HIGHMARK. Delaware
HEALTH OPTIONS

Provider Manual

www.highmarkhealthoptions.com

2019

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CHAPTER 1: GENERAL INFORMATION AND CONTACT INFORMATION

UNIT 1: HIGHMARK HEALTH OPTIONS OVERVIEW

IN THIS UNIT

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.

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.

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 which is the efficient and convenient method for you and your staff.

CHAPTER 1: GENERAL INFORMATION AND CONTACT INFORMATION

UNIT 2: QUICK REFERENCE DIRECTORY

IN THIS UNIT

1.2 HIGHMARK HEALTH OPTIONS CONTACT INFORMATION

Highmark Health Options website

Our website, www.highmarkhealthoptions.com, provides up-to-date information.

Important addresses

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

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.

1.2 HIGHMARK HEALTH OPTIONS CONTACT INFORMATION, Continued

NaviNet®

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

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

Pharmacy network

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

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: www.highmarkhealthoptions.com.

1.2 STATE OF DELAWARE CONTACT INFORMATION

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

Dental Services

Telephone: 1-800-372-2022

FOR MORE INFORMATION

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

CHAPTER 2: MEMBER INFORMATION

UNIT 1: ENROLLMENT AND ELIGIBILITY

IN THIS UNIT

2.1 ENROLLMENT AND ELIGIBILITY DETERMINATION

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 the recipient 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.

2.1 MEMBER RESOURCES

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.

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 member in navigating the grievance and appeals process, and to identify resources necessary to assist those members with limited English proficiency or communication barriers.

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

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.

2.1 VERIFYING ELIGIBILITY

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.

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, unless the member changes their primary care practitioner or requests a new card. 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 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 8-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, just 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

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.

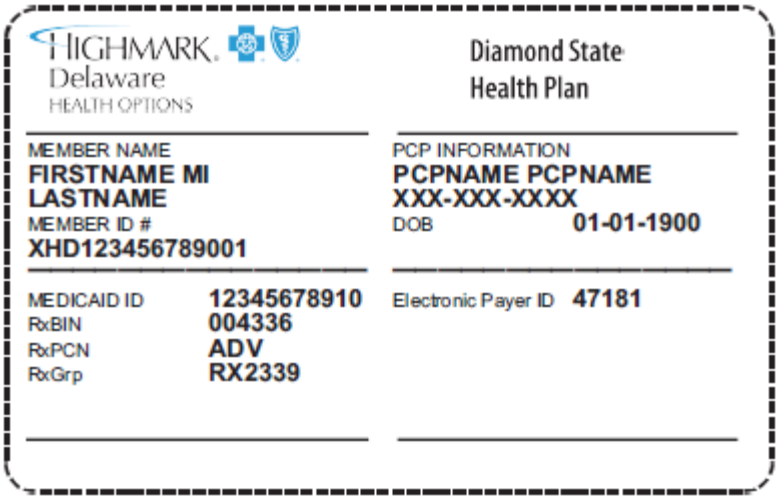
If members insist they are effective but do not appear on the list, the practitioner should call the Highmark Health Options Provider Services Department at 1-844-325-6251 for help in determining eligibility.

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 the 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)



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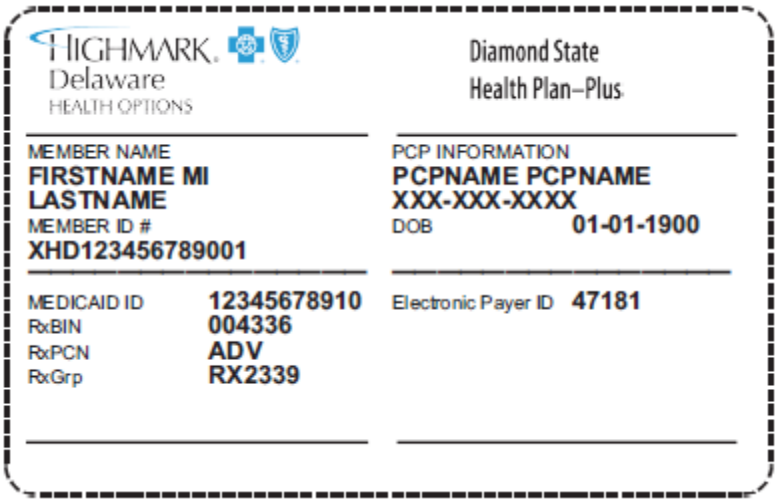
2.1 MEMBER IDENTIFICATION CARDS, Continued

SAMPLE ID CARD: Diamond State Health Plan – Plus (DSHP Plus)


HIGHMARK. Delaware HEALTH OPTIONS

Diamond State Health Plan–Plus

MEMBER NAME
FIRSTNAME MI LASTNAME
MEMBER ID #
XHD123456789001

PCP INFORMATION
PCPNAME PCPNAME
XXX-XXX-XXXX
DOB **01-01-1900**

MEDICAID ID **12345678910**
RxBIN **004336**
RxPCN **ADV**
RxGrp **RX2339**

Electronic Payer ID **47181**


www.highmarkhealthoptions.com

Member Service **1-855-401-8251**
TTY Hearing Svc **Dial 711 or 1-800-232-5460**
24 Hr. Nurse Line **1-844-325-6251**
Behavioral Health **1-844-325-6251**
For Providers:
Eligibility IVR **1-844-325-6251**
Pre-Certification **1-844-325-6251**
Pharmacy Help Desk* **1-800-364-6331**

24 Hour Nurse Line: 24 hour access to nurses who provide health education and support.

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.

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.

CVS caremark

*Pharmacy Benefits Administrator

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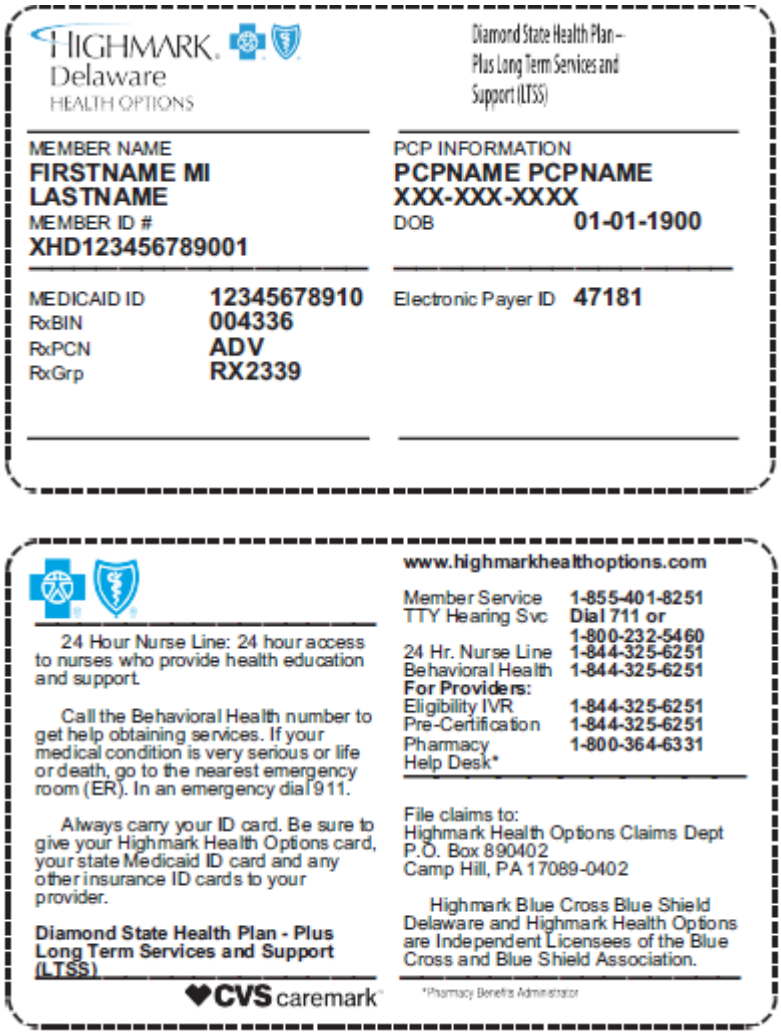
2.1 MEMBER IDENTIFICATION CARDS, Continued

SAMPLE ID CARD: ***Diamond State Health Plan – Plus Long Term Services and Support (DSHP Plus LTSS)***



HIGHMARK. Delaware HEALTH OPTIONS

Diamond State Health Plan – Plus Long Term Services and Support (LTSS)

MEMBER NAME
FIRSTNAME MI LASTNAME
MEMBER ID #
XHD123456789001

PCP INFORMATION
PCPNAME PCPNAME
XXX-XXX-XXXX
DOB **01-01-1900**

MEDICAID ID **12345678910**
RxBIN **004336**
RxPCN **ADV**
RxGrp **RX2339**

Electronic Payer ID **47181**

24 Hour Nurse Line: 24 hour access to nurses who provide health education and support.

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.

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.

Diamond State Health Plan - Plus Long Term Services and Support (LTSS)

CVS caremark

www.highmarkhealthoptions.com

Member Service	**1-855-401-8251**
TTY Hearing Svc	**Dial 711 or 1-800-232-5460**
24 Hr. Nurse Line	**1-844-325-6251**
Behavioral Health	**1-844-325-6251**
For Providers:	
Eligibility IVR	**1-844-325-6251**
Pre-Certification	**1-844-325-6251**
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*Pharmacy Benefits Administrator

HIGHMARK. Delaware HEALTH OPTIONS

CHAPTER 2: MEMBER INFORMATION

UNIT 2: MEMBER RIGHTS

IN THIS UNIT

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.

Continued on next page

2.2 MEMBER RIGHTS AND RESPONSIBILITIES, Continued

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.

2.2 CRITICAL INCIDENTS

What are critical incidents?

Critical incidents shall include, but are not limited to, the following:

- Unexpected death of a member, including deaths occurring in any suspicious or unusual, 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: 1-844-325-6251.

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.

2.2 SECOND OPINIONS

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.

2.2 INTERPRETATION SERVICES

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.

Highmark Health Options will assist providers by arranging for translation services through the Highmark Health Options Language Line when needed. Provider offices using this option will be required to demonstrate the availability of a secure and private speakerphone at the provider office to be used for this purpose.

Interpreter services for members who are hearing impaired

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.

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.

2.2 BILLING FOR MISSED SCHEDULED APPOINTMENTS PROHIBITED

Policy for missed scheduled appointments	The 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.

CHAPTER 3: COVERED BENEFITS AND SERVICES

UNIT 1: MEMBER BENEFITS

IN THIS UNIT

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 s/b consistent with all services that need "Prior Auth" – list needs to reflect accurately, If list is not updated - just list Services as "Covered" & 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	• 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) • Age 18 and older: Covered

Behavioral Health – Inpatient Mental Health and Substance Abuse Services	• Under age 18: Covered by DSCYF • Age 18 and older: Covered
Behavioral Health – Partial Hospitalization, Intensive Outpatient	Covered
Behavioral Health – Residential Treatment Facility	Covered
Blood and Plasma Products	Covered
Bone Mass Measurement (Bone Density)	Covered
Boney Impacted Wisdom Teeth	Covered
Care Management	Covered
Chemotherapy	Covered
Chiropractic Services	Adult members age 21 and older can receive one manual manipulation per day a maximum of 20 manual manipulations per calendar year without prior authorization. Members under the age of 21 require a prior authorization for chiropractic services.
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	The Delaware Medical Assistance Program covers certain dental care for children up to age 21. (Note: Dental benefit for the Delaware Healthy Children Program is up to the 19th birthday.) • Removal of bony impacted wisdom is covered
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.
Family Planning Services	Covered
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 in need of non-emergency transportation should contact LogistiCare 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	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/formulary whenever possible. The PDL/formulary is updated on a regular basis and can be accessed online at www.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 formulary/PDL supplemental formulary deletion is made that affects one of your patients, Highmark Health Options will provide you with notification within thirty (30) days prior to the change.

Additional copies of the formulary/PDL 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 formulary/PDL, 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 formulary/PDL medication is not medically advisable for a member, you must initiate a Request for Medicaid Drug Exception. Please refer to the provider section of the Highmark Health Options website at www.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 p 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.

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

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information has been communicated to Highmark Health Options from DMAP (Delaware Medical Assistance Program), 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

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 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.

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.

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 for obesity
- Drugs used to correct sexual dysfunction
- 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

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3.1 PRESCRIPTION DRUGS, Continued

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.

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 days' 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 URGENT AND EMERGENT SERVICES

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

3.1 URGENT AND EMERGENT SERVICES, Continued

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 and injury.

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

Health Options provides coverage for chiropractic services.

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 chir opractor 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

A maximum of one (1) manual manipulation per member per day and a maximum of twenty (20) manual manipulations per member per calendar year

- X-ray of complete spine only to document medical necessity for spinal subluxation; the x-ray must be taken within twelve (12) months of the date of service; coverage of spinal x-rays is limited to one set of spinal x-rays for a member in a twelve-month period.
- X-rays may be used to determine progress, if determined medically necessary by Health Options
- Physical exam to document spinal subluxation or to determine progress; once in a twelve-month period; evaluation must be demonstrated by meeting two of the following four criteria, one of which must be “b” below;
  a. Pain/tenderness evaluated in terms of location, quality and intensity;
  b. Asymmetry/misalignment identified on a sectional or segmental level;
  c. Range of motion abnormality (changes in active, passive, and

accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility);

d. Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

- One (1) PART exam per member per year to determine progress; PART exams may be conducted more frequently if determined medically necessary by Health Options
- Includes manipulation and adjunctive therapy associated with the treatment of neck, back, pelvic/sacral pain, extraspinal pain and/or dysfunction and for chiropractic supportive care
- Does not include treatment for any condition not related to a diagnosis of subluxation or neck, back, pelvic/sacral or extraspinal pain and/or dysfunction

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.

Non-covered Services

Non-covered chiropractic services include the following:

- Acupuncture
- Vitamins
- Minerals
- Supplements
- Or 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.

Prior authorization	Prior authorization is not required for the first twenty (20) manipulations within a calendar year. However, authorization and supporting clinical documentation is required for additional manipulations beyond the first twenty (20).
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 provider's records.

3.1 NON-COVERED SERVICES

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

3.2 OVERVIEW

Introduction

Highmark Health Options ensures high quality behavioral health services encompassing substance recovery care and mental health treatment within the least restrictive environment through contractual relationships with behavioral health providers able to support the member's behavioral care needs across the continuum of care.

Highmark Health Options partners with providers, community-based stakeholders, appropriate State-based case management services, and the member to develop care plans that support the member's behavioral wellness. Highmark Health Options supports the member's behavioral health wellness through care management support and oversight of behavioral health utilization to ensure quality of care and member engagement within the process.

Referring members

A Highmark Health Options provider can refer a member to the Behavioral Health Program for assessment of possible behavioral health need and assistance with behavioral health coordination of care. Providers can call 1-844-325-6257 and select the Clinical Care Coordination option.

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

1. A patient with major depressions being treated with a primary care or other physical health provider prescribing psychotropic medications to treat a patient with depression.
2. A patient who has experienced a significant life stressor and is demonstrating issues with coping.
3. A patient who has a behavioral health issue that is adversely impacting the medical treatment plan.

3.2 BENEFITS AND SERVICES

Limitation of benefit

The behavioral health benefit for members under the age of 18 is limited to thirty (30) units per calendar year. After the member has reached 30 units of behavioral health service for the calendar year, Highmark Health Options is no longer responsible for the member's behavioral health utilization until the calendar year ends.

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 State Division of Prevention and Behavioral Health Services. Members obtaining Applied Behavioral Analysis (ABA) will have their utilization managed by the Division of Developmental Disability Services.

Verifying eligibility

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.

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

Provider appointment standards

The following are standards for appointment:

- 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 admission or residential setting to a community setting, or after being seen within an emergency room for behavioral health related purposes -- 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 48 hours

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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3.2 BENEFITS AND SERVICES, Continued

Coordination between physical health and behavioral health

To support the holistic care needs of the Highmark Health Options member, providers rendering behavioral health care should identify who the member's primary care physician is and/or other physical health provider(s) actively treating the member and take steps to coordinate care plans. Physical health providers should assess if a member is receiving behavioral health care and coordinate with the behavioral health provider to coordinate care plan.

In the event the provider does not have access to appropriate consent forms needed for information sharing and collaboration, a Highmark Health Options' consent form may be used. Highmark Health Options' consent forms are available through the website. If assistance is needed with coordinating care between behavioral health and physical health, the provider may call the Highmark Health Options Behavioral Health Program at 1-844-325-6257 and select the Clinical Care Coordination option for assistance.

3.2 CRISIS INTERVENTION SERVICES

Overview

Members experiencing an acute mental health crisis are able to access the State crisis centers for support 24 hours a day. The Department of Substance Abuse and Mental Health (DSAMH) provides for crisis intervention services. These services are designed to divert members from the emergency room and unnecessary hospitalization.

More information about DSAMH crisis intervention can be found at:
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/*.

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 understanding of type of treatment and support services that will be needed.

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

NORTHERN DELAWARE	
LOCATION & HOURS	**PHONE**
Mobile Crisis Intervention Services(MCIS), Northern Delaware NCC Mobile Crisis new address: Fernhook Building at 14 Central Avenue New Castle, DE 19720 **Staffed 24 hours a day, 7 days a week** • Serves all of New Castle County and greater Smyrna in Northern Kent County. • Provides phone support, mobile outreach, and walk-in crisis services.	**1-302-577-2484;** or **1-800-652-2929** (toll free)
NET Detox 3315 Kirkwood Highway Wilmington, DE 19804 *24/7 Medically Monitored Inpatient Detoxification Treatment* *Individual and Group Counseling* *Consumer Engagement and Transition Program*	**1-302-691-0140** **Or** **1-800-359-1367**
Recovery Innovation Recovery Response Center (RRC) 659 East Chestnut Hill Rd, Newark DE 19713. 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**	**1-302-318-6070**

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3.2 CRISIS INTERVENTION SERVICES, Continued

Southern Delaware

SOUTHERN DELAWARE	
LOCATION & HOURS	**PHONE**
Mobile Crisis Intervention Services (MCIS), Southern Delaware 700 Main Street (rear entrance) Ellendale, DE 19941 **Staffed 24 hours a day, 7 days a week** • Serves all of Sussex County and Kent County south of greater Smyrna. • Provides phone support, mobile outreach, and walk-in crisis services.	**1-302-424-5550** **Or** **1-800-345-6785** (toll free)
Harrington Detox 1 East St. Harrington, DE 19952	**1-302-786-7800**
Recovery Response Center (RRC) 700 Main Street Ellendale, DE 19941 **Staffed 24/7** • Provides recovery support services and crisis stabilization services to divert people from inpatient hospitalization and communicate the message of hope and the possibility of recovery. • The RRC Living Room is a crisis alternative where people having a difficult time can become a guest where they receive comfort and hope from a team of Peer Support Specialists in recovery.	**1-302-424-5660**

3.2 BEHAVIORAL HEALTH AUTHORIZATIONS

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.

Requesting precertification

Providers requesting precertification 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 www.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

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 1-844-325-6257 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 1-855-412-7997 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 www.highmarkhealthoptions.com.

3.2 SUBSTANCE ABUSE TREATMENT AUTHORIZATIONS

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 Withdraw Management Treatment, or
- 31st day of an Intensive Outpatient Service.

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 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

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 www.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.

CHAPTER 3: COVERED BENEFITS AND SERVICES

UNIT 3: ADDITIONAL SERVICES

IN THIS UNIT

3.3 DENTAL AND VISION SERVICES

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.

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. The Highmark Health Options Member Services Department is available to provide information regarding the participation status of individual practitioners.

Members **under the age of 21** are eligible for one standard pair of eyeglasses (one frame and two lenses), or one pair of contact lenses from within Highmark Health Options network per 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.

3.3 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Overview

Highmark Health Options' Early and Periodic Screening, Diagnosis, 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.

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

Required

The required screen and tests are outlined in the provider section of the

screenings schedule

Highmark Health Options website at www.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, DIAGNOSIS, AND TREATMENT (EPSDT), Continued

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.

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.

3.3 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT), Continued

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.

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 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.

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.

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

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 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.

CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 1: HIGHMARK HEALTH OPTIONS PROVIDER NETWORK PARTICIPATION

IN THIS UNIT

4.1 INTRODUCTION TO NETWORK PARTICIPATION

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.

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; and
- Licensed dietitian – nutritionist.

Continued on next page

4.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

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

National Provider Identifier (NPI)

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 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 in one of 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).

Registering as a non-participating provider

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 rendering and billing NPIs:

Fax to: 1-800-236-8641

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

Continued on next page

4.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

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.

4.1 HOW TO PARTICIPATE IN HIGHMARK HEALTH OPTIONS' CREDENTIALED NETWORKS

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 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.

For CAQH participating practitioners

If you are already a CAQH participating practitioner with a CAQH ID, please visit 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 – 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' CREDENTIALED NETWORKS, Continued

If you are not yet registered with CAQH

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. Log in to Universal Provider Datasource to complete the CAQH credentialing application.

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.

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.

4.1 ASSIGNMENT ACCOUNTS

Overview

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.

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.

Continued on next page

4.1 ASSIGNMENT ACCOUNTS, Continued

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 – 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

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*.

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.

Continued on next page

4.1 ASSIGNMENT ACCOUNTS, Continued

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:

- 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.

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.

Continued on next page

4.1 ASSIGNMENT ACCOUNTS, Continued

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.

4.1 PROVIDER TAX IDENTIFICATION NUMBERS

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.

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.

4.1 ELECTRONIC TRANSACTION REQUIREMENTS

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.

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 Monday morning via NaviNet --which is two days earlier than receiving them by mail.

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

4.1 NON-NETWORK PROVIDER PAYMENT GUIDELINES

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.

4.1 FACILITY AND ANCILLARY PROVIDER NETWORKS

Facility network

Highmark Health Options holds contracts with acute care hospitals in Delaware's three 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 – 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,
Continued

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 www.highmarkhealthoptions.com.

CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 2: HIGHMARK HEALTH OPTIONS CREDENTIALING AND RECREDENTIALING

IN THIS UNIT

4.2 INTRODUCTION TO CREDENTIALING

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 years. This unit focuses on the credentialing process.

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.

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.

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, Continued

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.

Recredentialing

The recredentialing process is completed at least once every three 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 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 grievance 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.

4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY

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.

When are practitioners credentialed?

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

- Starting a solo practice, or
- Beginning to practice with an established network practice.

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, Continued

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; or
- Joining another established network practice of the same specialty in the **same** geographic area within six 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 – 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.*

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).

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, Continued

24/7 availability requirements

Highmark Health Options requires that all credentialed network practitioners provide coverage for members 24 hours a day, seven 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 this requirement:

- Audiologists
- Dermatopathologists
- Dieticians/nutritionists
- Occupational therapists
- Pathologists (only if working outside of the acute care setting)
- Oral and maxillofacial pathologists (only if working outside of the acute care setting)
- Physical therapists
- Preventive medicine specialists
- Read only practitioners
- Speech/language pathologists
- Non-practicing medical directors or physician advisors

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, Continued

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:

- Anesthesiology
- Dental anesthesiology
- Emergency medicine
- Nuclear medicine
- General dentistry
- Oral maxillofacial surgery
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Non-surgical podiatry
- 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.

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4.2 HIGHMARK HEALTH OPTIONS NETWORK CREDENTIALING POLICY, Continued

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.
Time frame	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 time frame, the applicant will be asked to re-sign and re-date the attestation statement.

4.2 PRACTITIONERS' CREDENTIALING RIGHTS

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.

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.

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.

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.

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.

Review Credentialing Status

Through NaviNet's 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.

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.

4.2 THE CREDENTIALING PROCESS

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 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.

If you already have a CAQH ID

If you are already a CAQH participating practitioner with a CAQH ID, please visit 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 NaviNet's 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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4.2 THE CREDENTIALING PROCESS, Continued

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. 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.

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4.2 THE CREDENTIALING PROCESS, Continued

Steps in the initial credentialing process (continued)

STEP	ACTION
3	The credentialing process will include, but is not limited to, verification or confirmation of the following: • Unrestricted licensing in the state(s) where practicing* • Drug Enforcement Agency (DEA) certificate issued by each state where practicing* • Medical education and training (as applicable)* • Board certification (if applicable)* • History of liability claims • Malpractice coverage amounts • Work history • Medicare participating status • National Practitioner Data Bank (NPDB)* • Office of the Inspector General (OIG) Medicare and Medicaid sanction lists* • Delaware Department of Health and Social Services (DHHS) Provider Disclosure List **Note:** 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. * These elements are verified through primary sources.
4	The Credentialing Department will also review the application for the following: • Ability to enroll new members • Ability to provide urgent/routine care • 24/7 coverage (if applicable) • Office hour availability of at least 20 hours/week (PCP)
5	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. **Note:** 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.
6	If the credentials file elements meet all Highmark Health Options credentialing criteria, the Medical Director will review the application and render a decision. 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.

4.2 THE CREDENTIALING PROCESS, Continued

Steps in the initial credentialing process (continued)

STEP	ACTION
7	• Upon approval of the Highmark Network Quality and Credentialing Committee or the Medical Director, practitioners will receive written notification. • 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.
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.

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.

4.2 THE RECREDENTIALING PROCESS

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.

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-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 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. Complete the CAQH online credentialing application. Be sure to add **Highmark** as an authorized plan, or grant global authorization.

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.**

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, Continued

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 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, Continued

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	Notification is sent to the practitioner that the recredentialing application is due several months prior to the end of the three-year credentialing period. • 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. • 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 www.caqh.org. Complete the online application and add **Highmark** as an authorized plan or grant global authorization.
2	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.
3	The Credentialing Committee or the Medical Director reviews the practitioner's qualifications and renders a decision.
4	The practitioner is notified of any adverse decision through a letter within sixty (60) calendar days.

4.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS

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 an *Affirmation of Medical Practice 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).

PARE Attestation

The PARE Attestation*, or Affirmation of Medical Practice 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.*

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.

4.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH CARE PROVIDERS

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.
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.
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, Continued

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.
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)

4.2 DUAL CREDENTIALING AND RECREDENTIALING AS BOTH PCP AND SPECIALIST

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.

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.”

Recredentialing

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

Provider directory

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

4.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION

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

Exceptions to board certification requirements

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:

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.

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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 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"; recredentialing applicants will be reviewed by the Medical Director.

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 (6th) 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

Overview	A provider must carry, at their own expense, the minimum required amount of malpractice insurance at all times to maintain credentialing.
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.
Requirements	All participating practitioners in Delaware are required to carry $1million per medical incident and $3 million in annual aggregate.

4.2 TERMINATION FROM THE NETWORKS

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 nay 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.

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, Continued

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, Continued

Continuation of care throughout a contract termination

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).

4.2 RECONSIDERATIONS AND APPEALS

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.

Continued on next page

4.2 RECONSIDERATIONS AND APPEALS, Continued

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.

CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 3: HIGHMARK HEALTH OPTIONS POLICIES AND PROCEDURES FOR PROVIDERS

IN THIS UNIT

4.3 MAINTAINING MEDICAL AND FINANCIAL RECORDS

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 standards

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
  - OB/GYN Practices
  - Skilled Nursing Facilities
  - Home Health Agencies
  - Behavioral Health Practitioners
- 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 each provider type will be reviewed every year on an on–going basis.

Primary Care & Specialist MRR standards

1. INDIVIDUAL RECORD*	Each member's individual medical record is maintained separately.
2. MEMBER ID*	Each page in the record contains member name of member ID number.
3. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the physician or nurse practitioner, as appropriate. PA notes are to be cosigned by physician.
5. ENTRY DATA*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PROBLEM LIST* (PCPs)	A separate problem list is current and completed for each member, including significant illness, medical conditions and health maintenance concerns are identified in the medical record.
8. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
9. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
10. MEDICAL HISTORY*	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
11. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
12. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
13. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded within 12 months of the member seeking care, or within 3 visits, whichever occurs first.

	Appropriate subjective and objective information is recorded for presenting complaints.
14. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
15. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the PCP that is consistent with finding for each member visit.
16. PLAN OF ACTION /THERAPIES /TREATMENT/ PRESCRIBED REGIMENS	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.
17. FOLLOW-UP VISIT	There is a notation concerning follow-up care, including encounter forms with notations concerning follow-up care or visits; return times noted in weeks, months or PRN; or to see a specialist.
18. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
19. CONSULTATION, REFERRAL AND SPECIALIST REPORTS	Review for under/over utilization of consultation. Notes from consultations, lab, and x-ray reports with the ordering physician's initials or other documentation signifying review, explicit notations in the record and follow-up plans for significantly abnormal lab and imaging study results.
20. CONTINUITY / COORDINATION OF CARE* (PCPs)	Chart contains consult reports, inpatient and ER discharge summary, records transferred from prior care and documentation from skilled nursing facilities and home health care agencies.
21. COMMUNICATION WITH PCP* (Specialists)	There is documentation of communication with the PCP, as well as suggested plan of treatment.
22. DISCHARGE SUMMARY	In the member was in the hospital, there is a discharge summary signed and dated within 30 days. Hospital discharge summaries should be present for all hospital admissions which occur while the patient is enrolled in the plan, and prior admissions as necessary.
23. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
24. INFLUENZA AND PNEUMOCOCCAL VACCINES	For members 65 and older and at a high risk record must indicate immunization

	status for influenza and pneumococcal. Documentation needs to also include past immunization history and of PCP's intent to immunize.
25. ADVANCE DIRECTIVE*	There is annual documentation of whether the member has executed an advance directive (ages 21 and older), and if "yes" a copy must be included in the medical record. If age 65 and older, need documentation of annual review.

OB/GYN MRR standards

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the physician or nurse practitioner, as appropriate. PA notes are to be cosigned by physician.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
6. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
7. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
8. PAST MEDICAL HISTORY	Documentation at the first OB/GYN visit includes serious injuries, operations, illnesses, LMP, and past pregnancies of the member. Family history includes inquiry regarding genetic disorders.
9. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
10. TOBACCO USER	Documentation that the member was advised to quit.
11. TOBACCO USER	Documentation that nicotine replacement medications were discussed.
12. TOBACCO USER	Documentation that smoking cessation strategies were discussed.
13. ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	Documentation of assessment of second hand smoke is included in the record whether the member smokes or not.

14. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
15. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded which includes BP, breast, abdomen, external genitals, vagina, cervix, rectal, pap (if appropriate), inquiries regarding existing or prior infections (e.g. STD, HIV, TB, etc.)
16. PRENTAL DEPRESSION SCREEN	Documentation of prenatal depression screening is required on all OB members.
17. POSTPARTUM DEPRESSION SCREEN	Documentation of postpartum depression screening is required on all OB members.
18. RISK ASSESSMENT	Documentation of a risk assessment is required.
19. LAB & OTHER STUDIES	• For gyne patients, lab tests and other diagnostic studies are ordered as medically indicated and are clearly documented in the chart. • For OB patients, labs are ordered according to Gateway's Routine and High Risk Prenatal Guideline.
20. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the Specialists that is consistent with findings for each member visit.
21. PLAN OF ACTION / TREATMENT	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Options and risks of treatments discussed as appropriate.
22. RETURN VISIT	There is a notation concerning follow-up care (i.e. to call with problems, to return within a specific time frame or as needed, or to see their PCP).
23. FIRST PRENATAL VISIT	Documentation of the first prenatal visit in the first trimester or within 42 days of enrollment.
24. POSTPARTUM VISIT	Documentation of postpartum visit 21-56 days post-delivery.
25. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
26. CONTINUITY / COORDINATION OF CARE*	Chart contains notations of any instructions/education given to member regarding follow-up visits, care, treatment, medication, diagnostic and therapeutic services where the member was referred for services by the specialists. Home Health, skilled nursing facility, hospital

	discharges, and outpatient/ambulatory surgery reports need to be included in the record.
27. COMMUNICATION WITH PCP*	There is documentation of communication with the PCP, as well as suggested plan of treatment.
28. CONSULTS / XRAYS / LAB / IMAGING STUDIES	Reports are filed in the chart and have been reviewed and initialed by physician.
29. CONSULTS ANY ABNORMAL RESULTS	Consultation and abnormal study results have explicit notation in the record of follow-up plans.
30. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
31. IMMUNIZATION HISTORY	There is documentation of Rubella, Varicella, and TDAP.
32. INFLUENZA VACCINE	Documentation that the member was offered influenza vaccine or referral to PCP/health agencies for the vaccine. (October through March)
33. COUNSELING FOR NUTRITION, FOLIC ACID AND OBESITY	Documentation that counseling was offered.
34. COUNSELING FOR DOMESTIC VIOLENCE	Documentation that counseling for domestic violence was offered.
35. POSITIVE PRENATAL DEPRESSION	Documentation that the member who screened positive for depression received counseling, or treatment and/or referral.
36. POSITIVE POSTPARTUM DEPRESSION	Documentation that the member who screened positive for depression received counseling, or treatment and/or referral.

Skilled nursing facility MRR standards

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the licensed professional (as appropriate). NA notes are to be cosigned by the supervising professional. All verbal orders are cosigned by the physician.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the originator.
6. MEDICATION LIST*	Medication listed must be up-to-date.

7. MEDICATIONS ADMINISTRATION*	All administered medications are recorded when given. Initials have corresponding complete signature.
8. PRESCRIBED MEDICATION*	Prescribed medications, including dosage and frequency that the member takes, are documented on a medication list.
9. PRN MEDICATIONS*	Documentation of effectiveness of PRN medications is noted.
10. ANNUAL MEDICATION REVIEW*	At minimum, medications are reviewed annually.
11. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
12. NURSING HISTORY*	Includes serious injuries, operations and illnesses, and secondary conditions and any other disorders that impact on the member's care. Documentation must include member's current condition, mental status, functional status and reason for admission to the skilled nursing facility.
13. PAST MEDICAL HISTORY*	Documentation in the record includes the physician's history, member's physical exam, and the current need for care.
14. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older. This includes tobacco, chew, pipe and/or snuff.
15. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
16. WORKING DIAGNOSIS	There is a clearly documented diagnosis related to services being rendered, whether from the hospital from which the members was discharged or from the physician referring the member directly to the skilled nursing facility.
17. DIETARY RESTRICTIONS	Documentation of nutritional assessment is required.
18. SPECIFIC CARE AND SERVICES*	Documentation includes skilled observations/assessment, intervention, treatments and updated orders.
19. INTERDISCIPLINARY TEAM	There is documentation of an interdisciplinary team approach to care.
20. SPECIFIC PLAN OF CARE*	Physician orders must be in writing and present in the record. Documentation of a completed medical plan developed in collaboration with the member. Plan of

	care must include any functional limitations.
21. FUNCTIONAL ASSESSMENT	Documentation of a functional assessment annually at a minimum.
22. DISCHARGE PLANNING*	There is documentation of discharge planning and a discharge summary within 30 days of discharge.
23. SOCIAL SERVICE	There is evidence of social service intervention or documentation by an appropriate staff member with suitable training or experience, and who is responsible for making integration arrangements so the member can return back into the community, transfer to a home, or transfer to another facility where appropriate level of care is available.
24. CONTINUITY & COORDINATION OF CARE*	There is documentation of relevant information to the PCP/ordering physician on a regular basis, and at discharge.
25. PAIN ASSESSMENT	There is comprehensive pain assessment annually.
26. COMMUNICATION WITH THE PCP	If the PCP is not the admitting physician, there is documentation of communication with the PCP on record prior to discharge.
27. DISCHARGE SUMMARY	There is evidence of discharge summary to the PCP.
28. DNR	There is documentation of the members' wishes for DNR status.
29. MEDICALLY APPROPRIATE CARE*	There will be no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality.
30. OBSERVATIONS	There is a notation on every tour of duty on critically/acutely ill members, and every 30 days on other members.
31. NUTRITIONAL SERVICES*	There is documentation of nutritional needs and responses at least quarterly.
32. ADVANCE DIRECTIVE	There is annual documentation of whether the member has executed an advance directive (ages 21 and older). If "yes," a copy must be included in the medical record. Advance care plans include advance directive, actionable medical orders, living wills and surrogate decision maker.

Home health agency MRR standards

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer,

	telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the licensed professional (as appropriate). NA notes are to be cosigned by the supervising professional. All verbal orders are cosigned by the physician.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the originator.
6. MEDICATION LIST*	Prescribed medications including dosage and frequency, and over-the-counter medications that the members take on a regular basis are documented on a separate medication list.
7. MEDICATION REVIEW	Documentation that medication names, doses, timing and method of administration are reviewed with the member/guardian/parent. Documentation must be signed and dated by the member/guardian/parent.
8. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
9. MEDICAL HISTORY*	Includes serious injuries, operations and illnesses, and secondary conditions and any other disorders that impact on the member's care. Documentation must include why the member is being treated by the home health agency.
10. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older. This includes tobacco, chew, pipe and/or snuff. If a smoker, documentation that smoking cessation strategies were discussed.
11. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
12. INITIAL ASSESSMENT AND REASSESSMENT	A complete initial assessment is in the record, including physical, psychosocial/mental health history, as well as complete pain assessment. Reassessment every 6 months in collaboration with the member minimally, and/or when the need arises.

13. DIETARY RESTRICTIONS	Documentation of nutritional assessment is required.
14. SPECIFIC CARE AND SERVICES	Documentation includes skilled observations/assessment, intervention, treatments, interdisciplinary team communication, and updated orders.
15. FUNCTIONAL ASSESSMENT	Documentation of a baseline functional assessment.
16. SPECIFIC PLAN OF CARE	Physician orders must be in writing and present in the record. Documentation of a completed medical plan developed in collaboration with the member is present in the record.
17. INDIVIDUALS INVOLVED IN CARE	There is a notation of other individuals or agencies involved in the members' care and, if indicated, an assessment of the ability of non-professionals to provide safe, appropriate care.
18. CONTINUITY & COORDINATION OF CARE*	If the members' care is being transferred to another agency or a facility, there is documentation the information was shared.
19. COMMUNICATION WITH PCP*	There is documentation of relevant information to the PCP/ordering physician on a regular basis.
20. DISCHARGE SUMMARY*	There is documentation of relevant information to the PCP/ordering physician/facility that includes members' conditions and follow-up care needs.
21. CONSENT FOR TREATMENT*	There is consent for treatment signed by the member/guardian/patient.
22. OB MEMBERS	Documentation includes a notation of a scheduled postpartum visit and/or offer of assistance in scheduling appointment.
23. CONSULTS/X-RAYS/LABS/IMAGING STUDIES	Documentation of all reports is current and present in the record.
24. ABNORMAL STUDY RESULTS	All abnormal reports are called/e-mailed/faced to the ordering physician, and the physician has signed and dated the reports.
25. MEDICALLY APPROPRIATE CARE	There will be no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality.
26. HOME ENVIRONMENT	The medical record contains a notation regarding home environment's physical suitability (condition, cleanliness, crowding), or adaptability (adequate space for necessary equipment/stairs for care and services that are being provided).

Behavioral Health practitioners MRR standards

27. EDUCATION	Members should be educated about their specific health care needs and encouraged to initiate appropriate self-care measures to promote their own health. Notation also includes members' ability to perform needed care.
28. ADVANCE DIRECTIVE	There is annual documentation of whether the member has executed an advance directive (ages 21 and older). If "yes," a copy must be included in the medical record. Advance care plans include advance directive, actionable medical orders, living wills and surrogate decision maker.

1. INDIVIDUAL RECORD*	Each member's individual medical record is maintained separately.
2. MEMBER ID*	Each page in the record contains member name or member ID number.
3. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID*	All entries include the responsible clinician's name, professional degree and relevant identification number, as appropriate.
5. ENTRY DATE*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PSYCHOLOGICAL ASSESSMENT / PRESENTING PROBLEM LIST*	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 prominently noted, documented and revised in compliance with protocol. A complete developmental history is documented for children and adolescents.
8. MEDICATION LIST*	Prescribed medications, dosages of each and prescription fill/refill dates are documented on a separate medication list.
9. ALLERGIES OR ADVERSE REACTIONS*	In addition presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart.

	An absence of allergies should also be clearly documented in the record.
10. TOBACCO USE	Use/nonuse of tobacco products is documented on members age 11 and older.
11. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
12. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
13. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the practitioner that is consistent with findings for each member visit. The appropriate DSM diagnosis code is documented.
14. PLAN OF ACTION /THERAPIES /TREATMENT/ PRESCRIBED REGIMENS	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. Progress notes include follow-up, and which describe the member's strengths and limitations in achieving the treatment plan are documented. Informed consent for medication and the member's understanding of the treatment plan are documented.
15. PREVENTIVE SERVICES	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.
16. CONSULTATION / REFERRALS / CONTINUITY / COORDINATION OF CARE*	The medical record reflects continuity and coordination of care between the primary clinician, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Notes from consultations with ordering physician's initials or other documentation signifying review and detailing plans moving forward are to be included. Discharge summaries are included, if applicable. Documentation should include member's consent or declination to release information to the member's Primary Care Physician (PCP).
17. DISCHARGE PLAN	If the member terminates treatment, documentation of a discharge plan is present.

18. CARE MEDICALLY APPROPRIATE	Documentation in the medical record describes the services provided to the member, and demonstrates that medically appropriate care is being provided. Record reflects that members who become homicidal, suicidal or unable to conduct activities of daily living, receive immediate and relevant interventions (behavioral and pharmacotherapeutic), and are promptly referred to the appropriate level of care.
19. CONFIDENTIALITY	Each record contains copies of confidentiality statements and copies of all signed consents to release information.

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.

Confidentiality and HIPAA requirements

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

Notification Rule,") and HITECH for the protection of PHI and PII, and for the notification of individuals, appropriate official bodies, and the media in theevent 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:

Confidentiality and HIPAA requirements (continued)

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, and164.
   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.

4.3 MAINTAINING MEDICAL AND FINANCIAL RECORDS, Continued

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 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.

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
PCPs & Specialists	
Emergency Services	Immediately 24 hours a day, 7 days a week
Routine appointment (including EPSDTs)	Within three weeks
Emergency condition appointment	Same day
Urgent Care	Within two calendar days
Maternity Care Providers	
Initial appointment in first trimester	Within three weeks
Initial appointment in second trimester	Within seven calendar days
Initial appointment in third trimester	Within three calendar days
Initial appointment for high risk pregnancy	Within three calendar days
Behavioral Health Providers	
Care for a non-life-threatening emergency	Within 6 hours
Potential suicidal individual	Within 1 hour or call Mobile Crisis Intervention Team or call police
Urgent care	Within 48 hours
Initial visit for routine care	Within 7 business days
Follow-up routine care	Within 3 weeks

Office wait times

Office wait times should not exceed one 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

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.

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).

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/

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.

4.3 SECOND OPINIONS

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.

4.3 ADVANCE DIRECTIVES

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.

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.

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 www.highmarkhealthoptions.com.

4.3 MEMBER NON-COMPLIANCE

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

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.

Determination of effective date

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

Exception

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

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.

4.3 FRAUD AND ABUSE

Overview

Highmark Health Options has a comprehensive policy for handling the prevention, detection, and reporting of fraud and abuse. 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

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 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.

Fraud and Abuse Tip line

If fraud or abuse is suspected, it is your responsibility to immediately notify Highmark Health Options by calling the Fraud and Abuse Tip line at 1-844-325-6256.

Examples of provider fraud and abuse

Some common examples of provider fraud and abuse are:

- Billing or charging Medical Assistance recipients for covered services
- Billing for services not rendered
- 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 and abuse

Some common examples of member fraud 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

4.3 OVERPAYMENTS

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.

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 a listing of claims is not provided, Highmark Health Options cannot guarantee that the claims will not be audited again, for the same reason. It is imperative that Providers provide an explanation of the Self Audit and the claims they represent. 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.

Highmark Health Options Payment Integrity Audit

Highmark Health Option’s Payment Integrity team will, from time to time, 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.

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 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 30 calendar days of Highmark Health Option’s request or sooner.

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

4.4 PRIMARY CARE PRACTITIONER ASSIGNMENTS

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.

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 25th 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 25th 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, Continued

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.

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 25th of the month, the new effective date will be the first of the following month. When the request is received on or after the 25th 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.

4.4 PRIMARY CARE PRACTITIONER RESPONSIBILITIES

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"

PCP responsibilities

The primary care practitioner is responsible for 24 hour a day, seven day 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.*

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

Overview

Highmark Health Options' Early and Periodic Screening, Diagnosis, 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.

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.

Required screens schedule

The required screen and tests are outlined in the provider section of the Highmark Health Options website at www.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.

Continued on next page

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

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.

4.4 OBSTETRICS AND GYNECOLOGY

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 family planning services.

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.

4.4 MATERNITY CARE PROVIDERS

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.

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 www.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

4.4 MATERNITY CARE PROVIDERS, Continued

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.

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.

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.

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.

CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 5: SPECIALTY, ANCILLARY, AND FACILITY PROVIDERS

IN THIS UNIT

4.5 SPECIALTY CARE PRACTITIONERS

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 days a week.

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.

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.

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.

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.

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 Heath 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 appropriate non-emergent, basic life support code and the modifier HH.

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

Continued on next page

4.5 ANCILLARY PROVIDERS, Continued

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.

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.

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.

4.5 HOSPITAL/FACILITY SERVICES

Authorization requirements

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 1-844-325-6254.

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.

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.

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.

Continued on next page

4.5 HOSPITAL/FACILITY SERVICES, Continued

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

4.5 HOSPITAL/FACILITY SERVICES, Continued

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.

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.

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.

Claims submission

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

Continued on next page

4.5 HOSPITAL/FACILITY SERVICES, Continued

On-site care 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.

CHAPTER 5: HEALTH CARE MANAGEMENT

UNIT 1: MEDICAL MANAGEMENT

IN THIS UNIT

5.1 MEDICAL NECESSITY CRITERIA

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

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, Diagnosis, 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

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; or
  - Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
  - 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; or
  - 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.

5.1 PRIOR AUTHORIZATION

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.

Information needed when calling for authorization

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 8-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

Continued on next page

5.1 PRIOR AUTHORIZATION, Continued

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 (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
- Cochlear and Auditory Implants
- Cosmetic Procedure
- Durable Medical Equipment purchase and rentals $500 or greater
- Electroconvulsive Therapy (ECT)
- Enteral/Parental Therapy
- Experimental or Investigational 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)

5.1 PRIOR AUTHORIZATION, Continued

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

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

Services requiring authorization (continued)

- 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
- Vericose 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

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.

Continued on next page

5.1 PRIOR AUTHORIZATION, Continued

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.

Continued on next page

5.1 PRIOR AUTHORIZATION, Continued

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 non-participating providers always require authorization.

Information needed when ordering durable medical equipment

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, Continued

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. Highmark Health Options will coordinate the necessary arrangements between the primary care practitioner and the nursing facility to provide the member with continuity and coordination of care. At the time the skilled nursing facility services are approved, the Highmark Health Options Utilization Management reviewer will provide the name, phone number, and fax number of the primary care practitioner in order to fax any discharge instructions to ensure coordination of discharge services.
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 outpatient therapist or 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.
Acute inpatient rehabilitation facility	Should a member be in need of admission to an acute inpatient rehabilitation facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the rehabilitation facility should contact the Highmark Health Options Utilization Management Department at 1-844-325-6251 for new requests. For ongoing reviews, please contact your assigned reviewer.
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.

Continued on next page

5.1 PRIOR AUTHORIZATION, Continued

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.

Behavioral health services

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

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 1-888-245-2049 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 of the pharmacist feels the member is in emergency need of medication.

5.1 HOME HEALTH CARE

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 1-844-325-6251.

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.

Continued on next page

5.1 HOME HEALTH CARE, Continued

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, hourly charge
G0152	Services of occupational therapist in home health setting, each 15 minutes	0432	Occupational therapy hourly charge
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	0442	Speech/language pathology, hourly charge
G0300	Home health LPN Visit	0552	Skilled nursing, hourly charge
G0299	Home Health RN Visit	0572	Home health aide (Home Health), hourly charge
G0156	Services of home health aide in home health setting, each 15 minutes. **Note:** This code shall be used for **all** home health aide services including home health aide provided to Assisted Living Waiver clients.		

5.1 PRIVATE DUTY NURSING SERVICES

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.

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.
6. If caregiver's ability to render care is limited, detail and provide documentation.
7. If a caregiver's availability to render care is limited, detail and provide documentation.

5.1 TRANSITIONS FROM HOSPITAL TO HOME

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 1-844-325-6251, Monday through Friday from 8 a.m. to 5 p.m.

5.1 MEDICAL CLAIMS REVIEW

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

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.

CHAPTER 5: HEALTH CARE MANAGEMENT

UNIT 2: CASE MANAGEMENT AND CARE MANAGEMENT

IN THIS UNIT

5.2 HIGHMARK HEALTH OPTIONS LIFESTYLE MANAGEMENT PROGRAM

What is the Highmark Health Options Lifestyle Management Program?

The Highmark Health Options Lifestyle Management Program includes population-based disease management programs that focus on improving the health status of Highmark Health Options members with chronic conditions. The Lifestyle Management Program provides patient education and self-empowerment for medication, diet, and lab adherence to reduce inpatient and emergency room utilization.

Program benefits and support

The program will provide the following member benefits and support:

- Welcome letter with information about their condition/disease and about the Lifestyle Management Program. The brochure includes information about how members can reach a clinical care coordinator.
- 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 Care Coordinator outreach

Clinical Care Coordinators 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.

5.2 HIGHMARK HEALTH OPTIONS LIFESTYLE MANAGEMENT PROGRAM, Continued

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.

5.2 ASTHMA PROGRAM

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.

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.

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.

5.2 DIABETES PROGRAM

Overview

The Highmark Health Options Lifestyle Management Program's Diabetes Program emphasizes education and personal responsibility for diabetes management to reduce the need for hospitalizations, emergency room visits, and to prevent diabetic complications.

Eligibility

All adult and pediatric Highmark Health Options members with Type 1 or Type 2 diabetes are eligible for this program. Members are automatically enrolled once they are identified with diabetes; however, they are able to opt out if they choose.

Program benefits

The program will help your patient:

- Learn how to keep blood sugars under control to help prevent diabetic complications
- Understand what tests/lab tests are needed to manage diabetes
- Know what is normal and what is not
- Understand when to call the doctor

Additional information and referrals

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

5.2 CARDIAC PROGRAM

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.

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.

5.2 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PROGRAM

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.

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.

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.

5.2 MOM MATTERS PRENATAL PROGRAM

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.

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.

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.

5.2 HIGHMARK HEALTH OPTIONS CARE MANAGEMENT PROGRAM

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.

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.

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

5.2 COMPLEX CASE MANAGEMENT PROGRAM

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:

- Members with multiple medical conditions
- Members with a complex medical history
- Members that need assistance to become more self-reliant managing their health care.
- Members who are taking Makena (17-P)
- Members who are diagnosed with Crohns/Colitis who have not seen a GI Provider

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.

CHAPTER 5: HEALTH CARE MANAGEMENT

UNIT 3: COMPLAINTS, GRIEVANCES, AND APPEALS

IN THIS UNIT

5.3 PROVIDER COMPLAINT PROCEDURES

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, www.highmarkhealthoptions.com , under Provider Forms & Reference Materials. Completed forms may be e-mailed to ProviderComplaints@HighmarkHealthOptions.com. Fax completed form to 1-844-221-1569.

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

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 22278
Pittsburgh, PA 15222

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.**

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:

- 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.
- 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 90 day time frame above. You will not receive an additional 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.

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 60 calendar days of notification.

Registering a Second Level Appeal (Formal Appeal)

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.

5.3 FILING GRIEVANCES AND APPEALS ON BEHALF OF A MEMBER

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 grievance and appeals process.

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 form a provider to help with their grievance or appeal review

5.3 GRIEVANCES

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:

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 www.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

Continued on next page

5.3 GRIEVANCES, Continued

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 22278
Pittsburgh, PA 15222-0188
Phone: 1-844-325-6251; Fax: 1-844-325-3435

When should I file a grievance?

A grievance must be filed within ninety (90) days of the date of the occurrence.

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.

5.3 APPEALS

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 provider services in a timely manner
- The failure of Highmark Health Options to act within 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:

What should I do if I have an appeal?

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.

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 www.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 22278
Pittsburgh, PA 15222-0188
Phone: 1-844-325-6251; Fax: 1-844-325-3435

Continued on next page

5.3 APPEALS, Continued

When should I file an appeal?

An appeal must be filed within ninety (90) days from the date of the "Notice of Action" letter.

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 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.

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.

Continued on next page

5.3 APPEALS, Continued

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.

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.*

Expedited ("Fast") Appeals

The following guidance on filing for an expedited appeal is given to members in the Member Handbook:

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.

Continued on next page

5.3 APPEALS, Continued

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' 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.

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.

5.3 STATE FAIR HEARINGS

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.

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)

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 120 calendar days of the date on the notice of resolution upholding the adverse benefit determination.

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.

Continued on next page

5.3 STATE FAIR HEARINGS, Continued

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 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 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.

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.

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.

5.3 DISPUTE RESOLUTION

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.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

CHAPTER 5: HEALTH CARE MANAGEMENT

UNIT 4: QUALITY MANAGEMENT

IN THIS UNIT

5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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 date 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.

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

5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW, Continued

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.

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;

5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW, Continued

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

5.4 QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAM OVERVIEW, Continued

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.

5.4 CLINICAL QUALITY

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.

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 www.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.

5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS

Overview Gateway Health 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. Gateway Health'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 Gateway Health'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 Gateway Health 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 30-days of receipt for non-compliant standards.

The Provider Relations Representative will conduct a follow-up visit within 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.

Gateway Health 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.

5.4 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT EVALUATIONS, Continued

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)				

	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 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, Continued

	ENVIRONMENTAL ASSESSMENT STANDARDS	MET	NOT MET	N/A	COMMENTS
20	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: a) Identifies how the laboratory, diagnostic procedures and/or consultation appointments are tracked b) Identifies staff responsible to ensure results are returned to the office c) Identifies when and how staff match test results with patient's chart d) Identifies how the reviewer (practitioner) notifies how the results should be handled. (PCP)				
21	There is a process in place to ensure patients are notified of abnormal results. (ALL)				
22	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: a) OB: High fever, persistent vomiting/diarrhea, bladder infection, increased swelling. b) GYN: Unusual vaginal discharge or vaginal bleeding post-menopause/hysterectomy, or detection of breast mass/breast lump. (OB-GYN)				
23	Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days: a) OB: Small amount of swelling in ankles or hands, sciatica pain (including hip/leg pain), respiratory infection, UTI symptoms b) GYN: Increased menstrual cramps. (OB-GYN)				
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, Continued

	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 SERVICE QUALITY

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

6.1 OVERVIEW

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.

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).

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.

6.1 ELIGIBILITY AND ENROLLMENT

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.

Medical eligibility determination

The State performs the initial and annual Level of Care Assessment for those being considered for the LTSS Level of Care benefits.

Financial eligibility determination

The State performs the financial assessment for those being considered for the DSHP Plus LTSS Program.

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.

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 Hospital LOC criteria and who receive HCBS as an alternative.

6.1 LONG TERM SERVICES AND SUPPORT (LTSS) BENEFITS

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
- 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 Money Follows the Person (MFP) 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.

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6.1 LONG TERM SERVICES AND SUPPORT (LTSS) BENEFITS, Continued

Money Follows the Person (MFP)

Money Follows the Person (MFP) is a program to assist eligible members to transition from a Nursing Facility to the community. Members who wish to participate must meet the federal definition of an "eligible individual" transitioning from a "qualified institution" to a "qualified residence."

- **Eligible Individual:**
  - Signed Informed Consent Form;
  - Enrolled in DSHP for a minimum of one (1) day;
  - Resided in "Qualified Institution" for a minimum of ninety (90) consecutive days;
  - None of the 90 consecutive days were Medicare; and
  - Transitions directly from Nursing Facility to Community.
- **Qualified Institution:** Includes the following licensed and Medicaid Certified Facilities:
  - Hospital;
  - Nursing Facility (NF); and
  - Intermediate Care Facility for Persons with Mental Retardation (ICF/MR).
- **Qualified Residence:**
  - Home owned or leased by member or family member;
  - Apartment;
  - Community-based residence with no more than four (4) unrelated residents.

6.1 LONG TERM SERVICES AND SUPPORT (LTSS) BILLING AND REIMBURSEMENT

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.

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 www.highmarkhealthoptions.com.

6.1 ADDITIONAL LTSS PROGRAM INFORMATION

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.

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.

6.1 ADDITIONAL LTSS PROGRAM INFORMATION, Continued

Critical incident reporting (continued)

- 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.

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 or the LTSS Support Center at 1-844-325-6258.

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 eight (8) hours 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 302-577-1406 for residents of a long term care facility that have a complaint about their rights.
- Division of Long Term Care and Residents Protection (DLTCRP) 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 DLTCRP.

6.1 ADDITIONAL LTSS PROGRAM INFORMATION, Continued

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 1-800-292-9582.

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.

CHAPTER 6: LONG TERM SERVICES AND SUPPORT (LTSS)

UNIT 2: CASE MANAGEMENT FOR LONG TERM SERVICES AND SUPPORT (LTSS)

IN THIS UNIT

6.2 PLAN OF CARE

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.

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.

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 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.

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6.2 PLAN OF CARE, Continued

Coordination with local departments and agencies

Based upon the member's needs as identified during the Needs Assessment, the member selects their top three 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.

6.2 LONG TERM SERVICES AND SUPPORT (LTSS) PROVIDERS

Overview

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

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.

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.

Role of the Case Manager

The Case Manager is responsible for assessment, planning, coordination, implementation, and evaluation as follows:

FUNCTION	DESCRIPTION
Assessment	**<u>Information to Members:</u>** • At the time of the initial assessment, the Case Manager provides and reviews with each member an *LTSS Education Materials* booklet. 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. **<u>Member Needs:</u>** • 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. • 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. • Member Needs are assessed upon Intake and at each on-site review. **<u>Member Safety:</u>** • 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. • During each assessment, the Case Manager completes an evaluation of the member's physical environment (Home Safety Monitoring Checklist) to ensure member safety. • Member Safety is assessed upon Intake and at each on-site review.

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6.2 LONG TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS, Continued

Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
Planning	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. 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. 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.
Coordination	• 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. • Based upon the member's needs as identified during the Needs Assessment, the member selects their top three 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.
Implementation	• 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 fourteen (14) calendar days of the on-site visit during which the need for the service was determined. • 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.

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6.2 LONG TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS, Continued

Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
Evaluation	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: **<u>On-site Reviews:</u>** • 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); • At least every ninety (90) calendar days for a member receiving Home and Community-Based Services (HCBS), including members residing in Assisted Living Facilities; • 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, • For members in the Money Follows the Person (MFP) program, in accordance with the monitoring requirements in the State's MFP Protocol. **<u>Nursing Facility Case Conferences:</u>** • 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. **<u>Monthly Contacts:</u>** • 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. **<u>Significant Change:</u>** • The Case Manager conducts an on-site review within ten (10) business days following notification of a significant change. A significant change is considered: ▪ Member has had a change of placement type; or, ▪ Member has had a change in needs or circumstances that might require a revision to the member's Plan of Care.

CHAPTER 6: LONG TERM SERVICES AND SUPPORT (LTSS)

UNIT 3: LONG TERM SERVICES AND SUPPORT (LTSS) PROVIDER CONTRACTING AND CREDENTIALING

IN THIS UNIT

6.3 LTSS CREDENTIALING PROCESS

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/recredentialed 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.

LTSS credentialing process

Once a Provider is approved to participate in the network, they must be recredentialed 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 recredentialed 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;

Continued on next page

6.3 LTSS CREDENTIALING PROCESS, Continued

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.

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.

Continued on next page

6.3 LTSS CREDENTIALING PROCESS, Continued

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.

Continued on next page

6.3 LTSS CREDENTIALING PROCESS, Continued

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.

6.3 LTSS CREDENTIALING CRITERIA

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, Continued

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, Continued

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) (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 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
HCBS Providers: 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
Adult Day Services	Adult Day Service License from Department of Health, Office of Health Facilities and Certification (OHFLC)
Assisted Living Facility	Assisted Living Facility (ALF) or Nursing Home Facility
Cognitive Services	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.
Day Habilitation	Day Habilitation Day Program licensed by the Division of Developmental Disabilities Services
Independent Activities of Daily Living (Chore) Services	Trained Housekeeper
Nutritional Supplements for Individuals Diagnosed with HIV/AIDS Not Covered in State Plan	DME license or other retail/wholesale supplier business license
Respite (Inpatient)	ALF or Nursing Home Facility
Specialized Medical Equipment Not Covered in State Plan	DME license or other retail/wholesale supplier business license
Home Delivered Meals	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.*
Personal Emergency Response System (PERS)	Nursing Home, Hospital, or general business license, FCC & UL certifications (if provided)
Minor Home Modifications	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

7.1 GENERAL INFORMATION

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

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.

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.

7.1 GENERAL INFORMATION, Continued

Hospital services

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.

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

Questions?

Any questions concerning billing procedures or claim payments can be directed to Highmark Health Options Provider Services Department at 1-844-325-6251.

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 (DHHS) or allowed per medical review determination by Highmark Health Options. Correct coding (procedure, diagnosis, HCPCS) must be submitted for each service rendered and, non-specific 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.

7.1 GENERAL INFORMATION, Continued

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 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, Continued

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.

7.1 COORDINATION OF BENEFITS

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.

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. 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) 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.

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.

7.1 COORDINATION OF BENEFITS, Continued

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; however, if the EOB is submitted after Highmark Health Options has paid as the primary insurance plan, Highmark Health Options shall return overpayment to DHSS.

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.

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.

7.1 CLEAN CLAIMS

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

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

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.

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.

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 180-day follow-up period from the date on the remittance will be denied.

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.

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.

7.1 ELECTRONIC CLAIM SUBMISSION

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 Health Options Payer ID#

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

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, Continued

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.

7.1 ELECTRONIC REMITTANCE ADVICE (ERA)

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: www.highmarkhealthoptions.com.

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.

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/.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

7.1 EPSDT CLAIM FORMAT REQUIREMENTS

CMS-1500 paper format requirements

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:

YO - Other	**YV** - Vision	**YH** - Hearing
YM - Medical	**YD** - Dental	**YB** - Behavioral

EDI format requirements

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:

YO - Other	**YV** - Vision	**YH** - Hearing
YM - Medical	**YD** - Dental	**YB** - Behavioral

Timely Filing for EPSDT Claims is 120 days from the Date of Service

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/en-us/Documents/periodicity_schedule.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

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, Diagnosis, 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.

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 *Refund Form* or a letter that contains all of the information requested on this form. This form is available in the *Forms and Reference Material* s 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

7.1 HIGHMARK HEALTH OPTIONS REIMBURSEMENT

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.

Missed scheduled appointments

Providers are prohibited from billing Medicaid members who miss scheduled appointments. A missed appointment is not a distinct reimbursable Medicaid service.

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 Patient's Sex	Required Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Reserved for NUCC Use	Not Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Reserved for NUCC Use	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 c. Other accident	Required, If Applicable
10d	Claim Codes (Designated by NUCC)	Not Required (see instructions for EPSDT claims instructions)
11	Insured's Policy Group or FECA Number	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 Signature	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

Field #	Description	Requirements
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.

Form #	CMS 1500
Form Title	Health Insurance Claim Form
Revision Date	2012-02-01
O.M.B. #	0938-1197
O.M.B Expiration Date	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 Recipient Number acceptable for electronic claims)
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.

Form #	CMS 1450
Form Title	UB-04 Uniform Bill
Revision Date	2007-03-01
O.M.B. #	0938-0997
O.M.B Expiration Date	2019-08-31

CHAPTER 7: CLAIMS, BILLING, AND REIMBURSEMENT

UNIT 2: HIGHMARK HEALTH OPTIONS SPECIFIC BILLING GUIDELINES

IN THIS UNIT

7.2 SPECIALTY/FEE-FOR-SERVICE PROVIDERS

Encounter submission

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 carrier

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.

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 Payment to the Highmark 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

Payment:

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 calculations

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, Continued

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

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.

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.

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, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES

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.

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.

Payment

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

7.2 OBSTETRICAL CARE SERVICES

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.
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.
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.

7.2 SURGICAL PROCEDURE SERVICES

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.
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.
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 physicians name, the **AS modifier** indicating this was a physician's assistant **must** be included on the claim.

7.2 ANESTHESIA SERVICES

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 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.

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.