PR 14-80

SPECIAL BULLETIN

FOR PROFESSIONAL PROVIDERS **DECEMBER 31, 2014**

HEALTH OPTIONS (MEDICAID): CONTINUITY OF CARE AND AUTHORIZATION REQUESTS

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) will offer Medicaid benefits to Delawareans through Health Options. We are committed to making the transition smooth for our members and our providers. Our goal is to minimize impact and ensure continuity for all necessary care.

The following are some of the most frequently asked questions we've received regarding continuity of care and prior authorizations. Please read this information carefully and share with all office staff.

Q. How will Health Options manage medical and behavioral health services already in progress?

A. For treatment of a condition or diagnosis that is in progress and a prior authorization has been issued, Health Options will cover services from the treating provider for the lesser of 90 calendar days or until the treating provider releases the patient from care.

If you are providing services that started prior to Jan. 1, 2015 or received a prior authorization from another Medicaid plan for services after Jan. 1, 2015, Health Options will honor the existing authorization or episode of care for the Health Options member for the lesser of 90 calendar days or completion of treatment.

Health Options is relaxing authorization requirements for services required by members for 30 days through the transition period except new services requiring prior authorization. After such time, please contact Health Options' Utilization Management (UM) Department at 1-844-325-6254 or the Behavioral Health Department at 1-844-325-6257.

Q. Will my claim be paid if services are provided during the transition period?

A. For treatment of a condition or diagnosis that is in progress and for which prior authorization for treatment has been issued, Health Options will cover services from the treating provider for the lesser of 90 calendar days or until the treating provider releases the patient from care. New services that are provided on or after Jan. 1, 2015 and require prior authorization will require Health Options approval from the UM Department.

Q. Will Health Options accept authorization requests prior to Jan. 1, 2015?

A. Yes. Health Options began reviewing and issuing prior authorization requests on Dec. 17, 2014.You can fax an authorization request to the Health Options UM Department at 1-855-445-4086 using the *Authorization Request* fax form, which follows this message. You can also find this form online at **www.highmarkhealthoptions.com**.

If an authorization has already been issued by another managed care organization (MCO), you do not need to get services reauthorized by Health Options.

Note: Authorizations for Durable Medical Equipment (DME) **and** Orthotics and Prosthetics are only required if the purchase or rental is $500 or more.

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Q. What if I am not contracted with Health Options, but provide services to Health Options members?

A. Non-contracted providers who provide services to Health Options members in an episode of care or previously approved service from another plan on or after Jan. 1, 2015, will be reimbursed at the amounts on the Delaware Medicaid Fee Schedule during the transition period. Service for members in an episode of care should not be disrupted.

Q. Are prenatal services covered for women in their second or third trimester?

A. Health Options will cover prenatal services for a pregnant woman in her second or third trimester from the treating provider through 60 calendar days post-partum.

Q. Who is financially responsible for inpatient admissions prior to Jan. 1, 2015?

A. Financial responsibility belongs to the MCO the member was enrolled with on the date of admission through discharge. For example, an inpatient stay with an admit date of 12/29/14 and discharge date of 1/2/15 is the responsibility of the MCO the member was enrolled with on 12/29/14.

Q. What about prescriptions?

A. New Health Options members will be able to continue treatment of any medications prior authorized by the State through the greater of: (a) the expiration date of active prior authorization by the State's FFS pharmacy program; and (b) the applicable time frame (60 or 90 calendar days) for medication not prior authorized by the State.

For non-behavioral health diagnosis, Health Options will provide a transition period of at least 60 days for medications prescribed by a treating provider that were not prior authorized by the State's FFS pharmacy program.

For behavioral health diagnoses, Health Options will provide a transition period of 90 days of medication prescribed by the treating provider for the treatment of a specific period of 90 days of medication for the treatment of a specific behavioral health diagnosis that was not prior authorized by the State's FFS pharmacy program.

Health Options Pharmacy Department is available to providers 24 hours a day, 7 days a week at 1-844-325-6253.

Pharmacies will be able to override authorization requirements for a 72-hour supply of medications starting Jan. 1, 2015.

Q. Are authorizations required for Long Term Services and Supports (LTSS)?

A. Health Options will cover services in the Diamond State Health Plan (DSHP) Plus LTSS benefit package authorized by another MCO, in accordance with the approved nursing facility level of service/plan of care, regardless of whether the providers are participating or non-participating, for a minimum of 30 calendar days after the member's enrollment date. Health Options will not reduce these services unless a case manager has conducted a comprehensive needs assessment and developed a plan of care, authorized and initiated services with the member's new plan of care.

Please share this Special Bulletin with all of your staff to help ensure a smooth transition between managed care organizations for Delawareans. If you have questions or need assistance regarding Health Options, please contact your Highmark Delaware Provider Relations Representative.

REMINDER:

Authorization requests can be faxed to Health Options using the *Authorization Request* form, which follows this message and can also be found online at **www.highmarkhealthoptions.com**. Select *Providers* from the menu at the top of the screen, and then choose *Transition Prior Authorization Form* under the Provider Forms section.

Requests must be faxed to Health Options at 1-855-445-4086.

Health Options
Highmark Blue Cross Blue Shield Delaware

Authorization Request Form
Transition/Continuity of Care

FAX to 1-855-445-4086

Please type or print.

Today's Date:	**Date of Service:** **Date of Admission (if applicable):**
Name of Member:	**Member's Health Option ID Number:**
Name of Requestor:	**Phone Number of Requestor:** **Fax number of requestor:**
Hospital Name if Applicable: **Hospital ID#:**	**Name of Doctor/Provider:** **Provider ID or NPI #:**
Diagnosis and ICD Codes:	**Procedure and CPT/HCPCS Codes:**

History / Additional Information

Note: Requests will be authorized ACCORDING TO THE Transition and Continuity of Care Plan.

- **Symptoms:**
- **Treatment:**
- **Past medical history**
- **Diagnostic labs and tests with results:**
- **Other diagnoses:**

Service Requested:

Date Service Initiated:

Previously authorized by another MCO: Y____N___
If yes, authorization expiration date:
MCO name: