HIGHMARK Delaware HEALTH OPTIONS

Key:
AI: Additional Information
LCD: Last Covered Date
LOMN: Letter of Medical Necessity
CC: Care Coordinator
POC: Plan of Care / 485

The information provided within this Helpful Tips document is intended as a guide to facilitate collaboration with the agencies rendering private duty services. The information is subject to change. Please call Health Options Private Duty Dept. for more information or with any questions.

Important Phone Numbers:

Private Duty Fax: 855-445-4239

- For LOMNs, POCs, Notes, etc.
- Information requested by CC
- Member's name must be written on the document (not the cover page)
- Information for multiple members (even siblings) must be sent in separate faxes (HIPAA requirement)
- All information intended for an appeal should be sent to the Appeal Dept. directly at fax# 844-325-3435

Private Duty Phone: 855-322-9932

Coordination of Care:

Illustrations of when the Health Options Care Coordinator must be immediately notified:

- When there is an event that necessitates an incident report, family complaint regarding practice, or agency concern
- When a member is switching health plans
- When there is a change in the member's medical needs
- When there is a change or question re: the caregiver's work (if services authorized to cover work obligation)
- When a member is discharged from the hospital (fax copy of the discharge summary to the CC)
- When there is DFS involvement, including caseworker's name and phone number
- When there is a change in the family's psychosocial needs
- When there is a change to the member's needs while at school or on the school bus (fax most recent school schedule / academic calendar/ bus schedule)
- When there are staffing issues
- Other situations based upon agency judgement

Timeframes:

Requests:

- Decision made typically within ten calendar days

Attempts to request information:

- Health Options will attempt up to 3 times to gather additional information if needed for the request
- A fourteen day extension period may be initiated by Health Options, the member, or the provider if additional information is still needed after ten days

Peer Review:

- Offered to the requesting physician when a request is reduced or denied
- Families and agencies are notified of the decision once it has been rendered

Written Extension for Additional Information:

- Allows 14 additional days for information to be gathered and submitted to Health Options
- AI gathered for a review (not an appeal/grievance) should be sent to the Private Duty fax number noted

Authorization Timeframes / Last Covered Date:

- LCD is specified in Health Options' written communication with agencies regarding approvals and reductions
- If services are required past the LCD, information must be submitted to Health Options for review prior to the last covered date to avoid interruption in services.

LOMN Formats:

- Must be on the requesting provider's letterhead or the provider's employer letterhead
- Must be signed by the requesting provider
- When the requesting provider is a PA or NP, the supervising physician needs to be noted
- Provider's name clearly printed below the signature and dated
- Clearly state level of care requested (Private Duty Skilled Nursing or Home Health Aide Services)
- Summary of medical history / needs requiring level of care requested
- LOMN must clearly outline how all requested hours would be scheduled, for all days that services are being requested
- If request is for an "episode of care," the LOMN must have clear start and end date for the episode
- Current caregiver information must be included
- Common errors:
  - No Level of care stated
  - No indication of how or when hours will be used
  - Insufficient clinical history
  - Unsigned, not legible or not on letterhead

Understanding Appeals:

Refer to Health Options' determination letter for additional information

Appeal / Grievance:

- Health Options internal review
- Continuity is extended only when requested by the member/family, when appeal is filed within 10 days of denial letter and services were previously approved
- Can be filed by member/family or provider (with member's written consent) up to 60 days from denial letter

State Fair Hearings:

- Filed externally from Health Options
- Health Options cannot ensure / authorize continuity until notification from DMMA has been received, confirming that filing occurred within 10 days of decision
- Families can file after the internal appeal process has been completed