HIGHMARK. HEALTH OPTIONS

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

# Provider Manual

## 2023

# About Highmark Health Options

Highmark Health Options is a Highmark Blue Cross Blue Shield Delaware affiliate and administered managed care organization (MCO). Highmark Health Options is contracted with the State of Delaware's Department of Health and Social Services (DHSS) to provide health services to eligible individuals. Medicaid covers 1 in 5 Americans as a state-run health insurance program. Highmark Health Options collaborates with providers and regulators to improve health outcomes, simplify the health care experience, and ensure affordability. Highmark Health Options helps more than 140,000 members receive the care and services they need to live healthier and more independent lives. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing or very little for their health coverage.

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

## Overview

This manual contains information about procedures and policies that apply to providers in the Highmark Health Options network. This manual, combined with other administrative requirements as defined or described in the applicable provider agreement, supplements and is made part of their provider agreement. This manual offers access to information on processes such as filing claims, researching patient benefits, and joining the network. It also includes important contact information on how to communicate with Highmark Health Options. This manual was designed to be a provider's primary reference guide to Highmark Health Options.

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| **Critical Incidents** | See a Critical Incident? Report it. |
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| **Highmark Health Options Community Support** | Community Support Search Tool |
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| **Provider Faxes** | Updates and Notices |
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# Highmark Health Options contact information

| Contact | Mailing Address | Numbers | Hours |
|---|---|---|---|
| **Appeals and Grievances** | Highmark Health Options<br>Appeals and Grievances<br>P.O. Box 106004<br>Pittsburgh, PA 15230 | 1-844-325-6251 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Authorizations (24/7 secure voicemail for inpatient admissions notification)** | | 1-844-325-6251 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Behavioral Health** | | 1-844-325-6257<br>Authorization requests: 1-844-325-6251 | Mon.–Fri., 8 a.m. to 8 p.m. |
| **Care Coordination** | | 1-844-325-6251<br>Fax: 1-855-501-3903 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Case Management** | | 1-844-325-6251<br>Fax: 1-855-476-4206 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Claims inquiries and administrative reviews (provider disputes)** | Highmark Health Options<br>Attn: Claims Review<br>P.O. Box 890402<br>Camp Hill, PA 17089-0402 | 1-844-325-6251<br>Claim Dispute faxes: 1-833-202-9390<br>Medical Appeal faxes: 1-833-841-8075 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Clinical Provider Appeals** | Highmark Health Options<br>Attn: Provider<br>Appeals Department<br>P.O. Box 22278<br>Pittsburgh, PA 15222 | 1-844-325-6251<br>Fax Member Appeals: 1-412-255-4503<br>Fax Medicaid Providers: 1-855-501-3904 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **EPSDT** | | 1-844-325-6251<br>Fax: 1-855-501-3903 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **For the hearing impaired** | | TTY# 711 or 1-800-232-5460 | |
| **Fraud, Waste, and Abuse** | Highmark Health Options<br>Attn: FWA<br>120 Fifth Avenue<br>FAPHM-052C<br>Pittsburgh, PA 15222<br>SIU_HHO@highmark.com | 1-844-325-6256 | Mon.–Fri., 8 a.m. to 5 p.m. |

| Contact | Mailing Address | Numbers | Hours |
|---|---|---|---|
| **Legal and Regulatory** | Highmark Health Options<br>Attn: Legal and<br>Regulatory Affairs<br>P.O. Box 890419<br>Camp Hill, PA 17089-0419 | | |
| **Member eligibility check (IVR)** | | 1-844-325-6251 | 24/7 |
| **Member Services**<br>• **DSHP and DHCP**<br>• **DSHP Plus LTSS** | Highmark Health Options<br>Member Mail<br>P.O. Box 890419<br>Pittsburgh, PA 15222-0188 | 1-844-325-6251<br>1-855-401-8251 | Mon.–Fri., 8 a.m. to 8 p.m.<br>(24/7 Nurse Line for after-hours support) |
| **NaviNet** | Providers can access NaviNet 24/7 for inquiries about eligibility and benefits, claim status, authorization requests, provider and facility directory searches, and provider information updates. | | |
| **ONAF** | | 1-844-325-6255<br>Fax: 1-855-501-3903 | |
| **Outpatient (OP) Utilization Management Home Health** | | Fax: 1-855-451-6667 | |
| **Payment Integrity and Overpayments** | Highmark Health Options<br>Payment Integrity<br>120 Fifth Avenue<br>FAPHM-052C<br>Pittsburgh, PA 15222 | Overpayment letters only:<br>ProviderSelfAudits@highmark.com | |
| **Pharmacy Services** | Highmark Health Options<br>Pharmacy Services<br>P.O. Box 890419<br>Camp Hill, PA 17089-0419 | 1-844-325-6251<br>Fax: 1-855-476-4158 | Mon.–Fri., 8 a.m. to 7 p.m. |

- **Pharmacy Network:** Highmark Health Options pharmacy network includes national chains and local independent pharmacies.
- **Preferred Drug List (PDL) and Supplemental Formulary:** Highmark Health Options offers coverage for drugs listed on the DHSS PDL and an additional Supplemental Formulary of drug classes not covered by the PDL. Any revisions to the PDL are owned by DHSS and the Delaware Medicaid Pharmaceutical and Therapeutics (P&T) Committee. The Highmark Health Options Pharmacy and P&T Committee approves revisions to the Supplemental Formulary on an as-needed basis.
- Updates and the Drug Exception form are posted on the Highmark Health Options website under Medication Information.

| Contact | Mailing Address | Numbers | Hours |
|---|---|---|---|
| **Privacy** | Highmark Health Options<br>Privacy Office<br>P.O. Box 1991<br>Wilmington, DE 19889 | | |
| **Private Duty Nursing (PDN) Utilization Management** | | Fax: 1-855-445-4239 | |
| **Provider Complaints** | HHO-ProviderComplaints@highmark.com | Fax: 1-888-778-8121 | |
| **Provider Information Management** | Highmark Blue Shield<br>P.O. Box 898842<br>Camp Hill, PA 17089-8842 | Fax: 1-800-236-8641 | |
| **Provider Relations** | HHO-ProviderRelations@highmark.com | Fax: 1-844-477-9420 | Mon.–Fri., 8 a.m. to 5 p.m. |
| **Provider Services** | Highmark Health Options<br>Provider Mail<br>P.O. Box 890419<br>Camp Hill, PA 17089-0419 | 1-844-325-6251 | Mon.–Fri., 8 a.m. to 5 p.m. |

**Provider Service Representatives** are available to answer questions and provide information. When contacting Provider Services, have the following information available:

- Patient's name and Highmark Health Options ID number.
- Type of service and date of service, if available.
- Claim number, if applicable.
- Provider's name and provider number.

# Vendor contact information

| Vendor | Phone |
|---|---|
| Change Health | 1-866-577-3536 |
| Davis Vision | 1-800-999-5431 |
| eviCore | 1-888-564-5492, 7 a.m. – 7 p.m. EST |
| United Concordia Dental | 1-800-372-2022 |

# State of Delaware contact information

| Department Contact | Mailing Address | Numbers |
|---|---|---|
| **Claims information for Delaware Medical Assistance Program** | Gainwell<br>P.O. Box 909<br>Manor Branch<br>New Castle, DE 19720-0909 | 1-800-999-3371<br>Fax: 1-302-454-7603 |

**Additional information about the Delaware Medical Assistance Program (DMAP) can be found on their website.**

## Crisis intervention services

| Northern Delaware | | |
|---|---|---|
| **Name and Hours** | **Address** | **Phone** |
| Mobile Crisis Intervention Services (MCIS), Northern Delaware<br>• Staffed 24/7.<br>• Serves all of New Castle County and greater Smyrna in Northern Kent County.<br>• Provides phone support, mobile outreach, and walk-in crisis services. | Fernhook Building<br>14 Central Ave.<br>New Castle, DE 19720 | 1-302-577-2484 or<br>1-800-652-2929 |
| NET Detox<br>• Staffed 24/7; medically monitored inpatient detoxification treatment.<br>• Individual and group counseling.<br>• Consumer Engagement and Transition program. | 3315 Kirkwood Highway<br>Wilmington, DE 19804 | 1-302-691-0140 or<br>1-800-359-1367 |
| Recovery Innovations Recovery Response Center (RRC)<br>• Staffed 24/7.<br>• Offers facility-based crisis services for adults experiencing mental health or substance abuse crisis. | 659 E. Chestnut Hill Rd.<br>Newark, DE 19713 | 1-302-318-6070 |

| Southern Delaware | | |
|---|---|---|
| **Name and Hours** | **Address** | **Phone** |
| Mobile Crisis Intervention Services (MCIS) Southern Delaware<br>• Staffed 24/7.<br>• Serves all of Sussex County and Kent County south of greater Smyrna.<br>• Provides phone support, mobile outreach, and walk-in crisis services. | 700 Main St.<br>(rear entrance)<br>Ellendale, DE 19941 | 1-302-424-5550 or<br>1-800-345-6785 |
| Recovery Innovations Recovery Response Center (RRC)<br>• Staffed 24/7.<br>• 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.<br>• The RRC Living Room is a crisis alternative where people having a difficult time can become a guest and receive comfort and hope from a team of Peer Support Specialists in recovery. | 700 Main St.<br>Ellendale, DE 19941 | 1-302-424-5660 |
| Mental Health Emergencies<br>DPBHS 24-Hour Mobile Response and Stabilization Services | Services are available to any child physically present in the state who is age 18 and younger and is determined to be at imminent danger to self or others as a result of a mental health disorder. | 1-800-969-HELP |

# Provider responsibilities

## Advance directives

Highmark Health Options providers should ask patients age 21 and older whether they have executed advance directives (Spanish version), also known as a Living Will. Providers are responsible for educating patients about advance directives when asked and determining if the patients have executed one. Providers should maintain the forms in the patient's medical record.

# Billing responsibilities

## Billing patients for covered services

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

## Billing for missed scheduled appointments

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.

## No-show policy

The following Member No-Show policy has been instituted to help providers manage Highmark Health Options members who violate office policy in regard to scheduled appointments:

> Highmark Health Options will recognize the individual practitioner's written office policy in regard to scheduled appointments. 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 PCP's practice.

## Payment for services

Payment by Highmark Health Options is considered payment in full. Providers may directly bill patients when noncovered services are provided; however, before providing such services, the provider must notify the patient in writing that:

- The service(s) to be provided are not covered.
- They have the right to appeal an adverse coverage decision.
- They will be financially liable for services if the appeal is not successful.
- That Highmark Health Options will not pay for nor be liable for those services.
- The patient must then sign the agreement, thereby accepting responsibility.

## Compliance requirement

Providers sign an agreement that requires compliance with Highmark Health Options policies and procedures for the detection and prevention of fraud, waste, and abuse (FWA). Such compliance may include referral of information regarding suspected or confirmed FWA to Highmark Health Options, and submission of statistical and narrative reports regarding FWA detection activities.

# Confidentiality and HIPAA requirement

All network providers agree to abide by all Highmark Health Options policies and procedures regarding member confidentiality. All personal health information (PHI) and personally identifiable information (PII) about Highmark Health Options members is subject to state and federal statutory and regulatory privacy standards.

The provider must have an established program to:

- Effectuate full compliance with all applicable state and federal privacy and breach notification laws for the protection of PHI and PII.
- Notify individuals, appropriate official bodies, and the media in the event of a breach of PHI or PII.

Providers will maintain a privacy compliance and breach notification program in accordance with industry best practices. Under these policies, the provider must:

- Ensure that a patient's individually identifiable health information as defined by HIPAA (necessary for treatment, payment, or health care operations [TPO]) is released to Highmark Health Options without seeking the consent of a patient. In addition, providers will assure that PHI for TPO will be made available to the DMMA, Department of Health, Department of Insurance, or Highmark Health Options business associates for use without patient 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 HIPAA requirements and limits its requests to the amount of PHI that is minimally necessary to meet the TPO function. This information includes PHI used for:
  - Accreditation surveys
  - Appeals
  - Case management
  - Claims payment
  - Continuity and coordination of care
  - Disease management
  - Medical management
  - Medical record audits
  - Quality assessment and measurement
  - Quality of care issues
  - Treatment
- Ensure that patient records are considered privileged information and, therefore, are protected by obligations of confidentiality.
- Conduct environmental security of confidential information and monitor practice and provider sites. Provider sites must comply with the Environmental Assessment standards that require patient records to be protected from public access.
- Make medical records available for all patient visits for established patients.
- Provide the highest level of protection and confidentiality of patients' medical and personal information used for any purposes in accordance with federal and state laws or regulations, including:
  - HIPAA, 45 CFR Parts 160, 162, and 164.
  - 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.

  - The 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.
  - 42 U.S.C. § 1396a(a)(7) – State plan for medical assistance.
  - 42 C.F.R. § 431.300 et seq. – Medical Assistance – Safeguarding Information on Applicants and Recipients.
- Provide the patient, or a patient's representative, including head of household, legal guardian, or durable power of attorney, access to view and receive copies of the medical record upon written request. Patients are entitled to one free copy of their medical records. The fee for additional copies should not exceed the costs of time and materials used to compile, copy, and furnish such records. Records should be available within 10 calendar days of the written request and follow the specific procedures of the provider.

## Continuity and coordination of care requirements

Specialists, hospitals, and skilled nursing facilities must ensure compliance with the continuity and coordination of care requirements. Providers can do this by ensuring that all discharge summaries and progress reports are reported back to the patient's primary care physician (PCP).

## Critical incidents

Providers must report critical incidents to Highmark Health Options. Highmark Health Options identifies, tracks, reviews, and analyzes critical incidents to address potential and actual quality-of-care and health-and-safety issues. Reported critical incidents helps develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care for patients.

Critical incidents include:

- Inappropriate or unprofessional conduct by a provider.
- Medication error.
- Severe injury sustained by a patient.
- Suspected physical, mental, or sexual mistreatment, abuse, or neglect.
- Suspected theft or financial exploitation.
- Unexpected death of a patient, including deaths occurring suspiciously, unusually, or suddenly when the deceased was not attended by a provider.

There are various types of critical incidents that providers should report to Highmark Health Options if they have knowledge of or witness:

- Abuse:
  - Includes inflicting pain, injury, mental anguish, unreasonable confinement, or other cruel treatment. Abuse can be:
    - Emotional
    - Physical
    - Sexual
- Financial exploitation:
  - Occurs when a caregiver improperly uses funds intended for the care or use of a patient. These funds are paid to the patient or caregiver by a government agency. Exploitation can include:
    - Forgery
    - Fraud or coercion
    - Unauthorized use of banking accounts, cash, or government cards

- Neglect:
  - When patients are unable to care for themselves or obtain needed care, placing their health or life at risk.
  - May be unintended, resulting from the caregiver's lack of ability to provide or arrange for the care the patient requires.
  - May be due to the intentional failure of the caregiver to meet the patient's needs.
- 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 term also covers any behavior by an adult or older adolescent toward 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.

## Reporting critical incidents

Providers are required to:

- Know the process for identifying and reporting critical incidents.
- Notify Highmark Health Options within one business day of the occurrence or knowledge of a critical incident.

Highmark Health Options immediately reports this information to DMMA and the appropriate investigative agency and cooperates with DMMA and any investigative agency in documenting, investigating, and addressing actual and suspected critical incidents within 24 hours of receipt.

In addition, Highmark Health Options provides a full written report to DMMA within 30 days of identifying a critical incident. The report includes:

- Information regarding the incident
- The findings
- Any corrective actions

Highmark Health Options reports critical incidents to the following investigative agencies:

- Adult Protective Service (APS)
- Community Services Program within the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
- Delaware Family Services (DFS)
- DHSS Long-Term Care Office of the State Ombudsman (OSO)
- Division of Health Care Quality (DHCQ)
- Office of Health Facilities Licensing and Certification (OHFLC)

Highmark Health Options collects and analyzes data regarding critical incidents, tracks and identifies trends, identifies root causes, and makes necessary changes to prevent reoccurrence.

# Cultural competency

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, and Berger, 2009). Highmark Health Options encourages providers to consider cultural and linguistic differences when treating patients.

# CLAS standards

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. Developed in 2000 by the 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 about CLAS standards can be obtained on the Health and Human Services website.

# Emergent services and urgent care

An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity 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:

- Serious jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

The following conditions are examples that most likely require emergency treatment:

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

The Member Handbook informs patients of general instances when emergency care is typically **not** needed:

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

## Emergency admission at an out-of-network hospital

When a patient requires hospitalization, the Highmark Health Options policy is to have the service rendered in an in-network hospital. However, at times it may not be possible to follow this policy when a patient presents to the closest medical facility due to a medical emergency. When the patient's medical condition requires an admission to an out-of-network hospital, the patient will be transferred within 24 hours of stabilization or when appropriate. Utilization Management staff will concurrently monitor the patient's condition by communicating with the hospital's Utilization Review staff and the attending provider to determine when the patient is medically stable for transfer. Highmark Health Options will coordinate all necessary transportation.

## Hospital guidelines for triage

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

## Urgent care

The definition of urgent care is medically necessary treatment that is needed within 48 hours to prevent deterioration to the patient's health. Examples are:

- Fever
- Nonspecific pain
- Persistent rash
- Recurring high-grade temperature

## Follow-up care after an emergency department visit

All follow-up care after an emergency department visit must be coordinated through the PCP. Members are told to contact their PCP for a referral for follow-up care for:

- Bandage change
- Cast check
- Further testing
- Stitches removal

## Home health care

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

- High-risk pregnancy nurse visit
- Home health aide
- Hospice
- Infant care (after initial postpartum visits)
- Occupational therapy
- Physical therapy
- Skilled nursing
- Social services
- Speech therapy

# Credentialing policy

Providers (e.g., physicians and any applicable allied health professionals) must be credentialed by Highmark on behalf of Highmark Health Options to participate in the network in Delaware.

## Board certification

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 to be credentialed in the Highmark Health Options network. The online provider directory indicates that providers are board certified if they are currently certified in a specialty category.

Effective Aug. 15, 2016, the board certification and exception policy requirements are applicable to all providers. Board certification is required in each specialty for which the provider is requesting to be credentialed. Providers who were in the network prior to Aug. 15, 2016, will be grandfathered in and processed as routine. These exceptions do not apply to providers practicing in emergency departments, urgent care centers, and medical aid units (MAUs), where board certification is required.

Highmark Health Options recognizes the following boards for certification:

- America Board of Medical Specialties (ABMS)
- American Academy of Oral and Maxillofacial Radiology (AAOMR)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Multiple Specialties in Podiatry (ABMSP) (Applies if ABPM or ABFAS boards are not available to provider.)
- American Board of Oral and Maxillofacial Surgery (ABOMS)
- American Board of Podiatric Medicine (ABPM)
- American Osteopathic Association Board (AOA)

Effective Aug. 15, 2016, all applicable providers 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:

- **Exception 1**: Completed training prior to Dec. 31, 1987:
  - Providers must have graduated from an accredited medical osteopathic, podiatric medical, or dental school; completed an applicable accredited residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which they practice; and completed training prior to Dec. 31, 1987.
- **Exception 2**: Board eligibility period:
  - Providers must have completed an approved, applicable residency or fellowship in the specialty in which they practice and complete board certification by Dec. 31 of the sixth year of completing approved, applicable residency training or contiguous subsequent fellowship training in the specialty in which they practice.
- **Exception 3**: Rural exception:
  - The ZIP code of the practice location is determined by Quest analytics software as a rural location, and providers have completed an ACGME/AOA-approved, applicable residency or fellowship in the specialty of practice.

## Emergency medicine requirements

Providers requesting to be credentialed in the specialty of emergency medicine must have board certification in emergency medicine, family medicine, internal medicine, pediatrics, or general surgery. If board certified or eligible in the above list, the provider must maintain current ACLS and PALS. The provider must have ACLS, PALS, and ATLS if working in an emergency department.

**Exception**: Providers who are in the Highmark-defined board eligibility period must have completed an approved, applicable residency or fellowship in the specialty in which they practice and completed board certification by Dec. 31 of the sixth year of completing approved, applicable residency training or contiguous subsequent fellowship training in the specialty in which they practice. Providers practicing in urgent care centers and MAUs must maintain current ACLS and PALS if they are not board certified in emergency medicine. Providers will also need ATLS if they are practicing in an emergency department.

# Language services

Providers 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. Providers are obligated to take reasonable steps to provide meaningful access to services for patients with limited English proficiency, including provision of translator services. Provider offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA) in adherence to Section 504, the Rehabilitation Act of 1973, and related federal and state requirements. Providers are expected to arrange and coordinate interpreter services to assist patients who are hearing impaired.

Highmark Health Options can provide information in a variety of languages and various formats, including large print, Braille, or audio format at no cost to patients. Encourage patients to call Member Services and Highmark Health Options will help locate resources upon request.

# Maintaining medical and financial records

Providers will develop and maintain a medical record for each patient in accordance with the requirements established by federal and state laws.

Medical records will include reports from referring providers, discharge summaries, records of emergency care received by patients, prescriptions written by the provider, and other information as federal and state laws and regulations or accreditation standards require. Providers will maintain medical records for a minimum of 10 years from the date of patient discharge or 10 years from the patient's date of majority, whichever is later. Providers will maintain a master history of appointments for a minimum of one year from the date of service to allow for monitoring and investigation of grievances related to scheduling.

# Malpractice insurance requirement

Providers 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 provider 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 coverage levels required by Highmark Health Options. Providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark Health Options at least 30 days in advance of any reduction or termination of malpractice coverage.

## Malpractice coverage requirements

Providers are required to carry $1 million per medical incident and $3 million in annual aggregate insurance.

# Mandatory provider screening and enrollment

In compliance with 42 CFR 438.602 and 42 CFR Part 455, subparts B and E and the 21st Century Cures Act, all current and prospective providers who wish to participate and continue to participate in HHO's provider network will need to be screened and enrolled in the Delaware Medical Assistance Program (DMAP). Screening refers to CMS-required activities for enhanced Program Integrity functions to reduce fraud, waste, and abuse in the Delaware Medicaid Program and includes the completion of a provider disclosure statement. Screening is required at initial enrollment, reenrollment, revalidation, and when adding or changing service locations.

Existing providers will receive a letter from DMAP with important information about the enrollment of each practice and service location. Duplicate addresses for practice and service locations for a NPI and taxonomy combination will need to be reviewed and registered or unregistered. Failure to complete the screening and enrollment process in the timeline provided may result in claims denials and termination from HHO's network.

Effective March 1, 2022, new providers seeking to join the HHO network will need to enroll with DMAP prior to participating in the credentialing process. Providers may find additional information about the screening and enrollment process on the DMAP website in the DHSS Provider Portal.

# Office wait times

Office wait times should not exceed one hour. Providers should notify patients as soon as possible of any delays. If a delay results in more than 90 minutes, the provider should offer the patient a new appointment.

# On-site care coordinators

Providers agree that Highmark Health Options may place a clinician on-site at in-network facilities to perform utilization management, case management, or quality improvement. The on-site clinician assists with coordination of the discharge plan and arranging additional services, including special diagnostics, home care, and durable medical equipment (DME). In certain instances, it may be necessary for the clinician to reach out to a patient's parent or guardian to perform these activities. The clinician must receive all clinical information on the inpatient stay as well as personal information regarding family members or caregivers in a timely manner to allow for assessment, clinical decision-making, and development of an appropriate plan of care. Providers should provide clinicians with a designated workspace where they can use a laptop computer to gain access to Highmark Health Options systems.

# 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 patients. Highmark Health Options prohibits the following marketing activities mandated by DHSS:

- Providers must avoid inadvertently providing advice to 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 respond only to questions from a patient about the coverage for which they have in-network status.
- Providers must submit to the Compliance Officer for prior written approval of any and all materials used to advise patients of the Medicaid health plans with which they have agreements. Failure to obtain such prior written approval may result in DHSS-imposed sanctions or other liabilities for which the provider shall be solely responsible.

# Provider disclosure statement

All providers must complete the Provider Disclosure Statement as required by CFR Title 42, Part 422, Subpart B. These disclosures allow Highmark Health Options to ensure program integrity by preventing excluded persons from participating in the Medicaid program. Providers may complete and submit the Provider Disclosure Statement on the DMAP website.

# Verifying eligibility

Every provider is responsible for verifying a patient's eligibility with Highmark Health Options before providing services. Verifying a patient's eligibility along with any applicable authorization will help ensure proper reimbursement for services. Providers can use the following to verify a patient's eligibility:

- **Highmark Health Options ID card:** The card itself does not guarantee that the individual is currently enrolled with Highmark Health Options. ID cards are not required to be returned when patients are no longer eligible for Highmark Health Options. ID cards are issued upon enrollment. New ID cards may be distributed if patients change their PCP or request a new card.
- **Highmark Health Options IVR system**: Available 24/7 by calling 1-844-325-6251. Providers should give the following information when prompted to verify patient eligibility:
  - NPI number
  - Member's 12-digit ID number

# Provider responsibilities

The following sections outline the various provider types and their particular responsibilities. It should be noted that this is not an all-inclusive list of the types of providers. Provider Services and Provider Account Liaisons (PALs) are available to answer any questions you may have.

## Primary care providers

Highmark Health Options follows the State's rules in defining PCPs as a:

> *Specific practitioner, practitioner group, or a CRNP operating under the scope of their licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating, and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a Medical Assistance consumer.*

In service areas that include institutions with teaching programs, PCP teams:

- Are composed of residents and a supervising faculty physician may serve as a PCP.
- Include certified nurse midwives or advanced nurse practitioners who, at the patient's discretion, may serve as the point of first contact for the patient.

In both instances, PCP teams must be organized to ensure continuation of care (COC) to patients and must identify a lead physician within the team for each patient. The lead physician must be an attending provider and available to provide direct service to the patient should the patient request it, and services must be provided under the lead physician's NPI.

### PCP responsibilities

PCPs are responsible for 24/7 coordination of assigned and attributed patients' health care needs and access to services provided by hospitals, specialty care providers, ancillary services, and other health care services. Highmark Health Options expects PCPs to play an active role in coordinating the health care services needed by patients, including scheduling annual visits. For DSHP Plus LTSS members, PCPs must engage with the member's case manager at least quarterly and as needed to address member care issues.

Highmark Health Options is able to provide comprehensive and high-quality care in a cost-effective manner by focusing all patient medical decisions through the PCP.

### PCP role in verifying eligibility and panel status

PCPs verify eligibility by using the methods outlined in the above section.  In addition, PCPs can confirm a patient's panel status by consulting their panel list to verify that a particular patient is assigned to them. The panel list is distributed around the first of every month. PCPs should check the panel list each time a patient is seen in the office.

### PCP assignments

A PCP agrees to accept a minimum number of Highmark Health Options members, as specified by their provider agreement, to their panel at each authorized office location without regard to their status as a new or existing patient to that practice or location. Each family member has the freedom to choose any in-network PCP. A PCP must regularly review the roster of patients assigned to the PCP's practice to ensure that appropriate care coordination activities are enforced.

### PCP assignment changes

Patients may change PCPs if a satisfactory relationship does not develop. PCPs will not seek to transfer a patient from their practice based on the patient's health status. However, a patient whose behavior would preclude delivery of optimum medical care may be transferred from the provider's panel.

PCP changes are processed under the following guidelines:

- If the request is received prior to the 25th of the current month, the new effective date will be the first of the following month.
  - Example: A patient's request is received on Oct. 7; the member's effective date with the new PCP will be Nov. 1.
- If 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.
  - Example: A patent's request is received on Oct. 28; the member's effective date with the new PCP will be Dec. 1.
- Immediate change requests:
  - An exception to the above guidelines can be made if the situation warrants.

## Patient noncompliance

### Written transfer requests

If inappropriate behavior or patient noncompliance with no-show policies should occur and the PCP desires to transfer a patient, the PCP must send a letter requesting that the patient be removed from their panel. The PCP must send the letter to Provider Services. The letter must:

- Include the patient's name and Highmark Health Options ID number.
- State the no-show policy and the patient who has violated the policy.

### Process and determination

All written requests are forwarded to Enrollment within 48 hours of receipt. Enrollment notifies the original provider in writing when the transfer has been completed. If the patient requests not to be transferred, the PCP will have the final determination regarding continuation of primary care services.

### Emergency care during the transfer process

PCPs are required to provide emergency care for any patient who is dismissed from their practice until the patient's transfer is complete.

## Second opinions

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

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

### Second surgical opinions

Second surgical opinions may be requested by Highmark Heath Options, the patient, the patient's caregiver, or the PCP. When requesting a second surgical opinion, providers issue a referral to a consulting provider who:

- Is in a practice other than that of the attending provider or the provider who rendered the first opinion.
- Possesses a different tax identification number than the attending provider.

## Specialty care providers

Specialty care providers must verify eligibility prior to rendering services to ensure reimbursement. Eligibility and benefits verifications are available 24/7.

### PCP coordination care with specialty providers and patients

Highmark Health Options members may receive specialty care services from in-network providers. A PCP referral is not required, but is encouraged, for members to receive specialty care services.

### Specialists functioning as primary care providers

A specialist may function as a PCP for a patient with complex illnesses or conditions. For a specialist to function as a PCP, the specialist must be approved by the Highmark Health Options Medical Director.

## Transportation

### Emergent transport

Highmark Health Options considers emergent transportation as transportation that allows immediate access to medical or behavioral health (BH) care and lack of access could precipitate a medical or BH crisis for the patient. Either an in-network or out-of-network ambulance provider may render emergent transportation without an authorization. Emergent situations are:

- Acute care to acute care BH facility.
- Emergency department to acute care or BH facility.
- Emergency department to emergency department.
- Hospital to hospital when a patient is being discharged from one hospital and being admitted to another.

### Nonemergent transport

Nonemergent transport is covered by the State for transportation to health care visits via ModivCare for DSHP members only, and is not covered for DHCP members. Authorization for nonemergent ambulance transportation is required. Highmark Health Options considers nonemergent transportation as transportation for a patient who does not require immediate access to medical or BH care, and if care is not provided the result would not be a medical or BH crisis. Nonemergent transportation scenarios are:

- Ambulance transport from home to a PCP office.
- Ambulance transport to home upon discharge.

Providers should contact in-network ambulance providers to render nonemergent 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 patient returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization. The originating facility should assume the cost for this type of transport even if, for unforeseen circumstances, the patient 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 authorization.

## Behavioral health services

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

### BH crisis intervention services (CIS)

The goal of CIS is the prevention of unnecessary or inappropriate hospitalization of a person experiencing severe symptoms of a mental illness or substance-related problem. CIS staff can better assess the patient's environment, support systems, and current level of functioning by providing services in the community and gaining a clear understanding of the type of treatment and support services that will be needed. The crisis staff works in conjunction with every police department throughout the state, providing training in police academies and 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.

## Maternity care providers

### Intake visit

The first visit with an obstetrical patient is considered the intake visit. If a patient becomes a Highmark Health Options member during her pregnancy, the first visit as a Highmark Health Options member is considered the intake visit.

### Obstetrical needs assessment form (ONAF)

At the intake visit, an ONAF (PDF) must be completed and faxed to Highmark Health Options immediately following completion, and then filed in the patient's medical record. The purpose of the ONAF is to help identify risk factors early in the pregnancy and engage in care management. The ONAF is not a claim.

### ONAF incentives

Highmark Health Options must receive the ONAF to process the claim for the outreach bonus and the intake visit. Two incentive payments are offered:

- **Outreach bonus**: $100 for an intake visit with completed form during the first trimester (99429-HD).
  - Procedure codes for first trimester outreach (99429-HD) and initial risk assessment (T1001-U9) must be reported together on the same claim form to allow the bonus payment. The appropriate evaluation and management codes (99202-99215) 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 and modifiers referenced above are not reported on the same claim. The ONAF 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**: $50 for an intake visit with completed form (T1001-HD).
  - If the patient's first prenatal visit does not occur within the first trimester, code 99429-HD should not be billed.

- At the intake visit, an ONAF must be completed and faxed to 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 nonstress tests and ultrasounds

Fetal nonstress 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 and gynecology

### PCP services

Highmark Health Options permits PCPs to perform routine gynecological exams and Pap tests and provide care during pregnancy if they are so trained and their office is equipped. PCPs who provide obstetrical services must bill in accordance with Highmark Health Options guidelines and may provide obstetrical services only to those patients assigned to their panel.

## Long-term services and supports (LTSS) providers

Delaware's Diamond State Health Plan Plus Long-Term Services and Supports (DSHP Plus LTSS) program provides enhanced benefits to DSHP Plus members who qualify for long-term services and supports. 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. Highmark Health Options serves as a managed care organization operating the DSHP Plus LTSS Program.

The primary goals of DSHP Plus LTSS are to:

- Expand access to and utilization of cost-effective home- and community-based services (HCBS) alternatives to nursing facility care.
- Improve coordination of all Medicaid services (acute, behavioral, and LTSS).
- Increase HCBS options.
- Provide streamlined, timely access to LTSS.
- Rebalance LTSS spending (i.e., funding spent on institutional services versus HCBS).
- Serve more people with existing LTSS funds.

# Appointment standards and referrals

Each year Highmark Health Options evaluates the number and geographic distribution of network providers in relationship to the location of its members. Highmark Health Options takes into consideration the special and cultural needs of members and its network providers.

## Provider appointment standards

Highmark Health Options members are expected to receive an appointment with a qualified primary care or specialty provider based on the following standards:

| Type of Care | Time Frame Requirement |
|---|---|
| **PCPs and Specialists** | |
| Emergency services | Immediately 24/7 |
| Routine appointment (including EPSDT) | Within 3 weeks |
| Emergency condition appointment | Same day |
| Urgent care | Within 2 calendar days |
| **Maternity Care Providers** | |
| Initial appointment in first trimester | Within 3 weeks |
| Initial appointment in second trimester | Within 7 calendar days |
| Initial appointment in third trimester | Within 3 calendar days |
| Initial appointment for high-risk pregnancy | Within 3 calendar days |

## Behavioral health provider appointment standards

Highmark Health Options members are expected to receive an appointment with a qualified behavioral health provider based on the following standards:

| Type of Care | Time Frame Requirement |
|---|---|
| **Behavioral health (BH)** | |
| Emergency services | Within 24 hours of request |
| Immediate treatment for patients experiencing a behavioral health crisis (including mobile team response based on the acuity of the patient) | Within 1 hour of request |
| Follow-up appointment after discharge from inpatient, residential, or BH emergency condition | Within 2 business days |
| Routine outpatient services with a non-prescribing clinician for an initial assessment | Within 7 calendar days of request |
| Non-emergency outpatient services for prescribing clinician services | Within 3 weeks of request |

All BH/SUD treatment providers are encouraged to identify a patient's PCP to coordinate care planning. In addition, providers are encouraged to determine if a patient is receiving BH/SUD treatment services.

In the event the provider does not have access to appropriate release of information form(s) that are needed for information sharing and collaboration, the Highmark Heath Options release of information form may be used. If assistance is needed to coordinate care between BH and physical health, the provider may call Care Management for assistance.

### BH crisis intervention services (CIS)

Division of Substance Abuse and Mental Health (DSAMH) offers a continuum of CIS. These services are located throughout Delaware in CIS Centers, Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) assessment and referral centers, recovery response centers, and emergency departments. CIS staff are available 24 hours a day to assist people age 18 and older with severe personal, familial, 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.

DSAMH crisis intervention provides additional information about their services. Patients age 18 and younger who are experiencing an acute mental health crisis can access CIS through the Division of Prevention and Behavioral Health Services.

In addition to these services, BH 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.

## LTSS alternative service wait times

Highmark Health Options LTSS members are expected to receive LTSS alternative services based on the following standards:

| Service | Time Frame Requirement |
|---|---|
| Minor home modification | No more than 60 calendar days |
| Home delivered meals | No more than 10 calendar days |
| Personal care attendant services for new members | No more than 10 calendar days |
| Personal care attendant services for members currently placed in a nursing facility but either will be or has been transitioned to the community | Immediately upon authorization |

## EPSDT screenings and services

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated program for patients age 20 and younger who are eligible for Medical Assistance. Through the EPSDT program, pediatric patients are eligible to receive medical, dental, vision, and hearing screenings to ensure they receive all medically necessary services without regard to Medical Assistance covered services. PCPs are required to ensure all patients age 20 and younger have timely access to EPSDT services and are responsible for ensuring continuation of care for all patients due to receive EPSDT services. PCPs are to arrange for medically necessary follow-up care after a screening or an encounter.

## Provider responsibilities for EPSDT

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 providers. Providers need to use a reliable validated and standardized tool to make a detection of a child's problems in development, behavior, social-emotional skills or mental health status, and make appropriate referrals to address any identified problems. Providers should follow the guidelines outlined by Bright Futures Periodicity Schedule, which outlines each age bracket in which a child/teen should be seen and what screenings are done at each interval. PCPs agree to coordinate ongoing monitoring of care provided by other providers. Also, PCPs agree to notify Highmark Health Options when a problem is detected and when a child is referred to a dentist for the first time.

PCPs should complete and fax the EPSDT Member Outreach Ref Form (PDF) to Highmark Health Options for patients who have abnormal findings or did not show up for their appointments, so Highmark Health Options can contact the patient. PCPs are responsible for:

- Providing health screenings.
- Reporting the results of the screenings to Highmark Health Options.

The form must communicate the patient's demographic information (e.g., telephone number, address, alternate address) to Highmark Health Options staff. This helps with scheduling, locating, and addressing compliance issues.

Highmark Health Options verifies that PCPs and special needs providers are able to provide EPSDT services. PCPs treating patients age 20 and younger who are unable to comply with the requirements of the EPSDT program must make arrangements for EPSDT screenings to be performed elsewhere by an in-network provider. Alternative PCPs and specialists should forward a copy of the completed progress report to the PCP so it can be placed in the patient's chart.

# Provider referrals

Highmark Health Options has established and maintains a referral process to effectively utilize and manage the care of its members. Highmark Health Options may require a referral for health care services that cannot be provided by the PCP, except where specifically provided for in this manual. Providers should submit and retrieve referrals through the Highmark Health Options online referral tool. Provider Services staff are available to provide information regarding the online referral process and applicable setup.

## Behavioral health referrals

Any in-network provider can refer a patient for Care Coordination for behavioral health (BH) needs. BH coordination of care might be indicated for a person:

- Seeking treatment for a mental illness or substance use disorder.
- With chronic comorbid medical and BH conditions and is being treated by multiple providers.
- With medical conditions that are adversely affected by a BH condition.
- With frequent hospitalizations and emergency department admissions for conditions that could be safely or effectively treated at lower levels of care.

## EPSDT referrals

If a developmental delay is suspected and the patient is not receiving services at the time of the screening, providers are required to refer the child (age 3 and younger) to Child Watch in Delaware.  Children under 3 should be referred to Child Watch and children 3 and older should be referred to school district. Patients age 17 and younger for inpatient and over 30 hours for outpatient who require BH services should be referred to the Delaware Department of Services for Children Youth & Their Families..

## OB/GYN member self-referral

To eliminate any perceived barrier to accessing OB/GYN services, Highmark Health Options allows members to self-refer to any in-network OB/GYN for any OB/GYN-related condition. When a member self-refers to the OB/GYN, the OB/GYN's office is required to verify the member's eligibility. Highmark Health Options members may also self-refer for in-network family planning services.

# Benefits and services

## Covered benefits and services

Highmark Health Options is responsible for all covered medical conditions within the basic benefit package for each 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 other services. These covered services are for participating providers. All non-participating providers require an authorization for all nonemergent and nonurgent care.

Members are also entitled to 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 medically necessary, and some services may have limitations (e.g., BH) or require authorization (e.g., orthotics).

The following list of basic benefits is in alphabetical order and is not all-inclusive:

| Extra Benefits from Highmark Health Options | Details |
|---|---|
| Benefits for expecting and new mothers | • MOM Options program for expecting moms who attend prenatal exams to qualify for a reward. Rewards include choice of infant car seat, stroller, Pack 'n Play, or Baby Shower in a Box.<br>• In partnership with DMMA: weekly (up to 8 weeks) delivery of free food, diapers, and wipes for new mothers. |
| Diabetes Prevention Program | Age 18 and older: Covers free year-long wellness program for people who do not have diabetes. Sponsored by Highmark Health Options and the YMCA of Delaware. |
| Digital bathroom scale | Age 20 and older: Covered for adults with specific heart conditions enrolled in the Cardiac Rehab Lifestyle Management program. |
| Eyeglasses and contacts lenses | Age 21 and older: Covers choice of select frames or contact lenses. (See Standard Benefits, below, for age 20 and younger.) |
| GED program | Age 18 and older: Covers the cost of GED testing and retesting through a voucher program. |
| Weight Management Program | Covers free wellness program sponsored by Highmark Health Options for those who qualify:<br>• Ages 3 through 18, with a body mass index (BMI) in the 85th to 95th percentile.<br>• Age 19 and older, with a BMI over 25 and one or more risk factors for heart disease.<br>• Age 19 and older, with a BMI over 30. |
| Hearing aids (through TruHearing) | Age 21 and older: Covers one hearing aid per ear every two years, and batteries for one year.<br>(See Standard Benefits, below, for age 20 and younger.) |
| Healthy Rewards Program | Opportunity to earn monetary rewards for qualifying activities. |

| LTSS Benefits | Details |
|---|---|
| Adult day services * | Community-based supervised and personal care during the day. |
| Attendant care * | Help with activities of daily living. |
| Cognitive services * | Counseling and therapy for members and their families. Limited to 20 visits per year plus an assessment. |
| Community-based residential alternatives | Homelike residential setting that offers support services, and social and recreational programs. |
| Day habilitation | Help with learning and development skills to aid in independence inside and outside the home. |
| Home-delivered meals * | Two meals delivered per day. |
| Independent activities of daily living * | Help with cooking, cleaning, shopping, and more. |
| Minor home modification * | Changes to the home to help independence. Limits per project, per year, and per lifetime. |
| Nursing facility | Includes skilled nursing, rehabilitation, and health care. |
| Nutritional supplements for HIV/AIDS * | Oral supplements for those with weight loss and malnutrition. |
| Personal emergency response system * | Personal electronic device that provides 24-hour access in case of emergency. |
| Respite care | Personal care at home, an assisted living facility, or nursing home so caregiver may rest. Limited to 14 days per year. |
| Self-directed attendant care service | Support for individual authority over decision-making for care services. |
| Specialized medical equipment | Helpful items, such as grabbers. Only for items not covered under the State plan. |
| Nursing facility transition services and workshops | Help with relocation costs up to $2,500. |

* Not offered to persons living in assisted living or nursing facilities.

| Standard Medicaid Benefits | Details |
|---|---|
| Allergy testing | Covered |
| Ambulance services | Covered |
| Behavioral health **outpatient** mental health and substance use services, including crisis intervention services | • Age 18 and older: Covered<br>• Age 17 and younger: Covers 30 outpatient hours per year. Additional outpatient hours are covered through the Department of Services for Children, Youth, and Their Families (DSCYF).<br>• Note: Outpatient and partial hospitalization care for patients participating in PROMISE are covered through the State. |
| Behavioral health **intensive outpatient** | Age 17 and younger: Covered |
| Behavioral health **partial outpatient** | Age 17 and younger: Covered |
| Behavioral health **inpatient** mental health and substance use services | • Age 18 and older: Covers inpatient mental health.<br>• Age 18 and older: Covers intensive inpatient services for **substance use disorder** for up to 14 days. Requires prior authorization if more than 14 days. Requires notification within 48 hours of admission and upon discharge.<br>• Age 17 and younger: Covered through the Department of Services for Children, Youth, and Their Families (DSCYF).<br>• Note: For those participating in PROMISE, medically managed inpatient detoxification is covered through the State. |

| Standard Medicaid Benefits | Details |
|---|---|
| Behavioral health **residential treatment** | • Ages 18 and older: Covered<br>• Age 17 and younger: Covered through the Department of Services for Children, Youth, and Their Families (DSCYF). |
| Blood and plasma products | Covered |
| Bone density screening | Covered |
| Cancer screening | Covers screenings for:<br>• Breast cancer (mammogram)<br>• Cervical cancer (Pap test)<br>• Colorectal cancer (colonoscopy)<br>• Prostate cancer |
| Care coordination services and care management | Covered |
| Chemotherapy and radiation | Covered |
| Chiropractic care | Covers diagnostic imaging and manipulation of the spine to reduce neck, back, pelvis, and sacrum pain. May require prior authorization.<br>Acupuncture can be covered under the chiropractic benefit. |
| Dental care | • Age 21 and older: Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care.<br>• Age 20 and younger: Covered by the State, excluding removal of bony impacted wisdom teeth.<br>• Removal of bony impacted wisdom teeth is covered under the Highmark Health Options medical benefit. |
| Diabetes care | Covers education, equipment, and supplies, including blood sugar monitors and strips. |
| Diapers | Age 4 and older: Covers up to 8 units per day or 240 units per 30 days with no prior authorization. Prior authorization is required for usage that exceeds this amount. |
| Dialysis | Covered |
| Durable medical equipment and supplies | Covers equipment and supplies ordered by a doctor, including bed liners for those age 4 and older. Requires prior authorization if more than $500 is billed. |
| Emergency department care | Covered |
| Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services | Age 20 and younger: Covered |
| Eye exam, routine visit | Age 20 and younger: One eye exam per year. (See Extra Benefits for age 21 and older.) |
| Eye exam, sick visit | Covers sick visits for conditions such as diabetic retinopathy, glaucoma, and infections. |
| Eyeglasses and contact lenses | Age 20 and younger: One pair of eyeglasses or contact lens per year, limitations apply. (See Extra Benefits for age 21 and older.) |
| Family planning services | • Covers network or out-of-network services for DSHP members.<br>• Covers services from network providers for DHCP members. Does not cover services from out-of-network providers for DHCP members. |

| Standard Medicaid Benefits | Details |
|---|---|
| Genetic testing | Covered |
| Glaucoma screening | Covered |
| Gynecology visit | Covers pelvic exam and Pap test. |
| Hearing aids and batteries | Age 20 and younger: Covered<br>(See Extra Benefits, above, for age 21 and older.) |
| Hearing exams | Covered |
| HIV/AIDS testing | Covered |
| Home health care | Covered |
| Hospice care | Covers hospice care in a facility or at home. |
| Hospital care | Covers inpatient care, including inpatient rehabilitation, and outpatient care. Note: As described in the behavioral care inpatient entry above, services for those age 17 and younger are covered through the Department of Services for Children, Youth, and Their Families (DSCYF). |
| Imaging services | Covers diagnostic imaging services: X-rays; CT, PET, MRI, and SPECT scans; and nuclear studies. |
| Infusion therapy | Covers inpatient and outpatient services. |
| Immunizations | Covered |
| Infusion therapy | Covers inpatient and outpatient services. |
| Lab services | Covers diagnostic tests, such as blood tests. |
| Long-term services and supports | Covered for DSHP Plus LTSS. |
| Maternity care | Covers care before, during, and following birth. Also covers childbirth and parenting education. |
| Nonemergency transportation | • Covered by the State for transportation to health care visits via ModivCare for DSHP members only; not covered for DHCP. |
| Nursing home care | Covered up to 30 days per year; additional days are considered long-term care. Apply to the Delaware Medical Assistance Program for long-term care. |
| Observation | Covered |
| Online doctor visits | Covers 24/7 virtual visits via HHO on the Go website or mobile app.<br>• All ages: Urgent care.<br>• Age 18 and older: Therapy and psychiatry. |
| Opioid addiction treatment | Covers medication-assisted therapy. |
| Organ transplant | Covers transplant and evaluation before transplant. |
| Orthopedic shoes | Covered; requires prior authorization if more than $500 is billed. |
| Outpatient surgery | Covers same-day and ambulatory surgery. |
| Pain management | Covered |
| Personal care | Covers services provided by aides in the home. |
| Physical, speech, and occupational therapy, outpatient | Covered with prior authorization. |

| Standard Medicaid Benefits | Details |
|---|---|
| Podiatry care | Covers routine podiatry care for people with diabetes or blood flow problems in the legs. |
| Prescription drugs | Covers medicine prescribed by a doctor. New: A 90-day supply is available for some medicines. |
| Primary care physician visits | Covers doctor office visits, checkups, and sick visits. |
| Private-duty nursing | Covered with prior authorization. |
| Prosthetics and orthotics | Covered; requires prior authorization if more than $500 is billed. |
| Second opinion | Covers advice from a second doctor to compare with the advice of another doctor. |
| Sleep apnea study | Covered |
| Specialist visits | Covers care from a doctor who has special training for a specific condition or illness. |
| Stop-smoking help | Covered by Quitline. |
| Surgery | Covers inpatient and outpatient surgery. |
| Urgent care/Walk-in care | Covers care or medical treatment needed within 48 hours. Not an emergency. |
| Wheelchair rental | Requires prior authorization. |

# Noncovered benefits and services

| Noncovered Services | |
|---|---|
| Autopsies | Nonemergency services from an out-of-network provider that are not prior approved |
| Care from Christian Science providers and sanitariums | Nonmedical items or services |
| Care outside the continental U.S. | Paternity tests |
| Care outside the service area, except in an emergency | Personal items or services, such as television or a telephone while in the hospital |
| Cosmetic surgery, unless medically necessary | Prescription drugs not listed on the approved drug list, unless an exception is made |
| Drugs designated as less than effective by the FDA (known as DESI drugs) | Residential weight loss clinics |
| Drugs prescribed for the treatment of erectile dysfunction | Services and items that are not medically necessary |
| Exercise equipment for the home | Services that are not covered by the Medicaid program |
| Experimental procedures, unless prior approval is received from Highmark Health Options | Sterilization for those age 20 and younger |
| Infertility treatment | Work-related and travel physicals |

# Behavioral health (BH) benefits and services

Outpatient BH benefits for patients age 17 and younger is limited to 30 units (a unit is defined as one hour of service) per calendar year. If a patient exhausts the 30 units for the calendar year, Highmark Health Options will no longer be responsible for the patient's BH utilization until the end of the calendar year. For patients requiring more than 30 units of BH services:

- The Delaware Division of Prevention and Behavioral Health Services manages the benefits of patients age 17 and younger.
- The Division of Developmental Disability Services manages the benefits of patients needing applied behavioral analysis (ABA).

Certain BH-related services for patients age 17 and younger are covered outside the 30 units of outpatient BH services. In general, both a diagnosis of BH and an acceptable (agreed to by the State) procedure (or revenue) code must be provided to be considered part of the 30 units of outpatient BH services for patients age 17 and younger. Highmark Health Options provides coverage of these services when medically necessary and will not count these services against the 30 units.

These services include:

- All nonpsychiatric treatment services provided in inpatient hospitals, regardless of the patient's BH diagnosis (e.g., an anorexic adolescent with life-threatening weight loss).
- All prescribed medications, including psychotropic, antidepressant, or other drugs used in BH treatment.
- EPSDT screening, including specific BH screening components.
- Medical detox services to adequately evaluate for appropriate triage and follow-up services.
- Medication management, inpatient or outpatient, for all prescribed medications, including psychotropic, antidepressant, or other drugs used in BH treatment.
- Outpatient provider or pediatrician visits, including emergency department visits for medical and BH reasons.

## PROMISE-eligible patents

For patients participating in DSAMH's PROMISE program, services from licensed BH providers (including licensed psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists) and SUD services, except for medically managed intensive inpatient detoxification, are the State's responsibility.

# Chiropractic services

Chiropractic services are furnished in accordance with 42 CFR 440.60(b). Qualified chiropractors must be licensed per Delaware licensure requirements codified in Chapter 7, Title 24 of the Delaware Administrative Code, Professions and Occupations. Services consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized perform:

- For individuals age 20 and younger, as an EPSDT service, per 42 CFR §441 Subpart B, furnished upon meeting defined benefit criteria (through prior authorization approval).
- For individuals age 13 and older, furnished upon meeting defined benefit criteria (through prior authorization approval, after the first 20 visits).

## Chiropractic covered services and limitations

| Service | Coverage |
|---|---|
| **Daily Maximum**<br>Chiropractic services are subject to a daily maximum benefit.<br>Other approved services for chiropractic, such as radiology and office visits for evaluation and re-evaluation, are not included in the daily maximum. | • Spinal manipulations; Providers will only be reimbursed for one qualifying visit per day. A qualifying visit is defined as a spinal manipulation, extraspinal manipulation, or adjunctive procedure, or any combination of the three. Evaluation and Management procedures and X-ray are not considered a qualifying visit. |
| **Evaluation and Management Services**<br>Manipulation includes a premanipulation assessment. | • Time-based physical medicine services include the time required to perform all aspects of the service, including pre-, intra-, and post-service work.<br>• Any separate evaluation and management (E/M) service outside of the premanipulation assessment requires prior authorization. |
| **Manipulations**<br>Manipulations should be provided in accordance with an ongoing, written treatment plan and must be appropriate for the diagnosis reported. | • Manipulation associated with the treatment of neck, back, and pelvic or sacral pain or extra spinal pain and/or dysfunction.<br>• Necessity for treatment: The patient must have a significant neuromusculoskeletal condition necessitating treatment.<br>• Manipulations can be provided manually or with the assistance of various mechanical or computer-operated devices.<br>• No additional payment is available for use of the device or for the device itself. |
| **X-rays**<br>X-rays are used to determine primary diagnosis and then to monitor progress. | • Coverage of spinal X-rays is limited to one set per member in a rolling 12-month period.<br>• Additional X-rays may be taken within the same calendar year to document a new condition or an exacerbation or re-injury. X-rays used to determine progress are limited to one study per calendar year. Progress X-rays, beyond the first in a calendar year, may be preauthorized. |

## Chiropractic noncovered services

A network provider cannot bill the member for the noncovered service, including:

- Any other chiropractic service not defined in this benefit
- Chiropractic maintenance therapy
- Orthopedic devices prescribed by chiropractor
- Treatment for any condition not related to a diagnosis of subluxation or back pain
- X-rays other than those needed to support a diagnosis of subluxation
- Any services outside of scope of state licensure
- Room and Board fees
- Hand-held and other devices may be used in treatment but are not eligible to be reimbursed (DMAP Practitioner Provider Specific Policy Manual, 13.3)

- Experimental/Investigational (E/I) services, regardless of place of service
- Quantity level limits or quantity of supplies that exceed the frequency guidelines listed on the policy
- Services rendered prior to Jan. 1, 2018, or prior to the provider's contractual effective date (Chiropractic Information Provider Manual 2019)
- Vitamins, minerals, or other supplements

# LTSS coverage and benefits

Highmark Health Options covers the following services:

- Adult day services.
- Attendant care services.
- Cognitive services for individuals with acquired brain injury (ABI); up to 20 visits per year, plus assessment.
- Community-based residential alternatives, including assisted living facilities.
- Day habilitation.
- Home-delivered meals; up to two meals 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.
- Nursing facility services (custodial/long-term care).
- 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 14 calendar days per year.
- Self-directed attendant care services (SDAC).
- Specialized medical equipment and supplies not covered under the State Plan.
- Transition services for those moving from a nursing facility to the community under the Nursing Facility Transition program; up to $2,500 per transition.
- Transition workshops for those moving from a nursing facility to the community under the nursing facility transition program.

## Self-directed attendant care services

Patients may opt to self-direct their attendant care services. Self-direction allows patients to have choice and control over how attendant care services are provided and who provides the services. Financial management and general support are available for patients who choose to self-direct their attendant care services. This means the patient, or an employer representative selected by the patient, serves as the legal employer of the paid caregiver. This benefit gives the patient or patient's employer representative support from a fiscal employer agent that takes care of the taxes, payroll withholding, and paychecks for the caregiver. The fiscal employer agent also helps the patient find and train an attendant care employee.

## Self-directed HCBS support

Support for Self-Directed HCBS includes two functions:

- Financial management services (FMS)
- Information and assistance in support of self-directed HCBS (support brokerage)

This includes, but is not limited to:

- Discharging self-directed HCBS employees.
- Evaluating self-directed HCBS employee performance, EVV requirements.
- Hiring self-directed HCBS employees as the common law employer.
- Including verifying time worked by self-directed HCBS employees and approving timesheets.
- Obtaining a criminal background check of self-directed HCBS employees.
- Recruiting self-directed HCBS employees.
- Selecting self-directed HCBS employees from a self-directed HCBS employee roster.
- Specifying additional self-directed HCBS employee qualifications based on member needs and preferences.
- Verifying self-directed HCBS employee qualifications.

Self-directed HCBS providers should conduct the following FMS functions:

- Assist members in verifying Self-Directed HCBS Employees' citizenship status
- Collect and process Self-Directed HCBS Employees' timesheets, including EVV requirements;
- Assist members in ensuring that workers compensation insurance is purchased and maintained
- Process payroll, withholding, filing and payment of applicable Federal, State and Local employment-related taxes and insurance
- Execute and hold Medicaid provider agreements; and
- Receive funds from the Contractor and disburse funds for payment of Self-Directed HCBS Employees.

Providers must submit a quarterly self-directed HCBS report.

Case managers monitor the quality of service delivery and the health, safety, and welfare of patients electing self-directed HCBS.

Providers should ensure that patients are informed of their right to voluntarily disenroll from self-directed HCBS at any time and return to the traditional service delivery system. The patient should provide their self-directed HCBS employee 10 calendar days advance notice regarding their intent to disenroll from self-directed HCBS. Providers should educate and assist the patient in providing such disenrollment

Providers must develop and implement measurable workforce development strategies to promote and maintain a qualified, competent, and sufficient workforce to support provider network adequacy and member access to care, with an emphasis on development of community-based providers and direct service workers, including self-directed HCBS employees.

Self-directed HCBS providers must, at a minimum, perform the following supports brokerage functions:

- Coordinate with the patient's case manager to develop, sign and update the patient's plan of care to include self-directed HCBS.
- Recruit self-directed HCBS employees.
- Maintain a roster of self-directed HCBS employees.
- Assist with developing and posting job descriptions for self-directed HCBS employees.

- Secure and pay for background checks on prospective self-directed HCBS employees on behalf of patients.
- Assist with hiring, supervising, evaluating and discharging self-directed HCBS employees.
- Assist with completing forms related to employers.
- Assist with approving timesheets.
- Provide information on employer/employee relations.
- Provide training to patients and self-directed HCBS employees.
- Provide assistance with problem resolution.
- Maintain patient files.
- Provide support to the patient when executing the patient's back-up plan for self-directed HCBS.

Self-directed HCBS training for patients and employer representatives should address the following topics:

- Understanding the role of patients or employer representatives with self-directed HCBS.
- Understanding the role of the provider of support for self-directed HCBS.
- Selecting self-directed HCBS employees.
- Reporting critical incidents, abuse and neglect prevention and reporting, and fraud, waste and abuse prevention and reporting, as each relates to self-directed HCBS.
- Being an employer, evaluating self-directed HCBS employee performance and managing self-directed HCBS employees.
- EVV requirements and member roles and responsibilities. Patients must be informed that EVV does not impact the amount, scope, and duration of services, or the patient's choice of provider.
- Performing administrative tasks such as reviewing and approving timesheets and complying with EVV requirements.
- Scheduling self-directed HCBS employees and contingency planning.
- How patients can request help when needed.

Providers should arrange for ongoing training for patients and employer representatives upon request or if a support broker, through monitoring, determines that additional training is warranted.

- Overview of DSHP, DSHP Plus LTSS and self-directed HCBS.
- Caring for elders and persons with disabilities.
- Abuse and neglect identification and reporting.
- Fraud, waste, and abuse prevention and reporting.
- Confidentiality and HIPAA requirements.
- Critical Incident reporting.
- EVV requirements.
- Submission of required documentation and withholdings.

Providers must verify that self-directed HCBS employees have successfully completed all required training prior to service initiation and payment for services.

Additional training may be provided to a self-directed HCBS employee to address issues identified by the provider of support for self-directed HCBS, patient, employer representative, or at the request of the self-directed HCBS employee.

## Nursing facility transition

The Nursing Facility Transition (NFT) program helps eligible patients transition from a nursing facility to the community. Patients who wish to pursue transition to the community will have an in-facility assessment conducted by the case manager within 14 calendar days. The assessment determines the patient's ability and desire to transition, and identifies any barriers to a safe transition.

In addition, patients can be referred by the treating provider, nursing facility, other providers, family, the state, and self-referrals. Within 14 days of the referral, the case manager conducts an in-facility visit to determine the patient's interest in and potential ability to transition to the community and provide orientation and information to the patient regarding transition activities.

# Case management for LTSS

## Plan of care

The plan of care is developed by the Case Manager, taking into consideration the:

- Advocacy for the patient.
- Care plan to address those needs.
- Facilitation of the plans.
- Needs of the member identified during an assessment.

The Case Manager gathers relevant, comprehensive information and data by interviewing the patient, caregiver, and family. When indicated, the PCP or specialist, other members of the health care team, and other appropriate individuals as approved by the patient may also be interviewed. To perform careful evaluation of the DSHP Plus LTSS program patient's situation, the Case Manager uses face-to-face visits, formal assessment tools that are prior approved by the State and in accordance with protocols specified by the State, telephonic assessment strategies, electronic communication, and other efficient modes of communication.

For assessment, it is important for the Case Manager to gather information concerning the patient's health behaviors, cultural influences, socioeconomics, and BH related to the current or proposed plan of care to identify potential barriers, to clarify or determine realistic goals and objectives, and seek appropriate alternatives for the patient. The Case Manager should recognize the importance of the patient's involvement in a successful assessment process and should provide and encourage opportunities for the patient to communicate and collaborate with the Case Manager or any member of the patient's health care team.

## Coordination with local departments and agencies

The Case Manager identifies service needs when developing the plan of care. Highmark Health Options does not require home- and community-based services (HCBS) to be ordered by a treating provider; however, the Case Manager may consult with a treating provider, as appropriate, regarding the patient' physical health, BH, and long-term services and supports needs. All services the patient will receive, regardless of payer source, are incorporated into the plan of care. In addition to coordinating LTSS, the Case Manager helps coordinate other Medicaid State Plan services, referral to BH, referral to Care Coordination, and services provided for duals by Medicare. All efforts of coordination are documented in the patient's plan of care.

## LTSS providers

Based on the patient's needs identified during the assessment, the patient selects their top three service providers for each LTSS documented on the plan of care. The LTSS Support Center coordinates and secures the providers, creates the authorizations, and sends the authorization confirmation to the providers to initiate service.

The Support Center secures providers per the patient's plan of care to initiate services within the required time frames. Upon verbal confirmation that the provider can begin, the Support Center authorizes the service for the specified provider in the system of record and sends the provider a plan of care that serves as an authorization confirmation. DSHP Plus LTSS providers receive a Provider Administration Manual as well as an LTSS Claims Reference Guide. Highmark Health Options has full-time staff 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.

### LTSS provider notifications

To notify the Case Manager, providers inform Highmark Health Options of any known significant change in the patient's condition or care, hospitalization, or recommendation for additional services. Nursing facilities are required to:

- Assist with the implementation of a discharge or transition plan.
- Consult with the patient's Case Manager to intervene in resolving issues.
- Notify the Case Manager of any change in a patient's medical or functional condition that could affect the patient's level of care for the currently authorized level of nursing facility services.
- Notify the Case Manager when considering discharging a patient.

## Complex case management program

The Complex Case Management program allows eligible patients to take control of their health care needs by coordinating health care services to help them regain optimal health or improve functional ability. Eligible patients are identified as needing comprehensive and disease-specific assessments and reassessments, and may include patients:

- At risk of a hospital admission.
- Who need assistance to become more self-reliant in managing their health care.
- With a complex medical history.
- With multiple medical conditions.

The program includes:

- Comprehensive assessment of the patient's condition.
- Determination of available benefits and resources.
- Development and implementation of a case management plan of care with patient-centered prioritized goals, monitoring, and follow-up.

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.

## Care management

Care Management provides a population health model that focuses on active condition monitoring, lifestyle management, preventive health, care coordination, and community resource referrals. Individualized care plans are established for members. Providers are invited to provide input into care plans, as needed.

To refer patients to the Care Management program, providers can call 1-844-325-6251. Patients have the choice to opt-out of all Care Management programs at any time.

Care Management can help providers:

- Decrease inpatient and emergency room utilization.
- Emphasize the importance of making and keeping appointments (and coach patients on how to make the best use of time with the provider and health care team).
- Encourage adherence to obtain flu and pneumonia immunizations.
- Increase appropriate lab testing and medication adherence.
- Educate and help patients understand their condition and lifestyle implications, and motivate them to take a proactive role in managing their health.

### Care coordination

For patients with more complex physical or BH needs, Care Coordinators are available to optimize health and help prevent disease progression. Care Coordinators are licensed clinicians (registered nurses) or licensed MH professionals (social workers) with medical or social service backgrounds.

The following problems or diagnoses are examples of appropriate referrals for Care Coordination:

- Chronic behavioral health conditions (e.g., chronic depression or schizophrenia)
- End-stage renal disease (ESRD)
- HIV/AIDS
- Intellectual or developmental disabilities
- Mental health or substance abuse issues
- Oncology
- Other high risk or high-cost chronic conditions
- Patients with special health care needs (e.g., cerebral palsy)
- Social issues (e.g., homelessness, domestic violence, transportation)

### Resource coordination

Highmark Health Options has Resource Coordinators available to assist patients with:

- Appointment scheduling
- Linkage to community resources
- Wellness programs

## Lifestyle management and wellness programs

Lifestyle management and wellness programs target patients who have chronic conditions, are pregnant, or may benefit from healthy weight or diabetes prevention management. Patients who meet eligibility criteria are automatically enrolled at no cost. Patients can opt out of the Lifestyle Management and Wellness programs at any time. To refer patients, providers can call 1-844-325-6251.

### Asthma program

This program emphasizes patient education, self-management, and medication adherence. Patients age 2 and older are eligible. The program encourages an active lifestyle while minimizing or preventing asthma exacerbations.

The program helps patients:

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

## Diabetes program

This program emphasizes education and personal responsibility for diabetes management to prevent diabetic complications. All adult and pediatric patients with type 1 or type 2 diabetes are eligible. The program helps patients:

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

## Cardiac program

This program emphasizes patient education and support to help patients with cardiac conditions. Patients age 21 and older with a diagnosis of heart failure, myocardial infarction, or coronary artery disease are eligible. The program helps patients understand:

- How other conditions play a part in worsening a cardiac condition.
- The meaning of specific cardiac symptoms to prevent further cardiac damage.
- The importance of lab tests for lipid testing and medications.
- When to call their PCP and the key words to tell the office.

## Chronic obstructive pulmonary disease (COPD) program

This program emphasizes patient education, lifestyle modification, safety, self-management, and medication adherence. Patients age 21 and older with a diagnosis of COPD are eligible.

The program helps patients:

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

## Weight Management Program

Highmark Health Options joined DMMA as a founding member of the first-ever collective national insurance initiative, My Healthy Weight for eligible individuals.

Delaware Division of Medicaid and Medical Assistance pledges to offer intensive behavioral interventions every plan year (12 months) for members with a qualifying diagnosis:

- At least 12 visits for adults with a BMI equal to or greater than 30.
- At least 6 contact hours for adults with a BMI equal to or greater than 25 and one or more risk factors for cardiovascular disease.
- At least 12 visits for children ages 3 years or older with a BMI equal to or greater than 95th percentile.
- At least 8 visits for children ages 3 years or older with a BMI 85th - 95th percentile.

This program helps patients:

- Identify the tools and resources they need to give them the best health, wellness, and nutritional options.
- Learn how to choose a healthier lifestyle that may prevent them from having other health problems.
- Understand how to control and manage their weight with better choices, such as diet and activity.

## Diabetes Prevention Program

Highmark Health Options has partnered with the YMCA of Delaware to provide the Diabetes Prevention Program (DPP). The DPP is designed to help patients take an active role in their well-being to avoid the risk of developing type 2 diabetes. Patients who are age 18 and older with a BMI ≥ 25 (≥ 23 if Asian) and identification of risk factors are eligible. The program is designed for patients at risk for developing diabetes. Patients with diabetes are not eligible to participate.

The DPP is a year-long, structured lifestyle and healthy behavior change program consisting of 25 group sessions. Participants meet in relaxed, small-group sessions to learn skills and strategies to:

- Cope with setbacks
- Eat healthier
- Increase physical activity
- Overcome stress
- Reduce the risk of chronic conditions
- Stay motivated

## Maternity program

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

The maternity program offers maternity care coordination to:

- Decrease the need for NICU admissions.
- Improve the frequency of prenatal and postpartum care.
- Reduce the incidence of low birth weight and preterm deliveries.

The program reinforces EPSDT program information for patients who are continuing to care for their newborns and helps patients:

- Identify signs and symptoms of preterm labor or pregnancy complications.
- Recognize how coexisting medical conditions can impact the pregnancy.
- Understand lifestyle modifications to maintain a healthy pregnancy.
- Understand the importance of postpartum follow-up.

# Hospital and facility services

## Acute inpatient rehabilitation facility

If a patient needs admission to an acute inpatient rehabilitation facility, the attending provider, hospital Utilization Review department, or rehabilitation facility should contact Utilization Management for new requests and ongoing (concurrent) reviews for prior authorization.

## Home infusion

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

## Hospice services

If a patient needs hospice services, including home hospice, inpatient hospice, continuous care, and respite, the PCP, attending provider, or hospice agency should contact Utilization Management. Case Managers will coordinate the necessary arrangements between the PCP and the hospice provider to ensure continuity and coordination of care. Due to interruptions of Medicaid coverage, Highmark Health Options strongly recommends that providers verify eligibility if the patient's need for an item or service extends beyond the calendar month in which the authorization was given.

## Pharmacy services

Highmark Health Options allows access to all nonformulary drugs, other than those excluded by the Department of Public Welfare's fee-for-service program, through the exception review process.

## Procedures in a hospital's short procedure unit (SPU) or ambulatory surgery unit (ASU)

Providers may utilize a hospital's SPU or ASU for any authorized medically necessary procedure. Medical necessity reviews may be required for certain procedures. Providers should call Utilization Management to verify if authorization is required.

## Outpatient therapy services

All outpatient therapy services, including physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary rehab, require authorization from Utilization Management. The ordering provider of the therapy must contact Utilization Management to request a precertification. The therapy provider will be asked to fax the prescription, fax the current progress notes, plan of treatment, and goals that support the medical necessity of the therapy services.

## Skilled nursing facility (SNF)

If a patient needs admission to an SNF, the PCP, attending provider, hospital Utilization Review department, or nursing facility should contact Utilization Management for new requests. The skilled nursing benefit is up to 30 calendar days. Additional days are considered long-term care. An application must be submitted to and approved by DMAP for long-term care benefits. Highmark Health Options will assist with coordinating the necessary arrangements between the acute care facility and SNF to provide medically necessary care.

## Transmission of laboratory data

Hospitals will electronically provide Highmark Health Options with all laboratory values relevant to HEDIS, accreditation, or regulatory requirements no less than four times per year or upon written request. All such laboratory values will be provided no later than the last business day of the calendar months of April, July, October, and January. In the event Highmark Health Options asks for additional clinical laboratory values, hospitals will receive advance notice of at least 90 calendar days.

## Private duty nursing (PDN) services

Care Management coordinates medically necessary PDN services with the ordering provider and the home health care provider.

## Ordering private duty nursing services

If a patient needs private duty nursing (PDN) services, the PCP or a specialist rendering care may submit a letter of medical necessity to Utilization Management. Providers should do the following when ordering PDN.

Submit a Letter of Medical Necessity to include:

- Specify the level of care being requested.
- Specify hours per day and schedule being requested.
- Outline care the patient requires assistance with during the hours of service being requested.
- Summarize the patient's past medical history, including review of current conditions driving the need for private-duty services, along with prognosis and treatment plan.
- List all caregivers supporting the patient's care.
- Include the emergency back up plan.

## Transitions from hospital to home

Initial contact is attempted by Care Coordination while patients are still in the acute care setting. Interventions are focused on:

- Assessing and arranging home health care needs.
- Assessing and coordinating durable medical equipment needs.
- Coordinating to address gaps in care and preventive screening needs.
- Discussing transportation options and resources for travel to appointments.
- Making and keeping follow-up appointments.
- Medication reconciliation.

# Pharmacy coverage

## Prescription drugs

Highmark Health Options provides coverage for outpatient prescription drugs and certain over-the-counter (OTC) products for noninstitutionalized patients when the drug labeler participates in the Federal Medicaid Drug Rebate program and the drug is included on the DHSS PDL or the Highmark Health Options Supplemental Formulary. Providers are asked to prescribe medications included in the PDL and Supplemental Formulary whenever possible. The PDL and Supplemental Formulary are updated on a regular basis.

Medication additions or deletions reflect decisions made by the Pharmacy and Therapeutics (P&T) Committee and inclusion on the DHSS-approved PDL. If a PDL and Supplemental Formulary deletion affects a patient, Highmark Health Options will notify the provider 30 days prior to the change. Additional copies of the PDL and Supplemental Formulary can be requested through Pharmacy Services.

Providers may request the addition of a medication to the Supplemental Formulary by letter, phone, or email. 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 reviews requests.

## CoverMyMeds Medication Prior Authorization Program

Highmark Health Options providers can use CoverMyMeds to electronically submit prior authorization request for any medications and all health plans. Providers can receive faster prior authorization determinations, automatically renew previously submitted prior authorization requests, and the program is free for providers and their staff.

## Prior authorizations and exceptions

Some medications, although listed on the PDL or Supplemental Formulary, require prior authorization to be covered. All prior authorization and step therapy criteria can be found on the Highmark Health Options website. If a medication is non-preferred on the PDL or not covered on the supplemental formulary, providers must initiate a Request for Medicaid Drug Exception (PDF) (prior authorization).

The exception process allows for a 24-hour turnaround when reviewing requests for nonformulary, nonpreferred, prior authorization, and step therapy medications. If a decision has not been made within 24 hours, Highmark Health Options will authorize a temporary supply of the nonformulary, nonpreferred, prior authorization, or step therapy medication. For emergently needed medications, the pharmacist may authorize up to a 72-hour supply of the medication.

## Electronic Prior Authorization (ePA)

- CoverMyMeds platform provides two-way connectivity between prescribers and HHO RX.
- HHO RX utilization management system connects with CoverMyMeds and CVSHealth.

## 340B claims

In adherence with State Plan Amendment #16-001, effective Jan. 1, 2016, pharmacies that purchase Section 340B of the Public Health Service Act products must ask to dispense and bill for these drugs from the State of Delaware for all DMAP patients.

Once approval information has been communicated to Highmark Health Options from DMAP, the pharmacy will be able to properly submit claims for 340B drugs using the following values:

- NCPDP data element 409-D9: Ingredient cost submitted = 340B acquisition cost.
- NCPDP data element 420-DK: Submission clarification code = 20.
- Claims for 340B drugs from pharmacies not approved by DMAP will be reversed and processed accordingly.

## Pharmacy and PCP lock-in

Highmark Health Options has the right to lock its members to specific provider types when it has been determined that members have abused their health care benefits. Highmark Health Options complies with all applicable state and federal regulations concerning member lock-in, including the requirements of DMAP and the Delaware Medicaid Managed Care Organizations Agreement.

There may be several reasons to lock a member to a specific clinician or pharmacy, such as:

- Altering a prescription.
- Continuity of care and coordination of care.
- Fraudulent use of any covered services (e.g., borrow or use of Highmark Health Options ID card other than their own to gain medical services).
- Overutilization of any provider type.
- Provider and pharmacy shopping for the purpose of obtaining controlled or noncontrolled drugs

Members selected for lock-in will be sent a notification letter. Included with the lock-in letter are instructions on how to file a grievance through the Highmark Health Options grievance process.

The Pharmacy Claims Analyst is responsible for monitoring the member's lock-in using the lock-in database. The Pharmacy Claims Analyst evaluates and reviews the member's pharmacy and medical claims utilization and inquires as to what providers other than the member's PCP are writing prescriptions, including the:

- Dosage as prescribed
- Number of days' supply
- Total number of units obtained

Providers can contact Pharmacy Services with questions or a need to refer a patient for lock-in consideration.

# Vision covered benefits and services

Highmark Health Options has subcontracted with Davis Vision to administer routine vision benefits. Member Services is available to provide information to patients regarding the participation status of individual providers. For children age 20 and younger, vision is covered by the State, and includes yearly routine eye exams, eyeglasses, and contact lenses.

Adults age 21 and older have coverage for routine eye exams. The vision benefit may be used once every 12 months and includes:

- $0 copay for eye exam and dilation, if necessary.
- Clear plastic prescription lenses from a limited selection of stylish frames.
- ***OR*** disposable or extended wear contact lenses, and includes materials, fitting, and evaluation,
- No warranty or replacement plan.

## Dental covered benefits and services

Highmark Health Options has subcontracted with United Concordia Dental to administer routine dental benefits. Member Services is available to provide information to patients regarding the participation status of individual providers. For children age 20 and younger, dental is covered by the State, excluding removal of bony impacted wisdom teeth. Removal of bony impacted wisdom teeth is covered under the Highmark Health Options medical benefit.

For adults age 21 and older, dental benefits include clinical oral evaluations, diagnostic imaging, oral and maxillofacial surgery, periodontics, preventive and restorative services, prosthodontics repair and realignment, testing, and examination. The removal of bony impacted wisdom teeth is covered under Highmark Health Options medical benefit as a surgical service. Patients are liable for any payment of dental services that exceed the benefit limit and are not covered.

## Adult hearing aid covered benefits and services

This benefit for adults age 21 and older includes a routine hearing exam and one hearing aid for each ear every 2 calendar years, as needed, with no copay. Members can select from six different brands of hearing aids. Also included: ear molds and fittings, 60-day trial period, 1-year supply of batteries, and 3-year manufacturer's warranty for repairs and maintenance. Batteries are not covered in year 2 for hearing aids. Hearing aid batteries are available to members for $39 for a year supply, which includes shipping and handling.

## Durable medical equipment (DME)

Patients are eligible to receive any covered and medically necessary DME needed for home health care.

## Procedures specific to DME

Procedures are as follows when ordering DME:

- All medical supplies, including wound care, ostomy, enteral products, diapers (for patients age 4 and older), and incontinence products, must be obtained through an in-network DME provider as opposed to an in-network pharmacy.
- Any item without an established Medicaid fee requires authorization by Utilization Management.
- Covered items under $500 billed charges can be obtained from an in-network DME provider with a prescription from the ordering provider. Provider Services can direct providers to a contracted vendor. DME vendors are also listed in the Highmark Health Options Specialty Care Provider Directory. A written prescription is required to obtain the item.
- 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 order was given.
- Highmark Health Options accepts the request for DME directly from the DME supplier. To request authorization, providers can contact an in-network DME provider to receive the appropriate billing code(s) before calling Utilization Management. Providers can call Provider Services for an updated list of in-network DME providers.
- If the billed charge of a single item or multiple quantities of a single item is $500, the ordering provider must obtain authorization from Utilization Management. A written prescription and authorization are necessary.
- Incontinence items are covered without requesting an EOB from any other plan; however, if the billed charge is $500 or greater, or a miscellaneous code, NOC code, or NOS DME code are now subject to the $500 charge rule are used to request the supply, authorization from Utilization Management is required according to plan guidelines. Any services provided by out-of- network providers always require authorization.
- Oral enteral feedings must be obtained through an in-network DME provider. An authorization from Utilization Management is required if the billed charge is $500 or greater. Providers should not direct patients to retail pharmacies for these services.
- Regardless of charge, when a miscellaneous code, NOC code, or NOS code is requested, an authorization from Utilization Management authorization is required.
- Rental equipment must be authorized if the monthly billed charge is $500 or greater.
- Services provided by out-of-network DME providers require an authorization from Utilization Management.

## Information needed when ordering DME

Provide the following information when ordering DME services:

- Patient name, Highmark Health Options ID number, and prior authorization number (if applicable).
- DME vendor or provider NPI number.
- Ordering provider, including NPI number.
- Patient's diagnosis.
- Name of requested equipment, medical assistance fee schedule code, cost.
- Whether this a purchase or a rental request.
- Number of items requested and over what period of time (if requesting rental).
- Clinical information to support the request.

To request a precertification for DME, providers can call Utilization Management.

# Medical management

## Medical necessity defined

Medical necessity is the essential need for medical care or services which, when prescribed by the PCP and delivered by or through authorized and qualified providers, will be:

- Appropriate and effective to the comprehensive profile of the patient and the patient's family.
- Directly related to the patient's diagnosed medical condition or the effects of the condition, and be provided to the patient only.
- Least costly, appropriate, and available health service alternative that represent an effective and appropriate use of program funds.
- Most appropriate care or service that can be safely and effectively provided to the patient, and will not duplicate other services provided to the patient.
- Primarily directed to treat the patient's diagnosed medical condition or the effects of the condition in all settings for normal activities of daily living, but will not be solely for the convenience of the patient, the patient's family, or the patient's provider.
- Recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the provider's peer group, or the functional equivalent of the other care and services that are commonly provided.
- 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.
  - 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.
  - Prevent the worsening of conditions or effects of conditions that endanger life, 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.
  - 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 patient might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into family, community, and facility.
  - 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.
- Sufficient in amount, scope, and duration to reasonably achieve its purpose.
- Timely, considering the nature and current state of the patient's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time.

# Medical necessity criteria

Highmark Health Options Utilization Management assesses the medical appropriateness of services using:

- American Society of Addiction Medicine (ASAM) criteria.
- Change Healthcare InterQual® criteria.
- Medical policy approval criteria based on a medical director's review of the latest medical literature and citations, and the DHSS definition of medical necessity when authorizing the delivery of health care services to its members.

Authorizations are used to:

- Assess the medical necessity and appropriateness of care.
- Confirm the member's eligibility.
- Establish the appropriate site for care.
- Identify Highmark Health Options members who would benefit from care management or disease management.
- Verify coverage of services.

Determination of medical necessity for covered care and services must be documented in writing. The determination is based on medical information provided by the patient, the patient's family or caretaker, the PCP, and any other providers, programs, or agencies that have evaluated the patient. 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 the provider agreement.

# Prior authorization

## Prior authorization process

Admitting or ordering providers are responsible for requesting authorization. If a service requires authorization and is being requested by an in-network specialist, the specialist's office must call Highmark Health Options to authorize the service. Hospitals may verify authorization by calling Utilization Management. Since a patient's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

For requested authorizations that cannot be approved as proposed by the provider, Utilization Management staff will suggest alternative program options. If an agreement cannot be reached between the provider and Utilization Management, the Medical Director will review the case.

Ordering providers can request a prior authorization either by faxing the Prior Authorization form (PDF) or contacting Utilization Management by phone:

- If Utilization Management is closed and an urgent request for authorization is needed, providers should call Provider Services. The Medical Director is available to review these requests when necessary. For urgent and emergency situations, providers are required to notify Highmark Health Options within 48 hours or two business days of rendering service.
- Services requiring authorization in less than 48 hours due to medically urgent conditions should be submitted online at evicore.com or over the phone to eviCore. Providers must indicate that the procedure is not routine or standard.

Advanced imaging authorization requests are submitted through eviCore, evicore.com, or eviCore Provider Services.

Cardiology and radiology services are submitted to eviCore at evicore.com or by calling eviCore's health care call center at 1-888-564-5492 between 7 a.m. and 7 p.m. EST.

### Information needed when calling for authorization

Providers should have the following information available when calling Utilization Management to authorize a service:

- Patient's name
- Patient's 12-digit Highmark Health Options ID number
- Diagnosis (ICD code or precise terminology
- Procedure code (CPT-4, HCPCS, or MA Coding) or billing codes for DME requests
- Treatment plan
- Date of service
- Name of admitting or treating provider
- Name of the provider requesting the authorized treatment
- NPI
- History of the current illness and treatments
- Any other pertinent clinical information

## Services requiring authorization

Highmark Health Options updates the Prior Authorization List (PDF) quarterly for providers to review the codes and prior authorization requirements for medical procedures and services. Below are services requiring authorization which include, but is not limited to:

- Abortion*, sterilization, hysterectomy, tubal ligations, vasectomy
- Bariatric surgery or stapling
- BH (psychiatric inpatient, residential treatment facility, partial hospitalization, intensive outpatient)
- Blepharoplasty
- Bone growth stimulator
- Bony impacted wisdom teeth removal
- Breast reduction
- Cardiac and pulmonary rehabilitation therapy
- Carpal tunnel surgery
- Chiropractic services
- Cochlear and auditory implants
- DME purchase and rentals $500 or greater
- Electroconvulsive therapy (ECT)
- Enteral or parental therapy
- Experimental or investigational services
- Gender transition services
- Genetic testing
- Genital reconstruction
- Hearing aids, ear molds, dispensing fees as well as hearing aid batteries and repair services (for patients 20 and younger; prior authorization via DME)
- Home health care
- Hospice
- Hospital admissions (medical, behavioral health, rehabilitation)
- Intensity modulated radiation therapy (IMRT)
- Joint replacement
- Medical supplies, including oral nutrition when $500 or greater
- Nonemergent air ambulance transport
- Orthotics and prosthetics $500 or greater
- Panniculectomy
- PDN (requires a letter of medical necessity)
- Proton beam
- Psychological testing
- Radiology services (complex, outpatient):
  - CT (computerized axial tomography)
  - MRA (magnetic resonance angiography)
  - MRI (magnetic resonance imaging
- Myocardial perfusion imaging or nuclear cardiology services authorization
- PET (positron-emission tomography)
- Removal of breast implant
- Rhinoplasty
- Septoplasty
- Services to be provided by an out-of-network provider (including DME 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 over $500
- SNF admissions (acute)
- Sleep apnea procedures and surgeries
- Speech, occupational, and physical therapies
- Spinal neuro stimulator services
- Spine surgeries
- Temporomandibular joint (TMJ) surgery
- Transplants or implants
- Vagus nerve stimulation
- Varicose vein procedures
- Ventricular assist devices
- Wound vac

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

# Behavioral Health (BH) authorizations

Highmark Health Options requires precertification for all inpatient and outpatient BH services. Providers can fax the Request for Authorization form (PDF) to initiate the review.

- **Crisis-related services**: Prior authorization is not required for crisis-related services.
- **Medication management**: Excluded from precertification.

The BH team can be reached by calling and selecting the option for authorization requests.

The following information is needed for a prior authorization request:

- Patient's name and date of birth.
- Presenting issue or concern necessitating request for service.
- Patient comorbidities (physical health and BH), including any complications with effective self-management or treatment.
- Any psychosocial factors impacting care or discharge planning including home situation, when applicable.
- Treatment plan.
- Any other information relevant to the review.

When services are needed beyond the initial precertification or last ongoing concurrent review, providers may contact the BH team for guidance on what information is required for further authorization. The provider will need to have access to the following information when calling:

- Patient's name
- Patient's ID number
- Authorization number or member's date of birth
- Summary of treatment progress since last authorization review
- Summary of current goals
- For admissions, any known factors impacting discharge planning, such as home situation
- Update on information asked for by the BH representative at a previous review
- Any other information relevant to the review

When a patient has been discharged from a behavioral-health-related admission, providers should fax the discharge notification form so the admission authorization can be updated and closed, enabling the BH Clinical Care Coordination team to initiate outreach to the member.

## BH substance abuse treatment authorizations

Providers must notify Highmark Health Options within 48 hours of admission by using the BH Substance Use Authorization form (PDF) or calling the BH team. Providers will be given a reference number upon notification. Highmark Health Options requires prior authorization upon the member's:

- 15th day of an inpatient substance use treatment.
- 6th day of withdrawal management.
- 31st day of intensive outpatient treatment.

Highmark Health Options staff can provide guidance on information needed for further authorization that support review of services beyond the precertification or last ongoing concurrent review.

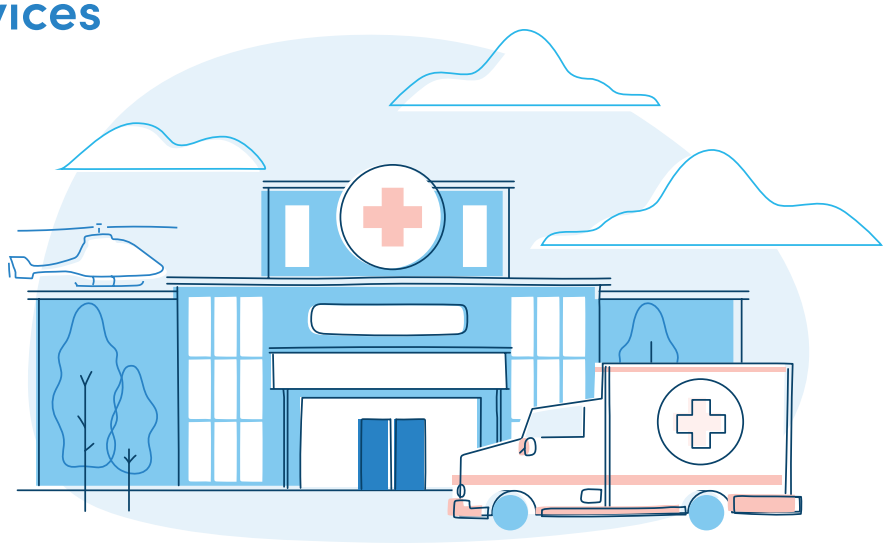
The provider will need to provide the following information:

- Patient's name and date of birth
- Presenting issue or concern necessitating request for service
- Patient comorbidities (physical health and BH), including any complications with effective self-management or treatment
- Any psychosocial factors impacting care or discharge planning including home situation, when applicable
- Treatment plan
- Any other information relevant to the review

# Chiropractic prior authorization

Prior authorization is not required for the first 20 manipulations within a calendar year. However, authorization and supporting clinical documentation is required for additional manipulations beyond the first 20.

# Hospital and facility services



## Authorization requirement

To monitor patients' quality of care and utilization of services, all providers are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by contacting Utilization Management.

## Authorization requests

Highmark Health Options will accept the PCP's, ordering provider's, or attending provider's request for an authorization of nonemergency hospital care; however, no party should assume the other has obtained authorization. Highmark Health Options will accept a call from the hospital's Utilization Review department. Utilization Management staff will refer to the Medical Director if criteria or established guidelines are not met for medical necessity. The ordering provider will be offered a peer review opportunity with the Medical Director for all potential denial determinations.

## Home health care authorization requests

Utilization Management coordinates medically necessary nonprivate-duty home health care with the ordering provider and home health care provider. 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 recommends that providers verify the patient's eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

# Provider network participation

## Introduction to network participation

Eligible providers must sign an agreement to participate in the Highmark Health Options provider 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 while in the network, including this Provider Manual.

Mutual obligations are contained in the agreements and regulations that professional providers execute when joining the network. Highmark Health Options encourages members to obtain health care services from in-network providers, which could increase the provider's patient base. Key contractual provisions include that network providers will:

- Accept the network allowance as payment in full for covered services.
- Handle basic claim-filing paperwork for the patient.
- Provide or arrange for the provision of medically necessary covered services for HHO members on the same basis as that of all of other patients.
- Recommend patients see other in-network providers when necessary.

In-network providers 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.

All providers who submit claims must obtain an individual National Provider Identifier (NPI) number. The NPI is a 10-digit numerical identifier for providers of health care services. Highmark Health Options makes payments only for eligible services rendered by a provider with a valid NPI.

## Eligible professional providers

The following is an illustrative list of professional providers eligible to participate in the Highmark Health Options network:

- Certain Certified Registered Nurses
- Doctor of Chiropractic
- Doctor of Dental Surgery
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Licensed Audiologist
- Licensed Clinical Social Workers
- Licensed Dietitian–Nutritionist
- Licensed Marriage and Family Therapists
- Licensed Occupational Therapists
- Licensed Physical Therapist
- Licensed Professional Counselors
- Licensed Psychologist
- Licensed Speech-Language Pathologist
- Nurse Midwives
- Licensed Physician Assistant
- Licensed Nurse Practitioner

# DMAP-enrolled Medicaid providers

All participating providers must be enrolled with DMAP and notify Highmark Health Options within 30 days of any changes in location, licensure, certification, or status. These changes must be updated in the DMAP web portal at Delaware Medical Assistance Portal for Providers.

All eligible providers receive one standard NPI number that they are required to use when submitting health care transactions. The NPI is a result of the CMS mandate that supports HIPAA simplification standards intended to improve the efficiency of the health care system and help reduce fraud and abuse.

The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system used for assigning NPIs. Providers can apply for NPIs three ways:

- Call NPPES for a paper application at 1-800-465-3203 (TTY 1-800-692-2326).
- Complete the web-based application process.
- Download and complete a paper application from the NPPES website and mail to NPPES.

# Registering as a non-participating provider

To be registered with HHO and submit claims to HHO, eligible providers who are not in-network must submit their provider name, billing tax ID, rendering and billing NPIs, billing and physical addresses with phone number, and specialty as follows:

Mail: Highmark Provider Information Management

P.O. Box 898842

Camp Hill, PA 17089-8842

Fax: 1-800-236-8641

# How to participate in the Highmark Health Options credentialed network

Professional providers can begin the application process through the online CAQH ProViewtm credentialing database developed by the Council for Affordable Quality Healthcare (CAQH). Providers complete one standard application that meets the needs of Highmark Health Options and other in-network health plans and health care organizations. Once CAQH registration is finished, the provider will receive additional information for completing the application process.

# Professional initial credentialing set up

## Providers who already have a CAQH ID

Providers who already have a CAQH participating practitioner with a CAQH ID, visit CAQH ProView. Log into CAQH ProView to review and re-attest to the CAQH application. Providers must add Highmark as an authorized plan or grant global authorization (Highmark Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc.).

Providers must also complete Highmark's Initial Provider Credentialing Request form. Providers can also access the Highmark Delaware Provider Resource Center.

In approximately 10 business days, an email with additional information and instructions will be sent to the credentialing contact email address supplied by the provider. In certain instances, the communication may be sent via postal mail to the credentialing mailing address supplied by the provider.

### Providers without a registered CAQH ID

Visit CAQH ProView to obtain a CAQH ID and complete the application. The online solution will guide you through the process, which will take several hours to complete the first time (however, the application does not need to be completed all at one time). Helpful resources are available through links on the login page to help you initially navigate the system. Be sure to select Highmark as a plan authorized to receive your information.

Access Highmark's Initial Provider Credentialing Request form and complete the form by providing your information in the blue [required] fields. Please include your CAQH ID when completing this portion of the form. CAQH is used for credentialing purposes only and not to update Highmark provider data. Provider data changes can be made by visiting NaviNet or by using the Provider Information Management Forms section of the Provider Resource Center.

To resign from the HHO network, providers must fax or mail a signed, written request to PIM. 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 the provider advising the effective date of a provider's resignation.

### Providers without internet access

Providers without internet access will need to contact CAQH by calling the toll-free CAQH help desk at 1-888-599-1771 for other options to complete the CAQH credentialing application.

## Assignment accounts

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 the applicable guidelines.

### Eligible entities and arrangements

To establish an assignment account:

- The billing entity must be:
  - **Incorporated solo practitioner**: Desires to have the corporation recognized as the entity or to use a tax identification number to receive payment from Highmark Health Options.
  - **Sole proprietorship**: 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.
  - **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 typical group practice arrangements:
    - Group of providers form a professional corporation, and the corporation becomes the providers' employer.
    - Provider employs one or more other providers as associates in his or her practice.
    - Two or more providers practice as a partnership.

- Limited license providers may not be included in a Highmark Health Options assignment account that also contains health service doctors (MDs and DOs).
- Out-of-network providers may not be included in a Highmark Health Options assignment account that also contains network providers.

## How to establish an assignment account

To establish an assignment account, providers must complete the Request for Assignment Account form and send the completed, signed, and dated form to PIM. For complete guidelines for assignment accounts, including detailed descriptions of eligible entities, providers can refer to the Assignment Account Regulations.

## Electronic transactions required

Highmark Health Options has taken steps to eliminate paper transactions with providers in support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As part of this initiative, all providers are strongly encouraged enrolled in:

- **Electronic funds transfer (ACH direct deposit)**: Secure process that directs Highmark Health Options claim payments to the provider's checking or savings account as directed by the provider's office.
- **NaviNet**: Provider portal that integrates all insurer-provider transactions in one system.
- **Paperless EOB statements**: Reduces the amount of paper flowing into the provider's office.

Providers will receive additional information when their assignment account application is received and reviewed. Providers who are not yet enrolled in ACH direct deposit, NaviNet, or paperless EOBs should contact Provider Services.

## Keep assignment account current

Providers must inform Highmark Health Options of any changes to their 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
- Potentially incorrect payments

Providers must notify Highmark Health Options of the following changes immediately through NaviNet or the Provider Change form:

- Additions or deletions of assignment account members
- Fax number
- Hours of operation
- Mailing address, if different from practice address
- Practice address (physical location)
- Specialty (requires signatures of assignment account members for providers changing their individual specialties)
- Tax identification number (TIN)
- Telephone number, including area code (member access telephone number)

## Notification of new or departing providers

Providers must give prior notice to Highmark Health Options when a provider leaves or a new provider joins their assignment account. Providers must also notify Highmark Health Options of a departing provider's new address and tax identification number, 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.

## How to make changes to an existing assignment account

NaviNet is the preferred method for notifying Highmark Health Options of provider changes. Use NaviNet for:

- **Address updates**: To add a new location or to make changes to an existing address.
- **Provider updates**: For new providers, to change information for an existing provider, or to remove a provider.

Providers without access to NaviNet can complete the applicable form as follows:

- **Address updates**: For adding new practice locations or to make changes to an existing location, complete the Provider Directory Update Request Form.
- **Provider updates**: For provider changes, complete the Addition Request to Existing Assignment.

These forms are also available on the Highmark Delaware Provider Resource Center.

## Account addition and deletion restrictions

Highmark Health Options has the right to deny a request to add to or delete any provider from an assignment account. Highmark Health Options will always deny such a request when an open utilization case is pending resolution.

## ACH direct deposit account changes

Changes to an electronic funds transfer (ACH direct deposit) account can be completed in NaviNet by a provider's ACH direct deposit responsible party. The NaviNet security officer must first enable the transaction for the ACH direct deposit responsible party for the ACH Direct Deposit Attestation and Registration button to display on the Highmark Health Options Plan Central menu.

## 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 or partners during the normal course of business operations.

The use of Social Security numbers (SSN) is discouraged in lieu of business tax identification numbers whenever the provider's tax identification number is asked for. Providers who choose to submit an SSN as a tax identification number acknowledge, understand, and agree that Highmark Health Options will treat the SSN in the same way it handles other providers' business tax identification numbers and will not be liable to a provider for any intentional or unintentional disclosures of the SSN. To avoid using SSNs as the provider tax identification number, providers should obtain and use a federal EIN issued by the IRS.

## Out-of-network provider payment guidelines

Providers choosing not to be in the Highmark Health Options network must register with Highmark Health Options prior to submitting claims for covered services. Although they do not sign an agreement with Highmark Health Options, out-of-network providers are required to accurately report services performed and fees charged.

# Facility and ancillary provider network

Highmark Health Options holds agreements with acute care hospitals in Delaware's three counties and in contiguous counties of bordering states. In addition, Highmark Health Options has agreements with additional facility-type providers in Delaware, including but not limited to:

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

Highmark Health Options has agreements with a network of ancillary providers to supplement the professional provider and facility network. These include freestanding and facility-based providers in the specialties:

- Ambulance
- DME
- Home infusion
- Independent laboratories
- Orthotics or prosthetics
- Personal emergency response system (PERS)
- Specialized medical equipment (assistive technology)
- Support for self-directed attendant care

Informational application packages are available on the Highmark Delaware Provider Resource Center for facilities and ancillary providers interested in joining the network.

## Clinical laboratory improvement amendment (CLIA) certificate

The CLIA certificate is required for each location performing lab services for Delaware Medicaid. The CLIA question is located in section 4 of the CAQH application. The following specialties are exempt from CLIA:

- Audiology
- Occupational therapy
- Optometry
- Orthodontics
- Speech therapy

# Directing care to network providers

Highmark Health Options network providers must refer members who need additional, nonemergent services to in-network providers when there is an in-network provider with the required specialty. Providers can access the Highmark Health Options provider directory through NaviNet or on the Highmark Health Options website. If a treating provider cannot identify a physician or facility (in- or out-of-network) to which to refer a patient (e.g., for highly specialized, unusual or infrequently performed services), then the provider may contact Provider Services or the member's care coordinator or LTSS case manager.

# Termination from the network

The decision to terminate a provider may be made by the Medical Director(s) of Quality Management in urgent situations or by the Termination from the networkHighmark Network Quality and Credentialing

Committee. A provider may also be terminated by the Director, Provider Experience and the Chief Operating Officer for any legitimate business reason.

A provider will be given a written decision to terminate with the specific reason for the decision and any reconsideration and appeal rights. Final termination decisions will negatively affect the provider's reimbursement for services provided to patients..

## Valid reasons for termination

Network providers will be terminated in accordance with the relevant terms of their provider agreement for failure to satisfy the following criteria:

- Maintain acceptable professional liability claims history.
- Maintain an active DEA certificate, where applicable.
- Maintain an active license to practice.
- Maintain coverage for malpractice insurance in the minimum amounts required.
- Meet appropriate recredentialing requirements.
- Participate in recredentialing, which requires providing all requested recredentialing information, and be recredentialed for network participation.
- Provide acceptable clinical quality of care to patients.

Network providers will also be terminated if, in Highmark Health Options' sole discretion, any of the following occur or are in imminent danger of occurring:

- Acts or omissions that cause Highmark Health Options to violate any law or regulation or which negatively affect Highmark Health Options under any regulatory or certification requirements.
- Acts or omissions that jeopardize the health or welfare of a patient.
- Acts or omissions that negatively affect the operation of the network.
- Failure to provide an acceptable level of care.

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

- Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill possessed by a reputable health care provider practicing according to the applicable legal standard of care.
- Discussing:
  - Highmark Health Options' decision to deny payment for a health care service.
  - Medically necessary and appropriate care with or on behalf of a patient, including information regarding the nature of treatment, risks of treatment, alternative treatment, or the availability of alternate therapies, consultations, or tests.
  - The process that Highmark Health Options uses or proposes to use to deny payment for a health care service.
- Filing a grievance against Highmark Health Options 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.
- Having a practice that includes a substantial number of patients with expensive medical conditions.
- Objecting to the provision of or refusal to provide health care service on moral or religious grounds.

- Protesting a decision, policy, or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the provider's ability to provide medically necessary and appropriate health care.
- Refusing to refer a patient for health care services when the provider's refusal is based on moral or religious grounds, and the provider has made adequate information available to the patients in their practice.

## Continuation of care throughout a contract termination

In the event of an agreement termination by either party, the provider will continue to render necessary care to Highmark Health Options member(s) consistent with contractual or legal obligations. Continuation of care (COC) is a process followed to permit a patient to continue an ongoing course of treatment with a PCP, specialist, or facility whose contract has been terminated for reasons other than for cause, and to be provided and paid in accordance with the terms and conditions of the agreement. COC also covers a patient in the second or third trimester of pregnancy; the transition period will last through postpartum care related to the delivery.

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

Notwithstanding the foregoing obligations, Highmark Health Options' obligations under this provision do not apply to the extent that other in-network providers are not available to replace the terminating in-network provider due to:

- Contractual provisions between the terminating provider and a facility where Highmark Health Options members receive care that limits or precludes other in-network providers from rendering replacement services to Highmark Health Options members (e.g., an exclusive services agreement between the terminating in-network provider and a facility where a Highmark Health Options members receives services).
- Geographic or travel-time barriers.

# Provider credentialing

## Introduction to credentialing

Providers are initially credentialed prior to network admission and recredentialed every three years unless they are DSHP Plus LTSS HCBS providers, which are recredentialed annually. Highmark Health Options must credential providers and utilize procedures that comply with National Committee for Quality Assurance (NCQA), CMS, and State of Delaware Regulation 1403 MCOs standards. The credentialing and recredentialing processes are performed by Highmark Health Options staff who work cooperatively with network providers to ensure patients have access only to providers who meet the Highmark Health Options standards of professional qualifications.

All network professional providers must use the CAQH system for credentialing and recredentialing. Organizational providers (ancillary and facility) will need to access the Organizational Initial Credentialing Setup form. Highmark Health Options has delegated credentialing responsibilities to Highmark Inc., its parent company. Highmark credentialing staff follow an established process to credential providers for the Highmark Health Options network. The initial credentialing process includes:

- Completion of a CAQH online application.
- Completion of the initial credentialing application.
- Inquiry to National Practitioner Data Bank for sanction history.
- 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 or privileges, felony, and disciplinary action.
- Verification of disclosure form on file with the State of Delaware.
- Verification of primary source.
- Other verification as needed.

All new providers must:

- Be approved by Highmark Inc. through a routine assessment process or by the Highmark Network Quality and Credentialing Committee, as applicable.
- Sign an agreement.

The provider's network participation and ability to treat Highmark Health Options members does not begin until the provider's signed contract is returned, and the contract is counter executed.

## The credentialing process

The provider's participation in the credentialed network is effective upon completion of a Highmark Health Options-executed agreement. The effective date is stated within the welcome letter.

During initial credentialing, providers in Delaware participate in the process of contracting with Highmark Health Options in the following steps:

- The provider must submit all information requested through CAQH. Highmark Health Options will then provide additional information and instructions.
- Highmark Health Options staff reviews the application. If the application is incomplete, Highmark Health Options will contact the practice to request the missing information.
- The credentialing process includes verification or confirmation of:
  - Board certification (if applicable)*
  - DHHS Provider Disclosure List
  - Drug Enforcement Agency (DEA) certificate issued by each state where practicing*
  - History of liability claims
  - Malpractice coverage amounts
  - Medical education and training (as applicable)*
  - National Practitioner Data Bank (NPDB)*
  - Unrestricted licensing in the state(s) where practicing*
  - Work history
- Credentialing reviews the application for:
  - 24/7 coverage (if applicable)
  - Office hour availability of at least 20 hours per week (PCP)
- Highmark Health Options staff verifies that all information required for NCQA and state and federal regulatory agencies is complete. If verification cannot be completed within the required 180 days, the provider 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.
- If the credentials file elements meet all the credentialing criteria, the Medical Director will review the application and render a decision. If the application does not meet the 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.
- Upon approval of the Highmark Network Quality and Credentialing Committee or the Medical Director, the provider will receive written notification. If denied initial credentialing status, the provider will receive written notification within 45 days.
- A copy of the agreement will be mailed to the provider for a signature. The provider will send the agreement back and Highmark Health Options will counter-execute it. The provider will then receive a fully executed contract and a welcome letter with the effective date of the new provider or group."

*These are verified through primary sources.

## Confidentiality and antibias statements

All provider information obtained in the credentialing process, except as otherwise provided by law, is kept confidential. Credentialing and recredentialing decisions will not be based on a provider's race, religion, ethnic or national identity, gender, age, sexual orientation, or the type of procedures or patients in which the provider specializes.

## Credentialing time frame

Highmark Health Options is required to verify all completed application information within 180 days from the date the provider signs the attestation statement. If verification cannot be completed within the 180-day time frame, the provider will be asked to re-sign and re-date the attestation statement.

## Credentialing Committee

The Credentialing Committee is responsible for reviewing and approving all initial credentialing and recredentialing requests.

- The committee reviews 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 considers all information obtained during the credentialing or recredentialing process to make a final decision.
- For Diamond State Health Plan Plus Long-Term Services and Supports (DSHP Plus LTSS) providers, the committee may consider any additional complaints against the provider or performance concerns that have been identified during the course of a provider's contract.

Final decisions and outcomes are determined by committee member vote and documented in the meeting minutes. Highmark Health Options furnishes written notification to providers regarding the status of the credentialing or recredentialing process. At a minimum, Highmark Health Options will reverify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or State Children's Health Insurance Plan (SCHIP) programs.

# LTSS provider credentialing

## LTSS credentialing process

The LTSS credentialing process meets the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of managed care organizations (MCOs). In addition, Highmark Health Options ensures that all LTSS providers meet applicable state requirements. Once providers are approved for the network, they must be recredentialed based on the service type provided. Ongoing DSHP Plus LTSS HCBS providers must be recredentialed at least annually.

Credentialing of LTSS providers includes the collection of required documents, ownership and disclosure statements, and verification that the provider:

- Attained an acceptable outcome for recent inspections or monitoring from licensing agencies as applicable.
- Has completed an accreditation, state site survey, or Highmark site survey for adult day care, assisted living facility, and day habilitation.
- Has a valid license or certification for the services they will contract to provide as required pursuant to state law.
- Has an NPI number, where applicable.
- Is not excluded from participation in the Medicare or Medicaid programs.
- Possesses general or professional liability insurance with acceptable limits.

At a minimum, recredentialing of HCBS providers will include verification of continued licensure and certification, as applicable, and compliance with policies and procedures identified during credentialing, including background checks, LEIE checks, training requirements, critical incident reporting, and management.

## LTSS credentialing criteria

Credentialing criteria for LTSS provider include:

For adult day services:

- Attestation to the correctness of the application.
- General liability or malpractice insurance.
- History of federal or state sanctions (Medicare and Medicaid).
- License to practice in accordance with LTSS license or certification below.
- Medicaid number and NPI number, if applicable.
- Ownership and disclosure statement.
- Site visit or accreditation.

Assisted-living facility:

- Attestation to the correctness of the application.
- General liability or malpractice insurance.
- History of federal or state sanctions (Medicare and Medicaid).
- License to practice in accordance with LTSS license or certification below.
- Medicaid number and NPI number, if applicable.
- Ownership and disclosure statement.
- Site visit or accreditation.

For attendant care, cognitive services, home-delivered meals, independent activities of daily living (chore) services, minor home modifications (recredentialed annually), nutritional supplements for individuals diagnosed with HIV/AIDS not covered under the State Plan, personal emergency response system (PERS), respite, specialized medical equipment supplies not covered under the State Plan:

- Attestation to the correctness of the application.
- General liability or malpractice insurance.
- History of federal or state sanctions (Medicare and Medicaid).
- License to practice in accordance with LTSS license or certification below.
- Medicaid number and NPI number, if applicable.
- Ownership and disclosure statement.
- Site visit from state or Highmark, or accreditation.*

*For home-delivered meals and PERS, site visit is only if the company is within the state of Delaware - waived if located outside Delaware.

## LTSS required license or certification

| LTSS Service | Required License/Certification |
|---|---|
| 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. |

| LTSS Service | Required License/Certification |
|---|---|
| Cognitive services | Physician, neuropsychologist, psychologist (or other MH 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 (DDDS), 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 program licensed by the DDDS. |
| 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. |
| Home-delivered meals | Adult day services, nursing home, ALF, hospital, home for the elderly, residential hospice, state department of agriculture (food processing facilities that deliver prepackaged meals out of state) (PSSA allowed for providers who only deliver meals.). |
| Independent activities of daily living (chore) services | Trained housekeeper. |
| Minor home modifications | Service agency, building supplier, contractor, carpenter, craftsman, or State-certified DME supplier. |
| Nutritional supplements for individuals diagnosed with HIV/AIDS not covered in state plan | DME license or other retail or wholesale supplier business license. |
| PERS | Nursing home, hospital, or general business license, FCC, and UL certifications (if provided). |
| Respite (inpatient) | Assisted living facility or nursing home facility. |
| Specialized medical equipment not covered in State Plan | DME license or other retail or wholesale supplier business license |

# Provider credentialing scenarios

## New providers

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

- Beginning to practice with an established network practice.
- Changing specialty or role.
- Starting a solo practice.

## Returning providers

A provider who wishes to return to the network will be required to undergo initial credentialing if the provider:

- Submitted a signed, explicit document stating that they no longer wish to be a network provider, and there has been a break in service or contract of greater than 30 days.
- Was terminated during the recredentialing process, and there has been a break in service or contract of greater than 30 days.

A provider returning to the network may also be required to execute a new agreement. If a network-credentialed provider moves from one network practice to another, no further credentialing is required if notification from the provider is received within 30 days and 90 days prior to the recredentialing due date. If the provider's notification is received more than 30 days after the move to another network practice or is not within 90 days of the recredentialing date, the provider will not be terminated; however, initial credentialing will be required.

## Scenarios when credentialing is not required

An established provider 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 or the same geographic area within six months.
- Leaving a group practice to begin a solo practice.

Highmark Health Options must be notified within 30 days if a credentialed provider joins an existing network provider of the same specialty. Providers with access to NaviNet can make these changes through the Provider File Management function. Providers who do not have access to NaviNet can use the Request for Addition/Deletion to an Existing Assignment Account form to notify Highmark Health Options.

## Failure to complete or supply required information

Providers who fail to complete the credentialing or recredentialing process, or fail to supply all required information, will be deemed as voluntarily withdrawing from the network. The process for initial applicants will be discontinued. For recredentialing providers, patients may receive notification that the provider no longer participates in the network. Credentialing representatives may ask detailed questions regarding malpractice cases. Providers not submitting the requested information could be denied or terminated from the network.

# Credentialing requirements

## 24/7 coverage

Highmark Health Options requires all credentialed network providers to provide coverage for appropriate treatment and referrals to patients 24/7. For this requirement to be met, patients must be able to speak to a provider after regular hours. This can be accomplished either directly or through an on-call arrangement with another Highmark Health Options-credentialed provider of the same or similar specialty. All hospital-based providers are exempt from answering the 24-hour coverage question at that location.

An answering service, pager, or direct telephone access where the provider or their 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 where the provider or their designee can be contacted directly, if needed.

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

- Audiologists
- Certified diabetic educator
- Dermatopathologists
- Dietitians and nutritionists
- Massage therapists
- Occupational therapists
- Oral and maxillofacial pathologists
- Pathologists
- Physical therapists
- Read only practitioners
- Speech and language pathologists

## Office hours

PCPs not joining an existing group must provide office hours at each practice site and be accessible to patients a minimum of 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 years.

PCPs (family practitioners, pediatricians, internists, general practitioners, geriatricians, adolescent medicine, obstetrics/gynecologists, and CRNPs) and Primary Care Physician Assistants are required to have admitting privileges in good standing at an in-network hospital.

Applicable provider specialists are not required to have clinical privileges in good standing at an in-network hospital, including:

- Addiction psychiatry
- Anatomic pathology
- Anesthesiology
- Audiology
- Certified behavioral analyst
- Certified diabetic educator
- Certified midwife
- Child and adolescent psychiatry
- Chiropractic
- CRN anesthetist
- CRN mental health
- CRNP specialist
- Cytopathology
- Dental anesthesiology
- Emergency medicine
- General dentistry
- Nonsurgical podiatry
- Nuclear medicine
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Physiatry or physical medicine
- Provider specialists that work in a Highmark Health Options credentialed urgent care or MAU setting only
- Psychiatry
- Radiology
- Read only providers

In addition, criteria for allied health providers include:

- Evidence of appropriate education and training, such as licensure which often verifies education.
- Physician assistants are required to practice within the state of Delaware, have a Physician Assistant license issued by the State board, and have a collaborative agreement with a provider who is credentialed and contracted in the same network.
- Registered nurses (RNs) must have an active advanced practice certification by an entity approved by the state licensing board.

## Clinical privileges

Clinical privilege requirements, including admitting, will be waived for all providers and CRNP PCPs who, on the application, document arrangements that are acceptable to Highmark Health Options for adequate coverage through another credentialed in-network provider. The provider must have privileges at an in-network hospital or belong to a credentialed in-network group of the same specialty. The names of the covering providers must be provided on the application. A co-signed document from the covering providers is not required. Providers are required to use in-network providers for all coverage arrangements, including ambulance.

# Providers credentialing rights

## Policy

Providers applying to the Highmark Health Options credentialed network have the right to:

- Be notified of information that varies substantially from primary sources.
- Correct erroneous information.
- Review information submitted in support of their credentialing application.

Primary sources that may be contacted as part of the credentialing process:

- American Board of Medical Specialties, or American Osteopathic Association, if applicable.
- DHHS Provider Disclosure List.
- Drug Enforcement Agency.
- Educational program(s) the provider completed.
- Federation of Chiropractic Licensing Board, if applicable.
- Federation of Podiatric Medical Board, if applicable.
- National Practitioner Data Bank.
- Office of the Inspector General Participation/Sanction Data.
- State Licensing Bureau.

Providers have the opportunity to review information submitted during the credentialing and 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. Providers can send a request for information in writing to PIM.

Within 30 days of receipt of the request, the information will be mailed with a cover letter in an envelope marked "Personal and Confidential." A copy of the communication will be maintained in the provider's credentialing file as documentation of receipt of the request.

## Notification of discrepancy

In the event information from a source varies substantially from that submitted by the provider, PIM will initiate notification and communication via phone, fax, email, or certified returned receipt requested letter within 30 days of discovery. A copy of the communication will be maintained in the provider's credentialing file as documentation of receipt of discrepancy notification.

## Right to correct erroneous information

Within 30 days of a request to correct information, the provider should submit any corrections in writing to PIM. 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. Any differences in demographic information, education, work history, or DEA certificate or license expiration dates may be handled by phone. The communication will be maintained in the provider's credentialing file as documentation of receipt of corrections. Providers can view network status and effective dates via the Provider File Management section in NaviNet.

### Review credentialing status

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

### Communication of provider rights

Communication regarding provider rights to review, be notified of and correct erroneous information, and receive notice of application status is made via inclusion of this information in the Highmark Blue Shield Office Manual. This online manual is available to in-network providers electronically on the Provider Resource Center, which is accessible via NaviNet and also Highmark's regional websites in Delaware. Annual notifications of the availability of this information in the Highmark Blue Shield Office Manual are published in the quarterly provider newsletters. Providers are notified when the newsletter 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.

## Credentialing requirements for BH providers

BH providers who are 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.
- Insurance. All providers in Delaware are required to carry $1 million 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.

### 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). In addition, 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 registered nurses in the state in which they practice or have a compact license. They must hold a certificate or license as a clinical nurse specialist in psychiatric mental health nursing as issued by the state board of nursing in the state in which they practice.

### Psychiatric-certified CRNP requirements

Psychiatric-certified registered nurse practitioners (CRNPs) must be licensed as a registered nurse in the state in which they practice or have a compact license and CRNP in the state in which they practice. The CRNP license must have a specialty type of mental health.

### 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 a licensed professional counselor (LPC) or marriage and family therapist (MFT).

# Credentialing requirements for facility-based providers

Highmark Health Options does not require providers to complete the credentialing or recredentialing process for the network if they are strictly facility-based and practice exclusively in an in-network acute care hospital setting. This includes:

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

The Highmark Health Options policy does not require credentialing or recredentialing for the network when the following requirements are met:

- Actively participate with Medicare or Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs.
- Have current active malpractice insurance that meets or exceeds state requirements.
- Have a current, valid unrestricted license (e.g., absence of a current prothonotary report or consent order) to practice in the state(s) where they provide care for the organization's members.
- Provide 100% of their services to patients exclusively in the acute care or general hospital setting.
- Sign a Facility-Based Provider Affirmation Statement (form No. 282).
  - The PARE Attestation, or Facility-Based Provider Affirmation Statement form, can be obtained and printed from the Highmark Delaware Provider Resource Center in the Forms section.

These providers must complete the appropriate provider agreements to participate in the network. If a provider begins to provide medical services to patients outside of an in-network acute care facility, the provider will be required to complete the initial credentialing and contracting processes.

# The recredentialing process

Recredentialing is completed at least once every three years with any applicable providers and allied health professionals in-network. DSHP Plus LTSS HCBS providers require annual recredentialing. Highmark Health Options policies require recredentialing to protect Highmark Health Options members. The three-year credentialing cycle is consistent with NCQA, CMS, and State of Delaware standards.

A quality review is conducted at the time of recredentialing and includes:

- Information regarding clinical quality actions or sanction activity.
- Member:
  - Complaints related to both administrative and quality-of-care issues.
  - Grievances and appeals issues, malpractice history, medical record reviews.
  - Satisfaction.
- Office site information.

## Notification to complete online process

All in-network providers must use CAQH's Universal Provider Datasource® for recredentialing. Six months prior to the end of the three-year credentialing cycle, the provider will receive notification that the recredentialing application is due:

- **For providers registered with CAQH**: Highmark will send a letter to notify the practitioner that it is time for recredentialing. The provider will then log into CAQH ProView to review and re-attest to their CAQH application.
- **For providers not yet registered with CAQH**: Use CAQH ProView to obtain a CAQH ID and complete the application. Providers must add Highmark as an authorized plan or grant global authorization.

## Assessment of clinical quality

During recredentialing, providers are evaluated on their professional performance, judgment, and clinical competence. Criteria used may include:

- Data completeness
- Malpractice history
- Member complaints
- Member grievances and appeals
- Overutilization
- Participation in quality improvement activities and condition management programs
- Quality-of-care concerns
- Sanctioning history
- Underutilization

## Assessment of data completeness

Highmark Health Options must include an evaluation of a provider's data completeness in the recredentialing process to comply with the standards of various accrediting and regulatory entities, such as the CMS. The data completeness evaluation occurs in concert with the 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 staff during a HEDIS or RADV chart audit, feedback sheet(s) will be left on each patient's medical record detailing the deficiencies found. If the individual provider receives five or more unique feedback sheets in the first year, the provider will be flagged in the database.
- **Year two**: If five or more feedback sheets are left with the same provider in the subsequent year, the provider will receive a letter that explains that the credentialing decisions for all providers in the practice could be affected if five or more feedback sheets are given to the provider for a third consecutive year.
- **Year three**: If a provider receives five or more feedback sheets for three consecutive years, the providers 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.

## Office site reviews

Quality Management nurses will conduct provider office, facility site quality and medical, and treatment record evaluations for all PCPs, OB/GYNs, and potential high-volume BH providers in the network. These evaluations will be based on the following:

- Annual random sampling with provider sites selected using a statistically valid sampling methodology.
- Patient dissatisfactions received about the quality of any provider office where care is delivered that is related to physical accessibility, physical appearance, or adequacy of waiting room and examining and treatment room space.

The review process occurs as follows:

- Notification is sent to the provider that the recredentialing application is due six months prior to the end of the three-year credentialing period.
  - CAQH-registered providers receive a letter from credentialing staff, and then log in to Universal Provider Datasource® to review and re-attest to their CAQH application.

  - Providers not yet registered with CAQH will receive a letter from credentialing staff with a CAQH ID that can be used to log in to Universal Provider Datasource; complete the online application, and add Highmark as an authorized plan or grant global authorization.
- Credentialing staff 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 45 days from the date the provider signs the attestation statement.
- The Credentialing Committee or the Medical Director reviews the provider's qualifications and enders a decision.
- The provider is notified of any adverse decision through a letter within 60 days.

# Dual credentialing and recredentialing as both PCP and specialist

All dual-credentialed providers will appear in the provider directories as both PCP and specialist.

## Provider categories

An individual provider may participate as both PCP and specialist if the provider meets network credentialing standards for each category. Highmark Health Options contracts with network providers as either:

- **PCPs**: adolescent medicine, family practitioners, general practitioners, geriatricians, internists, obstetrics/gynecologists, and pediatricians.
- **Specialists**: all other MDs or DOs.

## Dual credentialing criteria

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

- Be board certified or meet one of the board certification exceptions for each specialty requested.
  - Each specialty not boarded or not meeting exception will be process discontinued.
- Demonstrate that the practice adequately provides primary care services to patients.
- Meet the standards for PCPs.

## Recredentialing as both PCP and specialist

Dual-credentialed providers will undergo full recredentialing for PCP and specialist participation every three years.

## Reconsiderations and appeals

Reconsideration hearings are available to network providers in the event of a denial or termination action or a limited or modified decision made by the Highmark Network Quality and Credentialing Committee. This could be due to:

- Any reason reportable to the National Practitioner Data Bank (NPDB).
- The lack of required qualifications at the time of recredentialing. This includes:
  - Failure to obtain or keep appropriate board certification.
  - Insufficient malpractice insurance coverage.
  - Lack of adequate clinical hospital privileges.

  - Loss of an unrestricted state license.
  - Loss of DEA license.

The provider must request the reconsideration in writing within 30 days of receiving the notice of the termination. The provider will be given the opportunity to present information to the Highmark Network Quality and Credentialing Committee by the following options:

- Participating in a committee meeting via telephone conference call at a Credentials Committee meeting.
- Writing to the Credentials Committee for consideration, which will take place during a Credentials Committee meeting.

After the meeting, the provider will receive a written notice of the final decision, which includes the:

- Basis for the decision.
- Appeal process.
- Provider's right to an appeal to the Appeals Review Committee for Delaware providers within 30 days if the decision is upheld.

The provider will remain in the network until the Highmark Network Quality and Credentialing Committee's or Appeal Review Committee makes a final decision to terminate and an effective date of termination is established.

## Appeals of a Credentials Committee decision

An appeal of a decision is available to a network provider if the Credentials Committee upholds a denial or termination action following a reconsideration hearing. The written notice issued following the reconsideration hearing advises the provider of the right to appeal as well as the appeal process. It states the following:

- Providers are allowed at least 30 days after receipt of the notification to request a hearing.
- Providers may be represented by an attorney or another person of their choice.
- The appointment of a hearing officer or a panel of individuals to review the appeal.
- The specific time period for submitting the request.
- 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 Appeals Review Committee for Delaware providers. The Appeals Review 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 a provider's clinical privileges or network status for a period longer than 30 days, or a final decision notification of termination has been rendered, the Director of Quality Management or their designee will report such corrective action to the appropriate parties, including the state licensing agency or the NPDB, pursuant to the requirements of HIPAA.

# Quality management

## Quality improvement/utilization management (QI/UM) program overview

The QI/UM program ensures quality, safety, appropriateness, timeliness, availability, and accessibility of care and services provided to patients through data collection and outcome measurements to identify patient needs and improvement opportunities. Highmark Health Options asks that providers cooperate with QI/UM activities to collect and evaluate data, participate in various QI initiatives and programs, and allow Highmark Health Options to use and share their performance data.

The QI/UM program focuses on monitoring and evaluating the quality and appropriateness of care offered by providers and the effectiveness and efficiency of systems and processes that support the health care delivery system.

The program focuses on continuous quality improvement of:

- Prevalent chronic health care conditions
- Preventive health care
- Service indicators

The QI program strives to enhance:

- Continuous process improvement methods and tools to improve quality, safety, and care costs and enhance internal efficiencies.
- Data-driven, comprehensive health management services and programs to members and providers.
- Opportunities that affect racial and ethnic disparities and language barriers in health care.
- Patients' compliance with preventive care guidelines and disease management strategies.
- Patient safety by:
  - Assessing and identifying opportunities to improve patient safety throughout the provider network.
  - Communicating safety activities and provisions that may be in place throughout the network to patients and providers.
  - Educating patients and providers about safe practices (e.g., efforts to prevent, detect, and remediate critical incidents).
- Therapies essential to the successful management of certain chronic conditions.
- Transparency efforts to promote member engagement, customer intimacy, and support members in making appropriate decisions about care.

Highmark Health Options considers population demographics and health risks, utilization of health care resources, and financial analysis to ensure that major population groups are represented in QI/UM activities and health management programs chosen for assessment and monitoring. This information, along with high-volume and high-cost medical and pharmaceutical and drug reports, health risk appraisal data, disease management and care management data, satisfaction survey information, and other utilization reports, is used to identify patients with special health care needs or chronic conditions to develop programs and services to assist in managing diseases and conditions.

## QI/UM program objectives

An annual QI/UM work plan is developed to identify patient needs and quality improvement. Objectives are to implement a QI/UM work plan that identifies and ensures completion of planned activities for each year:

- 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.
- Conduct satisfaction surveys to determine patient 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.
- Conduct studies to measure the quality of care provided, including established guideline studies; evaluate improvements made, barriers, and opportunities, and develop actions to address those opportunities.
- Ensure 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.
- Evaluate the utilization and quality performance of providers and vendors to guarantee standards are met and identify opportunities and best practices. In a group effort with providers and vendors, identify barriers, opportunities, and apply interventions as needed.
- Resolve all clinical expressions of patient dissatisfaction within 30 days of receipt, and track to identify trend issues to identify opportunities for improvement.

## QI/UM program scope

The scope of the program includes:

- Appeals and grievances
- Accreditation and compliance (NCQA and contractual)
- Claims administration
- Clinical outcomes
- Continuous quality improvement using total quality management principles
- Critical incidents
- Enrollment
- Evaluating members' health care needs
- Fair, impartial, and consistent utilization review
- Health disparities and health equity
- Health education plan
- HEDIS
- Medical record standards
- Member and provider services
- Member, provider, and employee education and communication
- Members' rights and responsibilities
- Network accessibility and availability, including those related to special health care needs
- Network credentialing and recredentialing
- Oversight of delegated activities
- Patient safety
- Performance improvement plans (PIPs)
- Preventive health, disease management, long-term services and supports (LTSS), and care management services, including complex case management
- Quality of care reviews
- Reporting of critical incidents and quality of care concerns
- Utilization management monitoring, including over- and under-utilization

## QI/UM program materials

Contact Provider Services to obtain a copy of the Quality Improvement program, work plan, or annual evaluation.

# Clinical quality

Guidelines are developed using evidence-based clinical guidelines from recognized sources or through involvement of board-certified providers 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 patients, as well as applicable regulatory and accrediting body requirements. The use of guidelines permits Highmark Health Options to measure the effectiveness of the guidelines on outcomes of care and may reduce provider variation in diagnosis and treatment.

## Clinical guidelines

Clinical practice and preventive health guidelines are not meant to replace provider judgment based on direct patient contact. Some of the clinical guidelines offered include:

- Asthma (child and adult)
- Attention deficit hyperactivity disorder (ADHD)
- Cardiac
- Diabetes
- HIV (adolescent and adult)
- Hypertension
- Major depression
- Palliative care
- Prenatal care
- Preventive (child and adult)

A comprehensive list of guidelines can be found on the Highmark Health Options website. Additional clinical quality resources can be found at Provider: Guidelines and Resources. Providers can contact Quality Improvement to obtain a paper copy of these resources or individual clinical guidelines.

## Service quality

Highmark Health Options conducts numerous activities throughout the year to measure the quality of services provided to patients. Some of these activities include:

- Analysis of complaints and grievances.
- Availability and accessibility studies.
- Conducting the CAHPS® member experience survey.
- Review of disenrollment data.

## Provider office and facility site quality and medical and treatment evaluations

Highmark Health Options has established specific guidelines for conducting environmental assessment site visits, including medical record-keeping standards for all provider types. The purpose of the site visit is to ensure that providers are in compliance with environmental assessment standards. Environmental assessments will be conducted on an ongoing basis through the monitoring of complaints. Highmark Health Options subcontracts a vendor to conduct all site visits for contracted dental providers.

A Provider Relations representative will schedule an on-site visit at the office site when an environmental assessment is required. The Office Manager or a provider in the practice must be present during the assessment. The Provider Relations representative will:

- Assess the office for evidence of environmental assessment standards compliance.
- Complete the environmental assessment form.
- Examine the appointment schedule.
- Interview staff.
- Tour the office.

Upon completion of the review, the representative will conduct an exit interview with the office manager or provider.

## LTSS monitoring quality and performance

Highmark Health Options monitors providers' quality and performance using an interdisciplinary model that includes all departments contributing information in support of maintaining quality of care for members. All information is reported to Quality Improvement, which develops and tracks performance measures, including appropriate utilization management patterns and quality-of-care concern trends. HCBS providers are subject to quality monitoring and reporting. Highmark Health Options develops performance triggers relevant to in-home service providers, which could include such measures as provider-associated trends in:

- Frequent discrepancies between HCBS billing and service documentation.
- Member complaints and grievances.
- Member satisfaction survey results.
- Member use of back-up plans and gaps in care.

When HCBS services are provided in a patient'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. HCBS providers will be audited on a regular basis to ensure that services billed have been provided.

## LTSS background checks

Highmark Health Options will ensure that the FMS/FEA verify that potential self-directed attendant care employees meet all applicable qualifications prior to delivering services. The minimum qualifications are:

- Age of at least 18.
- Skills necessary to perform the required services.
- Valid Social Security number.
- Willingness to submit to a criminal record check.

For each potential self-directed attendant care employee, Highmark Health Options will ensure that the FMS/FEA check includes:

- Criminal history pursuant to 16 DE Admin Code 3110.
- Delaware's Adult Abuse Registry (see 11 DE Admin Code 8564).
- Excluded provider list.
- National and Delaware sex offender registries.

## LTSS provider site visits

For both credentialing and recredentialing processes, DSHP Plus LTSS staff will 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. The tools used to identify potential deficiencies during on the credentialing and recredentialing process include:

- Credential statement of attestation (for organizational providers)
- Documentation review form
- DSHP Plus LTSS enrollment checklist
- DSHP Plus LTSS representative checklist
- Highmark Health Options application
- Standards assessment

If documents are not available at the time of the on-site audit, the 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 be advised 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 on time or are not acceptable:

- **Existing providers** will be placed on a corrective action plan (CAP) and recredentialing will not be granted until all requirements are met.
- **New providers or initial credentialing**: The contract process will end.

If during the site visit any deficiencies are identified, DSHP Plus LTSS will require the provider to correct the deficiency and may ask the provider to submit a formal CAP that addresses the deficiency. Ongoing monitoring of the CAP will continue until all deficiencies have been adequately addressed and are no longer deficient. A CAP could be requested for any deficiency related to DSHP Plus LTSS's policies and procedures for credentialing and recredentialing. This includes when a provider does not meet DSHP Plus LTSS minimum requirements or deficiencies are identified related to the provider's policies, procedures, training, and reporting processes.

## LTSS case managers

DSHP Plus LTSS members receive intake and ongoing case management by licensed RNs or social workers with bachelor's or master's degrees and active licensure and credentials. Case managers engage the member, caregiver, and family in the planning and decision-making process. The case manager is the primary point of contact with the member.

The case manager is responsible for assessment, planning, coordination, implementation, and evaluation as follows:

| Function | Description |
|---|---|
| Assessment | At the time of the initial assessment, the case manager provides and reviews an LTSS education materials booklet with each member. The LTSS education materials booklet includes:<br>• An overview of the LTSS program.<br>• Case manager's contact information.<br>• Identification and reporting of abuse, neglect, and exploitation.<br>• Member grievances and appeals process.<br>• Services available.<br>Member needs are assessed upon intake and at each on-site review. The case manager utilizes a comprehensive needs assessment to:<br>• Analyzes and describe the medical, social, behavioral, and LTSS services that the member will receive, and goals for longer-term strategic planning.<br>• Identify the member's strengths, capacities, and preferences, and the member's LTSS needs and how to meet those needs. |

| Function | Description |
|---|---|
| Assessment, cont. | Member safety is assessed upon intake and at each on-site review. During each assessment, the case manager:<br>• Assesses for risks, and together with the member, documents any identified risk, a plan to reduce or prevent each risk, and the member's acknowledgement and acceptance of each risk.<br>• Completes an evaluation of the member's physical environment to ensure member safety. |
| Planning | The case manager, together with the member, develops a person-centered plan of care. The plan of care is signed by the member and is reviewed and updated:<br>• At each on-site review.<br>• Upon intake.<br>• When there is a change in services.<br><br>The plan of care:<br>• Considers appropriate options for the member related to their medical, BH, psychosocial, and case-specific needs at a specific point in time.<br>• Includes the type of service, tasks to be performed at each service, frequency of service, hours and amount, start and end dates, daily schedule, scheduled start time, and provider type. |
| Coordination | All services the member will receive, regardless of payer source, are incorporated into the plan of care. All coordination efforts are documented in the member's plan of care.<br><br>In addition to LTSS services, the case manager helps coordinate:<br>• Other Medicaid State Plan services.<br>• Referrals to BH and Care Coordination.<br>• Services provided for duals by Medicare.<br><br>Based on needs identified during the needs assessment, members select their top three service providers for each LTSS documented on their plan of care. The LTSS Support Center:<br>• Coordinates the selected providers.<br>• Creates the authorizations.<br>• Secures the providers.<br>• Sends the authorization confirmation to the providers so service initiation can begin. |

| Function | Description |
|---|---|
| Implementation | The case manager ensures the provision of all services to meet the member's needs occurs as soon as possible.<br>• Services determined to be medically necessary must be provided within 14 days of the on-site visit when the need for the service was determined.<br>• 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 business days. |
| Evaluation | Service provision and the need for such services are continually monitored and evaluated. These evaluations can take place during an on-site visit, by monthly telephonic contacts, or by certified mail. Time frames for member contacts are as follows:<br><br>On-site reviews:<br>• At least 180 days for a member in an institutional setting (this includes members receiving hospice services and those in a nursing facility).<br>• At least every 90 days for a:<br>– Member receiving HCBS, including members residing in assisted living facilities.<br>– Community-based DSHP.<br>– LTSS Plus member with HIV/AIDS (an on-site visit with the member must be completed at least once a year).<br><br>Members in the NFT program, in accordance with the monitoring requirements in the state's protocol.<br>• Member receiving HCBS, including members residing in assisted living facilities.<br>Monthly contacts:<br>• The case manager contacts members monthly between on-site reviews to monitor:<br>– Any changes to the member's needs or circumstances.<br>– The status of the delivery of approved services.<br><br>Nursing facility case conferences:<br>• The case manager attends all nursing facility case conferences as an opportunity to discuss the member's needs and services jointly with the member, the member's family, and providers.<br><br>Significant change:<br>• The case manager conducts an on-site review within 10 business days following notification of a significant change. A significant change is when a member has had a change:<br>– In needs or circumstances that might require a revision to the member's plan of care.<br>– Of placement type. |

## Noncompliant follow-up

Noncompliance issues must be addressed with a CAP within 30 days of receipt for noncompliant standards. The representative will conduct a follow-up visit within 90 days or until the office site is compliant. The Medical Director will:

- Assess the potential impact of the discrepancy to patient care and evaluate the CAP if any of the standards are not met.
- Present the information to the QI/UM Committee for review if the office is not agreeable to correcting the identified problem.
- Suggest a different CAP if the plan is not acceptable.

Special circumstances may be granted based on size, geographic location of the practice, and potential harm to patients. The representative will communicate the results to providers. Provider Relations staff conduct site visits that include compliance with the ADA and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by the Department of Public Welfare.

## Provider office site quality evaluation

| Environmental Assessment Standards | Met | Not Met | N/A | Comments |
|---|---|---|---|---|
| The office is reasonably accessible (noting the ease of entry into and the accessibility of space within the building) for patients with physical or sensory disabilities. (ALL) | | | | |
| The physical appearance of the office is clean, organized, and well maintained for the safety of patients, staff, and visitors. (ALL) | | | | |
| The waiting area is well lit, has adequate space and seating, and has posted office hours. (ALL) | | | | |
| There is adequacy of examining and treatment room space as well as patient interview areas and each are designed to respect patients' dignity and privacy. (ALL) | | | | |
| 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) | | | | |
| The office has a written confidentiality policy to avoid the unauthorized release or disclosure of confidential PHI, including computer screens, data disks, emails, telephone messages or calls, and fax machines. (ALL) | | | | |
| 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) | | | | |
| The office has 24-hour medical coverage that is available seven days a week. (ALL) | | | | |
| The office has a process to ensure after-hours calls are returned within 30 minutes. (ALL) | | | | |
| The office has a process to ensure after-hours calls are communicated to the office by the morning of the following business day. (ALL) | | | | |

| Environmental Assessment Standards | Met | Not Met | N/A | Comments |
|---|---|---|---|---|
| The office has mechanisms to assess behavioral health disorders, alcohol, and other drug dependence (e.g., screening tool or questionnaire). (PCP or OB-GYN). | | | | |
| No more than six office visits are scheduled per hour, per provider. (ALL) | | | | |
| Emergency, life-threatening, medical situations are handled immediately. (ALL EXCEPT BH) | | | | |
| Urgent medical care appointments, which require rapid clinical intervention as a result of an unforeseen illness, injury, or condition, are available within two calendar days (e.g., high fever, persistent vomiting, or diarrhea). (PCP, SPECIALIST) | | | | |
| Routine care appointments including well child exams and routine physical exams are available within three weeks. (PCP, SPECIALIST) | | | | |
| Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) are proactively notified by the office and encouraged to schedule an appointment. (PCP) | | | | |
| There is a process to ensure 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 (e.g., appointment scheduled, reminder care, etc.). (PCP) | | | | |
| A reminder call is made by the practice prior to scheduled appointments to encourage attendance at the scheduled visit. (PCP) | | | | |
| There is a process confirming that laboratory, diagnostic procedure, and consultation appointments were performed, and results were received, reviewed, and filed in the patient's medical record. The process identifies:<br>• How the laboratory, diagnostic procedures, and consultation appointments are tracked.<br>• How the reviewer (provider) notifies how the results should be handled. (PCP)<br>• Staff responsible to ensure results are returned to the office.<br>• When and how staff match test results with patient's chart. | | | | |
| There is a process in place to ensure patients are notified of abnormal results. (ALL) | | | | |
| Urgent medical care appointments that require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within one day. These include:<br>• OB: High fever, persistent vomiting or diarrhea, bladder infection, increased swelling.<br>• GYN: Unusual vaginal discharge or vaginal bleeding post-menopause or hysterectomy, or detection of breast mass or breast lump. (OB-GYN) | | | | |

| Environmental Assessment Standards | Met | Not Met | N/A | Comments |
|---|---|---|---|---|
| Regular and routine care appointments that are not urgent but in need of attention are available within two to seven days:<br>• OB: Small amount of swelling in ankles or hands, sciatica pain (including hip or leg pain), respiratory infection, UTI symptoms.<br>• GYN: Increased menstrual cramps. (OB-GYN) | | | | |
| Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., regular routine obstetrical and gynecological appointments). (OB-GYN) | | | | |
| Immediate intervention for a life-threatening emergency is required to prevent death or serious harm to the patient or others. (BH) | | | | |
| Intervention within six hours is required for an emergency that is not life-threatening to prevent acute deterioration of the patient's clinical state that compromises patient safety. (BH) | | | | |
| Timely evaluation (within 48 hours) is needed for urgent care to prevent deterioration of the patient's condition. (BH) | | | | |
| Routine office visits are available (within 10 days) when the patient's condition is considered to be stable. (BH) | | | | |
| An individual clinical record is established, organized, and easily located, and data is easily retrievable for each patient. (ALL) | | | | |
| 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) | | | | |
| 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) | | | | |
| Each record indicates which medications have been prescribed, the dosages of each, the date of the initial prescription and refill, and the date the medication was discontinued, as applicable. (ALL) | | | | |
| 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) | | | | |
| All entries in the record contain a valid, legible provider'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) | | | | |
| All entries in the record are dated and are legible to someone other than the writer. (ALL) | | | | |
| The medical and 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) | | | | |

# Medical record standards

Each year a randomly selected number of PCPs, specialists, and BH providers participate in the Highmark Health Options provider medical record audit to ensure records comply with medical record standards. These have been adopted by the Highmark Health Options QI/UM Committee. Medical record standards have been developed for PCPs, specialists, and BH providers. Standards verify that providers are:

- Assured that medical records are being evaluated in a consistent manner.
- Aware of the expected level of care and associated documentation.
- Aware of the requirements for maintenance of confidential medical information and record keeping.

The QI/UM Committee has established the scoring standard of 80% of the elements pertaining to the medical record standards. If during a provider medical record audit a score of 80% has not been met, a follow-up review will be scheduled to assess improvement. Providers are notified of their results and any areas of deficiency by letter within 45 days of the review.

## Frequency of reviews

A sample of medical records from a randomly selected group of providers are reviewed each year.

| Medical Record Standards – PCPs and Specialists | |
|---|---|
| 1. Member ID | Each page in the record contains member name or member ID number. |
| 2. Signed entry | All entries are signed or initialed (electronically) by the provider. |
| 3. Dated entry | All entries are dated. |
| 4. Legibility | The record is legible to someone other than the provider or provider's staff. |
| 5. Problem list (PCPs only) | Problem list is current and completed for each member, including significant illness, medical conditions, and health maintenance concerns. |
| 6. Medication list | Prescribed medications and dosages are documented on a medication list. |
| 7. Allergies | Presence/absence of allergies or adverse reactions to medications are prominently noted (1 year of age and older). |
| 8. Medical history | An absence of allergies should be clearly documented in the record. |
| 9. Tobacco use | Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses. |
| 10. Alcohol use | Use/nonuse of tobacco products is documented on members age 12 and older. |
| 11. Drug use | Use/nonuse of alcohol is documented on members 12 years of age and older. |
| 12. History and physical | Use/nonuse of illicit drugs is documented on members 12 years of age and older. |
| 13. Lab, diagnostic tests, and other studies | A complete history and physical exam including appropriate subjective and objective information for presenting complaints. |
| 14. Working diagnosis | Labs and other studies must be appropriate to the presenting complaint, or diagnosis. |
| 15.Plan of action, therapies, treatment, prescribed regimens | There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit. |
| 16. Follow-up visit | 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. |

| Medical Record Standards – PCPs and Specialists | |
|---|---|
| 17. Continuity of care | Includes documentation on communication between PCP or specialist care (whichever applicable), notes from consultations, follow-up plans for significantly abnormal lab or imaging results, ER discharge summaries, and records from transferred care or SNFs/home care agencies, as applicable. |
| 18. Discharge summary | If the member was in the hospital, there is a discharge summary signed and dated within 30 days. |
| 19. Care medically appropriate | Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. |
| 20. Confidentiality | Medical records contain confidentiality statements or a copy of signed consents to release information. |
| 21. Telehealth visit consent | For telehealth and virtual visits, the member's verbal consent must be documented in the member's medical record. |

| Medical Record Standards – BH Providers | |
|---|---|
| 1. Member ID | Each page in the record contains member name or member ID number. |
| 2. Signed entry | All entries are signed or initialed (electronically) by the provider. |
| 3. Dated entry | All entries are dated. |
| 4. Legibility | The record is legible to someone other than the provider or provider's staff. |
| 5. Psychological assessment and 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 documented. |
| 6. Medication list | Prescribed medications and dosages are documented on a medication list. |
| 7. Allergies | Presence/absence of allergies or adverse reactions to medications are prominently noted (1 year of age and older). |
| 8. Tobacco use | An absence of allergies should be clearly documented in the record. |
| 9. Alcohol use | Use/nonuse of tobacco products is documented on members age 12 and older. |
| 10. Drug use | Use/nonuse of alcohol is documented on members 12 years of age and older. |
| 11. Lab, diagnostic tests, and other studies | Use/nonuse of illicit drugs is documented on members 12 years of age and older. |
| 12. Working diagnosis | Labs and other studies must be appropriate to the presenting complaint, or diagnosis. |
| 13. Plan of action, therapies, treatment | There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit. |
| 14. Preventive services | The provider initiating a treatment plan must describe the active target interventions with specific, measurable goals, and stated in behavioral terms, at the level of care proposed. Includes follow-up care. |
| 15. Continuity of care | There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources. |

| Medical Record Standards – BH Providers | |
|---|---|
| 16. Discharge summary | The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Discharge summaries are included, if applicable.<br><br>If the member was in the hospital, there is a discharge summary signed and dated within 30 days. |
| 17. Care medically appropriate | Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. |
| 18. Confidentiality | Medical records contain confidentiality statements or a copy of signed consents to release information. |
| 19. Telehealth visit consent | For telehealth and virtual visits, the member's verbal consent must be documented in the member's medical record. |

## Financial records maintenance and retention

In accordance with Highmark Health Options policies and procedures and HIPAA, providers will develop and maintain:

- Billing records relating to the health care services provided to patients.
- Copayments, if any, received by provider from patients for covered services.
- Information on the charges for those services.

For a period of seven years following the termination or expiration of the provider agreement, or until the closure of any ongoing audit that was opened during such seven-year period, whichever is later, the 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.

# Fraud, waste, and abuse

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

## Provider fraud, waste, and abuse (FWA) training

FWA trainings by Payment Integrity can be found on the Highmark Health Options website. All providers are required to have a representative review the provider FWA training upon contracting with Highmark Health Options and annually thereafter. The provider representative will be responsible for communicating the information obtained from the training to the entire staff. It is the provider's responsibility to either attend the annual provider FWA training or independently review the required materials. Providers will be expected to submit proof of their completion of the training when asked.

## FWA policies and procedures

Highmark Health Options policies and procedures follow the guidelines set forth by CMS. For further information on FWA, providers should refer to the CMS website. It is Highmark Health Options' policy to discharge any employee, terminate any provider, or recommend any member be withdrawn from the Medicaid program who, upon investigation, has been identified as being involved in fraudulent or abusive activities. If fraud or abuse is suspected, it is the provider's responsibility to immediately notify Highmark Health Options by calling the Fraud, Waste, and Abuse Hotline.

Common examples of provider FWA

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

Common examples of member FWA:

- Misreporting or failing to report information such as income, ownership of resources and property, or who lives in the household.
- Sharing Medicaid ID card.
- Trafficking SNAP benefits.

## Overpayments

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

## Payment integrity recovery requirements

Highmark Health Options has payment integrity functions that help ensure claims payment accuracy and to detect and prevent FWA, which include:

- FWA investigations and audits
- Prepayment claims edits
- Provider education
- Retrospective claims reviews

Payment integrity functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in CMS, AMA, NCCI, NCQA, and state Medicaid regulations.

All claims should be coded and documented in accordance with the HIPAA Transactions and Code Set Standards, which includes ICD-10-CM, National Drug codes (NDC), Code on Dental Procedures and Nomenclature code, HCPCS codes, CPT code, and other HIPAA code sets.

# Payment Integrity reviews

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

- Comply with all federal and state guidelines to identify overpayments.
- Possibly recommend corrective actions that may include prepayment review, payment suspension, and potential termination from the network.
- Pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days.
- Refer suspected FWA to appropriate agencies.

Highmark Health Options may pursue overpayments for the following reasons:

- Add-on codes reported without a primary procedure code
- Altered or forged records
- Claims documentation issues
- Clinical documentation issues
- Diagnosis codes that do not support the diagnosis or procedure
- Different rendering provider
- Duplicate claims
- Excessive services
- Group size exceeds limitations
- Inaccurate claim information
- Incorrect fee schedule applied to claim
- Invalid code combinations
- Invalid code or modifier
- Insufficient documentation
- Missing laboratory results
- Missing medication records
- Missing physician orders
- Missing records
- NCCI add-on code edits
- NCCI Medically Unlikely (MUE) edits
- NCCI Procedure to Procedure (PTP) edits
- No authorization or invalid authorization
- No services provided including no-shows and cancellations
- Noncovered service
- Outpatient services while member was inpatient
- Overlapping services
- Patient different than member
- Per diem services billed as separate or duplicate charges
- Potentially fraudulent activities
- Provider does not meet the requirements to render services
- Provider excluded
- Provider license terminated or expired
- Retrospective coordination of benefits
- Retrospective rate adjustments
- Retrospective termed member eligibility
- Services provided outside of practice standards

# Provider self-audit

Federal and state regulations require providers to routinely audit claims for overpayments. A process is in place for 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 within 60 days after the date on which they identified the overpayment. If the claim is:

- Less than two years old, retraction is preferred.
- Over two years old, a check is preferred.

If a listing of claims is not provided, Highmark Health Options cannot guarantee that the claims will not be audited again, for the same reason. Provide a listing of claims as requested on the Provider Self-Audit/ Overpayment Form (PDF). Conversely, if providers use extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with the submission.

Deposit of a provider check or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. Payment Integrity may contact the provider to discuss self-audit results as necessary. Mail the overpayment letter and refunds to Payment Integrity:

Highmark Health Options

120 Fifth Avenue

FAPHM-052C

Pittsburgh, PA 15222

In addition, overpayment letters can be submitted electronically to the Provider Self Audit inbox at ProviderSelfAudits@highmark.com.

For more information on self-audits, use the Self-Audit Toolkit on the CMS website. The electronic version of this and other e-bulletins and additional program integrity information can also be found on the Highmark Health Options website.

# Highmark Health Options payment integrity audit

Payment Integrity will periodically conduct audits. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond. Highmark Health Options partners with multiple vendors to conduct various post-payment audits or reviews, such as:

- Inpatient chart review
- Retrospective data mining review.
- Subrogation.

Vendor specific questions should be directed to Provider Services.

# FWA medical records request

Highmark Health Options may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If medical records are requested, 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. The provider must provide access to any medical, financial, or administrative records related to the services provided to patients within 30 days of the request or sooner. All required documentation must be submitted at the time of the original medical record request. Documentation will not be accepted after the review is complete.

Providers are required to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Set Standards, and Medicaid regulations as well as other applicable professional associations and advisory agencies. Providers should follow the guidelines for basic medical records:

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

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| **Consent to treatment** | • Identifies the patient.<br>• Includes the benefits and any potential risks.<br>• Lists the types of services and treatments.<br>• Must be easy to read and legible.<br>• Signed and dated by patient.<br>• Signed, dated, and credentialed by provider.<br>• Valid for dates of service. |
| **Release of information for payment** | • Identifies the patient.<br>• Lists the types of services and treatments.<br>• Must be easy to read and legible.<br>• Signed and dated by patient.<br>• Signed, dated, and credentialed by author or provider.<br>• Valid for dates of service. |

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| **Privacy practices** | • Identifies the patient.<br>• Must be easy to read and legible.<br>• Signed and dated by patient.<br>• Signed, dated, and credentialed by author or provider.<br>• Valid for dates of service. |
| **Medical information** | • Allergies and adverse reactions.<br>• Continuity of care is documented.<br>• High risk behaviors (e.g., tobacco or cigarette, alcohol, substance use, HIV/STD, nutrition, social and emotional risks, etc.).<br>• Immunizations and dates.<br>• Laboratory and other studies ordered.<br>• Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates.<br>• Must be easy to read and legible.<br>• Must contain the minimum personal biographical data:<br>– Address<br>– DOB<br>– Employer<br>– Gender<br>– Home telephone number<br>– Marital status<br>– Name of next of kin<br>– Next of Kin telephone number<br>– Occupation<br>– Work telephone number<br>• Significant illnesses and medical conditions. |
| **Treatment plan** | • Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice.<br>• Documents necessity for treatment.<br>• Documents that patient or guardian reviewed or participated with the development of the treatment plan.<br>• Identifies the diagnosis.<br>• Identifies interventions and goals of treatments.<br>• Identifies the patient.<br>• Must be easy to read and legible.<br>• Reviews are completed timely as applicable.<br>• Signed and dated by provider (e.g., witness or author's identification).<br>• Valid for dates of service. |

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| **Progress or clinical entry note** | • Corresponding encounter or timesheets, as applicable.<br>• Dates of service.<br>• Identifies the patient.<br>• Must be easy to read and legible.<br>• Note does not identify follow-up or next steps in treatment.<br>• Note does not identify the treatment goals and objectives.<br>• Note does not list symptoms and behaviors.<br>• Note is missing narrative or description of services.<br>• Place of service.<br>• Signed, dated, and credentialed by author or provider.<br>• Start and stop times for time-based services.<br>• Units of service. |
| **Medication list** | • Lists dosages, dates, and refills.<br>• Medication prescribed.<br>• Must be easy to read and legible.<br>• References the side effect and symptoms.<br>• Signed and dated by provider. |

# Risk adjustment

The Risk Adjustment programs reflect Highmark Health Options' commitment to improving the way it partners with providers to ensure members' chronic conditions are assessed, monitored, completely and accurately documented, and treated each year. While these comprehensive risk adjustment programs are used by Highmark Health Options to ultimately improve the member's quality of care, they also help to offset the medical cost for providing care to patients with more severe conditions.

Providers can currently participate in two Risk Adjustment programs:

- Prospective Gap Closure Campaign (PGC)
- Retrospective Gap Closure Campaign (RGC)

Both programs are designed to:

- Accurately report overall health condition codes to DMMA.
- Confirm or refute risk gaps for patients with chronic conditions.
- Improve patients' quality of care.
- Offer providers with payment incentives for Risk Adjustment program participation.

Email Risk Adjustment at DE-Provider-Engagement@highmark.com to learn more about the programs.

# Complaints, grievances, and appeals

## Provider complaint procedures

Highmark Health Options has created a provider complaint system for providers to raise issues with Highmark Health Options policies, procedures, and administrative functions, including proposed actions, claims, payments, and service authorizations. Complaints are 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 the complaint, Highmark Health Options will provide status updates to the provider. Providers have the option of calling a Provider Services representative or sending a written complaint within 45 days regarding any policy, procedure, or administrative function using the following methods:

- NaviNet® Provider Complaint Messaging Center.
- The Provider Complaint Form (PDF).
  - Fax or e-mail completed forms to HHO-ProviderComplaints@highmark.com.

Any misdirected submissions into the provider complaint system will be routed to the appropriate department. The provider will be advised of the redirection.

### Complaints about claim payments

Complaints about administrative claims payment are handled as a provider dispute. Providers may file a written complaint about claims payment by fax, through the enhanced provider features tab in NaviNet®, or send it to the address listed below within 180 days of the date of service, or 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
Fax: 1-833-202-9390

When a service has been denied due to lack of prior authorization or denied based on medical necessity and still provided to the patient, providers can appeal that decision after the service through the clinical provider appeals process. Providers can fax or mail these requests along with all supporting documentation to:

Highmark Health Options
Attn: Clinical Provider Appeals
P. O. Box 106004
Pittsburgh, PA 15230
Fax: 1-833-841-8074

A provider not involved in the original decision will review the clinical information and render a decision. The provider requesting the appeal will be notified of the status of this review within 60 days of the request. Follow the member appeals process, if the services have not been provided to the member.

# Registering a first level appeal

Any provider may file an 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. The provider appeal process must be initiated by the provider through a written request. Providers request for appeal must be received within:

- 60 days of the date of the Notice of Adverse Benefit Determination denying an authorization, unless otherwise negotiated by the agreement. In this instance, there is a denied authorization, however, services have already been provided.
- 180 days of the date of the denial notice denying a post-service claim, unless otherwise negotiated by the agreement. When an authorization has been denied, providers must adhere to the 60 day time frame. Providers 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 all supporting documentation including:

- A copy of the denied claim.
- Patient's medical records containing all pertinent information regarding the services rendered by the provider.
- Reason for the appeal.

Providers will be informed of:

- The decision in writing within 60 days from receipt.
- Approval or denial; payment for approvals will be issued within 60 days of notification.
- Additional appeal rights as applicable.

# Registering a second level appeal

If a 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 in writing within 60 calendar days of the date on the first level provider appeal decision letter, or as otherwise indicated via the contract.
- Include specific reasons as to why the provider does not agree with the first level provider appeal committee's decision.

All second level provider appeal reviews will:

- Be completed within 60 calendar days of the date the second level provider appeal request was received.
- Inform the provider of its decision in a written decision notice within 60 calendar days.

This is the final level of appeal and the decision is binding, unless otherwise governed per contract.

# Appeals and grievances

## Appeals

An appeal is a request for a review of an adverse benefit determination:

- 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.
- Highmark Health Options' failure to act within 30 calendar days from the date the plan receives a grievance or appeal.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities.

## Grievances

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (appeal) 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.

Examples of a nonmedical grievance:

- If a provider or Highmark Health Options employee was rude.
- If Highmark Health Options did not grant a "fast decision" for an appeal.
- If the member feels a provider or Highmark Health Options did not respect their rights as a member.

Examples of medical grievances are:

- If a member has a concern with the quality of care or services they have received.
- If a member has trouble finding or getting services from a provider, resulting in a delay in treatment.

# Filing grievances and appeals on behalf of a patient

Patients and providers will not be punished for filing an appeal, complaint, or grievance. A patient or provider may contact a Member Advocate or grievance coordinator at any time for help or any questions about the appeals and grievances process. Patients have a right to appoint a representative to act on their behalf. If a provider is acting on behalf of a patient, Highmark Health Options requires obtain the patient's consent in writing prior to reviewing a request for an appeal or grievance.

# Member advocates

Patients may ask a Member Advocate for help with their appeal or grievance who can help:

- Answer patient questions about the appeal or grievance process.
- File an appeal or grievance.
- Help the patient get additional information from a provider to help with their appeal or grievance review.
- Help the patient through the appeal or grievance process.

# Filing an appeal

Providers can file appeals by phone or in writing. For written appeal requests, complete the Member Appeal Form (PDF) online or send by fax. When filing an appeal include:

- Patient's name and ID number
- Provider phone number(s)
- Provider address
- State what the appeal is about
- State why the appeal is being filed
- State the desired outcome of the appeal

An appeal must be filed within 60 days from the date of the Notice of Adverse Benefit Determination letter. Providers can send or attach any additional information that will help with the appeal review to:

Highmark Health Options
Member Correspondence
P.O. Box 106004
Pittsburgh, PA 15230
Phone: 1-844-325-6251
Fax: 1-833-841-8074

# Rendering services during appeal process

It is **important** to know that the patient may have to pay for the services received during the appeal or State Fair Hearing process if the final decision is not in the patient's favor. If the decision is in the patient's favor, Highmark Health Options will authorize services within 72 hours from the date when the notice reversing the determination is received.

If the patient was previously authorized and getting services, the patient may ask to continue getting these services if:

- The patient files the request for an appeal timely (within 10 calendar days of Highmark Health Options 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.

If Highmark Health Options continues the patient's services during the appeal process, Highmark Health Options will cover these services until:

- The patient or patient's representative withdraws the appeal or request for a state fair hearing.
- The patient or patient's representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after Highmark Health Options sends the notice of an adverse resolution.
- A decision from the State Fair Hearing Officer was not in the patient's favor.

# After filing an appeal

A letter confirming receipt of the appeal will arrive within five business days after the appeal is received. It will also include information about the appeal review process. Providers may:

- Ask to look over all documents for the appeal.
- Present additional information in person or in writing as a representative on behalf of the patient.
- Request a copy of the information used to review free of charge.
- Submit additional information to support the appeal.

A health care professional who has the appropriate clinical expertise, as determined by the state, in treating the member's condition or disease will review the case. Providers may extend the time frame for making the appeal decision for up to 14 days. Highmark Health Options may also extend the time frame for decision up to 14 days if additional information is necessary and the delay is in the member's best interest. Providers will receive a written notice with the reason for the delay.

After review, a decision letter will be mailed within 30 days from the date the appeal was filed or within two days of the decision, whichever is sooner. This letter will state the reason for the decision and further appeal rights including the right to ask for a State Fair Hearing.

# Expedited ("fast") appeals

If the normal time frame to review an appeal could seriously jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function, providers may ask for an expedited either orally or in writing. Decisions are sent within 72 hours from the day the request is filed. The following information is required for expedited appeals:

- Patient's name and ID number.
- Provider phone number(s).
- Provider address.
- State the service or item being appealing.
- State why the member's life or health or ability to attain, maintain, or regain maximum function is in jeopardy.
- State the desired result from the appeal.

# After filing expedited appeals

The time frame for an expedited appeal is very short. Immediate action is required. Providers may submit:

- Additional information to support the appeal.
- Ask to look over all documents for the appeal.
- Present additional information as a representative on behalf of the patient.
- Request a copy of the information used to review the appeal free of charge.

A health care professional who has the appropriate clinical expertise, as determined by the state, in treating the patient's condition or disease will review the case. Providers may extend the time frame for making the appeal decision for up to 14 days. Highmark Health Options may also extend the time frame for decision up to 14 days if additional information is necessary and the delay is in the patient's best interest. Providers will receive a written notice with the reason for the delay.

Providers will be contacted about the outcome of the expedited appeal after a decision is made. A decision letter will also be mailed within 72 hours or three business days, whichever is sooner, from the date the appeal was filed. This letter will provide the reason for the decision and further appeal rights including the right to ask for a State Fair Hearing.

## State fair hearings

A State Fair Hearing is an appeal process provided by the State of Delaware either in person or by telephone. If providers do not agree with a denial of an appeal decision, they may request a State Fair Hearing within 90 calendar days of the date on the notice of resolution upholding the adverse benefit determination. A State Fair Hearing can be requested by calling or writing to the State's 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)

If providers are acting on behalf of a patient, they may request a State Fair Hearing instead of, or in addition to, filing an appeal. Providers may ask for a State Fair Hearing if Highmark Health Options has:

- Delayed service.
- Denied, suspended, terminated, or reduced a service.
- Failed to give a timely service.

## After filing a state fair hearing

Providers will receive a letter from the State Fair Hearing Officer that will provide the date, time, and location of the hearing. The letter will also tell providers how to prepare for the hearing. Providers 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 a letter with their decision within 30 days from the date of the hearing.

## Continuing services during the state fair hearing process

It is **important** to know that the patient might have to pay for the services they received while the State Fair Hearing was pending if the final decision is not in the patient's favor. If the decision is in the patient's favor, Highmark Health Options will authorize services immediately.

If the patient was previously authorized and getting services, the patient may ask to continue getting these services if:

- The patient files the State Fair Hearing request timely (within 10 calendar days of Highmark Health Options 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.
- The patient timely files for continuation of the benefits.

If Highmark Health Options continues the patient's services during the State Fair Hearing process, Highmark Health Options will cover these services until:

- The patient or patient's representative withdraws the appeal or request for a State Fair Hearing.
- The patient or patient's representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after Highmark Health Options sends the notice of an adverse resolution.
- A decision from the State Fair Hearing Officer was not in the patient's favor.

## Disagreeing with the state fair hearing decision

If the patient or patient's representative disagrees with the State Fair Hearing decision, they can ask for a judicial review in Superior Court. They must file an appeal with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the State Fair Hearing decision.

## Grievance process

To file a grievance or a grievance on behalf of a patient, call Member Services or submit in writing or by filling out a Member Grievance Form (PDF). If a provider files a grievance on behalf of a patient, the patient cannot file a separate grievance. When filing a grievance include:

- Patient name and ID number.
- Provider phone number.
- Provider address.
- Those involved in the grievance.
- Details of the occurrence.
- Date of the occurrence.
- Where the occurrence happened.
- The desired outcome from the filed grievance.

There is no time limit to file a grievance. Providers may send or attach to the Member Grievance Form (PDF) any additional documents to support the grievance and send to:

Highmark Health Options
Member Appeals
P.O. Box 106004
Pittsburgh, PA 15230
Phone: 1-844-325-6251
Fax: 1-833-841-8074

## After a grievance is filed

A letter will arrive within five business days after the grievance is filed to confirm receipt by Highmark Health Options.

It will include:

- Information about the grievance review process.
- Provider rights as a patient representative, including the right to:
  - Review or request a copy of all documentation regarding the grievance free of charge.
  - Submit additional information.

A grievance coordinator will then send the case to a subject matter expert or a health care professional.

- If the grievance does not involve a medical issue, a Highmark Health Options staff members, who has not been involved with the grievance but is a subject matter expert, will review the request.
- If the grievance is medical in nature, a health care professional that has the appropriate clinical expertise, as determined by the state, in treating the patient's condition or disease will review.

A decision will be made within 30 days after the grievance is received and will tell providers the reason(s) for the decision.

Providers may extend the time frame for the grievance decision up to 14 days. Highmark Health Options may also extend the time frame for decision of the grievance up to 14 days if additional information is necessary and the delay is in the patient's best interest. Providers will receive a written notice with the reason for the delay.

# Provider disputes

Provider disputes are requests that are administrative in nature such as:

- Appeals of denials regarding lack of modifiers.
- Coordination of benefit issues.
- Disputes regarding the amount paid.
- Refunded claim payments due to incorrect payments.

# Dispute resolution process

In the event that the 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 benefit plan or the medical necessity of an individual claim, procedure, or service, a provider may appeal that decision pursuant to the procedures set forth in this provider manual. Parts B and C will 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 provider to the attention of the corporate officer of Highmark Health Options, or their designee, responsible for provider agreements. The parties will attempt to resolve any such dispute through informal negotiations. If attempts at resolving the dispute fail, the corporate officer for provider agreements will respond to the notification of the alleged breach in writing within 30 days of termination of the parties' negotiation efforts. Highmark Health Options' response will state its determination as to whether a breach occurred.
- This decision will be final unless the provider notifies Highmark Health Options of its desire to have the matter decided through arbitration. The provider must notify Highmark Health Options within 30 days after the date upon which the 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.

- The arbitration will 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, will be divided equally between Highmark Health Options and the 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.

# Claims

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 form for hospital or facility expenses. 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 or denial. To ensure 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 provider 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 provider or an employee under the provider's direction. The provider certifies that the information contained in the claim is true, accurate, and complete.

## Claim submission requirements

### Attachments not currently accepted on electronic claims

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, services billed by report cannot be submitted as attachments along with electronic claims.

### Diagnosis coding

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

### Hospital service

Submit hospital claims on a UB-04 claim form. Include the patient's 12-digit Highmark Health Options ID number (UMI) or Medicaid ID number on all claims to ensure that claims are processed for the correct patient. Providers rendering services in an outpatient hospital clinic should include:

- CMS-1500: Provider's group NPI and the provider's individual NPI must be reported.
- UB-04: Facility NPI and the provider's individual NPI must be on the claim.

Patient account numbers recorded on the claim form by the provider are indicated in the Patient ID field of the Highmark Health Options remittance advice. Any questions concerning billing procedures or claim payments can be directed to Provider Services.

### Information resources

Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website. The Provider Remittance provides detailed payment data based on the information provided to Highmark Health Options. 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). CARC and RARC codes are on the Washington Publishing Company website. Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

### Reporting provider identification number

PCPs and specialty care providers must submit claims under the individual national provider identifier (NPI) and tax identification number (TIN) to comply with encounter data reporting. Claims will be rejected up-front if the individual provider number is not included. The only exception to this requirement applies to UB-04 charges for providers services when a remittance advice is issued to a hospital facility.

DMMA billing guidelines state 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 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 department provider groups must include the individual provider identification number.

Any claim billed on a CMS-1500 form must include the individual provider identification number in Box 24J.

It is extremely important to notify Highmark Health Options of any change that involves adding providers to any group practice, as failure to do so may result in a denial of service.

## Timely filing guidelines

Providers must submit a complete original, initial claim within 120 calendar days after the date of service or 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 Highmark Health Options initial remittance advice.

If billing on paper, Highmark Health Options will only accept paper claims on original CMS-1500 form (version 02/12), or UB-04 forms. Paper claims 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:

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

## Patients with other insurance coverage

Highmark Health Options, like Delaware's DHSS, is the payer of last resort on claims for services provided to patients when any commercial or Medicare plan covers the patient. 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 the timely filing guidelines.

### Submission of Highmark Health Options secondary payer claims

To receive payment for services provided to patients with other insurance coverage, the provider must first bill the patient's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's EOB, the provider should submit a claim to Highmark Health Options. Providers must bill within 60 days from the date of an 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.

The provider must:

- Follow all authorization procedures.
- File all claims within timely filing limits as required by the primary insurance carrier.
- Submit a copy of the primary carrier's EOB with the claim to Highmark Health Option within 60 days of the date of the primary carrier's EOB, Advance Beneficiary Notice of Noncoverage (ABN), or Letter of Denial.
  - Secondary and tertiary claims can be sent electronically.
- Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.
- The amount billed 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.

## 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 provider 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.

The provider has the option of submitting an original claim; however, it must be submitted within 120 days. These claims will be denied for timely filing if they are not received within 120 days of service. The 60 day rule for third party liability (TPL) applies to auto and casualty when the provider attaches either an EOB or auto casualty exhaustion letter. If the provider submits the claim with the EOB, Highmark Health Options will coordinate benefits.

## Verifying if primary coverage no longer applies

If a patient indicates they no longer have primary coverage, but the state system contains information indicating other medical coverage is still active, the patient should contact their caseworker to have the state system updated. If this is not possible, the provider 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 patient 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 patient. If the investigation confirms that the patient 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 the system immediately and reprocess claims finalized within the 120 day period prior to the date of the onset of the investigation. Patients cannot be billed for any co-payments or co-insurance, as regulated by DHSS.

# Claim submission procedures

- Submit claims for all services provided.
- The billing provider's five digit plus four 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.
- Payment for CPT and HCPCS codes are covered to the extent that they are recognized by DHHS or allowed per medical review determination by Highmark Health Options. Correct coding must be submitted for each service rendered and nonspecific CPT codes will require a description added to the claim form.

- Highmark Health Options utilizes 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.
- Hospitals and facilities should bill on original UB-04 forms; 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 and current provider information must be entered on all claims; The 10-digit NPI is required.
- Correct and current patient information, including the 12-digit patient ID number or Medicaid number, must be entered on all claims.
- Allow four to six weeks for a remittance advice; It is the provider's responsibility to research the status of the claim.
- Timely filing criteria for initial bills are 120 days from the date of service or 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 Highmark Health Options initial remittance advice.
- 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 the timely filing guidelines.
- Any reimbursement or coding changes made by the DHSS to its current inpatient and outpatient fee schedules will 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.

# EPSDT claims

All EPSDT claims and primary care services must be submitted within within 120 calendar days after the date of service or 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 Highmark Health Options initial remittance advice. Highmark Health Options will process and pay EPSDT, early intervention services, services for children ages 0-3 years old, and prenatal visits as primary even when records indicate Highmark Health Options is secondary and a primary plan exists. If an EOB is attached to the EPSDT, Early Intervention Services, or prenatal claim, then coordination of benefits will be applied. Highmark Health Options will continue to coordinate benefits and require the primary EOBs when submitting the delivery claim.

## EPSDT paper claim format requirements

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385 and 99391-99395) along with EP modifier.
  - **Note:** Providers must also include the coding for each individual screening they have provided for the member along with the age-appropriate E and M codes.
- 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, 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 form 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 form. 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 |

## Submit EPSDT claim via paper (1500) or electronic format (837P)

All EPSDT screening services, including vaccine administration fees, should be submitted either on a CMS-1500 form or the corresponding 837P electronic format for EDI claims within 120 days from the date of service. EPSDT screenings on a UB-04 form or the corresponding 837I electronic format are not accepted.

An EPSDT screening 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 (Bright Futures Periodicity Schedule and Coding Matrix (PDF) and 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, FQHCs or RHCs may not bill for partial screens.

## EPSDT payment

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

Electronic data interchange (EDI) requirements for EPSDT claims:

- All EPSDT screening services must be reported with the age appropriate evaluation and management code (99381-99385, and 99391-99395) along with the EP modifier. Each EPSDT screening as a child well visit should be listed as outlined above.
  - Providers should call out each individual screening that is done with a well visit should be listed.
- 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, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21 on paper claims. Electronic claims should be a loop or segment.
  - Appropriate evaluation and management codes must be included.
  - Appropriate referral codes for first time referrals to dental and first-time referrals to specialists.
- 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.
- 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 |

### All EPSDT submissions must use ICD 10 codes

Highmark Health Options requires PCPs who are treating children to enroll them in the Vaccine for Children (VFC) Program. This program provides vaccines at no cost to providers. The VFC website provides an overview of the program and includes information regarding eligibility requirements. Highmark Health Options will reimburse an administrative fee when a vaccine administration codes is billed for each vaccine code along with the appropriate NDC number.

Contact a Provider Account Liaison or Provider Services with any questions. More information on EPSDT or VFC can be found below:

- EPSDT Program Periodicity Schedule and Coding Matrix
- Bright Futures/AAP Periodicity Schedule (PDF)
- CDC Immunization Schedule (PDF)
- DHSS Immunizations – Infants & and Children (PDF)
- CDC Vaccine for Children Program (PDF)

## Obstetrical care services

Obstetric providers are reimbursed on a per visit basis. All visits and dates of service must be included on the CMS-1500 Form or 837P form 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 with Highmark Health Options are processed under the newborn name and newborn's Highmark Health Options identification number. For prompt payment, 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 mother's confinement.

## 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. The program used is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, provider, and provider-specialty level. This coding program contains complete sets of rules that correspond to:

- AMA CPT-4
- HCPCS
- ICD-10
- CMS guidelines and industry standards
- Medical policy
- Literature and academic affiliations

### Electronic claim submission

Highmark Health Options can accept claims electronically through Emdeon. Providers are encouraged to use the electronic claims processing capabilities. Submitting claims electronically offers:

- Faster claims submission and processing
- Increased claims accuracy
- Reduced paperwork
- Time and cost savings

For professional or institutional electronic claims for Highmark Health Options members, use the Highmark BCBSD Highmark Health Options, Inc. Change Health Payer ID Number 47181.

## Electronic remittance advice (ERA)

Providers may receive an electronic claims remittance advice (ERA). Highmark Health Options uses Change Health or Relay Health to transfer the 835 Version 5010 Healthcare Claim Remittance Advice to claim submitters.Providers must register to receive electronic funds transfer (ACH Direct Deposit) transactions. A registration form is available on the Highmark Health Options website.

## Electronic claims 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 12-digit member identification number.
- The member number field allows 10 digits to be entered.
- For providers who do not know the member's Highmark Health Options identification number, it is acceptable to submit the member's recipient number.

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.

Providers must be diligent in reviewing all acceptance and rejection reports to identify claims that may not have successfully been accepted by Emdeon and Highmark Health Options. Edits applied when claims are received 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. Providers should receive and review the following reports on a daily basis:

- Change Health - Provider Daily Statistics (RO22)
- Change Health - Daily Acceptance Report by Provider (RO26)
- Change Health - Unprocessed Claim Report (RO59)

## Nonelectronic submissions

Providers not submitting claims electronically can contact the EDI vendor for information on how to submit claims electronically. Providers may also call Emdeon.

## CMS-1500 form data elements for paper claim submission

| Field # | Description | Requirements |
|---|---|---|
| 1 | Insurance type | Required |
| 1a | Insured's identification number | Member ID number required |
| 2 | Patient's name | Required |
| 3 | Patient's birth date<br>Patient's sex | Required<br>Required |

| Field # | Description | Requirements |
|---|---|---|
| 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:<br>• Auto accident<br>• Employment<br>• Other accident | Required, if applicable |
| 10d | Claim codes (designated by NUCC) | Not required (see instructions for EPSDT claims) |
| 11 | Insured's policy group or FECA | Required |
| 11a | Insured's date of birth<br>Insured's sex | Required, if applicable<br>Required, if applicable |
| 11b | Other claim ID (designated by NUCC) | Required, if applicable |
| 11c | Insurance plan name or program name | Required, if applicable |
| 11d | Another health benefit plan | Required, if applicable |
| 12 | Patient's or authorized person's signature. | Required |
| 13 | Insured's or authorized person's | Required |
| 14 | Date of current illness, injury or pregnancy (LMP) | Required, if applicable |
| 15 | Qual<br>Other date | Not required<br>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 | Required, if a corrected claim |
| 23 | Prior authorization number | Required, if applicable |
| 24a | Date(s) of service | Required |
| 24b | Place of service | Required |

| Field # | Description | Requirements |
|---|---|---|
| 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)<br>Rendering provider ID number (unshaded) | Required<br>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 provider name and date required |
| 32 | Service facility location information | Name and address where services were rendered required |
| 32a | Facility NPI | Required, if applicable |
| 33b | Other | Not required |
| 33 | Billing provider info and phone number | Highmark Health Options vendor name, address, and number required |
| 33a | Billing provider NPI | Required |
| 33b | Other | Billing provider taxonomy code required |

The above field numbers and descriptions were pulled from the CMS-1500 form published on the CMS website. Form details are 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 | 2023-08-31 |

## UB-04 form data elements for paper claim submission

| Field | Description | Requirements |
|---|---|---|
| 1 | Provider name, address, phone number | Required |
| 2 | Unlabeled field | Not required |

| Field # | Description | Requirements |
|---|---|---|
| 3b | Medical record number | Not required |
| 4 | Type of bill | Required |
| 5 | Federal tax number | Required |
| 6 | Statement covers period – from to 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 |
| 49 | Unlabeled field | Not required |
| 50 | Payer name | Required |
| 51 | Health plan ID | Highmark Health Options provider identification number required |
| 52 | Release of information | Not required |

| Field # | Description | Requirements |
|---|---|---|
| 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 ID number required |
| 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 |
| 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 |

The above field numbers and descriptions were pulled from the CMS 1450 form published on the CMS website. Form details are on the following page.

| | |
|---|---|
| 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 |

# Claim types

## Clean claims

Clean claim refers to a claim for payment for a health care service that has no defect or impropriety. Claims will 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) or an acceptable electronic format through a Highmark Health Options-contracted clearinghouse:

- Patient name
- Patient medical plan identifier
- Date of service for each covered service
- Description of covered services rendered using valid coding and abbreviated description
- Name of provider and plan identifier
- NIAC code
- Provider tax identification number
- Provider's NPI
- Provider's taxonomy code

- Valid CMS place of service code
- Billed charge amount for each covered service
- Primary carrier EOB when patient has other insurance
- 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
- DRG code for inpatient hospital claims

### Nonclean claims

A defect or impropriety will include but is not limited to:

- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
- Lack of required substantiating documentation.

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. within 120 calendar days from the date of service or 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 Highmark Health Options initial remittance advice.

## Requests for claim review

Requests for reviews or corrections of processed claims must be submitted within 180 days from the date of the corresponding remittance advice. All claims submitted after the following time periods will be denied:

- 120-day period for initial claims
- 60 day period from the date of remittance from a primary payer
- 180-day follow-up period from the date on the initial remittance

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

Claims status inquiries can be researched via NaviNet.

### Review process

When 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, the Medical Director will make the final decision to approve or deny the claim. A final decision is made within 30 days from receipt of the inquiry. If the Medical Director does not approve the services, a denial letter is sent to the provider. If the provider is not satisfied with the results of the medical necessity review, a written complaint can be submitted which will be treated as an appeal.

## Claim inquiries

Any claim that has been submitted but does not appear on a remittance advice within 60 days following submission should be researched by the provider. Claims status inquiries can be researched via NaviNet® or by calling Provider Services to inquire whether the claim was received or processed.

# Exceptions

Exceptions to timely filing criteria are evaluated upon receipt of documentation supporting the request for the exception. Exceptions are granted on a one-time basis upon approval and the claim system is noted accordingly.

# Claim adjustments, reconsiderations, and appeals

Highmark Health Options will review any claim that a provider feels was denied or paid incorrectly. The request can be made in writing or verbally to Provider Services if the inquiry relates to an administrative issue. Forward all the appropriate documentation to expedite the review process. Initial claims that are not received within the 120 day timely filing limit will not qualify for review. All follow-up review requests must be received within 180 days of the date of service or 60 days of the date of payment, whichever is later.

# Highmark Health Options reimbursement

Reimbursement by Highmark Health Options is considered payment in full. Providers may not seek compensation from a patient unless:

- The patient accepts financial responsibility in a signed document that includes:
  - Notification that Highmark Health Options will not pay or be liable for the listed services.
  - Notification that the patient will be financially liable for listed services.
  - The cost of noncovered services.
  - The services provided.
- The patient is informed in advance that a proposed service is not a covered benefit.
- Services were rendered as an ongoing service during the appeal process and the result of the appeal process was a denial determination.

## 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 patient. 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.

## Pharmacy reimbursements

Prescription medications are reimbursed when the medication is prescribed for:

- FDA-approved indication(s).
- Indications, dosages, and formulations that are part of nationally developed standards.
- 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 patient based on a demonstration of medical necessity. In addition, Highmark Health Options will not reimburse any providers for any Part D covered drugs provided to a member who is dual eligible.

Select over-the-counter (OTC) pharmaceuticals, including vitamins, are a covered benefit for all noninstitutionalized patients. Patients must have a written prescription for each OTC pharmaceutical or

vitamin and the prescription must be filled by a Highmark Health Options network pharmacy. The labeler of the OTC product must also be participating in the Federal Medicaid Drug Rebate Program.

The following are noncovered pharmacy services:

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

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. Providers registered with the PMP can obtain immediate access to an online report of current or prospective patient's-controlled substance prescription history. Pharmacies and providers are not permitted to distribute prescription history reports from the PMP system to patients.

Providers are encouraged to use this information as part of their clinical assessment to improve patient care and monitor for misuse and diversion of controlled substances. All PMP users must comply with HIPAA Privacy Rule requirements.

# Specific billing guidelines

## Specialty and 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 patient 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 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 within 60 days of the date of the EOB. If required, all authorization requirements must be met in order for payment to be issued.

### Determining Highmark Health Options liability after primary

Highmark Health Options uses the Benefit Less Benefit methodology for COB. If a primary payer paid more than the HHO allowed amount or there is no patient liability, HHO would not make a payment. Otherwise, HHO pays the lessor of:

- The difference between what the primary paid and our allowed amount.
- The patient responsibility.

## Payment types

Example of in-network providers with primary plan.

| | |
|---|---|
| Provider charges | $1,500 |
| Primary carrier allowable | $1,000 |
| Primary payment (80% of allowable) | $800 |
| Highmark Health Option allowable if primary | $600 |
| Highmark Health Option compares the primary carrier Highmark Health Option allowable | $800 vs. $600 |
| Highmark Health Option does not issue payment | $0 |

### Example of patient responsibility remaining after primary plan

| | |
|---|---|
| Provider charges | $1,500 |
| Primary care allowable | $1,000 |
| Primary payment (80% of allowable) | $800 |
| Patient responsibility under primary plan | $200 |
| Highmark Health Option allowable if primary | $850 |
| Highmark Health Option compares the primary carrier Highmark Health Option allowable | $800 vs. $850 |
| Highmark Health Option issues payment | $50 |

## Highmark Health Options members with Medicare coverage

When Medicare is the other insurance, the following processing criteria applies:

- For Medicare Part A and Medicare Part B services, coverage is provided according to a benefits-less-benefits calculation.
- 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.

## Payment calculation

Highmark Health Options determines the amount that would normally be paid 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 80 percent of the Medicare approved amount.

### Examples of payment calculations

| Example A | |
|---|---|
| Provider charges | $1,500 |
| Deductible is satisfied | - |
| Medicare allowable | $1,000 |

| | |
|---|---|
| Medicare payment (80% of allowable) | $800 |
| Highmark Health Options allowable if primary | $600 |
| Highmark Health Options compares the Medicare payment to the Highmark Health Options allowable | $800 vs. $600 |
| Highmark Health Options does not issue payment | $0 |

| **Example B** | |
|---|---|
| Provider charges | $1,500 |
| Deductible is satisfied | - |
| Medicare allowable | $1,000 |
| Medicare payment (80% of allowable) | $800 |
| Highmark Health Options allowable if primary | $850 |
| Highmark Health Options compares the Medicare Payment to the Highmark Health Options allowable | $800 vs. $850 |
| Highmark Health Options issues payment for the difference | $50 |

| **Example C** | |
|---|---|
| Provider charges | $1,500 |
| Medicare allowable | $1,000 |
| Medicare applies $50 to satisfy the deductible | $50 |
| Medicare payment (80% of allowable) remaining after deductible is satisfied | $760 |
| Highmark Health Options allowable if primary | $850 |
| Highmark Health Options compares the Medicare payment to the Highmark Health Options allowable | $760 vs. $850 |
| Highmark Health Options Issues payment for the difference | $90 |

# Subrogation

According to the agreement with the Delaware DHSS, if a patient 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, provider 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 team and will be forwarded to the DHSS TPL department.

# Claims submission

Claims submitted by a provider and without an EOB statement from auto insurance or casualty plans without any notation on the original bill of the primary payer, will be processed similar to any other claims. Highmark Health Options may neither unreasonably delay payment nor deny payment of claims because Highmark Health Options is involved in injury stemming from an accident, such as a motor vehicle accident, where the services are otherwise covered.

Timely filing criteria of 120 days apply and original claims must be received timely to be eligible for payment. EOB or auto, workers' compensation, or casualty exhaustion letters qualify for consideration if they are received within 60 days of the date of the primary payer's EOB or letter along with submission of the initial bill in order for Highmark Health Options to coordinate benefits. However, if the auto or casualty EOB is submitted after Highmark Health Options has already paid as primary, claims cannot be adjusted, as Highmark Health Options complies with criteria set by DHSS.

# Requests for information

All requests from legal representatives, or insurers for information concerning copies of patient bills or medical records must be submitted to Highmark Health Options' legal team. 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 patient should be forwarded to:

Highmark Health Options

Attn: Legal/Regulatory Affairs

P.O. Box 890419

Camp Hill, PA 17089-0419

# 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 surgical procedures or operating sessions. Reimbursement percentage paid may vary. We follow Medicare guidelines for multiple surgeries.

## Reimbursement

Highmark Health Options determines reimbursement upon the clinical intensity of each procedure and reimbursement percentage paid may vary. We follow Medicare guidelines for multiple surgery. 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 procedure per date of service and will be reimbursed at 20 percent of the 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 provider's name, the AS modifier indicating this was a physician's assistant must be included on the claim.

## Anesthesia services

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 form for providers who bill in paper format. In addition, Highmark Health Options requires all anesthesia services be submitted with pricing modifiers in the first modifier position.

Additional tips

- If providing pain management services, then continue to bill with surgical codes.
- If providing 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, providers 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.

## Chiropractic billing of services

Services that do not meet the criteria of this policy will not be considered medically necessary. A provider cannot bill the patient for the denied service unless:

- The patient agrees in writing to assume financial responsibility in advance of receiving the service. The signed agreement must be maintained in the patient's medical records.
- The patient is provided with an estimate of the cost.
- The provider has given advance written notice, informing the patient that the service may be deemed not medically necessary.

## Long-term services and supports (LTSS) billing and reimbursement

When billing for services rendered to DSHP Plus LTSS Program patients, 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 appropriate electronic filing format. In addition to the following DSHP Plus LTSS patient-specific billing guidelines outlined below, all the billing guidelines apply.

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

| HCPCS Code | Description | Revenue Code | Description |
|---|---|---|---|
| G0151 | Services of physical therapist in home health setting, each 15 minutes | 0422 | Physical therapy, 15-minute charge |
| G0152 | Services of occupational therapist in home health setting, each 15 minutes | 0432 | Occupational therapy, 15-minute charge |

| HCPCS Code | Description | Revenue Code | Description |
|---|---|---|---|
| G0153 | Services of speech and language pathologist in home health setting, each 15 minutes | 0442 | Speech or language pathology, 15-minute charge |
| G0300 | Home health LPN visit | 0552 | Skilled nursing, 15-minute charge |
| G0299 | Home health RN visit | 0552 | Skilled nursing, 1- minute charge |
| G0156 | Services of home health aide in home health setting, each 15 minutes.<br>**Note**: This code will be used for all home health aide services including home health aide provided to assisted living waiver clients. | 0572 | Home health aide (home health), 15-minute charge |

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 LTSS-specific billing guidelines is available on the Highmark Health Options website.

# Highmark Health Options member information

## Enrollment and eligibility determination

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

DHSS employs a Health Benefit Manager (HBM) who performs outreach, education, enrollment, transfer, and disenrollment of clients and members. The HBM explains the benefits covered by Highmark Health Options and other MCOs and helps recipients choose an MCO that meets their needs. Potential members are encouraged to select a PCP from a list of in-network providers. If a member does not select a PCP at the time of enrollment, the member will be auto-assigned to an in-network PCP.

Eligible recipients 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. Recipients approved by DHSS are added to the Highmark Health Options information system with the effective date assigned by the State. Newly enrolled members receive a welcome letter and ID card.

## LTSS eligibility and enrollment

An individual must qualify both financially and medically to enroll into the DSHP Plus LTSS Program. The state performs the initial level of care (LOC) determination for those being considered for the LTSS LOC benefits and financial assessment for those being considered for the DSHP Plus LTSS Program. 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 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 through a managed care delivery system to the following populations:

- Individuals age 18 and older or disabled individuals age 18 and over who do not meet the NF LOC, but who, in the absence of HCBS, are at risk of institutionalization and meet the at-risk for NF LOC criteria.
- Individuals with a diagnosis of AIDS or HIV, age one and older, who meet the acute hospital LOC criteria and require assistance with at least one activity of daily living (ADL).
- Institutionalized individuals in NF who meet the NF LOC.

### At-risk members

At-risk members are individuals who do not meet the NF LOC but are at risk of institutionalization.

### LTSS reporting

The Division of Medicaid and Medical Assistance (DMMA) requires Highmark Health Options to report all missed hours/shifts/visits each month for members who receive home health services. It is imperative that providers submit their reports for the prior month no later than the 8th of the current month.

Providers failing submit the report by the 8th of each month will be reported as non-compliant to DMMA and be subject to corrective action by Highmark Health Options.

Providers must submit a report each month to Highmark Health Options, even if there are no missed hours/shifts/visits. These reports help track the total shifts not provided, the number of hours authorized, the number of hours completed, and the number of hours not provided per month.

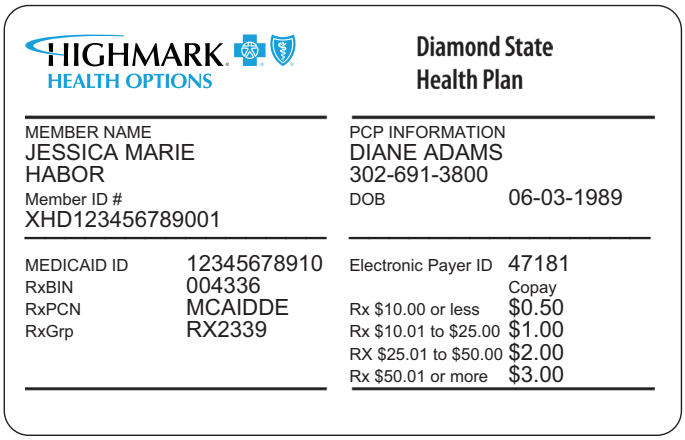
### LTSS case management

Case management involves the systematic process of assessment, planning, coordinating, implementing, and evaluating care through a fully integrated physical health, BH, and LTSS program to ensure the care needs of the member are met.

## Member identification cards

Recipients approved by DHSS are added to Highmark Health Options information system with the effective date assigned by DHSS. Newly enrolled members receive a welcome letter and ID card (See samples below).

**Sample ID Card**


HIGHMARK HEALTH OPTIONS

Diamond State Health Plan

MEMBER NAME
JESSICA MARIE HABOR
Member ID #
XHD123456789001

PCP INFORMATION
DIANE ADAMS
302-691-3800
DOB 06-03-1989

MEDICAID ID 12345678910
RxBIN 004336
RxPCN MCAIDDE
RxGrp RX2339

Electronic Payer ID 47181

| | Copay |
|---|---|
| Rx $10.00 or less | $0.50 |
| Rx $10.01 to $25.00 | $1.00 |
| RX $25.01 to $50.00 | $2.00 |
| Rx $50.01 or more | $3.00 |


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, call 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.

CVS caremark

www.highmarkhealthoptions.com

| | |
|---|---|
| **Member Services** | 1-844-325-6251 |
| **TTY Hearing Svc** | Dial 711 or 1-800-232-5460 |
| **24 Hr. Nurse Line** | 1-844-325-6251 |
| **Behavioral Health** | 1-844-325-6251 |
| **For Providers:** | |
| **Eligibility IVR** | 1-844-325-6251 |
| **Pre-Certification** | 1-844-325-6251 |
| **Pharmacy Helpdesk** | 1-800-364-6331 |

**File claims to:**
Highmark Health Options Claims Dept
P.O. Box 890402
Camp Hill, PA 17089-0402

*For Hospitals or Physicians: File claim with local Blue Cross Blue Shield Plan.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

*Pharmacy Benefits Administrator

## Highmark Health Options member rights and responsibilities

### 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, covered services, PCPs, and other health care providers.
- See their medical records as allowed by law.
- Have their medical records kept private unless they tell Highmark Health Options in writing that it is okay for Highmark Health Options to share them or it is allowed by law.

- Complete facts from their provider 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 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 providers are paid.
- Find out how Highmark Health Options decides 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 Highmark Health Options, their PCPs, 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 provider 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 Highmark Health Options, 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 the Provider Directory that are taking new patients.
- Use providers who are in-network.
- Get medical care in a timely manner.
- Get services from providers out-of-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 Highmark Health Options their concerns about Highmark Health Options and the health care services they receive.
- Question a decision Highmark Health Options makes about coverage for care they got from their provider.
- 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 Highmark Health Options what they think about their rights and responsibilities and suggest changes.
- Ask Highmark Health Options about the Quality Improvement Program and tell Highmark Health Options how they would like to see changes made.
- Ask Highmark Health Options about the utilization review process and give Highmark Health Options ideas on how to change it.
- Know that Highmark Health Options only cover health care services that are a part of their plan.
- Know that Highmark Health Options can make changes to their health plan benefits as long as Highmark Health Options tells 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 ask for a copy of the Member Handbook at any time; they will be notified annually of their right to ask for a handbook.
- Know how they can get a list of in-network providers, including the names and education level of all network providers, and how they may choose providers within Highmark Health Options.

## Member responsibilities

Highmark Health Options members must do their part to receive the best care. Members have the responsibility to:

- Tell Highmark Health Options, their PCPs, and their health care providers what they need to know to treat them.
- Ask Highmark Health Options to correct their health and claims records if they feel they are incorrect or incomplete.
  - Highmark Health Options may say "no" to their request, but Highmark Health Options 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 can 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 PCP.
- Ask questions about any medical issue and make sure they understand what their PCP tells them.
- Follow the care plan and instructions that they have agreed on with their providers or other health care professionals.
- Do the things that keep them from getting sick.
- Make and keep medical appointments and tell their PCP at least 24 hours in advance when they cannot make it.
- Always show their Highmark Health Options member ID card when they get health care services.
- Use the emergency department only in cases of an emergency or as their PCP tells them.
- If they owe a copay to their pharmacies, pay at the time the services are received.
- Tell Highmark Health Options 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 providers 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 Highmark Health Options does not take the place of workers' compensation insurance.

- Tell the Delaware Division of Social Services (DSS) Change Report Center and Highmark Health Options 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 (age 16 or older), or marries, the minor shall be responsible for following all Highmark Health Options member guidelines set forth above.

## Member resources

The Member Handbook explains the benefits and services available to Highmark Health Options 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 members are notified annually of any changes made to the member handbook and may request a copy of the handbook at any time.

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

## LTSS 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 LTSS Education Materials with the member.

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HighmarkHealthOptions.com

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