

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## 2.2 BILLING FOR MISSED SCHEDULED APPOINTMENTS PROHIBITED

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**Policy for  
Missed  
Scheduled  
Appointments**

Centers for Medicare & Medicaid Services (CMS) prohibits providers from billing Medicaid recipients who miss scheduled appointments. Missed appointments are not a distinct reimbursable service and are included in the overall cost of doing business.

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# CHAPTER 3: COVERED BENEFITS AND SERVICES

## UNIT 1: MEMBER BENEFITS

### IN THIS UNIT

### TOPIC

#### Covered Services

- Overview
- Basic Benefits

#### Prescription Drugs

- Overview
- Prior Authorization and Exceptions
- 340B Claims
- When Prescription Medications are Covered
- Over-the-Counter (OTC)
- Non-Covered Pharmacy Services
- Delaware prescription Monitoring Program
- Pharmacy and PCP Lock-In

#### Emergent Services and Urgent Care

- Emergency Services
- Situations When Emergency Care is Typically Not Needed
- Hospital Guidelines Followed for Triage
- Follow-up Care After Emergency room Visit
- Urgent Care

#### Chiropractic Services

#### Non-Covered Services

## 3.1 COVERED SERVICES

### Overview

Highmark Health Options is responsible for all covered medical conditions within the Basic Benefit Package for each Highmark Health Options member. The package includes inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; limited behavioral health services; and a variety of others services.

Highmark Health Options members are also entitled to a number of services that are not included in the Basic Benefit Package. These services, referred to as “wrap-around” services, are covered under the State of Delaware’s fee-for-service program.

**All services provided must be medical necessary and some services may have limitations (e.g., behavioral health) or require authorization (e.g., orthotics).** Please see Chapter 5, Unit 1 of this manual for the definition of medically necessary. A listing of services that require authorization can also be found in Chapter 5, Unit 1 of this manual.

The following list of Basic Benefits is not all-inclusive (recommend consistency – if referencing “Prior Auth” per table – this should be consistent with all services that need “Prior Auth” – list needs to reflect accurately. If list is not updated – just list Services as “Covered” and add disclaimer – “some services may need Prior Authorization.”

Information on Additional Benefits can be found in Chapter 3, Unit 3 of this manual. Information on LTSS benefits can be found in Chapter 6, Unit 1 of this manual.

### Basic Benefits

SERVICES	COVERAGE DESCRIPTION
Abortion	Covered under certain circumstances; Consent form required
Acupuncture	Not covered
Allergy Testing	Covered
Bed Liners	Covered for members age 4 and up
Behavioral Health – Outpatient Mental Health and Substance Abuse Services	<ul style="list-style-type: none"> <li>∞ Under age 18: Covered for 30 visits per year; After 30 visits per year, services are covered by the Department of Services for Children, Youth and Families (DSCYF)</li> <li>∞ Age 18 and older: Covered</li> </ul>

Behavioral Health – Inpatient Mental Health and Substance Abuse Services	<ul style="list-style-type: none"> <li>• Under age 18: Covered by DSCYF</li> <li>• Age 18 and older: Covered</li> </ul>
Behavioral Health – Partial Hospitalization, Intensive Outpatient	Covered
Behavioral Health – Residential Treatment Facility	Covered
Blood and Plasma Products	Covered
Bone Mass Measurement (Bone Density)	Covered
Bony Impacted Wisdom Teeth	Covered
Care Management	Covered
Chemotherapy	Covered
Chiropractic Services	Services may be subject to prior authorization and/or medical review.
Colorectal and Prostate Screening Exams	Covered
CT Scans	Covered
Dental Services (Under age 21) Call 1-302-571-4900 or toll free 1-800-372-2022	<p>The Delaware Medical Assistance Program covers certain dental care for children up to age 21</p> <p>(Note: Dental benefit for the Delaware Healthy Children Program is up to the 19th birthday)</p> <ul style="list-style-type: none"> <li>• Removal of bony impacted wisdom is covered</li> </ul>
Dental Services (Adult)	Not covered except removal of bony impacted wisdom teeth
Diabetic Education	Covered
Diabetic Equipment	Covered Prior authorization if over \$500 billed charges
Diabetic Supplies	Covered Glucose monitors/strips

Dialysis	Covered
Diapers (for members age 4 and up)	Covered Prior Authorization if over \$500 billed charges
Drugs Prescribed by a Doctor	Covered
Durable Medical Equipment	Covered Prior Authorization if over \$500 billed charges
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (for under age 21)	Covered
Emergency Medical Transportation (air and ambulance)	Covered
Emergency Room Care	Covered
Eye Exam, Medical (for conditions such as eye infections, glaucoma, and diabetes)	Covered for all members
Eye Exam, Routine	Covered if age 20 and younger See additional benefits for adult coverage
Eyeglasses or Contacts	Covered if age 20 and younger; See additional benefits for adult coverage
In-Network Family Planning Services	Covered
Non-Par Family Planning Services	Covered for DSHP; Not covered for DHCP
Genetic Testing	Covered
Glaucoma Screening	Covered
Gynecology Visits	Covered
Hearing Aids and Batteries	Covered if age 20 and younger
Hearing Exams	Covered
HIV/AIDS Testing	Covered
Home Health Care and Infusion Therapy	Covered
Hospice Care	Covered
Hospitalization	Covered
Imaging (CT, MR, PET, SPECT, Nuclear Studies)	Covered
Immunizations	Covered
Lab Tests and X-rays	Covered
Mammograms	Covered

Medical Supplies	Covered Prior authorization if over \$500 billed charges
Methadone/Medication Assisted Therapy	Covered
MRI, MRA, PET Scan	Covered
Non-Emergency Medical Transportation	Eligible Delaware Medicaid clients <b>excluding DHCP members</b> in need of non-emergency transportation should contact ModivCare at 1-866-412-3778

Nursing Home	Covered up to 30 days per year; Additional days are considered long-term care; an application must be submitted to and approved by the Delaware Medical Assistance Program for long-term care
Observation	Covered
Obstetrical/Maternity Care	Covered
Organ Transplant Evaluation	Covered
Organ Transplant	Covered
Orthopedic Shoes	Covered Prior authorization if over \$500 billed charges
Outpatient Surgery, Same Day Surgery, Ambulatory Surgery	Covered
Pain Management Services	Covered
Pap Smears and Pelvic Exams	Covered
Parenting/Childbirth Education	Covered
Personal Care/Aide Services (in home)	Covered
Podiatry Care (routine diabetic care or peripheral vascular disease)	Covered
Prescription Drugs	Covered
Primary Care Provider Visits	Covered
Private Duty Nursing	Covered
Prosthetics and Orthotics	Covered Prior authorization if over \$500 billed charges
Radiation Therapy	Covered

Rehabilitation (inpatient hospital)	Covered
Skilled Nursing Facility Care 2019	Covered up to 30 days per year
Sleep Apnea Studies	Covered
Smoking Cessation Counseling	Covered
Specialty Physician Services	Covered
Surgical Center	Covered
Therapy – Outpatient Occupational, Physical, Speech	Covered

## 3.1 PRESCRIPTION DRUGS

### Overview

Highmark Health Options provides coverage for outpatient prescription drugs and certain over-the-counter products for non-institutionalized members when the drug labeler participates in the Federal Medicaid Drug Rebate Program and is included on the Delaware Department of Health and Social Services (DHSS) Preferred Drug List (PDL) or the Highmark Health Options Supplemental Formulary. Practitioners are requested to prescribe medications included in the PDL/Supplemental Formulary whenever possible. The PDL/Supplemental Formulary is updated on a regular basis and can be accessed online at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

Medication additions or deletions reflect the decisions made by Highmark Health Options Pharmacy and Therapeutics (P&T) Committee and inclusion on the DHSS-approved PDL. If a PDL and Supplemental Formulary deletion is made that affects one of your patients, Highmark Health Options will provide you with notification thirty (30) days prior to the change.

Additional copies of the PDL and Supplemental Formulary can be printed directly from our website or requested through Pharmacy Services by calling 1-844-325-6251.

Providers may request the addition of a medication to the Supplemental Formulary. Requests must include the drug name, rationale for inclusion on the Supplemental Formulary, role in therapy, and formulary medications that may be replaced by the addition. The P&T Committee will review requests. All requests should be sent in writing to:

**Highmark Health Options P&T Committee**

Four Gateway Center  
444 Liberty Avenue  
Suite 2100  
Pittsburgh, PA 15222

### Prior Authorization and Exceptions

Some medications, although listed on the PDL or Supplemental Formulary, require prior authorization to be covered. All prior authorization and step therapy criteria can be found on the Highmark Health Options website. If use of a PDL or Supplemental Formulary medication is not medically advisable for a member, you must initiate a Request for Medicaid Drug Exception (prior authorization). Please refer to the provider section of the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com) for a copy of this form.

The exception process allows for a 24 hour turnaround when reviewing requests for non-formulary, non-preferred, prior authorization, and step therapy medications. In the event that a decision has not been made within 24 hours, Highmark Health Options will authorize a temporary supply of the non-formulary, non-preferred, prior authorization, or step therapy medication.



For emergently needed medications, the pharmacist may authorize up to a 3-day supply of the medication.

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### **340B Claims**

In adherence with State Plan Amendment #16-001, effective 1/1/2016, pharmacies that purchase Section 340B of the Public Health Service Act products must request to dispense and bill for these drugs from the State of Delaware for all Delaware Medical Assistance patients. Once approval information has been communicated to Highmark Health Options from the Delaware Medical Assistance Program (DMAP), the pharmacy will be able to properly submit claims for 340B drugs, using the following values:

- NCPDP Data Element 409-D9: Ingredient Cost Submitted = 340B Acquisition Cost
- NCPDP Data Element 420-DK: Submission Clarification Code = 20 Claims for 340B drugs from pharmacies not approved by DMAP will be reversed and processed accordingly

### 3.1 PRESCRIPTION DRUGS, Continued

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**When Prescription Medications are Covered**

Prescription medications are reimbursed when the medication is prescribed for a Food and Drug Administration (FDA) approved indication(s); prescribed for indications, dosages, and formulations that are part of nationally-developed standards; prescribed for indications, dosages, and formulations that have been shown to demonstrate both efficacy and safety in a minimum of two (2) peer-reviewed journals.

Any other prescription is considered experimental and, therefore, not covered unless specific authorization has been given by Highmark Health Options for an individual member based on a demonstration of medical necessity.

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**Over-the-Counter (OTC)**

Select over-the-counter (OTC) pharmaceuticals, including vitamins, are a covered benefit for all non-institutionalized members. Members must have a written prescription for each OTC pharmaceutical/vitamin and the prescription must be filled by a Highmark Health Options participating pharmacy. The labeler of the OTC product must also be participating in the Federal Medicaid Drug Rebate Program.

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**Non-Covered Pharmacy services**

The following are non-covered pharmacy services:

- Drugs or devices marketed by a manufacturer who does not participate in the Federal Medicaid Drug Rebate Program
  - Drug Efficacy Study Implementation (DESI) drugs
  - Drugs used for cosmetic purposes or hair growth
  - Fertility drugs
  - Investigational/experimental drugs
  - Drugs not approved by the FDA
  - Compounded prescriptions that do not contain at least one FDA-approved covered ingredient
  - Drugs used for treatment of sexual or erectile dysfunction
  - Drugs to promote weight gain not due to AIDS wasting or cachexia
  - Drugs not medically necessary
- 

*Continued on next page*

## 3.1 PRESCRIPTION DRUGS, Continued

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### **Delaware Prescription Monitoring Program**

Providers are required to follow all requirements of the Delaware Prescription Monitoring Program (PMP), including mandatory registration to access the PMP.

The PMP system collects information on all controlled substances (schedules II-V) prescriptions. Prescribers registered with the PMP can obtain immediate access to an online report of their current or prospective patient's controlled substance prescription history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the PMP system to patients.

Providers are encouraged to use this information as part of your clinical assessment to improve patient care and monitor for misuse and diversion of controlled substances. All PMP users must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.

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### **Pharmacy and PCP Lock-In**

Highmark Health Options has the right to lock members to specific provider types when it has been determined that the member has abused his or her health care benefits. Highmark Health Options complies with all applicable State and Federal regulations concerning member lock-in, including the requirements of the Delaware Medicaid and Medical Assistance Program and the Delaware Medicaid Managed Care Organizations Agreement.

Several reasons may indicate the need to lock a member to a specific primary care physician and/or pharmacy, such as continuity of care and coordination of care, physician and pharmacy shopping for the purpose of obtaining controlled or non-controlled drugs, altering a prescription, over-utilization of any provider type, or fraudulent use of any Highmark Health Options services, i.e., borrow or use of Highmark Health Options identification card (other than their own) to gain medical services.

Members who have been selected for lock-in will be sent a letter notifying them of the lock-in. Included with the lock-in letters are instructions on how to file a grievance through Highmark Health Options' grievance process.

The Pharmacy Fraud Analyst is responsible for monitoring the member's lock-in by utilizing the "Lock-in Database." The Pharmacy Fraud Analyst evaluates/reviews the member's pharmacy and medical claims utilization and inquires as to what physicians other than the member's PCP are writing prescriptions, including the total number of units obtained, number of day's supply, and the dosage as prescribed.

Providers should contact the Highmark Health Options Pharmacy Department at 1-844-325-6251 if they have questions or they need to refer a member for lock-in consideration.

## 3.1 EMERGENT SERVICES AND URGENT CARE

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### **Emergency Services**

The definition of an emergency is: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

The following conditions are examples shared with the patient of those conditions that most likely require emergency treatment:

- Danger of losing life or limb
- Poisoning
- Chest pain and heart attack
- Overdose of medicine or drug
- Choking
- Heavy bleeding
- Car accidents
- Possible broken bones
- Loss of speech
- Paralysis
- Breathing problems
- Seizures
- Criminal attack (mugging or rape)
- Heart attack
- Blackouts
- Vomiting blood

### **Situations When Emergency Care is Typically Not Needed**

Highmark Health Options members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold
- Sore throat
- Small cuts and bruises
- Ear ache
- Vomiting
- Rash
- Bruises
- Swelling
- Cramps
- Cough

*Continued*

## 3.1 EMERGENT SERVICES AND URGENT CARE, Continued

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### Hospital Guidelines for Triage

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital's preestablished guidelines allow for the triage of illness and injury.

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### Follow-Up Care After Emergency Room Visit

All follow-up care after an emergency room visit must be coordinated through the primary care practitioner. Members are informed via the Member Handbook to contact their primary care practitioner for a referral for follow-up care in instances such as:

- Removal of stitches
  - Changing of bandages
  - Cast check
  - Further testing
- 

### Urgent Care

The definition of urgent care is medically necessary treatment that is needed within forty-eight (48) hours to prevent deterioration to the member's health. Examples of urgent care include:

- Persistent rash,
- Recurring high-grade temperature,
- Non-specific pain, or
- Fever

## 3.1 CHIROPRACTIC SERVICES

### Overview

Highmark Health Options provides coverage for chiropractic services.

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Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State. Services consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform as follows:

1. For Medicaid-eligible Individuals under age 21, as an EPSDT service, per 42 CFR §441 Subpart B, furnished upon medical necessity; or
2. For Medicaid-eligible individuals over age 21, furnished upon medical necessity and following the service utilization criteria below:
  - a. One (1) office visit per year;
  - b. One (1) set of X-rays per year, and
  - c. Twenty (20) manipulations per year

### Provider Qualifications

Qualified chiropractors must be licensed per Delaware licensure requirements codified in Chapter 7, Title 24 of the Delaware Administrative Code, Professions and Occupations.

---

### Covered Services and Limitations

- Manipulation associated with the treatment of neck, back, and pelvic/sacral pain
- Necessity for Treatment: The patient must have a significant neuromusculoskeletal condition necessitating treatment
- Evaluation and management services
- X-rays may be used to diagnose spinal subluxation. Coverage of spinal x-rays is limited to one (1) set per member in a rolling twelve (12) month period.

- Additional x-rays may be taken within the same calendar year to document a new condition or an exacerbation/re-injury. X-rays used to determine progress are limited to one (1) study per calendar year. Progress x-rays, beyond the first in a calendar year, may be pre-authorized

**Manipulations**

Manipulations should be provided in accordance with an ongoing, written treatment plan and must be appropriate for the diagnosis reported. The treatment plan should be updated as the patient's condition changes and maintained in the medical records.

Manipulations can be provided manually or with the assistance of various mechanical or computer operated devices. No additional payment is available for use of the device or for the device itself.

**Evaluation and Management Services**

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be medically necessary. A separate E/M service should not be routinely reported with manipulation or time-based physical medicine services.

**X-rays**

Used to determine primary diagnosis and then to monitor progress.

**Daily Maximum**

There is a daily maximum for chiropractic care. Included in the daily maximum are:

- Spinal manipulations
- Adjunctive services/physical therapy codes as follows:

Code	Narrative
97012	Mechanical Traction
97014	Electrical Stim (Unattended)
97016	Vasopneumatic
97022	Whirlpool
97024	Diathermy
97026	Infrared
97032	Electrical Stim (Attended)
97035	Ultrasound

97110	Therapeutic Procedure
97112	Neuromuscular Reeducation
97113	Aquatic Therapy
97116	Gait Training
97124	Massage Therapy
97140	Manual Therapy
97535	Activities of Daily Living
97010	Cold/Hot Packs

Other approved services for chiropractic such as radiology and office visits for evaluation and re-evaluation are *not* included in the daily maximum.

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**Non-Covered Services**

Non-covered chiropractic services include the following:

- Acupuncture
  - Vitamins
  - Minerals
  - Supplements
  - Any other chiropractic service not defined in this benefit
  - Chiropractic maintenance therapy is not considered to be medically necessary and is not covered.
  - Orthopedic devices prescribed by chiropractor
  - Physiotherapy modalities including diathermy and ultrasound provided by chiropractor
  - Treatment for any condition not related to a diagnosis of subluxation or low back pain
  - X-rays other than those needed to support a diagnosis of subluxation.
  - Any services outside of scope of state licensure
  - Room and ward fees are not covered
  - Hand-held and other devices may be used in treatment but are not eligible to be reimbursed
  - Experimental/Investigational (E/I) services are not covered regardless of place of service
  - Quantity level limits or quantity of supplies that exceed the frequency guidelines listed on the policy will be denied as non-covered
  - Services rendered prior to January 1, 2018 or prior to the provider's contractual effective date
- 

***A network provider cannot bill the member for the non-covered service.***



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**Prior Authorization**

within a calendar year. However, authorization and supporting clinical documentation is required for additional manipulations beyond the first twenty (20).

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**Billing of Services**

Refer to the payable service codes within section Covered Services.

Services that do not meet the criteria of this policy will not be considered medically necessary. A network provider cannot bill the member for the denied service unless: (a) the provider has given advance written notice, informing the member that the service may be deemed not medically necessary; (b) the member is provided with an estimate of the cost; and (c) the member agrees in writing to assume financial responsibility in advance of receiving the service. The signed agreement must be maintained in the

## 3.1 NON-COVERED SERVICES

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### Services That Are Not Covered

Some of the services not covered by the Delaware Medical Assistance Program or Highmark Health Options include the following:

- Autopsies
  - Cosmetic surgery, unless medically necessary
  - Dental services for members 21 years of age and older
  - Christian Science nurses and/or sanitariums
  - Experimental procedures, unless prior approval is received from Highmark Health Options
  - Exercise equipment for the home
  - Care outside of the service area *except* in an emergency
  - Care outside of the continental U.S
  - Non-emergency services from an out-of-network provider that are not prior approved
  - Personal items or services such as television or a telephone while in the hospital
  - Prescription drugs not listed on the approved drug list, unless an exception is made
  - Drugs designated as less than effective by the Food and Drug Administration (FDA) (These are known as DESI for the Drug Efficacy Study Implementation drugs)
  - Drugs prescribed for the treatment of erectile dysfunction
  - Infertility treatment
  - Work-related and travel physicals
  - Services/items that are not medically necessary
  - Services that are not covered by the Medicaid Program
  - Non-medical items or services
  - Hearing aids for members 21 years of age and older
  - Residential weight loss clinics
  - Paternity tests
-

# CHAPTER 3: COVERED BENEFITS AND SERVICES

## UNIT 2: BEHAVIORAL HEALTH SERVICES

### IN THIS UNIT

### TOPIC

#### Overview

- Introduction
- Referring Members

#### Benefits and Services

- Limitation of Benefit
- Verifying Eligibility
- Provider Appointment Standard
- In-Office Wait Time
- Coordination Between Physical Health and Behavioral Health

#### Crisis Intervention Services

- Statewide Service Locations
- Northern Delaware
- Southern Delaware

#### Behavioral Health Authorizations

- Services Requiring Authorization
- Requesting Precertification
- Requesting Ongoing (Concurrent) Authorization
- Discharge Notification Form

#### Substance Abuse Treatment Authorizations (*Update*)

- Services Requiring Authorization
- Requesting Precertification

## 3.2 OVERVIEW

### Introduction

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Highmark Health Options ensures that members have access to high-quality behavioral health (BH) services for treatment of mental health (MH) and substance use disorders (SUD) at a level of care within the least restrictive environment. An array of contracted providers offer services and supports for our members' BH/SUD needs across a continuum of care. Highmark Health Options Behavioral Health program adheres to the Mental Health Parity Act and Delaware Senate Bill 109 related to coverage for MH/SUD.

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### Referring Members

Any Highmark Health Options provider can refer a member for Care Coordination around behavioral health and/or physical health needs. Providers should call 1-844-325-6251 and select the Clinical Care Coordination option.

Some scenarios where behavioral health coordination of care might be indicated:

1. A person seeking help getting treatment for a mental illness or substance use disorder
2. A person with chronic comorbid medical and behavioral health conditions who is being treated by multiple providers
3. A person who has frequent hospitalizations and ER admissions for conditions that could be safely/effectively treated at lower levels of care
4. A person with medical conditions that are being adversely impacted by has a behavioral health condition

## 3.2 BENEFITS AND SERVICES

### Verifying Eligibility

Outpatient behavioral health benefits for members under the age of 18 is limited to thirty (30) units per calendar year. After the member has exhausted 30 units of behavioral health services for the calendar year, Highmark Health Options is no longer responsible for the member's behavioral health utilization until the end of the calendar year.

### Limitation of Benefit

Members under age 18 requiring more than 30 units of behavioral health services during the calendar year will have their behavioral health utilization managed by the Delaware Division of Prevention and Behavioral Health Services. Members needing more than 30 units of Applied Behavioral Analysis (ABA) will have their benefits managed by the Division of Developmental Disability Services.

Certain behavioral health-related services and services to members under age 18 with behavioral health needs are covered services outside of the 30 units of outpatient behavioral health services. Highmark Health Options provides coverage of these services when medically necessary and shall not count these services against the 30 units of outpatient behavioral health services. These services include, but are not limited to the following:

1. EPSDT screening, including specific behavioral health screening components
2. All non-psychiatric treatment services provided in inpatient hospitals, regardless of the child's behavioral health diagnosis, for example, an anorexic adolescent with life-threatening weight loss
3. All prescribed medications, including psychotropic, anti-depressant, or other drugs used in behavioral health treatment
4. Medication management, inpatient or outpatient, for all prescribed medications, including psychotropic, anti-depressant, or other drugs used in behavioral health treatment
5. Outpatient physician or pediatrician visits, including emergency room visits for medical and behavioral health reasons
6. Medical detox services to adequately evaluate for appropriate triage and follow-up services
7. In general, both a diagnosis of behavioral health and an acceptable (agreed to by the State) procedure (or revenue) code must be provided to be considered part of the 30 units of outpatient behavioral health services for members under age 18

For members participating in PROMISE, licensed behavioral health practitioner services (including licensed psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists) and substance use disorder services, except for medically managed intensive inpatient detoxification, are the responsibility of the State.

Behavioral health providers must verify member eligibility prior to rendering care. An authorization is not a guarantee of payment. Providers rendering care to a member who is no longer eligible for Medicaid or who is no longer enrolled with Highmark Health Options will not be paid for claims. Eligibility can be verified using the Interactive Voice Response (IVR) system by calling 1-844-325-6161.

## Provider Appointment Standards

For more information on verifying eligibility, please see Chapter 2, Unit 1 of this manual.

The following are standards for appointments:

- Non-emergency outpatient services for medication management within three (3) weeks of request
- Request for outpatient services other than for medical management, including initial assessment, following discharge from an inpatient or residential setting to a community setting, or after being seen within an emergency room for behavioral health crisis - within seven (7) days
- Member requires emergency services - within twenty-four (24) hours of request
- Immediate treatment for a potentially suicidal member with care within one (1) hour
- Urgent care – within forty-eight (48) hours

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## In-office Wait Time

As a matter of practice, a provider must not require a member to wait more than one (1) hour for a scheduled appointment. For members who are unable to be seen within ninety (90) minutes of their scheduled appointment time due to the provider being delayed by other patients requiring immediate or emergent care, the member will be offered a new appointment.

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## Coordination Between Physical Health and Behavioral Health

To holistically integrate physical health and behavioral health for Highmark Health Options members, all behavioral BH/SUD treatment providers are encouraged identify the member's primary care physician and/or other physical health provider(s) to coordinate for care planning. Physical health providers are also encouraged to determine if a member is BH/SUD treatment services to coordinate for care planning.

In the event the provider does not have access to appropriate Release of Information Form(s) that are needed for information sharing and collaboration, a Highmark Health Options Release of Information Form may be used. Highmark Health Options' release forms are available on the Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com). If assistance is needed with coordinating care between behavioral health and physical health, the provider may call the Highmark Health Options Care Management Department at 1-844-325-6251 and select the Care Coordination option for assistance.

## 3.2 CRISIS INTERVENTION SERVICES

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### Overview

Members experiencing an acute crisis are able to access Crisis Intervention Services (CIS) at any time, 24 hours a day, 7 days a week, 365 days a year. The Division of Substance Abuse and Mental Health (DSAMH) provides assistance and support with crisis intervention services.

More information about DSAMH crisis intervention can be found at: [http://dhss.delaware.gov/dsamh/crisis\\_intervention.html](http://dhss.delaware.gov/dsamh/crisis_intervention.html).

Members under the age of 18 experiencing an acute mental health crisis are able to access crisis intervention services through the Division of Prevention and Behavioral Health Services. More information may be found at: <https://kids.delaware.gov/>.

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### Crisis Intervention Services (CIS)

The Division offers a continuum of Crisis Intervention Services. These services are located throughout the State in the Crisis Intervention Service Centers, the Community Mental Health Centers, the Recovery Response Center, and Emergency Rooms. Crisis Intervention Services (CIS) staff are available 24 hours a day to assist people 18 years of age and older 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 abuse.

The goal of CIS is the prevention of unnecessary or inappropriate hospitalizations of a person experiencing severe symptoms of a mental illness or substance related problem. By providing services in the community, CIS staff can better assess the consumer's environment, support systems, and current level of functioning. They can gain a clear

In addition to these services, the crisis staff works in conjunction with every police department throughout the state, providing training in police academies, individualized roll call trainings, and assisting in the evaluation of persons picked up on criminal charges who may require mental health evaluations and who may be appropriate for the State's [Mental Health Courts](#).

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## 3.2 CRISIS INTERVENTION SERVICES, Continued

### Statewide Service Locations

The tables below provide locations and hours for crisis intervention services in Northern Delaware and Southern Delaware.

### Northern Delaware

<b>NORTHERN DELAWARE</b>	
<b>LOCATION &amp; HOURS</b>	<b>PHONE</b>
<p><b>Mobile Crisis Intervention Services(MCIS), Northern Delaware</b>                      Fernbook Building                      14 Central Avenue                      New Castle, DE 19720</p> <p><b>Staffed 24 hours a day, 7 days a week</b></p> <ul style="list-style-type: none"> <li>• Serves all of New Castle County and greater Smyrna in Northern Kent County</li> <li>• Provides phone support, mobile outreach, and walk-in crisis services</li> </ul>	<p><b>1-302-577-2484; or 1-800-652-2929</b> (toll free)</p>
<p><b>NET Detox</b>                      3315 Kirkwood Highway                      Wilmington, DE 19804</p> <ul style="list-style-type: none"> <li>• 24/7 Medically Monitored Inpatient Detoxification</li> <li>• Treatment</li> <li>• Individual and Group Counseling</li> <li>• Consumer Engagement and Transition Program</li> </ul>	<p><b>1-302-691-0140</b> or <b>1-800-359-1367</b></p>
<p><b>Recovery Innovations Recovery Response Center (RRC)</b>                      659 East Chestnut Hill Road                      Newark DE 19713</p> <p>Offers facility based crisis services for adults experiencing mental health or substance abuse crisis. Services are available 24 hours a day, 365 days a year.</p>	<p>1-302-318-6070</p>





## 3.2 BEHAVIORAL HEALTH AUTHORIZATIONS

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### Services Requiring Authorization

Highmark Health Options requires precertification for all inpatient and outpatient behavioral health services. Services for medication management are excluded from need for precertification.

Prior authorization is not required for crisis-related services under procedure codes 90839 or 90840. The provider may bill Highmark Health Options for services under these procedure codes with no authorization required.

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### Requesting Precertification

Providers requesting precertification will fax the Request for Authorization Form to 1-844-325-6251 to initiate the review. The Request for Authorization Form can be found on the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

The Behavioral Health team can be reached at 1-844-325-6257 by selecting the option for Authorization Requests.

Minimal information needed for a prior authorization request:

1. Member's name and date of birth
2. Presenting issue/concern necessitating request for service
3. Member co-morbidities (physical health and behavioral health), including any complications with effective self-management or treatment
4. Any psychosocial factors impacting care or discharge planning including, when applicable, home situation
5. Treatment plan
6. Any other information relevant to the review

The Highmark Health Options Behavioral Health representative rendering the precertification authorization will provide guidance on information needed for further authorization. This information will support review of services beyond the precertification or the last ongoing concurrent review.

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## 3.2 BEHAVIORAL HEALTH AUTHORIZATIONS, Continued

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### **Requesting Ongoing (Concurrent) Authorization**

When services are needed beyond the initial precertification or last ongoing concurrent review, the provider may contact the Behavioral Health team at 1-844-325-6251 and select the Authorization Request option to request continued authorization.

When calling the Behavioral Health team for continued authorization, the provider will need to have access to the following information:

1. Member's name
  2. Member's Highmark Health Options Member ID number
  3. Authorization number or member's date of birth
  4. Summary of treatment progress since last authorization review
  5. Summary of current goals
  6. For admissions, any known factors impacting discharge planning, such as home situation
  7. Update on information requested by Highmark Health Options Behavioral Health representative at previous review
  8. Any other information relevant to the review
- 

### **Discharge Notification Form**

When a member has been discharged from a behavioral health-related admission, the provider will fax the Discharge Notification Form to 1-855-4127997 so the admission authorization can be updated and closed and the Highmark Health Options Behavioral Health clinical care coordination team can initiate outreach to the member.

The Discharge Notification Form is located on the Highmark Health Options website at [highmarkhealthoptions.com](https://highmarkhealthoptions.com).

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## 3.2 SUBSTANCE ABUSE TREATMENT AUTHORIZATIONS

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### Services Requiring Authorization

Highmark Health Options requires prior authorization only upon the member's:

- 15th day of an Inpatient Substance Abuse Treatment,
- 6th day of Withdrawal Management, or
- 31st day of an Intensive Outpatient Treatment

Providers are required to notify Highmark Health Options within 48 hours of admission. A 48 hour BH Notification Form is available via website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com) or by calling Behavioral Health at 1-844-325-6251. Upon notifying Highmark Health Options providers will be given a reference number. A copy of the 48 hour admission notification can be found on the Highmark Health Options website at <https://www.highmarkhealthoptions.com/sites/default/files/48HourNotification.pdf>.

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### Requesting Authorization

Providers requesting authorization will fax the Request for Authorization Form to 1-855-412-7997 to initiate the review. The Request for Authorization Form can be found on the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

The Behavioral Health team can be reached at 1-844-325-6251 by selecting the option for Authorization Requests.

Minimal information needed for a prior authorization request:

1. Member's name and date of birth
2. Presenting issue/concern necessitating request for service
3. Member co-morbidities (physical health and behavioral health), including any complications with effective self-management or treatment
4. Any psychosocial factors impacting care or discharge planning including, when applicable, home situation
5. Treatment plan
6. Any other information relevant to the review

The Highmark Health Options Behavioral Health representative rendering the precertification authorization will provide guidance on information needed for further authorization. This information will support review of services beyond the precertification or the last ongoing concurrent review.

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# CHAPTER 3: COVERED BENEFITS AND SERVICES

## UNIT 3: ADDITIONAL SERVICES

### IN THIS UNIT

### TOPIC

Dental and Vision Services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

- Primary Care Practitioner Responsibilities
- Required Screenings Schedule
- Initial Assessments
- Coordinating Services
- Reporting Services
- Referrals
- Member Outreach Form

Transplant Services

- Covered Transplant Services
- [Eligibility Requirements](#)

### 3.3 DENTAL AND VISION SERVICES

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#### Dental Services

Dental services for Highmark Health Options members **under the age of 21** are covered by the Delaware Department of Health and Social Services (DHSS) with the exception of the removal of boney impacted wisdom teeth which is covered under Highmark Health Options medical coverage as a surgical service.

For information on dental coverage, please call 1-800-372-2022.

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#### Vision Services

Highmark Health Options members **under the age of 21** have coverage for routine eye examinations. Highmark Health Options has subcontracted with Davis Vision to administer routine vision benefits, providing Highmark Health Options members with access to the largest number of vision care practitioners possible. Highmark Health Options Member Services is available to provide information regarding the participation status of individual practitioners.

Members **under the age of 21** are eligible for one (1) standard pair of eyeglasses (one (1) frame and two (2) lenses), or one (1) pair of contact lenses from within Highmark Health Options network per twelve (12) month period, as well as replacement, if medically necessary.

For all members, cosmetic tinted contacts are excluded.

If a member chooses frames or specialty contact lenses costing more than Highmark Health Options allows, the member may be charged an additional fee.

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### 3.3 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

#### Overview

Highmark Health Options' Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is based upon the federally-mandated ESPDT Program for Medical Assistance-eligible children under the age of 21 years. Through the EPSDT Program, children are eligible to receive medical, dental, vision, and hearing screens to assure that they receive all medically necessary services without regard to Medical Assistance covered services.

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#### Primary Care Practitioner Responsibilities

Each primary care practitioner and primary care/specialist is responsible for providing the health screens for Highmark Health Options members to include the early detection of behavioral health needs, including the use of a reliable and validated screening tool prior approved by Highmark Health Options, and make appropriate referrals to address behavioral health needs, including referral to PROMISE as appropriate. The results of these screens are to be reported to Highmark Health Options, as well as communicating demographic information (e.g. telephone number, address, alternate address) with the staff to assist with scheduling, locating, and addressing compliance issues. Highmark Health Options verifies that primary care practitioners and PCP/specialists for special needs are able to provide EPSDT services at the time of the practitioner's office site visit. Primary care practitioners who treat children under the age of 21 who are unable to comply with the requirements of the EPSDT Program must make arrangements for EPSDT screens to be performed elsewhere by a Highmark Health Options participating provider. Alternative primary care practitioners and specialists should forward a copy of the completed progress report to the primary care practitioner so it can be placed in the member's chart.

Primary care practitioners are required to assure all children under the age of 21 have timely access to EPSDT services, and are responsible for assuring continued coordination of care for all members due to receive EPSDT services. Also, primary care practitioners are to arrange for medically necessary follow-up care after a screen or an encounter.

The State and Highmark Health Options encourages and supports the establishment and use of patient-centered, multi-disciplinary, team-based approaches to care, including but not limited to patient-centered medical homes (PCMHs), nurse-managed primary care clinics, integrated primary and behavioral health services, use of non-traditional health workers, and accountable care organizations (ACOs).

Primary care practitioners are responsible for the above activities, Highmark Health Options shall monitor Primary care practitioners to ensure they comply with the requirements.

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#### Required Screenings Schedule

The required screen and tests are outlined in the provider section of the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com). Primary care practitioners are required to follow this schedule to determine when the necessary screens and tests are to be performed. Members must receive, at a minimum, eight screens between the ages of birth and 18 months, and seventeen screens between 19 months and 21 years.

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### 3.3 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

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#### Initial Assessments

When treating Supplemental Security Income (SSI) and SSI-related members under the age of 21, an initial assessment must be conducted at the first appointment. Written assessment must be discussed with the member's family or custodial agency; grievance or appeal rights must be presented by the primary care practitioner; and recommendations regarding case management must be documented.

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#### Coordinating Services

Primary care practitioners are responsible for ongoing coordination and monitoring of care provided by other practitioners.

Highmark Health Options staff works collaboratively with provider offices in coordinating medically necessary services to members. Staff provides outreach via telephone and mail to members who are under 21 years of age to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to health care. Staff is also available to outreach to members identified by the primary care practitioner offices who are delayed with screens and/or immunizations or who are non-adherent with appointments.

The primary care practitioner is responsible for contacting new members identified on encounter lists as not adhering to EPSDT periodicity and immunization schedules.

---

#### Reporting Services

All EPSDT screening services must be reported to Highmark Health Options on a HIPAA-compliant claim form. Please note the following concerning EPSDT encounters:

- The appropriate diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21
- Appropriate evaluation and management codes must be included
- Appropriate charges must be listed for each line item
- Providers have one hundred twenty (120) days to submit completed EPSDT encounters

Procedure codes must be included on the form. A description of the services will not be accepted. The practitioner's tax identification number must be included on the form to avoid problems with payment of services. Highmark Health Options does not apply coordination of benefits to EPSDT screens.

See section 7.1 EPSDT Claim Format Requirements for detail description of reporting requirements for CMS-1500 and EDI claim submission.

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### 3.3 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

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**Reporting Services**  
(continued)

Completed paper claim forms must be submitted within one hundred twenty (120) days of the date of service to:

Highmark Health Options  
Claims Department  
P.O. Box 890402  
Camp Hill, PA 17089-0402

The 1500 Health Insurance Claim Form does not indicate findings from the clinical exam. It is the responsibility of the primary care practitioner to document these findings in the medical record.

Please refer to Chapter 7, Unit 2 for additional information regarding submission of claims for EPSDT visits.

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**Referrals**

Following an EPSDT screen, if a developmental delay is suspected and the child is not receiving services at the time of the screening, the primary care practitioner is required to refer the child (not over three (3) years of age) to the Birth to Three Early Intervention system at 1-302-255-9134.

Members under age 21 who require behavioral health services should be referred to the Delaware Department of Services for Children, Youth, and Their Families at 1-302-633-2600.

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**Member Outreach Form**

Please complete and mail to Highmark Health Options the [Member Outreach Form](#) for any members with abnormal findings, or who did not show up for his/ her appointment, so we may contact the member.

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**Payment: Claims will be paid at the provider's EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.**

## 3.3 TRANSPLANT SERVICES

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### Covered Transplant Services

Highmark Health Options covers the following transplant services based upon applicable eligibility requirements and medical necessity criteria:

- Bone marrow
  - Cornea
  - Heart
  - Heart/lung
  - Liver
  - Kidney
  - Pancreas
- 

### Eligibility Requirements

The following eligibility requirements/conditions must be met:

- Current medical therapy has failed and will not prevent progressive disability and death;
  - The patient does not have any other major systemic disease that would compromise the transplant outcome;
  - There is every reasonable expectation, upon considering all circumstances involving the patient, that there will be strict adherence by the patient to the long-term difficult medical regimen which is required;
  - The transplant is likely to prolong life for at least two (2) years and restore a range of physical and social functions suited to the activities of daily living (ADLs);
  - The patient is not both in an irreversible terminal state (moribund) and on a life support system;
  - The patient has a diagnosis appropriate for the transplant; and
  - The patient does not have multiple uncorrectable severe major system congenital anomalies
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# CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

## UNIT 1: HIGHMARK HEALTH OPTIONS PROVIDER NETWORK PARTICIPATION

### IN THIS UNIT

	TOPIC
	Introduction to Network Participation
	Introduction to Network Participation
	<ul style="list-style-type: none"><li>• Eligible Professional Providers</li><li>• Provider Disclosure Statement</li><li>• National Provider Identifier (NPI)</li><li>• Registering as a Non-Participating Provider</li></ul>
	<ul style="list-style-type: none"><li>• Mutual Roles and Obligations for Network Participating Providers and Highmark Health Options</li></ul>
	How to Participate in Highmark Health Options' Credentialed Networks
	<ul style="list-style-type: none"><li>• For CAQH Participating Practitioners</li><li>• If You Are Not Yet Registered with CAQH</li><li>• Notification of Application Status</li><li>• How to Resign from Network Participation</li></ul>
	Assignment Accounts
	<ul style="list-style-type: none"><li>• Eligible Entities and Arrangements</li><li>• How to Establish an Assignment Account</li><li>• Electronic Transactions Required</li><li>• Keeping Assignment Account Information Up-to-Date</li><li>• Notification of New or Departing Practitioners</li><li>• Restrictions</li><li>• How to Make Changes to an Existing Assignment Account</li><li>• Changes to ACH Direct Deposit Account</li></ul>
	Provider Tax Identification Numbers
	Electronic Transaction Requirements
	Non-Network Provider Payment Guidelines
	Facility and Ancillary Provider Networks

## 4.1 INTRODUCTION TO NETWORK PARTICIPATION

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### Overview

Highmark Health Options pays claims for services performed by licensed, eligible health care providers. Eligible providers may sign an agreement to participate in the Highmark Health Options provider network. Providers who choose not to participate in Highmark Health Options networks must register with Highmark Health Options prior to submitting claims for covered services.

As a participant in the Highmark Health Options network, providers agree to provide services to Highmark Health Options members according to the terms of their agreement, the regulations that outline their obligations, and any relevant administrative requirements. Although they do not sign an agreement with Highmark Health Options, non-network providers are required to accurately report services performed and fees charged.

All providers who submit claims must obtain an individual National Provider Identifier (NPI) number. Highmark Health Options will only make payments for eligible services rendered by a provider with a valid NPI.

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### Eligible Professional Providers

Eligible professional providers include:

- Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Dental Surgery
  - Doctor of Podiatry
  - Doctor of Optometry
  - Nurse Midwives
  - Licensed Physical Therapist
  - Licensed Psychologist
  - Certain Certified Registered Nurses
  - Licensed Audiologist
  - Licensed Speech-Language Pathologist
  - Licensed Clinical Social Workers
  - Licensed Occupational Therapists
  - Licensed Marriage and Family Therapists
  - Licensed Professional Counselors
  - Licensed Dietitian–Nutritionist
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## 4.1 INTRODUCTION TO NETWORK PARTICIPATION

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### Provider Disclosure Statement

All providers enrolling with Highmark Health Options must complete a Provider Disclosure Statement as required by the Code of Federal Regulations Title 42, Part 422, Subpart B. These disclosures allow us to ensure program integrity by preventing excluded persons from participating in the Medicaid Program.

Providers may complete and submit the Provider Disclosure Statement directly from the Delaware Medical Assistance Program website at: <https://www.highmarkhealthoptions.com/Portals/5/provider/forms/disclosure-form.pdf?ver=2019-03-13-110702-507>.

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### National Provider Identifier (NPI)

#### DMAP ENROLLED MEDICAID PROVIDERS

If you are a Medicaid provider enrolled with DMAP, you will need to notify Highmark Health Options of any changes in location, licensure, certification, or status, you must also visit the DMAP Web Portal at <https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx> and update the enrollment information status with DMAP.

The National Provider Identifier (NPI) is a 10-digit numerical identifier for providers of health care services. The NPI is a result of the Centers for Medicare & Medicaid Services (CMS) mandate which supports the Health Insurance Portability and Accountability Act of 1996 (HIPPA) simplification standards. All eligible health care providers receive one (1) standard number that they are required to use when submitting health care transactions. It is intended to improve the efficiency of the health care system and to help reduce fraud and abuse.

The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system in place for assigning NPIs. Health care providers can apply for NPIs three ways:

- Complete the web-based application process online at: <https://nppes.cms.hhs.gov>;
- Download and complete a paper application from the NPPES website and mail to NPPES; or
- Call NPPES for a paper application at 1-800-465-3203 (TTY: 1-800-692-2326)

To be registered on Highmark Health Options' files and submit claims to Highmark Health Options, eligible providers who are not participating in Highmark Health Options' networks must submit their provider name, billing tax ID, rendering and billing NPIs, billing and physical addresses with phone number, and specialty:

**Fax to:** 1-800-236-8641

**Mail to:** Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

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## 4.1 INTRODUCTION TO NETWORK PARTICIPATION

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### **Mutual Roles and Obligations for Network Participating Providers and Highmark Health Options**

As a participant in Highmark Health Options' network, professional providers agree to a set of regulations that outline their obligations to Highmark Health Options' members. Highmark Health Options has obligations to its network participants as well.

The mutual obligations are contained in the agreements and regulations that professional providers execute when joining the network.

Key contractual provisions include:

- Network providers will accept the network allowance as payment-in-full for covered services
- Network providers will handle basic claims filing paperwork for the member
- Highmark Health Options will encourage members to obtain health care services from network providers which could increase the provider's patient base
- Network providers will recommend their patients see other network providers when necessary

Providers participating in the Highmark Health Options professional provider network are eligible to become actively involved with Highmark Health Options as corporate professional members and as members of the company's various professional committees and advisory councils.

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## 4.1 HOW TO PARTICIPATE IN HIGHMARK HEALTH OPTIONS' CREDENTIALLED NETWORKS

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### Overview

To participate in Highmark Health Options' credentialed network in Delaware, the provider begins the application process through the online Universal Provider Datasource® (UPD) credentialing database developed by the Council for Affordable Quality Healthcare (CAQH).

The CAQH national standardized online system eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Practitioners complete one (1) standard application that meets the needs of Highmark Health Options and other participating health plans and health care organizations.

Once CAQH registration is completed, the provider will receive additional information for completing the application process for participation in the Highmark Health Options Provider Network.

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### For CAQH Participating Practitioners

If you are already a CAQH participating practitioner with a CAQH ID, please visit [www.caqh.org](http://www.caqh.org). Log in to Universal Provider Datasource® to review and re-attest to your CAQH application. Be sure to add **Highmark** as an authorized plan, or grant global authorization (Highmark Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc. ("Highmark")).

In addition, you must complete Highmark's online Initial Provider Credentialing Request Form. The form can be found on Highmark Blue Cross Blue Shield Delaware's ("Highmark Delaware") Provider Resource Center via NaviNet®.

The Highmark Delaware Provider Resource Center can also be accessed at [www.highmark.com](http://www.highmark.com) – click on the orange CONSUMERS/MEMBERS/PROVIDERS button, and then select the link for Highmark Blue Cross Blue Shield Delaware from the options under FOR PROVIDERS.

Select Provider Forms from the main menu of the Provider Resource Center, and then click on the Provider Applications link. Complete the form, including your CAQH ID, and click on Submit. You will receive a printable confirmation that your request has been received.

In approximately ten (10) business days, an email with additional information and instructions will be sent to the Credentialing Contact Email address supplied on your request (In certain instances, the communication may be sent via postal mail to the Credentialing Mailing Address supplied on your request).

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## 4.1 HOW TO PARTICIPATE IN HIGHMARK HEALTH OPTIONS' CREDENTIALLED NETWORKS

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### If You Are Not Yet Registered

If you have not yet registered with CAQH, you will first need to obtain a CAQH ID. The CAQH ID Request Form is available on Highmark Delaware's Provider Resource Center. From the Provider Resource Center main menu, select CAQH ID Request, and then click on the CAQH ID Request link. Complete the required fields on the Initial Provider Credentialing Request Form, and then submit.

Once the form is successfully submitted, a confirmation email will be sent containing your CAQH ID. Your request for a CAQH ID serves as notification to Highmark of your intention to participate in Highmark Health Options' credentialed network(s).

Once you receive your CAQH ID, you must then complete the credentialing process via [www.caqh.org](http://www.caqh.org). Log in to Universal Provider Datasource® to complete the CAQH credentialing application.

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### Notification of Application Status

After careful review of your application, Highmark Health Options will advise you in writing of your acceptance or non-acceptance into the network(s). A formal appeals process is available to any provider whose application is not accepted. This information is detailed in the communication you will receive.

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### How to Resign From Network Participation

To resign from Highmark Health Options' Credentialed network(s), fax or mail a signed, written request as follows:

**Fax to:** 1-800-236-8641

**Mail to:** Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

A resignation may be submitted at any time and is effective in accordance with the termination provision in the agreement the provider has executed. A letter will be sent to you advising the effective date of your resignation.

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## 4.1 ASSIGNMENT ACCOUNTS

### Overview

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An assignment account is an account established by Highmark Health Options to permit one or more individual providers, practicing together, to direct Highmark Health Options payments to an entity other than the individual provider(s).

An assignment account will be permitted only if the provider(s), as well as the entity to which payment is being directed, meet and continue to comply with guidelines set forth by Highmark Health Options.

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### Eligible Entities and Arrangements

To establish an assignment account, the following conditions must be met:

- 1) The billing entity must be arranged in one of these manners:
    - a. **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number to receive payment from Highmark Health Options.
    - b. **Sole proprietorship** – A sole proprietorship is unincorporated, owned by one individual, and its liabilities are the sole proprietor's personal liabilities. The sole proprietor takes the risks of the business for all assets owned. For legal and tax purposes, the business does not exist separately from the owner.
    - c. **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
      - Two or more providers practice as a partnership;
      - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
      - A provider employs one or more other providers as associates in his or her practice.
  - 2) Limited license providers may not be included in a Highmark Health Options assignment account which also contains health service doctors (MDs and DOs);
  - 3) A provider not participating in a Highmark Health Options provider network may not be included in a Highmark Health Options assignment account which also contains participating providers.
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## 4.1 ASSIGNMENT ACCOUNTS

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### How to Establish an Assignment Account

To establish an assignment account, complete the [Request for Assignment Account](#) Form. This form can also be found on the Highmark Blue Cross Blue Shield Delaware's ("Highmark Delaware") Provider Resource Center -first select Provider Forms, and then click on Provider Information Management Forms.

The Highmark Delaware Provider Resource Center can be accessed via NaviNet® or at [www.highmark.com](http://www.highmark.com) – click on the orange CONSUMERS/MEMBERS/PROVIDERS button, and then select the link for Highmark Blue Cross Blue Shield Delaware from the options under FOR PROVIDERS.

Send the completed form – signed and dated -- to the applicable fax number or mailing address below:

**Fax to :** 1-800-236-8641

**Mail to:** Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

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### IMPORTANT!

For complete guidelines for assignment accounts, including detailed descriptions of eligible entities, please refer to the [Assignment Account Regulations](#).

The regulations are also available on the Highmark Delaware Provider Resource Center -- select Provider Forms, and then click on Provider Information Forms.

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### Electronic Transactions Required

All new assignment accounts are automatically enrolled in NaviNet®, Electronic Funds Transfer (ACH Direct Deposit), and paperless Explanation of Benefits (EOB) statements.

NaviNet® is Highmark Health Options provider portal which integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, authorization inquiries, etc.). ACH Direct Deposit is a secure process that directs Highmark Health Options claim payments to the provider's checking or savings account as directed by your office. Paperless EOB statements reduce the amount of paper flowing into the provider's office.

Additional information will be provided by Highmark Health Options once your assignment account application is received and reviewed.

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## 4.1 ASSIGNMENT ACCOUNTS

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### **Keeping Assignment Account Information Up-to-Date**

Please inform Highmark Health Options of any changes to your assignment account. Failure to keep this data current may lead to incorrect listing in directories viewed by Highmark Health Options members, missed mailings or checks, and, possibly, incorrect payments.

When any of the following information changes, please notify Highmark Health Options immediately through NaviNet® or by accessing the Provider Change Form on the Provider Resource Center:

- Hours of operation
  - Practice address (physical location)
  - Mailing address if different from practice address
  - Specialty (requires signatures of Assignment Account members if you are changing their individual specialties as well)
  - Tax Identification Number (TIN)
  - Additions/deletions of Assignment Account members
  - Telephone number, including area code (member access telephone number)
  - Fax Number
- 

### **Notification of New or Departing Practitioners**

When a practitioner leaves or a new practitioner joins your assignment account, please provide prior notice to Highmark Health Options.

Please be sure to notify Highmark Health Options of a departing provider's new address and tax identification number — an employer identification number or Social Security Number, as appropriate. Highmark Health Options will send written notification to departing providers to advise them of the transfer of their profiles to their individual provider number.

NaviNet® is the preferred method for notifying Highmark Health Options of practitioner changes. Select Provider File Management from the main menu on Highmark Health Options Plan Central. Please see the next page for additional information on making changes to an existing assignment account.

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### **Restrictions**

Highmark Health Options has the right to deny a request to add to or delete any practitioner from an Assignment Account. Highmark Health Options will always deny such a request when a utilization case is open that is pending resolution.

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## 4.1 ASSIGNMENT ACCOUNTS

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### How to Make Changes to an Existing Assignment Account

You can notify Highmark Health Options of any changes to your existing assignment account quickly and easily by using NaviNet®, Highmark Health Options' preferred method for updating your assignment account information. Select Provider File Management from the main menu on Highmark Health Options Plan Central.

- **Practitioner Updates:** For new practitioners, click on the Add a Practitioner button. To change information for an existing practitioner or to remove a practitioner, select the practitioner, and then click on Edit or Delete, as applicable.
- **Address Updates:** To add a new location, click on Add an Address. To make changes to an existing address, select the address, and then click Edit or Delete, as applicable.

If you are not NaviNet®-enabled, complete the applicable form as follows:

- **Practitioner Updates:** For practitioner changes, use the [Request for Addition/Deletion to an Existing Assignment Account](#) Form.
- **Address Updates:** For adding new practice locations or to make changes to an existing location, complete the [Provider File Maintenance Request](#) Form.

These forms are also available on the Highmark Delaware Provider Resource Center--select Provider Forms, and then click on Provider Information Forms.

Fax or mail completed forms as follows:

**Fax to:** 1-800-236-8641

**Mail to:** Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

### Changes to ACH Direct Deposit Account

Changes to your electronic funds transfer (ACH Direct Deposit) account can be completed in NaviNet® by your practice's "ACH Direct Deposit Responsible Party." Your NaviNet® Security Officer must first enable the transaction for the ACH Direct Deposit Responsible Party in order for the ACH Direct Deposit Attestation and Registration button to display on the Highmark Health Options Plan Central menu.

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## 4.1 PROVIDER TAX IDENTIFICATION NUMBERS

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### Highmark Health Options' Use of Provider Tax Identification Numbers

In addition to claims processing, Highmark Health Options uses a provider's tax identification number to accurately identify providers for other business functions and with outside vendors/partners during the normal course of business operations.

**Highmark Health Options strongly discourages the use of Social Security Numbers in lieu of business tax identification numbers whenever it requests a provider's tax identification number.**

**A provider who chooses to submit his or her Social Security Number as a tax identification number hereby acknowledges, understands, and agrees that Highmark Health Options will treat the Social Security Number in the same manner in which it handles other providers' business tax identification numbers and shall not be liable to such provider for any intentional or unintentional disclosures of such Social Security Number.**

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### How to Obtain a Federal Employer Identification Number (EIN)

To avoid using your Social Security Number as your provider tax identification number, you may instead use a Federal Employer Identification Number (EIN) issued by the Internal Revenue Service (IRS).

To obtain an EIN, please visit [www.irs.gov](http://www.irs.gov).

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## 4.1 ELECTRONIC TRANSACTION REQUIREMENTS

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### Overview

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark Health Options has taken steps to eliminate paper transactions with our contracted practitioners. As part of this initiative, all practitioners are required to enroll in NaviNet®, Electronic Funds Transfer (ACH Direct Deposit), and paperless Explanation of Benefits (EOB) statements.

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### **Enrollment in NaviNet, ACH Direct Deposit, and Paperless EOBs Required for All Participating Providers**

All new assignment accounts and practitioners who are newly participating with Highmark Health Options are automatically enrolled in NaviNet®, the free, easy online solution linking physician offices with Highmark Health Options and other health plans. NaviNet integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, authorization inquiries, etc.).

These newly participating practitioners are also automatically enrolled to receive electronic funds transfers and paperless EOB statements.

- ACH Direct Deposit is a secure process which directs Highmark Health Options claim payments to the practitioner's checking or savings account as directed by your office. Payments are typically in the designated bank account by Wednesday of each week.
- Paperless EOB statements reduce the amount of paper flowing into the practitioner's office. EOBs are available for viewing on

If you are not yet enrolled in NaviNet®, ACH Direct Deposit, or paperless EOBs, please contact Highmark Health Options Provider Services.

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## 4.1 NON-NETWORK PROVIDER PAYMENT GUIDELINES

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### Overview

Non-network providers do not sign an agreement with Highmark Health Options. Therefore, they have no contractual obligation to accept Highmark Health Options' allowances as payment in full. However, non-network providers are required to accurately report services performed and fees charged.

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## 4.1 FACILITY AND ANCILLARY PROVIDER NETWORKS

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### Facility Network

Highmark Health Options holds contracts with acute care hospitals in Delaware's three (3) counties and in contiguous counties of bordering states. In addition, Highmark Health Options contracts with additional facility-type providers in Delaware including:

- Psychiatric facilities
- Substance abuse treatment centers
- Skilled nursing facilities (SNFs)
- State-owned psychiatric hospitals
- Ambulatory surgical centers (ASCs)
- Renal dialysis facilities
- Hospice
- Home health
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Rehabilitation hospitals
- Long-term acute care facilities (LTACs)

**Note:** To participate in Highmark Health Options' facility networks, an application package is available on Highmark Blue Cross Blue Shield Delaware's ("Highmark Delaware") Provider Resource Center. Select Provider Forms from the main menu, and then click on Provider Applications for Facilities.

The Highmark Delaware Provider Resource Center can be accessed via NaviNet® or at [www.highmark.com](http://www.highmark.com) – click on the orange CONSUMERS/MEMBERS/PROVIDERS button, and then select the link for Highmark Blue Cross Blue Shield Delaware from the options under FOR PROVIDERS.

### Ancillary Provider Network

To supplement the professional provider and facility networks, Highmark Health Options has contracted with a network of ancillary providers.

These include freestanding and facility-based providers in the specialties including, but not limited to:

- Ambulance
- Durable medical equipment
- Home infusion
- Orthotics/prosthetics
- Independent laboratories

An informational application package is available on the Highmark Delaware Provider Resource Center for ancillary providers interested in participating in Highmark Health Options' networks. Select Provider Forms from the main menu, and then click on Provider Applications for Ancillary Providers.

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## 4.1 FACILITY AND ANCILLARY PROVIDER NETWORKS

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### **Recommending Other Network Providers**

In order for our members to receive the highest level of benefits that their plan offers, please be sure to use other network providers when you must recommend members for care.

Providers can access Highmark Health Options' health care directory through NaviNet®. Providers and members can access the directory through Highmark Health Options' website at [highmarkhealthoptions.com](https://highmarkhealthoptions.com).

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# CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

## UNIT 2: HIGHMARK HEALTH OPTIONS CREDENTIALING AND RECREDENTIALING

### IN THIS UNIT

TOPIC
Introduction to Credentialing
Highmark Health Options Network Credentialing Policy
Practitioners' Credentialing Rights
The Credentialing Process
If You Already Have a CAQH ID
If You Are Not Yet Registered with CAQH
Steps in the Initial Credentialing Process
The Recredentialing Process
Assessment of Clinical Quality
Assessment of Data Completeness
Office Site Reviews
Step-by-Step Process
Credentialing Requirements for Facility-Based Providers
Facility-Based Practitioner Credentialing Policy
PARE Attestation
Credentialing Requirements for Behavioral Health Care Providers
Dual Credentialing and Recredentialing as Both PCP and Specialist
Practitioner Quality and Board Certification
Malpractice Insurance Requirement
Termination from the Networks
Reconsiderations and Appeals

## 4.2 INTRODUCTION TO CREDENTIALING

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### Overview

Where the Highmark Health Options professional provider networks are utilized to support managed care products, Highmark Health Options must credential providers and utilize procedures to comply with National Committee for Quality Assurance (NCQA); the Centers for Medicare & Medicaid Services (CMS); and State of Delaware Regulation 1403 Managed Care Organizations. Providers are initially credentialed prior to network admission and recredentialed every three (3) years. This unit focuses on the credentialing process.

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### Purpose

The credentialing and recredentialing processes are performed by employees who work cooperatively with network practitioners to ensure members have access only to those practitioners who meet Highmark Health Options' high standards of professional qualifications.

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### Online Process Utilized

Highmark Health Options utilizes the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) as our exclusive provider credentialing system. All Highmark Health Options network providers must use the CAQH system for credentialing and recredentialing.

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### Initial Credentialing

Highmark Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc. ("Highmark"). Highmark credentialing staff follows an established process to credential professional providers for the Highmark Health Options network. In addition, there are delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

The initial credentialing process includes, but is not limited to:

- Completion of a CAQH online application
  - Signed attestation verifying all information on the application and stating any reasons for inability to perform essential duties, lack of illegal drug use, loss of license/privileges, felony, and disciplinary action
  - Primary source verification
  - Inquiry to National Practitioner Data Bank for sanction history
  - Verification of Disclosure Form on file with the State of Delaware
  - Other verification as needed
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## 4.2 INTRODUCTION TO CREDENTIALING

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### **Initial Credentialing** (continued)

To be considered a participating practitioner and support Highmark Health Options, all new practitioners must complete the CAQH online credentialing application, be approved by Highmark through a routine assessment process or by the Highmark Network Quality and Credentialing Committee, as applicable, and then sign a contract.

The practitioner's participation and ability to treat Highmark Health Options members does not begin until the signed contract is returned and the contract is executed by Highmark Health Options. A welcome letter specifying the effective date of participation will be sent along with a copy of the executed contract.

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### **Recredentialing**

The recredentialing process is completed at least once every three (3) years with any applicable physicians and allied health professionals in the Highmark Health Options network. Our internal policies require recredentialing for the protection of our members. Additionally, Highmark Health Options' three (3) year credentialing cycle is consistent with the NCQA, CMS, and State of Delaware standards.

The recredentialing process includes most of the same components as initial credentialing with some added components. At the time of recredentialing, a quality review is conducted. This review includes, when available, member satisfaction, member complaints related to both administrative and quality of care issues, member grievances and appeals issues, malpractice history, medical record reviews, and office site information. Information regarding clinical quality actions or sanction activity will also be considered for continued network participation.

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## 4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

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### Overview

Physicians and any applicable allied health professionals must be credentialed by Highmark Inc. (“Highmark”) on behalf of Highmark Health Options to participate in the Highmark Health Options network in Delaware.

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### When Are Practitioners Credentialed?

A practitioner who has never been credentialed by Highmark Health Options must be credentialed when:

- Starting a solo practice,
- Beginning to practice with an established network practice
- Credentialed practitioner changes Specialty

In addition, a practitioner who wishes to return to the network(s) will be required to undergo initial credentialing if:

- The practitioner submitted a signed, explicit document stating that he or she no longer wishes to be a participating provider, and there has been a break in service/contract of greater than thirty (30) days
- The practitioner was terminated by Highmark Health Options during the recredentialing process, and there has been a break in service/contract of greater than thirty (30) days

**Note:** A practitioner returning to the network(s) may also be required to execute a new agreement.

If a network credentialed practitioner moves from one network practice to another, no further credentialing is required if the notification from the practitioner is received within thirty (30) days and is ninety (90) days prior to the recredentialing due date.

If the notification from a practitioner is received more than thirty (30) days after the move to another network practice or is not within ninety (90) days of the practitioner’s recredentialing date, the practitioner will not be terminated; however, initial credentialing will be required.

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## 4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

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### When Credentialing Is Not Required

An established practitioner who has already been credentialed by Highmark Health Options is not required to be credentialed again when:

- Joining another established network practice of the same specialty in a **different** geographic area within six months;
- Joining another established network practice of the same specialty in the **same** geographic area within six (6) months; or
- Leaving a group practice to begin a solo practice

However, if a credentialed practitioner joins an existing participating group of the same specialty, Highmark Health Options must be notified within thirty (30) days.

NaviNet®-enabled providers can make those changes through the Provider File Management function on NaviNet®. For those providers not NaviNet®-enabled, the [Request for Addition/Deletion to an Existing Assignment Account](#) form can be used to notify us.

This form is also available on the Highmark Blue Cross Blue Shield Delaware (“Highmark Delaware”) Provider Resource Center -- select Provider Forms, and then click on Provider Information Forms.

The Provider Resource Center can be accessed at [www.highmark.com](http://www.highmark.com) – click on the orange CONSUMERS/MEMBERS/PROVIDERS button, and then select the link for Highmark Blue Cross Blue Shield Delaware from the options under FOR PROVIDERS.

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### Completion of Applications

For practitioners who fail to complete the credentialing or recredentialing process, or fail to supply all required information, this action **will be deemed as a practitioner’s intention** to voluntarily withdraw from the applicable network(s) or result in discontinuation of the credentialing process for initial applicants. For recredentialing practitioners, your members may receive notification that you no longer participate in the network(s).

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### Malpractice Information

Credentialing representatives may ask detailed questions regarding malpractice cases. If physicians do not submit the requested information, they could be denied or terminated from the network(s). In order to receive an accurate score, please submit the requested information regarding malpractice.

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## 4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

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### **24/7 Availability Requirements**

Highmark Health Options requires that all credentialed network practitioners provide coverage for members 24 hours a day, seven (7) days a week. This can be accomplished either directly or through an on-call arrangement with another Highmark Health Options credentialed participating practitioner of the same or similar specialty.

An answering service, pager, or direct telephone access whereby the practitioner or his designee can be contacted is acceptable. A referral to a crisis line is NOT acceptable unless a prior arrangement has been made with the crisis line whereby the practitioner (or his/her designee) can be contacted directly, if needed.

The following specialties are exempt from 24/7 coverage requirements:

- Audiologists
- Certified Diabetic Educator
- Dermatopathologists
- Dietitians/Nutritionists
- Message Therapists
- Occupational Therapists
- Oral and Maxillofacial Pathologists
- Pathologists
- Physical Therapists
- Preventive Medicine
- Read Only Practitioners
- Speech/Language Pathologists
- All practitioners when they are Hospital based are exempt from answering the 24 hour coverage question at that location

### **Availability for Urgent and Routine Care**

At the time of initial credentialing, primary care practitioners (PCPs) not joining an existing group must provide office hours at each practice location accessible to members a minimum of twenty (20) hours a week at each practice site.

PCP practice sites not meeting this requirement will be subject to an on-site review every three (3) years.

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## 4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

### Admitting and Clinical Privilege Requirements

Primary care physicians (family practitioners, pediatricians, internists, geriatricians, and general practitioners) are required to have admitting privileges in good standing at a network participating hospital. Applicable physician specialists are required to have clinical privileges in good standing at an in-network hospital. Primary care certified registered nurse practitioners (CRNPs) must have full admitting privileges or a collaborative agreement with a network participating primary care physician (as applicable). The hospital clinical privilege requirement is waived for the following specialties:

- Addiction Psychiatry
- Anatomic Pathology
- Anesthesiology
- Audiology
- Certified Behavioral Analyst
- Certified Diabetic Educator
- Certified Nurse Specialist
- Certified Midwife
- Child & Adolescent Psychiatry
- Chiropractic
- Clinical Nurse Specialist
- CRN Anesthetist
- CRN Mental Health
- CRNP Specialist
- Cytopathology
- Dental Anesthesiology
- Emergency Medicine
- General Dentistry
- Non-surgical Podiatry
- Nuclear Medicine
- Oral Maxillofacial Surgery
- Oral Maxillofacial Pathology
- Oral Maxillofacial Radiology
- Pathology
- Physiatry/Physical Medicine
- Physician Specialists that Work in a Highmark Credentialed Urgent Care/MAU Setting Only
- Psychiatry
- Radiology
- Read Only Practitioners

Clinical privilege requirements, including admitting, will be waived for all physicians who, on the application, document arrangements that are acceptable to Highmark Health Options for adequate coverage through another credentialed in-network practitioner. The practitioner must have privileges at an in-network hospital or belong to a credentialed in-network group of the same specialty. The name(s) of the covering physician(s) must be provided on the application (a co-signed document from the covering physician[s] is not required.)

**IMPORTANT!** Highmark Health Options practitioners are required to use participating practitioners for all coverage arrangements, including ambulance.





## 4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

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### **Confidentiality and Anti-Bias Statements**

All practitioner information obtained in the credentialing process, except as otherwise provided by law, is kept confidential.

Credentialing and recredentialing decisions will not be based on an applicant's race, religion, ethnic/national identity, gender, age, sexual orientation, or the type of procedures or patients in which the practitioner specializes.

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### **Timeframe**

Highmark Health Options is required to verify all completed application information within one hundred eighty (180) days from the date the practitioner signs the attestation statement.

If verification cannot be completed within the 180 day timeframe, the applicant will be asked to re-sign and re-date the attestation statement.

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## 4.2 PRACTITIONERS' CREDENTIALING RIGHTS

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### Policy

Practitioners who are applying for participation in Highmark Health Options' credentialed network have the right to review information submitted in support of their credentialing application, be notified of information that varies substantially from primary sources, and to correct erroneous information.

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### Primary Sources

Primary sources that may be contacted as part of the credentialing process include, but are not limited to, the following:

- State Licensing Bureau
  - Drug Enforcement Agency
  - Educational Program(s) the Practitioner Completed
  - American Board of Medical Specialties, or American Osteopathic Association, if applicable
  - National Practitioner Data Bank
  - Office of the Inspector General Participation/Sanction Data
  - Federation of Chiropractic Licensing Board, if applicable
  - Federation of Podiatric Medical Board, if applicable
  - Delaware Department of Health and Social Services (DHHS) Provider Disclosure List
- 

### Right to Review Information

Providers have the opportunity to review information submitted during the credentialing/recredentialing process. This includes information obtained from outside sources except for references, recommendations, or other peer review protected information and any other data that is prohibited from being disclosed by law.

The request for information should be made in writing and directed to:

Highmark Provider Information Management (PIM)  
P.O. Box 898842  
Camp Hill, PA 17089-8842  
Or  
Fax: 1-800-236-5907

Within thirty (30) calendar days of receipt of the request, the information, except for references, recommendations, or other peer review protected information and any other data that is prohibited from being disclosed by law, will be mailed with a cover letter in an envelope marked "Personal and Confidential."

As documentation of receipt of request, a copy of the communication will be maintained in the provider's credentialing file.

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**Notification of Discrepancy**

In the event information from a source varies substantially from that which was submitted by the provider, Provider Information Management (PIM) will initiate notification and communication via phone, fax, email, or certified returned receipt requested letter within thirty (30) calendar days of discovery.

As documentation of receipt of discrepancy notification, a copy of the communication will be provided in the provider's credentialing file.

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**Right to Correct Erroneous Information**

Within thirty (30) calendar days of request to correct information, the provider should submit any corrections in writing to PIM:

Highmark Provider Information Management (PIM)  
P.O. Box 898842  
Camp Hill, PA 17089-8842  
or  
Fax: 1-800-236-5907  
or  
Email address provided by staff assigned

This information is reviewed with the Medical Director to make a decision on a case by case basis. The information received from the provider may be presented to the Network Quality and Credentials Committee, if applicable.

Any differences in demographic information, education, work history, and/or Drug Enforcement Agency (DEA) certificate/license expiration dates may be handled via telephone.

As documentation of receipt of corrections, the communication will be maintained in the provider's credentialing file.

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**Right to be Informed of Provider File Management Credentialing Status**

Providers can view network status and effective dates via the Provider File Management selection in NaviNet®. Select from the main menu on the ACH Direct Deposit on Highmark's NaviNet® Plan Central, and then click on the link at the top of your Provider File Management page.

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**Review Credentialing Status**

Through the NaviNet® Provider File Management, providers can also complete real-time demographic changes (address updates, phone number changes, site of service selections, upload provider picture to the directory, office hours, new patients information); addition and termination of providers; request credentialing; and view credentialing specialist contact information.

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**Communication  
of Practitioner  
Rights**

Communication regarding provider rights to review, to be notified of and correct erroneous information, and to receive notice of application status is made via inclusion of this information in this manual, the Highmark Blue Shield Office Manual.

This online manual is available to network participating providers electronically on the Provider Resource Center, which is accessible via NaviNet® and also Highmark's regional websites in Pennsylvania, Delaware, and West Virginia.

Annual notifications of the availability of this information in the Highmark Blue Shield Office Manual are published in the Provider News newsletters, which are published bi-monthly. Providers are notified when Provider News is published online via e-Subscribe email notifications. Providers not subscribed to e-Subscribe email notifications receive an annual postcard indicating newsletter publication dates for the calendar year.

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## 4.2 THE CREDENTIALING PROCESS

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### Overview

Highmark Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc. (“Highmark”). Highmark uses the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) for initial credentialing because it greatly improves processing times. Universal Provider Datasource® eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Through this online service, practitioners complete one (1) standard application that meets the needs of Highmark Health Options and other participating health plans and health care organizations.

Highmark uses CAQH Universal Provider Datasource® as the exclusive provider credentialing system for all applicable networks in Delaware. All Highmark Health Options network providers must use CAQH for credentialing and recredentialing.

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### If You Already Have a CAQH ID

If you are already a CAQH participating practitioner with a CAQH ID, please visit [www.caqh.org](http://www.caqh.org). Log in to Universal Provider Datasource® to review and re-attest to your CAQH application. Be sure to add **Highmark** as an authorized plan, or grant global authorization (Note: As stated above, Highmark Health Options has delegated credentialing responsibility to Highmark).

In addition, please notify Highmark Health Options of your intention by completing the Initial Provider Credentialing Request Form. It can be found on the Highmark Blue Cross Blue Shield Delaware (“Highmark Delaware”) Provider Resource Center by selecting Provider Forms, and then Provider Applications. A link to the form is available within the text under the first bullet.\*

Complete the form, including your CAQH ID, and click on Submit. You will receive a printable confirmation that your request has been received. In approximately ten (10) business days, you will receive an email at the Credentialing Contact Email address supplied on your request. The email will provide additional information and instructions for completing the credentialing process with Highmark Health Options (In certain instances, the communication may be sent via postal mail to the Credentialing Mailing Address supplied on your request..)

\* The Initial Provider Credentialing Request form is also available on the NaviNet® Highmark Delaware Plan Central. To access the form via NaviNet® Plan Central, select Provider File Management, and then click on the Request Credentialing button.

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*Continued on next page*

## 4.2 THE CREDENTIALING PROCESS

### If You Are Not Yet Registered with CAQH

If you have not yet registered with CAQH, you will need a CAQH ID for access to the CAQH credentialing application. The CAQH ID Request Form is available on Highmark Delaware's Provider Resource Center. Select CAQH ID Request from the main menu to access the link to the Initial Provider Credentialing Request Form.

Complete the required fields on the Initial Provider Credentialing Request Form, and then submit. Once the form is successfully submitted, you will receive a confirmation email that will contain your CAQH ID. Your request for a CAQH ID serves as notification to Highmark of your intention to participate in Highmark Health Options' credentialed network(s).

Once you receive your CAQH ID, you must then complete the credentialing process via [www.caqh.org](http://www.caqh.org). Log in to Universal Provider Datasource® using your CAQH ID to complete the credentialing application. Be sure to add **Highmark** as an authorized plan, or grant global authorization. Following completion of the CAQH application, you will receive additional information and instructions from Highmark Health Options.

### If You Do Not Have Internet Access

If you are not yet registered with CAQH please visit the Highmark Provider Resource Center and follow the credentialing request links and a CAQH ID will be sent to you.

Once you receive your CAQH ID call the toll-free **CAQH Help Desk** at **1-888-599-1771** for other options for completing the CAQH credentialing application.

### Steps in the Initial Credentialing Process

During initial credentialing, practitioners in Delaware also participate in the process of contracting with Highmark Health Options. The initial credentialing and contracting process is as follows:

STEP	ACTION
1	To begin the process, the practitioner must submit all information requested through CAQH. Highmark Health Options will then provide additional information and instructions.
2	The Credentialing Department representative reviews the application. If the application is incomplete, the representative contacts the practice to request the missing information.

*Continued on next page*

## 4.2 THE CREDENTIALING PROCESS

### Steps in the Initial Credentialing Process (continued)

STEP	ACTION
3	<p>The credentialing process will include, but is not limited to, verification or confirmation of the following:</p> <ul style="list-style-type: none"> <li>• Unrestricted licensing in the state(s) where practicing*</li> <li>• Drug Enforcement Agency (DEA) certificate issued by each state where practicing*</li> <li>• Medical education and training (as applicable)*</li> <li>• Board certification (if applicable)*</li> <li>• History of liability claims</li> <li>• Malpractice coverage amounts</li> <li>• Work history</li> <li>• Medicare participating status</li> <li>• National Practitioner Data Bank (NPDB)*</li> <li>• Office of the Inspector General (OIG) Medicare and Medicaid sanction lists*</li> <li>• Delaware Department of Health and Social Services (DHHS) Provider Disclosure List</li> </ul> <p><b>Note:</b> Primary source verification of hospital clinical privileges and medical liability insurance coverage is no longer required. A signed attestation statement is all that is needed.</p> <p>* These elements are verified through primary sources.</p>
4	<p>The Credentialing Department will also review the application for the following:</p> <ul style="list-style-type: none"> <li>• Ability to enroll new members</li> <li>• Ability to provide urgent/routine care</li> <li>• 24/7 coverage (if applicable)</li> <li>• Office hour availability of at least 20 hours/week (PCP)</li> </ul>
5	<p>A Credentialing Department Specialist verifies that all information required for National Committee for Quality Assurance (NCQA) and/or State and Federal Regulatory Agencies is complete.</p> <p><b>Note:</b> If verification cannot be completed within the required 180 days, the applicant will be asked to re-sign and re-date the attestation page of the application and provide valid, current information. Electronic signatures are accepted on the application.</p>
6	<p>If the credentials file elements meet all Highmark Health Options credentialing criteria, the Medical Director will review the application and render a decision.</p> <p>If the application does not meet Highmark Health Options credentialing criteria, the Highmark Network Quality and Credentialing Committee reviews the application. In some instances, the Committee may request additional information before rendering a decision.</p>

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## 4.2 THE CREDENTIALING PROCESS

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### Steps in the Initial Credentialing Process (continued)

STEP	ACTION
7	<ul style="list-style-type: none"><li>∞ Upon approval of the Highmark Network Quality and Credentialing Committee or the Medical Director, practitioners will receive written notification</li><li>∞ If denied initial credentialing status, the practitioner will receive written notification within sixty (60) calendar days and will be offered an opportunity to have the decision reconsidered</li></ul>
8	A copy of the contract will be mailed to the practitioner for a signature. The practitioner will send the contract back and Highmark Health Options will counter execute it. The practitioner will then receive a fully executed contract and a welcome letter with the effective date of the new provider or group, as applicable.

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**IMPORTANT!** The practitioner's participation in Highmark's credentialed networks is effective only upon completion of a Highmark Health Options-executed contract. The participation effective date is stated within the welcome letter.

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## 4.2 THE RECREDENTIALING PROCESS

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### Overview

The process for credentialing new practitioners and recredentialing existing network practitioners is essentially the same. Network practitioners must be recredentialed at least every three (3) years.

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### Notification to Complete Online Process

Highmark Health Options uses the standardized online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) exclusively for initial credentialing and also for recredentialing of existing network practitioners for applicable networks in Delaware.

All Highmark Health Options network providers must use CAQH's Universal Provider Datasource® for recredentialing. Paper applications and NaviNet® functionality for recredentialing have been eliminated.

Several months prior to the end of the three (3) year credentialing cycle, the practitioner will receive notification that the recredentialing application is due.

- **For Practitioners Registered With CAQH:** Credentialing staff will send a letter to notify the practitioner that it is time for recredentialing. The practitioner will then log in to Universal Provider Datasource® at [www.caqh.org](http://www.caqh.org) to review and re-attest to their CAQH application.
  - **For Practitioners Not Yet Registered With CAQH:** Credentialing staff will provide you with a CAQH ID to log in to Universal Provider Datasource® at [www.caqh.org](http://www.caqh.org). Complete the CAQH online credentialing application. Be sure to add **Highmark** as an authorized plan, or grant global authorization.
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### If You Do Not Have Internet Access

If you do not have internet access, please contact the CAQH Help Desk for other options by calling **1-888-599-1771**.

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### Assessment of Clinical Quality

During recredentialing, practitioners are evaluated on their professional performance, judgment, and clinical competence. Criteria used may include, but may not be limited to, quality-of-care concerns, malpractice history, sanctioning history, member complaints, member grievances and appeals, participation with quality improvement activities and condition management programs, data completeness, overutilization, and underutilization.

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## 4.2 THE RECREDENTIALING PROCESS

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### Assessment of Data Completeness

Highmark Health Options must include an evaluation of a practitioner's data completeness in the recredentialing process in order to comply with the standards of various accrediting and regulatory entities such as the Centers for Medicare & Medicaid Services (CMS). The Data Completeness Evaluation occurs in concert with the Healthcare Effectiveness Data and Information Set (HEDIS®) and Risk Adjustment Data Validation (RADV) chart audits.

Data Completeness Evaluations are incorporated into the recredentialing process as follows:

- **Year One:** If a Data Completeness deficiency or deficiencies are noted by one of the Clinical Quality Consultants during a HEDIS or RADV chart audit, a feedback sheet(s) will be left on each member's medical record detailing the deficiencies found. If the individual practice receives five (5) or more unique feedback sheets in the first year, the practice will be "flagged" in Highmark Health Options' database.
- **Year Two:** If five (5) or more feedback sheets are left with the same practice in the subsequent year, the practice will receive a letter that explains that the credentialing decisions for all practitioners in the practice could be impacted if five (5) or more feedback sheets are given to the practice for a third consecutive year.
- **Year Three:** If a practice receives five (5) or more feedback sheets for three (3) consecutive years, the practitioners at that office will be evaluated as "exceptions" at the time of their next recredentialing review, which could potentially lead to termination from the network(s).

For the basic elements reviewed during this assessment, please see Chapter 5, Unit 4 of this manual.

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## 4.2 THE RECREDENTIALING PROCESS

### Office Site Reviews

For all PCPs, OB/GYNs, and potential high-volume behavioral health practitioners, Quality Management nurses will conduct Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations for any practitioner in the network.

These evaluations will be based on the following:

- 1) Member dissatisfactions received about the quality of any practitioner office where care is delivered that is related to physical accessibility, physical appearance, or adequacy of waiting room and examining/treatment room space; or
- 2) Annual random sampling with practice sites selected using a statistically valid sampling methodology

For more detailed information on this process, please see Chapter 5, Unit 4 of this manual.

### Step-by-Step Process

The recredentialing process is essentially the same as the initial process for credentialing new practitioners in Delaware.

STEP	ACTION
1	<p>Notification is sent to the practitioner that the recredentialing application is due several months prior to the end of the three (3) year credentialing period.</p> <ul style="list-style-type: none"> <li>• CAQH registered practitioners receive a letter from credentialing staff, and then log in to Universal Provider Datasource® to review and re-attest to their CAQH application</li> <li>• Practitioners not yet registered with CAQH will receive a letter from credentialing staff with a CAQH ID for you to log in to Universal Provider Datasource® at <a href="http://www.caqh.org">www.caqh.org</a>; Complete the online application and add</li> </ul> <p><b>Highmark</b> as an authorized plan or grant global authorization</p>
2	<p>A Credentialing Department representative conducts primary source verification. If additional documents are required, they should be emailed, faxed, or mailed. Highmark Health Options is required to verify all completed application information within 180 days from the date the practitioner signs the attestation statement.</p>
3	<p>The Credentialing Committee or the Medical Director reviews the practitioner's qualifications and renders a decision.</p>
4	<p>The practitioner is notified of any adverse decision through a letter within sixty (60) calendar days.</p>

## 4.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS

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### Facility-Based Practitioner Credentialing Policy

Highmark Health Options does not require practitioners to complete the credentialing or recredentialing process for the network(s) if they are strictly facility-based and practice exclusively in a network participating acute care hospital setting. This includes, but is not limited to, the following provider types:

- Pathologists
- Oral maxillofacial pathologists
- Anesthesiologists
- Radiologists
- Oral maxillofacial radiologists
- Emergency medicine specialists

Highmark Health Options policy does not require credentialing or recredentialing for the network(s) when the following requirements are met. The practitioner must:

- Provide one hundred (100) percent of his or her services to members exclusively in the acute care or general hospital setting
- Have a current, valid unrestricted license (i.e., absence of a current Prothonotary report or consent order) to practice in the state(s) where he/she provides care for the organization's members
- Have current active malpractice insurance that meets or exceeds Delaware state requirements
- Actively participate with Medicare/Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs
- Sign a Facility-Based Provider Affirmation Statement (Form No. 282) (See PARE Attestation information below)

**These practitioners, however, must complete the appropriate provider agreements to participate with Highmark Health Options' participating provider network(s).**

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### PARE Attestation

The PARE Attestation, or Facility-Based Provider Affirmation Statement Form, can be obtained and printed from the Highmark Delaware Provider Resource Center. Select the Provider Forms link, and then click on Provider Information Management Forms.

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### IMPORTANT!

If a practitioner begins to provide medical services to members outside of a network-participating acute care facility, the practitioner will be required to complete the initial credentialing and contracting processes.

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## 4.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH CARE PROVIDERS

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### **Behavioral Health Practitioner Requirements**

Behavioral health practitioners considered for participation must provide evidence of the following as applicable:

- A current license in their specialty at the highest level in the state in which they practice; Licensure must be for independent practice, if applicable
  - All practitioners in Delaware are required to carry \$1million per medical incident and \$3 million in annual aggregate
- 

### **Professional Organization Membership**

Membership in a national professional organization that ascribes to a professional code of ethics, such as the American Psychiatric Association or the American Psychological Association, is preferred.

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### **Psychologist Requirements**

Psychologists must be licensed as a psychologist in the state(s) in which they practice. PhD level psychologists must meet one of the following criteria:

- Certification from the Council for the National Register of Health Services Providers in Psychology
  - Certification from the American Board of Professional Psychology, Diplomate in Clinical Counseling, Family Psychology, Neuropsychology, or Health Psychology
  - A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical counseling or professional-scientific psychology
  - Graduation from an American Psychological Association (APA) approved internship or successful completion of an APA-equivalency form
- 

### **Licensed Clinical Social Worker Requirements**

Licensed clinical social workers (LCSWs) must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work Education (CSWE). Additionally, they must be licensed at the highest level for independent practice in the state in which they practice.

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### **Clinical Nurse Specialist Requirements**

Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice. They must hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the American Nurses' Association (ANA)/American Nurses Credentialing Center (ANCC).

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## 4.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH CARE PROVIDERS

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### **Psychiatric-Certified CRNP Requirements**

Psychiatric-certified registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice. A CRNP with a secondary license type in mental health must have a collaborative agreement with a network participating psychiatrist.

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### **Master's-Prepared Therapist Criteria**

Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in the state in which they practice at an independent practice level in an accepted human services specialty, such as one of the following:

- Licensed professional counselor (LPC)
  - Marriage and family therapists (MPT)
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## 4.2 DUAL CREDENTIALING AND RECREDENTIALING AS BOTH PCP AND SPECIALIST

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### Physician Categories

Highmark Health Options contracts with network physicians as either:

- Primary Care Physicians (PCPs) -- family practitioners, general practitioners, internists, and pediatricians; or
- Specialists -- all other MDs or DOs

An individual practitioner may participate as both PCP and specialist if the practitioner meets network credentialing standards for each category.

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### Criteria

All practitioners who want to be credentialed as both a PCP and a specialist must:

- Demonstrate that the practice adequately provides primary care services to Highmark Health Options members;
  - Meet the standards for PCPs; and
  - Must be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded/meets exception will be “Process discontinued.”
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### Recredentialing

Dual-credentialed practitioners will undergo full recredentialing for PCP and specialist participation every three (3) years.

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### Provider Directory

All dual-credentialed physicians will appear in the provider directories as both PCPs and specialists and can receive referrals from other PCPs.

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## 4.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION

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### Policy

To be credentialed in networks, primary care practitioners (PCPs) and specialists -- including podiatrists -- are required to be board certified in the specialty in which they practice or meet one of the exceptions to board certification. Our online provider directories will indicate that a physician is board certified if he/she is currently certified in a specialty category. Note: Effective August 15, 2016, the board certification and exception policy requirements will be applicable to all practitioners. Board certification is required in each specialty for which the practitioner is requesting to be credentialed. Practitioners in the network prior to August 15, 2016, will be grandfathered and processed as routine. Please note that these exceptions do not apply to practitioners practicing in Emergency Departments or Urgent Care Centers/Medical Aid Units (MAUs); board certification is required.

### Highmark Health Options Recognized Boards for Certification

Highmark Health Options recognizes the following boards for certification:

- America Board of Medical Specialties (ABMS)
- American Osteopathic Association Board (AOA)
- American Board of Podiatric Medicine (ABPM)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Multiple Specialties in Podiatry (ABMSP)\*
- American Board of Oral and Maxillofacial Surgery (ABOMS)
- American Academy of Oral and Maxillofacial Radiology (AAOMR)

\*If ABPM or ABFAS boards not available to practitioner.

Effective August 15, 2016, all applicable practitioners who are not board certified and are applying to participate in a Highmark credentialed network must meet one of the following exception criteria to be considered eligible for credentialed network participation:

### Exceptions to Board Certification Requirements

#### **Exception 1: Completed training prior to December 31, 1987**

Practitioners must have graduated from an accredited medical osteopathic, or podiatric medical school, or dental school; completed an applicable accredited residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which the practitioner practices; and completed training prior to December 31, 1987.

### Exception 2: Board eligibility period

Practitioners must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete board certification by December 31 of the sixth (6<sup>th</sup>) year of completing approved, applicable residency training or a contiguous subsequent fellowship training in the specialty in which he/she practices.

### Exception 3: Geo Access Deficiency

An annual Geo Access report will be generated and practitioners who are not board certified will be evaluated using network access requirements for specialty and practice location(s). If there is an access deficiency for any location, the practitioner's file will meet the exception. If it is determined that there are no access deficiencies in any location, initial applicants will be "Process Discontinued"; recertifying applicants will be reviewed by the Medical Director.

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## Emergency Medicine Requirements

Practitioners practicing in Emergency Departments or Urgent Care Centers/Medical Aid Units (MAUs) must have board certification in Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or General Surgery.

Practitioners who are in the Highmark defined board eligibility period must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete board certification by December 31 of the sixth (6<sup>th</sup>) year of completing approved, applicable residency training or a contiguous subsequent fellowship training program in the specialty in which he/she practices.

Note: If not board certified in Emergency Medicine, practitioners practicing in Urgent Care Centers/MAUs must maintain current Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). If practicing in an Emergency Department, practitioners will also need Advanced Trauma Life Support (ATLS).

## 4.2 MALPRACTICE INSURANCE REQUIREMENT

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### Overview

A provider must carry, at their own expense, the minimum required amount of malpractice insurance at all times to maintain credentialing.

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### Network Malpractice Insurance Criteria

Providers must carry and maintain at all times liability and professional liability (malpractice) insurance to insure the group provider and each individual practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than those coverage levels required by Highmark Health Options.

Network providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark at least thirty (30) days in advance of any reduction or termination of malpractice coverage.

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### Requirements

All participating practitioners in Delaware are required to carry \$1million per medical incident and \$3 million in annual aggregate.

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## 4.2 TERMINATION FROM THE NETWORKS

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### Overview

Decisions to terminate a practitioner may be made by the Medical Director(s) of Quality Management in urgent situations or by the Highmark Network Quality and Credentialing Committee. A practitioner shall be provided with a written decision to terminate with the specific reason for the decision and may reconsideration/appeal rights.

Final termination decisions will negatively affect the practitioner's reimbursement for services provided to members in the Highmark Health Options products services by Highmark Health Options' Credentialed provider networks.

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### Valid Reasons for Termination

Professional network providers shall be terminated in accordance with the relevant terms of their provider contracts for failure to satisfy the following criteria which includes, but is not limited to:

1. Maintain an active license to practice.
2. Maintain an active Drug Enforcement Agency (DEA) certificate, where applicable.
3. Maintain coverage for malpractice insurance in the minimum amounts required.
4. Maintain acceptable professional liability claims history.
5. Participate in recredentialing, which requires providing all requested recredentialing information, and be recredentialed for network participation.
6. Provide acceptable clinical quality of care to members.
7. Meet appropriate recredentialing requirements.

Professional network practitioners shall also be terminated if, in the Plan's sole discretion, any of the following occur, or are in imminent danger of occurring:

1. Acts or omissions that jeopardize the health or welfare of a member.
  2. Acts or omissions that negatively affect the operation of the network.
  3. Acts or omissions which cause the Plan to violate any law or regulation or which negatively impact the Plan under any regulatory or certification requirements.
  4. Failure to provide an acceptable level of care.
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## 4.2 TERMINATION FROM THE NETWORKS

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### Invalid Reasons for Termination

A practitioner may not be terminated for any of the following reasons or actions:

1. Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill possessed by a reputable health care practitioner practicing according to the applicable legal standard of care.
2. Filing a grievance against the Plan in response to a disapproval of payment for requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service,
3. Protesting a decision, policy, or practice that the practitioner, consistent with the degree of learning and skill ordinarily possessed by a reputable health care practitioner practicing according to the applicable legal standard of care, reasonably believes interferes with the practitioner's ability to provide medically necessary and appropriate health care.
4. The provider has a practice that includes a substantial number of patients with expensive medical conditions.
5. Objection to the provision of or refusal to provide a health care service on moral or religious grounds.
6. Any refusal to refer a patient for health care services when the refusal of the practitioner is based on moral or religious grounds and the practitioner has made adequate information available to the members in the practitioner's practice.
7. Discussing: (a) the process that the Plan uses or proposes to use to deny payment for a health care service; (b) medically necessary and appropriate care with or on behalf of a member, including information regarding the nature of treatment, risks of treatment, alternative treatment, or the availability of alternate therapies, consultations, or tests; or (c) the decision of the plan to deny payment for a health care service.

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## 4.2 TERMINATION FROM THE NETWORKS

### Continuation of Care Throughout a Contract Termination

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In the event of a contract termination by either party, the provider will continue to render necessary care to Highmark Health Options Plan member(s) consistent with contractual or legal obligations.

Continuation of care (COC) is a process followed to permit a member to continue an ongoing course of treatment with a primary care physician (PCP), a specialist, or a facility whose contract has been terminated by Highmark Health Options for reasons other than for cause, to be provided and paid in accordance with the terms and conditions of the agreement. Continuation of care also covers a member in the second or third trimester of pregnancy; the transition period shall last through post-partum care related to the delivery.

The provider must notify Highmark Health Options that the member is in a continuation of care situation. If Highmark Health Options does not take actions to make alternative care available to the member within ninety (90) days after receipt of the provider notice, then for continuation of care services provided after termination Highmark Health Options will pay the provider the standard rates paid to non-participating providers for that geographical area.

Notwithstanding the foregoing obligations, Highmark Health Options' obligations under this provision do not apply to the extent that other Participating Physicians are not available to replace the terminating participating physician due to:

- Geographic or travel-time barriers; or
  - Contractual provisions between the terminating physician and a facility at which Highmark Health Options member receives care that limits or precludes other participating physicians from rendering replacement services to Highmark Health Options members (e.g., an exclusive services agreement between the terminating participating physician and a facility where a Plan member receives services)
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## 4.2 RECONSIDERATIONS AND APPEALS

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### **Reconsideration of a Credentials Committee Decision**

A reconsideration hearing is available to a professional network practitioner in the event that a denial or termination action or a limited or modified decision is made by the Highmark Network Quality and Credentialing Committee due to:

1. The lack of required qualifications at the time of recredentialing (This includes, but is not limited to, loss of an unrestricted state license, loss of Drug Enforcement Agency (DEA) license, failure to obtain or keep appropriate board certification, lack of adequate clinical hospital privileges, and/or insufficient malpractice insurance coverage).
2. Any reason reportable to the National Practitioner Data Bank (NPDB).

The practitioner must request the reconsideration in writing within thirty (30) days of notice of the termination. The provider shall be given the opportunity to present information to the Highmark Network Quality and Credentialing Committee by one or any of the following options:

1. In writing, to the Credentials Committee for consideration which shall take place during a Credentials Committee meeting.
2. Appearing in person at a Credential Committee meeting.
3. Participating via telephone conference call at a Credentials Committee meeting.

After the meeting, the provider shall receive written notice of the final decision of the Highmark Network Quality and Credentialing Committee which will include the basis for the decision, the appeal process, and the practitioner's right to an appeal to the Quality Improvement Committee for Delaware practitioners within thirty (30) days if the decision is upheld. The provider will remain in the network until the Highmark Network Quality and Credentialing Committee's final decision to terminate and an effective date of termination is established.

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## 4.2 RECONSIDERATIONS AND APPEALS

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### **Appeals of a Credentials Committee Decision**

An appeal of a Highmark Network Quality and Credentialing Committee decision is available to a professional network practitioner if the Credentials Committee upholds a denial or termination action following a reconsideration hearing. The written notice issued following the reconsideration hearing advises the practitioner of the right to appeal as well as the appeal process and states the following:

- The specific time period for submitting the request
- The appointment of a hearing officer or a panel of individuals to review the appeal
- Practitioners are allowed at least thirty (30) calendar days after receipt of the notification to request a hearing
- Practitioners may be represented by an attorney or another person of their choice
- Written notification of the appeal decision will be provided that contains the specific reasons for the decision

In the event of an appeal, the panel of individuals to review the appeal will be the Quality Improvement Committee (comprised of professional peers, including representatives from Delaware) for Delaware practitioners. The Quality Improvement Committee decisions are final and not subject to further appeal.

When the final determination has been made concerning a proposed corrective action that adversely affects the clinical privileges or network status of a practitioner for a period longer than thirty (30) days, or a final decision notification of termination has been rendered, the Director of Quality Management or his/her designee shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank (NPDB), pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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# CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

## UNIT 3: HIGHMARK HEALTH OPTIONS POLICIES AND PROCEDURES FOR PROVIDERS

### IN THIS UNIT

### TOPIC

#### Maintaining Medical and Financial Records

- Medical Records Maintenance and Retention
- Medical Record Review (MRR) Standards
- Primary Care & Specialist MRR Standards
- Behavioral Health Provider MRR Standards
- Financial Records Maintenance and Retention
- Confidentiality and HIPAA Requirements
- Availability and Accessibility Standards
- Office Wait Times

#### Cultural Competence

- What is Cultural Competence?
- The CLAS Standards
- Language Interpretation Standards

#### Second Opinions

#### Advance Directives

#### Member Non-Compliance

#### Fraud and Abuse

#### Prohibited Marketing Activities

## 4.3 MAINTAINING MEDICAL AND FINANCIAL RECORDS

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### Medical Records Maintenance and Retention

Participating Highmark Health Options providers will develop and maintain a medical record for each member in accordance with the requirements established by federal and state laws. Medical records will include reports from referring providers when available, discharge summaries, records of emergency care received by members, prescriptions written by the practitioner, and such other information as federal and state laws and regulations or accreditation standards may require.

Providers will maintain medical records for a minimum of ten (10) years from the date of member discharge or ten (10) years from the member's date of majority, whichever is later.

Providers will maintain a master history of appointments for a minimum of one (1) year from the date of service to allow for monitoring of investigation of Grievances related to scheduling.

### Medical Records Review

#### Introduction:

- Medical Record Review (MRR) Standards have been adopted by the Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Committee
- Medical Record Review Standards have been developed for:
  - PCPs and Specialists
  - Behavioral Health Providers
- The importance of having standards is to verify that Practitioners and Providers:
  - Are aware of the expected level of care and associated documentation
  - Are aware of the requirements for maintenance of confidential medical information and record keeping
  - Are assured that medical records are being evaluated in a consistent manner

#### Goals:

- The Quality Improvement/Utilization Management Committee has established the scoring standard of 80% for the Medical Record Review elements
- If the score of 80% has not been met for MRR, a follow-up review will be scheduled to assess improvement
- Practitioners and providers are notified of their results and any areas of deficiency by letter within forty-five (45) calendar days of the review

### **Frequency of Reviews:**

- ∞ A sample of medical records from a randomly selected group of providers will be reviewed each year

## **MEDICAL RECORD REVIEW STANDARDS - PCPs & SPECIALISTS**

<b>1. MEMBER ID</b>	Each page in the record contains member name or member ID number.
<b>2. SIGNED ENTRY</b>	All entries are signed or initialed (electronically) by the provider.
<b>3. DATED ENTRY</b>	All entries are dated.
<b>4. LEGIBILITY</b>	The record is legible to someone other than the provider or provider's staff.
<b>5. PROBLEM LIST (PCPs Only)</b>	Problem list is current and completed for each member, including significant illness, medical conditions and health maintenance concerns.
<b>6. MEDICATION LIST</b>	Prescribed medications and dosages are documented on a medication list.
<b>7. ALLERGIES</b>	Presence/absence of allergies or adverse reactions to medications are prominently noted (age 1+). An absence of allergies should be clearly documented in the record.
<b>8. MEDICAL HISTORY</b>	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
<b>9. TOBACCO USE</b>	Use/nonuse of tobacco products is documented on members age 12 and older.
<b>10. ALCOHOL USE</b>	Use/nonuse of alcohol is documented on members age 12 and older.
<b>11. DRUG USE</b>	Use/nonuse of illicit drugs is documented on members age 12 and older.
<b>12. HISTORY &amp; PHYSICAL</b>	A complete history and physical exam including appropriate subjective and objective information for presenting complaints.
<b>13. LAB, DIAGNOSTIC TESTS &amp; OTHER</b>	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
<b>14. WORKING DIAGNOSIS</b>	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
<b>15. PLAN OF ACTION /THERAPIES/TREATMENT/ PRESCRIBED REGIMENS</b>	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Treatment options (e.g. medical versus surgical, etc.) and risks of treatments are discussed as appropriate.
<b>16. FOLLOW-UP VISIT</b>	Notation concerning follow-up care included.
<b>17. CONTINUITY OF CARE</b>	Includes documentation on communication between PCP or specialist care (whichever applicable), notes from consultations, follow-up plans for significantly abnormal lab or imaging results, ER discharge summaries, and records from transferred care or SNFs/home care agencies, as applicable.
<b>18. DISCHARGE SUMMARY</b>	If the member was in the hospital, there is a discharge summary signed and dated within 30 days.
<b>19. CARE MEDICALLY APPROPRIATE</b>	Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk.
<b>20. CONFIDENTIALITY</b>	Medical records contain confidentiality statements or a copy of signed consents to release information.

## MEDICAL RECORD REVIEW STANDARDS – BEHAVIORAL HEALTH PROVIDERS

<b>1. MEMBER ID</b>	Each page in the record contains member name or member ID number.
<b>2. SIGNED ENTRY</b>	All entries are signed or initialed (electronically) by the provider.
<b>3. DATED ENTRY</b>	All entries are dated.
<b>4. LEGIBILITY</b>	The record is legible to someone other than the provider or provider's staff.
<b>5. PSYCHOLOGICAL ASSESSMENT/PRESENTING PROBLEM LIST</b>	A mental status examination is documented in the medical record. Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are documented. Imminent risk of harm or suicidal ideation are documented.
<b>6. MEDICATION LIST</b>	Prescribed medications and dosages are documented on a medication list.
<b>7. ALLERGIES OR ADVERSE REACTIONS</b>	Presence/absence of allergies or adverse reactions to medications are prominently noted. An absence of allergies should be clearly documented in the record.
<b>8. TOBACCO USE</b>	Use/nonuse of tobacco products is documented on members age 12 and older.
<b>9. ALCOHOL USE</b>	Use/nonuse of alcohol an illicit drugs is documented on members age 12 and older.
<b>10. DRUG USE</b>	Use/nonuse of illicit drugs is documented on members age 12 and older.
<b>11.LAB, DIAGNOSTIC TESTS &amp; OTHER STUDIES</b>	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
<b>12. WORKING DIAGNOSIS</b>	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
<b>13.PLAN OF ACTION /THERAPIES /TREATMENT</b>	The provider initiating a treatment plan must describe the active target interventions with specific, measureable goals, and stated in behavioral terms, at the level of care proposed. Includes follow-up care.
<b>14. PREVENTIVE SERVICES</b>	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.
<b>15.CONSULTATION / REFERRALS / CONTINUITY/ COORDINATION OF CARE</b>	The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Discharge summaries are included, if applicable.
<b>16.DISCHARGE PLAN</b>	If the member terminates treatment, documentation of a discharge plan is present.
<b>17.CARE MEDICALLY APPROPRIATE</b>	Medical record describes appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. Record reflects that members who become homicidal or suicidal receive immediate and relevant interventions.
<b>18.CONFIDENTIALITY</b>	Medical records contain confidentiality statements or a copy of signed consents to release information.

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**Financial  
Records  
Maintenance  
and  
Retention**

Participating Highmark Health Options providers will develop and maintain billing records relating to the health care services provided to members, information on the charges for those services, and copayments, if any, received by provider from members for covered services, all in accordance with Highmark Health Options' policies and procedures and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For a period of seven (7) years following the termination or expiration of the Participating Provider Agreement, or until the closure of any ongoing audit that was opened during such seven (7) year period, whichever is later, provider will maintain financial reports and source records that include any revenues from, expenditures for, or other financial activity related to, services rendered under the Agreement.

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**Confidentiality  
and HIPAA  
Requirement**

All practitioners and providers participating with Highmark Health Options have agreed to abide by all Highmark Health Options policies and procedures regarding Member confidentiality. The performance goal for confidentiality is maintaining patient records secure from public access.

All personally identifiable information about Highmark Health Options Members ("Protected Health Information" or "PHI") is subject to state and federal statutory and regulatory privacy standards, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), and regulations adopted thereunder by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160, 162, 164 ("the HIPAA Rules").

Provider has established a program to effectuate full compliance with all applicable state and federal privacy and breach notification laws including, without limitation, HIPAA, 45 CFR §§ 164.400-414 (the "HIPAA Breach

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**Confidentiality  
and HIPAA  
requirements**  
(continued)

Notification Rule”), and HITECH for the protection of PHI and PII, and for the notification of individuals, appropriate official bodies, and the media in the event of a breach of PHI or PII. Moreover, Provider will maintain its privacy compliance and breach notification program in accordance with industry best practices.

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

1. 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 including the following:
  - a. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162, and 164.
  - b. Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.
  - c. The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations.
  - d. 42 U.S.C. § 1396a(a)(7) – State plan for medical assistance.
  - e. 42 C.F.R. § 431.300 et seq. – Medical Assistance – Safeguarding Information on Applicants and Recipients.
2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
3. 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 health care operations (TPO) is released to Highmark Health Options without seeking the consent of a member. 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, medical management, appeals, case management and disease management. Further, providers will assure that PHI for TPO will be made available to the Delaware Health and Social Services’ Division of Medicaid & Medical Assistance, Department of Health, Department of Insurance or Business Associates of Highmark Health Options for use without member consent. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations. Highmark Health Options follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the treatment, payment, or operations function.

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## 4.3 MAINTAINING MEDICAL AND FINANCIAL RECORDS, Continued

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4. The member, or a member's representative, including head of household, legal guardian, or durable power of attorney, shall have access to view and/or receive copies of the medical record upon written request. Each member is entitled to one free copy of his/her medical records. The fee for additional copies should not exceed the costs of time and materials used to compile, copy, and furnish such records. Request should be available within ten (10) calendar days of the written request and follow the specific procedures of the practitioner or provider.
  5. All providers are required to conduct environmental security of confidential information and monitor practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment standards that require the patient records be protected from public access.
  6. Medical records must be available for all member visits for established patients.
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## 4.3 AVAILABILITY AND ACCESSIBILITY

### Overview

Network evaluations are performed annually on the number and geographic distribution of the practitioner network in relationship to the location of its members. In addition, Highmark Health Options takes into consideration the special and cultural needs of members in maintain its network of practitioners.

### Availability and Accessibility Standards

Health Plan members are expected to receive an appointment with a qualified primary care/specialty practitioner based on the following standards:

TYPE OF CARE	TIME FRAME REQUIREMENT
<b>PCPs &amp; Specialists</b>	
Emergency services	Immediately 24 hours a day, 7 days a week
Routine appointment (including EPSDTs)	Within three (3) weeks
Emergency condition appointment	Same day
Urgent Care	Within two (2) calendar days
<b>Maternity Care Providers</b>	
Initial appointment in first trimester	Within three (3) weeks
Initial appointment in second trimester	Within seven (7) calendar days
Initial appointment in third trimester	Within three (3) calendar days
Initial appointment for high risk pregnancy	Within three (3) calendar days
<b>Behavioral Health Providers</b>	
Care for a non-life-threatening emergency	Within six (6) hours
Potential suicidal individual	Within one (1) hour or call Mobile Crisis Intervention Team or call police
Urgent care	Within forty-eight (48) hours
Initial visit for routine care	Within seven (7) business days
Follow-up routine care	Within three (3) weeks

### Office Wait Times

Office wait times should not exceed one (1) hour. Members should be notified as soon as possible of any delays. Additionally, if a delay results in more than a ninety (90) minute delay, the member should be offered a new appointment.



## 4.3 CULTURAL COMPETENCE

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### Overview

In order to help improve the quality of life of our members, we must take into account their cultural and linguistic differences. For this reason, addressing disparities in health care is high on our leadership agenda. 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 and language barriers. Highmark Health Options is continuously working to close the gap in health outcomes by focusing on education and prevention.

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### What is Cultural Competence?

Cultural competence is care delivery that acknowledges the importance and incorporation of culture, assessment of cross-cultural relations, and vigilance of dynamics that result from cultural differences, expansion of cultural knowledge, and adaptations of interventions to meet culturally unique needs (Sue, Zane, Hall & Berger, 2009).

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### The CLAS Standards

The National Standards for Culturally & Linguistically Appropriate Services in Health & Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

First developed in 2000 by the Department of Health and Human Services (HHS) Office of Minority Health, these standards are intended to advance health equity, improve quality, and help eliminate health care disparities.

Additional information on the CLAS Standards can be obtained from the following website: <https://www.thinkculturalhealth.hhs.gov/>

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### Language Interpretation Standards

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color, or national origin discrimination in programs receiving Federal funds. Practitioners 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.

Practitioner offices 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 will assist practitioners in locating resources upon request. Highmark Health Options offers the Member Handbook and other Highmark Health Options information in large print, Braille, on cassette tape, or computer diskette at no cost to the member.

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## 4.3 SECOND OPINIONS

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### **Second Opinions**

Highmark Health Options ensures member access to second opinions. Second opinions may be requested by Highmark Health Options, the member, or the primary care practitioner. Highmark Health Options will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network at no cost to the member.

The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider of Highmark Health Options. Second opinions from out-of-network providers may be authorized when no participating provider is accessible to the member or when no participating provider can meet the member's needs.

### **Second Surgical Opinions**

Second surgical opinions may be requested by Highmark Health Options, the member, or the primary care practitioner. When requesting a second surgical opinion consultation, Highmark Health Options recommends that you coordinate with a consulting practitioner who is in a practice other than that of the attending practitioner or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner.

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## 4.3 ADVANCE DIRECTIVES

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### Overview

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective 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 assure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives.

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### Participating Provider Responsibilities

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

You can also request a copy of a Living Will form from the Quality Improvement Department by calling Highmark Health Options Provider Services at 1-844-325-6251. There is no governmentally-mandated form.

A copy of the Living Will form should be maintained in the medical record. Highmark Health Options Medical Record Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response.

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### Educational Materials and Forms

Providers will receive educational materials regarding member's rights to advance directives upon entering the Highmark Health Options' practitioner network.

Member outreach or advance directive forms are made available through Highmark Health Options' Member Handbook and Member Newsletter or by visiting Highmark Health Options' website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

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## 4.3 MEMBER NON-COMPLIANCE

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### **Written Request Required**

Should an incidence of inappropriate behavior or member non-compliance with no-show policies occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel.

The letter must include the member's name and Highmark Health Options ID Number, and, when applicable, state their no-show policy, and the member(s) who has(have) violated the policy. The letter should be sent to Highmark Health Options at:

Highmark Health Options  
Attention: Provider Correspondence  
P.O. Box 890419  
Camp Hill, PA 17089-0419

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### **Process**

All written requests are forwarded to the Enrollment Department within forty-eight (48) hours of receipt. The Enrollment Department notifies the original practitioner in writing when the transfer has been completed.

If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services.

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### **Determination of**

When the request is received prior to the 25<sup>th</sup> of the month, the new effective date will be the first of the following month. When the request is received on or after the 25<sup>th</sup> of the month, the new effective date will be the first of the subsequent month.

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### **Exception**

An exception to the above guidelines can be made if the situation warrants an immediate transfer.

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### **Emergency Care During Transfer Process**

Primary care practitioners are required to provide emergency care for any Highmark Health Options member dismissed from their practice until the member transfer is complete.

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## 4.3 FRAUD AND ABUSE

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### Overview

Highmark Health Options has a comprehensive policy for handling the prevention, detection, and reporting of fraud, waste, and abuse (“FWA”). It is Highmark Health Options policy to investigate any action by members, employees, or practitioners that affects the integrity of Highmark Health Options and/or the Medical Assistance Program. Highmark Health Options enforces all industry standard claim coding requirements including those from NCCI, AMA CPT and ICD10.

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### Participating Provider Compliance

As a participating provider with Highmark Health Options, the contract that is signed requires compliance with Highmark Health Options policies and procedures for the detection and prevention of fraud, waste, and abuse. Such compliance may include referral of information regarding suspected or confirmed fraud and abuse to Highmark Health Options, and submission of statistical and narrative reports regarding fraud and abuse detection activities.

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### Provider Fraud, Waste, and Abuse Training

Providers can find FWA trainings created by Highmark Health Options’ Payment Integrity team on the website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com). All providers are required to have a representative review the Provider FWA Training upon contracting with Highmark Health Options 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 Highmark Health Options.

Further information and updates concerning the Provider FWA Training can be found on the Fraud & Abuse website.

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### Fraud, Waste, and Abuse Policies & Procedures

Highmark Health Options’ policies and procedures follow the guidelines set forth by CMS. For further information on fraud, waste, and abuse, providers should refer to the CMS website <https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Fraud-and-Abuse/Fraud-page>.

It is Highmark Health Options’ policy to discharge any employee, terminate any practitioner, or recommend any member be withdrawn from the Medicaid program who, upon investigation, has been identified as being involved in fraudulent or abusive activities.

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### Fraud, Waste, and Abuse Hotline

If fraud or abuse is suspected, it is your responsibility to immediately notify Highmark Health Options by calling the Fraud, Waste, and Abuse Hotline at 1-844-325-6256. The Fraud Hotline is 24 hours a day, seven (7) days a week.

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**Examples of Provider Fraud, Waste, and Abuse**

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

- Billing or charging Medical Assistance recipients for covered services
  - Balance billing
  - Billing for services not rendered
  - Upcoding
  - Billing separately for services in lieu of an available combination code
  - Billing more than once for the same service
  - Dispensing generic drugs and billing for brand name drugs
  - Falsifying records
  - Performing inappropriate or unnecessary services
- 

**Examples of Member Fraud, Waste, and Abuse**

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

- Sharing Medicaid ID card
  - Misreporting or failing to report information such as income, ownership of resources and property, or who lives in the household
  - Trafficking Supplemental Nutrition Assistance Program (SNAP) benefits
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## 4.3 OVERPAYMENTS

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**Overview**

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

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**Payment Integrity Recovery Requirements**

Highmark Health Options has payment integrity functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits
- Retrospective claims reviews
- Provider education
- FWA investigations and audits

Highmark Health Options' payment integrity 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. 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.

continued

Highmark Health Options will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. Highmark Health Options will recover claims payments that are contrary to national and industry standards. Highmark Health Options will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews. If any of the payment integrity efforts identify overpayments, the following activities will occur:

- Highmark Health Options will comply with all Federal and State guidelines to identify overpayments;
- Highmark Health Options will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within sixty (60) days;
- Highmark Health Options will refer suspected FWA to appropriate agencies, such as Medicaid oversight; and
- Highmark Health Options may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from Highmark Health Options' provider network

Highmark Health Options may 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

*continued*

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
Potential fraudulent activities
Excessive services
Altered/forged records

**Provider  
Self-Audit**

Federal and State regulations require providers to routinely audit claims for overpayments. Highmark Health Options has a process in place for our network providers to report the receipt of an overpayment. Providers must notify Highmark Health Options in writing of the reason for the overpayment as well as returning the full amount of overpayment to Highmark Health Options within sixty (60) calendar days after the date on which they identified the overpayment. If the claim is over two (2) years old, a check is preferred. If the claim is less than two (2) years old, retraction is preferred. If a listing of claims is not provided, Highmark Health Options cannot guarantee that the claims will not be audited again, for the same reason. Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form. Conversely, if providers use 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. Highmark Health Options' Payment Integrity Department may contact the provider to discuss self-audit results as necessary. The overpayment letter and refunds should be mailed directly to:

Highmark Health Options  
 Attention: Payment Integrity Department  
 Four Gateway Center  
 444 Liberty Avenue, Suite 2100  
 Pittsburgh, PA 15222-1222

For more information on self-audits, see the "Self-Audit" Toolkit posted to <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website. The electronic version of this and other E-Bulletins and additional program integrity information can also be found on the site.



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**Highmark  
Health  
Options  
Payment  
Integrity  
Audit**

Highmark Health Option's Payment Integrity team will periodically conduct audits. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted by Highmark Health Options, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond.

Additionally, Highmark Health Options partners with multiple vendors to conduct various post-payment audits or reviews. Such audits or reviews could include:

- Retrospective data mining review
- Subrogation
- Inpatient chart review

Vendor specific questions should be directed to Highmark Health Options' Provider Services by calling 1-844-325-6251.

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**Medical  
Record  
Requests**

Highmark Health Options may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged fraud, waste, and abuse. If Highmark Health Options requests 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. 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 Highmark Health Option's 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.

Highmark Health Options requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, and Medicaid regulations 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, 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 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)

<b>CONSENT TO TREATMENT</b>	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
<b>RELEASE OF INFORMATION FOR PAYMENT</b>	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
<b>PRIVACY PRACTICES</b>	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
<b>MEDICAL INFORMATION</b>	Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, 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 abuse, 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
	<b>REVIEW OF RECORDS</b>
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 treatments	
Documents necessity for treatment	
Reviews are completed timely as applicable	

Must be easy to read and legible

<b>PROGRESS / CLINICAL ENTRY NOTE</b>	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
<b>MEDICATION LIST</b>	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

## 4.3 PROHIBITED MARKETING ACTIVITIES

### Marketing Activities Prohibited per DHSS Mandate

Providers experienced with working with a Medicaid population may have knowledge regarding the limitations required when discussing health plans with their patients.

Highmark Health Options prohibits the following marketing activities as mandated by the Delaware Department of Health and Social Services (DHSS):

- Providers must avoid inadvertently providing advice to their patients on which plan might be right for them
- Providers are not permitted to advise or sway a patient into selecting a plan that is preferred by the provider
- Providers may only respond to questions from a patient about the plans for which they have in-network status
- Providers must submit to the Highmark Health Options Compliance Officer, for prior written approval, any and all materials used to advise members of the Medicaid health plans with which they have contracts; Failure to obtain such prior written approval from Highmark Health Options may result in DHSS-imposed sanctions or other liabilities of which the provider shall be sole responsible

# CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

## UNIT 4: PRIMARY CARE PROVIDERS

### IN THIS UNIT

### TOPIC

#### Primary Care Practitioner Assignments

- PCP Assignment Changes
- Highmark Health Options Member No-Show Policy
- Written Transfer Requests

#### Primary Care Practitioner Responsibilities

#### Delivery of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

- Primary Care Practitioner Responsibilities
- Required Screens Schedule
- Initial Assessments for SSI Members Under Age 21

#### Obstetrics and Gynecology

#### Maternity Care Providers

- Intake Visit
- Perinatal Care and Risk Assessment Form
- Obstetrics Billing

## 4.4 PRIMARY CARE PRACTITIONER ASSIGNMENTS

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### Assignment of Members to a PCP

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 members, as specified by their practitioner agreement, to their patient panel at each authorized office location without regard to their status as a new or existing patient to that practice or location.

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### PCP Assignment Changes

When a member wishes to change his or her primary care practitioner, the change is processed under the following guidelines:

- When the request is received **prior to the 25<sup>th</sup> of the current month**, the new effective date will be the first of the following month. For example, if a member's request is received on October 7, the member will be effective November 1 with the new primary care practitioner.
- When the request is received **on or after the 25<sup>th</sup> of the current month**, the new effective date will be the first of the subsequent month. For example, if a member's request is received on October 28, the member will be effective December 1 with the new primary care practitioner.
- If the member requests to change his or her primary care practitioner immediately, an exception to the above guidelines can be made if the situation warrants.

Primary care practitioners agree: (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Highmark Health Options members on the basis of race, sex, age, religion, place of residence, health status, or source of payment; and (b) 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. Highmark Health Options' goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

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## 4.4 PRIMARY CARE PRACTITIONER ASSIGNMENTS

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### Highmark Health Options Member No-Show Policy

In order to assist Highmark Health Options practitioners in the management of members who violate office policy in regard to scheduled appointments, Highmark Health Options has instituted the following Member No-Show Policy:

**Highmark Health Options will recognize the individual practitioner's written office policy in regard to scheduled appointment. Highmark Health Options practitioners are responsible for recording no-show appointments in the member's medical record.**

When a transfer is being conducted due to member no-show, the practitioner's notification should indicate that the practitioner wants to transfer the member to another primary care practitioner's practice.

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### Written Transfer Requests

Should an incidence of inappropriate behavior or member non-compliance with no-show policies occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel.

The letter must include the member's name and Highmark Health Options ID Number, and, when applicable, state their no-show policy and the member(s) who has (have) violated the policy. The letter should be sent to the Provider Services Department at:

Highmark Health Options  
Attention: Provider Services  
P.O. Box 890419  
Camp Hill, PA 17089-0419

All written requests are forwarded to the Enrollment Department within forty-eight (48) hours of receipt. The Enrollment Department notifies the original practitioner in writing when the transfer has been completed. If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services.

When the request is received prior to the 25<sup>th</sup> of the month, the new effective date will be the first of the following month. When the request is received on or after the 25<sup>th</sup> of the month, the new effective date will be the first of the subsequent month. An exception to the above guidelines can be made if the situation warrants an immediate transfer. Primary care practitioners are required to provide emergency care for any Highmark Health Options member dismissed from their practice until the member transfer is complete.

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## 4.4 PRIMARY CARE PRACTITIONER RESPONSIBILITIES

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### **Definition: Primary Care Practitioner**

Highmark Health Options will follow the rules of the State in defining Primary Care (PCP) practitioners.

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, and 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 Medical Assistance Consumer.”

In service areas which include institutions with teaching programs, PCP teams (comprised of residents, and a supervising faculty physician) may serve as a PCP. Additionally, the establishment of PCP teams that include certified nurse midwives, or advanced nurse practitioners who, at the member’s discretion, may serve as the point of first contact for the member is encouraged. In both instances, PCP teams must be organized so as to ensure continuity of care to members and must identify a “lead physician” within the team for each member. The “lead physician” must be an attending physician and available to provide direct service to the member should the member request it, and services must be provided under the NPI of the “lead physician.”

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### **PCP Responsibilities**

The primary care practitioner is responsible for 24 hour a day, seven (7) days a week coordination of a member’s health care needs and access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services. Although members may obtain health care services without a PCP referral, Highmark Health Options strongly encourages members to work through their PCP to access any health care service.

Highmark Health Options also strongly encourages PCPs to play an active role in coordinating the health care services needed by their patients, including working with specialty providers and other practitioners to meet the patients’ health care needs.

By focusing all of a member’s medical decisions through the primary care practitioner, Highmark Health Options is able to provide comprehensive and high quality care in a cost-effective manner. Our goal 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.

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## 4.4 DELIVERY OF EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES

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### Overview

Highmark Health Options' Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is based upon the federally-mandated ESPDT Program for Medical Assistance-eligible children under the age of 21 years. Through the EPSDT Program, children are eligible to receive medical, dental, vision, and hearing screen to assure that they receive all medically necessary services without regard to Medical Assistance covered services.

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### Primary Care Practitioner Responsibilities

Each Highmark Health Options primary care practitioner and primary care/specialist is responsible for providing the health screen for Highmark Health Options members, and reporting the results of the screenings to Highmark Health Options, as well as communicating demographic information (e.g. telephone number, address, alternate address) with the Highmark Health Options staff to assist with scheduling, locating, and addressing compliance issues. Highmark Health Options verifies that primary care practitioners and PCP/Specialists for special needs are able to provide EPSDT services at the time of the practitioner's office site visit.

Primary care practitioners who treat children under the age of 21 who are unable to comply with the requirements of the EPSDT Program must make arrangements for EPSDT screen to be performed elsewhere by a Highmark Health Options participating provider. Alternative primary care practitioners and specialists should forward a copy of the completed progress report to the primary care practitioner so it can be placed in the member's chart.

Primary care practitioners are required to assure all children under the age of 21 have timely access to EPSDT services, and are responsible for assuring continued coordination of care for all members due to receive EPSDT services. Also, primary care practitioners are to arrange for medically necessary follow-up care after a screen or an encounter.

PCPs are responsible for early detection of a child's problems in development, behavior, social emotional skills or mental health status. PCPs agree to coordinate ongoing monitoring of care provided by other practitioners.

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### Required Screens Schedule

The required screen and tests are outlined in the provider section of the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com). Primary care practitioners are required to follow this schedule to determine when the necessary screens and tests are to be performed. Members must receive, at a minimum, eight (8) screens between the ages of birth and 18 months, and seventeen (17) screens between 19 months and 21 years.

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## 4.4 DELIVERY OF EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES

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### **Initial Assessments for SSI Members Under Age 21**

When treating Supplemental Security Income (SSI) and SSI-related members under the age of 21, an initial assessment must be conducted at the first appointment. Written assessment must be discussed with the member's family or custodial agency, grievance or appeal rights must be presented by the primary care practitioner; and recommendations regarding case management must be documented.

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## 4.4 OBSTETRICS AND GYNECOLOGY

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### **Member Self-Referral**

To eliminate any perceived barrier to accessing obstetrics and gynecology (“OB/GYN”) services, Highmark Health Options 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 verify eligibility of the member. Highmark Health Options members may also self-refer for in-network family planning services.

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### **Primary Care Practitioner Services**

Highmark Health Options 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. Primary care practitioners who provide obstetrical services must bill in accordance with Highmark Health Options guidelines and may only provide obstetrical services to those patients assigned to their panel.

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## 4.4 MATERNITY CARE PROVIDERS

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### Intake Visit

The first visit with an obstetrical patient is considered to be the intake visit; or, if a member becomes a Highmark Health Options member during the course of her pregnancy, her first visit as a Highmark Health Options member is considered to be her intake visit.

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### Perinatal Care and Risk Assessment Form

At the intake visit, a Perinatal Care and Risk Assessment Form must be completed and faxed to Highmark Health Options immediately following completion, and then filed in the member's medical record. The form is available in the provider section of the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

The purpose of the Perinatal Care and Risk Assessment Form is to help identify risk factors early in the pregnancy and engage the woman in care management. For that reason, Highmark Health Options offers two incentive payments:

1. **Outreach Bonus** -- \$100 for an intake visit with completed form during the first trimester (99429-HD)
2. **Intake Visit** -- \$50 for an intake visit with completed form (T1001-HD)

The Perinatal Care and Risk Assessment Form is not a claim. However, the Perinatal Care and Risk Assessment Form must be received by Highmark Health Options in order to process the claim for the Outreach Bonus and the Intake Visit. Please bill as indicated below to receive incentive payments.

### OUTREACH BONUS

Procedure codes 99429-HD (first trimester outreach) and T1001-U9 (initial risk assessment) must be reported together on the same claim form to allow the bonus payment. Additionally, the appropriate Evaluation and Management codes (99201-99215) and HD pricing modifier, in the first position, must also be included on the claim form.

**The bonus payment will not be paid if both codes/modifiers referenced above are not reported on the same claim.** The Perinatal Care and Risk Assessment Form must be received by Highmark Health Options and documented in the claims system prior to receipt of the claim to allow the appropriate bonus and intake visit payment.

### INTAKE VISIT

If the member's first prenatal visit does not occur within the first trimester, then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is considered to be the intake visit. If a patient becomes a Highmark Health Options member during the course of her pregnancy, her first visit as a Highmark Health Options member is considered to be her intake visit. At the intake visit, a Perinatal Care and Risk Assessment Form must be completed and faxed to

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## 4.4 MATERNITY CARE PROVIDERS

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Highmark Health Options, and a claim submitted with code T1001-HD for reimbursement. The appropriate Evaluation and Management code and pricing modifier should also be included on the claim form.

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### Fetal Non-Stress Tests and Ultrasounds

Fetal non-stress tests and obstetrical ultrasounds can be performed in the OB/GYN's office or at a hospital without an authorization or a referral from Highmark Health Options.

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### Obstetrics Billing

**Prenatal visits are reimbursed on a per visit basis.** All prenatal visits and dates of service must be included on the claim and identified with Evaluation & Management codes (99201–99215) **ONLY**. The **HD pricing modifier** must follow the code in the first position on the claim form.

Delivery charges must be identified with CPT codes.

Newborns of Highmark Health Options' mothers will be covered by Highmark Health Options for services rendered during the neonatal period. All charges for newborns that become enrolled in Highmark Health Options, other than hospital bills covering the confinement for both Mom and baby, are processed under the newborn name and newborn Highmark Health Options ID Number.

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### Coordinating Care

If an OB/GYN determines that the assessment or treatment by another specialty care practitioner is necessary, the OB/GYN is required to contact the member's primary care practitioner to notify them that the member is being directed to that specialist. The OB/GYN practitioner is responsible for providing written correspondence to the member's primary care practitioner for coordination and continuity of care.

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# CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

## UNIT 5: SPECIALTY, ANCILLARY, AND FACILITY PROVIDERS

### IN THIS UNIT

### TOPIC

#### Specialty Care Practitioners

- Verifying Eligibility
- Billing Members for Covered Services Prohibited
- Specialists Functioning as Primary Care Practitioners
- Continuity and Coordination of Care Requirements

#### Ancillary Providers

- Ambulance Services
- Durable Medical Equipment
- Imaging Services

#### Hospital/Facility Services

- Authorization Requirements
- Authorization Requests
- Transmission of Laboratory Data
- Procedures in a Hospital's SPU or ASU
- Emergency Services
- Continuity and Coordination of Care Requirements
- On-Site Care Coordinators

## 4.5 SPECIALTY CARE PRACTITIONERS

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### **Verifying Eligibility**

Due to frequent changes in a member's eligibility, specialty care practitioners must verify eligibility prior to rendering services to assure reimbursement. This can be done by calling Highmark Health Options' interactive voice response system (IVR) at **1-844-325-6161**. Eligibility and benefits verifications is available through IVR 24 hours a day, seven (7) days a week.

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### **Members Encouraged to Coordinate Care with PCP**

Highmark Health Options members may receive specialty care services from participating practitioners. A primary care practitioner (PCP) referral is not required for Highmark Health Options members to receive specialty care services; however, Highmark Health Options strongly encourages members to work through their PCP to access specialty services.

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### **Billing Members for Covered Services Prohibited**

Payment by Highmark Health Options is considered payment in full. Under no circumstance, including, but not limited to, non-payment by Highmark Health Options for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Health Options member.

Practitioners may directly bill members for non-covered services provided; however, prior to the provision of such non-covered services, the practitioner must inform the member: (i) of the service(s) to be provided; (ii) that Highmark Health Options will not pay for or be liable for said services; (iii) of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual; and (iv) absent a successful appeal, that the member will be financially liable for such services.

Refer to Chapter 7 of this manual for additional information regarding submission of claims.

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### **Specialists Functioning as Primary Care Practitioners**

Specialists may function as a primary care practitioner for members with complex illnesses or conditions. In order for a specialist to function as a primary care practitioner, the specialist must be approved by the Highmark Health Options Medical Director.

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### **Continuity and Coordination of Care Requirements**

Specialists, hospitals, and skilled nursing facilities (SNFs) 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.

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## 4.5 ANCILLARY PROVIDERS

### Overview

Highmark Health Options has a network of ancillary providers to complement the benefit packages available to Highmark Health Options members.

### Ambulance Services

#### EMERGENT TRANSPORTS

Emergent transportation (911), including air ambulance, does not require authorization by Health Options. Highmark Health Options 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 without an authorization from Highmark Health Options.

Highmark Health Options also considers the following situations emergent, and thus they **do not require authorization**:

- 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

Provider should bill the above types of transports with the

#### NON-EMERGENT TRANSPORTS

Authorization for non-emergent ambulance transportation is required by Highmark Health Options Utilization Management department. Highmark Health Options considers non-emergent 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 as non-emergent. 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
- Ambulance transport from home to a PCP office

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## 4.5 ANCILLARY PROVIDERS

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### **Ambulance Services** (continued)

A Highmark Health Options 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. 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 an ambulance service of their choosing to provide transport in this scenario only.

### **WHEELCHAIR VAN TRANSPORT**

All wheelchair van transportation requires an authorization from Highmark Health Options Utilization Management Department.

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### **Durable Medical Equipment (DME)**

Highmark Health Options members are eligible to receive any covered and medically necessary durable medical equipment (DME) needed for home health care.

Please refer to the Prior Authorization section in Chapter 5, Unit 1 of this manual for more information.

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### **Imaging Services**

Please refer to the Prior Authorization section in Chapter 5, Unit 1 of this manual for a list of imaging services that require authorization.

Authorizations are the responsibility of the ordering provider.

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## 4.5 HOSPITAL/FACILITY SERVICES

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### **Authorization Requirement**

In order for Highmark Health Options to monitor the quality of care and utilization of services by our members, all Highmark Health Options practitioners are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by contacting Highmark Health Options' Utilization Management Department at 1-844-325-6251.

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### **Authorization Requests**

Highmark Health Options will accept the primary care practitioner, ordering practitioner, or the attending practitioner's request for an authorization of non-emergency hospital care; however, no party should assume the other has obtained authorization. Highmark Health Options will also accept a call from the hospital's Utilization Review Department.

The Utilization Management representative refers to the Highmark Health Options Medical Director if criteria or established guidelines are not met for medical necessity. The ordering practitioner is offered a peer review opportunity with the Highmark Health Options Medical Director for all potential denial determinations.

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### **Transmission of Laboratory Data**

Hospitals will electronically provide Highmark Health Options with all laboratory values relevant to the Healthcare Effectiveness Data and Information Set ("HEDIS"), accreditation or regulatory requirements no less than four (4) times per year or upon Highmark Health Options' written request.

All such laboratory values shall be provided to Highmark Health Options no later than the last business day of the calendar months of April, July, October, and January. In the event Highmark Health Options requests additional clinical laboratory values, Hospitals shall receive at least ninety (90) calendar days advance written notice of any such request.

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### **Procedures in a Hospital's SPU or ASU**

Highmark Health Options practitioners may utilize a hospital's Short Procedure Unit (SPU) or Ambulatory Surgery Unit (ASU) for any authorized medically necessary procedure.

Medical necessity reviews may be required for certain procedures. Please call Highmark Health Options' Utilization Management Department to verify if authorization is required or refer to the Quick Reference Guide on the Highmark Health Options' website.

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## 4.5 HOSPITAL/FACILITY SERVICES

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### **Emergency Services**

The definition of an emergency is: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

The following conditions are examples of those most likely to require emergency treatment:

- Danger of losing life or limb
  - Poisoning
  - Chest pain and heart attack
  - Overdose of medicine or drug
  - Choking
  - Heavy bleeding
  - Car accidents
  - Possible broken bones
  - Loss of speech
  - Paralysis
  - Breathing problems
  - Seizures
  - Criminal attack (mugging or rape)
  - Heart attack
  - Blackouts
  - Vomiting blood
- 

### **Situations When Emergency Care is Typically Not Needed**

Highmark Health Options members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold
  - Sore throat
  - Small cuts and bruises
  - Ear ache
  - Vomiting
  - Rash
  - Bruises
  - Swelling
  - Cramps
  - Cough
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## 4.5 HOSPITAL/FACILITY SERVICES

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### **Hospital Guidelines for Triage**

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital's pre-established guidelines allow for the triage of illness or injury.

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### **Follow-up Care After an Emergency Room Visit**

All follow-up care after an emergency room visit must be coordinated through the primary care practitioner. Members are informed via the Member Handbook to contact their primary care practitioner who will coordinate follow-up care in instances such as:

- Removal of stitches
  - Changing of bandages
  - Cast check
  - Further testing
- 

### **Emergency Admission at a Non-Participating Hospital**

When a Highmark Health Options member requires hospitalization, Highmark Health Options' policy is to have the service rendered in a Highmark Health Options participating hospital. However, Highmark Health Options recognizes that it may not be possible to follow this policy when a member presents to the closest medical facility due to a medical emergency. When the medical condition of the member requires an admission to a non-participating hospital, the member will be transferred within twenty-four (24) hours of stabilization, when appropriate.

In order to determine that the member is medically stable for transfer, the Highmark Health Options Utilization Management staff will concurrently monitor the condition of the member by communicating with the hospital's Utilization Review staff and the attending practitioner. Highmark Health Options will coordinate all necessary transportation for the timely transfer of the member.

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### **Continuity and Coordination of Care Requirements**

Specialists, hospitals, and skilled nursing facilities (SNFs) 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 primary care practitioner.

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### **Claims Submission**

Please see Chapter 7 of this manual for information regarding claims submission.

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*Continued on next page*

## 4.5 HOSPITAL/FACILITY SERVICES

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### **On-Site cCre Coordinators**

Participating providers agree that Highmark Health Options may place a care coordinator on site at participating facilities as part of the Highmark Health Options concurrent review and care coordination process. The on-site care coordinator will assist with coordination of the discharge plan and arranging additional services including, but not limited to, special diagnostics, home care, and durable medical equipment. In certain instances, it may be necessary for the care coordinator to reach out to a member's parent/guardian to perform these activities.

The care coordinator must receive all clinical information on the inpatient stay as well as personal information regarding family members/caregivers in a timely manner to allow for decision and appropriate management of care.

The participating provider will provide the care coordinator with a designated work space where the care coordinator will be able to utilize a laptop computer to gain access to Highmark Health Options' systems.

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# CHAPTER 5: HEALTH CARE MANAGEMENT

## UNIT 1: MEDICAL MANAGEMENT

### IN THIS UNIT

### TOPIC

Medical Necessity Criteria

- Medical Necessity Defined

Prior Authorization

- Requesting Prior Authorization
- Services Requiring Authorization
- Authorization Process
- Procedures Specific to Durable Medical Equipment
- Skilled Nursing Facility (SNF)
- Outpatient Therapy Services
- Acute Inpatient Rehabilitation Facility
- Home Infusion
- Hospice Services
- Behavioral Health Services
- Pharmacy Services

Home Health Care

Private Duty Nursing Services

Transitions from Hospital to Home

Medical Claims Review

## 5.1 MEDICAL NECESSITY CRITERIA

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### Overview

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 would benefit from care management or disease management.

Please visit our website to see Medical and Payment Policies  
[www.highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy](http://www.highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy).

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### Medical Necessity Defined

Highmark Health Options' Utilization Management Department assesses the medical appropriateness of services using McKesson's InterQual® Procedure Criteria, American Society of Addiction Medicine (ASAM) criteria, approval criteria based on a Medical Director's review of the latest medical literature and citations, and the Delaware Health and Social Services (DHSS) definition of medical necessity when authorizing the delivery of health care services to members. The definition of medical necessity is:

The essential need for medical care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements for children up to the age of 21) which, when prescribed by the member's primary care physician care manager and delivered by or through authorized and qualified providers, will:

- Be directly related to the diagnosed medical condition or the effects of the condition of the member (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only;
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member's family;
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living, but will not be solely for the convenience of the member, the member's family, or the member's provider;
- Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member;
- Be sufficient in amount, scope, and duration to reasonably achieve its purpose;

## 5.1 MEDICAL NECESSITY CRITERIA, Continued

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**Medical  
Necessity  
Defined**  
(continued)

- Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of the other care and services that are commonly provided;
- Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has and will be reasonably determined to:
  - Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions or the effects of such conditions;
  - Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay;
  - Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program;
  - Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or
  - Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition, in order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the primary care practitioner, as well as any other providers, programs, agencies that have evaluated the member.

All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

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## 5.1 PRIOR AUTHORIZATION

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### **Requesting Prior Authorization**

The Utilization Management Department is committed to assuring prompt, efficient delivery of health care services and to monitor quality of care provided to Highmark Health Options members. The ordering provider can request a prior authorization either via fax using the Highmark Health Options Prior Authorization Form, or by phone. The Utilization Management Department can be contacted at 1-844-325-6251 between the hours of 8 a.m. and 5 p.m., Monday through Friday.

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. If the Highmark Health Options Utilization Management Department is closed and you are seeking an authorization for urgent requests, you may call 1-844-325-6251. A Highmark Health Options Medical Director is available for review of these requests when necessary. For urgent and emergency situations, Highmark Health Options requires that the practitioner notify the plan within forty-eight (48) hours or two (2) business days of rendering service.

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### **Information Needed When Calling for Authorization**

Authorization requests for advanced imaging are submitted through RadMD, [www.RadMD.com](http://www.RadMD.com) or the RadMD Provider Services line 1-800-327-0641.

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

1. Member Name
  2. Member's 12-digit Highmark Health Options ID Number
  3. Diagnosis (ICD Code or precise terminology)
  4. Procedure Code (CPT-4, HCPCS, or MA Coding) or billing codes for durable medical equipment requests
  5. Treatment Plan
  6. Date of Service
  7. Name of Admitting/Treating Practitioner
  8. Name of the Practitioner/Provider requesting the authorized treatment
  9. NPI
  10. History of the current illness and treatments
  11. Any other pertinent clinical information
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## 5.1 PRIOR AUTHORIZATION

### Services Requiring Authorization

The services requiring authorization include, but may not be limited to, this list of services:

- Abortion\*, Sterilization, Hysterectomy, (Tubal Ligations, Vasectomy)
- Bariatric Surgery/Stapling
- Behavioral Health (psychiatric inpatient, residential treatment facility, partial hospitalization, intensive outpatient)
- Blepharoplasty
- Bone Growth Stimulator
- Boney Impacted Wisdom Teeth Removal
- Breast Reduction
- Cardiac and Pulmonary (lungs) Rehabilitation Therapy
- Carpal Tunnel Surgery
- Chiropractic Services
- Cochlear and Auditory Implants
- Durable Medical Equipment purchase and rentals \$500 or greater
- Electroconvulsive Therapy (ECT)
- Enteral/Parental Therapy
- Experimental or Investigational Services
- Gender Transition Services
- Genetic Testing
- Genital Reconstruction
- Hearing Aids, Ear Molds, Dispensing Fees as well as Hearing Aid Batteries and Repair Services (for age 20 and younger; Prior Authorization via Pharmacy)
- Home Health Care
- Hospice
- Hospital Admissions (Medical, Behavioral Health, Rehabilitation)
- Injectable Medications – Botulinum Toxins, H.P. Acthar®, Intravenous Immune Globulin (IVIG), Xolair®
- Intensity Modulated Radiation Therapy (IMRT)
- Joint Replacement
- Medical Supplies, including oral nutrition when \$500 or greater
- Non-Emergent Air Ambulance Transport
- Orthotics and Prosthetics (over \$500)
- Panniculectomy
- Private Duty Nursing requires a letter of medical necessity
- Proton Beam
- Psychological Testing
- Radiology Services (Complex, Outpatient):
  - MRI (magnetic resonance imaging)
  - MRA (magnetic resonance angiography)
  - CT (computerized axial tomography)

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## 5.1 PRIOR AUTHORIZATION

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### Services Requiring Authorization (continued)

- PET (positron-emission tomography)
- Myocardial Perfusion Imaging/Nuclear Cardiology Services

**\* Does not require authorization but consent form may be required.**

- Removal of Breast Implant
  - Rhinoplasty
  - Septoplasty
  - Skilled Nursing Facility Admissions (acute)
  - Sleep Apnea Procedures and Surgeries
  - Speech, Occupational, and Physical Therapies
  - Spinal Neuro Stimulator Services
  - Spine Surgeries
  - Temporomandibular Joint (TMJ) Surgery
  - Transplants/Implants
  - Vagus Nerve Stimulation
  - Varicose Vein Procedures
  - Ventricular Assist Devices
  - Wound Vac
  - All services to be provided by an out-of-network practitioner/provider (including durable medical equipment and home health)
  - Services without a code or fee on the Medicaid fee schedule (including medical equipment and supplies) or Not Otherwise Classified (NOC) procedure codes
-

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**Authorization Process**

Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by calling the Highmark Health Options Utilization Management Department at 1-844-325-6251.

If a service requires authorization and is being requested by a participating specialist, the specialist's office must call Highmark Health Options to authorize the service. Hospitals may verify authorization by calling the Highmark Health Options Utilization Management Department.

When a call is received, the above information will be reviewed and the member's 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.

If an authorized service is not able to be approved as proposed by the practitioner, alternate programs such as home health care, rehabilitation, or additional outpatient services may be suggested to the practitioner by the Utilization

Management staff. If an agreement cannot be reached between the practitioner and the Utilization Management staff, the case will be referred to a Highmark Health Options Medical Director for review. A practitioner may appeal the decision within ninety (90) days of the date of the notice of action.

Please refer to Chapter 5, Unit 3: Complaints, Grievances, and Appeals for the process to appeal a decision.

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## 5.1 PRIOR AUTHORIZATION

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### Procedures Specific to Durable Medical Equipment

Highmark Health Options members are eligible to receive any covered and medically necessary durable medical equipment needed. When ordering durable medical equipment, these procedures are followed:

- If the cost of a single item or multiple quantities of a single item billed charges is \$500 or greater as reimbursed by Medicaid, the ordering practitioner/provider must obtain authorization from the Utilization Management Department. A written prescription and Highmark Health Options authorization are necessary to obtain them.
- Rental equipment must be authorized if the monthly rental cost billed charges is \$500 or greater.
- Covered items under \$500 billed charges can be obtained from a participating durable medical equipment provider with a prescription from the ordering practitioner/provider. Provider Services can direct practitioners to a contracted vendor to supply durable medical equipment. Durable medical equipment vendors are also listed in the Highmark Health Options Specialty Care Practitioner Directory. A written prescription is required to obtain the item.
- Any item without an established Medicaid fee requires authorization by the Utilization Management Department.
- Regardless of price, when a miscellaneous code is requested, an authorization from Highmark Health Options Utilization Management Department is required.
- Due to potential interruptions of Medicaid coverage, Highmark Health Options strongly recommends that all providers verify eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
- All medical supplies, including wound care, ostomy, enteral products, diapers (for age 4 and older), and incontinence products, must be obtained through a contracted durable medical equipment vendor as opposed to a participating pharmacy.
- Oral enterals must be obtained through a participating durable medical equipment provider. Based on the cost of the product ordered, an authorization from Highmark Health Options Utilization Management Department may be necessary if the product billed charges is \$500 or greater. Please do not direct members to retail pharmacies for these services.

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## 5.1 PRIOR AUTHORIZATION

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### Procedures Specific to Durable Medical Equipment (continued)

- Highmark Health Options will accept the request for durable medical equipment directly from the durable medical equipment supplier. If the practitioner is requesting the authorization, please contact a participating durable medical equipment provider to receive the appropriate billing code(s) before calling the Highmark Health Options Utilization Management Department. Please call your Highmark Health Options' Provider Services Department at 1-844-325-6251 if you need an updated list of participating providers.
- Services provided by non-participating durable medical equipment providers require an authorization from the Highmark Health Options Utilization Management Department.
- Incontinence items will be covered by Highmark Health Options without requesting an Explanation of Benefits from any other plan; however, if the billed charge is \$500 or greater, and/or a miscellaneous code is used to request the supply, a Utilization Management authorization will be required according to plan guidelines. Any services provided by nonparticipating providers always require authorization.

### Information Needed When Ordering Durable Medical Equipment

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The following information will provide assistance to offices when ordering durable medical equipment services:

1. Patient Name, Highmark Health Options ID Number, Prior Authorization Number (if applicable).
2. Durable Medical Equipment Vendor/Provider NPI number.
3. Ordering Practitioner/Provider, including NPI number.
4. Diagnosis.
5. Name of Requested Equipment, Medical Assistance Fee Schedule Code, Cost.
6. Is this a Purchase or a Rental request?
7. Amount of items requested and over what period of time (if requesting rental).
8. Clinical information to support the request.

To request a precertification for durable medical equipment, please call the Highmark Health Options Utilization Management Department at 1-844-325-6251.

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## 5.1 PRIOR AUTHORIZATION

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### **Skilled Nursing Facility (SNF)**

Should a member be in need of admission to a skilled nursing facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the nursing facility should contact the Highmark Health Options Utilization Management Department at 1-844-325-6251 for new requests. The skilled nursing benefit is up to **30** calendar days. Additional days are considered long-term care; an application must be submitted to and approved by the Delaware Medical Assistance Program for long-term care benefits.

Highmark Health Options will assist with coordinating the necessary arrangements between acute care facility and the skilled nursing facility to provide the member with medically necessary care.

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### **Outpatient Therapy Services**

All outpatient therapy services – including physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehab – require an authorization from the Highmark Health Options Utilization Management Department.

The ordering provider of the therapy must contact the Highmark Health Options Utilization Management Department to request a precertification by calling 1-844-325-6251. 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.

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### **Acute Inpatient Rehabilitation Facility**

Should a member be in need of admission to an acute inpatient rehabilitation facility, the attending practitioner, hospital Utilization Review Department, or the rehabilitation facility should contact the Highmark Health Options Utilization Management Department at 1-844-3256251 for new requests and ongoing (concurrent) reviews.

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### **Home Infusion**

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

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*Continued on next page*

## 5.1 PRIOR AUTHORIZATION

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### **Hospice Services**

Should a member be in need of hospice services – including home hospice, inpatient hospice, continuous care, and respite – the primary care practitioner, attending physician, or hospice agency should contact the Highmark Health Options Utilization Management Department. Highmark Health Options will coordinate the necessary arrangements between the primary care practitioner and the hospice provider in order to assure continuity and coordination of care.

Due to interruptions of Medicaid coverage, Highmark Health Options strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

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### **Behavioral Health Services**

For information about authorization for behavioral health services, please see the Chapter 3, Unit 2 of this manual.

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### **Pharmacy Services**

Highmark Health Options allows access to all non-formulary drugs, other than those excluded by the Department of Public Welfare's Fee-For-Service Program, through the exception review process. If changing to a formulary medication is not medically advisable for a member, a practitioner must initiate a Request for Medicaid Drug Exception.

The Request for Medicaid Drug Exception Form should be faxed to 1-855-476-4158 during normal business hours. Requests during off-hours and weekends should be made by calling 1-844-325-6251. Practitioners should assure that all information on the form is available when calling.

The Request for Medicaid Drug Exception Form can also be found in Highmark Health Options Drug Formulary or on the Highmark Health Options website. The form may be photocopied. You can also request a copy of the form by calling 1-844-325-6251.

All requests for exception will receive a response within twenty-four (24) hours. The pharmacy has the ability to dispense a 72-hour supply of prior authorization medications if the pharmacist feels the member is in emergency need of medication.

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## 5.1 HOME HEALTH CARE

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### Overview

Highmark Health Options encourages the use of home-based services as an alternative to hospitalization when medically appropriate in order to:

- Allow for timely and appropriate discharge from the hospital
- Avoid unnecessary admissions of members who could effectively be treated at home
- Permit members to receive care in greater comfort due to familiar surroundings

Home-based services may include, but are not limited to, the following type of services:

- Skilled Nursing
  - Speech Therapy
  - Hospice
  - Home Health Aide
  - Physical Therapy
  - Infant Care (after initial postpartum visits)
  - Occupational Therapy
  - High-Risk Pregnancy
  - Social Services
- 

### Authorization Requests

The Highmark Health Options Utilization Management Department coordinates medically necessary non-private duty home health care needs with the ordering practitioner and the home health care provider. Please call the Highmark Health Options Utilization Management Department at 1-844325-6251.

Authorization is required for all home-based services. Highmark Health Options will accept the request for home health services directly from the home health provider.

Due to interruptions of Medicaid coverage, Highmark Health Options strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

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## 5.1 HOME HEALTH CARE

### Billing for Home Health Services

Billing for home health services must be on a UB-04 form or 837I electronic transaction. Include a HCPCS procedure code along with the appropriate revenue code as listed below:

HCPCS CODE	DESCRIPTION	REVENUE CODE	DESCRIPTION
G0151	Services of physical therapist in home health setting, each 15 minutes	0422	Physical therapy, 15 minute charge
G0152	Services of occupational therapist in home health setting, each 15 minutes	0432	Occupational therapy, 15 minute charge
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	0442	Speech/language pathology, 15 minute charge
G0300	Home health LPN Visit	0552	Skilled nursing, 15 minute charge
G0299	Home Health RN Visit	0552	Skilled nursing, 15 minute charge
G0156	Services of home health aide in home health setting, each 15 minutes. <b>Note:</b> This code shall be used for <b>all</b> home health aide services.	0572	Home health aide (Home Health), 15 minute charge

## 5.1 PRIVATE DUTY NURSING SERVICES

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### Overview

Highmark Health Options Care Management Department coordinates medically necessary private duty nursing services with the ordering practitioner and the home health care provider. The Care Management Department can be reached by calling 1-844-325-6251. The Care Management Department can be contacted between the hours of 8 a.m. and 5 p.m., Monday through Friday.

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### Ordering Private Duty Nursing Services

Should a member be in need of private duty services, the member's primary care practitioner or a specialist rendering care to the member may submit a letter of medical necessity to the Highmark Health Options Care Management Department.

The following information will provide assistance to physicians when ordering private duty nursing:

1. Specify the level of care being requested.
  2. Specify hours per day being requested and schedule.
  3. Outline care the member requires assistance with during hours services are being requested.
  4. Summary of the member's past medical history, including review of current conditions driving need for private duty services, along with prognosis and treatment plan.
  5. Outline of all caregivers supporting the member's care. If caregiver's ability to render care is limited, detail and provide documentation.
  6. If a caregiver's availability to render care is limited, detail and provide documentation.
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## 5.1 TRANSITIONS FROM HOSPITAL TO HOME

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### Overview

Seeing a patient in the office following an admission can be a challenging experience for both your office and the patient. Highmark Health Options is dedicated to making that transition less confusing for you and your patients.

The initial contact with members is attempted while they are still in the acute care setting and interventions are focused in six areas:

1. Medication reconciliation.
  2. Making and keeping follow-up appointments.
  3. Assessing and arranging home health care needs.
  4. Assessing and coordinating durable medical equipment needs.
  5. Discussing transportation options and resources to appointments.
  6. Coordination to have gaps in care and preventive screening needs addressed.
- 

### Highmark Health Options Offers Assistance to Members

The Highmark Health Options team works with members related to these activities:

1. Keeping the discharge instruction and bringing them to the appointment.
  2. Understanding and adhering to their medications, both dosing and frequency.
  3. Keeping a current list of all medicines and sharing that with the physician and members of their care team.
  4. Making and keeping follow-up appointments with their primary care practitioner and specialists.
  5. Making sure there is transportation to appointment by coordinating with transportation programs if needed.
- 

### Referring a Member for Transition Coordination

If you have a patient who you feel would benefit from coordination during a transition, please contact the Care Management Department 1-844-3256251, Monday through Friday from 8 a.m. to 5 p.m.

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## 5.1 MEDICAL CLAIMS REVIEW

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### Requesting a Claim Review

Claims rejected for services that did not have medical records attached or the appropriate authorizations are subject to a Medical Management Review. All claim records should be sent to Highmark Health Options. When submitting a written request for a claim review, please provide the following:

- A copy of the Highmark Health Options Remittance Advice
  - The member's name and Highmark Health Options ID Number
  - The reason the review is requested and include as much supporting documentation as possible to allow for a complete and comprehensive review
  - Date(s) of service in question
  - A copy of the medical record for the service(s) in question, if applicable
- 

### Mailing Address

Claim inquiries for administrative/medical review should be mailed to:

Highmark Health Options  
Attention: Claims Review Department  
P.O. Box 890419  
Camp Hill, PA 17089-0402

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### Review Process

In the event that the claim cannot be reprocessed administratively, a medical necessity review is undertaken. The records will be reviewed by a Medical Review Nurse. If the Medical Review Nurse cannot approve the services, a Highmark Health Options Medical Director makes the final decision to approve or deny the claim. A final decision is made within thirty (30) days from receipt of the inquiry.

If the Medical Director does not approve the services, a denial letter is sent to the practitioner. If the practitioner is not satisfied with the results of the medical necessity review, a written complaint can be submitted which will be treated as an appeal.

For more information on this process, please see Chapter 5, Unit 3 of this manual.

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# CHAPTER 5: HEALTH CARE MANAGEMENT

## UNIT 2: CASE MANAGEMENT AND CARE MANAGEMENT

### IN THIS UNIT

### TOPIC

Highmark Health Options Lifestyle Management Program  
Asthma Program  
Diabetes Program  
Cardiac Program  
Chronic Obstructive Pulmonary Disease (COPD) Program  
Mom Matters prenatal Program  
Highmark Health Options Care Management Program  
Complex Care Management Program

## 5.2 HIGHMARK HEALTH OPTIONS LIFESTYLE MANAGEMENT & WELLNESS PROGRAM

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### Clinical Care Coordinator Outreach

The Highmark Health Options Lifestyle Management & Wellness Program includes population-based disease management programs that focus on improving the health status of Highmark Health Options members. These programs are offered at no cost to our members with chronic illnesses such as asthma, COPD, diabetes, and heart disease. They are also offered to our pregnant moms and/or members who may benefit from our Healthy Weight Management or Diabetes Prevention Program.

The Lifestyle Management & Wellness Program provides patient education and self-empowerment for medication, diet, and lab adherence to reduce inpatient and emergency room utilization. The Program also provides strategies to reduce the risk of developing chronic conditions.

The program will provide the following member benefits and support:

- Flyer and/or welcome letter with information about the Lifestyle Management & Wellness Program. Each include information about how members can reach Care Management staff
- Member newsletters with educational information about their condition
- Highmark Health Options website provides educational materials and links to the Delaware Quit Line to assist members with smoking cessation
- General educational materials may be mailed (such as flu or pneumonia immunization reminders)
- Pre-Queue condition-specific messages (a recorded message heard when a member calls Highmark Health Options) provide members with health tips
- Interactive voice response (IVR) campaigns with tips to help members manage their condition
- Text message programs may be offered to certain member populations

Clinical Staff proactively reach out to higher risk members to:

- Assess overall well-being
- Determine the member understands of their condition(s)
- Assess behavioral, economic, environmental, social, spiritual, and medical needs
- Discuss lifestyle management issues including, but not limited to, diet, nutrition, meal planning, weight management, exercise, and smoking cessation
- Refer members to a health educator, home health visits, or any other discipline if indicated
- Communicate with the member's care team as needed
- Perform medication reconciliation to assess compliance and understanding; assess for polypharmacy and multiple prescribers
- Review claims for laboratory testing and follow up with member for results
- Provide pill boxes if needed

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## 5.2 HIGHMARK HEALTH OPTIONS LIFESTYLE MANAGEMENT & WELLNESS PROGRAM

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### **Clinical Care Coordinator Outreach** (continued)

Provider benefits and support:

- Decrease inpatient and emergency room utilization
  - Increase appropriate lab testing and medication adherence
  - Emphasize the importance of making and keeping appointment and provide coaching on how to make the best use of time with the physician/health care team
  - Encourage adherence to obtain flu and pneumonia immunizations
  - Provide education to assist your patients in understanding their condition and lifestyle implications and motivating them to take a proactive role in managing their health
- 

### **Additional Information and Referrals**

We would like to work with you to make a positive impact on your patient's health! For more information or to refer a patient to any of the Lifestyle Management Programs, call Highmark Health Options at 1-844-325-6251.

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## 5.2 ASTHMA PROGRAM

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### Overview

The Highmark Health Options Lifestyle Management Program's Asthma Program emphasizes patient education, self-management, and medication adherence. The goal of this program is to reduce inpatient utilization and emergency room visits in our asthma population.

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### Eligibility

Highmark Health Options members age 2 years and older are eligible for the program. The program encourages an active lifestyle while minimizing or preventing asthma exacerbations. Members are automatically enrolled once they are identified with asthma; however, they are able to opt out if they choose.

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### Program Benefits

The program will help your patient:

- Identify their asthma triggers
  - Recognize early symptoms requiring medical attention
  - Understand the difference between a rescue inhaler and a controller medication
  - Understand and prevent potential risks of uncontrolled asthma
- 

### Additional Information and Referrals

For more information or to refer a patient to the Asthma Program, call Highmark Health Options at 1-844-325-6251.

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## 5.2 DIABETES PROGRAM

### Overview

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Highmark Health Options partnered with the YMCA of Delaware to provide the Diabetes Prevention Program to our members. The Diabetes Prevention Program is designed to help patients take an active role in their well-being to avoid the risk of developing type 2 diabetes.

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### Eligibility

The program is available at **NO COST** to Highmark Health Options members (age 18 and older) who meet standardized identification criteria set by the Centers for Disease Control and Prevention. Criteria includes being at least 18 years of age, a body mass index (BMI)  $\geq 25$  ( $\geq 23$  if Asian), and identification of risk factors, like family history and/or sedentary lifestyle. The program is designed for members at risk of developing diabetes; therefore, members with diabetes are not eligible to participate.

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### Program Benefits:

The Diabetes Prevention Program is a year-long, structured lifestyle and health behavior change program consisting of 25 one-hour group sessions. During the program, participants meet in relaxed, small group sessions to learn skills and strategies to eat healthier, increase physical activity, overcome stress, cope with setbacks, stay motivated and ultimately reduce the risk of chronic conditions; including type 2 diabetes. Sessions are led by a Lifestyle Coach who is trained specifically for the program.

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### Additional Information and Referrals:

Have Questions about eligibility, the program and/or how your patients can enroll?

You can call your Highmark Health Options Care Management Department at 844-325-6251, or visit our Highmark Health Option website:

<https://www.highmarkhealthoptions.com/Portals/5/provider/Announcements/DiabetesPreventionProgram.pdf>.

Or you can contact the YMCA of Delaware Healthy Living Department at 302-572-9622, or visit the YMCA of Delaware website:

<https://www.ymcade.org/preventdiabetes>.

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## 5.2 CARDIAC PROGRAM

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### Overview

The Highmark Health Options Lifestyle Management Program's Cardiac Program emphasizes patient education and support to help members with cardiac conditions take an active role in their well-being by adopting a heart healthy lifestyle, by taking medications as prescribed, and by understanding how to avoid sudden flare-ups of their condition.

---

### Eligibility

All adult Highmark Health Options members, age 21 or older, with a diagnosis of heart failure, myocardial infarction, or coronary artery disease are eligible for the program. Members are automatically enrolled once they are identified with one of these cardiac conditions; however, they are able to opt out if they choose.

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### Program Benefits

The program will help your patient:

- Learn the meaning of specific cardiac symptoms to prevent further cardiac damage
  - Understand the importance of lab tests for lipid testing and medications
  - Understand how other conditions play a part in worsening a cardiac condition
  - Understand when to call the physician and the key words to tell the office
- 

### Additional Information and Referrals

For more information or to refer a patient to the Cardiac Program, call Highmark Health Options at 1-844-325-6251.

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## 5.2 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PROGRAM

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### Overview

The Highmark Health Options Lifestyle Management Program's Chronic Obstructive Pulmonary Disease (COPD) Program emphasizes patient education, self-management, and medication adherence. The program promotes lifestyle modification and safety to reduce inpatient utilization, emergency room visits, and preventable flare-ups.

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### Eligibility

Highmark Health Options members 21 years of age and older with a diagnosis of COPD are eligible for the program. Members are automatically enrolled once they are identified with COPD; however, they are able to opt out if they choose.

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### Program Benefits

The program will help your patient:

- Understand the importance of medication adherence as well as proper use of their inhalers
  - Identify and avoid COPD triggers to help prevent an exacerbation and recognize when they should call their physician
  - Understand the role of supplemental oxygen and/or the benefits of a pulmonary rehabilitation program
  - Understand the importance of lifestyle modifications, including smoking cessation
- 

### Additional Information and Referrals

For more information or to refer a patient to the COPD Program, call Highmark Health Options at 1-844-325-6251.

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## 5.2 HEALTHY WEIGHT MANAGEMENT PROGRAM

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### Overview

Highmark Health Options joined the Delaware Division of Medicaid and Medical Assistance (DMMA), as a founding member of the first ever collective national insurance initiative, My Healthy Weight, a pledge to provide obesity prevention and treatment for eligible individuals.

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### Eligibility

Highmark Health Options adults with a body mass index (BMI) > 25 and one or more risk factors for cardiovascular disease or adults with a BMI > 30. Highmark Health Options children ages three (3) years or older with a BMI 85TH – 95th percentile.

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### Program Benefits

This program will help your patient:

- Learn simple ways to take care of their health to help them live longer
  - Understand how to control and manage their weight with better choices such as diet and activity
  - Identify the tools and resources they need to give them the best health/wellness and nutritional options
  - Learn how to choose a healthier lifestyle which may prevent them from having other health problems, like high blood pressure or diabetes
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### Additional Information and Referrals

For more information or to refer a patient to the Healthy Weight Management Program, call Highmark Health Options at 1-844-325-6251.

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## 5.2 MOM MATTERS PRENATAL PROGRAM

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### Overview

The MOM Matters® Prenatal Program offers maternity care coordination to improve the frequency of prenatal and postpartum care; to reduce the incidence of low birth weight and pre-term deliveries; and to decrease the need for neonatal intensive care unit (NICU) admissions.

This is a population-based program directed toward improving outcomes for all pregnant members. Specific interventions are designed to identify and prospectively intervene with members at high risk for adverse pregnancy outcomes.

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### Eligibility

All Highmark Health Options members identified as pregnant are eligible for this program. Pregnant members are automatically enrolled; however, they are able to opt out if they choose.

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### Program Benefits

The program will help your patient:

- Identify signs and symptoms of preterm labor or complications with the pregnancy
  - Understand lifestyle modifications to maintain a healthy pregnancy
  - Recognize how co-existing medical conditions can impact the pregnancy
  - Understand the importance of postpartum follow-up
  - Follows mother for 56 days post-partum to ensure follow up is completed and reinforces ESPDT program information for those members who are continuing to care for their newborns.
- 

### Additional Information and Referrals

For more information or to refer a patient to the MOM Matters Prenatal Program, call Highmark Health Options at 1-844-325-6251.

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## 5.2 HIGHMARK HEALTH OPTIONS CARE MANAGEMENT PROGRAM

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### **What is Care Management?**

Highmark Health Options Care Management Program is a population health model that supports participating providers and members by promoting health behaviors and providing face-to-face and/or telephonic care coordination as needed.

Resource Coordinators are available to assist your members with appointment scheduling and linkage to community resources and wellness programs. For members with more complex physical or behavioral health needs, Clinical Care Coordinators are also available to optimize health and help prevent disease progression. Clinical Care Coordinators are individuals with medical or social service backgrounds.

Care Management focuses on active condition monitoring, lifestyle management, preventive health, care coordination, and community resource referrals. Individualized care plans will be established for members and physicians are invited to provide input into the care plans as needed.

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### **Contacting Resource and Clinical Care Coordinators**

Resource Coordinators and Clinical Care Coordinators in the Care Management Department are available by calling Highmark Health Options at 1-844-325-6251, Monday through Friday from 8 a.m. to 5 p.m., to accept referrals from providers and assist with coordination of the member's health care needs.

Members also have access to a 24 hour Nurse Line at 1-855-445-4241.

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### **Identifying Members for Care Management**

In addition to the chronic conditions referenced in the Highmark Health Options Lifestyle Management programs, the following problems and/or diagnoses are examples of appropriate referrals for Care Management:

- Children with special health care needs (i.e., Cerebral Palsy)
  - HIV/AIDS
  - Mental health or substance abuse issues
  - Chronic behavioral health conditions such as chronic depression or schizophrenia
  - Mental retardation/developmental disabilities
  - Social issues (e.g., homelessness, domestic violence, transportation)
  - Oncology
  - End Stage Renal Disease (ESRD)
  - Other high risk or high cost chronic conditions
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## 5.2 COMPLEX CASE MANAGEMENT PROGRAM

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### **Complex Case Management**

Highmark Health Options provides a Complex Case Management Program for eligible members. Complex Case Management can help members to better understand their health condition and benefits. Complex Case Management can coordinate health care services and community resource referrals. Eligible members may include:

- Any Pregnant Member taking Makena (17-P)
- Any Member receiving Private Duty Nursing Services
- Any Member enrolled in the PROMISE Program
- Any Member with a Diagnosis of Severe Persistent Mental Health, Substance Use, or Self Harm, not enrolled in PROMISE
- Any Pediatrics Member enrolled in Care Coordination (ages 0-21)
- Any member/caregiver self-referred to Care Coordination

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### **Referrals**

Please call the Care Management Department at 1-844-325-6251 to make a referral to the Complex Case Management Program.

Highmark Health Options will review the request for enrollment and make the final decision for inclusion in the program.

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# CHAPTER 5: HEALTH CARE MANAGEMENT

## UNIT 3: COMPLAINTS, GRIEVANCES, AND APPEALS

### IN THIS UNIT

### TOPIC

Provider Complaint Procedures

- Registering a Formal Complaint
- Complaints About Claim Payments
- Registering a First Level Appeal (Informal Appeal)
- Registering a Second Level (Formal Appeal)

Filing Grievances and Appeals on Behalf of a Member

Grievances

Appeals

State Fair Hearings

Dispute Resolution

## 5.3 PROVIDER COMPLAINT PROCEDURES

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### Registering a Formal Complaint

Highmark Health Options has created a Provider Complaint system for participating and non-participating providers to raise issues with Highmark Health Options' policies, procedures and administrative functions. Providers can call 1-844-228-1364 to discuss their issue with a Provider Representative. Complaints will be investigated and the details of the findings and disposition will be communicated back in writing to the provider within 30 days of receipt. If additional time is needed to resolve Highmark Health Options will provide status updates to the provider as applicable. In addition to calling, providers have the option of sending a written complaint within 45 days regarding any policy, procedure or administrative function using one of the following methods:

- NaviNet® Provider Complaint Messaging Center
- Highmark Health Options Provider Complaint Form – available on the Highmark Health Options website, [highmarkhealthoptions.com](http://highmarkhealthoptions.com) under Provider Forms & Reference Materials. Completed forms may be e-mailed to [HHO-ProviderComplaints@highmak.com](mailto:HHO-ProviderComplaints@highmak.com). Fax completed form to 1-844221-1569.

Highmark Health Options will send an e-mail or fax message confirming that a written response should be expected within 30 calendar days. 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.

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### Complaints About Claim Payments

Provider inquiries for administrative payment disputes/medical review should be faxed to 1-844-207-0334, complaints about claims payment administrative in nature are handled as a provider dispute. The provider may file a written complaint about claims payment by faxing a request to 1-844-207-0334 or through the Enhanced Provider Features tab in Navinet®. Complaints may also be sent to the address listed below within twelve (12) months of the date of service, or sixty (60) days of the date of payment, whichever is later.

Highmark Health Options  
Attn: Claims Review  
P.O. Box 890402  
Camp Hill, PA 17089-0402

Clinical Provider appeals, when a service has been denied due to lack of prior authorization or denied based on medical necessity and still provided to

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the member, the provider can appeal that decision after the service. You may fax these requests along with all supporting documentation to 1-855-501-3904 or mail to:

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

A physician not involved in the original decision will review the clinical information and render a decision. The provider will be notified of the status of this review within thirty (30) days of the request. **NOTE: If the services have not been provided to the member, please follow the Member Appeals process as documented below.**

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**Registering  
a First Level  
Appeal  
(Informal  
Appeal)**

Any provider may file a provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Appeal process. The Provider Appeal Process must be initiated by the provider through a written request for an appeal. Providers request for appeal must be received by Highmark Health Options within:

- Sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination denying an authorization, unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
- One hundred eighty (180) calendar days of the date of the denial notice denying a post-service claim, unless otherwise negotiated by contract. When an authorization has been denied, providers must adhere to the ninety (90) day time frame above. You will not receive an additional One hundred eighty (180) days once the claim has been denied.

When submitting a written request for an appeal, providers are required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.

All first level provider appeal reviews will be completed within sixty (60) calendar days of the date the written request was received by Highmark Health Options.

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**Registering  
a Second  
Level Appeal  
(Formal  
Appeal)**

Providers will be informed of the decision in writing by mailing notification within sixty (60) calendar days from receipt. This notification will include additional appeal rights as applicable (i.e. Second Level Provider Appeal) (see below). If the appeal is approved, payment will be issued within sixty (60) calendar days of notification.

If the provider is not in agreement with the first level provider appeal committee's decision, the provider may seek a second level provider appeal. A request for a second level provider appeal must be submitted to Highmark Health Options in writing within sixty (60) calendar days of the date on the first level provider appeal decision letter, or as otherwise indicated via contract. All second level provider appeal requests must include specific reasons as to why the provider does not agree with Highmark Health Options' first level provider appeal committee's decision.

All second level provider appeal reviews will be completed within sixty (60) calendar days of the date the second level provider appeal request was received by Highmark Health Options.

The second level appeal committee will inform the provider of its decision in a written decision notice within sixty (60) calendar days. This is the final level of appeal and the decision is binding, unless otherwise governed per contract.

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## 5.3 FILING GRIEVANCES AND APPEALS ON BEHALF OF A MEMBER

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### Overview

The sections to follow describe the appeals and grievance process. You may call Highmark Health Options Member services if you need help or have questions about this process. There will be no punishment against a member or provider who files a complaint, grievance, or appeal.

Our members have a right to appoint a representative to act on their behalf. If a provider is acting on behalf of a member, we will need to obtain the member's consent in writing prior to reviewing a request for an appeal or grievance (except for an expedited request). A member or provider may contact a grievance coordinator at any time for help or any questions about the grievances and appeals process.

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### Member Advocates

Members may also ask for help with their grievance or appeal by asking for a Member Advocate. A Member Advocate can be assigned by calling our Member Services at 1-844-325-6251.

A Member Advocate can help:

- File a grievance or appeal
  - Help the member through the grievance or appeal process
  - Answer member questions about the grievance or appeal process
  - Help the member get additional information from a provider to help with their grievance or appeal review
-

## 5.3 GRIEVANCES

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### Overview

A grievance is a statement of unhappiness, like a complaint, and can either be filed in writing or verbally. A grievance can be about any service that a member received from a provider or by Highmark Health Options. A grievance does not include a denial of benefits for health care services. Those matters are handled as appeals (see the next section of this unit on Appeals).

Some examples of a non-medical grievance are:

- If we did not grant a “fast decision” for an appeal
- If a provider or our employee was rude
- Is the member feels a provider or the plan did not respect their rights as a member

Some examples of medical grievances are:

- If member has a concern with the quality of care or services they have received
  - If the member has trouble finding or getting services from a provider
  - If a provider or our employee was verbally abusive to the member
- 

**The following guidance on how to file a grievance is given to members in the Member Handbook:**

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### What Should I Do If I Have a Grievance?

To file a grievance, on behalf of a member, you can call Member Services to help you file a grievance. However, we will need to get the member’s consent in writing prior to processing the grievance. If a provider files a grievance on behalf of a member, the member cannot file a separate grievance.

A grievance can also be filed in writing or by filling out a Member Grievance Form. You can find this form on our website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

When you file your grievance, here are the things you should include:

- Member name
  - Member’s ID number
  - Your phone number
  - Your address
  - Who is involved in the grievance
  - Details of the occurrence
  - Date of the occurrence
  - Where did the occurrence happen
  - What you want as the outcome of the grievance
- 

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## 5.3 GRIEVANCES

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### **What Should I do If I Have a Grievance?** (continued)

You may send or attach any additional documents to support your grievance to the Member Grievance Form. You can contact us with this information at:

Highmark Health Options  
Member Appeals  
P.O. Box 106004  
Pittsburgh, PA 15230  
Phone: 1-844-325-6251; Fax: 1-833-841-8074

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### **When Should I File a Grievance?**

A grievance must be filed within ninety (90) days of the date of the occurrence.

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### **What Happens After I File a Grievance?**

After you file a grievance, you will get a letter from us within five (5) working days. This letter will tell you that we have received your grievance. It will include information about the grievance review process and your rights as a member representative, including your right to submit additional information and your right to review or request a copy of all documentation regarding the grievance upon request free of charge.

After requesting additional information, the grievance coordinator will send the case to a subject matter expert or a health care professional. If your grievance does not involve a medical issue, one of our staff members, who has not been involved with your grievance but is a subject matter expert, will review your request. If your grievance is medical in nature, a health care professional that has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease will review. A decision will be made within thirty (30) days after we receive your grievance.

You may extend the time frame for decision of the grievance up to fourteen (14) days. We may also extend the time frame for decision of the grievance up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice of the reason for the delay.

After a decision is made, a decision letter will be mailed to you. This letter will tell you the reason(s) for the decision.

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## 5.3 APPEALS

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### Overview

An appeal is a request for a review of an adverse benefit determination. This could include any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- Highmark Health Options' failure to provide services in a timely manner
- The failure of Highmark Health Options to act within thirty (30) calendar days from the date the plan receives a grievance and/or appeal
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities

**The following guidance on how to file an appeal is given to members in the Member Handbook:**

To file an appeal on behalf of a member, you can call Member Services to help you file an appeal. However, we will need to get the member's consent in writing prior to processing the appeal. If a provider files an appeal on behalf of a member, the member cannot file a separate appeal.

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### What Should I Do If I Have an Appeal?

If you file your appeal by phone, you must also put your appeal request in writing (with your signature) within ten (10) days of calling Member Services. An appeal review will not take place without your written signature. This does not apply to expedited appeal requests.

You can file an appeal in writing, by mail or fax by completing a Member Appeal Form. You can find this form on our website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com). When you file your appeal, here are the things you should include:

- Member's name
- Member ID number
- Your phone number
- Your address
- State what you are appealing
- State why you are appealing
- State what you want as the outcome of your appeal

You may send or attach any additional information that will help us with the review of your appeal. You can contact us at:

Highmark Health Options  
Member Correspondence  
P.O. Box 106004  
Pittsburgh, PA 15230  
Phone: 1-844-325-6251; Fax: 1-833-841-8074

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## 5.3 APPEALS

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### When Should I File an Appeal?

An appeal must be filed within sixty (60) days from the date of the “Notice of Adverse Benefit Determination” letter.

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### Can I Continue to Render Services During the Appeal Process?

If the member was previously authorized and getting services the member may ask to continue getting these services if:

- The member files the request for an appeal timely (within 10 calendar days of us sending the “Notice of Adverse Benefit Determination”);
- The appeal involves the termination, suspension, or reduction of a previously authorized service;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of the benefits

If we continue the member’s services during the appeal process, we will cover these services until:

- The member or member’s representative withdraws the appeal or request for a state fair hearing
- The member or member’s representative fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after we send the notice of an adverse resolution
- A decision from the State Fair Hearing Officer was not in the member’s favor

It is important to know that the member may have to pay for the services received during the appeal or state fair hearing process if the final decision is not in the member’s favor. If the decision is in the member’s favor, we will authorize services within 72 hours from the date we receive notice reversing the determination.

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### What Happens After I File an Appeal?

You will get a letter from us within five (5) working days after your appeal is received. This letter will tell you that we have received your appeal. It will also include information about the appeal review process. You may submit additional information to support the appeal and you may ask to look over all documents for the appeal.

You may also request a copy of the information used to review your appeal free of charge. In addition, as a representative on behalf of the member, you have the right to present additional information in person or in writing by sending it to the address or fax number above.

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## 5.3 APPEALS

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### **What Happens After I File an Appeal?** (continued)

After requesting additional information, the grievance coordinator will send the case to a health care professional who has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease for review. If your doctor would like to discuss your appeal with one of our medical directors, you may call us at 1-844-325-6254.

You may extend the time frame for making the appeal decision for up to fourteen (14) days. We may also extend the time frame for decision up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice with the reason for the delay.

A decision letter will be mailed to you within thirty (30) days from the date you filed your appeal or within two (2) days of the decision, whichever is sooner. This letter will tell you the reason for our decision and further appeal rights including your right to ask for a State Fair Hearing.

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### **What if I Don't Like Highmark Health Options' Decision About My Appeal?**

If you do not agree with our decision, you may ask for a State Fair Hearing. Please see the next section of this unit on State Fair Hearings.

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### **Expedited ("Fast") Appeals**

**The following guidance on filing for an expedited appeal is given to members in the Member Handbook:**

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### **What Should I Do If I Need a Decision Faster Than 30 Days?**

If you think the normal time frame to review your appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, you may ask for an expedited appeal.

You can request an expedited appeal orally or in writing. You will receive a decision within seventy-two (72) hours from the day you file your request.

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## 5.3 APPEALS

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**What Should I Do If I Need a Decision Faster Than 30 Days?**  
(continued)

When you file an expedited appeal, please include the following:

- Member's name
  - Member ID number
  - Your phone number
  - Your address
  - State the service/item you are appealing
  - **State why you feel the member's life or health or ability to attain, maintain, or regain maximum function is in jeopardy**
  - State what you want as a result of your appeal
- 

**What Happens After I File an Expedited Appeal?**

You may submit additional information to support the appeal and you may ask to look over all documents for the appeal. You may also request a copy of the information used to review your appeal free of charge. In addition, as a representative on behalf of the member, you have a right to present additional information by fax using the fax number above. **Please Note:** The time frame for an expedited appeal is very short. Immediate action is required.

After requesting additional information, the grievance coordinator will send the case to a health care professional who has the appropriate clinical expertise, as determined by the State, in treating the member's Condition or disease for review. If your doctor would like to discuss your appeal with one of our medical directors, you may call us at 1-844-325-6254.

You may extend the time frame for making the appeal decision for up to fourteen (14) days. We may also extend the time frame for decision up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice with the reason for the delay.

After a decision is made, the grievance coordinator will promptly contact you with the outcome of the expedited appeal. A decision letter will also be mailed to you within seventy-two (72) hours or three (3) working days, whichever is sooner, from the date you filed your appeal. This letter will tell you the reason for our decision and further appeal rights including your right to ask for a State Fair Hearing.

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**What if I Don't like Highmark Health Options' Decision About My Appeal?**

If you do not agree with our decision, you may ask for a State Fair Hearing.

For more information about State Fair Hearings, please see the next section of this unit beginning on the next page.

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## 5.3 STATE FAIR HEARINGS

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### Overview

A State Fair Hearing is an appeal process provided by the State of Delaware. If you are acting on behalf of a member, you may request a State Fair Hearing instead of or in addition to filing an appeal with us.

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### What should I do to get a State Fair Hearing?

You may ask for a State Fair Hearing if:

- We have denied, suspended, terminated, or reduced a service
- We have delayed service
- We have failed to give you timely service

You can ask for a State Fair Hearing by calling or writing to the State's Division of Medicaid and Medical Assistance (DMMA) office at:

Division of Medicaid & Medical Assistance  
DMMA Fair Hearing Officer  
1901 North DuPont Highway  
P.O. Box 906, Lewis Building  
New Castle, DE 19720  
Phone: 1-302-255-9500; or 1-800-372-2022 (toll free)

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### When Should I File a State Fair Hearing?

If you are not happy with a denial of an appeal decision, you may request a State Fair Hearing within one hundred twenty (120) calendar days of the date on the notice of resolution upholding the adverse benefit determination.

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### What Happens After I File a State Fair Hearing?

You will receive a letter from the State Fair Hearing Officer that will tell you the date, time, and location of the hearing. The hearing can be held in person or by telephone. The letter will also tell you what you need to know to get ready for the hearing. You may ask to review and copy all documentation regarding the State Fair Hearing. Highmark Health Options will also have a representative at a State Fair Hearing.

The DMMA State Fair Hearing Officer will send you a letter with their decision within thirty (30) days from the date of the hearing.

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## 5.3 STATE FAIR HEARINGS

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### **How Do I Continue Getting Services During the State Fair Hearing Process?**

If the member was previously authorized and getting services, the member may ask to continue getting these services if:

- The member files the State Fair Hearing request timely (within ten (10) calendar days of us sending the denial of appeal);
- The State Fair Hearing involves the termination, suspension, or reduction of a previously authorized service;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of the benefits

If we continue the member's services during the State Fair Hearing process, we will cover these services until:

- The member or member's representative withdraws the appeal or request for a State Fair Hearing
- The member or member's representative fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after we send the notice of an adverse resolution
- A decision from the State Fair Hearing Officer was not in the member's favor

It is important to know that the member might have to pay for the services they received while the State Fair Hearing was pending if the final decision is not in the member's favor. If the decision is in the member's favor, we will authorize services immediately.

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### **What if I do not like the State Fair hearing decision?**

If the member or member's representative is unhappy with the State Fair Hearing decision, they can ask for a judicial review in Superior Court. To do this, they must file an appeal with the clerk (Prothonotary) of the Superior Court within thirty (30) days of the date of the State Fair Hearing decision.

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### **Alternative formats**

All notices can be provided in a language other than English or in another format (i.e., Braille) for those who are unable to see or read written materials. We also have oral interpretation services available in non-English languages free of charge. If you need services, please call Member Services at 1-844-325-6251.

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## 5.3 DISPUTE RESOLUTION

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### **Dispute Definition**

Provider disputes are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, appeals of denials regarding lack of modifiers, refunded claim payments due to incorrect payments or coordination of benefit issues.

For disputes related to credentialing, claims and authorizations or for information related to filing grievances and appeals on behalf of a member, refer to the applicable sections of this unit of the Provider Manual -- Chapter 5: Health Care Management, Unit 3: Complaints, Grievances, and Appeals.

- A. In the event that the Participating Provider provides services in a given case which result in disagreement regarding the denial, in whole or in part, of an individual claim under the Customer Benefit Plan or the medical necessity of an individual claim, procedure, or service, he or she may appeal that decision pursuant to the procedures set forth in this Provider Manual. Parts C through E shall govern any alleged breaches of the Participation Agreement other than those described in Part A of this section. Any alleged breaches shall be brought by the Participating Provider to the attention of the Corporate Officer of Highmark Health Options, or his designee, responsible for Provider Agreements. The Parties shall attempt to resolve any such dispute through informal negotiations.

If attempts at resolving the dispute fail, the Corporate Officer for Provider Agreements shall respond to the notification of the alleged breach in writing within thirty (30) days of termination of the parties' negotiation efforts. Highmark Health Options' response shall state its determination as to whether a breach occurred.

- B. This decision shall be final unless the Participating Provider notifies Highmark Health Options of its desire to have the matter decided through arbitration. The Participating Provider must notify Highmark Health Options within thirty (30) days after the date upon which Highmark Health Options' reconsidered decision is mailed. The appeal is considered to be entered on the date mailed. All notices of decisions and appeals shall be mailed by Certified Mail.
  - C. The arbitration shall be conducted by a single arbitrator who shall be selected in conformity with the rules of the American Arbitration Association. The fees of the American Arbitration Association, if any, shall be divided equally between Highmark Health Options and the Participating Provider. If either party is unsatisfied with the arbitrator's decision, in whole or in part, that party may file suit in a court of appropriate jurisdiction for a trial de novo.
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# CHAPTER 5: HEALTH CARE MANAGEMENT

## UNIT 4: QUALITY MANAGEMENT

### IN THIS UNIT

### TOPIC

- Program Purpose
  - Program Goal
  - Program Objectives
  - Program Scope
- Clinical Quality  
Practitioner Office/Facility Site Quality and Medical/Treatment Evaluations
- Environmental Assessment Standards
- Risk Adjustment  
Service Quality



## 5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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### Program Purpose

The Quality Improvement/Utilization Management (QI/UM) Program's purpose is to assure quality, safety, appropriateness, timeliness, availability, and accessibility of care and services provided to Highmark Health Options members. The comprehensive evaluation and assessment of clinical, demographic, and community data in conjunction with current scientific evidence is paramount to meet the identified needs.

The development of health care programs must be done in collaboration with all partners, including members, practitioners, community agencies, regulators, and staff, not only to meet the current health care needs of the members served but to begin to address the future needs of the members.

Essential to the success of these partnerships and programs is the establishment of meaningful data collection and measurement of outcomes to assess the improvements in the quality of care and to identify where opportunities exist for improvement.

As a participating provider, Highmark Health Options asks that you cooperate with Quality Improvement activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various Quality Improvement initiatives and programs, and allowing the plan to use and share your performance data.

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### Program Goal

The goal of the QI/UM 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/UM Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Highmark Health Options health care 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, such as qualitative, quantitative, and root/cause barrier analyses, Highmark Health Options 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.

Of specific importance, the Quality Improvement Program focuses on three key areas: (a) preventive health care; (b) prevalent chronic health care conditions; and (c) service indicators. The Program strives to improve members' compliance with

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## 5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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### Program Goal (continued)

preventive care guidelines and disease management strategies, therapies that are essential to the successful management of certain chronic conditions, and identify opportunities to impact racial and ethnic disparities and language barriers in health care. Also, the QI/UM Program strives to improve patient safety by educating members and practitioners in regard to safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network and by communicating to members and practitioners' safety activities and provisions that may be in place throughout the network.

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

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### Program Objectives

The objectives of the QI/UM Program are consistent with Highmark Health Options' mission, commitment to effective use of health care resources, and to continuous quality improvement. To ensure that the current needs of the population are being evaluated, changes noted, programs implemented to address the needs of members, and to ensure continuous quality improvement, an annual QI/UM Work Plan is developed.

The QI/UM Program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI/UM Program objectives. Objectives are as follows:

Implement a QI/UM Work Plan that identifies and assures completion of planned activities for each year:

- Assure processes are in place using Total Quality Management values to assess, monitor, and implement actions when opportunities are identified regarding the utilization of health care resources, quality of care, and access to services;
  - Based on assessment of the population, develop and update guidelines that address key health care needs, which are based on scientific evidence and recommendations from expert and professional organizations and associations;
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## 5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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### Program Objectives (continued)

- Conduct studies to measure the quality of care provided, including established guideline studies, evaluate improvements made, barriers, opportunities and develop actions to address those opportunities;
  - Evaluate the utilization and quality performance of practitioners and vendors to assure standards are met and to identify both opportunities and best practices. In a group effort with practitioners and vendors, identify barriers, opportunities and apply interventions as needed;
  - Conduct satisfaction surveys to determine member and provider satisfaction with services and programs, organizational policies, and the provision of health care. Review results for barriers, opportunities and apply interventions to increase satisfaction and to improve the quality of care and services provided.
- 

### Program Scope

Implementation and evaluation of the QI/UM Program is embedded into Highmark Health Options' daily operations. The Q/UM Program has available and uses appropriate internal information, systems, practitioners, and community resources to monitor and evaluate use of health care services, the continuous improvement process, and to assure implementation of positive change.

The scope of the Program includes:

- Enrollment
  - Members' Rights and Responsibilities
  - Network Accessibility and Availability, including those related to Special Needs
  - Health Care Disparities
  - Network Credentialing/Recredentialing
  - Medical Record Standards
  - Member, Provider, and Employee Education
  - Member and Provider Services
  - Claims Administration
  - Fair, Impartial, and Consistent Utilization Review
  - Evaluating the Health Care Needs of Members
  - Preventive Health, Disease Management, Long Term Services and Support (LTSS), and Care Management Services, including Complex Case Management
  - Clinical Outcomes
  - Oversight of Delegated Activities
  - Patient Safety
  - Critical Incident Reporting
  - Continuous Quality Improvement using Total Quality Management Principles
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## 5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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### **To Request Program Materials**

To request a copy of the Quality Improvement Program, Work Plan, or Annual Evaluation, please contact Highmark Health Options Provider Services Department at 1-844-325-6251.

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## 5.4 CLINICAL QUALITY

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### Overview

Highmark Health Options has developed and/or adopted clinical practice and preventive health guidelines to assist practitioners in the treatment and care of members. Guidelines are developed using evidence-based clinical guidelines from recognized sources or through involvement of board-certified practitioners from appropriate specialties when the guidelines are not from recognized sources.

The guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases or conditions of Highmark Health Options members, as well as applicable regulatory/accrediting body requirements. The use of guidelines permits Highmark Health Options to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

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### Clinical Guidelines

Clinical practice and preventive health guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. Some of the clinical guidelines offered include: Adult HIV, Adult Preventive Care, Comprehensive Diabetes Mellitus, Child Preventive, Attention Deficit Hyperactivity Disorder (ADHD) Cardiac Medical Management, Hypertension, Management of the Patient with Asthma, Chronic Obstructive Pulmonary Disease (COPD), Major Depression in Adults in Primary Care, Schizophrenia, Bipolar, Palliative Care, and Routine and High Risk Prenatal Care.

To facilitate distribution of the most current version of these guidelines, a comprehensive list can be found on the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

Additional resources for Clinical Quality can be found at “Quality Improvement: Guidelines and Resources” on the website. For a paper copy of these resources or individual clinical guidelines, please contact the Quality Improvement Department at 1-412-255-4291.

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## 5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

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### Overview

Highmark Health Options has 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. HHO's 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 HHO's Environmental Assessment Standards.

When an environmental assessment is required, a Provider Relations Representative will schedule an on-site visit at the office site to conduct an Environmental Assessment. The Environmental Assessment must be conducted with the Office Manager or with a practitioner of the practice. The Provider Relations Representative will complete the Environmental Assessment Form and tour the office as well as interview staff and examine the appointment schedule. The HHO Provider Relations Representative will assess the office for evidence of compliance with the Environmental Assessment Standards.

Upon completion of the review, the Provider Relations Representative 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 Relations Representative 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 circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The Provider Relations Representative will communicate the final results to the practitioners.

HHO Provider Relations Representatives 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.

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## 5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

### HIGHMARK HEALTH OPTIONS PRACTITIONER OFFICE SITE QUALITY EVALUATION

	ENVIRONMENTAL ASSESSMENT STANDARDS	MET	NOT MET	N/A	COMMENTS
1	The office is reasonably accessible (noting the ease of entry into and the accessibility of space within the building) for patients with physical and/or sensory disabilities. (ALL)				
2	The physical appearance of the office is clean, organized, and well maintained for the safety of patients, staff, and visitors. (ALL)				
3	The waiting area is well lit, has adequate space and seating, and has posted office hours. (ALL)				
4	There is adequacy of examining/treatment room space as well as patient interview areas and each are designed to respect patients' dignity and privacy. (ALL)				
5	Clinical records are filed in an organized, systematic manner, easily located, and kept in a secure, confidential location and way from patient access. Only authorized persons have access to clinical records. (ALL)				
6	The office has a written confidentiality policy to avoid the unauthorized release or disclosure of confidential personal health information including, but not limited to, computer screens, data disks, emails, telephone messages/calls, and fax machines. (ALL)				

## 5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

	ENVIRONMENTAL ASSESSMENT STANDARDS	MET	NOT MET	N/A	COMMENTS
7	The medical equipment utilized in the office appears to be adequate, well maintained, and up to date, appropriate for the patients' age and appropriate for the specialty of the practice. (ALL)				
8	The office has 24 hour medical coverage that is available seven (7) days a week. (ALL)				
9	The office has a process to ensure after-hours calls are returned within thirty (30) minutes. (ALL)				
10	The office has a process to ensure after-hours calls are communicated to the office by the morning of the following business day. (ALL)				
11	The office has mechanisms to assess behavioral health disorders, alcohol and other drug dependence (i.e., screening tool or questionnaire), (PCP or OB-GYN).				
12	No more than six (6) office visits are scheduled per hour, per practitioner. (ALL)				
13	Emergency, life-threatening, medical situations are handled immediately. (ALL EXCEPT BH)				
14	Urgent medical care appointments, which require rapid clinical intervention as a result of an unforeseen illness, injury, or condition, are available within two (2) calendar days (e.g., high fever, persistent vomiting/diarrhea). (PCP, SPECIALIST)				
15	Routine care appointments including well child exams and routine physical exams are available within three weeks. (PCP, SPECIALIST)				
16	Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) are proactively notified by the office and encouraged to schedule an appointment. (PCP)				
17	There is a process to assure that patients who either no show or cancel their appointments are contacted and encouraged to reschedule the appointments as evidenced by documentation of such in the medical record (appointment scheduled, reminder care, etc.). (PCP)				
19	A reminder call is made by the practice prior to scheduled appointments to encourage attendance with the scheduled visit. (PCP)				

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## 5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

	ENVIRONMENTAL ASSESSMENT STANDARDS	MET	NOT MET	N/A	COMMENTS
20	<p>There is a process confirming that laboratory, diagnostic procedure, and/or consultation appointments were performed and results were received, reviewed, and filed in the patient's medical record. The process:</p> <ul style="list-style-type: none"> <li>a) Identifies how the laboratory, diagnostic procedures and/or consultation appointments are tracked</li> <li>b) Identifies staff responsible to ensure results are returned to the office</li> <li>c) Identifies when and how staff match test results with patient's chart</li> <li>d) Identifies how the reviewer (practitioner) notifies how the results should be handled (PCP)</li> </ul>				
21	There is a process in place to ensure patients are notified of abnormal results. (ALL)				
22	<p>Urgent medical care appointments which require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within one (1) day such as:</p> <ul style="list-style-type: none"> <li>a) OB: High fever, persistent vomiting/diarrhea, bladder infection, increased swelling</li> <li>b) GYN: Unusual vaginal discharge or vaginal bleeding post-menopause/hysterectomy, or detection of breast mass/breast lump (OB-GYN)</li> </ul>				
23	<p>Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days:</p> <p>OB: Small amount of swelling in ankles or hands, sciatica pain (including hip/leg pain), respiratory infection, UTI symptoms</p> <ul style="list-style-type: none"> <li>a) GYN: Increased menstrual cramps. (OB-GYN)</li> </ul>				
24	Regular and routine care appointments for routine wellness appointments are available within thirty (30) days (e.g., regular routine obstetrical and gynecological appointments). (OB-GYN)				
25	Immediate intervention for a life-threatening emergency is required to prevent death or serious harm to patient or others. (BH)				

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## 5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

	ENVIRONMENTAL ASSESSMENT STANDARDS	MET	NOT MET	N/A	COMMENTS
26	Intervention within six (6) hours is required for a non-life-threatening emergency to prevent acute deterioration of the patient's clinical state that compromises patient safety. (BH)				
27	Timely evaluation (within 48 hours) is needed for urgent care to prevent deterioration of the patient's condition. (BH)				
28	Routine office visits are available (within 10 business days) when the patient's condition is considered to be stable. (BH)				
1	An individual clinical record is established, organized, easily located, and data is easily retrievable for each patient. (ALL)				
2	Each page in the medical record contains the patient's name. Another form of patient identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record. (ALL)				
3	Significant illnesses and medical and behavioral health conditions are indicated on the current problem list and are updated after each office visit and hospitalization. (ALL)				
4	Each record indicates which medications have been prescribed, the dosages of each, the date of the initial prescription and/or refill, and the date the medication was discontinued, as applicable. (ALL)				
5	Medication and other allergies, adverse reactions, and relevant medical conditions are clearly documented and dated prominently in the record. It is noted if the patient has no known allergies, no history of adverse reactions or relevant medical conditions. (ALL)				
6	All entries in the record contain a valid, legible author's signature, which may be a handwritten signature with credentials, printed name and credentials accompanied by handwritten provider initials, or unique electronic identifier with credentials. (ALL)				
7	All entries in the record are dated and are legible to someone other than the writer. (ALL)				
8	The medical/treatment records have a notation regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months, or as needed. (ALL)				

## 5.4 Risk Adjustment

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### What is Risk Adjustment?

Our Risk Adjustment programs reflect our commitment to improving the way we partner with providers to assure our members' chronic conditions are: assessed, monitored, completely/accurately documented, and treated each year. While these comprehensive Risk Adjustment programs are used by Highmark to ultimately improve our member's quality of care, they also help to offset the medical cost for providing care to members with more severe conditions. Risk Adjustment is a comprehensive program to maximize the State's health-based capitated payments for its Medicaid members.

Risk Adjustment is not a standalone function, it is a holistic enterprise that coordinates the activities of our various internal cross-functional departments (i.e., Enrollment, Claims, Provider Relations, Care Management, HEDIS, Compliance, etc.) to drive successful outcomes for our providers and members. Providers can currently participate in two (2) Risk Adjustment programs which are the RCG Prospective and RGC Retrospective Campaigns. Both programs are designed to 1. Confirm or refute risk gaps for members with chronic conditions; 2. Accurately report overall health [condition codes](#) to CMS; 3. Improve Highmark Health Options members' quality of care; and 4. Provide Highmark Health Options providers with payment incentives for Risk Adjustment program participation.

Please [contact DEPROVIDERENGAGEMENT@highmark.com](mailto:DEPROVIDERENGAGEMENT@highmark.com) to learn more about our programs.

## 5.4 SERVICE QUALITY

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### Measuring the Quality of Services to Members

Highmark Health Options also has numerous activities that are conducted throughout the year to measure the quality of services provided to members. Some of these activities include: Conducting the CAHPS® and behavioral health member satisfaction surveys, availability and accessibility studies, analysis of complaints and grievances, and review of disenrollment data.

# CHAPTER 6: LONG TERM SERVICES AND SUPPORT (LTSS)

## UNIT 1: GENERAL INFORMATION AND COVERED SERVICES

### IN THIS UNIT

### TOPIC

Overview

- Goals of the DSHP Plus LTSS Program

Eligibility and Enrollment

Long-Term Services and Support (LTSS) Benefits

- Covered Services
- At-Risk Members
- Self-Directed Attendant Care Services
- Nursing Facility Program

Long Term Services and Support (LTSS) Billing and Reimbursement

Additional LTSS Program Information

- Background Checks
- Critical Incident Reporting

## 6.1 OVERVIEW

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### Introduction

Delaware's Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) Program provides enhanced benefits to DSHP Plus members who qualify for Medicaid Long-Term Services and Support. Highmark Health Options serves as a managed care organization (MCO) operating the DSHP Plus LTSS Program.

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### Goals of the DSHP Plus LTSS Program

The primary goals of DSHP Plus LTSS are to:

- Provide streamlined, timely access to LTSS;
  - Expand access to and utilization of cost-effective Home and Community-Based Services (HCBS) alternatives to nursing facility care;
  - Serve more people with existing LTSS funds;
  - Increase HCBS options;
  - Improve coordination of all Medicaid (acute, behavioral, and LTSS) services; and
  - Rebalance LTSS spending (i.e., funding spent on institutional versus HCBS)
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### DSHP Plus LTSS Promotes Coordination of Care

DSHP Plus LTSS promotes quality and cost-effective coordination of care for eligible DSHP Plus LTSS members with chronic, complex, and complicated health care, social service, and custodial needs in a Nursing Facility or Home and Community-Based setting. Case Management involves the systematic process of assessment, planning, coordinating, implementing and evaluating care through a fully integrated physical health, behavioral health, and LTSS program to ensure the care needs of the member are met.

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## 6.1 ELIGIBILITY AND ENROLLMENT

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### Overview

In order to be enrolled into the Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) Program, an individual must qualify both financially and medically. The State of Delaware, through contracting with a Health Benefits Manager (HBM), performs functions related to outreach, education, enrollment, transfer, and disenrollment of members.

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### Medical Eligibility Determination

The State performs the initial Level of Care Determination for those being considered for the LTSS Level of Care benefits.

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### Financial Eligibility Determination

The State performs the financial assessment for those being considered for the DSHP Plus LTSS Program.

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### Enrollment Process

Once the State determines the individual is both medically and financially eligible, Highmark Health Options is notified on an outbound report from the State. In general, a member's effective date of enrollment will be the first day of the month.

Effective dates are not retroactive *except* in the case of DSHP Plus LTSS members residing in a Nursing Facility who may be retroactive up to ninety (90) calendar days prior to the member's date of application for Medicaid.

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### DSHP Plus LTSS Target Population

The DSHP Plus LTSS Program provides services, including LTSS, through a managed care delivery system to the following populations:

- Institutionalized individuals in Nursing Facilities who meet the Nursing Facility (NF) Level of Care (LOC);
  - Aged and/or disabled individuals over age 18 who do not meet the NF LOC, but who, in the absence of Home and Community-Based Services (HCBS), are "at risk" of institutionalization and meet the "At-Risk" for NF LOC criteria; and
  - Individuals with a diagnosis of AIDS or HIV, over age one (1), who meet the acute hospital LOC criteria and require assistance with at least 1 Activity of Daily Living (ADL)
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## 6.1 LONG-TERM SERVICES AND SUPPORT (LTSS) BENEFITS

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### Covered services

Highmark Health Options offers the following services as part of its benefit package:

- Adult Day Services
- Community-Based Residential Alternatives That Include Assisted Living Facilities
- Attendant Care Services
- Self Directed Attendant Care Services (SDAC)
- Cognitive Services for Individuals with Acquired Brain Injury (ABI)
  - Up to twenty (20) visits per year, plus assessment
- Day Habilitation
- Home-Delivered Meals
  - Up to One (1) Meal Per Day
- Independent Activities of Daily Living (Chore) Services
- Minor Home Modifications
  - Up to \$6,000 per Project;
  - \$10,000 per Benefit Year; and
  - \$20,000 per Lifetime
- Nutritional Supplements for Individuals Diagnosed with HIV/AIDS Who Are Not Covered Under the State Plan
- Personal Emergency Response System (PERS)
- Respite Care, both at Home and in Nursing and Assisted Living Facilities
  - Up to Fourteen (14) Calendar Days per Year
- Specialized Medical Equipment and Supplies not covered under the State Plan
- Transition Services For Those Moving From a Nursing Facility (NF) to the Community Under the Nursing Facility Transition Program up to \$2,500 per Transition
- Transition Workshops For Those Moving From a NF to the Community Under the MFP Program
- Nursing Facility Services

### At-Risk Members

At-Risk Members are members who do not meet the Nursing Facility Level of Care but are “at risk” of institutionalization.

### Self-Directed Attendant Care Services

Members may opt to self-direct their Attendant Care Services. Self-direction allows members to have choice and control over how Attendant Care Services are provided and who provides the services. Financial management and general support are available for members who choose to self-direct their Attendant Care Services. This means the member, or an Employer Representative selected by the member, serves as the legal employer of the paid caregiver. This benefit gives the member or member's Employer Representative support from a Fiscal Employer Agent that takes care of the taxes, payroll withholding, and paychecks for the caregiver. The Fiscal Employer Agent also helps the member find and train an Attendant Care Employee.

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## 6.1 LONG-TERM SERVICES AND SUPPORT (LTSS) BENEFITS

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### **Nursing Facility Transition**

Nursing Facility Transition is a program to assist eligible members to transition from a Nursing Facility to the community. Members can be referred from the treating physician, nursing facility, other providers, family, the State, and self-referrals. Within fourteen (14) days of the referral the case manager will conduct an in-facility visit to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities.

Members who wish to pursue transition to the community will have an in-facility assessment conducted by the case manager within fourteen (14) calendar days. The assessment will determine the member's ability and/or desire to transition. The assessment shall include the identification of any barriers to a safe transition.

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## 6.1 LONG-TERM SERVICES AND SUPPORT (LTSS) BILLING AND REIMBURSEMENT

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### Overview

When billing for services rendered to Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) Program members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional and UB-04 facility health insurance claim forms and/or appropriate electronic filing format.

In addition to the following DSHP Plus LTSS members-specific billing guidelines outlined below, all Highmark Health Options billing guidelines apply.

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### DSHP Plus LTSS Members-Specific Billing Guidelines

Only those HCPCS (CPT® and HCPCS Level II) codes on the fee schedule will be considered for reimbursement when filed in conjunction with the corresponding Revenue Code(s) and modifiers, otherwise charges will be denied for billing guidelines. **Services billed outside of the agreement are subject to recovery.** All services require prior authorization. Additional information on the Highmark Health Options LTSS-specific billing guidelines is available on the Highmark Health Options website at [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

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## 6.1 ADDITIONAL LTSS PROGRAM INFORMATION

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### Background Checks

Highmark Health Options will verify that potential Attendant Care Employees meet all applicable qualifications prior to delivering services including the following minimum qualifications: at least 18 years of age, have the skills necessary to perform the required services, possess a valid Social Security number, and is willing to submit to a criminal record check.

For each potential Attendant Care Employee, Highmark Health Options will conduct a criminal history check pursuant to 16 DE Admin Code 3110, a check of the Delaware's Adult Abuse Registry (see 11 DE Admin Code 8564; registry is available on the Delaware Department of Health and Social Services (DHHS) website), a check of the national and Delaware sex offender registries, and a check of the excluded provider list.

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### Critical Incident Reporting

- Critical incidents include, but are not limited to, the following:
- Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician;
  - Suspected physical, mental, or sexual mistreatment, abuse, and/or neglect of a member;

- Suspected theft or financial exploitation of a member;
- Severe injury sustained by a member;
- Medication error involving a member; or,
- Inappropriate/unprofessional conduct by a provider involving a member

**Member Education**

At time of the Intake Visit and at each subsequent face-to-face visit, the Case Manager will review the Abuse/Neglect/Exploitation Identification and Reporting section of the Long-Term Services and Support (LTSS) Education Materials with the member. Documentation of review will be documented in the Home Safety Monitoring Checklist.

**Identification**

The Case Manager utilizes the LTSS Education Materials to educate the member regarding the identification and reporting of Abuse, Neglect and Exploitation, which are all considered Critical Incidents.

- Abuse includes inflicting pain, injury, mental anguish, unreasonable confinement or other cruel treatment. Abuse can be:
  - Physical abuse;
  - Emotional abuse; or,
  - Sexual abuse

Sexual abuse, also referred to as molestation, is usually undesired sexual behavior by one person upon another. It is often perpetrated using force or by taking advantage of another. When force is immediate, of short duration, or infrequent, it is called sexual assault. The offender is referred to as a sexual abuser or molester. The term also covers any behavior by an adult or older adolescent towards a child to stimulate any of the involved sexually. The use of a child, or other individuals younger than the age of consent, for sexual stimulation is referred to as child sexual abuse or statutory rape.

- Neglect can occur:
  - When an adult is unable to care for him/herself or to obtain needed care, placing their health or life at risk;
  - The neglect may be unintended, resulting from the caregiver's lack of ability to provide or arrange for the care the person requires;
  - Neglect may be due to the intentional failure of the caregiver to meet the person's needs
- Financial exploitation occurs when a caregiver improperly uses funds intended for the care or use of an adult. These funds are paid to the adult or caregiver by a government agency. Exploitation can include:
  - Fraud or coercion;
  - Forgery; or,
  - Unauthorized use of banking accounts, cash or government cards

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## 6.1 ADDITIONAL LTSS PROGRAM INFORMATION

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### Reporting

**Providers should notify Highmark within one business day of a critical incident by calling their assigned Case Manager or by calling LTSS Member Services at 1-855-401-8251.**

Highmark Health Options immediately reports to the State's Division of Medicaid and Medical Assistance (DMMA) at 1-877-453-0012 or fax 1-877-264-8516 and the appropriate investigative agency by telephone all current information received or known about a Critical Incident and follows up in writing to DMMA and the appropriate investigative agency within one (1) business day of identifying any Critical Incident.

Highmark Health Options provides a full written report to DMMA within thirty (30) days of identifying a Critical Incident that includes, at a minimum, information regarding the Critical Incident, the investigation conducted by Highmark Health Options and/or investigative agency (if applicable), findings by Highmark Health Options and the investigative agency (as applicable), and any corrective actions.

Highmark Health Options reports Critical Incidents to the following appropriate investigative agencies:

- Adult Protective Service (APS) at 1-800-223-9074 for suspected abuse, neglect, disruptive behavior, and exploitation. Inadequate self-care cases are handled by the Community Services Program within the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD).
- DHSS Long-Term Care Office of the State Ombudsman (OSO) at 1-877-453-0012 for residents of a long-term care facility that have a complaint about their rights.
- Division of Health Care Quality at 1-877-453-0012 for members receiving services in a long-term care facility and there is an incident of abuse, neglect, or mistreatment, and/or financial exploitation. Reports of suspected abuse, neglect, and exploitation of members who are children residing in pediatric nursing facilities must also be reported to DHCQ.

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## 6.1 ADDITIONAL LTSS PROGRAM INFORMATION

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### **Critical Incident Reporting** (continued)

- Office of Health Facilities Licensing and Certification (OHFLC) at 1-800-942-7373 is the designated agency to regulate acute and outpatient health care facilities/agencies and receives Critical Incidents occurring in these facilities involving abuse, neglect, or harassment; hospital, hospice seclusion, and restraint deaths
- Any person having reasonable cause to suspect that a child has suffered abuse, neglect, or exploitation must be reported or cause the report to be made to Delaware Family Services (DFS) at 1-800-2929582

Highmark Health Options cooperates with DMMA and any investigative agency in documenting, investigating, and addressing actual and suspected Critical Incidents. Highmark Health Options collects and analyzes data regarding Critical Incidents, tracks and identifies trends, identifies root causes, and makes necessary changes in order to prevent reoccurrence.

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### **Reporting**

Highmark Health Options is required to report on missed attendant care hours to the State monthly. Providers must send their missed hours report to Health Options each month. This report should be submitted for the prior month by the fifth of each month.

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# CHAPTER 6: LONG-TERM SERVICES AND SUPPORT (LTSS)

## UNIT 2: CASE MANAGEMENT FOR LONG-TERM SERVICES AND SUPPORT (LTSS)

### IN THIS UNIT

### TOPIC

- Plan of Care
- Long-Term Services and Support (LTSS) Providers
- Long-Term Services and Support (LTSS) Case Managers

## 6.2 PLAN OF CARE

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### Overview

The Plan of Care is developed by the Case Manager taking into consideration the needs of the member identified during an assessment, the care plan to address those needs, the facilitation of the plans, and advocacy for the member.

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### Case Manager Assessment

The assessment will consist of the Case Manager gathering relevant, comprehensive information and data by interviewing the member, caregiver, and family. When indicated, the primary care physician/provider or physician specialist, other members of the health care team, and other appropriate individuals as approved by the member may also be interviewed.

The Case Manager utilizes formal assessment tools prior approved by the State and in accordance with protocols specified by the State, telephonic assessment strategies, electronic communication, and/or other efficient modes of communication in addition to face-to-face visits as a means to perform careful evaluation of the Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) Program member's situation.

Assessment is important for the Case Manager to gather information concerning the member's health behaviors, cultural influences, socio-economics, and behavioral health information related to the current or proposed plan of care to identify potential barriers, clarify or determine realistic goals and objectives, and seek appropriate alternatives for the member.

The Case Manager should recognize the importance of the member's involvement in a successful assessment process and should provide and encourage opportunities for the member to communicate and collaborate with the Case Manager or any member of the member's health care team.

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### Coordination with Local Departments and Agencies

Service needs are identified by the Case Manager during development of the Plan of Care. Highmark Health Options does not require home and community-based services to be ordered by a treating physician, however, the Case Manager may consult with them as appropriate regarding the member's physical health, behavioral health, and long-term service and support needs.

All services the member will receive, regardless of payer source, are incorporated into the Plan of Care. In addition to LTSS, the Case Manager helps coordinate other Medicaid State Plan services, referral to Behavioral Health, referral to Care Coordination, and services provided for Duals by Medicare. All efforts of coordination are documented in the Member's Plan of Care.

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## 6.2 PLAN OF CARE

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### **Coordination with Local Departments and Agencies**

Based upon the member's needs as identified during the Needs Assessment, the member selects their top three (3) service providers for each LTSS that is documented on their Plan of Care. The member's selection of providers is documented on the Provider Selection List. The Provider Selection List is submitted to the Member Associate in the Support Center for coordination. The Member Associate secures the providers, creates the authorizations, and sends the authorization confirmation to the providers so service initiation can begin.

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## 6.2 LONG-TERM SERVICES AND SUPPORT (LTSS) PROVIDERS

### Overview

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The Member Associate secures providers per the member's Plan of Care to initiate services within the required time frames. Upon verbal confirmation that the provider can begin, the Member Associate authorizes the service to the specified provider in the system of record and sends the provider a *Provider Plan of Care* which serves as an Authorization Confirmation.

Diamond State Health Plan Plus Long Term Services and Support (DSHP Plus LTSS) providers receive a *Provider Administration Manual* as well as a *LTSS Claims Reference Guide*. Highmark Health Options has a full-time staff person dedicated to DSHP Plus and DSHP Plus LTSS provider services and provider relations, including all network development, staff and management issues, provider payment issues, and provider education.

### Monitoring Quality and Performance

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Highmark Health Options monitors quality and performance of participating providers using an interdisciplinary model that includes all departments contributing information in support of maintaining quality of care for members. All information is reported to the Quality Improvement Department, which develops and tracks performance measures including appropriate utilization management patterns and quality of care concern trends.

Home and Community-Based Services (HCBS) providers will be subject to quality monitoring and reporting, and Highmark Health Options will develop performance triggers relevant to in-home service providers. These could include such measures as provider-associated trends in:

- Member use of back-up plans and gaps in care
- Member complaints and grievances
- Member satisfaction survey results
- Frequent discrepancies between HCBS billing and service documentation

When HCBS services are provided in a member's residence, the service provider is required to document the service through service logs. Highmark Health Options will select a random sample of service logs and phone records on a monthly basis for review to verify services provided. In addition, HCBS providers will be audited on a regular basis to ensure that services billed have been provided.

### Significant Change

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- The participating provider is to facilitate notification of the member's case manager by notifying the Contractor of any known significant change in the member's condition or care, hospitalization or recommendation for additional services.
  - Nursing facilities are required to notify the case manager when considering discharging a member and to consult with the member's case manager to intervene in resolving issues and assist with the implementation of a discharge or transition plan.
  - Nursing facilities are required to notify the case manager of any change in a member's medical or functional condition that could impact the member's level of care for the currently authorized level of nursing facility services.



## 6.2 LONG-TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS

### Overview

Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) members receive intake and ongoing case management by licensed Registered Nurses (RNs) and/or Social Workers with Bachelor or Master Degrees with active licensure and credentials serving as Case Managers who engage the member, caregiver, and family in the planning and decision-making process. The Case Manager is the primary point of contact with the member.

The Case Manager is responsible for assessment, planning, coordination, implementation, and evaluation as follows:

FUNCTION	DESCRIPTION
<b>Assessment</b>	<ul style="list-style-type: none"> <li>• At the time of the initial assessment, the Case Manager provides and reviews with each member an LTSS Education Materials booklet</li> <li>• The LTSS Education Materials booklet includes, but is not limited to, an overview of the LTSS program, services available, member Grievances and Appeals process, identification and reporting of abuse, neglect, and exploitation, and contact information for the Case Manager</li> </ul> <p><b>Member Needs:</b></p>
	<ul style="list-style-type: none"> <li>• The Case Manager utilizes a Comprehensive Needs Assessment (Plan of Care Summary) to identify the strengths, capacities, and preferences of the member, as well as to identify the member's LTSS needs and how to meet those needs</li> <li>• The assessment analyzes and describes the medical, social, behavioral, and LTSS services that the member will receive, as well as goals for longer term strategic planning</li> <li>• Member Needs are assessed upon Intake and at each on-site review</li> </ul> <p><b>Member Safety:</b></p>
	<ul style="list-style-type: none"> <li>• During each assessment, the Case Manager creates a Risk Agreement in conjunction with the member; The Risk Agreement includes any risk identified, a plan to reduce or prevent each risk, and the member's acknowledgement and acceptance of each risk</li> <li>• During each assessment, the Case Manager completes an evaluation of the member's physical environment (Home Safety Monitoring Checklist) to ensure member safety</li> <li>• Member Safety is assessed upon Intake and at each on-site review</li> </ul>

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## 6.2 LONG-TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS

### Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
<p><b>Planning</b></p>	<p>The Case Manager, in conjunction with the member, develops a person-centered Plan of Care (Plan of Care Services). The Plan of Care considers appropriate options for the member related to his/her medical, behavioral health, psychosocial, case-specific needs as a specific point in time.</p> <p>The Plan of Care Services includes the type of service, tasks to be performed at each service, frequency of service, hours/amount, start/end dates, daily schedule, scheduled start time, and provider type.</p> <p>The Plan of Care Services is signed by the member and is reviewed and updated upon Intake, when there is a change in services, and at each onsite review.</p>
<p><b>Coordination</b></p>	<ul style="list-style-type: none"> <li>• All services the member will receive, regardless of payer source, are incorporated into the Plan of Care. In addition to LTSS services, the Case Manger helps coordinate other Medicaid State Plan services, referral to Behavioral Health, referral to Care Coordination, and services provided for Duals by Medicare. All efforts of coordination are documented in the member's Plan of Care.</li> <li>• Based upon the member's needs as identified during the Needs Assessment, the member selects their top three (3) service providers for each LTSS service that is documented on their Plan of Care. The member's selection of providers is documented on the Provider Selection List. The Provider Selection List is submitted to the Member Associate in the Support Center for coordination. The Member Associate secures the providers, creates the authorizations, and sends the authorization confirmation to the providers so service initiation can begin.</li> </ul>
<p><b>Implementation</b></p>	<ul style="list-style-type: none"> <li>• The Case Manager ensures the provision of all services to meet the member's needs occurs as soon as possible. Services determined to be Medically Necessary must be provided to the member within ten (10) calendar days of the on-site visit during which the need for the service was determined.</li> <li>• If the member's life, health, or ability to attain, maintain, or regain maximum function would otherwise be jeopardized, then a decision regarding the provision of services must be made within three (3) business days.</li> </ul>

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## 6.2 LONG-TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS

### Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
<p><b>Evaluation</b></p>	<p>Service provision and the need for such services are continually monitored and evaluated at each on-site visit, and at monthly telephonic contacts. Time frames for member contacts are as follows:</p> <p><b>On-site Reviews:</b></p> <ul style="list-style-type: none"> <li>• At least every one hundred eighty (180) calendar days for a member in an institutional setting (this includes members receiving hospice services and those in a nursing facility);</li> <li>• At least every ninety (90) calendar days for a member receiving Home and Community-Based Services (HCBS), including members residing in Assisted Living Facilities;</li> <li>• At least every ninety (90) calendar days for a community-based DSHP Plus LTSS member with HIV/AIDS (May be conducted on-site, via telephone, or by certified letter. However, an on-site visit with the member must be completed at least once a year.); and,</li> <li>• For members in the Nursing Facility Transition (NFT) program, in accordance with the monitoring requirements in the State's Protocol</li> </ul> <p><b>Nursing Facility Case Conferences:</b></p> <ul style="list-style-type: none"> <li>• The Case Manager attends all Nursing Facility Case Conferences as an opportunity to discuss the member's needs and services jointly with the member, providers, and the member's family</li> </ul> <p><b>Monthly Contacts:</b></p> <ul style="list-style-type: none"> <li>• The Case Manager contacts members, at a minimum of monthly, between on-site reviews to monitor the status of the delivery of approved services and any changes to the member's needs or circumstances</li> </ul> <p><b>Significant Change:</b></p> <ul style="list-style-type: none"> <li>• The Case Manager conducts an on-site review within ten (10) business days following notification of a significant change. A significant change is considered:               <ul style="list-style-type: none"> <li>• Member has had a change of placement type; or,</li> <li>• Member has had a change in needs or circumstances that might require a revision to the member's Plan of Care</li> </ul> </li> </ul>

# CHAPTER 6: LONG-TERM SERVICES AND SUPPORT (LTSS)

## UNIT 3: LONG-TERM SERVICES AND SUPPORT (LTSS) PROVIDER CONTRACTING AND CREDENTIALING

**IN THIS UNIT**

**TOPIC**

- LTSS Credentialing Process
- LTSS Credentialing Criteria
- Attachment A

## 6.3 LTSS CREDENTIALING PROCESS

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### Overview

Highmark Health Options has a process for credentialing and recredentialing Long-Term Service and Support (LTSS) providers. Highmark Health Options ensures that its process, as applicable, meets the minimum National Committee for Quality Assurance (NCQA) requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs.

In addition, Highmark Health Options ensures that all LTSS providers, including those credentialed/recruited in accordance with NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations (MCOs), meet applicable State requirements.

For information on the credentialing process, please see Chapter 4, Unit 2 of this manual.

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### LTSS Credentialing Process

Once a Provider is approved to participate in the network, they must be recruited based on the service types each provider provides. Ongoing Diamond State Health Plan Plus Long-Term Services and Support (DSHP Plus LTSS) Home and Community-Based Services (HCBS) providers must be recruited at least annually. This includes, but is not limited to, providers of the following services: Adult Day Services, Assisted Living Facility, Home Delivered Meals, Attendant Care, Respite, Personal Emergency Response System (PERS), Minor Home Modifications, Day Habilitation, Cognitive Services, Independent Activities of Daily Living (Chore) Services, Nutritional Supplements for Individuals Diagnosed with HIV/AIDS that are not covered under the State Plan, and Specialized Medical Equipment and supplies not covered under the State Plan.

Credentialing of LTSS providers shall include the collection of required documents, including ownership and disclosure statements, and verification that the provider:

1. Has a valid license or certification for the services it will contract to provide as required pursuant to State law;
  2. Attained an acceptable outcome for recent inspections or monitoring from licensing agencies as applicable;
  3. Is not excluded from participation in the Medicare or Medicaid programs;
  4. Has a National Provider Identifier (NPI) Number, where applicable;
  5. Possesses General and/or Professional Liability insurance with acceptable limits;
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## 6.3 LTSS CREDENTIALING PROCESS

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### **LTSS Credentialing Process** (continued)

6. Has policies and processes in place to conduct and evaluate, in accordance with federal and state law and rule. Criminal background checks, which shall include a check of the Delaware Abuse Registry, Delaware Felony Offender Registry, National and Delaware Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective employees who will deliver DSHP Plus LTSS HCBS and to document these in the worker's employment record. Additionally, has policies and procedure to check the LEIE monthly on an ongoing basis for each worker; and
7. Has a process in place to provide and document initial and ongoing education to its employees who will provide services to DSHP Plus LTSS members that includes, at a minimum:
  - a. Caring for Elderly and Disabled population;
  - b. Abuse, neglect, and exploitation prevention, identification, and reporting;
  - c. Critical incident identification and reporting;
  - d. Documentation of service delivery;
  - e. Deficit Reduction Act information regarding False Claim Act and detecting fraud, waste, and abuse;
8. Has policies and processes in place to ensure:
  - a. Compliance with Highmark Health Options' critical incident reporting and management process;
  - b. Documentation, retention, and disclosure of enrollee specific data;
  - c. Documentation, retention, and disclosure of service delivery; and
  - d. Deficit Reduction Act: False Claim Act and detecting fraud, waste, and abuse

At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks, LEIE checks, training requirements, critical incident reporting, and management.

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### **Site Visits**

For both credentialing and recredentialing processes, DSHP Plus LTSS staff shall conduct a site visit. If the provider is located out of state, Highmark Health Options may waive the site visit and perform a documentation audit in lieu of the on-site visit, documenting the reason in the provider file. During the site visits conducted for each DSHP Plus LTSS HCBS provider type, Highmark Health Options will document and verify compliance with all requested documentation.

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## 6.3 LTSS CREDENTIALING PROCESS

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**Site  
Visits**  
(continued)

The tools used to identify potential deficiencies during the credentialing and recredentialing process include, but are not limited to, the following:

- Highmark Health Options application
- DSHP Plus LTSS Rep Checklist
- DSHP Plus LTSS Enrollment Checklist
- Credential Statement of Attestation for Organizational Providers
- Standards Assessment
- Documentation Review Form

If documents are not available at the time of the on-site audit, the Highmark Health Options Provider Network Manager records the missing documents in the comment section of the DSHP Plus LTSS Site Visit Report. The provider will be instructed to provide the missing documentation and of the obligation to supply the documentation by the due date established at the time of the on-site visit. The provider may submit documents in the mutually agreed upon manner to include: email, fax, mail, or hand-delivery.

If required documents are not submitted timely and/or not acceptable:

- New providers/initial credentialing: The contract process will end
- Existing providers will be placed on a corrective action plan and recredentialing will not be granted until all requirements are met

If during the site visit any deficiencies are identified, DSHP Plus LTSS will require the provider to correct the deficiency and may request the provider submit a formal corrective action plan (CAP) that addresses the deficiency. Ongoing monitoring of that CAP will continue until all deficiencies have been adequately addressed and are no longer deficient.

While a CAP could be requested for any deficiency related to DSHP Plus LTSS's policies and procedures for credentialing and recredentialing, it could include any time a provider does not meet DSHP Plus LTSS minimum requirements and/or deficiencies are identified related to the provider's policies, procedures, training, and reporting processes.

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## 6.3 LTSS CREDENTIALING PROCESS

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### **Highmark Health Options Credentialing Committee**

The Highmark Health Options Credentialing Committee is responsible for reviewing and approving all initial credentialing and recredentialing requests. The committee will take into account all information obtained during the credentialing or recredentialing process to make a final decision. The committee will also review any findings or deficiencies along with an evaluation of the provider's corrective actions identified during the credentialing or recredentialing process to aid in the decision-making process.

The committee may also take into account any additional complaints against the provider or performance concerns that have been identified during the course of a provider's contract with DSHP Plus LTSS. Highmark Health Options' provider contract permits either party to terminate the Provider Agreement or any applicable network Attachment within sixty (60) days prior written notice. Final decisions are determined via committee member vote and outcomes are documented in the committee meeting minutes.

Highmark Health Options furnishes written notification to the providers regarding the status of the credentialing or recredentialing process. At a minimum, Highmark Health Options shall reverify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid and/or State Children's Health Insurance Plan (SCHIP) programs.

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## 6.3 LTSS CREDENTIALING CRITERIA

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### Adult Day Services

#### Adult Day Services (Recredentialed Annually)

- General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
  - License to practice in accordance to Attachment A
- 

### Specialized Medical Equipment

#### Providers of Specialized Medical Equipment and Supplies Not Covered Under the State Plan (Recredentialed Annually)

- General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
  - License to practice in accordance to Attachment A
- 

### Assisted Living Facility

#### Assisted Living Facility (Recredentialed Annually)

- General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
  - License to practice in accordance to Attachment A
- 

### Home Delivered Meals

#### Home Delivered Meals (Recredentialed Annually)

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit - only if company is within the state of Delaware - waived if location outside Delaware
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

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## 6.3 LTSS CREDENTIALING CRITERIA

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### Respite

#### Respite (Recredentialed Annually)

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

### Minor Home Modifications

#### Minor Home Modifications (Recredentialed Annually)

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

### Attendant Care

#### Attendant Care (Recredentialed Annually)

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

### Cognitive Services

#### Cognitive Services

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
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## 6.3 LTSS CREDENTIALING CRITERIA

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### **Independent Activities of Daily Living (Chore) Services**

#### **Independent Activities of Daily Living (Chore) Services**

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

### **Nutritional Supplements for Individuals Diagnosed with HIV/AIDS**

#### **Nutritional Supplements for Individuals Diagnosed with HIV/AIDS Not Covered Under State Plan**

- License to practice in accordance to Attachment A
  - General liability and/or malpractice insurance
  - Medicaid number and NPI number, if applicable
  - Ownership and disclosure statement
  - Site visit
  - History of federal and/or state sanctions (Medicare/Medicaid)
  - Attestation to the correctness of the application
- 

### **Personal Emergency Response System (PERS)**

#### **Personal Emergency Response System (PERS) (Recertified Annually)**

- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit - only if company is within the state of Delaware - waived if located outside Delaware
- History of federal and/or state sanctions (Medicare/Medicaid)
- Attestation to the correctness of the application

## 6.3 ATTACHMENT A

LTSS SERVICE	REQUIRED LICENSE/CERTIFICATION
<b>HCBS Providers:</b> Attendant Care, Respite (In-Home)	Personal Assistance Services Agencies (PASA) or Professional Support Services Facility, Home Health Agency, or Nursing Facility PSSA or Home Health Agency
<b>Adult Day Services</b>	Adult Day Service License from Department of Health, Office of Health Facilities and Certification (OHFLC)
<b>Assisted Living Facility</b>	Assisted Living Facility (ALF) or Nursing Home Facility
<b>Cognitive Services</b>	Physician, Neuropsychologist, Psychologist (or other mental health professionals to the extent authorized under State Law), Social Workers, Trained Psychiatric Nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the member's condition) and diagnostic services. Staff must meet all requirements as set forth by the Division of Developmental Disabilities Services (DDS), the Division of Long-Term Care Resident Protection (DLTCRP), Delaware Board of Psychology, and any other applicable licensure requirements in the State of Delaware prior to being approved as a Cognitive Services provider.
<b>Day Habilitation</b>	Day Habilitation Day Program licensed by the Division of Developmental Disabilities Services
<b>Independent Activities of Daily Living (Chore) Services</b>	Trained Housekeeper
<b>Nutritional Supplements for Individuals Diagnosed with HIV/AIDS Not Covered in State Plan</b>	DME license or other retail/wholesale supplier business license
<b>Respite (Inpatient)</b>	ALF or Nursing Home Facility
<b>Specialized Medical Equipment Not Covered in State Plan</b>	DME license or other retail/wholesale supplier business license
<b>Home Delivered Meals</b>	Adult Day Services, Nursing Home, ALF, Hospital, Home for the Aged, Residential Hospice, State Department of Agriculture (food processing facilities who deliver pre-packaged meals out of state) *PSSA allowed for providers who only deliver meals.
<b>Personal Emergency Response System (PERS)</b>	Nursing Home, Hospital, or general business license, FCC & UL certifications (if provided)
<b>Minor Home Modifications</b>	Service Agency, Building supplier, contractor, carpenter, craftsman, or DME supplier

# CHAPTER 7: CLAIMS, BILLING, AND REIMBURSEMENT

## UNIT 1: HIGHMARK HEALTH OPTIONS CLAIMS SUBMISSION AND REIMBURSEMENT

### IN THIS UNIT

	TOPIC
	General Information
	<ul style="list-style-type: none"><li>• Reporting Practitioner Identification Number</li><li>• Diagnosis Coding</li><li>• Hospital Services</li><li>• Claims Mailing Address</li><li>• Claim Submission Procedures</li><li>• Claim Coding Software</li></ul>
	Coordination of Benefits
	<ul style="list-style-type: none"><li>• Submission of Highmark Health Options Secondary Payer Claims</li><li>• Auto and Casualty Claims</li></ul>
	Clean Claims
	Timely Filing Guidelines
	Electronic Claim Submission
	Electronic Remittance Advice (ERA)
	EPSDT Claim Format Requirements
	Claim Adjustments, Reconsiderations, and Appeals
	Highmark Health Options Reimbursement
	CMS-1500 Data Elements for Paper Claim Submission
	UB-04 Data Elements for Paper Claim Submission

## 7.1 GENERAL INFORMATION

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### Overview

Highmark Health Options processes medical expenses upon receipt of a correctly completed CMS-1500 form for professional services and upon receipt of a correctly completed UB-04 for hospital/facility expenses. A description of each of the required fields for each form is identified later in this unit. Paper claim forms must be submitted on **original** red claim forms.

A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To assure reimbursement to the correct payee, the group NPI must be included on every claim.

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.

Please visit our website to see Medical and Payment Policies  
[www.highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy](http://www.highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy)

### Reporting Practitioner Identification Number

To comply with encounter data reporting, primary care practitioners, and specialty care practitioners must submit claims under the individual practitioner identification number rather than the practice or group identification number. To comply with Delaware Division of Medicaid and Medical Assistance (DMMA) billing guidelines, all providers must submit a taxonomy code on every claim. The submitted taxonomy must be associated with the specialty with which the provider has been credentialed. In instances where the provider's National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the services rendered should be submitted on the claim. Submissions for anesthesiology, pathology, radiology, and emergency room practitioner groups must also include the individual practitioner identification number. Any claim billed on a CMS-1500 form must include the individual practitioner identification number in Box 24J.

Please note that it is extremely important to promptly notify Highmark Health Options of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. Claims will reject up-front if the individual practitioner number is not included on the claim. The only exception to the individual practitioner number requirement applies to UB-04 charges for practitioner services when a remittance advice is issued to a hospital facility.

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**Diagnosis  
Coding**

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.

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## 7.1 GENERAL INFORMATION

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### Hospital Service

Hospital claims are submitted to Highmark Health Options on a UB-04 claim form. To assure that claims are processed for the correct member, the member's 12-digit Highmark Health Options ID number (UMI) or Medicaid ID number must be used on all claims.

Practitioners rendering services in an outpatient hospital clinic should include the facility NPI and the practitioner's individual NPI on the claim when submitting on a UB-04, while the practice's group NPI and the practitioner's individual NPI must be reported when submitting claims on a CMS-1500 claim form.

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 of the Highmark Health Options remittance advice.

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### Claims Mailing Address

The Highmark Health Options claims mailing address is:

Highmark Health Options  
Claims Processing Department  
P.O. Box 890402  
Camp Hill, PA 17089-0402

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### Questions?

Any questions concerning billing procedures or claim payments can be directed to Highmark Health Options Provider Services Department at 1-844-325-6251.

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### Claim Submission Procedures

Procedures for Highmark Health Options are as follows:

- Submit claims for all services provided
  - The billing provider's five (5) digit plus four (4) zip code is required on all claims in the billing field (and service facility field if used)
  - All drug-specific claim information reported to Highmark Health Options using the 837P and 837I electronic format **MUST** be reported with a HCPCS code (such as a J-code) **AND** an 11 digit NDC code. Claims submitted without both the appropriate HCPCS code and NDC will be rejected.
  - Payment for CPT and HCPCS codes are covered to the extent that they are recognized by the Delaware Department of Health and Social Services (DHSS) or allowed per medical review determination by Highmark Health Options. Correct coding (procedure, diagnosis, HCPCS) must be submitted for each service rendered and, nonspecific CPT codes will require a description added to the claim form.
  - Highmark Health Options utilizes Centers for Medicare & Medicaid (CMS) place of service codes to process claims, and they are the **only** place of service codes that are accepted
  - Highmark Health Options will add new codes to the respective fee schedules effective the first of the month upon receipt from DHSS from DHSS
- 

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## 7.1 GENERAL INFORMATION

### Claim Submission Procedures (continued)

- Hospitals/facilities should bill on original UB-04 forms, and other providers, including ancillary providers, should bill using an **original** CMS-1500 form
- Highmark Health Options does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format
- Correct/current practitioner information must be entered on all claims; The 10 digit NPI is required
- Correct/current member information, including Highmark Health Options 12 digit Member ID Number or Medicaid number, must be entered on all claims
- Please allow four (4) to six (6) weeks for a remittance advice. It is the practitioner's responsibility to research the status of the claim
- Timely filing criteria for initial bills are one hundred twenty (120) days from the date of service or sixty (60) days from the date of remittance from a primary payer. Corrected claims or requests for review are considered if information is received within the 180-day follow-up period from the date on the Health Options initial remittance advice.
- Payment by Highmark Health Options is considered payment in full. In no circumstance, including, but not limited to, non-payment by Highmark Health Options for non-approved services, may a practitioner bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Health Options member.
- Highmark Health Options is the payer of last resort when any commercial or Medicare plan covers the member. Highmark Health Options is obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. Claims must be submitted within Highmark Health Options timely filing guidelines.

Any reimbursement or coding changes made by the DHSS to its current inpatient **and** outpatient fee schedules shall be implemented by Highmark Health Options the month the DHSS notifies Highmark Health Options of such change. There will be no adjustments made to previously processed claims due to any retroactive change implemented by DHSS.

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## 7.1 GENERAL INFORMATION

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### **Claim Coding Software**

Highmark Health Options uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, American Medical Association (AMA), and CMS guidelines as well as industry standards, medical policy, and literature and academic affiliations.

The program used at Highmark Health Options 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.

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## 7.1 COORDINATION OF BENEFITS

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### Overview

Some Highmark Health Options recipients have other insurance coverage. Highmark Health Options, like Delaware's Department of Health and Social Services (DHSS), is the payer of last resort on claims for services provided to members with any commercial or Medicare plan covers the member. Highmark Health Options may not delay or deny payment of claims unless the probable existence of third party liability is established at the time the claim is submitted. Claims must be submitted within Highmark Health Options timely filing guidelines.

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### Submission of Highmark Health Options Secondary Payer Claims

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. The practitioner must:

1. Follow all Highmark Health Options authorization procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.
3. Submit a copy of the primary carrier's EOB with the claim to Highmark Health Options within sixty (60) days of the date of the primary carrier's EOB, ABN, or Letter of Denial. Secondary and tertiary claims can be sent electronically
4. Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.
5. The amount billed to Highmark Health Options must match the amount billed to the primary carrier. Highmark Health Options will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

**Note:** Highmark Health Options will process and pay Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Early Intervention services 0-3 years old, services and prenatal visits as primary even when our records indicate Highmark Health Options is secondary and a primary plan exists. If an EOB is attached to the EPSDT or prenatal claim, then coordination of benefits will be applied. We will continue to coordinate benefits and require the primary explanation of benefits when submitting the delivery claim.

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### Auto and Casualty Claims

Per DHSS, Highmark Health Options is considered the primary insurer when auto or casualty claims are involved. When a claim is submitted by a practitioner without an EOB from the auto insurance or a casualty plan, and the original bill does not include any notation of a primary payer payment, Highmark Health Options must take a primary position on the claim and not deny to the extent that plan criteria was followed.

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## 7.1 COORDINATION OF BENEFITS

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### **Auto and Casualty Claims** (continued)

The practitioner has the option of submitting an original claim; however, it must be submitted within one hundred twenty (120) days. These claims will be denied for timely filing if they are not received within 120 days of service.

The sixty (60) day rule for Third Party Liability applies to auto and casualty when the practitioner attaches either an EOB or auto casualty exhaustion letter. If the practitioner submits the claim with the EOB, Highmark Health Options will coordinate benefits.

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### **Verifying If Primary Coverage No Longer Applies**

If a member indicates they no longer have primary coverage, but the State System contains information indicating other medical coverage is still active, the member should contact his or her caseworker to have the State System updated. If this is not possible, the practitioner may contact the primary carrier and request written verification of the coverage.

When Highmark Health Options receives a letter from the primary carrier indicating that the member no longer has coverage, Highmark Health Options will use the letter to investigate the situation and verify if the coverage is canceled and if there is a new plan covering the member.

If Highmark Health Options' investigation confirms that the member no longer has primary coverage, Highmark Health Options will submit an electronic request to the State to update the system. Highmark Health Options will update our system immediately and reprocess claims finalized within the one hundred twenty (120) day period prior to the date of the onset of the investigation.

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### **Members Cannot be Billed for Copays or Coinsurance**

Highmark Health Options members cannot be billed for any co-payments and/or co-insurance, as regulated by DHSS.

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## 7.1 CLEAN CLAIMS

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### **Clean Claims Defined**

A “clean claim” as used in this section means a claim for payment for a health care service that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. A claim from a health care provider who is under investigation for fraud or abuse regarding that claim will not be considered a “clean claim.”

In addition, a claim shall be considered “clean” if the appropriate authorization has been obtained in compliance with Highmark Health Options Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a Highmark Health Options-contracted clearinghouse:

1. Patient name;
  2. Patient medical plan identifier;
  3. Date of service for each covered service;
  4. Description of covered services rendered using valid coding and abbreviated description;
  5. ICD-10 surgical diagnosis code (as applicable);
  6. Name of practitioner/provider and plan identifier;
  7. Provider tax identification number;
  8. Provider’s National Provider Identifier (NPI);
  9. Provider’s Taxonomy code;
  10. Valid Centers for Medicare & Medicaid Services (CMS) place of service code;
  11. Billed charge amount for each covered service;
  12. Primary carrier Explanations of Benefits (EOB) when patient has other insurance;
  13. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or, in the case of emergency room claims, the presenting ICD-10-CM diagnosis code;
  14. DRG code for inpatient hospital claims
-

## 7.1 TIMELY FILING GUIDELINES

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### Overview

Practitioners must submit a complete original, initial claim within one hundred twenty (120) calendar days after the date of service.

If you bill on paper, Highmark Health Options will only accept paper claims on **original** CMS-1500 (Version 02/12), or UB-04 forms. No other billing forms will be accepted. Paper claims that are not received on original forms with red ink may delay final processing as original forms are required for every claim submission. These forms are accepted at a centralized mailroom:

Highmark Delaware Health Options-Claims Department  
P.O. Box 890402  
Camp Hill, PA 17089-0402

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### EPSDT Claims

All Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) claims and primary care services must be submitted within one hundred twenty (120) calendar days from the date of service.

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### Highmark Health Options as Secondary Payer

Practitioners must bill within sixty (60) days from the date of an Explanation of Benefits (EOB) from the primary carrier when Highmark Health Options is secondary. An original bill along with a copy of the EOB is required to process the claim.

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### Requests for Claim Review

Requests for reviews/corrections of processed claims must be submitted within one hundred eighty (180) days from the date of the corresponding remittance advice. All claims submitted after the 120 day period for initial claims or after the one hundred eighty (180) day follow-up period from the date on the initial remittance will be denied.

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### Claim Inquiries

Any claim that has been submitted to Highmark Health Options but does not appear on a remittance advice within sixty (60) days following submission should be researched by the practitioner.

Claims status inquiries can be researched via NaviNet® or by calling Highmark Health Options Provider Services Department at 1-844-325-6251 to inquire whether the claim was received and/or processed.

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### Exceptions

Exceptions to timely filing criteria are evaluated upon receipt of documentation supporting the request for the exception. Upon approval, exceptions are granted on a one-time basis, and the claim system is noted accordingly.

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## 7.1 ELECTRONIC CLAIM SUBMISSION

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### Overview

Highmark Health Options can accept claims electronically through Emdeon. Highmark Health Options encourages practitioners 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
- 

### Highmark

For professional or institutional electronic claims for Highmark Health Options members, please use the Highmark BCBSD Highmark Health Options, Inc.

**Emdeon: Payer ID Number 47181.**

**Relay Health: Payer ID Number 7148 Professional, 7693 Institutional**

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### Edits

Highmark Health Options has a health plan specific edit through Emdeon for electronic claims that differs from the standard electronic submission format criteria. The edit requires: A Highmark Health Options assigned 8-digit member identification number, the member number field allows 6, 8, or 12 digits to be entered. For practitioners who do not know the member's Highmark Health Options identification number, it is acceptable to submit the member's Recipient Number on electronic claims.

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

Practitioners must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by Emdeon and Highmark Health Options. Edits applied when claims are received by Highmark Health Options will appear on an EDI Report within the initial acceptance report or Claims Acknowledgment Report. A claim can be rejected if it does not include an NPI and current procedure and diagnosis codes.

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

- Emdeon -- Provider Daily Statistics (RO22)
  - Emdeon -- Daily Acceptance Report by Provider (RO26)
  - Emdeon -- Unprocessed Claim Report (RO59)
- 

*Continued on next page*

## 7.1 ELECTRONIC CLAIM SUBMISSION

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**Attachments  
Not  
Currently  
Accepted**

Highmark Health Options will accept electronic claims for services that would be submitted on a standard CMS-1500 (02/12) or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- ∞ Services billed by report
- 

**If You Are Not  
Submitting  
Electronically**

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. You may also call Emdeon directly at 1-877-469-3263.

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## 7.1 ELECTRONIC REMITTANCE ADVICE (ERA)

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### Overview

Providers may receive an electronic claims remittance advice (ERA). Highmark Health Options uses Emdeon or Relay Health to transfer the 835 Version 5010 Healthcare Claim Remittance Advice to claim submitters

You must register to receive electronic funds transfer (ACH Direct Deposit) transactions.

A registration form is available on the Highmark Health Options website at: [highmarkhealthoptions.com](http://highmarkhealthoptions.com).

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### Information Resources

Rules for format, content, and field values can be found in the *Implementation Guides* available on the Washington Publishing Company's website at: [www.wpc-edi.com](http://www.wpc-edi.com).

The Provider Remittance provides detailed payment data based on the information provided to us. If all or part of the claim has been denied, consult the Claim Adjustment Reason Code (CARC) and or the Remittance Advice Remark Code (RARC). To find the text of the CARC or RARC code, go to Washington Publishing Company at [www.wpc-edi.com/reference/](http://www.wpc-edi.com/reference/).

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

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## 7.1 EPSDT CLAIM FORMAT REQUIREMENTS

### CMS-1500 Paper Format

The following format requirements apply when submitting CMS-1500 paper claims for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens:

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99341, and 99345) along with EP modifier.
- The EP modifier must follow the evaluation and management code in the first line of Box 24D on the claim form. Use CPT Modifier (52 or 90) plus CPT codes when applicable.
- The appropriate diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21.
- Report visit code 03 in Box 24(h) of the CMS-1500 when providing EPSDT screening service.
- Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in Box 10(d) on the CMS-1500.

Codes for referrals made or needed as a result of the screen are:

<b>YO</b> - Other	<b>YV</b> - Vision	<b>YH</b> - Hearing
<b>YM</b> - Medical	<b>YD</b> - Dental	<b>YB</b> - Behavioral

### EDI Format Requirement

#### EDI Format Requirements

Electronic data interchange (EDI) requirements for EPSDT claims are as follows:

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier.
- The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.
- The appropriate diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21.
- Populate the SV111 of the 2400 loop with a “yes” for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the 2300 Claim Information Loop with “01” (meaning EPSDT).
- Populate NTE01 of the NTE segment with “ADD”. This means that the additional information is available in ‘field’ NTE02 (see below).
- Populate NTE02 with the NTE segment of the 2300 Claim Information Loop with the appropriate referral codes:

<b>YO</b> - Other	<b>YV</b> - Vision	<b>YH</b> - Hearing
<b>YM</b> - Medical	<b>YD</b> - Dental	<b>YB</b> - Behavioral

**Timely Filing for EPSDT Claims is 120 days from the Date of Service**

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**All Submissions  
must utilize ICD  
10 Codes**

Highmark Health Options requires Primary Care Physicians who are treating pediatric patients to be enrolled in the Vaccine for Children (VFC) program. This program provides vaccines at no cost to providers so they can be given to those patients who are eligible for the program. The VFC website provides an overview of the program and includes information regarding eligibility requirements. Highmark Health Options will only reimburse an administrative fee for any covered VFC vaccine and the actual vaccine codes along with the appropriate NDC #s must be billed in order to receive reimbursement.

**If you have questions, please contact Highmark Health Options Provider Services at 1-844-325-6251 or your Provider Account Liaison.**

If you would like more information on EPSDT or VFC please consult the following websites:

**Bright Futures/AAP Periodicity Schedule:**

<https://www.aap.org/enus/Documents/periodicityschedule.pdf>

**CDC Immunization Schedule:**

<https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

**DHSS Immunizations – Infants & Children:**

<http://www.dhss.delaware.gov/dph/dpc/immunize-children.html>

**CDC Vaccine for Children Program:**

<https://www.cdc.gov/vaccines/programs/vfc/index.html>

## 7.1 CLAIM ADJUSTMENTS, RECONSIDERATIONS, AND APPEALS

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### Overview

Highmark Health Options will review any claim that a practitioner feels was denied or paid incorrectly. The request may be conveyed in writing or verbally through Highmark Health Options Provider Services Department if the inquiry relates to an administrative issue.

Please forward all the appropriate documentation (i.e., the actual claim, medical records, and notations regarding telephone conversations) in order to expedite the review process.

Initial claims that are not received within the one hundred twenty (120) day timely filing limit (including Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] services), will not qualify for review. All follow-up review requests must be received within twelve (12) months of the date of service or sixty (60) days of the date of payment, whichever is later.

For information on how to submit complaints about claims payment, please see Chapter 5, Unit 3 of this manual.

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### **Overpayments Highmark Health Options cannot accept verbal requests to retract claim(s) overpayments.**

Providers can submit a corrected claim.

Providers may also complete and submit a Self Audit Overpayment Form or a letter that contains all of the information requested on this form. This form is available in the Forms and Reference Materials section under Providers on our website.

This form, together with all supporting materials relevant to the claim(s) reversal request being made, including but not limited to, the Explanation of Benefits (EOB) from other insurance carriers and your refund check should be mailed to:

Highmark Health Options Payments/Refunds  
P.O. Box 890407  
Camp Hill, PA 17089-0407

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## 7.1 HIGHMARK HEALTH OPTIONS REIMBURSEMENT

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### Overview

Reimbursement by Highmark Health Options is considered payment in full. Highmark Health Options participating providers may not seek compensation from a member unless:

- Services were rendered as an ongoing service during the appeal process and the result of the appeal process was a denial determination
  - The member is informed in advance that a proposed service is not a covered benefit; and
  - The member accepts financial responsibility in a signed document that includes:
    - The services provided;
    - The cost of non-covered services;
    - Notification that Highmark Health Options will not pay or be liable for the listed services; and
    - Notification that the member will be financially liable for listed services
- 

### Authorization and Reimbursement

Failure to obtain a prior authorization for services requiring prior authorization will result in the denial of a claim or reduced benefits to the member. In addition, when submitting the claim for the prior authorized service, it is important to remember to include the Prior Authorization number in the appropriate space on the claim.

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### Missed Scheduled Appointments

**Providers are prohibited from billing Medicaid members who miss scheduled appointments.** A missed appointment is not a distinct reimbursable Medicaid service.

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## 7.1 CMS-1500 DATA ELEMENTS FOR PAPER CLAIM SUBMISSION

**NOTE:** EDI requirements must be followed for electronic claims submissions.

FIELD #	DESCRIPTION	REQUIREMENTS
1	Insurance Type	Required
1a	Insured's Identification Number	Highmark Health Options Member Identification Number Required (10-digit MA Recipient Number acceptable for Electronic Claims)
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	Required, If Applicable
9b	Reserved for NUCC Use	Required, If Applicable
9c	Reserved for NUCC Use	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident	Required, If Applicable
10d	Claim Codes (Designated by NUCC)	Not Required (see instructions for EPSDT claims)
11	Insured's Policy Group or FECA	Required
11a	Insured's Date of Birth Insured's Sex	Required, If Applicable Required, If Applicable
11b	Other Claim ID (Designated by NUCC)	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's or Authorized Person's Signature	Required
13	Insured's or Authorized Person's	Required
14	Date of Current Illness, Injury or Pregnancy (LMP)	Required, If Applicable
15	Qual Other Date	Not Required Required, if Applicable
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable

17	Name of Referring Provider or Other Source	Required, if Applicable
17a	Other	Not Required
17b	Identification Number of Referring Provider	Required, if Applicable
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Additional Claim Information (Designated by NUCC)	Not Required
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	EMG	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required (see instructions for EPST claims submissions)
24i	ID Qualifier	Not Required
24j	Rendering Provider Taxonomy Code (shaded) Rendering Provider ID# (unshaded)	Required Required
25	Federal Tax Identification Number	Required
26	Patient's Account Number	Not Required, but Highmark Health Options includes payment information when present to assist with reconciliation in provider records
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Reserved for NUCC Use	Not Required
31	Signature of Physician or Supplier including Degrees or Credentials	Highmark Health Options Individual Practitioner Name and Date Required
32	Service Facility Location Information	Name and Address where Services were Rendered Required
32a	Facility NPI	Required, If Applicable
33b	Other	Not Required
33	Billing Provider Info and Phone Number	Highmark Health Options Vendor Name, Address, and Number Required
33a	Billing Provider NPI	Required
33b	Other	Billing Provider Taxonomy Code Required

**NOTE:** The above field #'s and descriptions were pulled from the CMS 1500 form published on the CMS website. Please see form details below.

<b>Form #</b>	CMS 1500
<b>Form Title</b>	Health Insurance Claim Form
<b>Revision Date</b>	2012-02-01
<b>O.M.B. #</b>	0938-1197
<b>O.M.B Expiration Date</b>	2020-03-31



## 7.1 UB-04 DATA ELEMENTS FOR PAPER CLAIM SUBMISSION

**NOTE:** EDI requirements must be followed for electronic claims submissions.

FIELD	DESCRIPTION	REQUIREMENTS
1	Practitioner Name, Address, Phone Number	Required
2	Unlabeled Field	Not Required
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required
5	Federal Tax Number	Required
6	Statement Covers Period – From/Through	Required
7	Unlabeled Field	Not Required
8a	Patient ID Number	Required, If Inpatient
8b	Patient Name	Required
9a	Patient Address – Street	Required
9b	Patient Address – City	Required
9c	Patient Address – State	Required
9d	Patient Address – Zip	Required
9e	Patient Address – Country Code	Required
10	Patient Birth Date	Required
11	Patient Sex	Required
12	Admission Date	Required, If Inpatient
13	Admission Hour	Required, If Inpatient
14	Admission Type	Required, If Inpatient
15	Source of Admission	Required, if inpatient
16	Discharge Hour	Required
17	Patient Discharge Status	Required
18-28	Condition Codes	Minimum of One Required, If Applicable
29	Accident State	Not Required
30	Unlabeled Field	Not Required
31-34	Occurrence Codes and Dates	Minimum of One Required, If Applicable
35-36	Occurrence Span Codes and Dates	Minimum of One Required, If Applicable
37	Unlabeled Field	Not Required
38	Responsible Party Name and Address	Not Required

39-41	Value Codes and Amounts	Required for DRG Reimbursement, Value Code Record Type 41 must be entered as ZZ and DRG Code must be entered in Value Amount Field
42	Revenue Codes	Required
43	Descriptions	Required
44	HCPCS Rates / Codes	Required, If Outpatient
45	Service Date	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Required
50	Payer Name	Required
51	Health Plan ID	Highmark Health Options Practitioner Identification Number Required
52	Release of Information	Not Required
53	Assignment of Benefits	Not Required
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due	Not Required
56	NPI	Required
57	Other Provider ID	Not Required
58	Insured's Name	Required
59	Patient Relationship to Insured	Not Required
60	Insured's Unique ID	Highmark Health Options Member Identification Number Required (10-digit MA
61	Group Name	Required
62	Insurance Group Number	Not Required
63	Treatment Authorization Codes	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Not Required
66	DX	Required
67	Principal Diagnosis Code	Required
67a-q	Other Diagnosis Codes	Required, if Applicable
68	Unlabeled Field	Not Required
69	Admitting Diagnosis Code	Required, If Applicable
70	Patient Reason for Visit Code	Not Required
71	PPS Code	Not Required
72	ECI (External Cause of Injury) Code	Not Required
73	Unlabeled Field	Not Required

## 7.1 UB-04 DATA ELEMENTS FOR PAPER CLAIM SUBMISSION, Continued

### UB-04 data elements (continued)

FIELD	DESCRIPTION	REQUIREMENTS
74	Principal Procedure Code and Date	Required, if inpatient only
74a-e	Other Procedure Codes and Date	Required, if inpatient only
75	Unlabeled Field	Not Required
76	Attending Provider Information	NPI, First Name, and Last Name Required
77	Operating Provider Information	NPI, First Name, and Last Name Required, if Applicable
78-79	Other Provider Information	Not Required
80	Remarks	Not Required
81a	Qual/Code/Value	Taxonomy Code related to Field 56 (NPI) Required
81b-d	Qual/Code/Value	Not Required

**NOTE:** The above field #'s and descriptions were pulled from the CMS 1450 form published on the CMS website. Please see form details below.

<b>Form #</b>	CMS 1450
<b>Form Title</b>	UB-04 Uniform Bill
<b>Revision Date</b>	2007-03-01
<b>O.M.B. #</b>	0938-0997
<b>O.M.B Expiration Date</b>	2019-08-31

# CHAPTER 7: CLAIMS, BILLING, AND REIMBURSEMENT

## UNIT 2: HIGHMARK HEALTH OPTIONS SPECIFIC BILLING GUIDELINES

### IN THIS UNIT

### TOPIC

Specialty/Fee-For Service Providers  
Highmark Health Options Members with Medicare Coverage  
Subrogation  
Early And Periodic Screening, Diagnostic, And Treatment (EPSDT) Services  
Obstetrical Care Services  
Surgical Procedure Services  
Anesthesia Services

## 7.2 SPECIALTY/FEE-FOR-SERVICE PROVIDERS

### Encounter Submissio

Highmark Health Options reimburses providers on a fee for service basis. Since there are no capitated payment arrangements, there are no encounter reporting requirements.

### Submitting to Highmark Health Options as Secondary Payer

If a member has other coverage, the other carrier is always the primary insurer. The specialist will bill the other insurer and the other insurer will issue payment with an Explanation of Benefits (EOB) statement, which outlines the payment made for each procedure. The specialist will then submit a copy of the EOB with a copy of the claim to Highmark Health Options for secondary coverage.

The claim must be received by Highmark Health Options within sixty (60) days of the date of the EOB. If required, all Highmark Health Options authorization requirements must be met in order for payment to be issued.

### Determining Highmark Health Options Liability After Primary

If the member has commercial insurance, and the commercial carrier's payment is greater than Highmark Health Options payment if Highmark Health Options were primary, then the following reimbursement example would apply. The primary carrier amount is the basis for the benefit determination of Highmark Health Options liability when the practitioner is a participating practitioner with the primary plan. The primary carrier allowable paid amount is used as the basis for the benefit determination of Highmark Health Options liability when there is a patient responsibility remaining after the primary carrier has processed the claim.

### Payment

#### Example of Practitioner Participating with Primary Plan:

Practitioner Charges	\$1,500.00
Primary Carrier Allowable	\$1,000.00
Primary Payment (80% of Allowable)	\$800.00
Highmark Health Options Allowable if Primary	\$600.00
Highmark Health Options compares the Primary Carrier Health Options Allowable	\$800.00 vs. \$600.00
Highmark Health Options does not issue payment	\$0.00

#### Example of Patient Responsibility remaining after Primary Plan

Practitioner Charges	\$1,500.00
Primary Care Allowable	\$1,000.00
Primary Payment (80% of Allowable)	\$800.00
Patient Responsibility Under Primary Plan	\$200.00
Highmark Health Options Allowable if Primary	\$850.00
Highmark Health Options compares the Primary Carrier Payment to the Highmark Health Options Allowable	\$800.00 vs. \$850.00
Highmark Health Options Issues Payment	\$50.00

## 7.2 HIGHMARK HEALTH OPTIONS MEMBERS WITH MEDICARE COVERAGE

### Overview

Highmark Health Options members 21 years of age or younger may have Medicare Fee For Service. When Medicare is the other insurance, the following processing criteria applies:

- Referrals and authorizations are not required for services covered by Medicare. Once Medicare benefits have been exhausted, or if a service is not covered by Medicare, authorization criteria will apply.
- For Medicare Part A and Medicare Part B services, coverage is provided according to a benefits-less-benefits calculation.

### Payment Calculation

Highmark Health Options determines the amount that would normally be paid under the plan using the allowable amount from the Medicare Plan as the billed amount. If the amount Highmark Health Options would pay is more than the amount Medicare pays, then Highmark Health Options may pay the difference up to the maximum allowable, contingent on the benefit-less-benefit calculation. If the amount Highmark Health Options would pay is equal to or less than the amount Medicare pays, Highmark Health Options does not issue any additional payment.

For Medicare services that are not covered by Medical Assistance or Highmark Health Options, Highmark Health Options must pay cost sharing to the extent that the payment made under Medicare for the service and the payment made by Highmark Health Options does not exceed eighty (80) percent of the Medicare approved amount.

### Examples

EXAMPLE A	
Practitioner Charges	\$1,500.00
Deductible is Satisfied	-
Medicare Allowable	\$1,000.00
Medicare Payment (80% of Allowable)	\$800.00
Highmark Health Options Allowable if Primary	\$600.00
Highmark Health Options compares the Medicare Payment to the Highmark Health Options Allowable	\$800.00 vs. \$600.00
Highmark Health Options does not issue payment	\$0.00

*Continued on next page*

## 7.2 HIGHMARK HEALTH OPTIONS MEMBERS WITH MEDICARE COVERAGE

Examples  
(continued)

EXAMPLE B	
Practitioner Charges	\$1,500.00
Deductible is Satisfied	-
Medicare Allowable	\$1,000.00
Medicare Payment (80% of Allowable)	\$800.00
Highmark Health Options Allowable if Primary	\$850.00
Highmark Health Options compares the Medicare Payment to the Highmark Health Options Allowable	\$800.00 vs. \$850.00
Highmark Health Options issues Payment for the Difference	\$50.00

EXAMPLE C	
Practitioner Charges	\$1,500.00
Medicare Allowable	\$1,000.00
Medicare Applies \$50.00 to Satisfy the Deductible	\$50.00
Medicare Payment (80% of Allowable) Remaining After Deductible is Satisfied	\$760.00
Highmark Health Options Allowable if Primary	\$850.00
Highmark Health Options compares the Medicare Payment to the Highmark Health Options Allowable	\$760.00 vs. \$850.00
Highmark Health Options Issues Payment for the Difference	\$90.00

## 7.2 SUBROGATION

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### Overview

According to Highmark Health Options' agreement with the Delaware Department of Health and Social Services (DHSS), if a member is injured or becomes ill through the act of a third party, medical expenses may be covered by casualty insurance, liability insurance, or litigation.

Any correspondence or inquiry forwarded to Highmark Health Options by an attorney, practitioner of service, insurance carrier, etc. relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement, will be handled by Highmark Health Options Legal Department and will be forwarded to DHSS Third Party Liability Department.

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### Claims Submission

Claims submitted by a provider and without an Explanation of Benefits statement from auto insurance or casualty plans without any notation on the original bill of the primary payer, will be processed by Highmark Health Options similar to any other claims. Highmark Health Options may neither unreasonably delay payment nor deny payment of claims because they are involved in injury stemming from an accident, such as a motor vehicle accident, where the services are otherwise covered.

Timely filing criteria of one hundred twenty (120) days apply and original claims must be received timely to be eligible for payment. Explanation of Benefits or auto/workers compensation/casualty exhaustion letters qualify for consideration if they are received within sixty (60) days of the date of the Explanation of Benefits/letter along with submission of the initial bill in order for Highmark Health Options to coordinate benefits.

However, if the auto/casualty Explanation of Benefits is submitted after Highmark Health Options has already paid as primary, claims cannot be adjusted, as Highmark Health Options must comply with criteria set by DHSS.

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### Requests for Information

All requests from legal representatives, and/or insurers for information concerning copies of patient bills or medical records must be submitted to Highmark Health Options Legal Department.

A cover letter identifying the date and description of the injury, requested dates of services for billing statements, and release of information signed by the member should be forwarded to the following address:

Highmark Health Options  
Attention: Legal/Regulatory Affairs  
P.O. Box 890419  
Camp Hill, PA 17089-0419



## 7.2 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SERVICES

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### **Submit EPSDT Screens via 1500/837P**

All Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening services, including vaccine administration fees, should be submitted to Highmark Health Options either on a CMS-1500 or the corresponding 837P format for electronic data interchange (EDI) claims within one hundred twenty (120) days from the date of service.

**Highmark Health Options cannot accept an EPSDT screen on a UB-04 or the corresponding 837I format.**

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### **Guidelines**

An EPSDT screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, are documented. Consult the current Children's Checkup (EPSDT) Program Periodicity Schedule and Coding Matrix as well as the Recommended Childhood Immunization Schedule for screening eligibility information and the services required to bill for a complete EPSDT screen.

With the exception of the dental component for clinics that do not offer dental services, Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) may not bill for partial screens.

Highmark Health Options uses fully automated coding review software. The software programmatically evaluates claim payments in accordance with CPT-4, HCPCS, ICD-10, American Medical Association (AMA), and Centers for Medicare & Medicaid Services (CMS) guidelines as well as industry standards, medical policy, and literature and academic affiliations.

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### **Payment**

Claims will be paid at the provider's EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.

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## 7.2 OBSTETRICAL CARE SERVICES

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### **Reimbursed per Visit**

Obstetric practitioners are reimbursed on a per visit basis. All visits and dates of service must be included on the CMS-1500 Form or 837P and identified with appropriate maternity codes for appropriate reimbursement.

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### **Delivery Charges**

Delivery charges are to be coded with CPT Codes. The date billed for a Delivery Code, in CPT code format, must be the actual date of service. Highmark Health Options payment allowance for the delivery includes all postpartum visits.

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### **Newborn Inpatient Claims**

All charges for newborns that become enrolled in the plan are processed under the newborn name and newborn's Highmark Health Options identification number. For prompt payment, please submit claims with the newborn patient information or the claim will be pended for manual research.

Inpatient hospital bills for newborns should be submitted separately from the mom's confinement. Per diem payments for inpatient maternity services that cover the confinement for both mom and baby will be issued under the mother's Highmark Health Options identification number and the newborn's claim will be processed for informational purposes only.

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## 7.2 SURGICAL PROCEDURE SERVICES

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### Payment Limits

Highmark Health Options reimburses surgical procedures in accordance with industry standard protocols and limits payment to a maximum of three (3) surgical procedures/operating sessions.

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### Reimbursement

Highmark Health Options determines reimbursement upon the clinical intensity of each procedure and reimburses at one hundred (100) percent for the most clinically intensive surgery, and fifty (50) percent for the second and third procedures.

Pre- and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria.

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### Assistant Surgeon

An assistant surgeon may bill for one (1) procedure per date of service, and will be reimbursed at twenty (20) percent of Highmark Health Options maximum allowable fee, as long as the surgical procedure code allows an assistant surgeon to be present for the surgery.

If the assistant surgeon charges are submitted under the supervising physician's name, the **AS modifier** indicating this was a physician's assistant **must** be included on the claim.

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## 7.2 ANESTHESIA SERVICES

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### Overview

Highmark Health Options processes anesthesia services based on anesthesia procedure codes only.

All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or greater: round up; less than thirty (30) seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in space 24G on the CMS-1500 for providers who bill in paper format. Additionally, Highmark Health Options requires all anesthesia services be submitted with pricing modifiers in the first modifier position.

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### Additional Tips

- If you provide pain management services, continue to bill with surgical codes
  - If you provide medical procedures such as Swan Ganz, Laryngoscopy Indirect with Biopsy, Venipuncture Cutdown, Placement of Catheter or Central Vein, then continue to bill with the medical procedure code
  - When billing OB anesthesia codes 01960, 01961, 01962, 01963 and 01967, you do not need to add an additional hour for patient consultation; The Department of Public Welfare has already added 4 to the relative value unit for these codes.
  - When billing anesthesia for all obstetrical procedures, use the anesthesia procedure codes as defined in the Anesthesia section of the CPT-4 manual
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