Search Keyword or Code

Chapter 1 – General Information

The *Highmark Provider Manual* is designed to be your primary reference guide to Highmark. It contains information, policies, and procedures for all providers participating in Highmark's provider networks in Delaware, New York, Pennsylvania, and West Virginia, and contiguous counties in their bordering states. The manual combines information for all Highmark service areas to give providers a comprehensive understanding of Highmark's health insurance programs.

Unit 1: Introduction

The *Highmark Provider Manual*, together with other administrative requirements as defined or described in the applicable provider agreement, supplements and is made part of your provider agreement(s).

READ MORE

Unit 2: Online Resources & Contact Information

Highmark is committed to providing timely and pertinent information about our policies and programs to the provider community. Highmark has a number of easy-to-use electronic sources of information accessible through your computer as well as service representatives available by telephone.

READ MORE

Unit 3: Electronic Solutions: EDI & Availity

Highmark places a high priority on electronic exchange of information and electronic claims filing. This process is more efficient and cost-effective than conventional means – benefiting health care facilities, professionals, members, and insurers.

READ MORE

Unit 4: Highmark Member Information

Highmark members are individuals who are enrolled in a health plan and meet eligibility requirements, but they can also be subscribers or dependents. Highmark members can be easily identified by the information on their identification (ID) card.

READ MORE

Unit 5: Member Rights & Responsibilities

Members have both rights and responsibilities which vary from state to state and sometimes plan. These rights and responsibilities are made available to members through their Evidence of Coverage (EOC) booklets and updated in member newsletters. Rights and responsibilities are also available in the Appendix of this manual in Chapter 7.

READ MORE

Disclaimer

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

About Highmark

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Unit 1: Introduction

1.1 Manual Purpose and History

The *Highmark Provider Manual* is designed to be your primary reference guide to Highmark. It contains information, policies, and procedures for all providers participating in Highmark's provider networks in Delaware, New York, Pennsylvania, and West Virginia, and contiguous counties in their bordering states.The manual combines information for all Highmark service areas to give providers a comprehensive understanding of Highmark's health insurance programs.

The *Highmark Provider Manual*, together with other administrative requirements as defined or described in the applicable provider agreement, supplements and is made part of your provider agreement(s). The manual includes, but is not limited to, information such as:

- Services we offer providers and members
- Requirements for participation in our provider networks
- Administrative requirements and guidelines
- Electronic solutions for efficiency and convenience
- Claim submission guidelines for quick and accurate processing

The *Highmark Provider Manual* is applicable to all provider types who have provider agreements with Highmark, including:

- Physicians and other professional practitioners;
- Hospitals and other facilities; and
- Ancillary and other organizational providers.

Where indicated or as is apparent by the content, certain sections of the manual may not be applicable to all provider types.

Manual History

The online *Highmark Provider Manual* was first published in 2018, providing one comprehensive resource for all providers participating in Highmark's provider networks in all service areas in Delaware, New York, Pennsylvania, and West Virginia. This online manual replaces any provider manuals previously used in any of Highmark's service areas.

Disclaimer

All revisions to this *Highmark Provider Manual* (the "manual" or "*Highmark Provider Manual*") are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose. The *Highmark Provider Manual* is the property of Highmark Inc. and its affiliated health plans, Highmark BCBSD Inc. (Highmark Blue Cross Blue Shield Delaware), Highmark West Virginia Inc. (Highmark Blue Cross Blue Shield West Virginia), Highmark Blue Cross Blue Shield of Western New York, and Highmark Blue Shield of Northeastern New York (individually and collectively referred to herein as "Highmark"). The information, content, and design/organization of the *Highmark Provider Manual* are maintained by Highmark. Links to external websites referenced in the manual are for the convenience of the user. Such links do not constitute an official endorsement or approval by Highmark or any of its subsidiaries or affiliates with respect to the links' content.

Highmark complies with all state and federal laws, including laws related to Medicare and our Medicare Advantage products. In cases where administrative requirements (as defined or described in the

applicable provider agreement, including but not limited to, Highmark policy, Highmark Medical Policy, and/or the *Highmark Provider Manual*) conflict with federal or state laws or regulations, or directives of the Centers for Medicare & Medicaid Services (CMS) or other regulators, such laws, regulations, and/or directives shall apply.

Information in the *Highmark Provider Manual* is subject to change by Highmark. Information in the *Highmark Provider Manual* is subject to regulatory review and may also be changed at any time in accordance with regulatory requirements. All such changes may be published in provider newsletters, special mailings, and/or forms of online communications such as the Provider Resource Center.

In addition to the *Highmark Provider Manual*, please check the Provider Resource Center's home page and its Latest Updates section often for policy and procedure updates. The *Highmark Provider Manual* is binding upon providers together with other administrative requirements (as defined or described in the applicable provider agreement).

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1.1 How to Use this Manual

The *Highmark Provider Manual* is designed to be your primary reference guide to doing business with Highmark. It contains information specific to procedures required of all Highmark network participating providers — professional, facility, and ancillary — and is intended as a companion to other Highmark provider requirements, publications, and communications.

The *Highmark Provider Manual* is binding upon providers and may be supplemented or superseded, in whole or in part, by other Highmark guidance and/or requirements furnished or otherwise made available to providers.

Tips for Using This Manual

- Most recent updates: When changes are made to the *Highmark Provider Manual*, we will communicate those changes on our What's New page.
- Resources for all Highmark service areas: Because the manual applies to all service areas in Delaware, New York, Pennsylvania, and West Virginia, only the Highmark Blue Shield brand will be referenced.

    - The What Is My Service Area? map can be used to help you determine the service area for your location.
    - The Quick Reference/Contact Guide contains contact information for all Highmark Provider Service Centers and Highmark Clinical Services.
- Information specific to a service area: For information that does not apply to all service areas, either separate links will be provided or the information will be designated for a specific area by the use of an icon indicating the specific state or states to which the information applies.

State Icons:

For providers in Delaware

For providers in New York

For providers in Pennsylvania

For providers in West Virginia

- **Is the information applicable to facility or professional provider types?** Most units of the manual contain information that would be applicable to all provider types. If a unit is specific to professionals or facilities only, it will be noted **within the text of the unit.**
- **Organized by Chapters/Units:** The manual is organized by chapters and units. Chapters and their titles are listed in the navigation menu on the left side of the manual webpage. You can click on the arrow to the right of the chapter name to expand the menu, revealing the units and the list of topics covered within that chapter. Click on a unit to access its content.
    - To collapse the chapter menu, click on the arrow to the right of the chapter name.
- **Search:** To make it easier to find answers, there is a search box located at the top of every page. Type a term or phrase into the search box to see where it can be found throughout the manual.
- **Intended** to be an online resource: Keeping the *Highmark Provider Manual* electronic allows us to provide you with the most up-to-date information. All revisions to the manual are controlled electronically. Paper copies, screen prints, and all alternate versions noted below are considered

uncontrolled and should not be relied upon for any purpose, as they may not be the most recent revision.

Emailing the Manual

To email the manual, click the **Share** button at the top of the page, and then **Copy Link.** You can then paste the link in an email.

Printing the Manual

- An entire version of the manual can be printed by clicking the print button at the top right of the page.

Note: Please review the disclaimer in Chapter 1, Unit 1: Introduction (Manual Purpose and History) regarding saved or printed versions of the *Highmark Provider Manual*.

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1.1 About Highmark

In the 1930s, Highmark's predecessor companies were established to help individuals in the communities they served pay for hospital and medical services. Today, that remains our mission — to deliver high quality, accessible, understandable, and affordable experiences, outcomes, and solutions for our customers. It guides our actions throughout Highmark's businesses.

Highmark Inc. was created in 1996 by the consolidation of two Pennsylvania licensees of the Blue Cross and Blue Shield Association — Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania. Highmark Inc. and its health insurance subsidiaries and affiliates now operate health insurance plans in Delaware, New York, Pennsylvania, and West Virginia that serve millions of members as well as hundreds of thousands of additional Blue Plan members through the BlueCard® program:

- Highmark Blue Cross Blue Shield (PA) provides integrated Blue Cross and Blue Shield coverage throughout the 42 counties of western, north central, and northeastern Pennsylvania.
- Highmark Blue Shield (PA) serves the 21 counties of central Pennsylvania, 5 counties of southeastern Pennsylvania, and the Lehigh Valley.
- Highmark Blue Cross Blue Shield (WV) serves the entire state of West Virginia.
- Highmark Blue Cross Blue Shield (DE) serves the entire state of Delaware.

- Highmark Blue Cross Blue Shield (WNY) serves 8 counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.
- Highmark Blue Shield (NENY) serves 13 counties: Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

Highmark Health, established in Pittsburgh in 2013, is a national health and wellness organization that employs approximately 40,000 people and serves nearly 50 million individuals in all 50 states and the District of Columbia.

Highmark Health is the parent company of Highmark Inc. and its subsidiaries and affiliates. It is also the parent company for Allegheny Health Network, an integrated health care delivery network, which provides health care delivery, research, medical education, and wellness services.

The company's diversified businesses provide a spectrum of specialty products such as dental insurance, vision care, and supplemental health programs across the country, including more than 600 Visionworks optical retail stores.

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1.1 Highmark Works With Health Care Providers

Highmark understands the tremendous value that physicians, facilities, and other health care professional and organizational providers bring to its organization and to its members. That is why Highmark is constantly striving to make its relationships stronger and better through:

- Enhancing electronic communications and the exchange of data through websites like Availity®;
- Collaborating with providers to implement programs that lead to better medical outcomes for our members; and
- Restructuring our processes to make them easier and more efficient.

At Highmark, physicians and other health care professionals play an important role in the company's governance and policy making. Independent health care professionals are active in a variety of positions that influence the core of Highmark's operations — they make up the majority of committees that help resolve claims disputes and promote the delivery of quality medical care to Highmark members.

Health care professionals are also involved at various key junctures during the development of Highmark's Medical Policy — the guidelines used in our coverage and reimbursement determinations.

Board of Directors

The Board of Directors of Highmark Inc. includes health care professionals (referred to as "Professional Directors") and representatives from customers and the community (referred to as "Lay Directors"). The Bylaws of the Corporation require that at least fifteen percent (15%) (or as near to that number as can reasonably be achieved) but not more than twenty-five percent (25%) of the Board of Directors be Professional Directors. The business and affairs of the Corporation are managed under the direction of the Board of Directors.

Highmark's Quality Program Committees

As a way for Highmark to promote objective and systematic monitoring, evaluation, and continuous quality improvement, various program committees have been established. Highmark's Quality Program Committees are made up predominantly of health care professionals and established by Highmark's Board of Directors. For additional information about these Quality Program Committees, please see the manual's Chapter 5.6: Quality Management.

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1.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 2: Online Resources & Contact Information

1.2 Variety of Informational Resources

Highmark is committed to providing timely and pertinent information about our policies and programs to the provider community. Highmark has a number of easy-to-use electronic sources of information as well as service representatives available by telephone.

Highmark's Informational Public Websites:

- HighmarkHealth.org
- Highmark.com
- MyHighmark.com - member website for all Highmark regions

Highmark's **Provider Resource Centers** for all Service Areas are accessible from Highmark.com, MyHighmark.com, and Availity®:

- Delaware Provider Resource Center
- Northeastern New York Provider Resource Center
- Pennsylvania Central, Southeastern, and Northeastern Region Provider Resource Center
- Pennsylvania Western Region Provider Resource Center
- Western New York Provider Resource Center
- West Virginia Provider Resource Center

The website links above will take you to the current Provider Resource Center (PRC) websites, which are region specific. Highmark is in the process of redesigning and consolidating our PRC into a single site for all regions. Once that consolidation is complete, the sites above will be decommissioned and this website you are on (providers.highmark.com) will be your primary source for provider information from Highmark.

Newsletters for Professional and Facility Providers:

- Provider News
- Medical Policy Update

Additional Sources:

- News and Announcements via Highmark's Payer Spaces in Availity
- Special Bulletins
- Join Our Mailing List
- Provider Service Center

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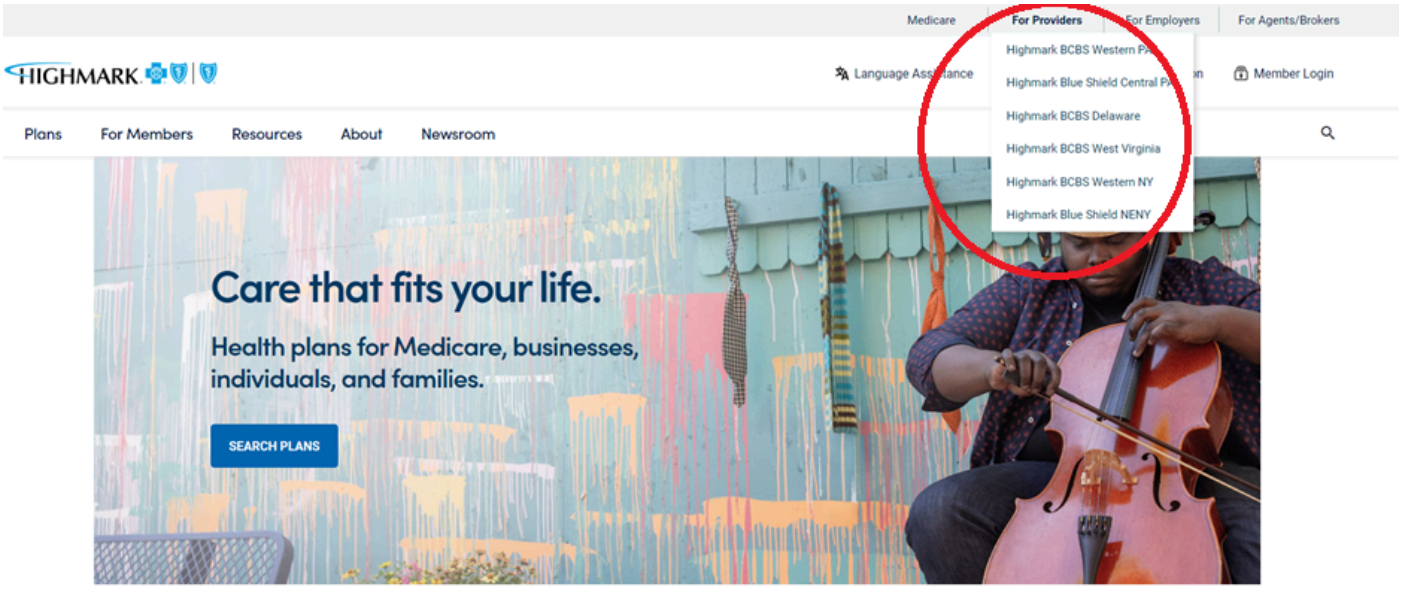
1.2 Highmark Websites

Highmark's informational public websites cover all core business and subsidiary companies. They provide a broad range of information to customers, health care professionals, and the public.

Highmark.com

To learn about Highmark's history and access information about Highmark companies, subsidiaries, and affiliates, visit highmark.com. This website also provides you with information about Highmark's community involvement, event sponsorships, and programs. In addition, you can learn about our Highmark Direct retail stores, access health and safety tips, and so much more. The public website for Highmark plans with service areas in Delaware, New York, Pennsylvania, and West Virginia can also be accessed from highmark.com.

Access to the Provider Resource Center is also available at highmark.com. Click on **For Providers** at the top of the screen.



Highmark has your health insurance needs covered

MyHighmark.com

The public website for Highmark Inc. service areas in Delaware, New York, Pennsylvania, and West Virginia is MyHighmark.com. This website provides information specific to individuals, members, employers, producers, and providers living in these locations. You can also access the Provider Resource Center from MyHighmark.com

Directing Our Members

When Highmark members have questions related to their coverage, your office may want to direct them to the appropriate public website for their service area. On each of these sites, members can find the following information and more:

Provider, Pharmacy, and Drug Information: By selecting the Find Doctor or Rx tab, members can access the Highmark Provider Directory and find information about participating doctors, hospitals, and other medical providers in their service area. In addition, this link allows them to search for participating pharmacies and also access drug formulary information.

Member Login: Members can register on this site for access to their secure account information. Once registered, members can log in to view their benefits and health and wellness information. They can also access their claim information and manage their health spending accounts.

Product Information: Individuals looking for insurance can learn about the Highmark products available in their service area by selecting the applicable tab: Individual & Family, Medicare, Employer, or Producer.

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1.2 Highmark Provider Directory

The **Highmark Provider Directory,** located on each of our public websites, is a fast, easy way for our members to find providers near their homes or their workplace. And, it is a valuable tool that offers your current and potential patients important details about your practice, including office location, hours of operation, parking availability, and nearby public transit information.

The Centers for Medicare & Medicaid Services (CMS) requires Highmark to have the most current information on our network providers and also requires ongoing review of all physician information listed in the Provider Directory. The National Committee for Quality Assurance (NCQA) also requires the Provider Directory to include, and Highmark to confirm, the same physician information as for CMS, as well as the physician's hospital affiliation. Hospital affiliation means the hospital(s) in Highmark's networks where physicians have admitting or attending privileges.

Providers are required to review and update their information as soon as a change occurs. All data should be reviewed once a quarter, at a minimum, to ensure accuracy. If you determine that your information is inaccurate in the online directory, you can conveniently update the information online by accessing Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only) through Availity .

Providers who do not verify or update their data in a timely manner will be removed from the Highmark Provider Directory. In addition, the provider's status within Highmark's networks may be impacted.

For providers in Delaware, Pennsylvania, and West Virginia: We encourage you to take advantage of one of the more unique features of our online directory — the ability to add your photograph. The inclusion of a photo helps to personalize your directory listing and can make it easier to market your practice to potential patients. Your photo can be easily uploaded through Provider File Management in Availity.

Provider Directory Information

Providers acknowledge that the information listed in any Highmark Provider Directory, including, but not limited to, name, contact information, description of services, photographs, demographics, and other

information, may also be listed in any Blue Cross Blue Shield Association (“BCBSA”) and/or other BCBSA independent licensee Plan provider directory(s), as determined by Highmark.

Please see Chapter 3, Unit 3: Professional Provider Guidelines for additional details of CMS requirements and on reporting changes.

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1.2 Provider Resource Centers

The Provider Resource Center (PRC) is a repository of pertinent reference materials. This special section of our websites is specifically dedicated to providers and contains lots of helpful information and resources to assist in your daily interactions with Highmark members and with Highmark. We encourage you to bookmark the site and take advantage of this convenient reference resource.

The Provider Resource Center is available at highmark.com and MyHighmark.com.

For your convenience, the Provider Resource Center is also available to you in Highmark's Payer Spaces in Availity. Additional information not accessible on the public websites is available in the Provider Resource Center via your secure Availity logon.

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1.2 Provider Newsletters

Highmark regularly releases publications as part of our commitment to keep the provider community informed. Some of the most important ways Highmark communicates with all providers is through our newsletters – *Provider News* and Medical Policy Update.

Provider News

Provider News is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.

The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date With the Highmark Provider Manual

*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

Current and past issues of *Provider News* are always available online on the Latest Updates page of the Provider Resource Center.

Medical Policy Update

Medical Policy Update is a monthly newsletter that provides information for most health care professionals and facilities participating in our networks. It focuses exclusively on upcoming medical policy and claims administration updates (including coding guidelines and procedure code revisions), and is the sole source for this information.

It is important for all participating providers and their office staffs to review each issue of Medical Policy Update. This publication serves as one of Highmark's official notifications of new and revised policies and procedures. You can find current and past issues of Medical Policy Update on the Latest Updates page of the Provider Resource Center.

Distribution of Provider Newsletters

Distribution of all provider newsletters is primarily electronic. We publish all issues of the newsletters online in the Provider Resource Center on the Latest Updates page. Current and past issues of *Provider News* and Medical Policy Update are always available on the Provider Resource Center.

You may also sign up for electronic notification via email by clicking Join Our Mailing List in the top right corner of every page.

If you require a paper copy of the newsletter, please contact the Provider Service Center.

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1.2 Special Bulletins

In addition to our regular publications, Highmark uses Special Bulletins to inform providers of changes to Highmark policies and procedures, updates to the formulary and authorization list, upcoming initiatives, etc. Special Bulletins are intended to be a companion to Highmark's regularly scheduled periodicals.

Special Bulletins are used when we want to communicate information quickly, when the information is too complicated or lengthy to include in the newsletters, or when the information pertains to a limited group of providers or to a specific service area.

These communications from Highmark may be delivered to providers in any of the following formats:

- Online Communications
- Letters
- Brochures
- Fact Sheets
- Postcards
- Flyers included with checks and/or Explanation of Benefits

Because Special Bulletins contain important information about specific claims and coverage issues that could affect your practice, we hope you will take time to read them and retain them for future reference.

You can find current and past Special Bulletins on the Latest Updates page of the Provider Resource Center.

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1.2 Join Our Mailing List

The Join Our Mailing List feature on the Provider Resource Center allows you to subscribe to electronic notification of various online publications and information updates. The latest Highmark news and updates arrive in your email inbox with timely, up-to-date information at your fingertips.

Sign Up Now!

To subscribe to receive free email notifications with newly released publications or information updates, select Join Our Mailing List located in the top right corner of every page.

Enter the required information on the online form and select the applicable provider type – Professional Provider (837P & 1500 billers) and/or Facility/Institutional (837I & UB04 billers). Once you have completed the form, click on the Subscribe button at the bottom of the page. You will receive a confirmation message immediately when your subscription is successfully submitted.

The emails will be delivered to you from resourcecenter@email.highmark.com. To ensure delivery of the emails, please add the email address to your address book.

By subscribing, you agree to electronically receive administrative requirements that are legally binding upon contracted providers and upon Highmark. By doing this, you acknowledge that such communications and publications will be sent only by electronic means to the email address you provide. Please maintain such electronic publications in the event of future questions and to ensure such compliance. You may unsubscribe from this list at any time on future emails from Highmark.

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1.2 Provider Service Center

Immediate answers to most inquiries can be found by using Availity® - the preferred method for eligibility and benefit checks, prior authorization requests and inquiries, claims submission, and other transactions. For more complex issues or if Availity is unavailable, Provider Service Center representatives are available to answer questions and also provide information about Highmark programs.

Find the appropriate Provider Service Center for your region here.

When placing a call to Provider Service, please have all necessary information available including:

- Patient's name, member ID, and group number;
- If available, the type of services and dates the services were performed;
- Claim number (taken from the Explanation of Benefits); and
- The provider's name and provider number.

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1.2 Contact Information

This section includes additional important telephone numbers, fax numbers, and other helpful contact information for all Highmark service areas.

Contact Us

A contact sheet is available at the top of every page through the **CONTACT US** link for easy access to a printable document with the most frequently used telephone numbers for contacting Highmark – the Provider Service Center and Highmark Clinical Services.

Availity® Customer Support

If you need assistance with an existing account and cannot log in to submit a ticket , or have started the registration process and are experiencing issues, you can call **800-AVAILITY (282-4548).**

For more information contact Availity .

Authorization/Precertification Inquiries

Availity® is the preferred method for submitting authorization requests. Contact Highmark's Clinical Services for precertification/authorization inquiries that cannot be handled via Availity. Please call the applicable number for your service area and/or provider type.

Behavioral Health

When Availity® is not available and/or for medical management questions/issues that cannot be handled through Availity, Highmark's Behavioral Health Services can be reached by calling the applicable phone number for your service area.

Baby Blueprints

To enroll in this free maternity education and support program, expectant mothers can call: **866-918-5267**

BlueCard Eligibility

To verify eligibility and benefits for BlueCard® members, please use one of the following options:

- Eligibility and Benefits Inquiry in Availity®
- BlueCard eligibility telephone line: **800-676-BLUE (2583)**
- HIPAA 270/271 electronic transaction

BlueCard Participation

BlueCard® participating physicians in other Blue Plan areas can be located by calling **800-810-BLUE (2583),** or online at https://www.bcbs.com/ .

Blues On Call℠

For assistance or information about health care topics or support by a health coach, encourage your patients to call the Blues On Call phone line:

- **888-BLUE-428 (888-258-3428)**
- This phone number is available on the back of applicable Member ID cards.

Caring Program

For providers in Pennsylvania

The Highmark Caring Program in Pennsylvania assists children with chronic conditions and/or special health care needs and their families to gain needed services by providing family-centered, community-based care coordination.

- For questions regarding care coordination, please call: **866-823-0892**

Case Management

The Highmark case management staff can be contacted by calling:

- Pennsylvania: **800-596-9443**
- Delaware: **800-572-2872**
- West Virginia: **800-344-5245**; for Medicare Advantage **800-269-6389**
- New York: **877-878-8785**

Coordination of Benefits (COB)

If you received payments from more than one insurer and the combined payments exceed your claim charge, contact the Provider Service Center in your service area to speak to a representative.

Council For Affordable Healthcare (CAQH)

Highmark utilizes ProView,™ the online credentialing system developed by the Council for Affordable Healthcare (CAQH), for credentialing and recredentialing.

- https://proview.caqh.org
- CAQH Help Desk: **888-599-1771**

Electronic Data Interchange (EDI)

If you would like to begin to submit claims electronically or need assistance with electronic claims submission, contact the Highmark EDI Operations support line by calling **800-992-0246**.

Click on the applicable link to access the Highmark EDI Services website for your service area:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

eviCore Healthcare

Highmark partners with eviCore Healthcare (“eviCore”) for several care management programs. These include the following programs (may differ by Highmark region):

- Laboratory Management Program
- Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program
- Radiation Therapy Authorization Program
- Advanced Imaging and Cardiology Services Program

Although authorization requests for these programs can be submitted through the provider portal, there may be times when it is necessary to contact eviCore by phone at **888-564-5492.**

Federal Employee Program (FEP)

Contact the Federal Employee Program (FEP) Provider Service Department by calling the applicable phone number for your service area:

- Pennsylvania: **866-763-3608**
- Delaware: **800-721-8005**
- West Virginia: **800-535-5266**
- New York: **800-234-6008**

Delaware, Pennsylvania, and West Virginia hours: 8:30 a.m. to 5 p.m. EST, Monday through Friday

New York hours: 8 a.m. to 5 p.m. EST, Monday through Friday

Note: Eligibility and benefits can be verified through Availity for FEP members residing in Delaware, New York, Pennsylvania, and West Virginia.

For claims that cannot be submitted electronically, they can be mailed to the appropriate claims address for the member's service area which can be found later in this unit under Mailing Addresses.

Financial Investigations & Provider Review (FIPR)

If you suspect fraud, contact your local Financial Investigations & Provider Review (FIPR) Department within Highmark.

Pennsylvania and Delaware:

- P.O. Box 890138 Camp Hill, PA 17001-9782
- Phone: **800-438-2478**
- Fax: **717-635-4590**

West Virginia:

- 614 Market Street P.O. Box 1948 Parkersburg, WV 26102
- Phone: **800-788-5661**
- Fax: **717-635-4590**

Highmark Blue Cross Blue Shield (WNY):

- P.O. Box 80 Buffalo, NY 14240-9984
- Phone: **800-333-8451**
- Fax: **716-887-8591**

Highmark Blue Shield (NENY):

- P.O. Box 15013 Albany, NY 12214-5569
- Phone: **800-314-0025**
- Fax: **716-887-8591**

Due to the nature of these investigations, every effort will be made to keep information confidential. Report suspected health care fraud anonymously via the above phone numbers or the Health Care Fraud Form.

Health Options

For providers in Delaware

For information on Health Options, Highmark Delaware's managed care organization serving Delaware Medicaid recipients, please see the Health Options Provider Manual, which is accessible below on the website below.

- Health Options Provider Services: **844-325-6252**
- Authorizations: **844-325-6254**
- Health Options website: http://www.highmarkhealthoptions.com/

MyCare Navigator

MyCare Navigator is a telephone-based support service available to most Highmark members to help them make informed decisions and get the care that they need.

Highmark members and their families can reach a MyCare Navigator health advocate by calling the following toll-free telephone number:

- **888-BLUE-428 (888-258-3428)**
- This phone number is available on the back of applicable Member ID cards.

National Provider Identifier (NPI)

To obtain an NPI:

- Website https://nppes.cms.hhs.gov , or
- Phone: **800-465-3203** (TTY: 800-692-2326)

Spending Account Inquiries

For providers in Delaware, Pennsylvania, and West Virginia

For spending account questions or issues in Pennsylvania and West Virginia, please call the dedicated Provider Spending Account Information Line at **800-652-9478.**

For spending account questions or issues in Delaware, please contact Provider Service at **800-346-6262.**

Traditional Medicare

For providers in Delaware, Pennsylvania, and West Virginia

Pennsylvania and Delaware:

- Novitas Solutions, Inc.
- Website: www.novitas-solutions.com
- Medicare Part A & B Provider Inquiries: **877-235-8073** (TTY: 877-235-8051)
- Hours: 8 a.m. to 4 p.m. EST, Monday through Friday.

West Virginia:

- Palmetto GBA
- Website: www.palmettogba.com
- Medicare Part A & B Inquiries: **855-696-0705** (TDD: 866-830-3188)
- Hours: 8 a.m. to 4:30 p.m. EST, Monday through Friday.

1099-MISC Issues

If you have questions about Form 1099-MISC issues, please call **866-425-8275**, or send via email to 1099inquiry@highmark.com.

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1.2 Mailing Addresses

Claims Filing Addresses

Electronic claims are convenient, confidential, and operational around the clock. Highmark's claim processing system places a higher priority on claims filed electronically. And we offer options for HIPAA-approved claims submission via Availity and Highmark Electronic Data Interchange (EDI).

If you are not submitting claims electronically, use the tables below to determine the correct mailing address/addresses for your region.

Highmark Blue Cross Blue Shield (DE)

If type of claim is...	Mail to...
Provider Claims (All lines of business except FEP)	Highmark Blue Cross Blue Shield (DE) P.O. Box 8830 Wilmington, DE 19899
Federal Employee Program (FEP)	Federal Employee Program P.O. Box 8830 Wilmington, DE 19899

Highmark Blue Cross Blue Shield (WPA/NEPA)

If type of claim is...	Mail to...
• Commercial PPO and EPO Plans • Community Blue PPO and EPO Plans • Direct Blue (Individual) • BlueCard Claims	Claims Processing P.O. Box 890062 Camp Hill, PA 17089-0062
• Keystone Blue HMO • Direct Blue (Group) • Short Term Blue	Highmark Blue Shield P.O. Box 898819 Camp Hill, PA 17089-8819
Medicare Advantage • Freedom Blue PPO • Community Blue Medicare HMO • Community Blue Medicare PPO • Security Blue HMO	Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062
Highmark Blue Shield Medical – Surgical Claims	Claims Processing P.O. Box 890062 Camp Hill, PA 17089-0062
Highmark Blue Shield Indemnity – Major Medical	Highmark Major Medical P.O. Box 890393 Camp Hill, PA 17089-0393

Classic Blue Individual Traditional Indemnity	Highmark P.O. Box 890393 Camp Hill, PA 17089-0393
Medigap • Signature 65	Highmark Blue Shield P.O. Box 898845 Camp Hill, PA 17089-8845
• Complete Care Individual • Comprehensive Major Medical	Highmark Blue Shield P.O. Box 898819 Camp Hill, PA 17089-8819
Children's Health Insurance Plan (CHIP) HMO	Highmark Blue Shield P.O. Box 898819 Camp Hill, PA 17089-8819
Ambulance	Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062
DME/Respiratory Supplies/Orthotics/Prosthetics for PPO, EPO, and Traditional Indemnity Products	Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062
DME/Respiratory Supplies/Orthotics/Prosthetics for Major Medical	Highmark Major Medical P.O. Box 890393 Camp Hill, PA 17089-0393

DME/Respiratory Supplies/Orthotics/Prosthetics for HMO and Medicare Advantage	Highmark Blue Shield P.O. Box 898819 Camp Hill, PA 17089-8819
Home Infusion Therapy (HIT)	Highmark Home Infusion Therapy P.O. Box 890393 Camp Hill, PA 17089-0393
Federal Employee Program (FEP)	Federal Employee Program P.O. Box 890062 Camp Hill, PA 17089-0062
Personal Choice	Personal Choice Claims P.O. Box 69352 Harrisburg, PA 17106-9352
For Groups With DME Managed by DMEnsion, Inc.	DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460

Highmark Blue Cross Blue Shield (WNY) & Highmark Blue Shield (NENY)

If type of claim is...	Mail to...
Provider Claims (All lines of business except FEP)	Highmark P.O. Box 4208 Buffalo, NY 14240

Federal Employee Program (FEP)	Federal Employee Program P.O. Box 4208 Buffalo, NY 14240

Highmark Blue Cross Blue Shield (WV)

If type of claim is...	Mail to...
• All Highmark West Virginia Indemnity, POS, and PPO Claims • All BlueCard Claims • Out-of-Area Medicare Advantage	Highmark Blue Cross Blue Shield (WV) P.O. Box 7026 Wheeling, WV 26003
Medicare Advantage Freedom Blue PPO	Freedom Blue Claims P.O. Box 7026 Wheeling, WV 26003
Federal Employee Program (FEP)	FEP Claims Highmark West Virginia P.O. Box 7026 Wheeling, WV 26003

Highmark Blue Shield (CPA/SEPA)

If type of claim is...	Mail to...

Commercial PPO and EPO Plans Community Blue Plans • Short Term Blue • Classic Blue • Direct Blue	Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173
Medicare Advantage • Freedom Blue PPO • Community Blue HMO • Community Blue Medicare PPO/Plus PPO	Freedom Blue PPO P.O. Box 890062 Camp Hill, PA 17089-0062
Highmark Blue Shield Major Medical	Highmark Major Medical P.O. Box 890393 Camp Hill, PA 17089-0393
Comprehensive Major Medical	Highmark Blue Shield P.O. Box 898819 Camp Hill, PA 17089-8819
Medigap • Signature 65	Highmark Blue Shield P.O. Box 898845 Camp Hill, PA 17089-8845
Children's Health Insurance Plan (CHIP) PPO Plus	Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173

All Other Medical-Surgical Claims (Including BlueCard)	Highmark Blue Shield Claims P.O. Box 890062 Camp Hill, PA 17089-0062
DME/Respiratory Supplies/Orthotics/Prosthetics for Freedom Blue PPO and CHIP PPO Plus	Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062
DME/Respiratory Supplies/Orthotics/Prosthetics for PPO, EPO	Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173
Ambulance	Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173
Home Infusion Therapy (HIT)	Highmark Home Infusion Therapy P.O. Box 890393 Camp Hill, PA 17089-0393
Federal Employee Program (FEP)	Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062
Personal Choice	Personal Choice Claims P.O. Box 69352 Harrisburg, PA 17106-9352

For Groups With DME Managed by DMEnsion, Inc.	DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460

If you are considering a move from paper claim submissions, please see the manual's Chapter 1.3: Electronic Solutions — EDI & Availity and Chapter 6.2: Electronic Claim Submission.

IMPORTANT! Only original paper claim forms accepted. Highmark will accept and process only original red 1500/version 02/12 and UB-04 claim forms. Photocopies or outdated versions of the forms will be returned to the provider. The provider will need to resubmit the returned claims on the appropriate form.

Highmark utilizes the Optical Character Recognition (OCR) scanning system to assure accurate and efficient processing of paper claims. The OCR Scanner is programmed to read only the original red 02/12 version of the 1500 form and the original UB-04 institutional claim form.

Highmark Forms

Highmark provides recommended forms that providers may use when communicating with Highmark, Highmark members, or other providers in the network. The forms are readily available online on the Provider Resource Center; select **Resources & Education** from the main menu at the top of the page, and then **Forms**.

If you require forms that are not available on the Provider Resource Center, forms may be ordered by writing to:

Highmark Shipping Control
P.O. Box 890089
Camp Hill, PA 17089-0089

Please include the form number and title, quantity, and shipping address.

Premier Blue Shield Allowances and UCR Profile

For providers in Pennsylvania

To obtain a copy of Premier Blue Shield allowances for the most frequently reported codes for your specialty or a copy of your Highmark Blue Shield Usual, Customary, and Reasonable (UCR) profile, send a letter of request to:

Fee Based Pricing and Analysis
Highmark Blue Shield
P.O. Box 890089
Camp Hill, PA 17089-0089

Include your Highmark provider ID number, full name, address, and indicate whether you are requesting your UCR profile, Premier Blue Shield allowances, or both. This information is also available via Availity for those Availity-enabled offices.

Pre-Service Reviews

Pennsylvania	Delaware	West Virginia	Highmark BCBS (WNY)	Highmark BS (NENY)
Highmark 120 Fifth Avenue Place Suite P4301 Pittsburgh, PA 15222-3099	Highmark Delaware Medical Management Pre-Service Reviews P.O. Box 1991 Del Code 1-8-40	Highmark West Virginia 200 Tracy Way Charleston, WV 25311	Highmark BCBS (WNY) P.O. Box 4208 Buffalo, NY 14240	Highmark BS (NENY) P.O. Box 15112 Albany, NY 12212

	Wilmington, DE 19899-1991			

Retrospective Reviews

Pennsylvania	Delaware	West Virginia	Highmark BCBS (WNY)	Highmark BS (NENY)
Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392	Highmark Delaware Medical Management Retrospective Reviews P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991	Highmark West Virginia P.O. Box 1948 Parkersburg, WV 26102	Highmark BCBS (WNY) P.O. Box 4208 Buffalo, NY 14240	Highmark BS (NENY) P.O. Box 15112 Albany, NY 12212

Refund Checks For HSA, HRA, and FSA Overpayments Only

These postal addresses are to be used solely for overpayments from:

- Health Savings Accounts (HSAs)
- Health Reimbursement Accounts (HRAs)
- Flexible Spending Accounts (FSAs)

Pennsylvania	Delaware	West Virginia	Highmark BCBS (WNY)	Highmark BS (NENY)
Highmark Attn: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark Delaware Attn: Treasury P.O. Box 1991 Wilmington, DE 19899-1991	Highmark Attn: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark BCBS (WNY) Attn: Cashier P.O. Box 4208 Buffalo, NY 14240	Highmark BS (NENY) Attn: Cashier P.O. Box 4208 Buffalo, NY 14240

Refund Checks For All Other Overpayments

Pennsylvania	Delaware	West Virginia	Highmark BCBS (WNY)	Highmark BS (NENY)
Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17001-0150	Highmark Delaware Attn: Treasury P.O. Box 1991 Wilmington, DE 19899-1991	Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17001-0150	Highmark BCBS (WNY) Attn: Check Control P.O. Box 4208 Buffalo, NY 14240	Highmark BS (NENY) Attn: Check Control P.O. Box 4208 Buffalo, NY 14240

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1.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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About Highmark

Be Informed

Related Sites

Search Keyword or Code

Unit 3: Electronic Solutions: EDI & Availity

1.3 Introduction

Highmark places a high priority on electronic exchange of information and electronic claims filing. This process is more efficient and cost-effective than conventional means – benefiting health care facilities,

professionals, members, and insurers.

EDI Services and Availity®

The company's electronic commerce division, Electronic Data Interchange (EDI) Services, provides a host of services that make filing claims and accessing information faster and easier. These include:

- A claims clearinghouse where you can electronically submit claims and inquiries for Highmark
- Convenient technical support through a toll-free hotline
- Information on getting started in electronic claims filing

In addition, Highmark's provider portal, Availity, is available to all participating providers. Availity is an internet-based application for providers to streamline data exchanges between their offices and health insurance companies. Through Availity providers are able to submit claims through the HIPAA-compliant claim submission function. This provider portal also allows providers to verify enrollment, eligibility, benefits, claim status, and much more.

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1.3 Highmark Electronic Transaction Requirements

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark has taken steps to eliminate paper transactions with our contracted providers.

Due to their inherent speed and cost-effectiveness, electronic and online communications are integral in today's business world and Highmark requires that all network providers participate in electronic programs sponsored or utilized by Highmark now or in the future.

Enrollment in Availity, EFT, and Paperless Explanation of Benefits (EOBs) Required for All Participating Providers

All Highmark network participating providers are required to enroll in Availity®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements. All new assignment accounts must sign up for Availity and also enroll in EFT and paperless EOBs.

Availity is an easy online solution linking physician offices with Highmark and other health plans. Availity integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available at no cost to Highmark network participating providers.

Participating providers are also required to enroll to receive electronic funds transfers and paperless EOB statements.

- EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account as directed by your office. Payments are typically in the designated bank account by Wednesday of each week.
- Paperless EOB statements reduce the amount of paper flowing into the provider's office. EOBs are available for viewing on Monday morning via Availity – which is two days earlier than receiving them by mail. For Pennsylvania, Delaware, and West Virginia providers, this information is also available for viewing within PNC's Healthcare's ECHO Health platform.

For providers in New York

Important! Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) providers should use ASK for electronic claim submissions or Availity for administrative Transactions and EFT payments. Once an EFT payment is received, providers will be able to view EFT payments via Availity.

Additionally, Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) providers may still opt in to paper Explanation of Benefits.

How to Sign Up for Availity – All Providers

Providers who are not currently registered to use Availity should go to the Register and Get Started with Availity Essentials webpage.

Enrolling in EFT and Paperless EOBs

For providers in Delaware, Pennsylvania, and West Virginia

After becoming Availity-enabled, providers must also enroll in Electronic Funds Transfer (EFT) and paperless Explanation of Benefits (EOB) statements. Claims payments are generated from PNC-ECHO Health Trust. Electronic Remittance Advices (ERAs) are distributed using the ECHO Payer ID 58379. Providers may elect to receive EFT only or 835/EFT through the ECHO Health platform. To sign-up to receive EFT on the ECHO Health platform, visit their EFT/ERA enrollment page.

Virtual Credit Cards: Providers who have not registered to accept payments electronically will receive virtual credit card payments with their EOBs. Offices opted in to virtual credit cards (VCC) will receive notification for each payment via mail or fax, which will include a unique virtual credit card number and instructions for processing. Providers may opt out of VCC by visiting/calling ECHO Health at **800-890-4124**.

Additional Payment Options: ECHO also offers payments via Medical Payment Exchange (delivers payments and EOBs electronically and gives providers the option to print a check at no cost, receive a virtual card payment, or enroll for EFT) or paper check. Explore more details about these options on ECHO Health's platform.

Once providers are enrolled and start receiving EFT payments, they will no longer receive paper EOB statements or remittances. Providers will still be able to view the claims status and a copy of the EOB through Highmark's provider portal, Availity. However, providers will need to visit ECHO Health's platform to manage/change payment information.

Enrolling in EFT and Paperless EOBs

For providers in New York

After becoming Availity-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless Explanation of Benefits (EOB) statements. To do this, please contact the Provider Service Center.

Availity Support – All Providers

With Availity, an individual in your office or facility serves as the administrator. That individual can register with Availity online. The office administrator can begin the registration process on the Register and Get Started with Availity Essentials webpage. After registering an organization, the administrator can add other users from the administrator's organization.

To learn more about registering and getting started with Availity, go to the Register and Get Started with Availity Essentials webpage.

If you need assistance with an existing account and cannot log in to submit a ticket, or have started the registration process and are experiencing issues, you can call **800-AVAILITY (282-4548)**. For more information about contacting Availity, click here.

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1.3 Electronic Data Interchange (EDI)

Everyone has a stake in health care cost containment. Health care professionals, patients, insurance companies, and state and federal government are all affected by the high price of maintaining good health. Fortunately, technology can help simplify business operations and thus cut costs.

Due to their inherent speed and cost-effectiveness, electronic transactions and online communications are integral to today's business world. Electronic transactions between health care professionals and insurers are essential to maintain efficiency. EDI makes electronic communications a viable method of streamlining claims processing and eliminating wasted time and money.

Highmark provides you the convenience and cost savings of electronic data interchange through various means. Some of the most common forms of provider electronic exchanges with Highmark include streamlined claims filing, acknowledgement information about your claims, inquiry features, and information retrieval.

Background

In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop and maintain uniform standards for Electronic Data Interchange (EDI). ASC X12N is the section of ASC X12 for the health insurance industry's administrative transactions.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Administrative Simplification provisions named ASC X12N as the mandated standard to be used for electronic transmission of health care transactions. In 2010, the Affordable Care Act (ACA) included additional provisions that addressed the use of transactions, building upon the requirements already in place through HIPAA.

Highmark EDI Services

Highmark EDI Services supports a variety of HIPAA-compliant electronic inquiry and claims transactions including, but not limited to:

Transaction ID	Transaction Name

270/271	Health Care Benefit Eligibility Inquiry and Response
275	Health Care Services Review attachments (Solicited)
276/277	Health Care Claim Status Request and Response Transaction
278	Health Care Services Review Request and Response
837I	Health Care Claim Institutional
837P	Health Care Claim Professional
835	Health Care Claim/Payment Advice

To find out more about the EDI services available to Highmark Trading Partners in support of their electronic business activities, visit the Highmark EDI Services website. The site provides current information about transaction specifications, Trading Partner requirements, and enrollment applications.

Click on the applicable link to access the Highmark EDI Services website directly:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

The link to the EDI Services website is also available on the Provider Resource Center – select **Claims & Authorization,** then **Reimbursement Resources,** and then **Guidelines & Tips** from the main menu at the

top of the page.
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1.3 About Trading Partners

A **trading partner** is an entity that conducts business electronically with Highmark. Providers, clearinghouses/billing services, and software vendors are the most common types of trading partners who enter into agreements with Highmark.

Before a provider, clearinghouse/billing service, or software vendor can begin to do business electronically with Highmark, an agreement must be executed. The agreement explains both Highmark's and the Trading Partner's obligations as well as defines the terms, indemnification, and compliance with privacy standards. It further establishes the legal relationship and requirements within Highmark.

To view the Provider Trading Partner Agreement in its entirety, select the link titled Electronic Data Interchange (EDI) Services on the Provider Resource Center, or click on the applicable link below to access the site directly:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

Trading Partner Types

A provider is a health care professional, institution, or organization in whose name the bill is submitted and to whom payment should be made. A **clearinghouse,** or billing service, is an entity which submits claims or other transactions on behalf of professional or institutional providers.

- Providers doing their own electronic billing using a vendor software package must apply for their own Trading Partner number.

- Providers using a billing service or clearinghouse to conduct electronic billing must be affiliated with the Trading Partner number of the billing service or clearinghouse.
- Billing services and clearinghouses must obtain their own Trading Partner numbers for conducting electronic business with Highmark. In addition, customers (providers) must be affiliated to their Trading Partner number(s).

Complete an *EDI Transaction Application* to request a Trading Partner ID. The type of application depends on the business functions you will be performing. All applicants will be required to review and accept the terms of Highmark's *EDI Trading Partner Agreement.*

To complete an application, visit the Electronic Data Interchange (EDI) Services website via either the Provider Resource Center, or click on the applicable link below to access the site directly:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

Your Trading Partner Profile at Highmark includes many facts about your practice or facility, such as:

- Practice or facility name
- Address (both physical locations and where checks should be sent)
- National Provider Identifier (NPI)
- Individual Practitioners who submit claims under a practice's Billing Provider Number
- NPI for each Practitioner

Highmark relies on Trading Partner and vendor contact information in case there are technical and/or business issues that require communication.

Changes to provider or trading partner information can affect how claims are received or processed by Highmark. We recommend that you remain diligent about reporting all changes within your practice as quickly as possible.

When to Notify EDI

Electronic transaction exchanges with Highmark can be affected by certain changes made within your practice. In some cases, separate notification about your changes must be submitted to EDI Operations.

If a new provider is added to your staff who will receive payment directly from Highmark, you must add this provider to your Trading Partner number. If you do not complete this step, you will experience problems with receiving payment for this provider's services.

Reporting Changes to Your Trading Partner Profile

If you need to report changes to Highmark, a specific request to change your Trading Partner information must be submitted. The forms can be found on the EDI website. You can access the website by selecting Electronic Data Interchange (EDI) Services by clicking the applicable link below:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

If after visiting the EDI website you still have questions about your Trading Partner Profile, please call EDI Operations at **800-992-0246.**

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1.3 Getting Started with Electronic Claim Submission

There are numerous things to consider when selecting an EDI vendor or clearinghouse. List your needs, determine your budget, and talk to others in your specialty using EDI. The following document is available to help you get started with electronic claim submission: EDI Frequently Asked Questions.

Selecting the Right EDI Option

Practice Management System Vendor: Purchase a complete system from a reputable vendor. Complete system solutions typically include the hardware (personal computer, monitor, modem, and printer) and

the software which includes electronic claims submission and possibly accounts receivable posting capabilities. Terms and conditions of each system vary from vendor to vendor.

Clearinghouse or Billing Service: Health care professionals can outsource their electronic claim submissions to private billing services and/or a clearinghouse. Terms and conditions vary from billing service to billing service and clearinghouse to clearinghouse.

Selecting a Practice Management System Vendor

The following suggestions should be considered when selecting a practice management vendor:

- Do they offer electronic claims submission of Highmark claims? Is the transmission direct or through an intermediary such as a clearinghouse? Is this capability offered with the basic electronic claims submission module at no additional charge?
- Can they support the submission of secondary claims and additional documentation electronically?
- Does the software capture and print the electronic reports provided by Highmark?
- Do they offer clearinghouse capabilities?
- How is installation performed?
- Ask about training on the software and if there is ongoing education provided. Is system help available (online or through paper manuals)?
- How much additional office software is included (word processing, email)?
- Do they offer internet access?
- Can you get a list of their clients in your specialty? What is the average turnaround time for a service call?
- What is the cost of the system?
- What features are standard with the system?
    - Does the system support electronic eligibility and claim status inquiries and responses?
    - Does the system support electronic remittance advices?
    - Does the system support electronic acknowledgments?
- When there are changes in Highmark reporting requirements, how long will it take to update your software and how is it updated? What is the cost of normal updates, customization requests, and annual maintenance fees?

- Will the system automatically bill for co-insurance, copayment, or deductible after the primary insurance pays you?
- What other services do they offer (free conversion, loaner hardware)?
- Do they provide remittance advice information? Is there a fee for this package?
- What computer operating systems do they support?

Selecting a Clearinghouse/Billing Service

Questions for a billing service:

- How frequently does the company submit your claims to the carriers involved?
- What kind of tracking reports does the service offer to its clients?
- Does the company provide credit and collection services?
- What is the cost per transaction?
- Are electronic eligibility and claim status inquiries supported?
- Are electronic remittances supported?
- Are electronic acknowledgments supported?

Enrollment

If you will be submitting directly to any of the Highmark payers, enroll online by visiting the Electronic Data Interchange (EDI) Services website by clicking the applicable link below:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

Upon receiving your completed application, EDI Operations will process your request and verify that you have a valid National Provider Identifier (NPI). A Trading Partner ID will then be assigned to you.

Within 5 to 10 business days, you should receive a secure email listing your assigned Trading Partner number, login identification and password, and the transmission telephone number.

If you are billing through a Trading Partner, clearinghouse, or billing service, check with them regarding the registration process to affiliate your NPI to their Trading Partner number.

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1.3 Availity Automated Inquiries and Transactions

Availity is an internet-based application for providers to streamline data exchanges between their offices and Highmark. This service is available at no cost to network participating providers.

Availity gives users real-time access to Highmark's membership, claims, and provider and payment systems, making your job easier. Availity seamlessly integrates all insurer-provider transactions into one system, such as inquiries on referrals/authorizations, eligibility, benefits, claims status, claims investigations, procedure/diagnosis codes, and provider/facility searches.

Availity can also be used for claims submissions, authorization requests, and provider information changes. Availity provides access to Highmark's tools for real-time claim estimation and adjudication. Our Provider Resource Center is also accessible through Availity.

Availity is the preferred Highmark tool for inquiring about member information. **Availity-enabled providers are expected to use this tool for all routine eligibility, benefit, and claim status inquiries. Practices must use Availity for routine inquiries that can easily be answered online.** The expertise of the Provider Service staff will remain available for non-routine inquiries that require analysis and/or research.

Availity® Customer Support

If you need assistance with an existing account and cannot log in to submit a ticket, or have started the registration process and are experiencing issues, you can call **800-AVAILITY (282-4548)**. For more information about contacting Availity, click here.

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1.3 Real-Time Capabilities

Highmark's real-time tools are available to all Availity-enabled contracted providers and to providers who submit electronic claims through a practice management system.

These primary real-time capabilities include:

- **Real-Time Provider Estimation** allows providers to submit a claim (837) for a proposed service and receive a response (835) in real-time. The 835 response estimates the member liability based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member liability and set patient financial expectations prior to a service. This can also be used at the time of service to actually identify and discuss payment arrangements or collect member liability at the point of service.
- **Real-Time Claims Adjudication** allows providers to submit a claim (837) that is adjudicated in real-time and receive a response (835) at the point of service. This capability allows providers to accurately identify and discuss payment arrangements or collect member liability based on the finalized claim adjudication results.

Other supporting capabilities related to real-time claim adjudication include:

- Accelerated Payment
- Accelerated Member Explanation of Benefits (EOB) on the Highmark Member portal

These real-time capabilities give providers the ability to discuss member financial liability with patients when services are scheduled or provided. Providers could also collect applicable payment or make payment arrangements at the time of services, if they wish to do so.

Electronic Data Interchange (EDI)

Providers who are interested in integrating real-time capabilities within their practice management system should discuss this functionality with their software vendors. They should also review the Electronic Data Interchange (EDI) transaction and connectivity specifications in the Resources section on the EDI website.

- Pennsylvania: https://edi.highmark.com/edi/index.shtml

- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

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Ask Guidance (NY Only)

For providers in New York

Enrolling with Ask

To obtain information on or sign up for Electronic Claims Submission with ASK, please visit their website: https://www.ask-edi.com. Click on "Getting Started" on the menu bar.

Fill out the online form completely to register and click 'Submit'. If you would like to contact ASK by phone, call their toll free number at **800-472-6481**; press option 1 for New York Customers and select option 1 again to connect to an EDI Helpdesk specialist.

Click the 'Resource Center' tab for:

- Payer News
- General Information
- CAQH-CORE Operating Rules
- ANSI Testing Guidelines for Batch Transactions

Acceptable Claim Formats

ASK accepts and edits electronic claims submissions using the following formats:

- ANSI X12 837P 5010 based on the HIPAA Implementation Guides (Professional)
- ANSI X12 8371 5010 based on the HIPAA Implementation Guides (Institutional)

Providers receive a clearinghouse response report for each electronic submission that indicates:

- Whether we have received the file
- The number of claims submitted successfully
- The data fields that need to be corrected before electronically resubmitting a claim returned for edit errors

Changes in Claims Routing Services

When you enroll with ASK, you will be offered a one-year free trial membership to ASK's commercial clearinghouse, EDI Midwest. This offer provides you with the option of clearing other payers' claims through ASK. EDI Midwest routes claims to 800 payers around the nation.

EDI Midwest will only accept claims that can be sent to their final destination electronically. Your ASK EDI Account Representative can give you more detailed information about EDI Midwest at the time you enroll to submit your claims to ASK. You can contact ASK directly at **800-472-6481**.

If you elect not to use the services of EDI Midwest, please make arrangements with your current clearinghouse vendor or submitter to have non-Blue Cross Blue Shield claims submitted directly to the appropriate payer.

We will continue to process claims destined for our vendors and all of our lines of business including: Non Direct-Bill ITS/BlueCard, Express Scripts, and Federal Employee Program (FEP).

National Provider Identifier (NPI)

We require the submission of the provider's Billing NPI number and not the 12- digit provider number on the claim form. Mail all claims, (Local, Indemnity, and Managed Care, including Senior Blue HMO and BlueSaver plans), to:

Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield of (NENY)	Federal Employee Program (FEP)
Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) P.O. Box 80 Buffalo, New York 14240-0080	Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) Attention: FEP Department P.O. Box 80 Buffalo, New York 14240-0080

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1.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 4: Highmark Member Information

1.4 Unit Definitions

Member

A member is an individual who is enrolled in a health plan and who meets the eligibility requirements of the program.

Subscriber

A subscriber is a member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in a program.

Dependent

A dependent is any member of a subscriber's family who meets the applicable eligibility requirements and is enrolled in a program.

Managed Care Plans

Managed care plans are delivered through a provider network. Under some plans, members may visit providers in or out-of-network; however, the highest level of benefits are paid for visits to in-network providers.

Managed care plans include:

- Health Maintenance Organizations (HMOs);
- Point of Service (POS);
- Open Access;
- Preferred Provider Organizations (PPOs); and
- Exclusive Provider Organizations (EPOs).

Indemnity Plans

Traditional indemnity plans are sometimes referred to as fee-for-service plans in that they pay a set amount per health care service performed. It gives members the widest choice of physicians and services through participating providers. Generally, these plans are subject to a deductible and coinsurance.

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1.4 Identifying Highmark Members

A Highmark member can be easily identified by the information on his or her identification (ID) card. Always ask to see the ID card upon the patient's first visit. On subsequent visits, ask the patient if he or she has had a change in health insurance. A patient's insurance information can change at any time and incorrect information can result in delayed claim payment. Although the ID card provides enrollment information for a Highmark member, it is recommended that you always confirm eligibility for the date of service through Availity, Highmark's internet-based inquiry system, or by performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction.

Member ID Cards

All Highmark members receive an identification card so you can easily identify them and have essential information to help you understand their coverage. The identification cards may have slight variations depending upon the type of program and the location of the Blue Plan through which members are enrolled. There may also be some small variances on cards of each employer group. Practices with the fewest claim submission errors generally require the member to show the current ID card with each visit and verify eligibility on every visit/service. This is why it is important to check the member's identification card prior to each visit or service you provide.

Generally, the identification card includes the following information:

- Subscriber's name;
- Dependent's name, if applicable;
- Member's Unique Member Identifier (UMI), or "Member ID," which includes a 3-character prefix and a 12-digit identification number;
- Group number – a series of alphabetical and numeric characters assigned to employment groups, professional associations, and direct payment programs;
- Plan Code – three digits that identify the Blue Plan through which the member is enrolled;
- Type of agreement – a brief description of the type of agreements and coverage of the member (not all identification cards have this information); and

- BlueCard® – all BlueCard members can be identified by a 3-character prefix preceding the member identification number on their identification card. Always report the 3-character prefix from any ID card.

Members may have more than one identification card if they are covered under more than one plan. Please verify the correct prefix and identification number for reporting services.

Prefix

The 3-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The Blue Cross Blue Shield Association (BCBSA) issues "alphanumeric prefixes" to Blue Plans.

Occasionally, Highmark will assign new alphanumeric prefixes when new groups are created. Please be aware that you may be seeing local Highmark members with valid alphanumeric prefixes on their Member ID cards. Since existing prefixes will not change, you will also continue to see the familiar "alpha prefixes."

Please see the manual's Chapter 2 Unit 6: The BlueCard Program, section titled "How to Identify BlueCard Members," for more information on the BCBSA 3-character prefixes that can be either three alpha characters or a combination of alpha and numeric characters.

Important! Medicare Advantage members retain their Medicare cards even after they begin coverage under Highmark Medicare Advantage products. You should always ask Medicare-eligible patients if they have joined a Highmark Medicare Advantage plan and, if they have, request their Highmark Medicare Advantage ID card. If a new Highmark member comes to the office and has not yet received an identification card, they may present an enrollment form or, for Medicare Advantage, a letter of confirmation in lieu of an ID card.

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1.4 Member Identification Cards

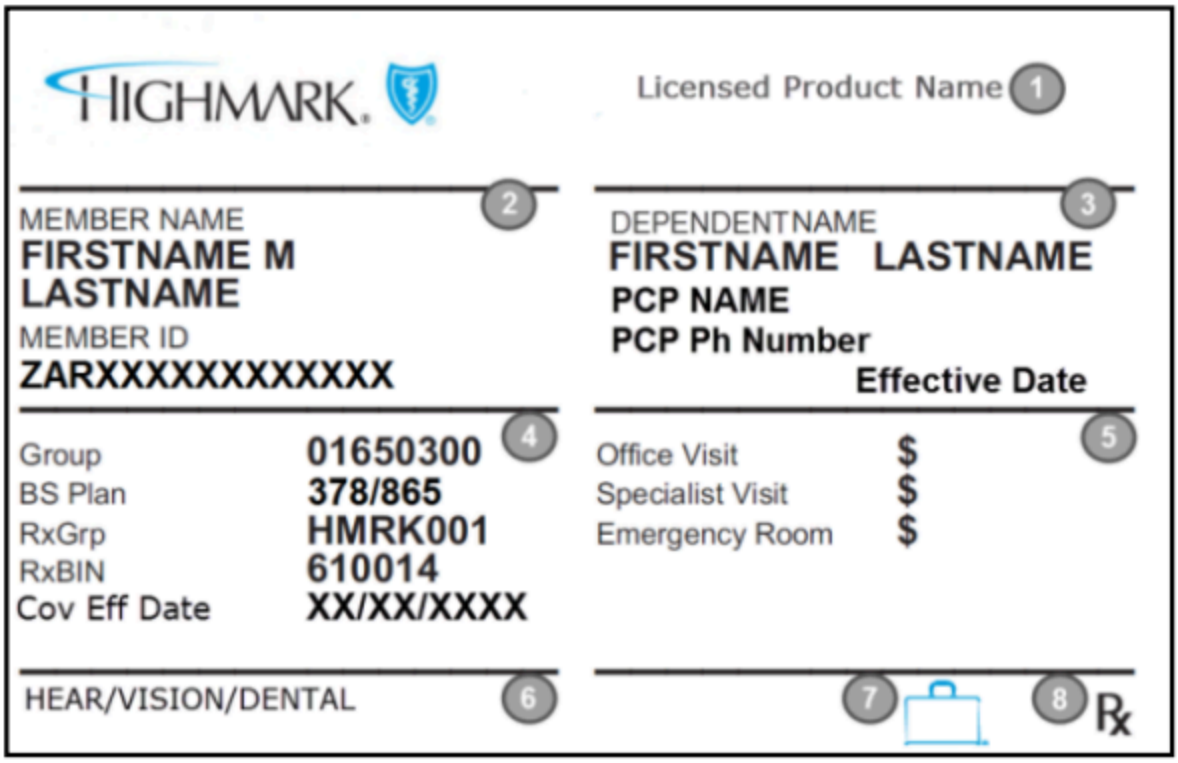
Identification cards are issued to all Highmark subscribers and their dependents. The ID cards feature a simplified format with key information regarding benefits and eligibility. Blue Cross and Blue Shield

Association (BCBSA) regulations require subscriber identification cards of all Blue Plans to follow the same format. Highmark's member identification cards satisfy BCBSA requirements.

The BCBSA required design features of the identification card include:

- **Background color:** The background of the card must be white only.
- **Easily identifiable standardized "zones" for display of information:** The front of the card features eight easily identifiable zones, while the back is divided into five zones. Horizontal black lines mark divisions among zones.
- **Blue Plan name and logo:** The Highmark company name and logo appears on the left side of the top section of the ID card.
- **Member name and Member ID:** The member name followed by the member identification number will always appear below the Highmark logo.
- **Name of the product under which the member has coverage:** The member's Highmark product is displayed on the right side of the top section of the ID card. An employer group name may also appear here.
- **Blue Cross Blue Shield Association's "suitcase" logo:** The suitcase logo, identifying BlueCard participation, appears in the lower right corner.
- **Prescription Drug Program group number:** This number appears on the front of the card, in the third zone on the left, along with the member's medical Group Number and the Blue Cross/Blue Shield Plan Area Code.
- **PCP:** The PCP name will appear if a valid PCP has been chosen.
- **ID cards for dependents:** Both the subscriber and dependent information appear on a dependent's ID card. Subscriber information is on the left side of the front of the card while dependent information is on the right.
- **Copays:** Copays - such as PCP, Office Visit, Specialist Visit, Emergency Room - may appear if applicable.
- **Coverage effective date information on individual products ("Direct Pay"):** This information is no longer provided on the ID card for members with employer-sponsored coverage.
- **Back of card:** The applicable Blue Cross and/or Blue Shield symbols will be at the top. The internet address of the Blue Plan must appear in bold-face type on the right side of the top section of the ID card, with all relevant telephone numbers in bold-face type below it.

Front of a Standard Member ID Card



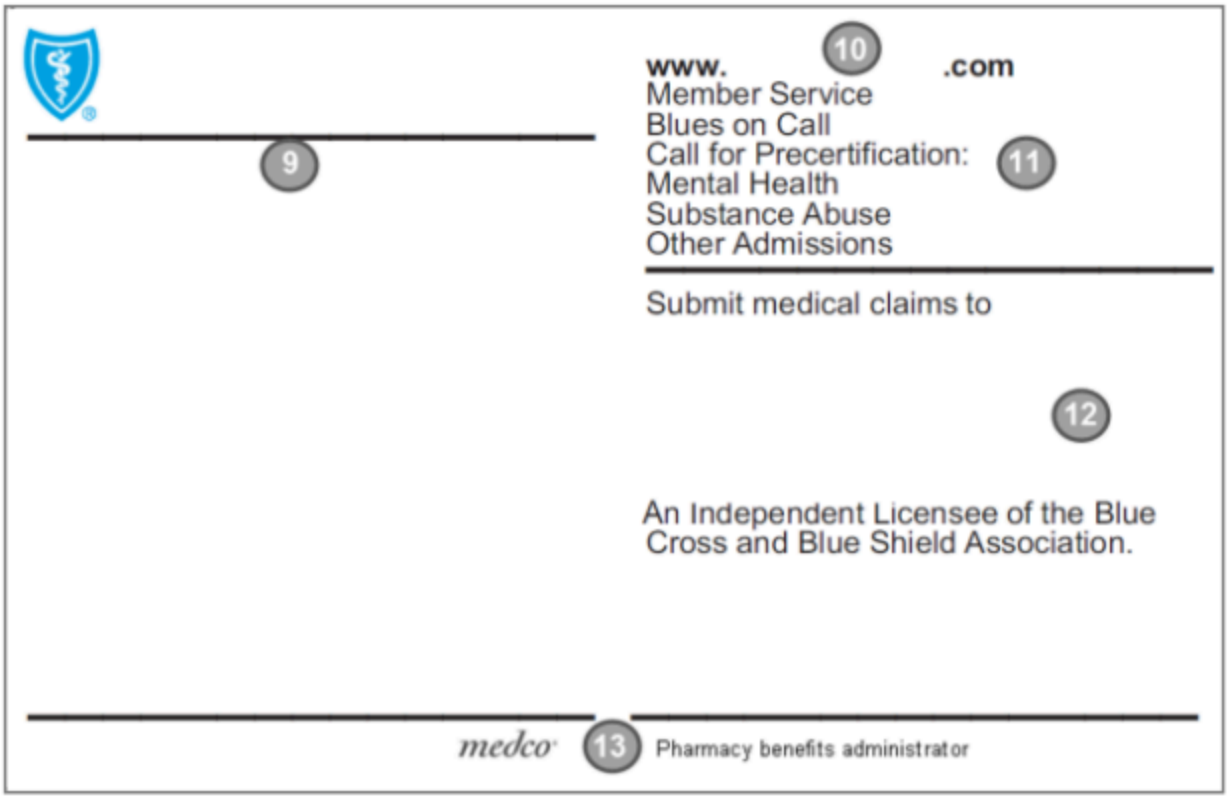
The Highmark company name/logo will always appear on the left side of the top section of the front of the ID card. Other areas will be populated as follows (numbers correspond to numbered areas on the sample ID card above):

1. **Licensed Product Name:** The product name, such as *PPO Blue* or *Community Blue PPO*, will appear here and will help you determine which network rules to follow.
2. **Member Identification Information:**
    a. The Member Name is the individual, or "subscriber," under whose name the coverage was established.
    b. The member's identification number, or Member ID," includes the 3-character prefix that varies by employer group or account (not applicable to Medicare Advantage products).
3. **Dependent and PCP Information (if applicable):**
    a. Both the subscriber and dependent information will appear on a dependent's ID card, with the dependent's name in this section on the right. Always verify that you have the card that corresponds with your patient and not that of another family member/dependent.
    b. The PCP's name will appear here if a valid PCP is chosen.
4. **Medical and Pharmacy Claims Processing Information:**
    a. The group number identifies the member's medical group.

   b. The 3-digit Plan Codes identify the corresponding Blue Plan.
   c. The RxGrp/RxBIN numbers identify the applicable prescription coverage information.
5. **Member Cost Sharing:**
   a. PCP, specialist office, office visit, and/or emergency room copayments may be listed. Specialist copays may not be the same for behavioral health care services, therapies, or diagnostic services; those copayments may be found via Availity or by calling the phone number on the back of the ID card.
   b. Pharmacy copayments are not listed. Participating pharmacies can verify copayment amounts online.
6. **Additional Coverage Information:** Other coverage information may be indicated here, such as hearing, vision, and/or dental.
7. **Suitcase Logo:** Indicates a member of the BlueCard® program. For more information about BlueCard, please refer to Chapter 2 Unit 6: The BlueCard Program of the *Highmark Provider Manual*.
8. **Rx Logo:** This will be on the ID card whenever a Highmark prescription drug program is included.

Back of the Member ID Card

The back of the member's identification card contains information mainly for the member's use. The information may differ based on the product and may include, but is not limited to, the information outlined below.



1. **Plan Specific Information:** Benefit and administrative information specific to Highmark and/or the member's coverage such as advising the member how to receive the highest level of benefits by obtaining care from an in-network provider.
2. **Plan Website:** Identifies the Blue Plan's website address to access Plan information online.
3. **Plan Contact Information:**
    a. Blues On Call phone number to call for health education and support services including myCare Navigator, if applicable.
    b. Member Service phone number for members to call Highmark with questions about benefits, claims, etc.
    c. Additional telephone numbers for members to receive assistance in obtaining admission to non-participating hospitals, facilities, mental health, and substance abuse treatment programs, etc.
4. **Claim Submission Information and Independent Licensee Disclosure:** Lists addresses for member submitted claims. The "tag line" identifying Highmark as an independent licensee of the Blue Cross Blue Shield Association will be found here.

5. **Pharmacy Benefits Administrator and Logo:** The name and logo of the pharmacy benefits administrator may appear here, if applicable.

Examples of Highmark Member ID Cards

The Blue Cross and Blue Shield Association (BCBSA) regulations require that all subscriber identification cards be in the requisite format. Therefore, you should accept only those cards in the design format described within this unit. Click on the link for your region to view samples of Highmark's ID cards:

- Highmark Blue Cross Blue Shield (DE) ID Card Samples
- Highmark Blue Cross Blue Shield (WNY) ID Card Samples
- Highmark Blue Cross Blue Shield (WPA/NEPA) ID Card Samples
- Highmark Blue Cross Blue Shield (WV) ID Card Samples
- Highmark Blue Shield (CPA/SEPA) ID Card Samples
- Highmark Blue Shield (NENY) ID Card Samples

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1.4 Verifying Eligibility and Benefits

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service. Highmark recommends that providers confirm a member's eligibility on the anticipated date of service or one business day prior to the anticipated date of service. You can verify a Highmark member's coverage by using Availity® or performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction, or by calling the Provider Service Center.

HIPAA 270 Eligibility and Benefit Inquiry Transaction

Highmark's Electronic Data Interchange (EDI) transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Eligibility and benefits for Highmark members can be verified by performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction. For more information on electronic connectivity with Highmark, click the applicable link below:

- Pennsylvania: https://edi.highmark.com/edi/index.shtml
- Delaware: https://edi.highmark.com/edi-bcbsde/index.shtml
- West Virginia: https://edi.highmark.com/edi-wv/index.shtml
- New York: https://www.ask-edi.com/

You may contact the EDI Operations support line at **800-992-0246.**

Provider Service Center

For those providers who are not Availity-enabled or without electronic capabilities, Provider Service Center representatives are available to provide information about Highmark member eligibility and benefits. For Provider Service Center contact information in your region, please see the manual's Chapter 1 Unit 2: Online Resources & Contact Information or access the Contact Guide.

Verifying Eligibility For Bluecard® Members

To verify eligibility for BlueCard® members, please use Availity or call **800-676-BLUE.** For additional information about BlueCard, please see the manual's Chapter 2 Unit 6: The BlueCard Program.

Additional information is also available in the BlueCard Information Center on the Provider Resource Center – select **Provider Network**, then **Inter-Plan Programs** from the main menu at the top of the page.

Limitations

It is a member's responsibility to timely notify his/her employer of eligibility changes (e.g., divorce, loss of student status) and the group's responsibility to notify Highmark timely of such changes. Highmark cannot accurately verify eligibility if the member or group does not timely notify us of eligibility changes.

On rare occasions, an insured group may be terminated retroactively by Highmark for non-payment of premiums (groups are allowed at least a thirty [30] day grace period for payment of premiums). Similarly, a self-funded group may be terminated retroactively for non-payment of claims or administrative expenses. In both cases, eligibility of the members is terminated as of the date the group is terminated. In all cases, a provider may bill the patient directly for the cost of any services provided after the effective date of termination. Also, Highmark may terminate an individual member retroactive to the last day of the month the individual was eligible.

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1.4 Dependent Eligibility

Health Care Reform (HCR)

The Patient Protection & Affordable Care Act (PPACA) is a federal law, enacted on March 23, 2010, that makes health insurance coverage available to all Americans. The provisions in the new law are collectively referred to as Health Care Reform (HCR).

One of the many provisions of the law requires that all health benefit plans provide coverage for dependents on their parents' policy up to age 26 years. All health plans (individual and group health insurance, including self-funded plans) that cover children as dependents must continue to make that coverage available until the adult dependent reaches age 26 regardless of whether the adult dependent is married or a student.

ACT 4 of 2009: Health Insurance Coverage for Adult Children

Pennsylvania Act 4 of 2009, Health Insurance Coverage for Adult Children, expands health insurance coverage for children of insured parents. It allows adults up to age thirty (30), under certain conditions, to remain covered by their parents' health insurance. It is a state mandate that gives employer groups the option to extend health insurance coverage to the children of their employees up to and including age twenty-nine (29) years.

While Act 4 provides an opportunity for many young adults to obtain health insurance, it does not require that employers offer coverage to adult children of their employees. Act 4 does require licensed insurers to offer employer groups this option at the insured employee's expense.

Verifying Dependent Eligibility

The changes in dependent eligibility will be relatively seamless for providers. Adult dependents with coverage under their parents' agreement will have a Highmark ID card providing the applicable member identification number.

As always, request the member's ID card on each visit, and then verify coverage and benefits through the Availity **Eligibility and Benefits** function. Availity is the preferred tool for inquiring about Highmark member information. Availity-enabled providers are expected to use this tool for all routine eligibility, benefit, and claim status inquiries. For those providers not Availity-enabled, eligibility can be verified by submitting a HIPAA 270 Eligibility/Benefit Inquiry transaction or by calling the Provider Service Center.

Please see Chapter 1 Unit 2: Online Resources & Contact Information for more information on contacting the Provider Service Center in your region.
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1.4 Confidentiality of Member Information

Confidentiality Policy

In accordance with the highest standards of professionalism, and as a requirement of all provider contracts, providers are obligated to protect the personal health information of their Highmark members from unauthorized or inappropriate use.

Member Rights and Responsibilities

Highmark treats members in a manner that respects their rights and will clearly communicate Highmark's expectations of our member responsibilities. Please see Chapter 1 Unit 5: Member Rights & Responsibilities to review our members' rights and responsibilities.

Normal Business Operation

The Health Insurance Portability and Accountability (HIPAA) Privacy Rule allows Highmark to use and disclose members' protected health information (PHI) for treatment, payment, and health care operations. Examples include:

- Claims management
- Certain types of routine audits by Highmark's group customers

- Coordination of care
- Quality assessment and measurement
- Case management
- Utilization review
- Performance measurement
- Customer service
- Credentialing
- Medical review
- Underwriting

Release of Information for Non-Routine Use

If member information is needed for reasons other than those listed above, Highmark must obtain the member's consent via an Authorization for Disclosure form.

If a member is unable to give informed consent, Highmark has a process to obtain this permission through a parent or legal guardian signature, signature by next of kin, or attorney-in-fact. The member has the right to limit the purposes for which the information can be used and all concerned are obligated to respect that expressed limitation.

Internal and External Controls

Members of Highmark products benefit from the many safeguards Highmark has in place to protect the use of data it maintains. This includes: comprehensive privacy and security training of members of Highmark's workforce; requiring Highmark employees to sign statements in which they agree to protect members' confidentiality; using computer passwords to limit access to members' PHI; and including confidentiality language in our contracts with doctors, hospitals, vendors, and other health care providers.

Providers' Responsibility to Protect PHI

Members must not be interviewed about medical, financial, or other private matters within the hearing range of other patients. Practitioners must have procedures in place for informed consent and the storage and protection of medical records. Highmark will verify that these policies/procedures are in place as part of the onsite review process, when applicable.

Others Who Have Occasion to Use Member Data

As a condition of employment, all Highmark employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Highmark participating providers are also bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information. Highmark provides aggregate information to employer groups whenever possible.

Confidentiality of Provider and Member Information and Medical Records

For providers in New York

Provider Profiling Data and Member information will be held confidential and will be limited to the Clinical Services staff involved in the initiatives.

- Requests for provider/member information must be in writing.
- Requests for provider information from outside sources, which may include, but not limited to, the New York State Department of Health and/or attorneys require a subpoena and accompanying court order be submitted to the Health Plan Legal Department. For release of drug and alcohol treatment records covered by 42 CFR Part 2, a subpoena by itself is insufficient. The subpoena must be accompanied by a court order, or the consent of the member, unless specific exceptions exist (for example, an emergency as defined in the regulations).
- Documents are retained and stored securely in accordance with the Records Management Compliance Program – Government Markets Policy: GUID- 5089764.
- Any documents prepared for external review must be approved by the Manager, and in some cases the Legal Department.
- A copy of the request is filed in the provider's file.
- Obsolete records (electronic or hard copy) are destroyed or discarded in a controlled, consistent, and confidential manner in accordance with the Enterprise Risk and Governance Records Management Compliance Program policy.
- For data pertaining to alcohol/substance use, during an audit, if the audit or evaluation is conducted by a health oversight agency, (e.g., NYS Department of Health is on site for contract survey purposes), patient-identifying information may be disclosed so long as the health oversight

agency makes the written commitments required by 42 CFR §2.53 and the disclosure meets the requirements in 45 CFR §164.512.

- Alcohol/Substance use: The records of patients treated for alcohol or drug use are protected from disclosure by both federal and state statutes. The federal restrictions on disclosure of such information are set forth at 42 U.S.C. §290dd-2 and in Regulations at 42 C.F.R. Part 2. These provisions generally prohibit the disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient, which is maintained in connection with any alcohol or drug abuse program, conducted, regulated, or assisted by a federal department or agency, without the prior written consent of the patient or under very limited exceptions.
- If the health oversight agency copies or removes patient records, it must agree in writing to abide by the requirements of 42 CFR §2.53(b).
- Article 27-F of the Public Health Law prohibits the disclosure of information concerning whether an individual has been tested for or has contracted HIV/ AIDS and any information which identifies or reasonably could identify an individual as having one or more of such condition. Section 33.13 of New York's Mental Hygiene Law prohibits the disclosure of data relating to a person's mental health. Any disclosure of information governed by these laws will be pre-approved by the Legal Department.

Provider Breach Notification Obligations

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

Provider has established a program to effectuate full compliance with all applicable state and federal privacy and breach notification laws including, without limitation, HIPAA, 45 CFR §§ 164.400-414 (the "HIPAA Breach Notification Rule,") and HITECH for the protection of PHI and PII, and for the notification of individuals, appropriate official bodies, and the media in the event of a breach of PHI or PII. Moreover, Provider will maintain its privacy compliance and breach notification program in accordance with industry best practices.

Member Access to PHI

Members of Highmark products have a right to access (i.e., to review and/or obtain a copy of) their PHI that is contained in a designated record set. Generally, a “designated record set” contains medical and billing records as well as other records that are used to make decisions about our members’ health care benefits. Therefore, each practitioner must have a mechanism in place to provide this access.

Use of Measurement Data

Highmark uses measurement data to manage members’ health care needs through appropriate quality improvement programs such as health, wellness, and disease management programs.

Protection of Information Disclosed to Plan Sponsors or Employers

Highmark, in general, will disclose PHI only to an authorized representative of a self-insured group health plan. However, Highmark may provide summary health and enrollment information, which has been aggregated and de-identified, to fully insured group health plans and plan sponsors.

Robocalls

Highmark Inc. and its affiliated companies do not release information to artificial intelligence agencies. We will be glad to provide the information needed to the appropriate human stakeholders. Please have a human use our self-service tools available at highmark.com, through our provider portal, or call Customer Service for any information needed.

The Privacy Department

Highmark’s Privacy Department reviews and approves policies regarding the handling of PHI and other confidential information. Online privacy policy may be viewed at highmark.com. At the bottom of the page, click Privacy.

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1.4 Advising Members of Treatment Options

Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel and to freely communicate with patients on all medically necessary treatment options available, including medication treatment options, regardless of benefit coverage limitations, that may be appropriate for the member's condition or disease.

In cases where the care, services, or supplies are needed from a provider who does not participate in Highmark's networks, authorization must be requested.

Members must make decisions based on a full disclosure of options, including potential insurance coverage. Disclosure is the obligation of the treating provider.

Background

Some managed care plans may include a "gag clause" in their provider contracts that limits a network physician's ability to provide full counsel and advice to enrollees.

Highmark network contracts for all products do not (and never did) contain such a "gag clause" relating to treatment advice, and, in Pennsylvania, complies with Act 68 requirements prohibiting such clauses.

Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel, and to freely communicate on all medically viable treatment options available, including medication treatment options, which may be appropriate for the member's condition or disease regardless of benefit coverage limitations. Therefore, we do not penalize and have never penalized physicians for discussing medically appropriate care with the member.

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1.4 Member Access to Physicians and Facilities

Accessibility Expectations for Providers

To stay healthy, members must be able to see their physicians when needed. To support this goal, we are sharing with you Highmark's expectations for accessibility of primary care physicians (PCPs), medical specialists, behavioral health specialists, and obstetricians. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

Note: Standards for Highmark Healthy Kids (CHIP) enrollees are available in Chapter 2 Unit 3: Other Government Programs and may differ from the expectations noted below.

PCP And Medical Specialist Expectations

Patient's Need:	Performance Standard:
Emergency/life threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	• Immediate response.
Urgent care appointments • An urgently needed service is a medical condition that requires rapid clinical intervention due to an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	• Immediate response.
Non-urgent, regular care appointments	• Must be scheduled within 48-72 hours (3 days)

• Non-urgent, regular care, but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain)	
Routine care appointments • Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physicial exams)	• Within 3 weeks • Subsequent routine wellness appointments must be scheduled within 7 days of request
Follow-up visit • After an emergency or hospital discharge for medical condition	• Care within 5 days of discharge or as clinically indicated.
After-hours care • Access to practitioners after practice's regular business hours	• Acceptable coverage in place to respond to members 24 hours per day, 7 days a week, which may be either directly or through an on-call arrangement with another Highmark credentialed participating practitioner of the same or similar specialty and of the same network(s). • An answering service, pager, or direct telephone access whereby the practitioner or his/her designee can be contacted is acceptable.
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A	• Within 15 minutes

reasonable attempt should be made to notify patients of delays.	

Maternity Care Expectations (Obstetrics)

Patient's Need:	Performance Standard:
Maternity Emergency	• Immediate response.
Maternity 1st Trimester	• Within 3 weeks of first request.
Maternity 2nd Trimester	• Within 7 calendar days of first request.
Maternity 3rd Trimester	• Within 3 calendar days of first request.
Maternity High Risk	• Within 3 calendar days of identification of high risk.

Behavioral Health Specialist Expectations

Patient's Need:	Performance Standard:
Care for a life-threatening emergency	• Immediate response

• Immediate intervention is required to prevent death or serious harm to patient or others	
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	• Care within 6 hours
Urgent Care • Timely evaluation is needed to prevent deterioration of patient condition	• Immediate response
Non-urgent office visit • Non-urgent but in need of attention appointment	• Appointment within 48-72 hours (3 days)
Routine office visit • Patient's condition is considered to be stable	• Office visit within 7 calendar days
After-hours care • Access to providers after the practice's regular business hours	• Acceptable coverage in place to respond to members 24 hours per day, 7 days a week, which may be either directly or through an on-call arrangement with another Highmark credentialed participating practitioner of the same or similar specialty and of the same network(s).

	• An answering service, pager, or direct telephone access (land line or cell phone) whereby the practitioner or his/her designee can be contacted is acceptable. • A referral to a crisis line/center is acceptable if prior arrangement has been made whereby the crisis line/center can reach the provider (or his/her designee), if needed.
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	• Within 15 minutes

Acceptable After-Hours Methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

Answering Process	Response/Message	Comments
Answering Service or Hospital Used as an Answering Service	Caller transferred directly to provider or clinical staff person covering for the provider	
	Service pages the provider on call (see comment to	A provider or clinical staff person is expected to return

	right)	the call within 30 minutes
Answering Machine	Message must provide the caller with a way to reach the provider on call by telephone (land line or cell phone) or pager	Provide clear instructions on how to record a message on a pager (i.e., "you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A provider or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment to right)	A provider or clinical staff person is expected to return the call within 30 minutes

Availability of Facility Services

Facility services need to be available to Highmark members on a 24 hour per day, 7 day per week basis when medically appropriate and in accordance with industry standards.

Access to physician services is an integral component of the facility services provided to members. Physician services are provided by either hospital-based physicians or physicians employed by a facility. If physician services are provided to Highmark members on behalf of a facility, the facility must verify that physician has the appropriate training, education, and licensure to provide such services.

Equal Access and Non-Discrimination in Treatment of Members

In addition to requirements contained in your provider agreement and in any other applicable administrative requirements, network providers agree to requirements of equal access and non-discrimination of Highmark members within this manual.

Providers will provide members with equal access at all times to provider services. Providers agree not to discriminate in the treatment of Highmark members, or in the quality of services delivered, on the basis of place of residence, health status, race, color, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment. Further, providers shall not deny, limit, discriminate or condition the furnishing of provider services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

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1.4 Communication Aids and Services

Communications Access for Individuals with Hearing, Visual, or Speech Impairments

According to the U.S. Department of Justice's Civil Rights Division (the "DOJ"), a "public accommodation" such as a physician's office must provide auxiliary aids and services when necessary to ensure that the practice is communicating effectively with individuals with disabilities, unless providing such an aid or service would pose an undue hardship on the practice or fundamentally alter the services provided.

For example, according to the DOJ, if a person has a vision, hearing, or other sensory impairment and that impairment substantially limits the patient's ability to communicate, a physician's office must provide auxiliary aids or services to ensure equal access to medical care. The impairment can be one that the patient has from birth or one that has recently developed.

The type of auxiliary aid or service that must be provided will vary according to the length and complexity of the expected communication involved and the nature of the patient's condition. Treating a hearing impaired patient for a simple cold or the flu may not require a physician's office to hire a sign language interpreter. Exchanging written notes, typing back and forth on a computer, or using a family member to convey information may be effective.

On the other hand, discussing a complicated diagnosis or answering questions about a planned surgical procedure may require the use of a professional sign language interpreter. Similarly, practices may need

to be prepared to have a telecommunication (TDD) device available to communicate effectively with deaf or speech impaired patients and may need to provide large print, audiotapes, or Braille materials for patients with significant sight impairments.

According to the DOJ, a practice may not charge a patient for the additional cost of providing such communication aids and services. Nor may it charge a patient directly for the cost of making the practice's policies, practices, or procedures ADA-compliant. A health care provider is expected to treat the costs of providing auxiliary aids and services as part of the overhead costs of operating a business.
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1.4 Fee Collection Guidelines

Services That are Permissable to Bill

Providers may collect fair and reasonable fees as permitted by law for providing the following services:

- Completion of forms related to any of the following: employment, driver's license, and school physicals.
- Providing copies of medical records for the member's own personal use.

Note: The fees for completion of forms and the provision of copies are permissible when communicated to members in writing prior to requesting payment. In Pennsylvania, the limits on copying charges are updated annually based on the consumer price index and published in the Pennsylvania Bulletin.

Cancellation Fee Assessments

Highmark members are encouraged to keep scheduled appointments or to give adequate notice of delay or cancellation. This is communicated to commercial members in Delaware and to Medicare Advantage members in Pennsylvania as a member responsibility (see Chapter 1 Unit 5: Member Rights and Responsibilities).

Providers may collect a reasonable fee from Highmark members as permitted by law for missed appointments or for cancelling less than 24 hours before a scheduled appointment. If your office policy is to charge for missed appointments or untimely cancellations, this is acceptable as long as the policy is

applicable to and enforced with all patients regardless of their payment method or insurance carrier. Members should be advised of the policy upfront prior to any services being rendered or fees assessed.

Providers Cannot Bill for These Services

Below please find common examples of when it is not appropriate to bill Highmark or its members for services. **The information below is not an all-inclusive list.**

Providers Cannot Bill Highmark Members For These Services	Providers Cannot Bill Highmark For These Services
• Telephone triage	• Review of members' test results by phone
• After-hours calls	• Review of members' test results in office without another reason for an office visit
• Transferring or copying of medical records to other providers as detailed in the applicable section of this unit	• Transferring or copying of medical records to other providers (as detailed in Chapter 4 Unit 1)

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1.4 After-Hours Physician Accessibility Study

The After-Hours Physician Accessibility Study is one of the methods by which physicians are evaluated to determine whether they meet accessibility standards.

Each practice meeting the following requirements participates in the after-hours study:

- New practice sites that have joined the network.

- An annual sample of existing practice site locations.
- Any practice site for which a member complaint (relating to after-hours access) has been received.
- Any provider who appeals a credentialing termination decision based on lack of 24/7 coverage.

The table below describes the process for the after-hours accessibility study:

Step	Action
1	A Highmark representative calls the practice's main telephone number after normal practice hours.
2	The Highmark representative verifies that the practice has an acceptable after hours process in place to respond to patient calls after regular business hours. Does the physician have an acceptable process? • If YES, no further action is necessary. • If NO, go to Step 3.
3	A letter is sent to the office informing the provider of the results and the requirements for after hours accessibility (answering service, provider is paged, etc). Highmark will call the provider's office after regular business hours two weeks after the letter is sent to the provider to determine if the office has implemented corrective actions.

Practices that remain non-compliant following Step 3 of the process may be subject to additional corrective action, sanctioning, and, ultimately, network termination.

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1.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 5: Member Rights & Responsibilities

1.5 Introduction

Highmark will treat members in a manner that respects their rights and will clearly communicate our expectations of member responsibilities to members, practitioners, and Highmark staff to promote effective health care, maintain a mutually respectful relationship with our members, and enhance cooperation among members, practitioners, and Highmark.

Highmark will communicate the member rights and responsibilities to all newly participating practitioners at the time of orientation via the *Highmark Provider Manual* and the applicable website, and annually to existing practitioners via the website. A paper copy will be provided upon request.

Highmark will communicate the member rights and responsibilities to the member through the *Member Handbook* upon enrollment, via the member website, and annually in the member newsletter.

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1.5 Member Rights & Responsibilities – Delaware

For providers in Delaware

The member rights and responsibilities for Highmark Blue Cross Blue Shield (DE) commercial products are outlined below.

Members have the right to:

1. Be treated with courtesy, consideration, respect, and dignity.
2. Have their protected health information (PHI) and health records kept confidential and secure, in accordance with applicable laws and regulations.
    a. Receive communications about how Highmark Blue Cross Blue Shield (DE) (Highmark Delaware) uses and discloses their PHI.
    b. Request restrictions on certain uses and disclosures of their PHI.
    c. Receive confidential communications of PHI.
    d. Inspect, amend, and receive a copy of certain PHI.
    e. Receive an accounting of disclosures of PHI.

   f. File a complaint when they feel their privacy rights have been violated.
3. Available and accessible services when medically necessary, including urgent and emergent care 24 hours a day, 7 days a week.
4. Receive privacy during office visits and treatment.
5. Refuse care from specific practitioners.
6. Know the professional background of anyone giving them treatment.
7. Discuss their health concerns with their health care professional.
8. Discuss the appropriateness or medical necessity of treatment options for their condition, regardless of cost or benefit coverage for those options.
9. Receive information about their care and charges for their care.
10. Receive from their provider, in easy to understand language, information about their diagnoses, treatment options including risks, expected results, and reasonable medical alternatives.
11. All rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medications and treatment after possible consequences of this decision have been explained to them in their primary language.
12. Received information about Highmark Delaware, its policies, procedures regarding its products, services, practitioners and providers, complaint procedures, and members'/enrollees' rights and responsibilities.
13. Prompt notification of termination or changes in benefits, services, or the provider network.
14. Play an active part in decisions about their health care including formulating an advance directive.
15. Receive benefits and care without regard to race, color, gender, country of origin, or disability.
16. File a complaint with Highmark Delaware and receive a response to the complaint within a reasonable period of time.
    a. This includes requesting an internal appeal or review by an independent Utilization Review Organization, or filing a petition for arbitration for decisions made about their coverage.
    b. To register a complaint or request an appeal, members are instructed to call the Customer Service number listed on their ID card.
17. Submit a formal complaint about the quality of care given by their providers.
18. Make recommendations regarding Highmark Delaware's members' rights and responsibilities policies.

Members have the responsibility to:

1. Double-check that any facilities from which they receive care are covered by Highmark Delaware. They can visit myhighmark.com or call the Customer Service number listed on their ID card to ask

about a facility.
2. Show their ID card to all caregivers before having care.
3. Keep their appointments. If they will be late or they need to cancel, give timely notice (in accordance with the provider's office policy). They may be responsible for charges for missed appointments.
4. Treat their providers with respect.
5. Provide truthful information (to the extent possible) about their health to their providers. This includes notifying their providers about any medications they are currently taking.
6. Understand their health and participate in developing mutually agreed upon treatment goals.
7. Tell their health care providers if they do not understand the care he or she is providing.
8. Follow the advice of their health care provider for medicine, diet, exercise, and referrals.
9. Follow the plans and instructions for care that they have agreed on with their practitioners.
10. Pay all fees in a timely manner.
11. Maintain their Highmark Delaware eligibility. Notify Highmark Delaware of any change in their family size, address, or phone number.
12. Tell Highmark Delaware about any other insurance they may have.

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1.5 Member Rights & Responsibilities - New York

For providers in New York

Members have the right to:

1. Be treated with courtesy, consideration, respect, and dignity.
2. Receive information about Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY), its services, practitioners and providers, and members'/enrollees' rights and responsibilities.
3. Voice complaints or appeals about the health plan or the care given by their providers.
4. Make recommendations regarding Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) members' rights and responsibilities policies.
5. Confidentiality of their medical records.

6. Candid discussions concerning appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.
7. Request to see the physician selected for their primary care services instead of another member of his/her office staff for an office visit, if they are willing to wait for an available appointment.
8. Information about all services available through the health plan, including how to obtain emergency and after-hours care.

As a patient, members have a right to expect the following from their physicians or other providers:

1. Refuse treatment to the extent permitted by law, and to be informed of the medical consequences of that action.
2. Know the professional background of anyone giving them treatment; information can be obtained from the provider or the administrator of any health care facility.
3. Receive information from their physician or other provider necessary to give informed consent prior to the start of any procedure.
4. Receive from their provider, in easy to understand language, complete and current information about their diagnoses, treatment options including risks, expected results, and reasonable medical alternatives; when it is not advisable to give such information to a member, the information shall be made available to an appropriate person on their behalf.
5. Play an active part in decisions about their health care including formulating an advance directive.
6. Submit a formal complaint about the quality of care given by their providers; they can refer to their member handbook or contact customer service.

Members have the responsibility to:

1. Establish themselves as a patient of the physician they have selected for their primary care services.
2. Show their ID card to all caregivers before having care.
3. Follow carefully the health plan's policies and procedures as described in their member handbook and their contract(s) and rider(s).
4. Provide truthful information (to the extent possible) about their health to their providers. This includes notifying their providers about any medications they are currently taking.
5. Understand their health and participate in developing mutually agreed upon treatment goals.
6. Be sure that their primary care physician coordinates any health care they receive in order to receive the highest level of benefits, if applicable under the terms of your plan coverage.
7. Keep their health plan informed of their concerns about the medical care they receive.

8. Follow the plans and instructions for care that they have agreed on with their practitioners.
9. Pay all fees in a timely manner, including appropriate copayments/deductible/coinsurance or other patient responsibility to providers when services or supplies are received.
10. Notify Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) (whichever is applicable) of any changes that affect them or their family, such as family size, address, or phone number.
11. Submit all bills they receive from a non-participating provider within one year from the date of service.
12. Tell Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) about any other group health insurance they may have or if anyone becomes eligible for Medicare.

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1.5 Member Rights & Responsibilities – Pennsylvania

For providers in Pennsylvania

The member rights and responsibilities for Highmark commercial products in Pennsylvania are outlined below.

Members have the right to:

1. Receive information about Highmark, its products and its services, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or file an appeal about Highmark or the care provided, and receive a reply within a reasonable time period.
6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

Members have the responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

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1.5 Member Rights & Responsibilities – West Virginia

For providers in West Virginia

The member rights and responsibilities for Highmark Blue Cross Blue Shield (WV) commercial products are outlined below.

Members have the right to:

1. Receive information about Highmark Blue Cross Blue Shield (WV) (Highmark West Virginia), its products and services, its practitioners and providers, and member rights and responsibilities.
2. Be treated with respect and recognition of their dignity and right to privacy.
3. Participate with practitioners in decision making regarding their health care. This includes the right to be informed of their diagnosis and treatment plan in terms they understand and to participate in decisions about their care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for their condition(s), regardless of the cost or benefit coverage. Highmark West Virginia does not restrict the information shared between practitioners and patients and has policies in place directing

practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or appeal about Highmark West Virginia or the care provided, and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Highmark West Virginia Members' Rights and Responsibilities policies.

Members have the responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to them, and that its practitioners and providers need in order to care for them.
2. Follow the plans and instructions for care that they have agreed on with their practitioners.
3. Communicate openly with the physician they choose. Ask questions and make sure they understand the explanations and instructions they are given, and participate in developing mutually agreed upon treatment goals.
4. Develop a relationship with their doctor based on trust and cooperation

Members receiving case management services from Highmark West Virginia are informed by letter at the initiation of services that they have the following rights:

1. Right to access needed health and social services.
2. Right to be informed of choices regarding services.
3. Right to be informed of available health care benefits, as well as where, when, and how they obtain these benefits.
4. Right to treatment with dignity and respect.
5. Right to have their health care records kept confidential except when disclosure is required by law or permitted in writing by them with adequate notice.
6. Right to be well-informed of any treatment plan in terms they understand, and to have input regarding decisions involving their medical care and treatment plan.
7. Right to comprehensive and fair assessment and notification of alternative approaches.
8. Right to receive notifications and rationale of discharge, termination, or change of service.
9. Right to withdraw from a case management program.
10. Right to an appeal/grievance procedure.
11. Right to choose a particular community service agency or long-term care provider.
12. Right to refuse treatment or services, including case management services, and be informed of the implications of such a refusal relating to benefits eligibility and/or health outcomes.

13. Right to obtain information regarding the plan's criteria for case initiation and case closure.
14. Right to have informed consent for services, advance medical care directives (including end of life directives), and power of attorney documents to be followed in the case management process.
15. Right to have assistance in seeking additional resources for resolution of legal questions.
16. Right to have services/treatment rendered consistent with the Americans With Disabilities Act, worker's compensation, and other laws protecting the rights of consumers as applicable.
17. Right to have alternative approaches to care if the member and/or family are not able to participate in the assessment process.

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1.5 Medicare Advantage Member Rights & Responsibilities - Delaware

For providers in Delaware

Members in Medicare Advantage Freedom Blue PPO plans are informed through their Member Evidence of Coverage booklets that they have certain rights and responsibilities.

Medicare Advantage members have the right to:

1. Not be discriminated against because of race, color, age, religion, national origin, or mental or physical disability.
2. To receive help with communication, such as help from a language interpreter.
3. Be treated with dignity, respect, and fairness at all times.
4. Privacy of medical records and personal health information. Generally, health information will not be released to anyone who is not providing or paying for the member's care without written permission from the member, except when allowed or required by law.
5. Review and obtain copies of medical records, and to ask providers to make additions or corrections to the records.
6. Obtain care from network and non-network providers. To choose a network provider (and be informed which physicians are accepting new patients). To see a women's health specialist (such as a gynecologist) without a referral or prior authorization

7. Timely access to providers and to see specialists when care from a specialist is needed. “Timely access” means to get appointments and services within a reasonable amount of time.
8. Get full information from providers when obtaining medical care and to participate fully in decisions about their care. Providers must explain things in a way the member can understand. The member’s rights include knowing about all the treatment choices that are recommended for the member’s condition, regardless of cost or coverage. This includes the right to be told about any risks involved. Members must be told in advance if any proposed treatment is part of a research experiment and be given the choice of refusing experimental treatments.
9. Refuse treatment, including the right to leave a hospital or other medical facility against a physician’s advice, and to stop taking medication. The member accepts responsibility for the consequences of refusing treatment.
10. Ask someone, such as a family member or friend, to help make health care decisions. This includes executing advance directives, such as a living will or power of attorney for health care, or to authorize someone to make decisions in the event the member becomes unable to make decisions for himself/herself.
11. Make a complaint or appeal if the member has concerns or problems related to coverage or care.
12. Get information about Highmark BCBSD Inc. (HBCBSD), which offers the Freedom Blue PPO product, health care coverage and costs, and network providers. Members may contact Member Services to request the following types of information:
    a. What services are covered and what the member has to pay;
    b. Explanation of any bills for services not covered;
    c. HBCBSD’s financial condition;
    d. Network providers and their qualifications;
    e. How Freedom Blue PPO pays physicians;
    f. Member rights and protections; and
    g. Summary of appeals and grievances Freedom Blue PPO has received.
13. Make recommendations regarding Highmark BCBSD Inc.’s, member rights and responsibilities policy.

Medicare Advantage members have the responsibility to:

1. Become familiar with their coverage, the rules they must follow to obtain care, and what they have to pay.
2. Give their physician and other health care providers the information they need to provide care. To follow the treatment plans and instructions that they and their physicians agree upon. To ask

questions of their physician or other provider if they have them.
3. Act in a way that supports the care given to other patients and helps the smooth operation of the physician's office, hospital, or other office.
4. Pay plan premiums and any copayments the member owes for covered services they receive.
5. To contact Highmark Blue Cross Blue Shield (DE) Member Services with any questions, concerns, problems, or suggestions.
6. Understand their health problems and participate in developing mutually agreed upon goals, to the degree possible.

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1.5 Medicare Advantage Member Rights & Responsibilities – New York

For providers in New York

Members in Medicare Advantage Freedom Value HMO, Senior Blue HMO, BlueSaver HMO, Freedom Plus HMO, Freedom Blue PPO, Freedom Nation PPO, and Forever Blue PPO plans are informed through their Member Evidence of Coverage booklets that they have certain rights and responsibilities.

Medicare Advantage members have the right to:

1. Not be discriminated against because of race, age, religion, gender, health, ethnicity, creed (beliefs), sexual orientation, national origin, or mental or physical disability.
2. Receive information in a way that works for you and is consistent with your cultural sensitivities (in languages other than English, in large print or other alternate formats, etc.)
3. Be treated with dignity, respect, and fairness at all times.
4. Privacy of medical records and personal health information. Generally, health information will not be released to anyone who is not providing or paying for the member's care without written permission from the member, except where allowed or required by law.
5. Review and obtain copies of medical records, know how they have been shared with others, and to ask Highmark to make additions or corrections to the records.

6. Obtain care from network and non-network providers. To choose a network provider (and be informed which physicians are accepting new patients). To see a women's health specialist (such as a gynecologist) without a referral or prior authorization
7. Timely access to providers and to see specialists when care from a specialist is needed. "Timely access" means to get appointments and services within a reasonable amount of time. You also have the right to get your prescriptions filled or refilled at any network pharmacies without long delays.
8. Get full information from providers when obtaining medical care and to participate fully in decisions about their care. Providers must explain things in a way the member can understand. The member's rights include knowing about all the treatment choices that are recommended for the member's condition, regardless of cost or coverage. This includes the right to be told about any risks involved. Members must be told in advance if any proposed treatment is part of a research experiment and be given the choice of refusing experimental treatments.
9. Refuse treatment- including the right to leave a hospital or other medical facility- against a physician's advice, and to stop taking medication. The member accepts responsibility for the consequences of refusing treatment. Ask someone, such as a family member or friend, to help make health care decisions. This includes executing advance directives, such as a living will or power of attorney for health care, or to authorize someone to make decisions in the event the member becomes unable to make decisions for themself.
10. Make a complaint or appeal if the member has concerns or problems related to coverage or care.
11. Members may contact Member Services to request the following types of information:
    a. Explanation of any bills for services not covered;
    b. The plan's financial condition;
    c. Network providers and their qualifications;
    d. Pharmacies in our network and how we pay the providers in our network;
    e. Coverage information and rules to follow when using coverage
12. Make recommendations regarding Highmark
13. Understand their health problems and participate in developing mutually agreed upon goals, to the degree possible.

Medicare Advantage members have the responsibility to:

1. Become familiar with their coverage, the rules they must follow to obtain care, and what they have to pay.
2. Inform Highmark of any other health insurance coverage or prescription drug coverage.

3. Tell their doctor and other health care providers they are enrolled in our plan.
4. Give their physician and other health care providers the information they need to provide care. To follow the treatment plans and instructions that they and their physicians agree upon. To ask questions of their physician or other provider if they have them.
5. Be considerate and respect the rights of other patients. Act in a way that supports the care given to other patients and helps the smooth operation of the physician's office, hospital, or other office.
6. Pay plan premiums and any copayments the member owes for covered services they receive.

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1.5 Medicare Advantage Member Rights & Responsibilities – Pennsylvania

For providers in Pennsylvania

The following information is made available to members through the Medicare Advantage Freedom Blue PPO, Community Blue Medicare PPO/PPO Plus, Community Blue Medicare HMO, and Security Blue HMO Member Evidence of Coverage booklets and updates in the member newsletters. The Member Evidence of Coverage booklets are available for viewing in the *Highmark Provider Manual's* **Appendix.**

Medicare Advantage members have the right to:

1. Be assured they will not be discriminated against in the delivery of health care services consistent with the benefits covered in their plan based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
2. Receive considerate and courteous care, with respect for personal privacy and dignity.
3. Select their own personal physician/preferred provider or physician group from Highmark's Medicare Advantage Primary Care Physician networks.
4. Expect their Primary Care Physician's/network provider's team of health care workers to provide or help them arrange for all the care that they need.
5. Participate in the health care process. If they are unable to fully participate in this discussion, they have the right to name a representative to act on their behalf.

6. Receive enough information to help them make a thoughtful decision before they receive any recommended treatment.
7. Be informed of their diagnosis and treatment plans in terms they understand and participate in decisions involving their medical care.
8. Talk openly with their Primary Care Physician and other network providers about appropriate and medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Have reasonable access to appropriate medical services.
10. Be provided with complete information about their Medicare Advantage HMO/Medicare Advantage PPO, including the services it provides, the practitioners who provide care, and information on member rights and responsibilities.
11. Confidential health records, except when disclosure is required by law or permitted in writing by the member with adequate notice. Members have the right to review their medical records with their PCP or other network provider.
12. Express a complaint and to receive an answer to your complaint within a reasonable period of time.
13. Appeal a decision by Medicare Advantage if they feel they have been denied a covered service.
14. Immediate Quality Improvement Organization review of decisions for hospital discharges, as explained in the Centers for Medicare & Medicaid Services' Important Message, which is given to Medicare members at the time of admission to a hospital, and in the Notice of Discharge and Appeal Rights given prior to discharge.
15. Call Member Services to request information about:
    a. How we control the use of medical services.
    b. The number of appeals and grievances we have received and how these cases were resolved.
    c. How we pay our participating doctors.
    d. The financial condition of our Plan.
16. Make suggestions about Medicare Advantage PPO and HMO policies on member rights and responsibilities.

Medicare Advantage members have the responsibility to:

1. Read all Medicare Advantage HMO and PPO materials carefully and immediately upon enrollment and ask questions when necessary. They have the responsibility to follow the rules of Medicare Advantage HMO/Medicare Advantage PPO membership.

2. Identify themselves as a Medicare Advantage HMO/Medicare Advantage PPO member when scheduling appointments, seeking consultations with their physician, and upon entering any Medicare Advantage HMO/Medicare Advantage PPO provider's office.
3. Treat all Medicare Advantage HMO/Medicare Advantage PPO network physicians and personnel respectfully and courteously as your partners in good health care.
4. Communicate openly with the physician they choose. The member has the responsibility to develop a physician-patient relationship based on trust and cooperation.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.
6. Ask questions and make certain that they understand the explanations and instructions they are given.
7. Consider the potential consequences if they refuse to comply with treatment plans or recommendations.
8. Pay any applicable copayments at the time of service.
9. Pay any applicable Medicare Advantage HMO/Medicare Advantage PPO premiums on time.
10. Pay their Medicare Part B premiums (and Part A, if applicable).
11. Help maintain their health and prevent illness and injury.
12. Help Medicare Advantage HMO/Medicare Advantage PPO maintain accurate and current medical records by being honest and complete when providing information to their health care professionals.
13. Express their opinions, concerns, or complaints in a constructive manner to the appropriate people at Medicare Advantage HMO/Medicare Advantage PPO.
14. Notify the Medicare Advantage HMO/Medicare Advantage PPO Member Service Department, Monday through Sunday, between 8 a.m. and 8 p.m. at 800-935-2583 (Medicare Advantage HMO) or 800-550-8722 (Medicare Advantage PPO) of any changes in their personal situation which may affect the Plan's ability to communicate with them or provide health care to them, including any changes in their address or phone number, any extended trips or vacations, and of their return to the service area from a trip of up to six (6) consecutive months. TTY users, please call 711.
15. Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

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1.5 Medicare Advantage Member Rights & Responsibilities – West Virginia

For providers in West Virginia

Members in Medicare Advantage Freedom Blue PPO plans are informed through their Member Evidence of Coverage booklets that they have certain rights and responsibilities. The Freedom Blue PPO Member Evidence of Coverage booklet is available for viewing in the *Highmark Provider Manual's* **Appendix.**

Medicare Advantage members have the right to:

1. Not be discriminated against because of race, color, age, religion, national origin, or mental or physical disability.
2. To receive help with communication, such as help from a language interpreter.
3. Be treated with dignity, respect, and fairness at all times.
4. Privacy of medical records and personal health information. Generally, health information will not be released to anyone who is not providing or paying for the member's care without written permission from the member, except when allowed or required by law.
5. Review and obtain copies of medical records, and to ask providers to make additions or corrections to the records.
6. Obtain care from network and non-network providers. To choose a network provider (and be informed which physicians are accepting new patients). To see a women's health specialist (such as a gynecologist) without a referral or prior authorization
7. Timely access to providers and to see specialists when care from a specialist is needed. "Timely access" means to get appointments and services within a reasonable amount of time.
8. Get full information from providers when obtaining medical care and to participate fully in decisions about their care. Providers must explain things in a way the member can understand. The member's rights include knowing about all the treatment choices that are recommended for the member's condition, regardless of cost or coverage. This includes the right to be told about any risks involved. Members must be told in advance if any proposed treatment is part of a research experiment and be given the choice of refusing experimental treatments.
9. Refuse treatment, including the right to leave a hospital or other medical facility against a physician's advice, and to stop taking medication. The member accepts responsibility for the

consequences of refusing treatment.

10. Ask someone, such as a family member or friend, to help make health care decisions. This includes executing advance directives, such as a living will or power of attorney for health care, or to authorize someone to make decisions in the event the member becomes unable to make decisions for himself/herself.
11. Make a complaint or appeal if the member has concerns or problems related to coverage or care.
12. Get information about Highmark Senior Solutions Company ("HSSC"), which offers the Freedom Blue product, health care coverage and costs, and network providers. Members may contact Member Services to request the following types of information:
    a. What services are covered and what the member has to pay;
    b. Explanation of any bills for services not covered;
    c. HSSC's financial condition;
    d. Network providers and their qualifications;
    e. How Freedom Blue pays physicians;
    f. Member rights and protections; and
    g. Summary of appeals and grievances Freedom Blue has received.
13. Make recommendations regarding Highmark Senior Solutions Company's member rights and responsibilities policy.

Medicare Advantage members have the responsibility to:

1. Become familiar with their coverage, the rules they must follow to obtain care, and what they have to pay.
2. Give their physician and other health care providers the information they need to provide care. To follow the treatment plans and instructions that they and their physicians agree upon. To ask questions of their physician or other provider if they have them.
3. Act in a way that supports the care given to other patients and helps the smooth operation of the physician's office, hospital, or other office.
4. Pay plan premiums and any copayments the member owes for covered services they receive.
5. To contact Highmark West Virginia Member Services with any questions, concerns, problems, or suggestions.
6. Understand their health problems and participate in developing mutually agreed upon goals, to the degree possible.

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1.5 Member Rights & Responsibilities – Highmark Healthy Kids (CHIP)

For providers in Pennsylvania

Highmark makes health care programs available to uninsured children in Pennsylvania through the subsidized Children's Health Insurance Program of Pennsylvania (CHIP) now called Highmark Healthy Kids (CHIP). Highmark is committed to providing CHIP enrollees with the highest quality care possible and is dedicated to serving them in a manner that respects their rights as individuals and maintains confidentiality about personal medical matters.

Until July 1, 2022, the following provider networks serviced children covered under CHIP: the Premier Blue Shield preferred provider network in the 21-county Central Region; the Keystone Health Plan West (KHPW) managed care network in the 29- county Western Region; and the First Priority Health (FPH) managed care network in the 13-county Northeastern Region. The children and parents have the right to timely and effective redress of complaints, grievances, and appeals about Highmark or the care provided by participating network providers.

Since July 1, 2022, Highmark has a HMO CHIP network that services all 62 counties of Pennsylvania.

Highmark encourages CHIP enrollees and their parents to know and exercise their rights and responsibilities as outlined below. Network participating providers who provide care to CHIP enrollees are expected to know and respect these rights and encourage member responsibilities.

Highmark Healthy Kids (CHIP) enrollees/parents have the following rights:

1. Receive information about Highmark, its products and services, its practitioners and providers, and members' rights and responsibilities.
2. Be treated with respect and recognition of their dignity and right to privacy.
3. Participate with practitioners in decision-making regarding their health care. This includes the right to be informed of their diagnosis and treatment plan in terms that they understand and participate in decisions about their care.

4. Have a candid discussion of appropriate and/or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or appeal about Highmark or the care provided, and receive a reply within a reasonable period of time.
6. To be free from any form of restraint or seclusions used as a means of coercion, discipline, convenience, or retaliation.
7. To be free to exercise their rights and exercising these rights will not adversely affect the way Highmark treats them.
8. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

Highmark Healthy Kids (CHIP) enrollees/parents have the following responsibilities:

1. Supply to the extent possible, information that the organization needs to make care available to them, and that its practitioners and providers need to care for them.
2. Follow the plans and instructions for care that they have agreed on with their practitioners.
3. Communicate openly with the physician they choose, ask questions and make sure they understand the explanations and instructions they are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with their doctor based on trust and cooperation.

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1.5 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West

Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Chapter 2 - Product Information

This chapter outlines Highmark's various product offerings including Medicare Advantage, Telemedicine, BlueCard, and other benefit and government programs.

Unit 1: Product Overview

Highmark and its affiliates operate health insurance plans in Delaware, New York, Pennsylvania, and West Virginia. Through its various product offerings, Highmark serves a wide array of large and small businesses, governmental agencies, individuals, and retirees.

READ MORE

Unit 2: Medicare Advantage Products & Programs

Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant, sometimes referred to as ESRD).

READ MORE

Unit 3: Other Government Programs

Highmark offers additional supplemental products including Medigap Blue, Signature 65, Highmark Healthy Kids (CHIP), Federal Employee Programs (FEP), and New York Medicaid and CHP.

READ MORE

Unit 4: Benefit Plan Programs

Highmark members can also benefit from programs such as Baby Blueprints, Blues on Call, the Diabetes Prevention Program, Health Promotion programs, Health Spending Accounts, MyCare Navigator, and our patient review tool Patient Experience Review.

READ MORE

Unit 5: Telemedicine Services

Advancements in technology have allowed visual communication and information exchange at a distance to meet the needs of our patient community. Highmark is integrating the use of this technology to provide care despite geography, weather, transportation, and availability of specialists.

READ MORE

Unit 6: The BlueCard Program

BlueCard® is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area. This unit describes the BlueCard Program and its advantages, and provides information to make filing claims easy.

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Disclaimers

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Unit 1: Product Overview

2.1 Disclaimers

2.1 Introduction

Highmark and its affiliates operate health insurance plans in Delaware, New York, Pennsylvania, and West Virginia. We offer a variety of health insurance plans in these service areas that are supported by our provider networks.*

Through its various product offerings, Highmark serves a wide array of large and small businesses, governmental agencies, individuals, and retirees.

All covered services are subject to specific benefit exclusions that are governed by the terms of the applicable contract and medical policy in effect at the time services are performed and are subject to change without prior notice.

*Please see Chapter 3 Unit 1: Network Participation Overview for information about Highmark's provider networks and to learn how to participate in the networks.

**Medicare Advantage will not be addressed in this unit. Please see Chapter 2 Unit 2: Medicare Advantage Products & Programs for information on Medicare Advantage.

Highmark's Corporate Entities

Highmark is licensed to offer products under various corporate entities in Delaware, New York. Pennsylvania, and West Virginia. These corporate entities include, but may not be limited to, the following:

- Highmark Blue Cross Blue Shield (DE): Serving the entire state of Delaware.
- Highmark Blue Shield (NENY): Serving 13 counties of Northeastern New York.
- Highmark Blue Cross Blue Shield (WNY): Serving 8 counties of Western New York.
- Highmark Blue Cross Blue Shield (PA): Serving Western and Northeastern Pennsylvania.

- Highmark Blue Shield (PA): Serving Central Pennsylvania, the Lehigh Valley, and 5 counties in Southeastern Pennsylvania.
- Highmark Blue Cross Blue Shield (WV): Serving all of West Virginia.
- Highmark Choice Company: Serving the Western, Central, and Northeastern Regions of Pennsylvania.
- Highmark Health Insurance Company: Serving Western and Central Pennsylvania and the Lehigh Valley.
- Highmark Coverage Advantage: Serving Western Pennsylvania.
- Highmark Benefits Group: Serving Central Pennsylvania and the Lehigh Valley.
- Highmark Select Resources: Serving Central Pennsylvania and the Lehigh Valley.
- Highmark Senior Health Company: Serving Pennsylvania's Western, Central, and Northeastern Regions.
- Highmark Senior Solutions Company: Serving West Virginia.

Reminder: Always verify benefits.

In response to rising health costs, more customers are choosing health plans that require their employees to have more cost-sharing. These plans include higher deductibles, copayments, and/or coinsurance. Be sure to verify a member's benefits and cost-sharing obligations at the time they receive services from you. Specific member information can be found on Availity®.

What We Mean by Program and Product

When used in this manual, program and product have approximately the same meaning, but somewhat different usage. They both refer to the patient's type of insurance coverage. They help to differentiate the types of insurance coverage, especially under a single insurance company.

- Program refers to the type of coverage (e.g., HMO, PPO, EPO, POS)
- Product refers to the brand name of the program (e.g., Freedom Blue PPO, PPO Blue, Connect Blue, BlueCare Custom PPO).

Essential Health Benefits

Essential Health Benefits are defined as a set of health care services that must be covered by certain health plans -- such as Highmark. The Affordable Care Act (ACA) ensures that health plans offer coverage that includes the following essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care

Highmark, and all insurance carriers, must include coverage for essential health benefits in order to be certified and offer products through the Health Insurance Marketplace.

Medicare Advantage Products

Medicare Advantage plans are available for individuals who are enrolled in both Medicare Part A and Part B.

For information on Medicare Advantage plans, please see Chapter 2 Unit 2: Medicare Advantage Products & Programs.

Partnership Products

For providers in Pennsylvania

Highmark recognizes that there are specific differences between the various regions that we serve; therefore, different strategies are being used to allow members to receive high quality care through lower-cost facilities within their communities.

In Pennsylvania, Highmark has partnered with certain hospitals, health systems, and independent providers to develop products that offer a variety of benefit structures and tiering options. These products are available in select counties served by these providers and include, but are not limited to, the following:

- Community Blue Flex Pennsylvania Mountains Healthcare Alliance
- Community Blue Flex Penn Highlands Region (available in the four-county Penn Highlands Region of western Pennsylvania)
- Lehigh Valley Flex Blue (Lehigh Valley Health Network [LVHN])

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2.1 Managed Care Overview

Managed care programs integrate the delivery and financing of medical care. The programs offer health care coverage through a network of contracted physicians who provide care to people who subscribe to the plan called members.

Managed care programs provide preventive coverage to members and use its network of physicians to assist in determining the appropriateness and the efficiency of the members' care to promote and maintain good health while conserving resources.

Highmark currently offers the following types of managed care programs:

- Preferred Provider Organizations (PPOs)
- Exclusive Provider Organizations (EPOs)
- Point of Service (POS) and Open Access Programs
- Health Maintenance Organizations (HMOs)
- Independent Practice Associations (IPAs)

The following terms are commonly used in reference to managed care programs:

Authorization: The official acknowledgement from Highmark that services/items requested meet the definition of “medically necessary and appropriate.”

Covered Services: Those medically necessary and appropriate services and supplies that are provided as part of a benefit plan.

Exclusions: Items or services that are not covered as part of a benefit plan.

Primary Care Physician (PCP): PCP is a practitioner selected by a member in accordance with the member’s managed care program requirements. The practitioner provides, coordinates, or authorizes the health care services covered by the managed care program. The PCP may be a general practitioner, family practitioner, internist, pediatrician, or certified registered nurse practitioner (CRNP).

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2.1 Preferred Provider Organization (PPO)

Preferred provider organization (PPO) programs typically offer members the ability to obtain care from a network participating provider at the higher in-network level of benefits and without the requirement to select a primary care physician (PCP).

PPO plans are offered in all of Highmark’s service areas in Delaware, New York, Pennsylvania, and West Virginia.

Outpatient Authorization Requirements

Highmark’s list of outpatient procedures/services requiring authorization apply to PPO products. These are the same authorization requirements that apply to other Highmark products (such as HMO and Medicare Advantage products).

The List of Procedures/DME Requiring Authorization is available on the Provider Resource Center by selecting Claims & Authorization from the top menu and then Obtaining Authorization.

General Characteristics of PPO Programs

PPO programs are generally characterized by the following:

- Benefits are offered at two levels (in-network and out-of-network) with the higher level of benefits received by using network participating providers. Some programs offer tiering at the in-network level of benefits, based on which providers render service.
- Members are usually not required to select PCPs to coordinate their care.
- Members can seek care without referrals.
- All practitioners are paid fee-for-service for care rendered to PPO members.

Note: See specific benefit details for the Medicare Advantage PPO products which vary from traditional PPOs.

In-Network and Out-of-Network Reimbursement

Payments made under PPO programs are based on the lesser of the applicable Highmark fee schedule allowance or the provider's charge.

PPO programs provide higher-level reimbursement for services received from in-network providers and lower-level reimbursement for services received outside the network.

Network providers agree to accept Highmark's allowance as payment in full for covered services, and to collect applicable co-payments, coinsurance and/or deductible amounts from their patient.

Network Providers for Delaware PPO Programs

For providers in Delaware

Highmark Blue Cross Blue Shield (DE)'s provider network, which spans the state of Delaware supports the PPO products. This extensive network, the largest in the state, provides PPO members with access to leading health care professionals in all specialties and to all hospitals in the state.

In addition, ancillary providers in the network include, but are not limited to, suppliers of durable medical equipment, orthotics and prosthetics, home infusion therapy, and ambulance transportation.

Network Providers for New York PPO Programs

For providers in New York

This extensive network provides PPO members with access to leading health care professionals in all specialties and to hospitals across all 200 networks in Highmark Blue Cross Blue Shield (WNY) and 200+ networks in Highmark Blue Shield (NENY). We also contract with ancillary providers, which include, but are not limited to, suppliers of durable medical equipment, orthotics and prosthetics, home infusion therapy, and ambulance transportation.

Payments made under PPO programs are based on the terms of each provider’s contract as it relates to the service rendered. PPO programs provide reimbursement for services received from network providers at the in-network fee schedule rate and reimbursement for services received outside the network at the out-of-network fee schedule rate. The percentage of member coinsurance for in-network and out-of-network services is determined by the specific member contract.

Network Providers for Pennsylvania PPO Programs

For providers in Pennsylvania

The foundation of PPO programs is the network. In the Central Region of Pennsylvania, the Premier Blue Shield network of preferred professional providers is located in the 21 counties of central Pennsylvania and the Lehigh Valley. Also included in the network are institutional and ancillary providers that contract with Highmark Blue Shield (PA) in this region. The Premier Blue Shield network also serves Highmark members with PPO plans in the Northeastern Region. In the 29 counties of western Pennsylvania, members have access to an additional network of professional, institutional, and ancillary providers. These providers will be reimbursed at the higher benefit level for covered services.

In addition, PPO products are available in Pennsylvania that use the select Community Blue networks and are designed to provide an affordable choice for customers seeking quality, lower-cost coverage and to encourage members to use hospitals and physicians who offer high quality and efficient care.

Also available are Community Blue Flex plans that give members two levels of in-network benefits, an “Enhanced Value Level” and a “Standard Value Level,” to let them choose the providers who will give them the most for their health care dollars. With Community Blue Flex, health care professionals and hospitals are grouped into two levels of in-network benefits. What the member pays for care is based on the level of benefits they choose. The plans give members more control over their health care costs.

Note: In Pennsylvania’s Central Region, the Premier Blue Shield network of preferred professional providers provides high-level access for out-of-area Blue Plan PPO members through BlueCard. The Keystone Health Plan West (KHPW) managed care network supports BlueCard PPO programs in the 29-county Western Region of Pennsylvania.

Network Work Providers for West Virginia PPO Programs

For providers in West Virginia

Highmark Blue Cross Blue Shield (WV)'s provider network is the basis for the PPO products. This extensive network provides PPO members with access to leading health care professionals in all specialties and to hospitals all across West Virginia. Also included in the network are ancillary providers, which include, but are not limited to, suppliers of durable medical equipment, orthotics and prosthetics, home infusion therapy, and ambulance transportation.

West Virginia Small Business Plan

For providers in West Virginia

The West Virginia Small Business Plan (WVSBP) is a PPO program created by the West Virginia State Legislature. The program makes health insurance coverage available to small businesses that meet certain eligibility criteria

Coverage is provided through health insurance plans offered by private insurance carriers. Highmark West Virginia is currently the only company that participates in the program.

Two features are unique to this program:

- First, carriers that participate can use the West Virginia Public Employees Insurance Agency's (PEIA) reimbursement rates for West Virginia providers. In most instances, PEIA's rates are significantly lower than those of private carriers.
- Second, all West Virginia providers who furnish services to PEIA members are automatically deemed to participate in the WVSBP unless the provider withdraws through an annual opt-out process administered by the PEIA each spring.

For its WVSBP product, Highmark West Virginia uses its regular PPO network minus those providers who have opted out of the WVSBP through the PEIA.

REMINDER: Always verify benefits! For inquiries about eligibility, benefits, claim status, or authorizations, Highmark encourages providers to use the electronic resources available to them – Availity and the applicable HIPAA transactions – prior to placing a telephone call to the Provider Service Center.

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2.1 Exclusive Provider Organization (EPO)

For providers in Delaware, New York, and Pennsylvania

Exclusive Provider Organization (EPO) plans provide members with coverage for a wide range of services when they are received from in-network providers. EPOs function like a PPO, but offer no out-of-network benefits except for emergency services. Members are not required to select a PCP to coordinate covered care, but it is recommended.

By utilizing the local Blue Plan PPO network, EPOs allow access to the largest provider network in the Highmark service area, as well as a large provider network across the country.

EPO Availability

Highmark offers EPO plans in the Western and Central Regions of Pennsylvania, Western (ASO groups only) and Northeastern regions of New York, and in Delaware.

The following are general characteristics of EPO plans:

- There is no coverage when a member receives services from an out-of-network provider, except emergency services, which are covered at the in-network level.
- Members are not required to select PCPs to coordinate their care, but it is recommended.
- Some plans offer “tiering” of benefits, based on which providers render services.
- Highmark’s list of outpatient procedures/services requiring authorization will apply to EPO plans.
- Providers are required to contact Clinical Services to obtain authorization for in-network inpatient admissions.

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2.1 Community Blue (PA Only)

For providers in Pennsylvania

Highmark's Community Blue plans utilize a select network of high-quality practitioners and facilities within the Community Blue network. Community Blue plans provide an affordable choice for members who are seeking greater levels of cost-savings with quality, cost-efficient care. With Community Blue plans, both in-network and out-of-network benefit levels are offered. Community Blue qualified High Deductible Health Plan (HDHP) options are available with a Health Savings Account (HSA).

Community Blue plans also offer "tiered" plans, which give the greatest level of cost-savings while still giving members the power to choose the care, the place, and the price that is right for them in their community.

Community Blue plans are offered in Pennsylvania service areas.

General Types of Community Blue Plans

Community Blue EPO is offered in Pennsylvania's Western Region. With all Community Blue EPO plans, members must receive services from providers participating in the Community Blue network. There is no out-of-network coverage, except for emergency services.

Community Blue Flex is offered in the Western Region, while Community Blue Premier Flex is offered in the Central Region. Both are available as PPO or EPO plans. Flex plans have a "tiered" benefit design and offer two levels of in-network options for added cost savings:

- Enhanced Value offers a lower level of cost-sharing for the member.

- Standard Value has a higher level of cost-sharing for the member.

Connect Blue is a Community Blue EPO plan design offered only in Pennsylvania's Western Region. Connect Blue also offers a "tiered" benefit design; however, there are three levels of in-network options for even more added cost-savings:

- Preferred Value offers the lowest level of cost-sharing for the member.
- Enhanced Value has a middle level of member cost-sharing.
- Standard Value has the highest level of cost-sharing for the member.

Community Blue HMO is only offered in Pennsylvania's Western Region. Members must select a PCP and must receive services from providers participating in the Community Blue network. Similar to other HMO plans, there is no out-of- network coverage, except for emergencies.

Total Health Products

Community Blue Total Health is a specific flex EPO/PPO plan design that includes reduced member cost-sharing for a PCP office visit when a member uses a provider affiliated with a Patient Centered Medical Home (PCMH), Accountable Care Alliance (ACA), or Accountable Care Organization (ACO).

The plan also has reduced cost-sharing for certain services for members with chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), diabetes, high cholesterol, and hypertension.

REMINDER: Always verify benefits! With the variety of products offered and various networks, it is more important than ever to always verify a member's specific benefits prior to rendering services.

For inquiries about eligibility, benefits, claim status, or authorizations, Highmark encourages providers to use the electronic resources available to them – Availity and the applicable HIPAA transactions – prior to placing a phone call to the Provider Service Center.

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2.1 Point of Service (POS)

For providers in Delaware, New York, and West Virginia

Point of Service (POS) is a managed care benefit plan in which a member selects a primary care physician (PCP) and maximizes benefit coverage by securing care directly from, or under authorization by, the selected PCP. Members may incur additional out-of-pocket expenses or reduced benefits for using non-network providers.

Point of Service plans contain some elements of the fully managed care provided by HMOs, plus some of the freedom of choice provided by traditional benefit plans. Unlike an HMO, which typically covers services only when provided in the HMO network under the direction of the member's PCP, a POS plan allows the member to select treatment by his or her PCP or choose to go to any other provider at the time care is needed (at the "point of service"). Benefits are highest when the member sees his/her PCP or is referred to another network provider by the PCP.

Point of Service plans are offered in Highmark's Delaware, West Virginia, and New York service areas.

Highmark Delaware POS Plans

For providers in Delaware

Point of Service members have coverage for eligible services by both in-network and out-of-network providers. Members who opt to have covered services either rendered by, or coordinated through, their PCP will receive the highest level of benefits. Referral authorizations are required for in-network specialist visits in most cases for the highest level of benefits.

Members may also seek care from a network participating provider without a referral authorization; however, the lower out-of-network benefit level would apply. Members seeking services from non-network providers will also have a greater out-of-pocket cost under the out-of-network coverage.

Under this managed care plan, authorization and pre-certification are required for hospital admissions both in and out of network. In addition, other targeted care may require authorization.

Highmark New York POS Plans

For providers in New York

Point of Service members have coverage for eligible services by both in-network and out-of-network providers. Members are required to select a physician as their primary health gatekeeper who will render services directly to the member or coordinate their care with other specialists and/or facilities within the New York networks. POS members are also required to use Quest Diagnostics for laboratory services. Referrals are not required on any New York POS member services.

Members seeking services from non-network providers do not require a referral but will have a greater out-of-pocket cost under the out-of-network coverage. Members can be billed the difference between the allowed fee schedule amount and the physician/facility charge.

New York's POS Wrap, or EX plan, functions like a PPO plan with access to the national BCBS PPO network but requires that the member enrolled in the plan reside within the 13-county service area of Northeastern New York or the 8-county service area of Western New York. EX members are required to select a primary care physician and use Quest Diagnostics for elective laboratory procedures. Effective September 1, 2018, referrals are no longer required for New York POS plans.

Under this managed care plan, authorization and pre-certification are required for hospital admissions both in- and out-of-network. In addition, other targeted care may require authorization.

The provider may not bill the member for services covered except for any applicable co-pays, co-insurance, or permitted deductibles. A copayment, or copay, is a set amount paid to the provider by the member at the time of service. This amount is deducted from the reimbursement we make to you. Some of the services that require copayments are office visits, emergency room visits, diagnostic services,

hospital admissions, and therapies. Copayments vary depending on the type of contract, provider (PCP or specialist) and service involved. Office visit copayments appear on most member identification cards.

In some cases, members are responsible for a coinsurance for covered services. Providers should submit the claim to Blue Cross Blue Shield for processing and then collect from the member their responsibility. Some products also have deductible amounts prior to copayments or coinsurance becoming applicable. Providers should submit the claim to Blue Cross Blue Shield to determine the member responsibility.

Highmark West Virginia POS Plans

For providers in West Virginia

Providers in Highmark Blue Cross Blue Shield (WV)'s PPO networks also participate in the POS network. In addition, Highmark in West Virginia contracts with PCPs to coordinate the care of POS plan members. All POS plan members must select a network PCP.

Standard POS plans include deductibles, copayments, and annual limits. Pre- certification/authorization is required for inpatient admissions and other selected services. Additional preventive services are also typically covered (e.g., annual physical exams, well baby care).

REMINDER: Always verify benefits! All services are subject to specific contract coverage and limitations. When providing service to a POS member, please verify the member's eligibility and benefits via Availity or the applicable HIPAA electronic transaction.

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2.1 Open Access (PA Only)

For providers in Pennsylvania

Open access programs do not require members to select a network primary care physician/practitioner (PCP), though it is recommended. Like Point of Service (POS) programs, open access programs allow members to receive care outside of the network.

For out-of-network care, benefits are paid at the program's lower level of reimbursement, and the members are responsible for filing claims and pre- certifying care.

Open Access products are offered to employer groups in Pennsylvania's Western and Central Regions.

General Characteristics of Open Access Plans

General characteristics of open access plans include:

- Members are not required to choose a PCP, but they are strongly encouraged to do so.
- Open access product members may receive care at the higher level of benefits for covered services in:
    - The 29 counties of western Pennsylvania when they access physicians, hospitals, or other health care providers within the Western Region network.
    - The 21 counties of central Pennsylvania when they access physicians, hospitals, or other health care providers within the Premier Blue Shield professional network and the Highmark Blue Shield (PA) facility network.
- Members may change PCPs upon request.
- Both PCPs and specialists are paid fee-for-service for care rendered to open access product members.
- For services requiring an authorization, the ordering physician should obtain the authorization.

Payment Levels Correspond to Member Options

The open access program provides two levels of payment, corresponding to the options the member chooses when accessing care:

- If members choose to receive care from providers associated with the Premier Blue Shield network located in the 21 counties of central Pennsylvania and the Lehigh Valley or the Highmark Managed Care network in the 29 counties of western Pennsylvania, covered services will be subject to lower co-payment, co-insurance and/or deductible.
- If members choose to seek services from a provider outside the 21 county Central Region Premier Blue Shield network or the 29 county Highmark Managed Care network in the Western Region, covered services will be subject to higher co-payment, co-insurance and/or deductible.

Each employer group that offers an open access plan determines the higher and lower cost-share for its own members. A member who chooses out-of-network care is responsible for any resulting deductible, coinsurance, and/or copayment amounts, as well as the difference between the provider's charge and the plan allowance.

When Care Cannot Be Provided By an In-Network Provider

Clinical Services, Highmark's medical management division, may authorize a member to receive services from a non-network provider if the care he or she requires cannot be provided within the network. In such situations, reimbursement will be made at the higher, in-network level.

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2.1 Value-Based Benefits (DE, PA, WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

When caring for patients with chronic conditions, patient compliance is critical. Skipped medications or screenings can cause long-term damage; therefore, patient incentive can be a key to promoting patient

compliance.

To give our members a “greater hand in their health,” Highmark created a Value-Based benefit design. In this benefit design, providers care for members with one or more chronic/targeted conditions by reducing or removing financial barriers to health care.

Benefit Options Available

Value-Based Benefits is coverage that promotes patient compliance in the management of chronic conditions. And, based on their unique employee populations, employer groups have some choices within the program. They can opt to cover all or some of the eight chronic/targeted conditions.

Employer groups can also choose to either waive or lower their employees’ cost-sharing (copays, coinsurance, etc.). These options apply to specific evidence-based, high-value medical services and prescriptions related to the selected condition(s).

Members with Value-Based Benefits who have a covered condition that an employer has selected will qualify if the member has signed up for that condition and completed the Wellness Profile. Reduced or waived cost sharing for services related to their health condition(s) will apply for the entire benefit year unless the member is required to complete certain protocols on a quarterly basis.

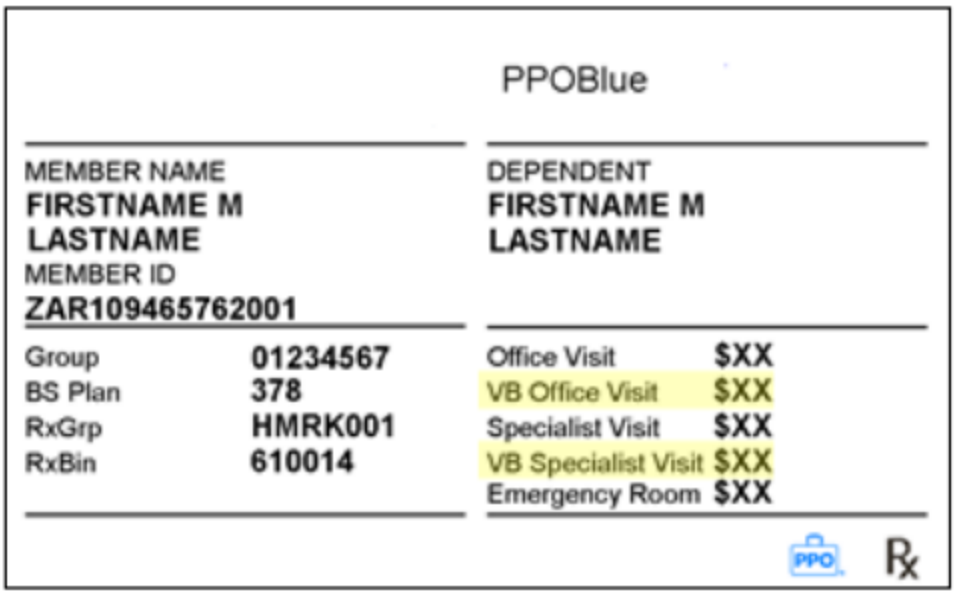
Targeted Conditions

The following are the chronic conditions targeted under Value-Based Benefits:

- Asthma
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- High blood pressure
- High cholesterol

Member ID Cards May Display “VB” Copays

Highmark strongly recommends that providers ask to see a member’s current ID card at every visit. For members with Value-Based Benefits, the card may show “VB” copay amounts (highlighted in yellow on the ID card sample below) along with the standard copay amounts. Although employer groups are given the option of displaying the value-based copayment on the ID card, they may choose not to include it on their ID cards.



Options Available for Verifying Coverage

Highmark advises providers to verify eligibility and benefits prior to rendering services to our members. You can use the appropriate HIPAA-compliant electronic transaction or our convenient, easy-to-use provider portal, Availity.

Program Options Continue to Expand

Value-Based Benefits offer many options to engage members. For example, employers may choose to:

- Require that certain health protocols related to the eight chronic/targeted conditions be met each quarter so employees continue to pay less for medical services and/or prescriptions to manage these conditions.
- Offer a reward for the completion of preventive services.
- Offer a waiver of an additional copay for specific surgeries if member engages in informed decision making and completes an online questionnaire.

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2.1 Health Maintenance Organization (HMO)

For providers in Delaware, New York, and Pennsylvania

A health maintenance organization (HMO) is a health care plan that provides comprehensive medical, surgical, hospital, and ancillary medical services including preventive care services. HMO plans are offered in Highmark service areas in Delaware, New York, and Pennsylvania. Members must use network participating providers to receive coverage for their care -- except for emergency care in Delaware, New York, and Pennsylvania, and also urgent care in Pennsylvania (urgent care requires authorization in Delaware).

Members receive this comprehensive benefits package in exchange for exclusive use of the HMO's established provider network and compliance with its requirements. Care and case management services and typically authorization requirements are inherent components of HMO programs and help ensure that care is medically necessary and provided in an appropriate setting.

The provider may not bill the member for services covered except for any applicable copays, coinsurance, or permitted deductibles. A copayment, or copay, is a set amount paid to the provider by the member at the time of service. This amount is deducted from the reimbursement we make to you. Some of the services that require copayments are office visits, emergency room visits, diagnostic services,

hospital admissions and therapies. Copayments vary depending on the type of contract, provider (PCP or specialist) and service involved. Office visit copayments appear on most member identification cards.

In some cases, members are responsible for a coinsurance for covered services. Providers should submit the claim to Blue Cross Blue Shield for processing and then collect from the member their responsibility. Some products also have deductible amounts prior to copayments or coinsurance being applicable. Providers should submit the claim to Blue Cross Blue Shield to determine the member responsibility.

Important! (NY Only)

For providers in New York

HMO members are also required to use Quest Diagnostics for laboratory services. Referrals are not required on any New York HMO member services.

Additionally, effective January 1, 2003, referrals were no longer required for HMO and HMO Senior members in New York. This means that primary care physicians can refer members directly to an in-network specialist without contacting the health plan for approval.

General Characteristics of HMOs

For providers in Delaware and Pennsylvania

The following are general characteristics of HMO products:

- HMO products require members to select a network-participating primary care physician who provides preventive care services, directs patients to seek specialty care if required, and communicates with specialists to ensure continuity and coordination of care.

- For all HMO products, routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP to receive coverage.
- Members may change PCPs upon request.
- For services requiring an authorization, the ordering physician should obtain the authorization.
- Blues On Call services, preventive care benefits, and myCare Navigator are integral components. (MyCare Navigator is an option for self-funded groups and is included only at the group's request.)

Coverage Outside the Service Area

For providers in Delaware and Pennsylvania

Highmark's commercial group/individual HMO members rely on a network of medical practitioners in the service area to supply medical care. However, members still have coverage when they are outside the network service area. The type of coverage that a member has depends on two elements:

1. the care required; and
2. whether they are traveling or living outside the service area.

Pennsylvania HMO Plans

For providers in Pennsylvania

In Pennsylvania's 29-county Western Region only, Highmark offers HMO products through Highmark Choice Company, which utilizes the Keystone Health Plan West (KHPW) managed care provider network. HMO coverage requires you to select a primary care physician (PCP) who will become familiar with all aspects of your health and health care and, as your personal physician, will be responsible for treating you for your basic health care needs.

In the Northeastern Region, Highmark offers HMO products that are supported by providers participating

in the First Priority Health (FPH) managed care network. The FPH network of professional providers and facilities spans throughout the 13-county service area and also includes several hospitals and their participating physicians in contiguous counties in Pennsylvania, New Jersey, and New York.

HMO Members are required to obtain preventive care (such as adult and pediatric routine physicals and pediatric immunizations) from their PCP, but can go directly to a network specialist for other covered services — without a referral.

The provider may not bill the member for services covered except for any applicable co-pays, co-insurance, or permitted deductibles. A copayment, or copay, is a set amount paid to the provider by the member at the time of service. This amount is deducted from the reimbursement we make to you. Some of the services that require copayments are office visits, emergency room visits, diagnostic services, hospital admissions and therapies. Copayments vary depending on the type of contract, provider (PCP or specialist) and service involved. Office visit copayments appear on most member identification cards.

In some cases, members are responsible for a coinsurance for covered services. Providers should submit the claim to Blue Cross Blue Shield for processing and then collect from the member their responsibility. Some products also have deductible amounts prior to copayments or coinsurance being applicable. Providers should submit the claim to Blue Cross Blue Shield to determine the member responsibility.

Delaware's IPA Plans

For providers in Delaware

Highmark Blue Cross Blue Shield (DE)'s managed care HMO offerings in Delaware are Independent Practice Association (IPA) plans. IPA plans provide comprehensive medical, surgical, hospital, and ancillary medical services, including preventive care services. Members are required to choose a PCP who will work with them to coordinate their health care needs. PCP referral authorizations are required to obtain care from specialists in some cases.

Delaware IPA plan members must use Highmark Delaware network participating providers to receive

coverage for their care, except for emergency care. Authorization and precertification is required for hospital admissions and other targeted care.

The IPA option is also offered as a plan for those members who choose to combine the medical plan with a Health Savings Account (HSA) or a Health Reimbursement Account (HRA).

Required Care Definitions for HMO Members

For providers in Delaware and Pennsylvania

The required care definitions for commercial group and direct pay HMO members are noted below. These definitions are not applicable to Medicare Advantage HMO products.

Care Required	Definition

Emergency Care	The initial treatment: • For bodily injuries resulting from an accident; or • Following the onset of a medical condition; or • Following, in the case of a chronic condition, a sudden and unexpected medical event; that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following: 1. Placing the health of the member or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part. • Transportation and related emergency services provided by an ambulance service shall constitute an emergency care service if the injury or the condition satisfies the criteria above.
	Medical needs that are symptomatic but can be treated at the discretion of the physician

Symptomatic Care	and patient. Reasonable delays will most likely not affect the outcome of service. For HMO members, this type of care may be considered “urgent care” when traveling outside of the service area. Urgent care is defined as an unexpected illness or injury that cannot wait to be treated until the member returns home. Note: Urgent care requires authorization for Highmark Delaware members.
Routine Asymptomatic and Preventive Care	Medically asymptomatic conditions that can be addressed at the discretion of the physician and patient. Reasonable delays will not affect the outcome of services. For HMO members, this type of care may be considered “follow-up” care when traveling outside of the service area. Follow-up care is defined as ongoing services that a member requires, even when they are traveling, for care that was initiated while they were home (e.g. allergy shots, suture removal, cast check). Note: Routine preventive care services such as routine physicals, immunizations, or screening diagnostic tests would not be covered out-of-area as “follow-up care.”

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2.1 Away From Home Care HMO Guest Membership

For providers in Delaware, New York, and Pennsylvania

Away From Home Care® (AFHC) is a registered trademark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

The Blue Cross and Blue Shield Association sponsors the AFHC Guest Membership Program through participating Blue HMOs at numerous locations throughout the United States. The Western Region commercial HMO product participates in this program both as a “home” HMO plan, offering this to our members, and also as a “host” HMO plan, where members from other Blue HMO plans may have a HMO guest membership in the western Pennsylvania, and Northeastern and Western New York service areas.

Note: This program is not available to Medicare Advantage HMO members in Pennsylvania’s Western Region. This program is also unavailable for Individual members in Western and Northeastern New York, including members in Essential Plans (Western NY).

Members Visiting The Highmark HMO Service Area

When home in a Highmark service area, our HMO members with a guest membership in another plan area who need non-emergency care may receive care only from a physician in the Highmark service area.

If the member had an established relationship with a Pennsylvania Western Region HMO, Delaware, or New York network PCP prior to their guest membership, this is the provider they should contact. If the member did not have an established PCP relationship prior to their guest membership, they should contact the Away From Home Care Coordinator at:

- In Pennsylvania: 800-249-9579

- In Delaware: 866-835-8977
- In New York: 800-888-1238 (Northeastern New York), 800-544-BLUE (2583) OR call the number on the back of ID card

A physician must authorize any covered services received while at home. In an emergency, no prior approval is required. The member should go to the nearest medical provider. If follow-up care is needed while the member is at home, it can be arranged in the same manner as described above.

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2.1 Visiting HMO Members

For providers in Delaware, New York, and Pennsylvania

The Away From Home Care® (AFHC) Guest Membership program offered through the Blue Cross and Blue Shield Association allows members enrolled in other Blue Plan HMOs across the country to receive services covered under the “host” HMO benefit program if they are temporarily or permanently residing in the 29-county Western Region in Pennsylvania, in Delaware, 8 counties of Western New York, or 13 counties of Northeastern New York.

Hosting Guest Members

For providers in Delaware, New York, and Pennsylvania

A Highmark PCP may be contacted by an AFHC coordinator from Highmark to host a member from another Blue Plan who will be temporarily or permanently residing in our region.

If a network PCP is chosen to host a member from another plan, they will be contacted by the AFHC

coordinator by letter. This letter will notify them of their selection as well as providing member information such as name, address, birthday, and Member ID.

During the duration of the guest membership, all Highmark authorization policies and procedures apply to the treatment of guest members. The AFHC coordinator assigned to the case will assist you with any administrative concerns.

During the time HMO members have a guest membership in another Blue HMO, these members' names will not appear on the PCP's membership roster (except in New York).

Note: The AFHC Guest Membership Program is not available in all areas of the country.

Claims For Guest Members

For providers in Delaware, New York, and Pennsylvania

Providers should submit claims in exactly the same manner as you would a claim for a local member.

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2.1 Traditional Fee-for-Service Plans

Indemnity Programs

Under Traditional indemnity plans, Highmark members can seek care directly from any participating provider without coordination from a Primary Care Physician (PCP).
Participating providers agree to accept Highmark's allowance as payment in full for covered services. The member is responsible for any applicable copayment, deductible, or coinsurance.

Providers For Indemnity Products

Highmark's traditional indemnity network includes inpatient and outpatient facilities, professional providers, and ancillary providers such as suppliers of home infusion therapy, durable medical equipment, orthotics and prosthetics, and ambulance transportation.

Payment

Payment for eligible services is based on the Plan Allowance. Participating providers agree to accept the Highmark allowance as payment in full and to collect all applicable copayments, deductible amounts, and/or coinsurance from their patient.

Billing

At the time of service, providers can collect applicable copayments, coinsurance, and/or deductible amounts. Participating providers must submit claims to Highmark for services rendered.

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2.1 Major Medical (NY and PA Only)

For providers in New York and Pennsylvania

Major Medical benefits supplement the hospital and medical/surgical portions of basic coverage. The member shares in the cost of medical expenses through an annual deductible and coinsurance.

Major Medical requires a program deductible for the member and each dependent. The amount of the deductible varies according to the member's contract. A new deductible amount is required each benefit period.

Generally, when the deductible is satisfied for the member or dependent(s), major medical pays 80 percent of the Plan Allowance for covered medical expenses, and the member is liable for the other 20 percent.

In accordance with the October 1, 2010, Health Care Reform mandate, both grandfathered and non-grandfathered maximum amounts have been changed to unlimited.

Major Medical extends the coverage available under basic contracts and provides coverage for additional services, such as:

- Ambulance service
- Blood products
- Doctors' office visits
- Durable medical equipment
- Outpatient therapy and rehabilitation services
- Prescription drugs

If the member is enrolled in a standalone Major Medical program and, during the benefit period the member or dependent's expenses exceed the deductible, the member should complete a Major Medical claim form. The member should submit the claim along with the provider's itemized bills, to the Blue Plan through which the member is enrolled.

In addition to being offered as a standalone benefit option, Major Medical can be incorporated into the traditional benefits package. Claims processing is automated through a feature called concurrent Major Medical processing -- which does not require a separate submission of a Major Medical claim form.

Please see Chapter 6, Unit 7: Payment/EOBs/Remittances for additional information.

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2.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 2: Medicare Advantage Products & Programs

2.2 Introduction

Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant, sometimes referred to as ESRD).

Medicare has:

- Part A Hospital Insurance that helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care), hospice care, and some home health care.
- Part B Medical Insurance that helps cover certain doctors' services, outpatient care, medical supplies, and preventive services.
- Part D Prescription Drug Coverage is an optional benefit for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

In an effort to make broader and more cost-effective coverage options available to people eligible for Medicare, the Centers for Medicare & Medicaid Services (CMS) created "Medicare Part C." This term includes a wide variety of delivery models, which serve as replacements for Traditional Medicare. All of these models are funded through a combination of payments from the Medicare program and the member's premium.

These plans, known as "Medicare Advantage" programs, are offered by private companies that contract with Medicare to provide members with Part A and Part B benefits. Most Medicare Advantage plans also offer prescription drug coverage. Medicare Advantage Plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service Plans (PFFS), Special Needs Plans, and Medicare Medical Savings Account Plans (MSAs).

While a person is a member of Medicare Advantage, services are not paid by Traditional Medicare except for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.

At a minimum, Medicare Advantage programs are required to provide coverage for the services covered by Traditional Medicare's Part A and Part B coverage. They may also provide additional services and benefits such as routine dental and vision.

Highmark's Compliance Commitment to CMS Regulations

Highmark complies with all state and federal laws related to Medicare and our Medicare Advantage Products. In cases where Highmark policy, Highmark Medical Policy, settlement provisions, and/or Centers for Medicare & Medicaid (CMS) policy vary, the CMS regulation prevails.

For more information on specific CMS regulations, please visit cms.gov.

Note: From time to time, CMS will issue coverage of payment directives that are subject to the terms of the Medicare Advantage plans' agreements in place with their participating providers. In those cases, Highmark will review our Medicare Advantage Provider Agreements and will determine whether the terms of the Medicare Advantage Provider Agreements will take precedence over the CMS directive. If Highmark, upon review of the Medicare Advantage Provider Agreement, makes the determination to reimburse pursuant to the CMS payment directive, such reimbursement will be subject to the terms of the Medicare Advantage Provider Agreement, any applicable administrative requirements, and any outcome-related goals as established by CMS and Highmark, collectively or individually.

Compliance Language and EOC Booklets

Medicare Advantage Compliance Language and Member Evidence of Coverage (EOC) Booklets are available in the Appendix of the *Highmark Provider Manual.*

Medicare Advantage HMO Network Sharing for Transplant Services

For providers in Pennsylvania

Blue Cross Blue Shield Association (BCBSA) policy requires Blue Plans that offer Medicare Advantage HMO products to participate in network sharing for transplant services. Under the policy, Blue Plans with Centers for Medicare & Medicaid Services (CMS) approved transplant facilities included in their Medicare

Advantage HMO networks are required to share contracted rates for transplant services with out-of-area Blue Plan Medicare Advantage HMO members.

Medicare Advantage HMO Network Sharing for Transplant Services will provide in-network access to all Blue Plans' Medicare Advantage HMO provider networks for Blue Plan Medicare Advantage HMO members who may require a transplant service outside of their home Plan's licensed service area.

Beginning January 1, 2018, transplant facilities participating in Highmark's Medicare Advantage HMO networks in Pennsylvania will be reimbursed according to their contracted Medicare Advantage HMO rate for approved transplant services for out-of-area Blue Plan Medicare Advantage HMO members. If you are a contracted Highmark Medicare Advantage HMO provider, you must provide the same access to transplant services for members of other Blue Plan Medicare Advantage HMO plans as you do for Highmark's Medicare Advantage HMO members. These members will receive in-network benefits for approved transplant services in accordance with their plan's in-network benefits, with any applicable member cost sharing applied.

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2.2 Highmark Medicare Advantage Products

Highmark offers the following Medicare Advantage products:

- Community Blue Medicare HMO – offered in select counties in Pennsylvania's Western, Central, and Northeastern regions
- Community Blue Medicare PPO – offered in select counties in Pennsylvania's Central and Northeastern regions
- Community Blue Medicare Plus PPO – offers exclusive access to Geisinger Danville facilities and doctors and is offered only to members living in select counties in Northeastern Pennsylvania
- Complete Blue PPO – offered across Pennsylvania
- Freedom Blue PPO – offered in Delaware, Pennsylvania, and West Virginia
- NENY Freedom HMO – offered in Northeastern New York
- NENY Medicare Advantage PPO – offered in Northeastern New York
- Security Blue HMO-POS – offered in Pennsylvania's Western region
- Together Blue HMO – offered in Pennsylvania's Western region

- WNY Forever Blue PPO – offered in Western New York
- WNY Medicare Advantage HMO – offered in Western New York

Community Blue Medicare HMO

For providers in Pennsylvania

(select counties in Pennsylvania's Western, Central, and Northeastern regions)

Community Blue Medicare HMO is a select high-value network product that offers high quality at a lower cost for seniors. Members must seek care from providers participating in the Community Blue Medicare HMO network, with the exception of urgent and emergency care.

To enroll in Highmark's Community Blue Medicare HMO, a member must have both Medicare Part A and Part B and must reside in the service area.

PLEASE NOTE: The Community Blue Medicare HMO network differs from the network associated with the commercial Community Blue products.

Community Blue Medicare HMO participating providers can be located by searching the Provider Directory in the applicable service area.

Community Blue Medicare PPO

For providers in Pennsylvania

(select counties in Pennsylvania's Central and Northeastern regions)

Community Blue Medicare PPO has a broader network of providers than Community Blue Medicare HMO and provides flexibility to use out-of-network providers.

It also provides more freedom for members who travel by providing in-network cost sharing when members use Medicare Advantage PPO participating providers of other Blue Plans.

The benefit design and cost sharing for the Community Blue Medicare PPO Signature plans are similar to Community Blue Medicare HMO.

Community Blue Medicare Plus PPO

For providers in Pennsylvania

(select counties in Northeastern Pennsylvania)

Community Blue Medicare Plus PPO provides the same level of benefits as Community Blue Medicare PPO, with the addition of exclusive access to Geisinger Danville facilities and doctors. It also provides coverage for out-of-network hospitals and physicians at a higher level of cost sharing for the member.

Complete Blue PPO

For providers in Pennsylvania

(across Pennsylvania)

Complete Blue PPO plans are available across Pennsylvania. As with other Medicare Advantage products, a member must have both Medicare Part A and Part B and must reside in the service area. It also provides more freedom for members who travel by providing in-network cost sharing when members use Medicare Advantage PPO participating providers of other Blue Plans.

Freedom Blue PPO

For providers in Delaware, Pennsylvania, and West Virginia

(Delaware, Pennsylvania, and West Virginia)

Freedom Blue PPO is a Medicare Advantage Preferred Provider Organization plan.

Freedom Blue PPO offers members a choice of where they receive in-network care throughout the Freedom Blue PPO network and from providers who participate in other Blue Plan Medicare Advantage PPO networks in 35 states and Puerto Rico. Members also have access to covered services out-of-network, both in area and out-of-area. Freedom Blue PPO members are not required to select a PCP; however, they are encouraged to select a Physician of Record, such as a primary care practice that will provide routine care and coordinate specialist care.

Freedom Blue PPO provides coverage for all of the member's health care needs, including medical, prescription drugs, routine dental, vision, hearing, and preventive care. Members are responsible for paying any applicable cost sharing for covered services.

NENY Freedom HMO

For providers in New York

(Northeastern New York)

NENY Freedom HMO plans are available across Northeastern New York. It is a select high-value network product that offers high quality at a lower cost for seniors. Members must seek care from providers participating in the NENY Freedom HMO network, with the exception of urgent and emergency care.To

enroll in NENY Freedom HMO, members must have both Medicare Part A and Part B and must reside in the service area..

NENY Medicare Advantage PPO

For providers in New York

(Northeastern New York)

NENY Medicare Advantage PPO plans are available across Northeastern New York. As with other Medicare Advantage products, members must have both Medicare Part A and Part B and must reside in the service area. It also provides more freedom for members who travel by providing in-network cost sharing when members use Medicare Advantage PPO participating providers of other Blue Plans.

Security Blue HMO-POS

For providers in Pennsylvania

(Pennsylvania's Western region)

Security Blue HMO-POS, A Medicare Advantage HMO Point of Service product, requires members to choose a primary care physician (PCP) who coordinates care with network participating specialists and facilities when necessary.

Members can receive care from Security Blue HMO-POS network of providers, except in emergencies, but also have coverage out-of-network for certain benefits and may have a higher cost-share.

Together Blue HMO

For providers in Pennsylvania

(Pennsylvania's Western region)

Together Blue HMO is a select high-value network product that offers high quality at a lower cost for seniors. Members must seek care from providers participating in the Together Blue HMO network, with the exception of urgent and emergency care.To enroll in Highmark's Together Blue HMO, members must have both Medicare Part A and Part B and must reside in the service area.

WNY Forever Blue PPO

For providers in New York

(Western New York)

WNY Forever Blue PPO plans are available across Western New York. As with other Medicare Advantage products, members must have both Medicare Part A and Part B and must reside in the service area. It also provides more freedom for members who travel by providing in-network cost sharing when members use Medicare Advantage PPO participating providers of other Blue Plans.

WNY Medicare Advantage HMO

For providers in New York

(Western New York)

WNY Medicare Advantage HMO plans are available across Western New York. It is a select high-value network product that offers high quality at a lower cost for seniors. Members must seek care from providers participating in the WNY Medicare Advantage HMO network, with the exception of urgent and emergency care.To enroll in WNY Medicare Advantage HMO, members must have both Medicare Part A and Part B and must reside in the service area.

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2.2 Prescription Drug Coverage Under Medicare Advantage

Medicare Advantage HMO and PPO products provide Medicare Part B Prescription Drug coverage (MA-only plans). Some Medicare Advantage plans may also include Medicare Part D Prescription Drug Coverage benefits (MA-PD plans).

Part B Prescription Drug Coverage

Medicare Part B covers certain types of injectable and infusible drugs that are not usually self-administered. These include drugs that are furnished and administered as part of a service performed by a health care professional.

Highmark's Medicare Advantage products also cover such drugs which can be categorized as follows:

- Drugs that include substances naturally present in the body, including blood clotting factors and insulin
- Clotting factors for patients with hemophilia
- Immunosuppressive drugs for patients who have had an organ transplant covered by Medicare
- Injectable osteoporosis drugs, for homebound patients with a bone fracture certified by a physician as related to post-menopausal osteoporosis
- Chemotherapy

- Drugs administered during outpatient dialysis, such as heparin, heparin antidote, topical anesthetics, erythropoietin (Epogen) or Epoetin Alfa and Darboetin Alfa
- Certain oral anti-cancer drugs and anti-nausea drugs
- Intravenous immune globulin for the home treatment of primary immune deficiency diseases

Highmark provides a link on the Provider Resource Center to the Centers for Medicare & Medicaid (CMS) Medicare Part B Drug website. This website includes the Medicare Part B Drug Regulations, the Medicare Part B Drug Average Sales Price (ASP) tables, which are updated quarterly, and the quarterly ASP NDC-HCPCS Crosswalks. To access this information from the Provider Resource Center, select Policies & Programs from the main menu and look under Pharmacy Programs.

Authorization May be Required

Some Medicare Part B drugs require authorization. Please check the List of Procedures/DME Requiring Authorization available on the Provider Resource Center – access the list quickly by selecting **Claims & Authorizations** then **Obtaining Authorizations** from the main menu at the top of the page.

IMPORTANT! Verify member cost sharing via Availity.®

If you have specific questions about the way Medicare Advantage members can obtain certain Part B prescription drugs, please contact the Provider Service Center.

Medicare Part D Prescription Drug Coverage

Highmark offers Medicare Part D prescription drug coverage under many of its Medicare Advantage HMO and PPO plans as well as through the Medicare-approved stand-alone Blue Rx Prescription Drug Plans.

These plans provide coverage for prescription drugs that are covered under the Medicare Prescription Drug Benefit (Part D) and that are also on the Highmark Medicare-Approved Formulary for Medicare Products.

For More Information

To locate participating retail pharmacies, please MyHighmark.com. Under **Find top-quality care close by** click **FIND DOCTORS AND RX.** You'll need to enter your ZIP Code to be taken to the correct site for your region. Scroll down to **Find a pharmacy.**

Additional information is also available to providers on the Provider Resource Center – select **Policies & Programs,** and then **Formulary** from the main menu at the top of the page.

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2.2 Hospice Benefit Election

To be eligible to elect hospice care under Medicare Part A, an individual must be eligible for Medicare Part A and be certified as terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare-certified hospice provider is covered under the Medicare Hospice Benefit. The Medicare beneficiary (or authorized representative) must elect hospice care to receive it.

Medicare beneficiaries enrolled in Medicare Advantage plans may elect hospice care under the Medicare Hospice Benefit. Federal regulations require that Original Medicare maintains payment responsibility for all Medicare-covered services during a hospice election period for all Medicare beneficiaries.

Effective Date of Hospice Election

A Medicare Advantage member (or the member's authorized representative) must elect hospice care to receive it. If the member (or authorized representative) elects to receive hospice care, he or she must file a hospice election statement with the hospice provider designating the Effective Date of Election, which is the same as the hospice admission date. An individual may not designate an Effective Date of Election that is retroactive (prior to the date the statement is filed and signed).

Original Medicare coverage begins on the Effective Date of Election, regardless of the day of the month. For example, if the member files a hospice election statement on March 9 with an Effective Date of Election of March 10, Original Medicare assumes payment responsibility beginning on March 10.

Member May Revoke Hospice Election

A Medicare Advantage member (or authorized representative) may revoke hospice election at any time in writing. **Claims will continue to be paid by Original Medicare until the first day of the following month in which hospice election was revoked.** The member's Medicare Advantage plan will resume payment responsibility for covered services beginning on the first day of the month after hospice election was revoked.

For example, if the Medicare Advantage member revokes their hospice election on June 6, Original Medicare will be responsible for payment of hospice services related to the terminal prognosis through June 30. The member's Medicare Advantage plan will provide coverage for all eligible services beginning July 1.

Services unrelated to the terminal illness Medicare-covered services unrelated to the treatment of the terminal condition for which hospice was elected, and which are furnished during a hospice election period, are billed to Medicare for payment. On professional claims, these services are coded with the GW modifier ("service not related to the hospice patient's terminal condition"). These services are coded with Condition Code 07 ("Treatment of Non-terminal Condition for Hospice") on institutional claims.

Claims for these services can be billed to Highmark with the GW modifier or 07 Condition Code, as applicable, for consideration of the Medicare cost sharing. The member's Medicare Advantage plan will cover the Medicare cost sharing and apply the Medicare Advantage plan's cost sharing for covered services according to the plan's benefits.

Reminder: Since Medicare Advantage HMO plans do not have out-of-network benefits, the Medicare cost sharing will not be covered for services provided by an out-of-network provider.

Medicare Non-Covered Services

Services that are not covered by Medicare but are eligible under the member's Medicare Advantage plan, whether or not they are related to the terminal prognosis, are billed to Highmark and reimbursed according to the member's Medicare Advantage plan.

Hospital Inpatient Admissions

When a Medicare Advantage member requires an inpatient hospital admission, the designated payer at the time of the hospital admission is responsible for payment of the hospital stay.

For example, when a Medicare Advantage member is admitted as an inpatient in a hospital while in a hospice election period, Medicare is responsible for payment of the hospital stay through discharge even if the member revokes hospice election during the hospital stay. However, if a Medicare Advantage member elects hospice during an inpatient hospital stay, the Medicare Advantage plan is the responsible payer for the entire hospital stay from admission through discharge, with Medicare assuming payment responsibility after discharge.

For More Information

For more information about the Medicare Hospice Benefit, please see the following Centers for Medicare & Medicaid Services (CMS) online program manuals:

- Pub. 100.2, Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance
- Pub. 100.4, Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims

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2.2 Dual Eligibility Under Medicare and Medicaid

"Dual eligible beneficiaries" is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B

and receive full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing through one of the Medicare Savings Programs (MSPs):

- **Qualified Medicare Beneficiary (QMB) Program**: Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments;
- **Specified Low-Income Medicare Beneficiary (SLMB) Program**: Helps pay for Part B premiums;
- **Qualifying Individual (QI) Program**: Helps pay for Part B premiums; and
- **Qualified Disabled Working Individual (QDWI) Program**: Pays the Part A premium for certain people who have disabilities and are working.

Medicare-covered services also covered by Medicaid are paid first by Medicare; Medicaid is generally the payer of last resort. Medicaid may cover the cost of care that Medicare may not cover or may partially cover (such as personal care and community-based services).

Qualified Medicare Beneficiary (QMB) Program

The goal of the Qualified Medicare Beneficiary (QMB) Program is to assure meaningful access to Medicare benefits for those individuals who are elderly and those with disabilities with limited assets and income under 100% of the Federal Poverty Level. It does so by requiring State Medicaid Plans to cover Medicare Part A and Part B premiums as well as the cost-sharing per service for which a Medicare beneficiary is normally liable.

Enrollees who meet the QMB program's qualifying criteria fall into two groups: "QMB Only" and "QMB Plus." QMB Only beneficiaries are entitled to QMB cost-sharing support for Medicare benefits, but do not qualify for any other Medicaid benefits; QMB Plus enrollees qualify for both QMB cost-sharing support and all services provided by their states' full Medicaid programs.

Within broad national guidelines established by federal statutes, regulations, and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own Medicaid program.

The 1997 Balanced Budget Act clarified that a state is not obligated to pay providers up to the full amount of Medicare cost-sharing if the total payment (including both the Medicare portion and the State's portion) would exceed the state's Medicaid rate for that service. Instead, states may limit their

reimbursement to the lesser of two amounts: the full amount of Medicare cost-sharing, or the difference between the Medicaid rate and the amount already paid by Medicare. The vast majority of states limit Medicare cost-sharing payment levels for QMB enrollees and other full-benefit dually eligible beneficiaries at their Medicaid rates.

Balance Billing Restrictions

An important component of the QMB Program is enrollee protection against “balance billing” (billing for Medicare cost-sharing, including deductibles, coinsurance, and copayments). Federal law prohibits all Medicare and Medicare Advantage providers from balance billing QMB individuals for all Medicare deductibles, coinsurance, or copayments. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary.

All original Medicare and Medicare Advantage providers – not only those that accept Medicaid – must abide by the balance billing prohibitions. Medicare and Medicare Advantage providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. Balance billing restrictions apply regardless of whether the State Medicaid Agency is liable to pay the full Medicare cost-sharing amounts. Even if payment is not available under the State Medicaid Plan, QMB enrollees are not liable for Medicare deductibles, coinsurance, and copayments.

Individuals in the QMB Program retain their protection from balance billing even when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient’s QMB benefit is provided by a different State than the State in which care is rendered. In addition, **QMB enrollees cannot choose to “waive” their QMB status and pay Medicare cost-sharing** (the federal statute supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect).

Prohibition on Discrimination Based on QMB Status

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

The Centers for Medicare & Medicaid Services (CMS) notes in the applicable anti-discrimination provisions that Medicare Advantage providers are prohibited from discriminating against patients based on their QMB status (see Managed Care Manual, Chapter 4, Section 10.5.2): “Discrimination based on ‘source of payment’ means, for example, that Medicare Advantage providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.”

Identifying QMB Enrollees

You can contact the Medicaid Agency in the State(s) in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for Medicare cost-sharing.

If you have questions concerning QMB status for Highmark Medicare Advantage members, please contact the Provider Service Center.

Tips to Avoid Inappropriate Billing of QMB Beneficiaries

The following practices will help Medicare and Medicare Advantage providers to ensure compliance with balance billing restrictions for QMB beneficiarie

- Contact the Medicaid Agency in the state(s) in which you practice to learn about identifying QMB enrollees and the processes in place to receive reimbursement for Medicare cost-sharing (different processes may apply for original Medicare and Medicare Advantage services).
- Determine whether a patient with original Medicare or Medicare Advantage coverage is a dual eligible beneficiary under the QMB program prior to providing services.
- Establish processes that identify QMB beneficiaries when a patient is first seen at a practice and during routine insurance information updates.
- Educate your administrative staff on the federal balance billing law and the policies regarding QMB individuals.
- Ensure that your billing software will exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

For more information on the QMB Program, please refer to the Medicare Learning Network publication titled Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program.

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2.2 TruHearing™ Hearing Aid Benefit Program

For providers in Delaware, Pennsylvania, and West Virginia

Highmark provides an enhanced hearing aid benefit to all individual Medicare Advantage members and most Medicare Advantage group plans through a partnership with TruHearing™, a national hearing aid provider. This partnership is designed to ensure quality, exceptional service, and minimize our members' out- of-pocket expense.

As an exclusive hearing aid provider to contracted health plans, TruHearing negotiates exceptional prices with top hearing aid manufacturers. This allows health plans to make hearing aids more affordable for their members. The benefit plan for Highmark Medicare Advantage members provides coverage, with a low copayment, for select TruHearing digital hearing aids.

IMPORTANT! Contract with TruHearing required.

Highmark participating providers must also be contracted with TruHearing in order to dispense hearing aids for eligible Medicare Advantage members. Providers interested in contracting with TruHearing should contact TruHearing's Provider Outreach:

Email: provider.outreach@truhearing.com

Phone: 855-286-0550

Benefit Coverage

Eligible Highmark Medicare Advantage members are covered for up to two TruHearing hearing aids per calendar year. The benefit is limited to the TruHearing Enhanced and Premium hearing aids, which come in various styles and colors. Copayments range from $499 to $999 depending on the member's benefit plan and the type of TruHearing hearing aid. Members should reference their Medicare Advantage Evidence of Coverage (EOC) booklet to determine their applicable copayment. Copayments for hearing aids apply only to TruHearing's Enhanced and Premium products.*

A routine hearing exam, including fitting and evaluation for up to two hearing aids, is covered once every calendar year (member copay applies as per their benefit plan). The benefit also includes:

- 48 free batteries per hearing aid
- Three year manufacturer's warranty for repair and one-time loss and damage replacement
- 45 day trial period during which returns or exchanges are permitted. (No returns or refunds will be issued for purchases beyond 45 days post-fitting.)

*__***All other hearing aid brands are not covered under the hearing aid benefit.**__ However, if members prefer another brand available through TruHearing, they can still utilize TruHearing's services to take advantage of TruHearing's discount program that offers savings off of regular retail prices.

Provider Responsibility

Highmark participating TruHearing providers conduct comprehensive hearing exams for eligible Highmark Medicare Advantage members, reviewing and discussing the results with the member. If the diagnosis requires treatment with hearing aids, the provider would recommend the appropriate hearing aids from the options available in the member's benefit, including specifics on products, styles, technology levels, and costs.

The provider places the orders for hearing aids through TruHearing. TruHearing will ship the hearing aids to the provider's office for fitting and programming for Highmark's members. The member receives up to three visits for programming, fitting, and adjustments that are included in the purchase of the hearing aid.

TruHearing will handle all claim submissions to Highmark. This includes claims for the following:

- Hearing exam (V5010 – assessment for hearing aid);
- Hearing aid(s); and
- Follow-up visits for programming or fitting

To receive payment, providers must collect the applicable copays for both the hearing exams and hearing aids from the member, and then enter the copay amounts into Echo, TruHearing's online provider portal. TruHearing will submit the claims to Highmark on behalf of providers, and then remit the full allowable amount to providers within 10 days.

Questions? For questions about the billing and payment process, please contact TruHearing's Provider Outreach by email at provider.outreach@truhearing.com, or by telephone at 855-286-0550.

Non-Covered Services

If it is believed that a service or item is not covered or may not be covered for a Highmark Medicare Advantage member, providers must advise the member that a written coverage decision ("pre-service organization determination") is required from Highmark before the service or item can be provided. Providers can request a pre-service organization determination on the member's behalf or direct members to request a pre-service organization determination by calling the phone number on their identification card.

If a provider supplies a non-covered hearing aid and a pre-service organization determination has not been issued, the member or Highmark will not be responsible for payment.

Directing Members

Highmark Medicare Advantage members can reference their Evidence of Coverage (EOC) booklet for their plan's hearing aid benefit and call Highmark Member Services with any questions. Member Services can transfer calls, when applicable, to a TruHearing Customer Care Representative.

Members can also be directed to call TruHearing Customer Care directly at 855-544-3128.

TruHearing's personal consultants will answer any questions, check a member's insurance eligibility, including verifying copayment amounts, and set up appointments with Highmark participating

TruHearing providers.

For More Information

For additional information about TruHearing, please visit their website at https://www.truhearing.com.

To learn more about the benefits under Highmark's Medicare Advantage plans, you can access Medicare Advantage Evidence of Coverage (EOC) booklets in the Appendix of the Highmark Provider Manual.

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2.2 House Call Program

Highmark launched the House Call Program to support Medicare Advantage, Affordable Care Act, and Medicaid members, and continues to expand the program to new geographies, as applicable. The program had been in place for a portion of our Medicare Advantage population since 2011. At no cost to the member, the House Call program is aimed at helping members who have chronic conditions or who are at risk of further health complications to better understand their conditions and how they can access the resources they need.

Highmark identifies members with chronic conditions and those who may be disengaged from their normal care routines through claims data. Once identified, we are able to reach out to them through the House Call program to evaluate the situation and to ensure their complete health needs are being met.

Visit Focus

Highmark has contracted with the following vendors: Matrix Medical Network, Signify Health, and Optum to administer the House Call Program. Members are contacted and asked if they would invite a licensed health professional into their homes to perform a free health assessment that lasts approximately one hour. The visit focuses on four primary areas:

- Assessing the member's current health status
- Reviewing the member's current medications
- Answering any health-related questions the member may have
- Ensuring the member's medical history is accurate and up to date with complete documentation

Since the assessments are conducted in the members' homes, or virtually via telehealth, they may feel comfortable discussing additional health issues or concerns. The in-home setting also can bring light to issues that may be difficult to detect in a clinical setting such as fall risk, home safety, medication adherence, and dietary and nutrition concerns. Recommendations from the visit are provided to the member and a summary of the visit is mailed to the primary care physician (PCP) or other provider indicated by the member. At the conclusion of the sessions, members are strongly encouraged to follow up with their PCPs to discuss the findings.

Note: The House Call Program does not replace or bypass the member's relationship with his or her PCP. The program is intended to complement the PCP-member relationship by helping to identify any health issues that may arise between office visits and to reinforce the importance of regular preventive care. A House Call is not performed or billed as a routine physical or as an Annual Wellness Visit (AWV).

Scheduling a Patient with Matrix Medical Network

Providers can schedule a House Call appointment with Matrix Medical Network on behalf of their patients if the patient is covered by one of Highmark's Medicare Advantage products and resides within Delaware, Northeastern New York, Pennsylvania, or West Virginia.*

To make an in-home visit or telehealth appointment on behalf of your patient:

- Call 888-912-8414 (TTY Users: 711) Monday-Friday between 8 a.m. and 8 p.m. EST
- Online at https://matrixforme.com

*For other regions, please connect with Highmark customer service for additional vendor identification.

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2.2 Annual Wellness Visit (AWV)

What is the Annual Wellness Visit?

The Annual Wellness Visit (AWV) benefit for Medicare beneficiaries, including Medicare Advantage members, is intended to encourage individuals to take an active role in accurately assessing and managing their health, and consequently improve their well-being and quality of life. This service also includes a comprehensive health risk assessment to provide a personalized prevention plan of services. Unlike much of medical care, which is primarily directed at treating acute and chronic illnesses, the AWV aims to prevent the onset of disease and disability or to slow the progression and exacerbation of existing illnesses. It is not to be considered a “physical exam.”

The AWV extends but does not replace the Initial Preventive Personal Examination (IPPE), also known as the “Welcome to Medicare Visit,” that is provided to new beneficiaries within 12 months of enrolling in Medicare. The AWV is not covered during the first 12 months of a beneficiary’s enrollment in Medicare.

The Medicare AWV and IPPE visits are both important aspects of Highmark’s overall wellness and prevention initiatives, and we feel that it is important for network physicians to conduct these assessments for our Medicare Advantage members. Highmark is offering incentives to members as well as to providers for completing the AWV.

Billing for AWVs

All Medicare Advantage members are eligible for an initial AWV as long as they have been Medicare beneficiaries for at least 12 months. Subsequent AWVs are covered once every calendar year. The Centers for Medicare & Medicaid Services (CMS) has created three HCPCS codes for AWVs:*

- G0438: The initial AWV is to be billed using code G0438, which is defined as “annual wellness visit, includes a personalized prevention plan of service first visit.” Procedure code G0438 is a once-in-a-lifetime benefit.
- G0439: The subsequent AWVs are to be billed with code G0439, which is defined as an “annual wellness visit, includes a personalized prevention plan of service subsequent visit.”
- G0468: The initial IPPE or AWV when performed by a Federally Qualified Health Center (FQHC)

Providers should submit a claim using a preventive diagnosis code; there are no required diagnosis codes. Deductibles and coinsurance do not apply for AWVs; the member has no financial responsibility.

Note: If the member is receiving care for any medical condition at the same time, deductibles and coinsurance do apply and the member should be advised if this may occur.

*HCPCS code G0402 is used when filing claims for the IPPE.
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2.2 Select DME Network (PA Only)

For providers in Pennsylvania

To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

Select DME Network

The Select DME Network is the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

Providers must refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

For More Information

Highmark provides two versions of the current list of providers in the Select DME Network. You can select a list of all participating providers or a list organized by category, which includes telephone numbers. These lists of providers in the Select DME Network are also available on the Provider Resource Center. Select **Provider Network** and then **High Performance Networks** from the main menu at the top of the page.

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

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2.2 Medicare Advantage PPO Network Sharing

For providers in Delaware, Pennsylvania, and West Virginia

All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. Under this inter-Plan arrangement, Blue Medicare Advantage PPO members -- including Highmark's Freedom Blue PPO, Community Blue Medicare PPO/Plus PPO (in PA only), Complete Blue PPO (in WPA only), -- will receive in-network benefits when traveling or living in the service area of any other participating Blue Medicare Advantage PPO Plan. As long as covered services are provided by participating Medicare Advantage PPO providers, the member's in-network benefit level will apply.

Identifying Out-of-Area Members

You can recognize an out-of-area Medicare Advantage PPO member covered under the Blue network sharing program when their ID card has the following logo:

The “MA” in the suitcase indicates a member who is covered under the Blue Medicare Advantage PPO network sharing program. Members have been asked to not show their standard Medicare ID card when receiving services. Instead, members should provide their Blue Cross and/or Blue Shield member ID card.

Eligibility and Benefits Verification

To determine whether a Medicare Advantage PPO member from another Blue Plan is covered under the network sharing program, please call the BlueCard Eligibility Line at 800-676-BLUE (2583).

Note: Please be sure to have the member’s three-character alpha prefix in order to obtain eligibility information.

Impact to Highmark Medicare Advantage PPO Providers

If you are a contracted Highmark Freedom Blue PPO Community Blue Medicare PPO/Plus PPO, and/or Complete Blue PPO provider, you should provide the same access to care for members of other

participating Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO members.

You will be reimbursed in accordance with your contracted rate under your Medicare Advantage PPO contract. These members will receive in-network benefits in accordance with their member contract.

If You are Not Contracted with Highmark for Medicare Advantage PPO Plans

If you are not a contracted Highmark Medicare Advantage PPO provider, you may see out-of-area Blue Medicare Advantage PPO members but are not required to do so.

Should you provide services to these members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent and emergency care, you will be reimbursed at the in-network benefit level.

Member Cost Sharing

A Medicare Advantage PPO member's cost sharing level and copayment is based on their health plan. A Medicare Advantage PPO participating provider may collect the copayment amounts at the time of service or bill for any deductibles, coinsurance, and/or copayments. However, you may not balance bill the member the difference between your charge and the Medicare Advantage PPO allowance for a particular service.

To determine the member's cost sharing, you should call the BlueCard Eligibility Line at 800-676-BLUE (2583).

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2.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 3: Other Government Programs

2.3 Medigap Blue

For providers in Pennsylvania

Medigap Blue, Highmark's Medicare supplemental product for individual direct-pay customers in Pennsylvania, is designed to assist beneficiaries by paying certain amounts not covered by the Medicare program. Depending on the design of the program, a supplemental product can pay Medicare deductibles, coinsurances, and/or other specific kinds of expenses.

Standardization Among Medigap Plans

The Omnibus Budget Reconciliation Act (OBRA) required insurers throughout the United States to standardize the benefits available under their direct-pay Medigap products. The purpose of this standardization was to simplify seniors' purchasing decisions for Medicare supplemental coverage. All "Plan A" products, for example, must provide the same benefits. Therefore, the only real points of comparison among the contenders would be price and customer service.

The legislation provided for a maximum of ten standardized benefit plans. States were permitted to limit these plans further, and the Commonwealth of Pennsylvania chose to eliminate three of the originally proposed benefit packages. All Pennsylvania insurers in the Medigap market were required to offer Plan A and Plan B; they could also offer Plans C, D, E H, and I. Highmark chose to offer Plans A, B, C, E, F, and High Deductible (HD) F, H, and I.

The plans are detailed in the chart below.

IMPORTANT: Plans E, H, and I have been closed to new enrollment; however, historic enrollment may still exist in these plans.

Service	Plan A	Plan B	Plan C	Plan E	Plan U	Plan I	Plan F	Plan F HD	Plan N

Basic Benefits (including hospice coinsurance)	X	X	X	X	X	X	X	X	X with copays
Skilled Nursing Facility Coinsurance			X	X	X	X	X	X	X
Part B Deductible			X				X	X	X
Foreign Travel Emergency			X	X	X	X	X	X	
Part B Excess Charges						X	X	X	X
Preventive Health Benefits							X	X	

At-Home Recovery						X		X	

Note: Basic benefits in these closed plans have no hospice coinsurance.

All six of the Medigap Blue benefit packages offered by Highmark provide the following core benefits:

- Hospital coinsurance for days 61 through 90.
- Hospital coinsurance for Lifetime Reserve Days – days 91 through 150.
- Three hundred 365 additional hospital days after Lifetime Reserve Days have been exhausted.
- First three pints of blood (not covered by Medicare).
- Medicare Part B coinsurance.

REMINDER: Always verify benefits. It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service. You can verify a member's coverage by using Availity, performing an electronic HIPAA Eligibility/Benefit Inquiry, or by calling the Provider Service Center.

Medigap Supplemental General Information

The Medicare Overcharge Measure (MOM) Act prevents the majority of all health care providers in the state of Pennsylvania from billing Medicare beneficiaries any amount in excess of the Medicare reasonable charge.

There are certain providers and suppliers who may charge beneficiaries for the difference between the billed amount and the Medicare allowance. You should contact the appropriate Medicare office for a listing of those types of providers.

When a member is enrolled in Medicare Part B and has supplemental coverage through Medigap Blue, Medicare is the primary carrier. Submit the claim to the member's Medicare carrier first for processing.

Medicap Blue Claim Submission

If you do not submit claims electronically, and payment under the supplemental coverage has not been received within 30 days after the Medicare payment and you have checked claim status, send a copy of the Explanation of Medicare Benefits (EOMB) statement to:

Highmark
Medigap Claims
P.O. Box 898845
Camp Hill, PA 17089-8845

- Please do not highlight any information on the EOMB statement. Use an asterisk (*) or some other form of notation to indicate the patient whose claims need to be processed under their supplemental coverage.
- The member's contract identification number and correct address should be on the EOMB statement; otherwise, please submit a completed CMS-1500 claim form.
- In the case of Medicare electronic remittance, a screen print of the electronic remittance and a copy of the 1500 Claim Form should be sent to the address listed above.

The beneficiary's Highmark agreement number and correct address should appear in the upper left corner of all documents submitted for processing.

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2.3 Signature 65

For providers in Pennsylvania

Signature 65 is designed to complement Medicare Part A and Part B covered services. Under this contract, Highmark will pay 20 percent of the Medicare Part B allowance after the Medicare annual deductible has been satisfied.

Core Benefits

Signature 65 is a Highmark group product available in Pennsylvania that provides coverage for the following core benefits (benefits vary by group):

- Medicare Part A deductible;
- Hospital coinsurance for approved Medicare benefits;
- Skilled Nursing Facility coinsurance for approved Medicare benefits;
- Three hundred 365 additional hospital days;
- The first three pints of blood per calendar year; and
- Medicare Part B coinsurance.

Carve-Out

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark.

Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark. Payment is made only for those services eligible under the group's Highmark benefits, even if the service was eligible under Medicare Part B.

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2.3 Delaware Medicare Supplemental Plans

For providers in Delaware

Highmark Blue Cross Blue Shield (DE)'s Medicare complementary and supplement programs help to pay some of the expenses not paid by Medicare. This may include payment of the Medicare deductibles and/or coinsurance depending on the individual plan.

Medicfill®

Highmark Blue Cross Blue Shield (DE)'s Medicfill® coverage is a health insurance plan designed to supplement Medicare coverage after an individual has retired or become eligible for Medicare due to a disability. Medicare is the primary payer; Highmark Delaware is the secondary payer. Usually, the individual or dependent must be enrolled in and retain Medicare Parts A and B to be eligible for Medicare supplementary coverage.

Carve-Out Plans

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark Delaware. Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark Delaware. Payment is made only for those services eligible under the group's Highmark Delaware benefits, even if the service was eligible under Medicare Part B.

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2.3 West Virginia Medicare Supplemental Programs

For providers in West Virginia

Highmark Blue Cross Blue Shield (WV) has Medicare standardized supplemental plans and Medicare complementary plans (pre-standardized). Standardized supplemental plans are available to individuals only, while complementary plans are available to both employer groups and individuals.

The individual or dependent must be enrolled in and retain Medicare Parts A and B to be eligible for Medicare supplementary or complementary coverage.

Medifil

Medifil is Highmark Blue Cross Blue Shield (WV)'s Medicare supplemental product for individuals who are retired and over age 65 or have become eligible for Medicare due to a disability. It is designed to assist Medicare beneficiaries by paying certain amounts not covered by the Medicare program. Medicare is the primary payer; Highmark West Virginia is the secondary payer.

Highmark West Virginia offers the standardized Plans A, C, F, F (High Deductible), and N. Depending on the design of the plan, a supplemental product can pay Medicare deductibles, coinsurance, and/or other specific kinds of expenses.

Carve-Out

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark West Virginia.

Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark West Virginia. Payment is made only for those services eligible under the group’s Highmark West Virginia benefits, even if the service was eligible under Medicare Part B.

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2.3 Highmark Healthy Kids (CHIP)

For providers in Pennsylvania

Highmark makes health care programs available to uninsured children in Pennsylvania through the subsidized Children's Health Insurance Program of Pennsylvania (CHIP). Highmark Healthy Kids (CHIP) coverage offers programs for all uninsured children regardless of household income.

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Highmark Healthy Kids (CHIP) is modeled after the Caring Program for Children, which was pioneered by Highmark through its Caring Foundation. CHIP expanded with the legislation to Cover All Kids, and now offers coverage to every uninsured child in Pennsylvania, regardless of household income. CHIP covers children from birth through 18 years of age.

This program is administered by Highmark on behalf of the Commonwealth of Pennsylvania Department of Human Services (DHS).

The more a child's family earns, the more cost sharing they will have in the form of higher premiums and copays.

- Free CHIP is funded through a portion of the state cigarette tax as well as federal funding. Families owe nothing for their child's premium and there are no copayments for office/ER visits and drugs.
- Low-Cost CHIP includes three levels with varying costs based on family income. Families pay some of the cost of CHIP coverage for each level of Low-Cost CHIP and copays for office/ER visits and drugs. Low-Cost CHIP began receiving federal money in addition to state money when CHIP expanded under Cover All Kids.
- Full-Cost CHIP provides health care coverage to children in households who are over the income limits for Free and Low-Cost CHIP. Families pay the full cost of CHIP coverage at this level and copays for office/ER visits and drugs.

It is only through a partnership with our providers that these programs are successful and Highmark can continue its social mission to provide health care coverage to as many children in Pennsylvania as possible.

Highmark extends its sincere appreciation to its providers for their continued commitment to provide services to children who qualify for these programs.

Please remember that you do not have to verify income or eligibility for these programs. Eligibility and income are determined before enrollment and annually thereafter by the Department of Human Services (DHS).

Utilizes Highmark Provider Networks

One of the keystones of this program is that families are “held harmless” from balance billing when covered services are provided by a network provider. To achieve that, members enrolled in CHIP prior to July 1, 2022, use the Premier Blue Shield preferred provider network to provide services to these children in the Central Region, the Keystone Health Plan West (KHPW) managed care network in the 29-county Western Region, and the First Priority Health (FPH) managed care network in the 13-county Northeastern Region. Members enrolled in CHIP after July 1, 2022, are enrolled in the Highmark Healthy Kids (CHIP) HMO network.

Prescription drugs are provided using the National Network. Vision coverage is administered by Davis Vision and dental coverage is provided by United Concordia’s network.

PROMISe™ ID Enrollment Required

Providers are required to complete a PROMISe™ ID enrollment application with Pennsylvania’s Department of Human Services (DHS) and obtain a PROMISe ID to provide services to Highmark Healthy Kids (CHIP) enrollees and receive reimbursement.

For more information about this requirement, please see the Highmark Provider Manual’s Chapter 3 Unit 1: Network Participation Overview.

Payment Directly to Participating Providers

As with our commercial group programs, Highmark pays providers in our Premier Blue Shield, KHPW, and FPH network (members enrolled in CHIP prior to July 1, 2022) and Highmark Healthy Kids (CHIP) HMO network (members enrolled after July 1, 2022) directly, and they agree to accept our payments as payment-in-full for covered services.

Highmark sends payments for services of out-of-network providers directly to the child's parents, who are responsible for paying the charges. Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that enrollees check the network status of their provider*.

Note: Highmark will deny any claims from providers who have not completed enrollment with Pennsylvania's DHS and obtained a valid PROMISe ID.

For more information about CHIP payment, please see the Highmark Provider Manual Chapter 6 Unit 7: Payment/EOBS/Remittances.

*Does not apply to emergency care.

Eligibility Requirements for Highmark Healthy Kids (CHIP)

The Department of Human Services (DHS) performs eligibility and enrollment functions for children with Highmark Healthy Kids (CHIP) coverage. The Individual Markets area performs marketing and outreach for CHIP to locate children and educate the community about the CHIP program. Children must meet these eligibility guidelines:

- Be a resident of Pennsylvania prior to applying for this coverage (except newborns);
- Be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Be under age 19;

- Not be covered by any health insurance plan, self-insured plan, or self-funded plan and not be eligible for or covered by Medical Assistance offered through the Department of Human Services or other governmental health insurance;
- Be eligible based on family size and income*;
- For all new applicants whose annual income falls in the Low-Cost and Full-Cost CHIP ranges, they must show that the child has lost health insurance because a parent lost their job or the child is moving from another public insurance program (not applicable if the child is under the age of two); and
- Full-Cost CHIP families must also show that access to coverage is unavailable and unaffordable.

**Depending on income levels, children may be eligible for either Free or Low-Cost CHIP insurance. If eligible for Low-Cost or Full-Cost CHIP insurance, families will be required to pay a monthly premium for their child's health insurance (as well as some copays).*

PH-95 Eligibility for Medical Assistance

In Pennsylvania, children under the age of 18 with certain disabilities or special health needs may qualify for Medical Assistance (also known as Medicaid), regardless of parental income. This eligibility is called PH-95, "Children with Special Needs." The Pennsylvania Department of Human Services requires Highmark to review billing and claims management information to identify any child that may be potentially eligible for PH-95 Medical Assistance.

Each child identified with certain special health conditions that would likely qualify for Medicaid PH-95 Program will be sent to the treating provider for completion of a **Physician Certification for Child with Special Needs** form. These forms will be sent using Adobe eSign which also provides a copy for the Physician's records. Additionally, Physicians will be able to attach documents to the Adobe form, if desired.

The Fax form process was discontinued when the Adobe eSign form process began.

If a child is identified as eligible for Medical Assistance per PH-95, the child will be referred to the Central Unit at County Assistance where the information will be reviewed and a determination made.

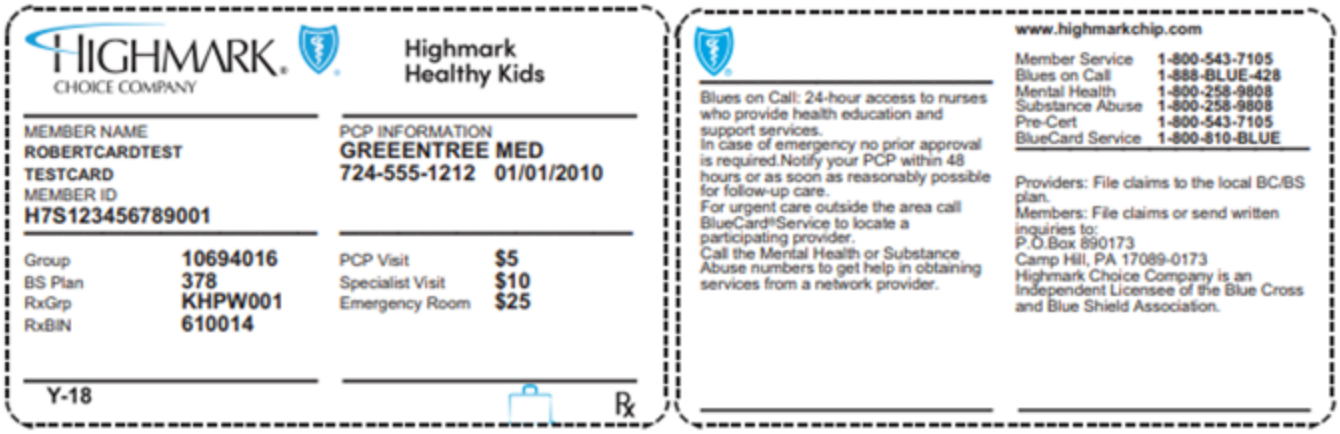
To complete the Physician Certification for Child with Special Needs form:

- The certification must be completed by a psychologist, physician, or medical professional under the physician's supervision and authority (e.g. physician assistant or certified nurse practitioner).
- The treating physician must note if the child is not considered disabled at all; temporarily disabled for less than 12 months; temporarily disabled for MORE than 12months; or permanently disabled.
- The date, name of each diagnosis (the ICD-10 code and the description), and any functional limitations and their impacts must be supplied.
- The form must be signed by the treating physician.

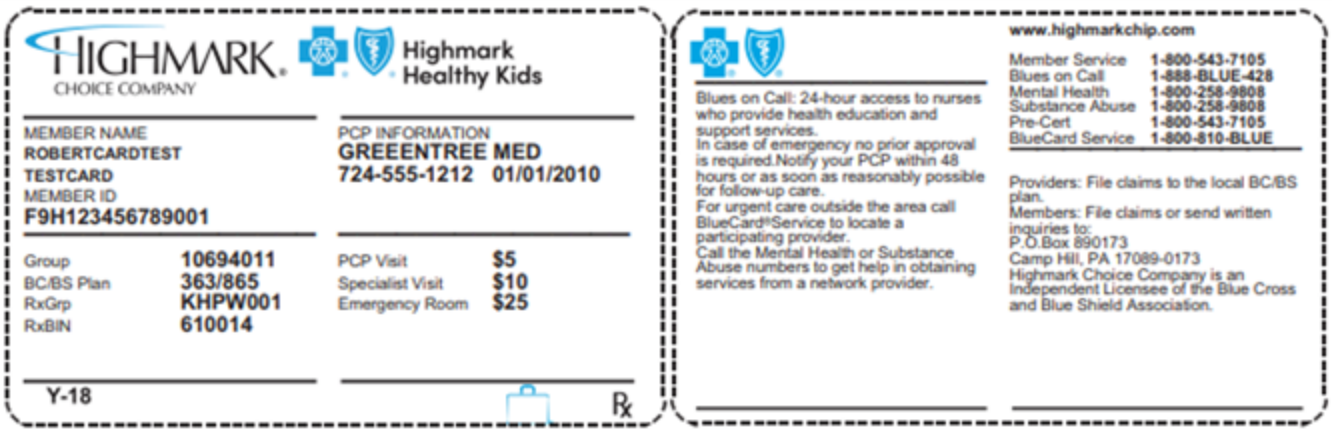
Highmark Healthy Kids (CHIP) ID Cards

A child enrolled in CHIP will have a Highmark Choice Company and Highmark Healthy Kids insurance card as any commercial or group member. The symbol "Y-18" will appear on ID cards for CHIP enrollees. It can be found in the bottom left-hand corner on the front of the card. You may use Availity to determine eligibility, coverage, and claim status.

Central Region:



Western and Northeastern Region:



CHIP benefits are offered through an HMO product utilizing the PA CHIP Network.

IMPORTANT! PCP required

All Highmark Healthy Kids (CHIP) enrollees must select a PCP to manage their care.

Enrollees are encouraged to select a PCP within 10 days of enrollment in CHIP. If a PCP is not chosen, a PCP will be assigned. Enrollees can change the PCP assignment at any time.

Information for PCPs of Highmark Healthy Kids (CHIP) Enrollees

Since the CHIP products offered in the Western, Central, and Northeastern Regions are managed care products, all CHIP enrollees must select a PCP to coordinate their care. All Act 68 and Managed Care regulations, including complaint and grievance rights, apply to the HMO product in PA.

Highmark Healthy Kids (CHIP) enrollees will have an identification card with the Highmark Healthy Kids in the upper right corner. The chosen PCP's practice name will also be on the front of all enrollee identification cards (see ID card samples above).

Although CHIP enrollees are required to select a PCP to oversee their care, traditional "referrals" are not required. If it is necessary to recommend that a CHIP enrollee see a specialist or other provider, PCPs should make every attempt to refer enrollees to providers within the network with a valid PROMISe ID.

Enrollees must use Highmark Healthy Kids (CHIP) HMO network providers to receive 100 percent coverage unless the non-emergency covered benefits are not available within the network and are pre-authorized by Highmark.

Member Rights and Responsibilities for CHIP enrollees are available in the Highmark Provider Manual Chapter 1 Unit 5: Member Rights and Responsibilities.

Accessibility Expectations for Highmark Healthy Kids (CHIP) Providers

To stay healthy, Highmark members must be able to see their physicians when needed. To support this goal, Highmark sets expectations for accessibility of primary care physicians (PCPs), medical specialists, behavioral health specialists, and obstetricians.

In addition, the Department of Human Services has set standards for specific time frames in which network providers should respond to Highmark Healthy Kids (CHIP) enrollee needs based on symptoms. Please note that some standards for CHIP enrollees may differ from those Highmark sets for commercial members.

Highmark Healthy Kids (CHIP) PCP and Medical Specialist Expectations

Patient's Need:	Performance Standard:
Emergency/life threatening care Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	• Immediate response.

PCP urgent care appointments An urgently needed service is a medical condition that requires rapid clinical intervention due to an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	• Office visit within one day (24 hours).
PCP regular care appointments Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain)	• Must be scheduled within 2-7 days (non-urgent).
PCP routine care appointments Routine Wellness appointments **(e.g., asymptomatic/preventive care, well child/patient exams, physical exams).**	• Physical and behavioral health assessments, general physical examination, and first examination must be scheduled within three weeks of enrollment. • Subsequent routine wellness appointments must be scheduled within 10 days.
Specialist urgent care appointments Urgent medical condition	• Appointments within 24 hours of referral.
Specialist routine care appointments Routine care appointments for the following specialty types: 1. Allergy and immunology; 2. Dermatology; 3. Orthopedic surgery;	

4. Otolaryngology; 5. Pediatric dentist; 6. Pediatric endocrinology; 7. Pediatric gastroenterology; 8. Pediatric general surgery; 9. Pediatric hematology; 10. Pediatric infectious disease; 11. Pediatric nephrology; 12. Pediatric neurology; 13. Pediatric oncology; 14. Pediatric pulmonology; 15. Pediatric rehab medicine; 16. Pediatric rheumatology; and 17. Pediatric urology. **All other specialty provider types.**	• Office visit within 15 days. • Highmark must schedule appointments for routine care within 10 business days of referral for all other specialty provider types not listed.
Persons with HIV/AIDS PCPs and specialists are to have scheduling procedures in place to allow for scheduling of appointments for enrollees that Highmark identifies at enrollment to be HIV positive or diagnosed with AIDs	PCPs and specialists must have procedures in place that allow scheduling an appointment with a PCP or specialist within 7 days from the effective date of enrollment.
After-hours care Access to practitioners after the practice's regular business hours.	Acceptable process in place to respond 24 hours per day, seven days a week to enrollee issues: • Answering service that pages the practitioner; or • Answering machine message telling caller how to reach the practitioner after hours
In-office waiting times	

• Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays • Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need.	• Within 15 minutes. • Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need.

Highmark Healthy Kids (CHIP) Maternity Care Expectations

Patient's Need:	Performance Standard:
Maternity Emergency	• Immediate response.
Maternity First Trimeste	• Within three weeks of first request. • Within 10 business days of the new enrollee being identified as being pregnant.
Maternity Second Trimester	• Within seven calendar days of first request. • Within five business days of the new enrollee being identified as being pregnant.
Maternity Third Trimester	• Within three calendar days of first request.

	• Within four business days of the new enrollee being identified as being pregnant.
Maternity High-Risk	• Within three days of identification of high risk. • For new enrollees, within 24 hours of identification of high risk to Highmark or the maternity care provider, or immediately if an emergency exists.

Highmark Healthy Kids (CHIP) Behavioral Health Provider Expectations

Patient's Need:	Performance Standard:
Care for a life-threatening emergency Immediate intervention is required to prevent death or serious harm to patient or others.	• Immediate response.
Care for a non-life-threatening emergency Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.	• Care within six hours.

Urgent care Timely evaluation is needed to prevent deterioration of patient condition.	• Office visit within 48 hours.
Routine office visit Patient's condition is considered to be stable.. **Note:** Physical and behavioral health assessments, general physical examination, and first examination must be scheduled within three (3) weeks of enrollment.	• Office visit within 10 business days.
After-hours care Access to practitioners after the practice's regular business hours.	Acceptable process in place to respond 24 hours per day, seven days a week to enrollee issues: • Answering service that pages the practitioner; or • Answering machine message telling caller how to reach the practitioner after hours.
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	• Within 15 minutes. • Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need.

• Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need.	

Acceptable After-Hours Methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark Healthy Kids (CHIP) patients.

Answering Process	Response/Message	Comments
Answering Service or Hospital Service	Caller transferred directly to physician.	
	Service pages the physician on call (see comments).	A physician or clinical staff person is expected to return the call within 30 minutes.
Answering Machine	Message must provide the caller with a way to reach the physician on call by telephone or pager.	Provide clear instructions on how to record a message on a pager (i.e., “you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up”). A physician or clinical staff person is expected to return the call within 30 minutes.

	Instruct caller to leave a message (see comment).	A physician or clinical staff person is expected to return the call within 30 minutes.

Outreach Following Missed Appointments

PCPs and specialists must conduct affirmative outreach whenever a Highmark Healthy Kids (CHIP) enrollee misses an appointment. Three attempts to contact the enrollee must be made and documented in the enrollee's medical record.

Attempts to contact the enrollee may include but are not limited to: written attempts; telephone calls; and home visits. However, at least one attempt must be a follow-up telephone call.

Preventive Services

Highmark Healthy Kids (CHIP) follows the Highmark Preventive Health Guidelines. This schedule is reviewed and updated periodically based on the advice of the American Academy of Pediatrics (AAP) and Bright Futures™, the U.S. Preventive Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

Highmark's Preventive Health Guidelines are available on the Provider Resource Center. Select Resources & Education from the main menu. You'll find Preventive Health Guidelines under Clinical Quality & Education.

The Bright Futures periodic screens must be conducted for all eligible CHIP enrollees to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule and recommended pediatric immunization schedules based on guidelines issued by the AAP and Centers for Disease Control and Prevention (CDC).

To view the current periodicity schedule, click on the following link: Bright Futures Periodicity Schedule

Blood Lead Levels Testing

Pediatric preventive care must include blood lead levels testing of all children at ages one and two years old. In addition, blood lead level tests must be completed for all children aged three through six without a confirmed prior lead blood test consistent with current Pennsylvania Department of Health and Medical Assistance program requirements.

The following requirements/procedures apply for lead blood tests for Highmark Healthy Kids (CHIP) enrollees:

- The lead blood test must be performed by a laboratory that participates in the PA CHIP network.
- The lead blood test can be performed with the routine hemoglobin test for anemia at 12 months, per Bright Futures; or, one finger stick can be completed for both the hemoglobin and lead tests without a blood draw.
- You must submit claims for both the hemoglobin and lead blood tests if they are performed together.
- The lead blood test is reimbursable if submitted using procedure code 83655.
- There is no out-of-pocket cost to members for lead blood tests.

IMPORTANT: You must submit the claim with the date that the lead blood test was performed along with the results of the test.

Developmental Screenings

Developmental screenings can assist in early detection and intervention of autism, learning disabilities, and developmental delays. Currently, providers who care for CHIP enrollees are required to perform developmental screenings for patients according to AAP guidelines for annual screening of children three years of age and younger for developmental disabilities.

The following requirements/procedures apply for developmental screenings for CHIP enrollees:

- You can perform developmental screenings during well-child visits.
- You must submit claims for both the developmental screening and the well-child visit if you perform the developmental screening during a well-child visit.
- Developmental screenings are reimbursable if submitted using procedure code 96110.
- There is no out-of-pocket cost to enrollees for developmental screenings.

Maternal Depression Screening

Highmark Healthy Kids (CHIP) policy requires that maternal depression screening is covered per the Bright Futures Periodicity Schedule and CMS.

- Screening may be done in the PCP or pediatrician's office as part of the well-child visit and covered under the child's benefit when screening is for the direct benefit of the child.
- Validated screening tools specific to maternal depressions screening, such as the Edinburgh Postnatal Depression Scale or Post-Partum Depression Screening Scale, must be used.
- Claims for maternal depression screening under the child's benefit are to be submitted with procedure code 96161 with diagnosis codes that designate screening is done for the welfare of the child.
- There is no out-of-pocket cost to enrollees for maternal depression screening performed as a preventative service as part of the well child visit.

Mental Health Assessments

If a PCP determines that a mental health assessment is needed, the PCP must inform the enrollee, or enrollee's parent or legal guardian, on how to access these mental health services and coordinate access to these services, when necessary.

Authorization Requirements

Authorization for select services is required for the Highmark Healthy Kids (CHIP) HMO products.

The following services require authorization for CHIP enrollees:

- All inpatient admissions including mental health/substance abuse.
- Any service that may potentially be considered experimental/investigational or cosmetic in nature.
- Home health services.
- Selected injectable and specialty tier program drugs.
- Non-emergency outpatient advanced imaging and cardiology services (coordinated by eviCore healthcare)*.
- Durable medical equipment (DME) and orthotics and prosthetics.
- Highmark's list of outpatient procedures requiring authorization (available on the Provider Resource Center under Claims & Authorization. Click on Obtaining Authorization**).**

**For more information, please see the manual's Chapter 4 Unit 5: Outpatient Radiology and Laboratory.*

The following are some examples of services on Highmark's list of outpatient procedures requiring authorization:

- Diabetes education.
- Enteral formula.
- Nutritional counseling (except for the treatment of diabetes).
- Non-emergency mental illness and substance abuse treatment services.
- Outpatient surgical services.
- Respiratory and cardiac rehabilitation therapy.

CHIP Special Needs and Case Management

CHIP coverage includes a comprehensive, community-based, care coordination program for children with special health care needs or chronic conditions. Nurses and other health care staff work directly with Highmark Healthy Kids (CHIP) enrollees and their parents/guardians to help them understand their child's medical condition and treatment; coordinate services among physicians; help them locate and receive the services available to meet their child's needs; provide them with educational materials; and link to the community resources that can help their family.

For questions regarding the program, please call 866-823-0892 Monday through Friday, 8:30 a.m. to 4:30 p.m. EST. If outside of business hours, please leave a message. All calls are returned within two business days.

Information regarding the program can also be accessed here by entering your ZIP code to access the Highmark Healthy Kids (CHIP) program page for your service area. Select **CHIP Resources and CHIP Special Needs and Case Management** from the menu on the left for access to more detailed information about the program.

Pediatric Disease Management Program

Highmark offers a pediatric disease management program to assist Highmark Healthy Kids (CHIP) enrollees with four targeted conditions: diabetes, asthma, obesity, and tobacco use - prevention and cessation.

The program is designed to reinforce the physician's treatment plan for the patient. Its goal is to proactively engage these enrollees and their families for better understanding of their conditions and, with assistance from Highmark Case Management staff, to help them manage their disease.

All children enrolled in Highmark Healthy Kids (CHIP) through Highmark who are identified as having diabetes, asthma, obesity, or using tobacco are automatically registered as participants in the disease management program.

The program will provide the following services to Highmark Healthy Kids (CHIP) enrollees and their families:

- Support from Highmark case management nurses and other health care staff to better manage their condition and periodically evaluate their health status;
- Educational and informational materials to assist them in understanding and managing the medications prescribed by their doctors; and

- Assistance in effectively planning for office visits with their physicians and reminders as to when those visits should occur.

The Highmark Case Management staff will notify a physician's office by letter or a telephone call to inform them when any of their CHIP patients are enrolled in the program. The assistance in care coordination and communication among the various entities involved in the child's care will be of benefit to the physician as well. Since membership in the program is voluntary, the CHIP enrollee who wishes to stop participating in the program can do so with a telephone call. To discuss a CHIP patient's involvement in the program, please contact us at 866-823-0892.

Highmark Healthy Kids (CHIP) Benefits and Services

CHIP covers a wide range of benefits and services, including medical care, prescription drugs, and dental and vision services. Except for emergency care and emergency ambulance services, benefits are provided only for services performed by a network provider with a valid PROMISe ID.

Commonly used CHIP medical benefits are outlined here. For detailed benefit information, please verify a CHIP enrollee's medical coverage via Availity® Eligibility and Benefits prior to rendering services.

Medical Benefits

Ambulance Services	Precertification required for non-emergent only
Hospital Services	**Inpatient Care** - Pre-admission review required: • Inpatient consultations • Anesthesia • Diagnostic services • Transplant services **Outpatient Services:** • Clinic services (in a hospital-affiliated clinic) • Diagnostic services

	• Emergency medical and accident • Surgery
Maternity	• Prenatal and postnatal care • Routine newborn care for the first 32 days
Medical Visits	• Primary care provider • Specialists (includes Specialist Virtual Visits) • Gynecologists • Retail clinic • Urgent care centers • Telemedicine • Second surgical opinion
Mental Health	• Inpatient care • Partial hospitalization • Outpatient visits • Emergency psychiatric care
Preventive Care (Follows the Highmark Preventive Schedule)	Includes the following, with no cost sharing or copays: • Routine physical examinations • Pediatric immunizations • Well baby care • Routine diagnostic screening • Routine lead screening • Mammograms, annual routine, and medically necessary • Routine gynecological exams, including a Pap Test
Private Duty Nursing	Requires Precertification

Substance Abuse	• Detoxification • Inpatient rehabilitation • Outpatient services
Surgical Services	• Assistant at surgery • Anesthesia • Oral surgery
Habilitative Services	• Physical medicine • Occupational therapy • Speech therapy Limited to a total of 30 outpatient visits for each type of service per benefit period. This limit does not apply when services for habilitative purposes are prescribed for the treatment of mental illness or substance abuse.
Therapy and Rehabilitative Services	• Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy • Infusion therapy • Inpatient rehabilitation • Cardiac rehabilitation • Physical medicine – limited to a total of 60 outpatient visits per benefit period • Occupational therapy - limited to a total of 60 outpatient visits per benefit period • Speech therapy - limited to a total of 60 outpatient visits per benefit period • Spinal manipulations – limited to 20 visits per benefit period

Other Medical Services	• Allergy testing • Autism spectrum disorders • Durable medical equipment • Home health care • Hospice • Skilled nursing facility • Transplant services

Other Highmark Health Kids (CHIP) Covered Services

Dental (administered by United Concordia)	The dental plan for CHIP enrollees meets the Minimum Essential Health Benefits requirements for pediatric oral health as required under the federal Affordable Care Act.
Hearing	• Hearing evaluation once every calendar year • Audiometric examination once every calendar year • Hearing aid – not more than one per ear in any two calendar years
Prescription Drugs	• Closed formulary with soft generic • Copayments required for Low-Cost and Full-Cost CHIP • 90 days at retail available
Vision	• Eye examination and refraction (once every 12 months) • Frame (one every 12 months) • Lenses – single vision, bifocal, trifocal (one pair every 12 months)

	• Contact lenses (pair) *Davis Vision network providers accept reimbursement as payment in full for standard services. Non-Davis network providers are reimbursed at an out-of-network fee schedule.

Highmark Healthy Kids (CHIP) Claims Submission

All claims, except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper claim form. Please note that in all cases, the child is the enrollee. **Report "Patient's relationship to insured" as "self."** Do not report the name of the parent.

Electronic claims are preferred. However, if necessary, paper claims can be submitted to the following addresses:

Central Region:
Highmark Blue Shield
P.O. Box 890173
Camp Hill, PA 17089-0173

Western and Northeastern Regions:
Highmark Blue Shield
P.O. Box 898819
Camp Hill, PA 17089-8819

Dental
United Concordia Companies, Inc.
Claims Processing
P.O. Box 69421
Harrisburg, PA 17106-9421

Routine Vision
Davis Vision

Vision Care Claims Unit
P.O. Box 1501
Latham, NY 12110

Timely Filing

The Pennsylvania Children's Health Insurance Program (CHIP) requires providers to submit all claims for services provided to Highmark Healthy Kids (CHIP) enrollees to Highmark within **180 days** from the date of service or discharge.

Complaints and Grievances

Under Pennsylvania CHIP, an enrollee or enrollee's representative, which may include the enrollee's provider, may file a complaint or grievance. For detailed information, please see the CHIP section in the Highmark Provider Manual Chapter 5 Unit 5: Denials, Grievances, & Appeals.

FQHC/RHC Payment and Claim Submission

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires payment for services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be at least equivalent to Medicaid Prospective Payment System (PPS) rates for all CHIP encounters. The PPS rates are all-inclusive rates for encounter services provided, except for vaccine services.

For more information, including claim submission guidelines, please see the Highmark Provider Manual Chapter 6 Unit 7: Payment/EOBs/Remittances.

Highmark Healthy Kids (CHIP) Enrollment

If you know of children who may qualify for this program, please refer them to the appropriate telephone number for the Highmark CHIP Administrative Unit (PA Western, Central, and Northeastern Regions):

800-KIDS-105 (800-543-7105); TTY Service: Dial 711

For more information on CHIP, please visit Pennsylvania's "We Cover All Kids" website
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2.3 Federal Employee Program (FEP)

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program. The FEHB allows insurance companies, employee associations, and employee unions (e.g., the National Association of Letter Carriers) to develop plans to be marketed to government employees.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to health maintenance organizations (HMOs). Some plans are offered nationwide while others are regionally-available plans. The number of choices for individual employees varies based on where they reside.

The Blue Cross Blue Shield Association (BCBSA) fee-for-service plan is offered to federal employees nationwide. The Federal Employee Program (FEP), also known as the Service Benefit Plan, has been part of the FEHB Program since its inception in 1960. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These subscribers and their families receive health coverage through the local Blue Plan where they reside.

FEP Benefit Plan Options

Federal employees have traditionally been offered two Preferred Provider Organization (PPO) benefit packages nationally through FEP -- Standard Option and Basic Option. The same types of services are covered under both options, but at different payment levels. Additionally, FEP includes the FEP Blue Focus℠ option.

- Standard Option PPO allows FEP members to seek covered services from both network participating and non-participating providers. When members use participating PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- Basic Option PPO has a lower premium than Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.
- FEP Blue Focus is also a PPO product that uses the same network as the Standard and Basic options with no out-of-network benefits, except in certain situations such as emergency care. The “Core” benefits, which provide coverage for all the essentials of good preventive health, are the base of the program. The Core benefits are covered at little or no cost to members when they use network providers.

The benefits under FEP Blue Focus are divided into three key categories: Core, Non-core, and Wrap. These categories describe the cost share the member will pay based on the services used.

- Core benefits, the base of the program, have a low or no copayment and are not subject to a deductible or coinsurance. These benefits are most commonly used to receive general care and to maintain overall health and well-being, in addition to coverage for accidental injuries.

  Copays under the Core benefits are ten dollars ($10) per visit for the first 10 visits for a primary care provider, specialist, or other health care provider, such as a mental health doctor. Each member on the subscriber’s coverage receives 10 visits per calendar year.

  On the eleventh visit in the calendar year, the member’s cost-sharing will change to include the plan’s deductible and 30 percent coinsurance. Preventive care visits, such as an annual physical, do not count toward the 10-visit limit and are at no cost to members.
- Non-core benefits provide coverage for any unexpected medical costs that may occur during the calendar year. All these services are subject to an annual deductible and coinsurance. When the

catastrophic out-of-pocket maximum is met, then services for the remainder of the calendar year are paid at 100 percent of the Plan allowance for services.

- Wrap benefits provide the final layer of protection and complete, or “wrap-up,” the FEP Blue Focus benefit package. These are benefits that members may or may not have a need to use during the year. These benefits have visit limitations and/or different copayments or coinsurance than the Core and Non-core benefit levels. The calendar year deductible does not apply to these benefits.

  FEP Blue Focus does not provide benefits for some services that are covered under the Standard and Basic options, such as routine dental care. A complete list of benefit exclusions is available at fepblue.org. The appeals process for FEP Blue Focus is the same as for the Standard and Basic options.

IMPORTANT! It is important to note that additional services require prior authorization under FEP Blue Focus that do not require prior authorization under the Standard and Basic options.

For prior authorization requirements for all FEP products, including a list of services requiring prior authorization, please see the Highmark Provider Manual Chapter 5 Unit 2: Authorizations.

For a full list of services that require prior authorization, go the Provider Resource Center main menu at the top of the page, click Claims & Authorization, then Authorization Guidance, and then Obtaining Authorizations.

Identifying FEP Members

Members who are part of the Blue Cross Blue Shield Association’s Federal Employee Program (FEP) can be identified by the following:

- The letter "R" in front of their member ID number instead of a three letter alpha prefix.
- The BlueCross BlueShield Federal Employee Program logo on their ID card.
- The FEP Blue Focus ID card has a thin blue border around the perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has a shaded blue front.

Note: Only the primary card holder’s name will appear on the ID card.

Sample: Standard Option ID card

SAMPLE: Basic Option ID card

Sample: FEP Blue Focus ID card

Verifying Eligibility & Benefits

Eligibility and benefits can be verified through Availity for FEP members residing in Delaware, New York, Pennsylvania, and West Virginia.

For out-of-state FEP members or FEP members in Highmark's service areas, if Availity is not available, please call the appropriate FEP Provider Service department:

- Pennsylvania: 866-763-3608
- Delaware: 800-721-8005
- West Virginia: 800-535-5266
- New York: 800-234-6008

Hours are Monday through Friday, 8:30 a.m. to 5 p.m. EST. Except in New York where hours begin at 8 a.m.

Claim Submission

Claims for FEP members should be submitted to the local Blue Plan where services were rendered. Each local Plan is responsible for processing and paying claims for services received within that area. Highmark participating providers should submit all claims for FEP members to Highmark, ***except*** for the following:

- **Lab providers should file FEP claims in the state where the lab tests were performed, not where the specimen is drawn**. The provider locations are determined by the mailing address.
- **DME providers should file FEP claims in the state where the provider is located, not where the DME supplies are delivered.** The provider locations are determined by the mailing address.
- **Facilities (UB/837I billers) must submit claims for FEP members to their local Blue Cross plan.**
    - In Pennsylvania, Highmark is the Blue Cross licensee in the Western and Northeastern Regions, therefore, facilities in those service areas would submit claims for FEP members to Highmark. However, in the Central and Eastern Regions, where other Blue Plans hold the Blue Cross licensing for the service areas, facilities must submit claims for FEP members to those Blue Cross plans (Capital Blue Cross in the Central Region; Independence Blue Cross in the Eastern Region).
    - Since Highmark is the only Blue Cross Blue Shield licensee in Delaware and in West Virginia, facilities located in Highmark Blue Cross Blue Shield (DE) and Highmark Blue Cross Blue Shield (WV) service areas will always submit claims for FEP members to their local Highmark plan.

For special tips on professional claim submission for FEP members, please see the section on FEP Processing in the Highmark Provider Manual Chapter 6 Unit 4: Professional (1500/837P) Reporting Tips.

For more information on the Blue Cross Blue Shield Federal Employee Program, please visit fepblue.org

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2.3 New York Medicaid and CHP

For providers in New York

Highmark Blue Cross Blue Shield (WNY) offers Medicaid and Child Health Plus (CHP) in our Western New York Service Area. For more information on these programs, please review the associated Medicaid and CHP Provider Manual

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2.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

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Unit 4: Benefit Plan Programs

2.4 Baby Blueprints®

Baby Blueprints® is a maternity education and support program available to expectant Highmark members. This free program is designed to help expectant families better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.

Baby Blueprints offers expectant Highmark members educational information on all aspects of pregnancy through online resources during each trimester of pregnancy. Topics include prenatal care,

proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes, and many others. Baby Blueprints will also provide program participants access to individualized support from a nurse Health Coach. Providers are encouraged to promote patient enrollment to reinforce medical care and maternity information so that pregnant women may “have a greater hand in their health.”

Baby Blueprints is available to expectant Highmark members enrolled in a commercial group product, direct pay product, or social mission product.

Baby Blueprints is not available for members enrolled in a Medicare/Medicare Advantage product, Federal Employee Program (FEP), or any self-funded employer groups that have opted out. How members can enroll Enrollment in Baby Blueprints is simple and convenient. Expectant mothers can enroll at no cost over the phone by calling toll free 866-918-5267.

If you have questions about Baby Blueprints, please contact the Provider Service Center.

If members have further questions about Baby Blueprints, please encourage them to call Member Services at the number on their ID card.

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2.4 Blues on Call

Highmark has an integrated program, Blues On Call, to attempt to address the total health care needs of the patient rather than focusing on one specific condition. Highmark members may contact Blues On Call 24 hours a day, every day of the year.

The Blues On Call team includes health coaches who provide support over the telephone to help members manage chronic conditions, offer education and support to those facing significant medical decisions and and/or to help members interpret and manage symptoms.

Most Highmark members are automatically eligible to make use of Blues On Call services. No registration is required and the service is free.

Chronic Condition Support

The program content is objective and evidence-based. Information and material is from national sources such as the American Diabetes Association. The scope of chronic condition support through Blues On Call includes:

- Condition-specific standards of care
- Medication adherence
- Specific activities related to medical condition monitoring (weight monitoring, blood sugar monitoring)
- Regular physician visits
- Flu and pneumonia vaccines

Blues On Call does not:

- Address benefit issues
- Address claims issues
- Provide diagnosis or medical advice

Refer a patient to Blues On Call any time he or she needs more information or assistance about a health care topic or if support by a Blues On Call Health Coach would benefit the patient.

Encourage your patient to call the Blues On Call phone line (this number is also located on the back of the member ID card): 888-BLUE-428 (888-258-3428).

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2.4 Diabetes Prevention Program

Certain Highmark members have access to a diabetes prevention program as part of their Highmark preventive benefits schedule. Self-funded employer groups may choose to opt out of the program.

The program is available to Highmark members who have coverage under their preventive benefits and meet the program's eligibility criteria. Eligible members can choose between attending in-person classes in the community or an option with online classes and support.

Note: The program was effective for State of Delaware employees with coverage under a State of Delaware Group Health Insurance Program administered by Highmark Delaware since 2017.

What is the Diabetes Prevention Program?

The Diabetes Prevention Program (DPP) is a structured lifestyle and health behavior change program with the goal of preventing the onset of type 2 diabetes in individuals who are prediabetic. The program is certified by the Centers for Disease Control and Prevention (CDC). The 12-month program includes:

- Choice of an in-person classroom setting or an online/mobile app program
- Sixteen "core" sessions
- Monthly follow-up meetings

The program's primary goal is to attain at least five percent (5%) average weight loss among participants. According to the CDC, losing five percent of your weight can help prevent diabetes.

Highmark has partnered exclusively with two vendors to deliver the Diabetes Prevention Program to our members. Members can choose the in-person classroom program available at participating YMCA locations **or** the online program through Retrofit.[SM]

Program Eligibility Criteria

The vendor of the program option the member chooses, YMCA or Retrofit, will confirm a member's program eligibility prior to offering program enrollment. Eligible members must be at least 18 years of age and meet criteria of being "prediabetic," which includes:

- Body Mass Index (BMI) of 25 or greater;
- Fasting blood glucose of 100-125mg/dl; and
- No previous diagnosis of diabetes.

Members may also be Identified as at-risk via the CDC risk screening questionnaire tool available on the YMCA and Retrofit websites as part of the enrollment process.

YMCA'S Classroom Program

The YMCA Diabetes Prevention Program provides a supportive environment where participants work together in a small group to learn about healthier eating and increasing their physical activity in order to reduce their risk for developing diabetes. The program is led by a trained Lifestyle Coach in a classroom setting over a 12-month period, beginning with 16 weekly sessions followed by monthly maintenance. The program is offered at select YMCA locations.

Under the YMCA in-person classroom program, the benefits/services include:

- Member attends structured sessions at an on-site location
- Led by a trained Lifestyle Coach
- Year-long program of 25 sessions
- Food, weight, and activity tracking
- Peer support and accountability
- CDC-approved curriculum

Retrofit's Online/Mobile Program

Retrofit is a leading provider of weight-management and disease-prevention solutions. Retrofit's online 12-month Diabetes Prevention Program provides personalized coaching from experienced clinicians through online sessions, personalized one-on-one coaching, tracking tools, and peer support.

The benefits/services of the Retrofit program for eligible Highmark members include:

- Welcome kit with wireless scale, activity tracker
- One-on-one expert coaching sessions for nutrition, behavior, exercise physiology
- Expert-led classes
- Expert moderated online community (peer support)
- Online dashboard and mobile app, including food, weight, and activity tracking
- Online proactive and reactive messaging

- Video (live) coaching sessions (telephonic support when preferred)
- Text messaging for “in the moment” personalized coaching
- CDC-approved curriculum

Verify Program Eligibility via Availity®

Providers can verify a member’s coverage for the Diabetes Prevention Program in Availity’s **Eligibility and Benefits Inquiry** by selecting **Additional Benefit Notes.**

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2.4 Health Promotion Programs

Health promotion and risk reduction is part of the overall health management program. Highmark's Health Management Services (HMS) department offers a variety of condition management, case management, and wellness programs. Services and programs are offered digitally, at the workplace, and telephonically.

Programs are designed to raise member awareness of healthy versus unhealthy habits, make healthy choices, reduce risk of injury, and help members with an acute or chronic condition. The health promotion activities focus on three key areas:

- Health Assessment
- Worksite Health Promotion Programs
- Lifestyle Improvement Programs

For providers in New York

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) are committed to helping our members take an active role in achieving and maintaining good health. That's why we offer health and

wellness programs. These programs support your efforts to keep our members healthy by providing them with coverage benefits for health promotion and education services.

Members are more likely to attend health and wellness classes if they receive encouragement from their physicians or other providers and we invite providers to encourage their patients to participate in the programs. We reimburse the health education provider directly, so the member may attend wellness classes without any out-of-pocket expense.

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) have an extensive network of credentialed providers offering health education classes. Patients do not require a referral or written approval for most approved programs.

Classes are currently offered in the following categories:

- Diabetes education
- Maternal and infant health nutrition
- Physical activity
- Smoking cessation
- Stress management
- Weight management

We also offer programs on topics such as AIDS/HIV, children and adolescent health, arthritis, cancer information, holistic health, substance abuse, senior health, women's health, asthma, heart health, and a variety of support groups.

We encourage our members to take a variety of classes in order to enhance their overall wellness. Programs of similar topics (stress management, diabetes education, nutrition etc.) are limited to one class/program per year with the exception of fitness programs (Pilates, yoga, spinning), which are limited to two programs each year. Maternal and infant health classes are unlimited.

To register, members should contact the health and wellness program provider directly. Members are able to verify program eligibility by calling the customer service number on the back of their identification card.

Digital Resources - All Providers

Digital resources are available to Commercial, Affordable Care Act (ACA), and individual medically insured members, as well as Medicare Advantage and Medigap members. Please see the Reference Guide of Highmark Member Programs for more information.

Worksite Programs

Worksite programs are offered as an optional service to employers wishing to promote a healthy culture among their employees through awareness, education, and activities to encourage engagement.

Services that encourage awareness include on-site biometric screenings. Education services include individual coaching in conjunction with the biometric screening experience, online resources, and newsletter campaigns. Engagement is encouraged through a variety of "Reward" and “Challenge” programs that track participation for incentive purposes.

Case and Disease Management Model

We have transitioned from a primary nurse model to a clinician-driven multidisciplinary team approach allowing us the ability to holistically manage our members and provide them with the right clinical resource at the right time. By leveraging the strengths of a multidisciplinary team, our goals are to meet member needs, improve care coordination, and manage medical expense. This physician-supported team consists of complex case and disease managers, behavioral health specialists, social workers, pharmacists, medical directors, and clinical coordinators.

Comorbidities Addressed

The case and disease managers address comorbidities that many seriously ill individuals face. The Case and Disease Management Model uses motivational interviewing and coaching techniques, and focuses on the whole person. These techniques allow the case and disease managers to address the member's full spectrum of health care issues rather than focusing on a single issue or condition.

Enrollment Time Period

The time period a member is enrolled in a condition management program varies, and is specific to the member's needs. The case and disease managers assist the member in developing care goals whose focus is member self-management. Once these goals are accomplished, the program is closed. Members are encouraged to re-engage with the case and disease managers at any time that their clinical condition requires, or when they simply want the additional support of the case and disease managers to work toward attainment of their goals.

Components of the Case and Disease Management Model

There are three main components in the Case and Disease Management Model:

High Risk Member Outreach

High risk members are coached using motivational interviewing techniques with a focus on self-management. Case and disease managers assess members using questionnaires then, in collaboration with the member, develop goal-directed plans of care. Case and disease managers individualize the length and frequency of each call based on member need or request.

Moderate Risk Member Outreach

Eligible moderate risk members are targeted for Interactive Voice Response (IVR) calls. The goals of these calls are to provide the member with basic information about their condition, to review the member's perception of their self- management and overall health, to provide health tips and reminders

specific to their condition, and to offer the member the opportunity to transfer to speak directly to the case and disease managers.

When the member accepts the opportunity to speak to case and disease managers, the member can be enrolled in a condition management program. This enrollment enables the member to have ongoing access to case and disease managers who will assist the member to develop short and long-term self-management goals and to develop strategies for overall health improvement.

The case and disease managers use the member contacts focused on condition management to assist the member with any gaps in care that may be impacting their overall health as well as any screening recommendations that may result in earlier detection of potential health concerns.

Low Risk Member Outreach

Low risk members are targeted for condition-specific mail campaigns. The materials include condition specific topics/questions to discuss with their doctor and a variety of health promotion educational topics such as smoking cessation, nutritional needs, and physical activity recommendations.
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2.4 Health Spending Accounts

In today's health care market, employers and consumers are looking for options to lower their health care costs and have more control over their health care spending. Highmark offers the following health spending account options to respond to those needs:

- Health Savings Accounts (HSAs)
- Health Reimbursement Accounts (HRAs)
- Flexible Spending Accounts (FSAs) including Limited Purpose FSA and Dependent Care FSA
- Commuter Accounts including Parking and Transportation

Health spending accounts help Highmark members to save money to cover their out-of-pocket medical costs, to better manage their health-related expenses, and to be more involved in their health care decisions while also receiving significant tax savings. Members are able to track all of their health care spending online at their secure Highmark member website.

Direct Payment to Provider

If a member's health spending account is set up for "Direct Payment to Provider" and money is available in the account, you will receive a separate payment (check or Electronic Funds Transfer, or EFT) and notice (known as an Explanation of Payment, or EOP) for claims paid under a member's spending account.

If the member's HSA, HRA, or FSA does not have sufficient funds for the entire amount due, you will receive whatever amount is available in the account. You can then bill the member directly for the remaining balance due. As subsequent deposits are made and additional funds become available in the account, the remaining portion of the payment will be distributed to the member.

Explanation of Payment (EOP)

Whenever a full or a partial payment is made to you from a member's health spending account, you and the member will receive an EOP to document the transaction. Availity-enabled providers will receive their EOPs via the Availity **Remittance Viewer** function. These are also available in PNC's ECHO Health platform (DE, PA, and WV only).

This Direct Payment to Provider option from a member's health spending account does not eliminate your ability to collect patient liability, such as copayments or other outstanding balances, due at the time of service. Highmark provides "Real-Time" tools, accessed via Availity, that help providers determine member responsibility prior to or at the time of services.

- The *Patient Cost Estimator* function can assist you in estimating the member's financial responsibility. The estimate will consider any deductible, coinsurance, and/or copayments included in the member's plan benefits.
- The *Claims and Encounters* function gives providers the added ability to submit claims for specific health care services and may receive a fully adjudicated response within seconds. This allows providers to determine, at the time of service, the correct amount the member owes.

These real-time estimation and adjudication tools provide immediate responses and give providers the ability to discuss member financial liability with patients when services are scheduled or provided. They also enable providers to collect payment or make payment arrangements for the member's share of the cost at the time of service. Please note, however, that if you collected payment upfront for member liability, and subsequently receive payment from the member's health spending account, the refund must be issued directly to the member.

Please note that real-time transactions are accurate at the time of viewing or request. The member's liability status could change by the time your claim is adjudicated based on claims received but not yet processed, additional services received prior to the adjudication of your claim, or if services rendered are different than those estimated.

For additional information about the Real-Time Tools available via Availity, please see Chapter 1.3: Electronic Solutions - EDI & Availity.

Spending Account Inquiries

For spending account questions or issues in, contact the dedicated Provider Spending Account Information Line:

- Pennsylvania and West Virginia: **800-652-9478**
- Delaware: **800-346-6262**

Refund Checks for HSA, HRA, and FSA Overpayments

If you receive an overpayment from a member's HSA, HRA, or FSA, it will be necessary for you to submit this overpayment back to Highmark at the applicable postal address below. Please do not send any overpayments directly to the member. Highmark will ensure that the proper monies are deposited back into the member's account.

Pennsylvania & West Virginia | Delaware

Highmark Attention: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark Blue Cross Blue Shield (DE) Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991

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2.4 MyCare Navigator

MyCare Navigator is a telephone-based support service available to Highmark members and their families to help them make informed decisions and get the care that they need. This service is offered as part of our commitment to support health advocacy for our members. The service is free and is available Monday through Friday from 8 a.m. to 8 p.m.

A dedicated myCare Navigator associate can assist members with specific health care issues such as finding a physician or pharmacy, verifying the network status of a physician or pharmacy, making appointments, transferring medical records or prescriptions, and arranging transportation for medical visits.

Highmark members and their families can reach a myCare Navigator health advocate by calling the following toll-free telephone number:

888-BLUE-428 (888-258-3428), Option 2

If you receive inquiries about myCare Navigator from your Highmark patients, you can direct them to this number on the back of their Member ID cards (listed as “Blues On Call”).

Navigator health advocates may be calling your office on behalf of Highmark members or their family members. Please be sure your staff is informed about this service for Highmark members so they are

aware of and prepared for these potential incoming calls.

If you have questions about myCare Navigator and the services it offers, please contact Highmark Provider Service.

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2.4 Disclaimers

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Unit 5: Telemedicine Services

2.5 Introduction to Telemedicine

Many factors can make it difficult for patients to get appropriate medical care when they need it — geography, weather, availability of specialists, transportation, and others. With advancements in technology that allow for visual communications and information exchange at a distance, the telemedicine field is evolving rapidly to meet the needs of the patient community.

Telemedicine includes a growing variety of applications and services using two-way forms of telecommunications technology. The use of this technology is now becoming integrated into the ongoing operations of hospitals, specialty departments, and physician offices. For both providers and patients, telemedicine can play a significant role in facing the challenges of maintaining or improving health care outcomes while reducing costs.

Some of the most important benefits of telemedicine include accessibility and flexibility for the patient community. With the mounting shortage of physicians, especially for primary care, telemedicine offers patients the convenience of connecting with medical professionals more easily when traveling, pressed for time, unable to take time off from work or school, or not able to drive long distances to see their health care provider.

What is Telemedicine?

Telemedicine is defined as the exchange of medical information between sites via electronic communication for transmitting clinical information for diagnostic, monitoring, and therapeutic purposes. The term “telehealth” is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. These terms are often used interchangeably.

Highmark is committed to expanding access to quality care for our members and providing new options for more timely and convenient access to meet their needs. In our efforts to expand services and coverage to more members, we are providing telemedicine coverage options through:

- A telemedicine service benefit that provides coverage for services provided by our approved telemedicine vendors via real-time interactive audio and video telecommunications technology. These vendors provide 24/7 access to a national network of board-certified physicians.

- Benefit enhancements that provide coverage for “virtual visits” with our members’ trusted primary care providers and specialists using telecommunications technology.

Telemedicine Legislation

A wide variety of organizations support the use of telemedicine and legislation to require reimbursement by insurance companies and the Medicare and Medicaid programs.

- The State of Delaware enacted telemedicine legislation in 2015 that affects commercial individual and group insurance coverage. For additional information, please see the section of this unit on the **Delaware Telemedicine Mandate – House Bill 69.** Delaware has also enacted House Bill 160 which expands the definition of telehealth and gives providers easier access to performing telehealth services across state boarders.
- West Virginia House Bill 4363, effective June 11, 2016, created new sections to West Virginia Code (§30-3-13(a) and §30-14-12(d)) and implemented a variety of telemedicine practice standards and prescribing rules; however, West Virginia still lacks a payment parity law for telehealth care that applies to commercial health plans. West Virginia House Bill 4003, effective on July 1 2020, created new sections to West Virginia Code (in relevant part §33-53- 1) requiring coverage of telehealth services. West Virginia House Bill 2024, amended and reenacted West Virginia Code (§33-57-1), all relating to telehealth, defining telehealth services to include audio only telephone calls, requiring coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation, and requiring payment parity in accordance with the mandate. For additional information, please see the section of this unit on the West Virginia Telemedicine Mandate – House Bill 2024.
- Proposed legislation for telehealth practice standards and coverage by commercial insurance plans is under consideration in Pennsylvania.

Reimbursement Policy Bulletin RP-046

For information on billing and reimbursement for commercial and Medicare Advantage products, please see:

Highmark Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services.

This policy includes complete guidelines for both professional and facility billing requirements for reimbursement, including the use of Place of Service code 02 or code 10 on all professional telehealth claims and the modifiers needed for both professional and facility claims.

Reimbursement policies are available on the Provider Resource Center under **Claims & Authorization,** then **Reimbursement Programs,** and choose **Reimbursement Policies.**
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2.5 Prescribing Protocol for Telemedicine Services

The standard of care applicable to an in-person patient encounter also applies to a virtual patient encounter. Telemedicine consultations and treatment, including the authorization and dispensing of prescription medication(s), must be held to the same professional standards of appropriate medical practice as traditional in- person patient encounters.

Prior to issuing prescriptions via telemedicine, providers must ensure that a provider-patient relationship is established and documented in the member's file. A proper "provider-patient relationship" may be established when the provider (physician/practitioner) obtains all relevant medical history and conducts an appropriate evaluation to establish a diagnosis(es) and identify underlying conditions or contraindications to recommended treatment.

A valid provider-patient relationship may be established using telemedicine technologies provided the appropriate standard of care is met and all applicable state and federal statutes and regulations are followed. The services to establish the provider-patient relationship during the initial encounter, as described above, must take place via an interactive audio **and** video telecommunications system (unless exceptions are allowed for certain medical services as appropriate under applicable state laws).

Providers should give careful consideration in determining whether an in-person office visit for the initial visit would be beneficial in establishing a provider-patient relationship based on the particular member's presenting condition(s). While some situations are appropriate for using telemedicine technologies for member care in lieu of the traditional in-person office visit, others are not.

Important

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY), and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Methods That Are Not Acceptable

A provider-patient relationship may not be established through, but not limited to, the following:

- Internet questionnaires;
- Social media;
- Email messages;
- Patient-generated medical history;
- **Pennsylvania Only**: Audio only communication including, but not limited to, interactive audio
- Text messages;
- Facsimile (fax) machine; or
- Any combination of the above.

These do not constitute acceptable standard of care and prescriptions cannot be issued to Highmark members when a provider seeks to establish a provider-patient relationship with the member based solely on these methods.

The following guidelines apply when using telemedicine technology to issue prescriptions to Highmark members:

- Prior to issuing a prescription, all relevant information that shows that a provider-patient relationship has been established (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, social history, etc.) must be documented and maintained in the member's medical record as required with in-person diagnosis and treatment services.
- If state law requires an in-person examination prior to the delivery of telemedicine services, the in-person services must be concluded and documented in the member's medical record prior to the initiation of any related telehealth visits and issuance of prescriptions.
- For situations in which the standard of care requires an in-person examination in order to establish a diagnosis and determine recommended treatment, the in-person examination must be

performed and documented in the member's medical record prior to issuing a prescription via telemedicine.

- If allowable per state regulations, a provider without an established provider-patient relationship may issue a prescription via telemedicine if the prescribing provider is:
    - Consulting at the request of another practitioner who maintains an ongoing relationship with the member;
    - The other practitioner has performed an in-person physical examination of the member; and
    - The other practitioner agrees to supervise the member's ongoing care and use of the prescribed medications.

All federal and state prescribing statutes and regulations, including any limitations on prescribing and dispensing controlled substances, must be adhered to in prescribing through telemedicine technology.
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2.5 Telemedicine Service Benefit and Approved Vendors

American Well™ (Amwell) is the Highmark-approved vendor for Well360 Virtual Health, Highmark's virtual care solution.

Effective January 1, 2022, we are introducing a long-term virtual health platform, Well360 Virtual Health. To support our Well360 Virtual Health platform, we have chosen Amwell as our exclusive vendor solution, with Highmark and Amwell both sharing a goal of offering the ultimate member experience for virtual urgent and behavioral health care, virtual primary care, dermatology, and women's health.

Well360 Virtual Health will be easy to access and navigate when members need convenient, real-time virtual urgent care visits and virtual access to behavioral health.

Important: Teladoc will still continue to be available to some ASO clients.

Services Provided by Well360 Virtual Health

Well360 Virtual Health provides national coverage by certified providers via real-time interactive video and audio telecommunications technology. If members use Well360 Virtual Health for any of the

following treatments, member cost sharing applies and can vary in the form of a copay or subject to network deductible and/or coinsurance as per their benefits:

- **24/7/365 Urgent Care:** Primary Care Physician (PCP)-type care, such as, but not limited to the following: cough, sinus infection, sore throat, vomiting, diarrhea, fever, pinkeye, flu/cold, headache. These practitioners belong to nationwide networks of licensed, board-certified physicians, including family practitioners, internists, and pediatricians for acute care for minor illness.
    - See member's **Telemedicine Service** benefit.
- **Virtual behavioral health provided by** Well360 Virtual Health. Scheduled video appointments, contingent upon provider availability, for conditions such as, but not limited to the following: Depression, anxiety, stress management, relationship challenges, and child behavior difficulties.
    - See member's **Outpatient Mental Health** benefit.
- **Virtual Primary Care:** The Virtual Primary Care solution connects members to virtual primary care doctors, providing easy and fast access to care. Primary care visits are scheduled visits with the member's virtual PCP. Pediatricians are available servicing children 12 and older. Primary Care appointments can typically be scheduled within seven days or less. Services include both medically necessary office visits and routine physical exams.
    - See member's **PCP/Physician Office** Visit benefit.
- **Dermatology:** The dermatology solution virtually connects a member to a dermatologist. This is done by secure asynchronous* capabilities which allow for more convenient skin examinations and faster turnaround times compared to in-person dermatology visits.
    - See member's **Specialist Office Visit** benefit.
- **Women's Health**: Women's Health provides services for women by providers who specialize in women's care. Women's Health service consists of three different services offered on the platform – Women's Health Medical Care, Women's Health Therapy and Women's Health Lactation Consulting.
    - See member's **Telemedicine Service, Outpatient Mental Health and Preventive Adult Care** benefit.

All vendors operate in accordance with state laws and regulations, and their providers are licensed to practice in the state in which the member is located. **Members must have the benefit associated with the service line to obtain these services from Well360 Virtual Health.**

Important! Well360 Virtual Health consists of providers within the Amwell Medical Group (AMG).

Important! Each Well360 Virtual Health service line is housed within a member's benefits. Urgent care within Telemedicine Service Benefit, Behavioral Health within Outpatient Mental Health, Primary Care under PCP/Physician Office Visit, Dermatology under Specialist Office visit, and Women's Health (Medical Care under Telemedicine Service, Therapy under Outpatient Mental Health, and Lactation under Preventive Adult Care).

Member Eligibility

The Telemedicine Service benefit provides coverage for Well360 Virtual Health services to most Highmark members with individual health plans and employer group coverage, both fully insured and self-insured.

Telemedicine coverage for services provided by Well360 Virtual Health is not available for members with Medicare supplemental plans, Medicare Carve Out, and Medicare Prime. Enhanced Services (Primary Care, Dermatology & Women's Health) are not available for Traditional, Comprehensive, or Indemnity plans.

Please Note: Certain self-insured employer groups will continue to retain Teledoc as their telemedicine vendor.

Using Availity® to Determine a Member's Coverage for Telemedicine Services

You can easily identify Highmark members with coverage for telemedicine services by our approved vendors by requesting the consultation benefit through **Eligibility and Benefits Inquiry** or by using **Additional Benefit Notes** in **Eligibility and Benefits Response**. If a member has coverage for telemedicine services, the Telemedicine benefit will indicate "Yes."

For More Information

To learn more about Amwell, visit amwell.com.

Important! Amwell is not available for providers in the New York service areas.

Additional Services Offered by Amwell

For providers in Delaware, Pennsylvania, and West Virginia

In addition to online consultations with Well360 Virtual Health powered by Amwell's nationwide network of providers, which are available to Highmark members through their Telemedicine Service benefit, as well as other benefits (see above), American Well offers an array of safe and secure HIPAA-compliant technology solutions for individual providers, group practices, and health care systems. These solutions allow providers to offer the convenience of a live, online virtual visit option for their own patients using the Amwell platform.

To learn more about the options American Well offers providers for use of their HIPAA-compliant technology platform, you can visit the Amwell website at business.americanwell.com.

Attention: Providers Using the Amwell Technology Platform for Their Private Practices

For providers in Delaware, Pennsylvania, and West Virginia

If you contract with American Well to provide an online virtual visit option for your patients using the Amwell technology platform, the agreement includes 24/7 support provided by Amwell's nationwide provider network, the "Online Care Group," whenever you/your staff are not available. Please keep in mind that Highmark member benefits may vary depending on who is actually performing the services:

- If you provide Virtual PCP Visits or Virtual Retail Clinic Visits to Highmark members, the services are eligible under the Highmark member's PCP/Physician Office or Retail Clinic benefits, as applicable.
- If primary care services are provided to a Highmark member by an Amwell Online Care Group provider, they are eligible under a Highmark member's Telemedicine Service benefit, if applicable.

As a result, the Highmark member's cost-sharing may vary depending on which provider performs the service — you or the Online Care Group. In addition, if the member does not have the Telemedicine Service benefit, as well as other benefits (see above), the services would not be covered when provided by an Online Care Group provider.

In your discussions with American Well, confirm that it will be clear to your patients **who is providing care** when they sign on for an online visit — you or the Online Care Group. In addition, educate your patients about your online access and availability, and ensure that your Highmark patients understand that their benefits/cost-sharing could differ if care is provided by the Online Care Group when you are not available.

Attention: Behavioral Health Providers

For providers in Delaware, Pennsylvania, and West Virginia

Virtual Behavioral Health visits, whether provided by you or by an Online Care Group provider, are subject to cost-sharing under the member's Outpatient Mental Health benefit; therefore, the member's cost-sharing is the same for services provided by you or by the Online Care Group. However, please remember that a Highmark member must have both the Telemedicine Service benefit and coverage for Outpatient Mental Health services for behavioral health visits provided by Amwell's Online Care Group.

Reminder: Most Highmark members have coverage for telemedicine services; however, benefits can vary by product and group. Always verify a member's benefits prior to providing service.

For More Information

Please see the applicable sections of this unit for more information on Highmark's benefit enhancements that provide coverage for Virtual PCP Visits and Virtual Retail Clinic Visits, Virtual Behavioral Health, Specialist Virtual Visits, and Teledermatology.

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2.5 Virtual PCP Visits and Virtual Retail Clinic Visits

For providers in Delaware, Pennsylvania, and West Virginia

Virtual PCP Visits and Virtual Retail Clinic Visits provide our network participating primary care providers with the option of delivering primary care services to our members via real-time interactive audio and video telecommunications, or "telemedicine," when appropriate. Telemedicine enables primary care providers to extend their reach and improve their efficiency and effectiveness while still maintaining high quality care and attention to patient safety.

Virtual PCP Visits and Virtual Retail Clinic Visits are the remote delivery of outpatient primary care services through the use of secure real-time interactive audio and video telecommunications technology.

A patient can participate in a virtual visit with a primary care provider from the privacy of their own home, office, or other private setting.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY), and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Why Virtual PCP Visits and Virtual Retail Clinic Visits?

For providers in Delaware, Pennsylvania, and West Virginia

Virtual PCP Visits and Virtual Retail Clinic visits are about more than convenience — it is about getting members the care they need when they need it.

Virtual PCP Visits and Virtual Retail Clinic Visits can provide expanded access to services, more efficient delivery of services, and also potential cost savings.

- Access to primary care can be increased for all members — especially for individuals with multiple chronic health conditions, those with severe illness and disability, and underserved populations in rural and remote areas.
- Virtual visits are a cost-effective way to engage with patients and deliver care anywhere, anytime, while reducing administrative costs for the provider and travel costs for the patient.
- Virtual PCP Visits and Virtual Retail Clinic Visits can be used to triage cases and help reduce emergency room visits and hospitalizations by diverting members to less costly forms of care.

Eligible Providers

For providers in Delaware, Pennsylvania, and West Virginia

Highmark participating primary care providers who have the required telecommunications technology to support Virtual PCP Visits and Virtual Retail Clinic Visits may participate. The services performed must

fall under the scope of the provider's license, and the sessions must be conducted following Highmark's service and security guidelines.

Providing Virtual PCP Visits and Virtual Retail Clinic Visits for Highmark members is optional and not a requirement of network providers.

Member Eligibility

For providers in Delaware, Pennsylvania, and West Virginia

Virtual PCP Visits and Virtual Retail Clinic Visits are available to most Highmark members with individual health plans and employer group coverage, both fully and self-insured, that include benefits for PCP/Physician Office Visits and/or Retail Clinic Visits. This is also available for Federal Employee Program (FEP) members.

Any member cost-sharing or visit limits under the PCP/Physician Office/Outpatient Visit benefits or the Retail Clinic benefit would apply. For example, if a member's benefit has a copay for a PCP visit, then the copay would be applied to Virtual PCP Visits.

Please consult coverage materials to determine eligibility for Medicare Advantage and Medicare Supplemental plans.

Reminder: Always Verify Benefits

For providers in Delaware, Pennsylvania, and West Virginia

Providers are reminded to always verify a member's eligibility and benefits prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service. You can verify benefits electronically quickly and easily via Availity's **Eligibility and Benefits Inquiry** or by submitting a HIPAA 270 transaction.

In Availity, use **Additional Benefit Notes** in **Eligibility and Benefits Response.**

If the member has coverage for Virtual PCP Visits and/or Virtual Retail Clinic Visits, the benefit category will indicate "Virtual Visits – Yes."

Important: Telemedicine Service Benefit Category is for Well360 Virtual Health and Teledoc Services Only

For providers in Delaware, Pennsylvania, and West Virginia

Virtual PCP Visits and Virtual Retail Clinic Visits are a service delivery option provided to our members under the PCP/Physician and Retail Clinic benefits. They are separate from the services provided by our approved telemedicine services vendors — Amwell and Teladoc, which are independent companies that provide online medical consultation services for patients through their network of practitioners.

In Availity's **Eligibility and Benefits Inquiry,** the "Telemedicine Service" benefit category under Professional Services is an indicator for **Well360 Virtual Health and Teladoc services only**. It does not indicate a member's eligibility for Virtual PCP Visits and Virtual Retail Clinic Visits. For more information on the services these vendors provide for Highmark members, please see the section in this unit titled **Telemedicine Service Benefit and Approved Vendors**.

Note: Highmark partners with Amwell to deliver Well360 Virtual Health, Highmark's virtual care solution.

Technology Requirements

For providers in Delaware, Pennsylvania, and West Virginia

The Virtual PCP Visits and Virtual Retail Clinic Visits must take place via real-time audio and video telecommunications. Interactive telecommunications technology must be multi-media communication that, at a minimum, includes audio and video equipment permitting real-time consultation among the patient location and provider location.

The provider must ensure that the aesthetic quality of the consultation is comparable to that of an in-person consultation (i.e., proper lighting, camera positioning, network connection, etc.). The provider's monitor resolution (matrix) must be a minimum of 512x512 at 8-bit pixel depth.

The technology needed by the member will be driven by the technology platform that the provider uses to conduct this service. Members can be at any location that they choose that is conducive for Virtual PCP Visits and Virtual Retail Clinic Visits, provided the member has access to both audio and video streaming technology. The member should be in a location that is private and away from distractions.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY), and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Security Guidelines

For providers in Delaware, Pennsylvania, and West Virginia

Virtual PCP Visits and Virtual Retail Clinic Visits must be conducted through real-time interactive audio and video telecommunications hardware and software that are HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliant.

Highmark supports the highest standards to protect the confidentiality of our members' information, but there may be risks in passing personal health information (PHI) virtually. Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any equipment and software used on either side of the virtual transmission.

Guidelines for Providing Services

For providers in Delaware, Pennsylvania, and West Virginia

Virtual visits are not intended to replace in-person visits and support; it is another care delivery option that can be used by primary care providers if they choose. The primary care provider can make the determination whether Virtual PCP Visits and Virtual Retail Clinic Visits are the right course of treatment for their patients. If you offer Virtual PCP Visits or Virtual Retail Clinic Visits but feel that it will not be the most effective approach for a patient, then you may refuse to see the patient virtually.

Virtual PCP Visits and Virtual Retail Clinic Visits can be conducted for initial, follow-up, or maintenance care; however, providers should give careful consideration in determining whether an in-person office visit

for the initial visit would be beneficial in establishing a doctor-patient relationship.

The following guidelines must be followed when conducting Virtual PCP Visits and Virtual Retail Clinic Visits:

- **Pennsylvania Only:** Any telecommunications technology used must provide both audio and video streams that meet Highmark's technology and security guidelines.
- **Delaware and West Virginia:** telemedicine can be delivered via a real time 2-way audio-only conversation in West Virginia (WV) and Delaware (DE) but in DE, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.
- All services provided must be medically necessary.
- Services performed must fall under the scope of the provider's licensure.
- Providers shall comply with local, state, and federal laws and other regulatory agency requirements.
- Mechanisms to ensure continuity of care, follow-up, and referrals for emergency services must be in place and transparent to patients. Telemedicine treatment and consultations, including the authorization and dispensing of prescription medication(s), shall be held to the same professional standards of appropriate medical practice as those in a traditional in-office face-to-face encounter.
- The provider must take the appropriate steps to establish a doctor-patient relationship and conduct all appropriate evaluations and history consistent with traditional standards.
- The provider must obtain all relevant medical information (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, and social history) prior to delivery of a medical diagnosis and treatment.
- Documentation of any visits using secure interactive audio and video telecommunications technology must be maintained in the patient's medical record as required with in-person diagnosis and treatment services.

Billing and Reimbursement

For providers in Delaware, Pennsylvania, and West Virginia

Claims for Virtual PCP Visits and Virtual Retail Clinic Visits are submitted based on how you are contracted with Highmark.

Reimbursement will be based on the plan allowance in place at the time services were rendered.

Member cost sharing (copay, deductible, and/or coinsurance) and visit limits apply if applicable.

For more information on billing and reimbursement, please see Highmark Reimbursement Policy RP-046: Telemedicine and Telehealth Services. Reimbursement policies are available on the Provider Resource Center under **Claims & Authorization,** and then **Reimbursement Policies,** and then choose **Reimbursement Policies.**

PCPs: Updating Your Information for the Online Provider Directory

For providers in Delaware, Pennsylvania, and West Virginia

If you are able to offer Virtual PCP Visits, you can have that noted in your practice information in the online Highmark Provider Directory. The Provider Directory is a valuable tool for our members to find providers who provide the services they need in locations convenient for them.

For instructions on reporting your ability to provide Virtual PCP Visits, please see the section in this unit on **Updating the Provider Directory for Virtual Services.**

Delaware House Bill 69

For providers in Delaware

In 2015, the State of Delaware enacted telemedicine legislation that provides coverage for the telemedicine services of most physicians and many other providers. For additional information, please see the section of this unit on the **Delaware Telemedicine Mandate – House Bill 69.**

West Virginia House Bill 2024

For providers in West Virginia

In 2021, the State of West Virginia enacted telemedicine legislation that amended and reenacted West Virginia Code (§33-57-1), defining telehealth services to include audio only telephone calls, requiring coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation, and requiring payment parity in accordance with the mandate. For additional information, please see **West Virginia Telemedicine Mandate – House Bill 2024.**

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2.5 Virtual Behavioral Health

The demand for behavioral health care services continues to steadily increase, while access to qualified behavioral health specialists remains limited. The growing demand often results in longer wait times for patients to receive treatment. However, telemedicine is now allowing behavioral health specialists to provide their expertise remotely, offering more flexibility and reducing the time it takes for patients to receive proper treatment. Effective for dates of service on and after January 1, 2015, Highmark will reimburse mental health providers for outpatient care delivery via Virtual Behavioral Health.

What is Virtual Behavioral Health?

Virtual behavioral health is the remote delivery of outpatient mental health services through the use of secure real-time interactive audio and video telecommunications technology. A patient can participate in a virtual visit with a behavioral health specialist from the privacy of their own home, office, or other private setting.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY), and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Why Virtual Behavioral Health?

Virtual behavioral health is about more than just convenience — it is about getting members the care that they need when they need it, or the care they are afraid to seek in person due to social stigma. It helps address barriers to access, stigma, and time constraints typically associated with mental health services. Virtual behavioral health can provide expanded access to services, more efficient delivery of services, and also potential cost savings.

- Access to mental health care can be increased for all patients but especially for individuals with multiple chronic health conditions, those with severe illness and disability, and underserved populations in rural and remote areas.
- Virtual visits can provide added comfort to patients who otherwise might be fearful and resistant to meet face-to-face in a clinic.
- Counseling and intervention services can be delivered more quickly via teleconferencing sessions versus on-site appointments that may take longer to arrange.
- Virtual visits are a cost-effective way to engage with patients and deliver care anywhere, anytime while reducing administrative costs for the provider and travel costs for the patient.
- Virtual behavioral health visits can be used to conduct psychiatric consultations to triage cases and help reduce emergency room visits and hospitalizations by diverting clients to less costly forms of care.

Eligible Providers

Any Highmark participating mental health provider who has the necessary telecommunications technology to support a virtual outpatient mental health visit may participate. The services performed must fall under the scope of the provider's license, and the sessions must be conducted following Highmark's recommended service and security guidelines. Providing virtual behavioral health visits for Highmark members is optional and not a requirement.

Member Eligibility

Virtual behavioral health is available to most Highmark members with individual health plans and employer group coverage, both fully and self-insured, that include an **Outpatient Mental Health benefit.** **Please Note:** If a member's group plan does not include or carves out mental health benefits to a vendor, then Highmark's virtual behavioral health coverage would not apply to the member.

Any member cost-sharing under the **Outpatient Mental Health** benefit would apply. For example, if a member's benefit plan has a copay for an outpatient mental health visit, the copayment will apply to virtual behavioral health services.

Virtual behavioral health services are not available for members with Medicare supplemental plans.

Note: This is also available for Federal Employee Program (FEP) members.

Important: Telemedicine Service Benefit Category is for Well360 Virtual Health and Teledoc Services Only

Virtual behavioral health is a service delivery option provided to our members under the **Outpatient Mental Health benefit.** It is separate from the services provided by our approved vendors — Amwell and Teladoc — under the Telemedicine Service benefit. Amwell and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In Availity's **Eligibility and Benefits Inquiry,** the "Telemedicine Service" benefit category under Professional Services is an indicator for **Well360 Virtual Health and Teladoc services only.** It does not indicate a member's eligibility for virtual behavioral health services. For more information on the services these vendors provide for Highmark members, please see the section in this unit titled **Telemedicine Service Benefit and Approved Vendors.**

Note: Highmark partners with Amwell to deliver Well360 Virtual Health, Highmark's virtual care solution.

Important!

For providers in New York

Amwell and Teladoc are not available for behavioral health providers in the New York service areas.

Reminder: Always Verify Benefits

Providers are reminded to always verify a member's eligibility and benefits prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service. You can verify benefits electronically quickly and easily via Availity's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

Technology Requirements

The virtual behavioral health visit must take place via real-time interactive video and audio telecommunications. Interactive telecommunications technology must be multi-media communication that, at a minimum, includes audio and video equipment permitting real-time consultation among the patient location and provider location.

The provider must ensure that the aesthetic quality of the consultation is comparable to that of an in-person consultation (i.e., proper lighting, camera positioning, network connection, etc.). The provider's monitor resolution (matrix) must be a minimum of 512x512 at 8-bit pixel depth.

The technology needed by the member will be driven by the technology platform that the provider uses to conduct this service. Members can be at any location that they choose that is conducive for virtual behavioral health visits, provided the member has access to both audio and video streaming technology. The member should be in a location that is private and away from distractions.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY) and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Security Guidelines

Virtual behavioral health visits must be conducted through real-time interactive audio and video telecommunications hardware and software that are HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliant.

Highmark supports the highest standards to protect the confidentiality of our members' information, but there may be risks in passing personal health information (PHI) virtually. Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any of the equipment and software used on either side of the virtual transmittal.

Guidelines for Providing Services

Virtual visits are not intended to replace in-person visits and support; it is another care delivery option that can be used by mental health providers if they choose. The provider can make the determination whether a virtual behavioral health visit is the right course of treatment for their patients. The mental health provider must determine what channel of care is the best for their patient. If you offer virtual behavioral health services but feel that it will not be the most effective approach for a patient, then you may refuse to see the patient virtually.

Virtual behavioral health visits can be conducted for initial, follow-up, or maintenance care; however, providers should give careful consideration in determining whether an in-person office visit for the initial visit would be beneficial in establishing a doctor patient relationship.

The following guidelines must be followed when conducting virtual behavioral health visits:

Any telecommunications technology used must provide both audio and video streams that meet Highmark's technology and security requirements.

- All services provided must be medically appropriate and necessary.
- Services performed must fall under the scope of the provider's licensure.
- Providers shall comply with local, state, and federal laws and other regulatory agency requirements.
- Telemedicine treatment and consultations, including the authorization and dispensing of prescription medication(s), shall be held to the same professional standards of appropriate medical practice as those in a traditional in-office face-to-face encounter.
- The provider must take the appropriate steps to establish a doctor-patient relationship and conduct all appropriate evaluations and history consistent with traditional standards.
- The provider must have all of the relevant medical information (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, and social history) to deliver a competent medical diagnosis, treatment, and counseling plan.
- Documentation of the real-time interactive audio and video telecommunication relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY) and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Billing and Reimbursement

Reimbursement for virtual behavioral health service is based on the fee schedule in place on the date of service and is subject to any applicable member cost-sharing (copay, deductible, and/or coinsurance).

For more information on billing and reimbursement, please see Highmark Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services. Reimbursement policies are available on the Provider Resource Center under **Claims & Authorization,** and then **Reimbursement Programs,** and then choose **Reimbursement Policies.**

Updating Your Information for the Online Provider Directory

If you offer virtual behavioral health services, you can have that noted in your practice information in the online Highmark Provider Directory. The Provider Directory is a valuable tool for our members to find providers who provide the services they need in locations convenient for them. For instructions on reporting your ability to provide virtual behavioral health services, please see the section in this unit on **Updating the Provider Directory for Virtual Services.**

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2.5 Specialist Virtual Visit

Telemedicine is defined as the exchange of medical information between sites via electronic communication for transmitting clinical information for diagnostic, monitoring, and therapeutic purposes. The term “telehealth” is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing.

An enhancement to the specialist visit benefit provides Highmark members with coverage for outpatient “virtual” visits with specialists using telecommunications technology. This “specialist virtual visit” benefit enhancement provides coverage for specialist services for members who do not have readily available access to such specialty services.

What is a Specialist Virtual Visit?

The specialist virtual visit is an outpatient telehealth service that is a real-time interactive audio and video transmission of a physician-patient encounter from one site to another using telecommunications technology.

The patient is located at an “originating site.” An originating site can be a **medical site** (e.g., PCP’s office, outpatient facility) or a **non-medical site** (e.g., member’s home or office) and is connected to a specialist

at a “distant site.” The benefit provides coverage for the services of the specialist at the distant site and also for an access fee billed by the **medical originating site** where the patient is located, when applicable.

Applicable Products

The specialist virtual visit benefit enhancement is applicable to all Highmark group products and to most individual products.

This benefit enhancement **does not apply** to the following:

- Medicare supplemental products in all service areas
- Individual HMO product available in Pennsylvania’s Western Region
- Complete Care in Pennsylvania

Verifying Member Eligibility

Participating providers should use **Eligibility and Benefits Inquiry** in Availity to verify a member’s coverage for specialist virtual visits. If Availity is not available, please call the Provider Service Center.

Important: Telemedicine Service Benefit Category is for Well360 Virtual Health and Teledoc Services Only

Specialist virtual visits are a benefit enhancement and separate from the services provided by our approved vendors — Amwell and Teladoc — under the Telemedicine Service benefit. Amwell and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In Availity's **Eligibility and Benefits Inquiry**, the "Telemedicine Service" benefit category under Professional Services is an indicator for **Well360 Virtual Health and Teladoc services only**. It does not indicate a member’s eligibility for specialist virtual visits. For more information on the services these vendors provide for Highmark members, please see the section in this unit titled **Telemedicine Service Benefit and Approved Vendors.**

Note: Highmark partners with Amwell to deliver Well360 Virtual Health, Highmark’s virtual care solution.

Important! (NY Only)

For providers in New York

Amwell is not available for providers in the New York service areas.

Requirements

The specialist virtual visit benefit enhancement provides coverage for outpatient specialist services for members who do not have readily available access to such specialty services. When a covered benefit, evaluation and management and consultation services that occur with the specialty physician using telecommunications technology may be covered under the following conditions:

- Any telecommunications technology **must provide both audio and video streams** that meet Highmark's technology and security requirements;
- When applicable, at a medical originating site, the medical examination of the patient at the originating site must be under the control of the specialty practitioner at the distant site;
- All services provided must be medically appropriate and necessary;
- Services performed must be under the scope of the provider's licensure;
- Providers shall comply with local, state, and federal laws and other regulatory agency requirements;
- Mechanisms to ensure continuity of care, follow-up, and referrals for emergency services must be in place and transparent to patients;
- The specialist consultation must take place via real-time interactive audio and video telecommunications technology. Interactive telecommunications systems must be multi-media communication that, at a minimum, include audio and video equipment permitting real-time consultation; Documentation of the real-time interactive audio and video telecommunication relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record;
- A designated room with appropriate equipment, including camera, lighting, transmission, and other needed electronics and the appropriate medical office amenities is established in both the medical originating site, when applicable, and the distant site.
- Telemedicine treatment and consultations, including the authorization and dispensing of prescription medication(s), shall be held to the same professional standards of appropriate medical practice as those in a traditional in-office face-to-face encounter.

- The provider must take the appropriate steps to establish a doctor-patient relationship and conduct all appropriate evaluations and history consistent with traditional standards; • The provider must have all of the relevant medical information (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, and social history) to deliver a competent medical diagnosis, treatment, and counseling plan.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY) and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Reminder: Directing Care to Network Providers

Providers are reminded that members will receive the highest level of benefits if the specialist involved in the specialist virtual visit is a participating Highmark network provider and, when applicable, is in the highest benefit tier. Depending on their benefit plan, some members may not receive coverage for services provided by an out-of-network specialist or may be responsible for higher cost- sharing amounts for services provided by an out-of-network specialist.

As a participating provider, you should direct members to other providers who participate in the network associated with the member's benefit plan. If a recommended specialist is not participating in the network associated with the member's benefit plan, the member must be notified in advance that a non-participating provider is not obligated to follow Highmark contractual guidelines and services could result in higher out-of-pocket expenses for the member.

Security Guidelines

Specialist virtual visits must be conducted through interactive audio and video telecommunications hardware and software that are HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliant, which must be certified by your technology platform vendor. The provider is responsible for ensuring that the aesthetic quality of the consultation is comparable to that of an in-person consultation (e.g., proper lighting, camera positioning, network connections, etc.).

Highmark supports the highest standards to protect the confidentiality of our members' information, but there may be risks in passing personal health information (PHI) virtually. Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any of the equipment and software used on either side of the virtual transmittal.

Important!

For providers in Delaware, New York, and West Virginia

Telemedicine can be delivered via a real time 2-way audio-only conversation in Delaware (DE), New York (NY) and West Virginia (WV) but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.

Originating Site Billing and Reimbursement

The originating site is the location of an eligible member at the time the evaluation or consultation service is being provided via a specialist virtual visit. The originating site can be either a **medical site** or a **non-medical site.**

Only a **medical originating site** **(e.g., PCP's office, outpatient facility) is eligible for an access fee.** Claims for the medical originating site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837). No other fees may be billed to either Highmark or to the member by the medical originating site and all contractual member hold harmless requirements shall apply.

Reimbursement will be based on the fee schedule in place at the time the services were rendered. The member will be responsible for applicable cost-sharing (deductible and/or coinsurance) according to their benefit plan.

Distant Site Billing and Reimbursement

The distant site is the location where the specialist rendering the professional service is located. Highmark will accept only a professional claim (1500 Claim Form/837P) for the specialist's evaluation/assessment services provided at the distant site.

Reimbursement will be based on the fee schedule in place at the time the services were rendered. Highmark will not accept or reimburse claims submitted for an access fee by the distant site. Member cost-sharing (copay, deductible, and/or coinsurance) will apply if applicable.

For More Information

For more information on billing and reimbursement for the originating and distant sites, please see Highmark Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services. Reimbursement policies are available on the Provider Resource Center under **Claims & Authorization,** and then **Reimbursement Programs,** and then choose **Reimbursement Policies.**

Updating Your Information for the Online Provider Directory

If you offer Specialist Virtual Visits, you can have that noted in your practice information in the online Highmark Provider Directory. The Provider Directory is a valuable tool for our members to find providers who provide the services they need in locations convenient for them.

For instructions on reporting your ability to provide Specialist Virtual Visits, please see the section in this unit on **Updating the Provider Directory for Virtual Services.**

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2.5 Teledermatology

The demand for access to dermatologists continues to steadily increase. However, patients in need of skin care often wait a long time for a face-to-face office appointment with a board-certified dermatologist. In some instances, the wait could result in delays in treatment of serious conditions such as skin cancer.

Highmark is committed to expanding access to quality care for our members. In order to provide faster and more convenient access to dermatologists for our members, teledermatology services are eligible for reimbursement for most Highmark members.

What is Teledermatology?

Teledermatology is the use of secure telecommunications technology to deliver dermatologic services and clinical information remotely. It uses technology that allows the patient to send digital images and personal information to the consulting dermatologist.

The dermatologist views the images and reviews the information provided by the patient to determine if the patient can be treated virtually. Patients for whom the diagnosis remains unclear or who have potentially serious conditions can be scheduled for an in-person office visit.

Teledermatology is not intended to replace an in-person doctor's visit and support. Rather, Highmark wants members to have access to the care they need, when then need it -- before their situation could turn into something more serious and costly. There may, however, be situations in which teledermatology is not right for the member's condition and this would need to be determined by the physician.

Benefits of Teledermatology for Physicians and Members

With secure technology, physicians are able to provide their expertise online and offer more flexibility to our members and reduce the time it takes to receive treatment. Many minor skin conditions can be safely diagnosed and treated virtually while serious cases requiring immediate in-person care can be identified more quickly.

For our members, the availability of virtual visits can eliminate the extended wait time for in-office visits and can significantly enhance access to dermatologic care. Members can get care when it is more convenient without having to miss work, school, or other activities. They can conduct a visit from the comfort of their home while allowing the dermatologist to use office visits for more critical cases.

Member Eligibility

Teledermatology is available to most Highmark members with individual health plans and both fully insured and self-insured employer group coverage. A **Specialist Office Visit**, which is eligible under most benefit plans, must be a covered service for a member to have coverage for teledermatology services.

Any member cost-sharing under the Specialist Office Visit benefit would apply. For example, if a member's benefit plan has a copay for a **Specialist Office Visit**, the copayment will be applied to teledermatology services.

Teledermatology is not available for members with Medicare supplemental plans.

Note: This is also available for Federal Employee Program (FEP) members.

Important: Telemedicine Service Benefit Category is for Well360 Virtual Health and Teledoc Services Only

Teledermatology is a service delivery option provided to our members under the **Specialist Office Visit** benefit. It is separate from the services provided by our approved vendors — Amwell and Teladoc — under the Telemedicine Service benefit. Amwell and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In Availity's **Eligibility and Benefits Inquiry,** the "Telemedicine Service" benefit category under Professional Services is an indicator for **Well360 Virtual Health and Teladoc services only.** It does not indicate a member's eligibility for teledermatology services. For more information on the services these vendors provide for Highmark members, please see the section in this unit titled **Telemedicine Service Benefit and Approved Vendors.**

Note: Highmark partners with Amwell to deliver Well360 Virtual Health, Highmark's virtual care solution.

Technology Requirements

Teledermatology services must be provided using store and forward technology. Store and forward is secure technology (HIPAA & HITECH compliant) that allows a member to log in to an online site, enter medical history, explain the medical issue, upload images, submit the request to a doctor, and receive an electronic response from the doctor.

Requirements for store and forward technology to be used for providing teledermatology services are outlined in Highmark Medical Policy Z-70. Highmark's medical policies are accessible on the Provider Resource Center in the main menu at the top of the page under **Policies & Programs,** and then **Medical Policies.**

Security Requirements

Teledermatology visits must be conducted through store-and-forward (asynchronous conferencing) hardware and software that are HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliant.

Highmark supports the highest standards to protect the confidentiality of our members' information, but there may be risks in passing personal health information (PHI) virtually. Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any of the equipment and software used on either side of the virtual transmittal.

Guidelines for Providing Services

Providing teledermatology services for Highmark members is optional and not a requirement. Any Highmark dermatologist who has the necessary technology to support secure online service delivery may participate as long as they follow Highmark's recommended guidelines for service and security.

Teledermatology services must be provided by dermatologists and services performed must fall under the scope of the provider's licensure. In addition, the following guidelines must be followed:

- The provider must take the appropriate steps to establish a doctor-patient relationship and conduct all appropriate evaluations and history consistent with traditional standards.
- All services provided must be medically necessary and appropriate.
- Providers shall comply with local, state, and federal laws and other regulatory agency requirements. Telemedicine treatment and consultations, including the authorization and dispensing of prescription medication(s), shall be held to the same professional standards of appropriate medical practice as those in a traditional in-office face-to-face encounter.
- Mechanisms to ensure continuity of care, follow-up, and referrals for emergency services must be in place and transparent to patients.
- The provider must have all of the relevant medical information (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, and social history combined with the appropriate review of high-quality digital images (serving as the physical examination) to deliver a competent medical diagnosis, treatment, and counseling plan.
- Documentation of online secure store and forward communications (asynchronous conferencing) relevant to the ongoing medical care of the patient and the downloaded image of the patient's medical issue should be maintained as part of the patient's medical record.
- Digital image(s) used should be a minimum of 800 X 600 pixel (480,000) resolution.
- Online platforms should maintain accurate and transparent information about their website, the owner(s)/operator(s), location, and contact information.

Billing and Reimbursement

Reimbursement will be based on the fee schedule in place at the time services were rendered. Member cost-sharing (copay, deductible, and/or coinsurance) would apply if applicable.

For more information on billing and reimbursement, please see Highmark Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services. Reimbursement policies are available on the

Provider Resource Center under **Claims & Authorization**, and then **Reimbursement Programs**, and then choose **Reimbursement Policies**.

Updating Your Information for the Online Provider Directory

If you offer teledermatology services, you can have that noted in your practice information in the online Highmark Provider Directory. The Provider Directory is a valuable tool for our members to find providers who provide the services they need in locations convenient for them.

For instructions on reporting your ability to provide teledermatology services, please see the section in this unit on **Updating the Provider Directory for Virtual Services.**

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2.5 Updating the Provider Directory for Virtual Services

The Highmark Provider Directory located on each of our public websites is a fast, easy way for our members to find providers near their homes or their workplace. And it is a valuable tool that offers your current and potential patients important details about your practice, including office location, hours of operation, parking availability, and nearby public transit information.

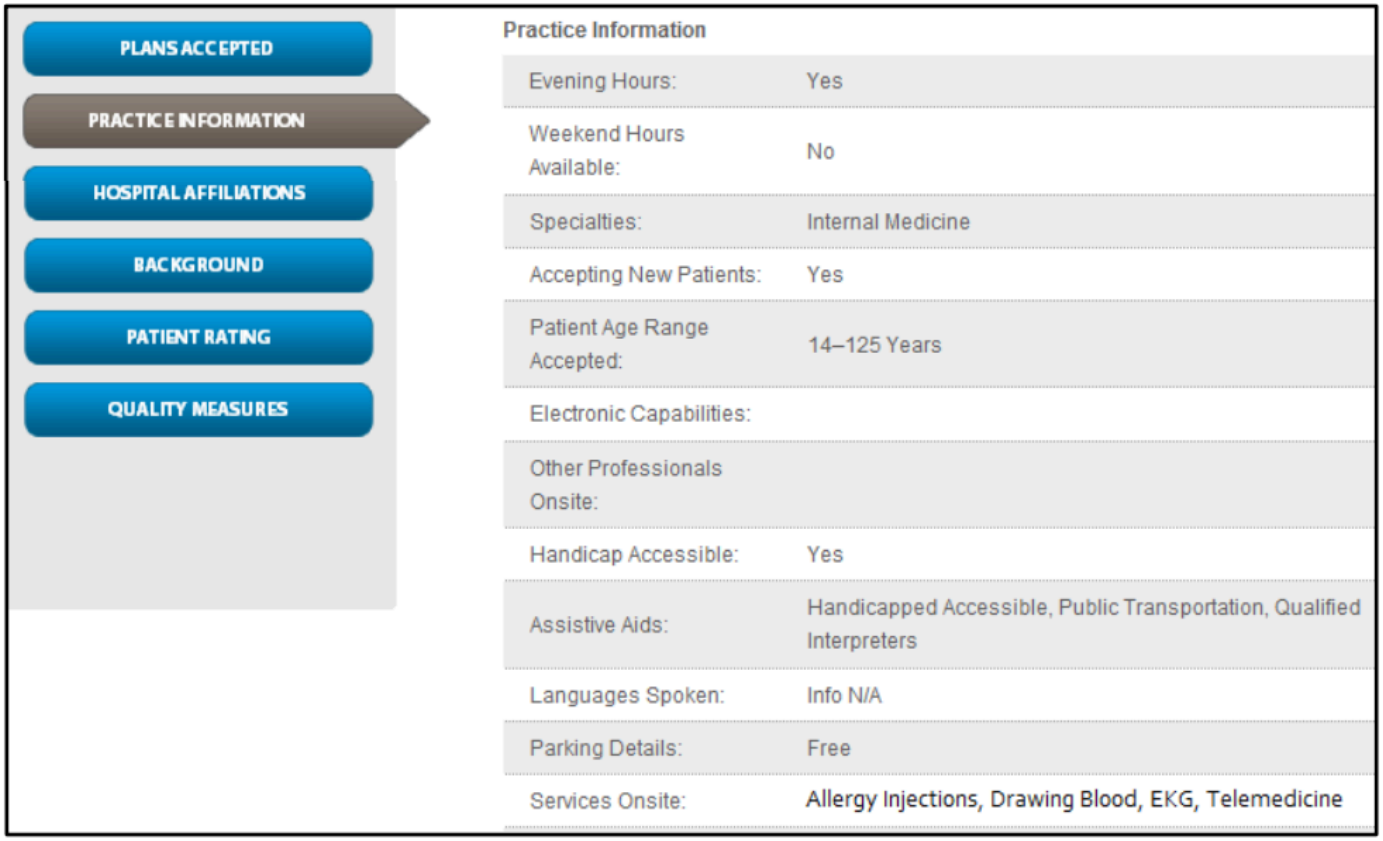
The online Provider Directory can also indicate if you are able to offer the “virtual” telemedicine services as described in this unit (Virtual PCP Visits; Virtual Behavioral Health; Specialist Virtual Visit; Teledermatology; and for providers located in Delaware, telemedicine services as applicable under Delaware House Bill 69 and Delaware House Bill 160). This is self-reporting and up to you to supply us with this information.

Updating Your Practice Information via Availity

If you are able to provide virtual visits/telemedicine services, you can notify Highmark by updating your practice information via Availity. Select **Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only)** in Availity's Payer Spaces.

Once your files are updated, your listing in the online Provider Directory will be updated to indicate that you can provide telemedicine services. Here is an example of how this would display in Practice

Information in your file of the Provider Directory:



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2.5 Delaware Telemedicine Mandate – House Bill 69

For providers in Delaware

In addition to the telemedicine programs discussed in the previous sections of this unit, effective January 1, 2016, Highmark Blue Cross Blue Shield (DE) will also provide coverage for the services of most physicians and many other providers performed via telemedicine. House Bill 69, now Delaware law, requires that insured members are covered for telemedicine services on the same basis as an in-person visit to their provider.

This new law affects all fully insured commercial group and individual health care plans. Self- insured employer groups may or may not elect to provider coverage.

Note: Medicare supplemental plans are exempt from this law.

Key Definitions Under Delaware House Bill 69

Telemedicine is a form of telehealth, which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

- **Distant site** – a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.
- **Originating site** – a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.
- **Store and forward transfer** – the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Applicable Products

Delaware House Bill 69 is applicable to all fully insured Highmark commercial group and individual products. Self-insured clients may or may not elect to provide coverage.

This benefit enhancement does not apply to Medicare supplemental products in Delaware.

REMINDER: Always verify benefits

Providers are reminded to always verify a member's eligibility and benefits prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

You can verify benefits electronically quickly and easily via Availity's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction. If Availity is not available, please call the Highmark Blue Cross Blue Shield (DE) Provider Service Center.

Highmark Blue Cross Blue Shield (DE) members can be directed to call the Member Services telephone number on their ID cards to inquire about coverage under their benefit plan.

Non-Covered Services

Services that are not covered include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, Skype, instant messaging, and email
- Provider-to-provider consultations, provider-to-provider telephone conversations, facsimile, or email communications

Security Guidelines

Services conducted through real-time interactive audio and video telecommunications (or via a real time 2-way audio-only conversation if the patient is not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection) or Store and Forward technology must use hardware and software that are HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliant.

Highmark Blue Cross Blue Shield (DE) supports the highest standards to protect the confidentiality of our members' information, but there may be risks in passing personal health information (PHI) virtually. Highmark Blue Cross Blue Shield (DE) is not responsible for the security of telemedicine communication and does not validate the safeguards of any of the equipment and software used on either side of the virtual transmission.

Guidelines for Providers

Services eligible under Delaware House Bill 69 are not intended to replace in-person visits. Providers should give careful consideration in determining whether an in-person office visit for the initial visit would be appropriate and beneficial.

The provision of telemedicine services is optional and not a requirement of network providers. Eligible Highmark Blue Cross Blue Shield (DE) providers with the appropriate technology must follow the

additional guidelines below:

- Provider must take the appropriate steps to establish a doctor-patient relationship and conduct all appropriate evaluations and history consistent with traditional standards.
- All services provided must be medically necessary and appropriate.
- Services performed must fall under the scope of the provider's licensure.
- Providers shall comply with local, state, and federal laws and other regulatory agency requirements.
- Telemedicine treatment and consultations, including the authorization and dispensing of prescription medication(s), shall be held to the same professional standards of appropriate medical practice as those in a traditional in-office face-to-face encounter.
- Mechanisms to ensure continuity of care, follow-up, and referrals for emergency services must be in place and transparent to patients.
- Provider must obtain all relevant medical information (e.g., patient demographic information, chief complaint, history of present illness, allergies, medications, past medical/surgical/family history, and social history) combined with the appropriate review of high-quality digital images (if applicable) prior to delivery of medical diagnosis and treatment.
- Documentation of the telemedicine service must be maintained in the patient's medical record, as with in-person diagnosis and treatment services.

Telemedicine services are not covered when the above criteria are not met. A participating, preferred, or network provider can bill the member for the non- covered service.

Billing and Reimbursement

Reimbursement for all services will be based on the fee schedule in place at the time services were rendered. Member cost-sharing (copay, deductible, and/or coinsurance) and service limits will apply if applicable.

For more information on billing and reimbursement, please see Highmark Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services. Reimbursement policies are available on the Provider Resource Center in the main menu at the top of the page under **Claims & Authorization**, and then **Reimbursement Programs**, and then choose **Reimbursement Policies**.

Updating Your Information for the Online Provider Directory

If you offer telemedicine services, you can have that noted in your practice information in the online Highmark Delaware Provider Directory. The Provider Directory is a valuable tool for our members to find providers who provide the services they need in locations convenient for them.

For instructions on reporting your ability to provide telemedicine services, please see the section in this unit on Updating the **Provider Directory For Virtual Services.**

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2.5 West Virginia Mandate – House Bill 2024

For providers in West Virginia

Providers who are licensed, in good standing in all states in which he or she is licensed, and not currently under investigation or subject to an administrative complaint; and registered as an interstate telehealth practitioner with the appropriate board in West Virginia are able to provide telehealth services when the health care practitioner-patient relationship is established.

The standard of care for the provision of telehealth services requires the patient visits an in-person health care practitioner within 12 months of using the initial telemedicine service or the telemedicine service will no longer be available to the patient until an in-person visit is obtained. Providers can use their discretion to suspend this requirement on a case-by-case basis.

This does not apply to the following services:

- Acute inpatient care,
- Post-operative follow-up checks,
- Behavioral medicine,
- Addiction medicine, or
- Palliative care.

Telemedicine Medical Records

The patient record established during the use of telemedicine technologies must be accessible and documented for both the provider and the member, consistent with the laws and legislative rules

governing patient health care records. All laws governing the confidentiality of health care information and governing patient access to medical records apply to records of practice of medicine or podiatry provided through telemedicine technologies. A provider solely providing services using telemedicine technologies must make documentation of the encounter easily available to the patient, and subject to the patient's consent, to any identified care provider of the patient.

Establishing a Patient-Physician Relationship

If an existing provider-member relationship does not exist prior to the utilization of telemedicine or if services are rendered solely through telemedicine, the relationship may only be established:

- Through the use of telemedicine technologies which incorporate interactive audio using store and forward technology, real-time videoconferencing, or similar secure video services during the initial physician-patient or podiatrist-patient encounter;
- For the practice of pathology and radiology, a physician-patient relationship may be established through store and forward telemedicine or other similar technologies; or
- Through the use of audio-only calls or conversations that occur in real time. Patient communication though audio-visual communication is preferable, if available or possible.

Telemedicine Medical Records

The patient record established during the use of telemedicine technologies must be accessible and documented for both the provider and the member, consistent with the laws and legislative rules governing patient health care records. All laws governing the confidentiality of health care information and governing patient access to medical records apply to records of practice of medicine or podiatry provided through telemedicine technologies. A provider solely providing services using telemedicine technologies must make documentation of the encounter easily available to the patient, and subject to the patient's consent, to any identified care provider of the patient.

Prescribing Medication via Telehealth

Providers may not prescribe controlled substances listed in Schedule II of the Uniform Controlled Substances Act to members who they see solely through telemedicine. This includes:

- Pain-relieving controlled substance listed in Schedule II of the Uniform Controlled Substance Act as part of a course of treatment for chronic nonmalignant pain solely based upon a telemedicine
- Drugs with the intent of causing an abortion

The prescribing limitations do not apply when:

- A physician is providing treatment to patients who are minors, or if 18 years of age or older, who are enrolled in a primary or secondary education program and are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism, or a traumatic brain injury in accordance with guidelines as set forth by organizations such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, or the American Academy of Pediatrics. In these cases, providers must maintain records supporting the diagnosis and the continued need of treatment.
- Submits an order to dispense a controlled substance listed in Schedule II of the Uniform Controlled Substances Act to a hospital patient for immediate administration in a hospital.

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2.5 Telestroke (DE, PA and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

What is Telestroke?

A telestroke service is a consultative modality that facilitates care for patients with acute stroke in a hospital emergency department by a vascular neurologist at stroke centers. These services are provided through telemedicine in the form of real-time video-conferencing for timely consultations with a vascular neurologist.

Telestroke services operate on a "hub and spoke" model allowing community hospitals that lack comparable staffing as larger urban hospitals and academic medical centers to access the expertise of the stroke centers and provide enhanced stroke care.

Applicable Products

The telestroke benefit enhancement applies to all eligible Highmark members with Commercial coverage.

Hub and Spoke

The "hub" is considered the specialist, the vascular neurologist at the stroke center. They are able to visualize real-time video feeds and conduct examinations of patients experiencing stroke-like symptoms from various emergency departments that represent the "spoke" via a video-conference link.

Originating Site Billing and Reimbursement

When a "spoke" facility is providing a telestroke service via a telecommunications system, they are to use HCPCs code Q3014 (telehealth originating site facility code) to bill for the technical services, along with Revenue Code 0780 with a stroke diagnosis.

Always check Medical Policy!

Medical Policy includes medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. For guidelines for telestroke services, please see **Highmark Medical Policy Z-65: Telestroke.**

Highmark's medical policies are accessible on the Provider Resource Center in the main menu at the top of the page under **Policies & Programs**, and then **Medical Policies**.

Verify Eligibility

Providers are reminded to always verify a member's eligibility and benefits prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

You can verify benefits electronically quickly and easily via Availity's Eligibility and Benefits Inquiry or by submitting a HIPAA 270/271 transaction.

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2.5 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 6: The BlueCard® Program

2.6 Introduction

The 35 independent, community-based and locally operated Blue Cross and Blue Shield companies and the Blue Cross and Blue Shield Association (BCBSA) comprise the Blue Cross and Blue Shield System, the nation's oldest and largest family of health benefits companies. The Blues cover 100 million Americans in all 50 states, the District of Columbia, and Puerto Rico. Nationwide, more than 96% of hospitals and 91% of professional providers contract with the Blue System — more than any other health insurer.

Offering a variety of products, programs, and services to all segments of the population, the Blues cover large employer groups, small business, and individuals. Moreover, the Blues have enrolled more than half of all U.S. federal workers, retirees, and their families, making the Federal Employee Program (FEP) the largest single health plan group in the world.

As a participating provider of Highmark, you may render services to patients who are members of other Blue Plans traveling to or living in Pennsylvania, Delaware, and West Virginia.

This unit describes the BlueCard Program and its advantages, and provides information to make filing claims easy. You will find helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining precertifications/preauthorizations
- Filing claims
- Who to contact with questions

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2.6 What is the BlueCard Program?

BlueCard® is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the independent Blue Cross Blue Shield (BCBS) Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Highmark is your sole contact for claim submission, payment, adjustments, and issue resolution.

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Highmark. Highmark will be your one point of contact for all of your claims-related questions.

Always look to Highmark first when you need help with information about out-of- area members. We are committed to meeting your needs and expectations. In doing so, your out-of-area Blue Plan patients will have a positive experience with each visit.

Highmark Networks Supporting BlueCard

The BlueCard Program is supported by Highmark's networks as follows:

Delaware

The Delaware Provider Network supports the BlueCard Program.

New York

- **Northeastern New York:** Northeastern New York Provider Networks support the BlueCard Program.
- **Western New York:** Western New York Provider Networks support the BlueCard Program.

Pennsylvania

Participating Provider Network: Supports all BlueCard programs for members with traditional, POS, or HMO coverage who are traveling or living outside of their Blue Plan's service area.

Keystone Health Plan West (KHPW)*: The KHPW network supports the BlueCard PPO programs in the 29-county Western Region of Pennsylvania for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.

Premier Blue Shield Network: The Premier Blue Shield Network supports the BlueCard PPO programs in all other Highmark service areas in Pennsylvania for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.

**Keystone Health Plan West is Highmark's managed care provider network in the 29-county Western Region of Pennsylvania.*

West Virginia

- **Indemnity Network:** Supports the BlueCard programs for members with traditional or HMO coverage who are traveling or living outside of their Blue Plan's area.
- **Preferred Provider Organization (PPO) Network**: Supports the BlueCard PPO programs for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.
- **Point of Service (POS) Network:** Supports the BlueCard POS programs for members in a POS plan who are traveling or living outside of their Blue Plan's service area.

BlueCard Program Exclusions

Claims for the following products are excluded from the BlueCard Program:

- Stand-alone dental
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Vision delivered through an intermediary model (using a vendor)
- The Federal Employee Program (FEP)*
- Medicare Advantage**

*For more information on FEP, please visit the manual's Chapter 2.3: Other Government Programs and for billing tips, see Chapter 6.4: Professional (1500/837P) Reporting Tips.

Medicare Advantage is a separate program from BlueCard and delivered through its own centrally administered platform; however, since you may see members of other Blue Plans who have Medicare Advantage coverage, Medicare Advantage information is available in this unit.

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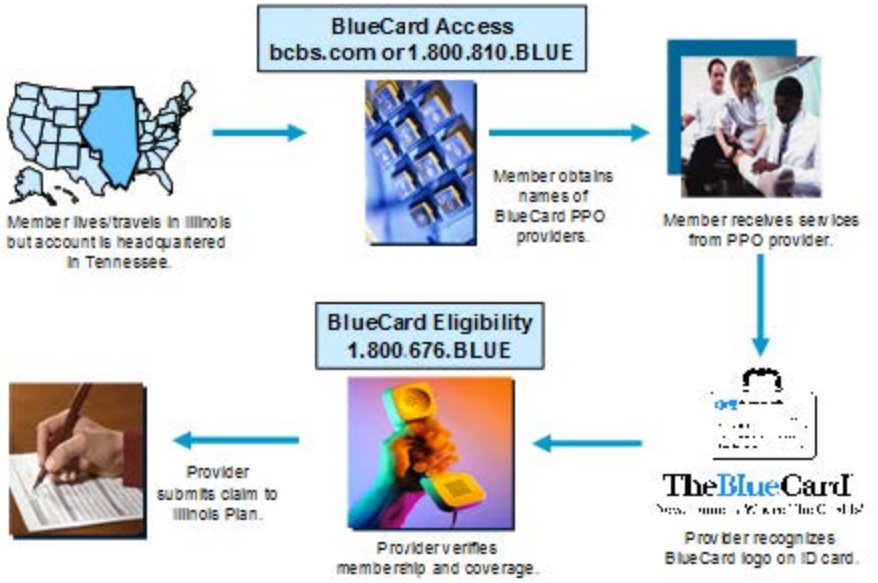
2.6 How the Program Works: An Example

The following diagram illustrates how the BlueCard® program works. In this example, a member with coverage through BlueCross BlueShield of Tennessee is seeking services in Illinois.



There are two scenarios where a Tennessee member might need to see a provider in the Illinois Blue Plan's service area:

1. If the Tennessee member was traveling in Illinois; or
2. If the member resides in Illinois and has employer-provided coverage through BlueCross BlueShield of Tennessee.

How the Member Can Find Participating Providers

In either scenario above, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access Line at 800-810-BLUE (2583).

The member also can obtain information online by using the BlueCard National Doctor and Hospital Finder available at bcbs.com.

Note: Although members are not obligated to identify participating providers through either of these methods, it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits.

How a Provider Verifies the Member's Eligibility and Benefits

When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at 800-676-BLUE (2583).

The provider may also obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois

Claim Submission and Payment

After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. The Illinois Blue Plan forwards the claim internally to BlueCross BlueShield of Tennessee.

The Tennessee Blue Plan adjudicates the claim according to the member's benefits and the provider's arrangement with the Illinois Plan. This information is sent back to Blue Cross and Blue Shield of Illinois.

When the claim is finalized, the Tennessee Plan issues an explanation of benefit (EOB) to its member. The Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.

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2.6 How to Identify BlueCard Members

When members of out-of-area Blue Plans arrive at your office, be sure to ask them for their current Blue Plan membership identification card. The card will display the member's identification number.

Important facts concerning Member IDs:

- The main identifier for out-of-area members is the prefix.
- A correct Member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numerals/letters following the prefix.
- Do not add/delete characters or numerals within the Member ID.
- Do not make up prefixes.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

Do not assume that the member's ID number is the social security number. All Blue Plans have replaced social security numbers on Member ID cards with an alternate, unique identifier.

Note: Members who are part of the Blue Cross Blue Shield Federal Employee Program (FEP), which is excluded from BlueCard, will have the letter "R" in front of their Member ID number instead of a 3-character prefix.

Prefix (Formerly "Alpha Prefix")

The 3-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

The 3-character prefix has historically been an "alpha prefix" – with all alpha characters. Beginning in 2018, the Blue Cross Blue Shield Association (BCBSA) issued alphanumeric "prefixes" to Blue Plans since the options for 3-character all alpha combinations were running low. The examples below illustrate the alpha and alphanumeric prefixes on the Member ID card (A = alpha; N = numeric):

There will be no change to existing 3-character alpha prefixes for products/accounts already in existence. Alphanumeric prefixes will be created and assigned to Blue Plans for new products or new large national group accounts.

Examples of Member ID Numbers

The following examples represent various numeral/letter combinations that may be seen as Member IDs for Blue Plan members (A = alpha; N = numeric):

Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the Member ID.

As a provider servicing out-of-area members, you may find the following tips helpful:

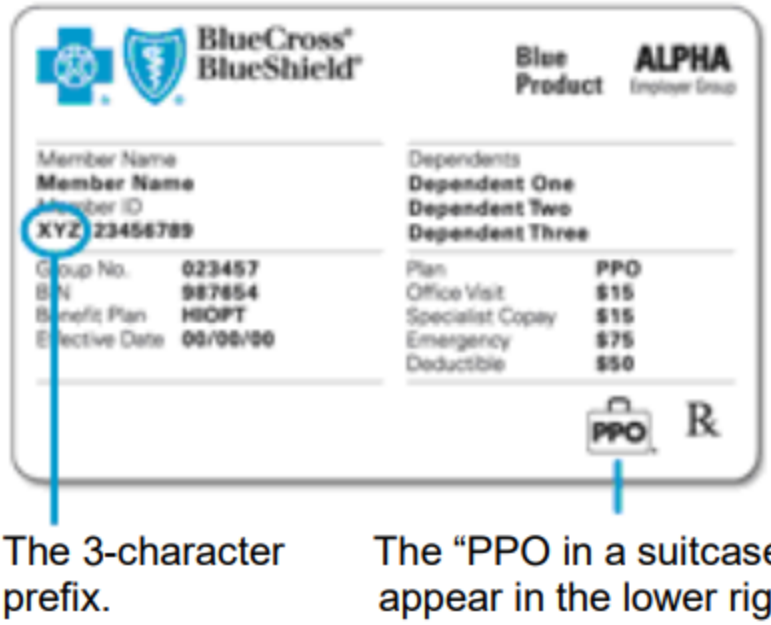
- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility Line at 800-676-BLUE to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Capture all ID card data to ensure accurate claim processing. If the information is not captured correctly, you may experience a delay with the claim processing.

Suitcase Logos

BlueCard Member ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The **PPO in a suitcase logo** indicates that the member is enrolled in either a PPO product or an Exclusive Provider Organization (EPO) product. In either case, you will be reimbursed according to Highmark's PPO provider contract.

Note: EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.



One of the key elements of health care reform under the Affordable Care Act (ACA) is the public "exchange" - officially known as the Health Insurance Marketplace. **The PPOB in a suitcase logo** on an ID card indicates that the member has a Blue Plan PPO or EPO product from the exchange. These members have access to a Blue System PPO network referred to as “BlueCard PPO Basic.”

Many Blue Plans have created a new BlueCard PPO Basic network; however, Highmark will utilize the same networks as we do for BlueCard PPO. You will be reimbursed for covered services in accordance with your PPO contract with Highmark.

The **empty suitcase logo** indicates that the member is enrolled in one of the following products: traditional, Health Maintenance Organization (HMO), or Point of Service (POS). For members with these products, you will be reimbursed according to Highmark's traditional participating provider contract.

Blue Plan ID Cards Without Suitcase Logos

Some Blue Plan ID cards do not have a suitcase logo. Those are the ID cards for Medicaid; State Children's Health Insurance Programs (SCHIP), if administered as part of a state's Medicaid program; and Medicare complementary and supplemental products, also known as Medigap.

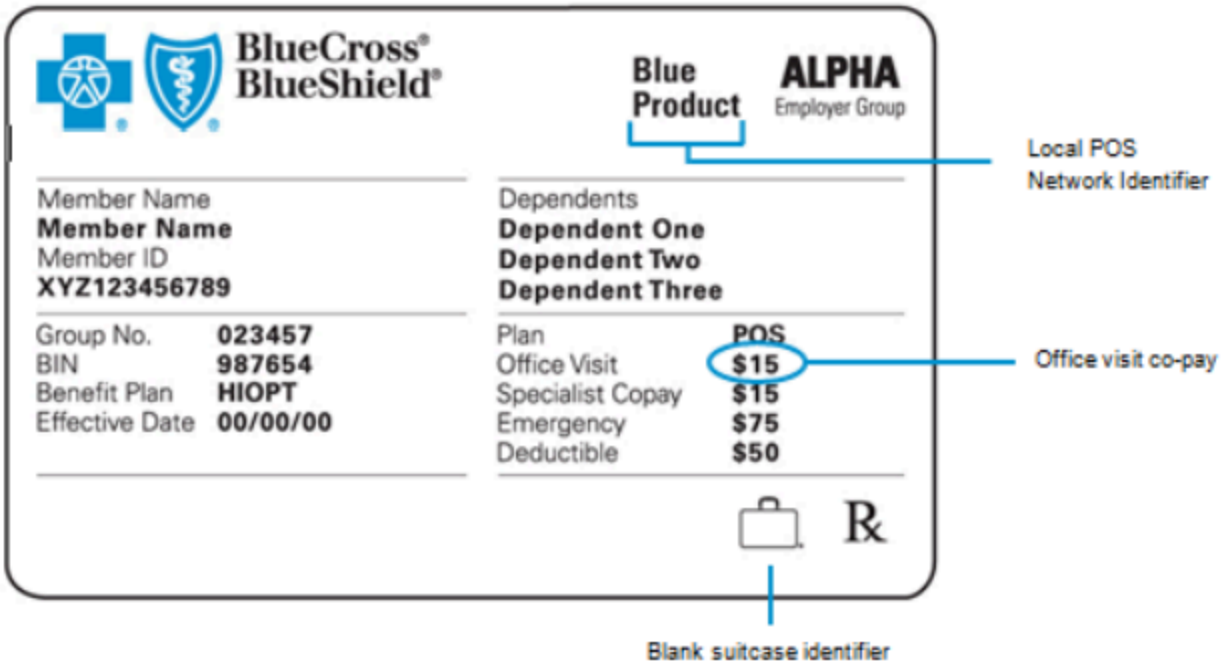
Government determined reimbursement levels apply to these products. While Highmark routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic Medicare crossover process.

BlueCard Managed Care/POS Program Members

The BlueCard Managed Care/POS Program is for members who reside outside their Blue Plan's service area. Unlike in the BlueCard PPO Program, the BlueCard Managed Care/POS members are enrolled in a Highmark network and have a primary care physician (PCP).

You can recognize BlueCard Managed Care/POS members who are enrolled in a Highmark network through the Member ID card as you do for all other BlueCard members. The ID cards will include:

- The 3-character prefix at the beginning of the member's ID number
- A local network identifier
- The blank suitcase logo



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2.6 Medicaid Programs Administered by Blue Plans

Medicaid is a government program that provides free or low-cost health care to an eligible population. States design their own Medicaid programs within federal guidelines – eligible populations, cost-sharing, benefits, and other rules vary by state. State Medicaid agencies contract with health insurers, including Blue Cross and Blue Shield (BCBS) Plans, as Managed Care Organizations (MCOs) to administer comprehensive Medicaid benefits.

Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out of state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires authorization. Reimbursement for covered services is limited to the Medicaid allowed amount established in the member's home state.

Blue Plan Medicaid ID Cards

Members enrolled in BCBS Medicaid plans are issued ID cards from the home plan where they reside, and are usually provided with state-issued Medicaid ID cards. It is important to note that:

- Blue Plan Medicaid ID cards do not always indicate that a member has a Medicaid product.
- Blue Plan Medicaid ID cards **do not have the suitcase logo.**
- The back of the Blue Plan Medicaid ID card must contain a disclaimer indicating limited out-of-area benefits.

Providers should submit an eligibility inquiry if the ID card has no suitcase logo and has a disclaimer with benefit limitations.

Obtaining Eligibility & Benefits and Prior Authorization

You can obtain eligibility and benefit information for out-of-area BCBS Medicaid members using the same tools as you would for other out-of-area Blue Plan members:

- Submit an eligibility inquiry using Availity;
- Submit a HIPAA 270/271 electronic eligibility inquiry; or
- Call the BlueCard Eligibility line at 800-676-BLUE (2583).

Providers can also request prior authorization for out-of-area Blue Plan Medicaid members using the same tools available for BlueCard:

- BlueExchange;
- BlueCard Eligibility Line at 800-676-BLUE (2583); and
- Electronic Provider Access (EPA) tool for pre-service review, including prior authorization.

Claim Submission and Reimbursment

Although BCBS Medicaid claims are processed through the BCBS Inter-Plan system, Medicaid is not officially part of the BlueCard Program since there is no network reciprocity and the locally negotiated rates do not apply to Medicaid claims. However, you still submit out-of-area Blue Plan Medicaid claims to Highmark as you would submit BlueCard claims, and you will receive reimbursement from Highmark. You will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

When you see a Blue Plan Medicaid member from another state, you must accept the Medicaid allowed amount applied in the member's home state even if you do not participate in Medicaid in your own state. Federal regulations limit providers to the Medicaid allowed amount applicable in the member's home state as payment in full. Billing Medicaid members for the amount between the Medicaid allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).

In some circumstances, a state Medicaid program will have an applicable copay, deductible, or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule in the member's home state for that service.

If you provide Medicaid services to a member who is not covered by Medicaid, you will not be reimbursed. In some states, you may bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of services being rendered.

Medicaid Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement. To view provider enrollment requirements for BCBS Medicaid states, please see the Medicaid Provider Enrollment Requirements by State. (This document is also available in the BlueCard Information Center on the Provider Resource Center; select **Inter-Plan Programs** from the main menu.)

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in the state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from Highmark regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

Required Data Elements for Medicaid Claims

Medicaid MCOs are required to report specific Medicaid encounter information to their states and may incur a financial penalty if the data is not submitted or incomplete. State Medicaid encounter data reporting requirements vary from state to state. When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides to understand the state's Medicaid requirements for reporting encounter data elements.

The data elements identified below are required on all out-of-area Blue Plan Medicaid claims so that BCBS Medicaid MCOs are able to comply with encounter data reporting applicable to their respective state.

Effective March 2016, applicable Medicaid claims submitted without these data elements will be denied:

- National Drug Code (NDC)
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

Billing Provider (Second) Address Line	Ordering Provider Identifier and Identification Code Qualifier
Billing Provider Middle Name or Initial	Ordering Provider Identifier and Identification Code Qualifier
(Billing) Provider Taxonomy Code	Attending Provider NPI

(Rendering) Provider Taxonomy Code	Operating Physician NPI
(Service) Laboratory or Facility Postal Zone or ZIP Code	Claim or Line Note Text
(Ambulance) Transport Distance	Certification Condition Applies Indicator and Condition Indicator (Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
(Service) Laboratory Facility Name	Certification Condition Applies Indicator and Condition Indicator (Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
(Service) Laboratory or Facility State or Province Code	Service Facility Name and Location
Value Code Amount	Ambulance Transport Information
Value Code	Patient Weight
Condition Code	Ambulance Transport Reason Code
Occurrence Codes and Date	Round Trip Purpose Description
Occurrence Span Codes and Dates	Stretcher Purpose Description

Referring Provider Identifier and Identification Code Qualifier	

Important: National Drug Codes (NDCs) are required on all applicable out-of-area Blue Plan Medicaid claims, including inpatient, outpatient, and professional; claims submitted without applicable NDCs reported will be denied.

837 Reference	837 Professional Data Element Reference	837 Institutional Data Element Reference	Professional Paper Claim Item Reference (CMS1500)	Institutional Paper Claim Form Locator (UB04)
National Drug Code	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43

Converting NDCS From 10-Digits to 11-Digits

Many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10- digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format.

The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted additional "0" is in a **bold font and underlined** in the following example. Note that hyphens indicated below are used solely to illustrate the various formatting examples for NDCs. **Do not use hyphens when entering the actual data in your paper claim form.**

Converting NDCs From 10-Digits to 11-Digits

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion of Example

4-4-2	9999-9999-99	5-4-2	09999-9999-99	09999-9999-99 0002-7597-01 Zyprexa® 10mg Vial	00002759701
5-3-2	99999-999-99	5-4-2	99999-0999-99	50242-040-62 Xolair® 150mg Vial	50242004062
5-4-1	99999-9999-9	5-4-2	99999-9999-09	60575-4112-1 Synagis® 50mg Vial	605754112 01

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2.6 International Blue Plans

The Blue Cross and Blue Shield Association licenses Blue Plans outside of the United States. International Licensees currently include the following:

- Blue Cross Blue Shield (BCBS) of U.S. Virgin Islands
- BlueCross & BlueShield of Uruguay
- Blue Cross and Blue Shield of Panama
- Blue Cross Blue Shield of Costa Rica

If in doubt, always check with Highmark as the list of International Licensees may change.

International Blue Plan ID Cards

The ID cards from International Licensees will also contain 3-character prefixes and may or may not have a benefit product logo. Please treat these members the same as domestic Blue Plan members (e.g., do

not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance, and copayment). Submit all claims for these international members to Highmark.

Front of card:

Back of card:

Canadian Association of Blue Cross Plans are Separate and Distinct

The Canadian Association of Blue Cross Plans and its member Plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Canadian plans for servicing their members. Instructions may be provided on their ID cards.

The Blue Cross Plans in Canada are:

- Alberta Blue Cross
- Ontario Blue Cross
- Saskatchewan Blue Cross
- Manitoba Blue Cross
- Quebec Blue Cross
- Pacific Blue Cross
- Medavie Blue Cross

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2.6 GeoBlue Travel Insurance

GeoBlue[sm] health plans help travelers and expatriates get high quality, safe, and convenient care around the world and are offered in cooperation with many Blue Cross and Blue Shield companies, including Highmark. Through innovative product offerings, including concierge-level service and unsurpassed mobile technology, members who are living or working abroad can find carefully selected doctors and hospitals in more than 180 countries.

These plans provide medical coverage outside the United States for ongoing conditions, preventive health care, or an unexpected medical crisis. GeoBlue enables participating Blue Plans to provide their clients traveling the world with the care they need, when and where they need it, from trusted doctors and hospitals.

GeoBlue is the trade name for the international health insurance programs of Worldwide Insurance Services, an independent licensee of the Blue Cross Blue Shield Association.

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2.6 Limited Benefit Products

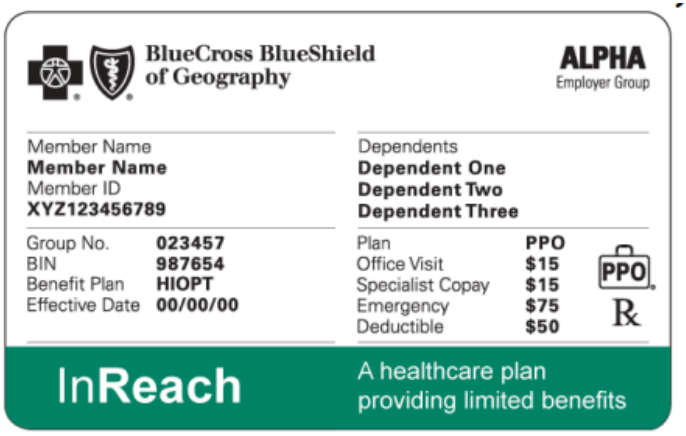
Verifying Blue Plan patient's benefits and eligibility is now more important than ever since new products and benefit types have entered the market. In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage with typically high lifetime coverage limits (i.e., $1 million or more), you may now see patients whose annual benefits are limited to $50,000 or less.

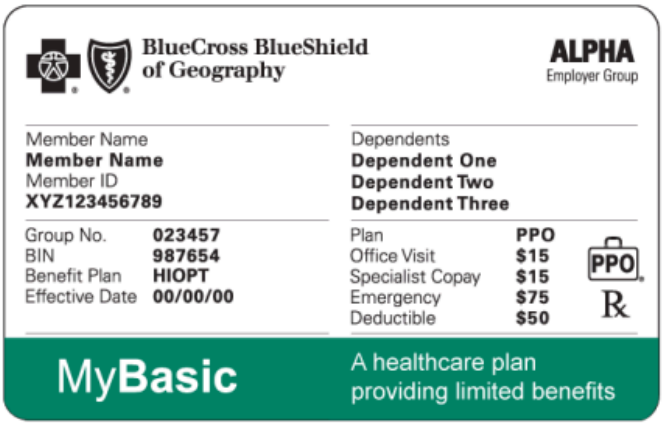
Currently, Highmark does not offer the limited benefit plans described here to our members; however, you may see patients with these limited benefit plans who are covered by another Blue Plan.

How to recognize members with limited benefits products Patients with Blue limited benefits coverage carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic;
- A green strip at the bottom of the card;
- A statement either on the front or back of the ID card stating that this is a limited benefit product;
- A black cross and/or shield to help differentiate it from other identification cards.

These Blue limited benefits ID cards may look like this:





Verify Eligibility and Benefits

In addition to obtaining a copy of the patient's ID card, and regardless of the benefit product type, we recommend that you verify the patient's eligibility and benefits. You may do so electronically or you may call the 800-676-BLUE Eligibility Line for out-of-area members.

Both electronically and via telephone, you will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatments are member liability.

We recommend you inform the patient of any potential liability they might have as soon as possible.

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2.6 Referenced Based Benefits

Some Blue Plans offer Reference Based Benefits to self-funded group accounts that limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.

The goal of Reference Based Benefits is to engage members in their health choices by giving them an incentive to shop for cost-effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated “Reference Cost” ceiling for a single episode of service.

Due to the possibility of increased member cost-sharing, Referenced Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost-effective providers and/or facilities that charge at or below the reference cost ceiling.

Reference Cost

The Blue Plan will pay up to a predetermined amount, called a “Reference Cost,” for specific procedures. If the allowed amount exceeds the reference cost, the excess amount becomes the member’s responsibility.

The Blue Cross Blue Shield Association (BCBSA) calculates reference costs on a state by state basis with each state representing a “cost region” with its own reference costs. The reference costs are established in a cost region based on claims data provided by the Blue Plan(s) in that region. Reference costs are updated on an annual basis.

Applicable Services

The Blue Plan and the employer group collaborate to define the services for which Referenced Based Benefits will apply. Services could include inpatient services, outpatient procedures, and diagnostic services; and services may vary by employer group with coverage under the same Blue Plan. Reference Based Benefits are not applicable to any service that is urgent or emergent.

Verifying Coverage

When you submit an electronic eligibility and benefits inquiry prior to performing services, you will be notified if a member is covered under Reference Based Benefits.

Additionally, you may call the BlueCard Eligibility phone number to verify if a member is covered under Referenced Based Benefits: 800-676-BLUE (800-676-2583).

Claims, Payment, and Member Responsibility

Reference Based Benefits do not alter the Highmark fee schedule. Providers are paid the applicable fee schedule allowance on all services where Reference Based Benefits apply.

When Reference Based Benefits are applied and the cost of the services rendered is less than the cost ceiling, then Highmark will pay eligible benefits as it has in the past. The member continues to pay their standard cost-sharing amounts in the forms of coinsurance, copay, or deductible as normal.

If the cost of the services rendered exceeds the reference cost ceiling, then Highmark will pay benefits up to that reference cost ceiling. The member continues to pay their standard cost-sharing amounts in the forms of coinsurance, copay, or deductible, as well as any amount above the reference cost ceiling up to the contractual amount.

Example 1: If a member has a reference cost of $500 for an MRI and the allowable amount is $700, then Highmark will pay up to the $500 for the procedure and the member is responsible for the $200.

Example 2: If a member has a reference cost ceiling of $600 for a CT scan and the allowable amount is $400, then Highmark will pay up to the $400 for the procedure.

Consumer Transparency Tools

Since members are subject to any charges above the Reference Cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost. Also, you can direct members to view their Blue Plan’s transparency tools to learn more about the cost established for an episode of care.

The National Consumer Cost Tool (NCCT) is a national effort by Blue Cross and/or Blue Shield Plans across the country to assist members in navigating the health care delivery system. A national database houses pre-calculated cost estimates submitted by Blue Plans, which allows members to view the total cost of specific medical procedures and common office visits for providers across the country.

Note: Highmark members have access to this information through the Care Cost Estimator which is available to them by logging into their account on Highmark’s websites.

Questions? If you have any questions regarding Reference Based Benefits, please contact the Highmark Provider Service Center.

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2.6 Consumer Directed Healthcare and Health Care Debit Cards

Consumer Directed Healthcare (CDHC) is a broad term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

Health Care Debit Cards

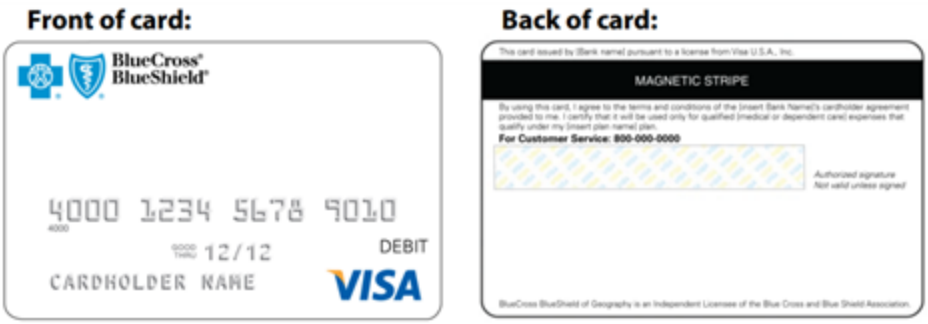
Members who have CDHC plans often have health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Account (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA). All three are types of tax-favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards to cover out-of-pocket costs while others also serve as a Member ID card with the member's ID number. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks along with the logo from a major debit card such as MasterCard® or Visa.®

Example: Stand-alone health care debit card



Example: Combined health care debit card and Member ID card

The health care debit card includes a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With health care debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA, or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards because of the payment capabilities.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Helpful Tips

The following tips will be helpful when you are presented with a health care debit card:

- Carefully determine the member's financial responsibility before processing payment. You can access the member's benefits and accumulated deductible by using online electronic capabilities

or by contacting the BlueCard Eligibility Line at 800-676-BLUE (2583).

- You may use the debit card for member responsibility (i.e., copay) for medical services provided in your office. Please do not use the card to process full payment upfront.
- You may choose to forego using the debit card on the date of service and wait for the claims to be processed by Highmark to determine the member's responsibility.
- All services, regardless of whether or not you have collected the member responsibility at the time of service, must be billed to Highmark for proper benefit determination and to update the member's claim history.

Questions? If you have any questions about the member's benefits, check eligibility and benefits electronically or by calling 800-676-BLUE (2583).

For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

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2.6 Health Insurance Marketplaces

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (or "Exchanges") in each state where individuals and small businesses can purchase qualified coverage. These exchanges are websites through which eligible consumers may purchase insurance.

The Marketplaces are intended to create a more organized and competitive marketplace for health insurance by offering members a choice of health insurance plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. The Marketplaces will enhance competition in the health insurance market, improve choice of affordable health insurance, and give individuals and small businesses purchasing power comparable to that of large businesses.

The Marketplaces offer consumers a variety of health insurance plans. Product and Plan information, such as covered services and cost sharing (i.e., deductibles, coinsurance, copayments, and out-of-pocket limits) are organized in a manner that makes comparisons across health insurance plans easier for consumers.

In conjunction with offering a choice of health insurance plans, the Marketplace is intended to provide consumers with transparent information about health insurance plan provisions such as premium costs and covered benefits as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Marketplace Options

Each state was given the option to set up its own "state-based" Marketplace approved by the Department of Health and Human Services (HHS) for marketing products to individual consumers and small employers. If the state did not set up a state-run marketplace, HHS has established either a federally-facilitated Marketplace or a Federal partnership Marketplace in the state.

Blue Plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and employer-sponsored health insurance products.

Pennsylvania has a Federally Facilitated Exchange (FFE) marketplace. The federal government, mainly through the Department of Health and Human Services, will operate nearly all of the functions. It will verify eligibility for buying coverage, determine subsidies, and oversee enrollment, plan management, consumer assistance, and financial management.

Delaware and West Virginia are two of the seven states that formed state-federal partnerships with the states operating the plan management and consumer assistance functions of the Marketplace.

OPM Multi-State Plan Program

Under the Affordable Care Act (ACA) of 2010, the Office of Personnel Management (OPM) was required to offer OPM-sponsored products on the Marketplaces beginning in 2014. For a coverage effective date of January 1, 2015, Blue Cross and Blue Shield Plans participated in this program by offering these Multi-State Plans on Marketplaces in 33 states and the District of Columbia, including Highmark in Pennsylvania, Delaware, and West Virginia. The ACA requires these products to be offered across all states and the District of Columbia by 2017.

These products are similar to the other Qualified Health Plan products offered on the Marketplaces. Generally, all of the same requirements that apply to other State Marketplace products also apply to these Multi-State Plan products.

Exchange Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally-mandated individual grace period, providers may receive a notification from Highmark indicating that the member is in the grace period.

Claims and Utilization Review

Providers should follow current practices with Highmark for claims processing and handling of Marketplace claims. You can make claim status inquiries through Highmark or by submitting an electronic inquiry to Highmark.

If authorization/precertification is needed, you should follow the same protocol as you do for any other BlueCard members.

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2.6 Blue Exchange for Inquiries and Authorization

Blue Exchange was developed by the Blue Cross Blue Shield Association as a gateway for routing inquiries about out-of-area members between providers and the member's Blue Plan. Blue Exchange transactions submitted through Highmark are routed to the member's Blue Plan based on the prefix.

Blue Exchange simplifies your exchanges for out-of-area members using HIPAA- compliant transactions. There are three primary types of transactions that can be routed via BlueExchange:

- Eligibility and Benefits Inquiry and Response;
- Claim Status Inquiry and Response; and

- Referral/Authorization Requests.

Accessing Blue Exchange Via Availity

Highmark provides you with convenient, easy-to-use access to Blue Exchange via Availity. Each of these transactions can be initiated through Availity's authorization workflow.

Electronic Transactions Routed Via Blue Exchange

If your office has the capability, the following transactions can be submitted to Highmark for out-of-area members via your practice management software and routed via Blue Exchange:

- 270 for Eligibility and Benefits
- 276 for Claim Status
- 278 for Utilization Review

Highmark will route both the inquiry and response transactions between you and the member's Blue Plan via Blue Exchange.

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2.6 BlueCard Eligibility and Benefits Verification

As a Highmark participating provider, you have three options for verifying eligibility for members of other Blue Plans:

- Submit an electronic HIPAA 270 transaction to Highmark;
- Initiate a Secure Message via Availity; or
- Call the BlueCard Eligibility line at 800-676-BLUE (2583).

Electronic Transactions Preferred

Electronic transactions and online communications have become integral to health care, and they are the preferred method of interaction between providers and Highmark. Today's technology can help you simplify business operations, cut costs, and increase efficiency in your office.

Electronic options for verifying eligibility and benefits for out-of-area Blue Plan members provide a quick turnaround. You can use the following electronic options for verifying eligibility and benefits for an out-of-

area member:

- Submit a HIPAA 270 Eligibility Inquiry transaction to Highmark: Highmark will route both the inquiry and the 271 response transactions between you and the member's Blue Plan via BlueExchange; or
- Initiate a Secure Message via Availity.

BlueCard Eligibility Phone Line

For those offices that are not electronically-enabled, the Blue Cross Blue Shield Association provides a toll-free phone line for eligibility and benefit inquiries for BlueCard members. Contact BlueCard Eligibility at 800-676-BLUE (2583).

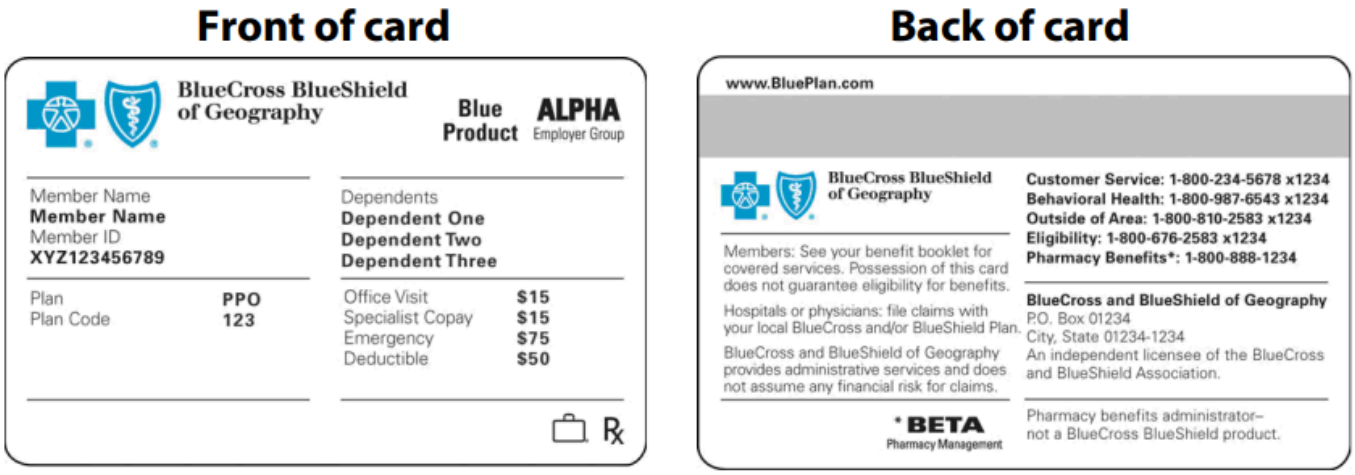
- English and Spanish speaking phone operators are available to assist you.
- Blue Plans are located throughout the country and may operate on a different time schedule than Highmark; you may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
- The BlueCard Eligibility Line is for eligibility, benefit, and precertification and referral authorization inquiries only; it should not be used for claim status. Direct all claim inquiries to Highmark.

Electronic Health ID Cards

Some Blue Cross Blue Shield Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.

- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
- A Blue Plan electronic health ID card has a magnetic stripe on the back of the card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the 3-track magnetic stripe.
- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth, and Plan ID.
- Providers will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 and 2 of the magnetic stripe; tracks 1 and 2 are proprietary to the financial industry).
- The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers in the marketplace.

- An example of an electronic ID card:



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2.6 Utilization Review

Traditionally, many Blue Plan members have been held responsible for obtaining pre-service review from their Home Plan when receiving inpatient and outpatient care in another Blue Plan's service area. If authorization is not obtained, the member could be subject to financial penalties.

Pre-service review is defined as the process of obtaining authorization for medical treatment prior to select procedures and services. The process is commonly referred to as precertification, preauthorization, notification, and/or pre-admission.

Inpatient Services

Effective July 1, 2014, under a Blue Cross Blue Shield Association (BCBSA) initiative, all Blue Plans must require participating providers to obtain pre-service review for inpatient facility services for out-of-area members. In addition, members are held harmless when pre-service review is required and not obtained by the provider for inpatient facility services (unless an account receives an approved exception).

These requirements apply to all fully-insured health benefit plans. However, if a self-funded employer group wishes to keep member precertification penalties in place, a formal exception can be filed with the

BCBSA. If an account receives an approved exception, a member penalty could apply if pre-service review is not obtained for inpatient services.

Highmark provider contracts require participating providers to obtain pre-service review for inpatient facility services for our members and also out-of-area BlueCard® members. Highmark participating providers are also required to hold members harmless if the member's plan requires pre-service review and the provider did not attempt to acquire an authorization.

This initiative also requires Blue Plan participating providers to keep the Home Plan informed of changes in a member's condition. Providers must notify the member's Home Plan within 48 hours when a change to the original pre-service review occurs, and within 72 hours for emergency and/or urgent admissions.

Note: This policy does not affect medical necessity. Services must still be medically necessary, appropriate, and a covered benefit. If, prior to service or care, the provider requests authorization and it is denied, a Highmark participating provider can bill the member if the member was informed of the denial and agreed in writing to be responsible for payment for the service or care.

Outpatient Services

Although providers are responsible for obtaining pre-service review for inpatient facility services, your out-of-area Blue Plan patients are responsible for obtaining precertification/preauthorization from their Blue Plan when required for outpatient services. However, you may contact the member's Blue Plan for authorization on behalf of the member.

Effective November 1, 2020, Highmark is expanding our prior authorization requirements for outpatient services to include those services provided by out-of-area providers participating with their local Blue Plan. This will assure that the care our members receive while living and traveling outside of the Highmark service areas is medically necessary and managed consistently as it is throughout our service areas.

Availity portal functionality is enabled to accept authorization requests for outpatient services from out-of-area Blue Plan providers when submitted via their local portals.

Claims for services on the prior authorization list received without authorization will be denied and a request for medical records will be sent to the provider's local Blue Plan.

Medical Policy and Precertification/Preauthorization Router for Out-of-Area Members

Highmark provides you with a tool to access Medical Policy and general precertification/preauthorization information for out-of-area members from other Blue Plans. All you need is the out-of-area member's prefix to find the information for the home plan.

On the Provider Resource Center, select **Provider Networ**k from the main menu. You'll find the **Medical Policy and Pre-Certification/Pre- Authorization Router for Out-of-Area Members** under **Inter-Plan Programs.** This link is also available in the **BlueCard Information Center.**

Note: This feature is not available for members in the Federal Employee Program (FEP) or in a Medicare Advantage Program.

How to Obtain Authorization

The following options are available to you for obtaining pre-service review/pre-authorization for out-of-area BlueCard members:

- **Submit an electronic HIPAA 278 transaction (Referral/Authorization) to Highmark** via your practice management software. Highmark will route both the inquiry and response transactions between you and the member's Blue Plan via BlueExchange.
- **Use Availity.** Select Patient Registration from the menu bar. Then choose Authorization & Referrals.
- **Call BlueCard Eligibility at 800-676-BLUE (2583)** and ask to be transferred to the utilization review area. Your call will be routed directly to the area that handles precertification/preauthorization at the member's Home Plan.

When obtaining precertification/preauthorization, please provide as much information as possible to minimize potential claims issues. Providers are encouraged to follow up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

The member's Blue Plan may contact you directly related to clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

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2.6 Electronic Provider Access (EPA)

On January 1, 2014, the Blue Cross and Blue Shield Plans launched a new tool that gives providers the ability to access an out-of-area member's Blue Plan (Home Plan) provider portal to conduct electronic pre-service review. The term pre- service review is used to refer to pre-notification, precertification, preauthorization, and prior approval, amongst other pre-claim processes.

Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The ability to access the Home Plan's portal for pre-service review will result in a more efficient pre-service review process, reduced administrative costs for both the provider and the Blue Plan, and improved provider and member satisfaction.

Determine if Precertification is Required

You can first check whether precertification is required by the member's Home Plan by either:

- Going to **Eligibilty and Benefits Inquiry** in Availity; or
- Accessing the Home Plan's precertification requirements pages by using the Medical Policy Router available on the Provider Resource Center. (Select **Provider Network** from the main menu, and then select the **Medical Policy and Pre-certification/Pre-authorization Information for Out-of-Area Members** link.)

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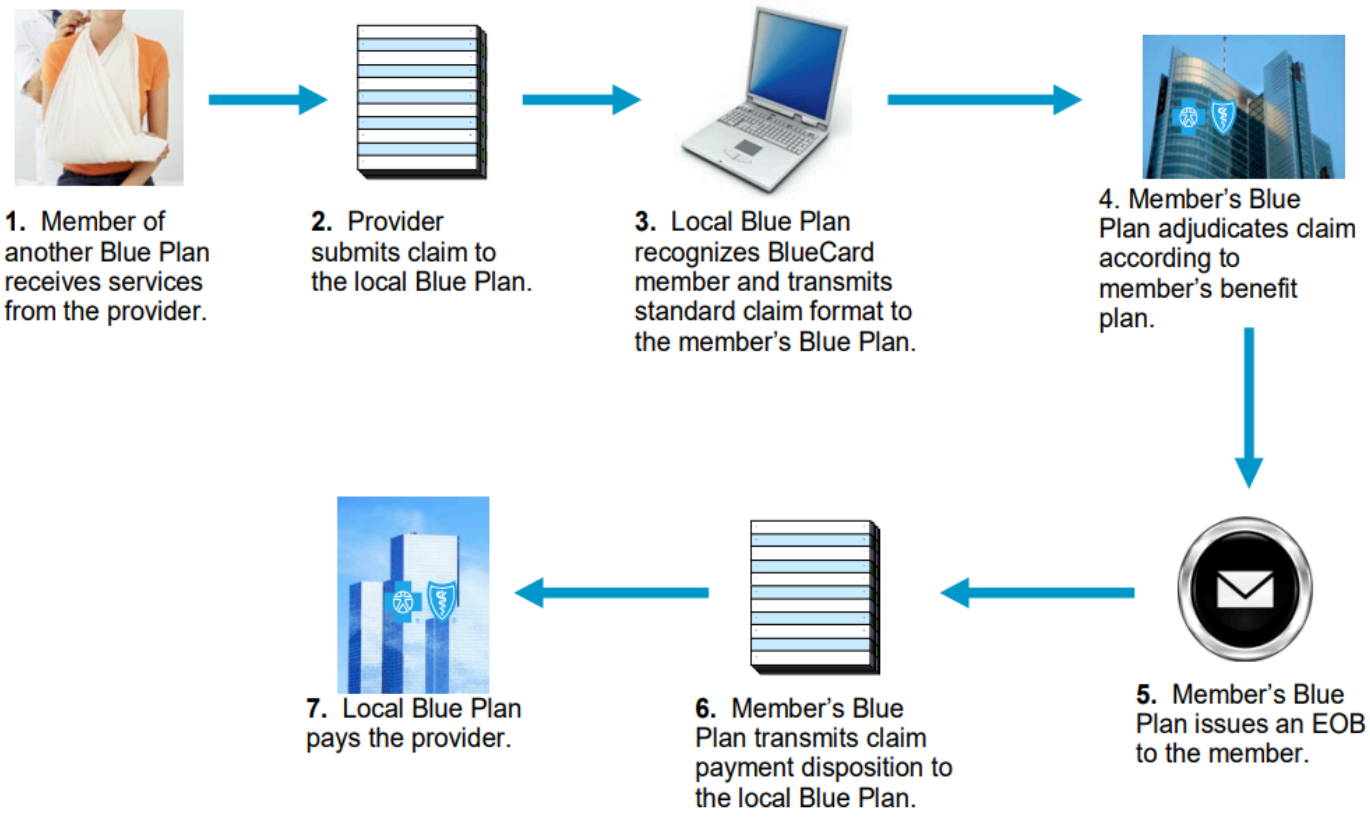
2.6 Claim Submission and Claim Status Inquiry

The diagram below illustrates how claims flow through BlueCard:



You should always submit out-of-area Blue Plan claims to Highmark using the applicable NAIC code as the payer code in the 837 Health Care Claim transaction. Highmark will work with the member's Blue Plan to process the claim. The member's Blue Plan will send an Explanation of Benefits (EOB) to the member.

Highmark will send you an explanation of payment or remittance advice. We will also issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

For More Information

Please see the NAIC Codes section of this unit for complete information on all Highmark NAIC payer codes.

Hepful Tips

Electronic claims submission is a valuable method of streamlining claim submission and processing, and results in faster payment. Following these helpful tips will improve your claim experience:

- Ask members for their current Member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member

information (including the prefix) and avoid unnecessary claims payment delays.

- Consider electronic inquiries if you wish to inquire about precertification requirements before the service is provided, or call 800-676-BLUE (2583) and ask to be connected with the utilization review area.
- Check eligibility and benefits to verify the member's cost-sharing amount before processing payment.
- Indicate on the claim any payment you collected from the patient.
    - On the 837I and the 837P electronic claim submission, use the Patient Amount Paid Segment (AMT01=F5 patient paid amount).
    - On the 1500 Claim Form, report the amount paid in locator Box 29. This is the total of patient and other payer(s) prior paid, not just patient prior paid.
    - On the UB-04, report this information in locator Box 54.
- Submit all Blue Plan claims to your local Highmark plan. Be sure to include the member's complete identification number when you submit the claim. This includes the 3-character prefix. Submit claims with valid prefixes only. **Claims with incorrect or missing prefixes and member identification numbers cannot be processed.**
- Check claim status through Availity's Claim Status Inquiry or by submitting an electronic HIPAA 276 transaction (Claim Status Request) to Highmark. All claim inquiries should be directed to Highmark and not the member's Plan.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and causes confusion for the member receiving multiple EOBs for the same services.

International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue Plan members. You should submit the claims directly to Highmark.

Note: Please see the section on How to Identify International Members in this unit for information on servicing members of the Canadian Blue Cross Plans.

Coding

Code claims as you would for Highmark claims.

Claim Status Inquiry

Highmark is your single point of contact for all claim inquiries.

- Availity's Claim Status, used to view local claims, can also be used to find the latest status on out-of-area claims. To view out-of-area claims electronically, you must include the prefix when entering the member's identification number.

Adjustments

Contact Highmark if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different. To initiate adjustments:

- Search for the claim in question via Claim Status within Availity, and then initiate an adjustment request via the *Claims Investigation Inquiry*.
- Providers who are not Availity-enabled should submit adjustments electronically via the HIPAA 837 transaction if your office system is capable

Provider Appeals

Provider appeals are handled through Highmark. We will coordinate the appeal process with the member's Blue Plan if needed.

However, if you are appealing on behalf of the member, direct your inquiry to the member's Blue Plan. To inquire about the Plan's process to initiate an appeal on behalf of the member, please call the Customer Service phone number on the member's identification card.

If Claim Payment is Not Received

If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs).

Claim processing times can differ at the various Blue Plans. If you do not receive your payment or a response regarding your payment within 30 days, please visit Availity, submit a HIPAA 276 (claim status request), or call Highmark's Provider Service Center to check the status of your claim.

In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Highmark may either ask you for the information or give the member's Blue Plan permission to contact you directly.

Coordination of Benefits

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract

language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- **Highmark or any other Blue Plan is the primary payer,** submit the other carrier's name and address with the claim to Highmark. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment which will increase your volume of bookkeeping.
- **A non-Blue health plan is primary and Highmark or any other Blue Plan is secondary,** submit the claim to Highmark only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment which will increase your volume of bookkeeping.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Highmark remittance advice as patient liability may be different from the actual amount the patient owes you due to a combination of two or more insurance payments.

Coordination of Benefits Questionnaire Available Online

Highmark depends on help from the member and/or provider to obtain accurate, up-to-date information about Coordination of Benefits (COB). The provider's assistance with this process will eliminate the need to gather the information later, thereby reducing potential claim processing delays.

If you would like to assist, the Coordination of Benefits Questionnaire for BlueCard Members is available to you here and also on the Provider Resource Centers in Pennsylvania. To access from the Pennsylvania Provider Resource centers, select **Inter-Plan Programs** from the main menu, and then **BlueCard Information Center.**

If you wish to have the questionnaire completed by the policyholder at the time of service, you can choose to fax the completed form with the policyholder's signature to Highmark. Be sure to use a fax cover sheet that includes contact information for your practice or facility. The toll-free fax number is provided on the instruction sheet attached to the COB form. **This fax number is for provider use only for submission of BlueCard COB Questionnaires. Please do not give this fax number to members.**

Or, you can ask the member to complete the form and then send it to their Home Plan – the Blue Plan through which they are covered – as soon as possible after leaving your office or facility. Members should mail the form to the Blue Plan address listed on the back of their member identification card where they will also find their Home Plan's telephone number if they have questions.

Calls From BlueCard Members

If BlueCard members contact you with questions about claims, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Blue Plan should not contact you directly regarding claims issues. If the member's Plan contacts you and asks you to submit the claim to them, refer them to Highmark.

For More Information

- Visit the **BlueCard Information Center** on the Provider Resource Center – go the main menu at the top of the page, select **Provider Network,** then **Inter-Plan Programs**.
- Call the Highmark Provider Service Center.

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2.6 Itemized Bills Required for High-Dollar Host Claims

Effective January 1, 2019, the Blue Cross Blue Shield Association (BCBSA) requires Blue Plans serving as the Host Plan for out-of-area Blue Plan members to perform high-dollar prepayment reviews for certain claims and communicate results of these reviews to the members' Home Plans. The review process must be conducted prior to passing the host claim to the Home Plan.

The **Home Plan** is the Blue Cross and/or Blue Shield Plan where the insured is enrolled. The **Host Plan** is any other Blue Plan whose contracted providers are providing health care services to a Blue Plan member outside of his or her home plan's service area.

For example, Highmark serves as the Host Plan when an out-of-area Blue Plan member (e.g., has coverage through BlueCross BlueShield of Illinois) seeks services from a Highmark participating provider in our service areas.

Therefore, a **host claim** would be a claim that you submit to Highmark for services you provided to an out-of-area Blue Plan member. Highmark forwards the host claim to the member's Home Plan internally through the BlueCard electronic system, and then the Home Plan adjudicates the claim, sending the information back to Highmark in order for Highmark to reimburse you.

Requirements For Providers

Highmark requires itemized bills for all high-dollar host claims that meet the criteria below and are received by Highmark beginning January 1, 2019, and after. The requirements under this initiative apply regardless of how claims were submitted.

Host claims that meet the following criteria require submission of itemized bills:

- Inpatient acute care;
- Allowance of $100,000 or greater;
- All lines of business, **except** Medicare Supplemental/Medigap and Medicaid; and
- Any pricing methodologies that are price based on charges (e.g., percentage-based).

Note: These requirements **do not apply** to the following claims pricing models that do not incorporate individual services or charges due to global pricing methodology:

- Per-diem
- Flat-fee case rate
- DRG (Diagnosis-Related Group) rate

Submitting Itemized Bills to Highmark

To send an itemized bill to Highmark, you can:

- Fax itemized bills to **855-329-8191**/Attention: Kelly Rizor
- Email itemized bills to HighmarkHostHighDollarReview@highmark.com

If Itemized Bills Not Received

If we do not receive an itemized bill for these claims **within three days** after they are submitted, they will be rejected with code E1224 – "In order to process the claim, additional information is required." As a result, payment will be delayed. If any discrepancies are found during the High Dollar Itemized Bill Audit, the claim will be amended during initial processing and only the lines that are not eligible will be denied E5027. Highmark will advise what the discrepancies are via our discrepancy sheet. The facility will not be responsible for refiling a corrected claim.

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2.6 NAIC Codes

The National Association of Insurance Commissioners (NAIC) is the U.S. standard- setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

NAIC codes are unique identifiers assigned to individual insurance carriers. Accurate reporting of NAIC codes along with associated prefixes and suffixes to identify the appropriate payer and to control routing is critical for electronic claims submitted to Highmark EDI (Electronic Data Interchange).

Claims billed with the incorrect NAIC code will reject on your 277CA report as A3>116, “Claim submitted to the incorrect payer.” If this rejection is received, please file your claim electronically to the correct NAIC code. Please refer to the tables below for applicable NAIC codes for your service area.

Delaware

DE **For providers in Delaware**

NAIC Code	Provider Type	Products

00070	Facility provider types	• All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
00570	All other provider types	• All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.

New York

For providers in New York

Providers must submit claims through the Administrative Services of Kansas (ASK): www.ask-edi.com.

NAIC Code	Provider Type	Products
55204	All provider types	• All Commercial Products: BlueCard Products and Medicare Advantage Claims for any other Blue Plan.

**Providers will continue to submit claims to Empire for Empire/Anthem members who are seen in — Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties — that comprise the 13 counties of the Highmark Blue Shield (NENY) service region.*

**Providers will continue to submit claims to Excellus for Excellus members who are seen in — Clinton, Essex, Fulton, and Montgomery counties — that comprise four of the 13 counties of the Highmark Blue Shield (NENY) service region.*

Pennsylvania

For providers in Pennsylvania

NAIC Code	Provider Type	Products
54771W	Western and Northeastern regions – facility type providers (UB-04/837I)	• All Highmark Commercial products; • Medicare Advantage Security Blue HMO-POS (prefixes **JOF, JOL**), Together Blue Medicare HMO (prefix **K9P**), and Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company (prefixes **ZPM, KHC**); and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771C	Central Region facility type providers (UB-04/837I)	• All Highmark Commercial products; • Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company (prefixes **ZPM, KHC**); and

		• All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771S	Southeastern Region facility type providers (UB-04/837I)	• All Highmark Commercial products; • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771	All other provider types (1500/837P)	• All Highmark Commercial products; • Medicare Advantage Security Blue HMO-POS (prefixes **JOF, JOL**), Together Blue Medicare HMO (prefix **K9P**) (Western region only), and Medicare Advantage Community Blue HMO all administered by Highmark Choice Company (prefixes **ZPM, KHC**); and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
15460	All provider types	• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes **HRT, HRF, FAS**); • Medicare Advantage Community Blue Medicare

		PPO) (prefixes **QLS, QMV, QJS, QKS**) and Community Blue Medicare Plus PPO (prefixes **FYO, FZO**); and • Medicare Advantage Complete Blue PPO (prefixes **C4K, CDE, FDE**) and Complete Blue Plus PPO (prefix **CDJ**).

West Virginia

For providers in West Virginia

NAIC Code	Provider Type	Products
54828	All provider types	• All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
15459	All provider types	• All provider types Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix **HSR**).

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2.6 Contiguous County Contracting

A **contiguous area** is generally a border county in another Blue Plan's service area one county over from the Plan's own service area. Per Blue Cross Blue Shield Association (BCBSA) regulations, a Plan ("Licensee") is permitted to use its Brands outside its service area when: "Contracting with health care providers in a contiguous area in order to serve its subscribers residing or working in the Licensee's own service area."

If you are a provider located in a contiguous area, your provider contract with Highmark only applies for services rendered in that contiguous area to members who live or work in a Highmark service area.

The contiguous area contract application limitation **does not apply** to ancillary providers (independent labs, durable/home medical equipment and supplies, and specialty pharmacy) or in overlapping service areas, where multiple Blue Plans share the same service area.

- Highmark Blue Shield shares the service area in the 21-county Central Region of Pennsylvania with Capital BlueCross.
- Highmark Blue Shield shares the service area in the 5-county Eastern Region of Pennsylvania with Independence Blue Cross.
- Highmark Blue Shield shares the service area in the 13-county Northeastern Region of New York with Anthem.

In the regions listed above, overlapping service area claim filing rules apply. You can click on the What Is My Service Area Guide? to identify the counties within these service areas.

Please refer to the applicable sections in this unit for claim submission guidelines for ancillary claims and for overlapping service areas.

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2.6 Overlapping Service Areas

An **overlapping service area** is formed when multiple Blue Plans are licensed by the Blue Cross Blue Shield Association (BCBSA) within the same service area.

Submission of claims in overlapping service areas is dependent on what Blue Plan(s) the provider contracts with in that state, the type of contract the provider has (i.e., PPO, Traditional), and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either Blue Plan.
- If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type.For example, if it is a PPO member, file the claim with the Plan with which you have the PPO contract.
- If you contract with one Plan and not the other, file all claims with your contracted Plan.

Within the 21-county central Pennsylvania and Lehigh Valley region, the 5-county southeastern Pennsylvania region, and the 13-county Northeastern New York region, Highmark Blue Shield markets in the same region as another Blue Plan. If you treat any Highmark member in one of these regions, you must send your claim to Highmark even if you also contract with the other Blue Plan. If you treat a member of the other Blue Plan marketing in one of these regions, you must send your claim to that Blue Plan even if you do not contract with that other Blue Plan.

Note: Overlapping service area guidelines do not apply to ancillary claims.

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2.6 Ancillary Claim Filing Rules

Ancillary providers include independent clinical laboratory, durable/home medical equipment and supplies, and specialty pharmacy providers. File claims for these providers as follows:

- **Independent Clinical Laboratory:** To the Blue Plan in whose state the specimen was drawn based on the location of the referring provider.
- **Durable/Home Medical Equipment and Supplies:** To the Blue Plan in whose state the equipment was shipped to or purchased at a retail store.

- **Specialty Pharmacy:** To the Blue Plan in whose state the Ordering Physician is located.

The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.

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2.6 Medical Records Requests

Blue Plans around the country have made improvements to the medical records process to make it more efficient. They are able to send and receive medical records electronically between Blue Plans.

This method significantly reduces the time it takes to transmit supporting documentation for out-of-area claims, reduces the need to request records multiple times, and significantly reduces lost or misrouted records.

You may get requests for medical records for out-of-area members under the following circumstances:

- **Preauthorization** – If you receive requests for medical records from other Blue Plans prior to rendering services (as part of the preauthorization process), you will be instructed to submit the records directly to the member's Home Plan that requested them. **This is the only circumstance where you would not submit medical records to Highmark.**
- **Claim Review and Adjudication** – These requests will come from Highmark in the form of a letter requesting specific medical records and including instructions for submission.

Submitting Records to Highmark for Claim Review

When medical records are needed as part of claim review, Highmark relays that request to you in the form of a letter sent via the postal mail. The request includes the following information about the claim: the patient name, claim number, date and place of service, procedure code, contract/identification number, and provider's charge. The letter will provide a fax number and mailing address to which your office can direct the requested records.

We recommend that, unless the number of pages you must provide is excessive, you return the requested medical record information to our BlueCard Host area via fax at 866-251-9601. Faxing is the preferred method of submission as information received via fax is able to be expedited and processed more quickly than records sent via postal mail.

Most often complete medical records are not necessary; therefore, send only the information requested. Return the records as quickly as possible to Highmark and use the request letter as a cover sheet placed in front of any records you return. In this way, the receipt of the records is streamlined; they are received directly by the appropriate department at Highmark and are easily identified, imaged, and routed to the Home Plan through secure software that facilitates the exchange.

Upon receipt of the requested information, the claim will be reviewed and Highmark will notify you of the final determination.

If You Receive a Remittance Advice Message About Medical Records

The medical records you submit may at times cross in the mail with the remittance advice; therefore, a remittance may be received by your office/facility indicating the claim is being denied pending receipt and review of records.

A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Highmark to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.

If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Highmark to determine if the records are needed from your office.

Important! Do not send unsolicited records

Please do not proactively send medical records with a claim unless requested. Unsolicited claim attachments may cause claim payment delays.

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2.6 BlueCard Quick Tips

The BlueCard® Program provides a valuable service that lets you file all claims for members from other Blue Plans with Highmark.

Here are some key points to remember:

1. Make a copy of the front and back of the member's ID card.
2. Look for the 3-character prefix that precedes the member's identification number on the ID card.
3. Consider electronic means first for eligibility inquiries:
    1. Submit a Secure Message via Availity®; or
    2. Submit a HIPAA 270 transaction to Highmark.
4. Or, call BlueCard Eligibility 800-676-BLUE (2583) for eligibility inquiries:
    1. English and Spanish speaking operators are available;
    2. Because of time zone differences, you may sometimes reach a voice response system linked to enrollment and benefits.
5. Submit the claim to Highmark using the appropriate NAIC code.
    1. **Pennsylvania:** Western Region Facility – 54771W; Central Region Facility – 54771C; SEPA Region Facility - 54771S; all other provider types – 54771.
    2. **Delaware:** Facility – 00070; all other provider types – 00570.
    3. **West Virginia:** All provider types – 54828.
    4. **New York:** All provider types - 55204.
6. Always report the patient's complete identification number, including the 3-character prefix.
7. Consider electronic means for claim inquiries:
    1. BlueCard claims can often be found within Claim Status in Availity. Remember to enter the entire identification
    2. number including the 3-character prefix; or
    3. Submit a Secure Message via Availity; or
    4. Initiate a HIPAA 276 transaction to Highmark.
8. Consider electronic means for utilization review inquiries:
    1. Submit a Secure Message via Availity; or
    2. Submit a HIPAA 278 transaction to Highmark.
9. Or, call BlueCard Eligibility 800-676-BLUE (2583) for utilization inquiries. Ask to be transferred to the Utilization Review area.

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2.6 Medicare Advantage Products

Medicare Advantage is **a separate program from BlueCard** and delivered through its own centrally-administered platform; however, since you may see members of other Blue Plans who have Medicare Advantage coverage, Medicare Advantage information is available in this manual.

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “Traditional” or “Original” Medicare). Medicare Advantage offers Medicare beneficiaries several product options (similar to those available in the commercial market), including Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service (POS), and Private Fee-For-Service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits. Many offer additional covered services as well (e.g., enhanced vision and dental benefits). Medicare Advantage plans may allow in and out-of-network benefits depending on the type of product selected. Level of benefits and coverage rules may vary depending on the Medicare Advantage plan.

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Prior to providing service, providers should always confirm the level of coverage by submitting an electronic inquiry or calling 800-676-BLUE (2583) for all Medicare Advantage members.

Highmark's Medicare Advantage Products

Highmark offers the following Medicare Advantage products: Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare PPO and Community Blue Medicare Plus PPO, Complete Blue PPO, Together Blue Medicare HMO, Security Blue HMO-POS, Senior Blue HMO, BlueSaver HMO, Freedom PPO, Forever Blue PPO, Freedom HMO, and Freedom PPO.

For additional information on Highmark Medicare Advantage products, please see Chapter 2.2: Medicare Advantage Products & Programs.

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally

(except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Note: The Medicare Advantage HMO Network Sharing for Transplant Services program provides all Blue Plan Medicare Advantage HMO members in-network access to Blue Plan Medicare Advantage HMO providers in other areas for transplant services. Please see the **Medicare Advantage Eligibility, Claims, and Payment** section of this unit for more information.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare Advantage HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

For providers in Delaware, Pennsylvania, and West Virginia

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost- sharing may be greater when covered services are obtained out-of-network.

Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Plan Medicare Advantage PPO members have in-network access to Blue Plan Medicare Advantage PPO providers in other areas. Please see the next section in this unit on "Medicare Advantage PPO Network Sharing."

Medicare Advantage PFFS

A Medicare Advantage Private-Fee-For-Service (PFFS) plan is one in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the

member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays for services rendered to PFFS members. Members are responsible for cost-sharing, as specified in their plan, and balance billing may be permitted in plan-specific limited instances where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products in that:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Highmark.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan. Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions.
- Medicare Advantage PFFS Terms and Conditions might vary for each Blue Plan. We advise that you review them before servicing Medicare Advantage PFFS members.
- You may choose to render services to an out-of-area Medicare Advantage PFFS member on an episode of care (claim-by-claim) basis.
- Submit your Medicare Advantage PFFS claims to Highmark.

Note: Highmark does not offer a Medicare Advantage PFFS product.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

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2.6 Medicare Advantage PPO Network Sharing (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Medicare Advantage PPO Plans are currently offered by Blue Plans in 35 states and in Puerto Rico. All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue Medicare Advantage PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Advantage PPO Plan. As long as covered services are provided by a contracted Medicare Advantage PPO provider, the member's in-network benefit level will apply.

Identifying Out-of-Area Members

You can recognize a Medicare Advantage PPO member when their Blue Cross Blue Shield member ID card has the following logo:

The "MA" in the suitcase indicates a member who is covered under the Blue Medicare Advantage PPO network sharing program. Members have been asked to not show their standard Medicare ID card when receiving services. Instead, members should provide their Blue Cross and/or Blue Shield Member ID card.

Eligibility and Benfeits Verification

To verify eligibility and benefits for a Medicare Advantage PPO member, you can initiate a Secure Message via Availity®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at 800-676-BLUE (2583). Be sure to ask if Medicare Advantage benefits apply.

Note: Please be sure to have the member's 3-character prefix in order to obtain eligibility information.

Impact to Providers

If you are a contracted Highmark Medicare Advantage PPO provider in Pennsylvania or West Virginia, you must provide the same access to care for members of other participating Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO members. You will be reimbursed in accordance with your contracted rate under your Freedom Blue PPO contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted Highmark Medicare Advantage PPO provider, you may see out-of-area Blue Medicare Advantage PPO members but are not required to do so.

Should you provide services to these members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent and emergency care, you will be reimbursed at the in-network benefit level.

Member Cost Sharing

A Medicare Advantage PPO member's cost sharing level and copayment is based on their health plan. A Medicare Advantage PPO participating provider in Delaware, Pennsylvania, or West Virginia may collect the copayment amounts at the time of service or bill for any deductibles, coinsurance, and/or copayments. However, you may not balance bill the member the difference between your charge and the Medicare Advantage PPO allowance for a particular service.

To determine the member's cost sharing, you should call the BlueCard Eligibility Line at 800-676-BLUE (2583).

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2.6 Medicare Advantage Eligibility, Claims, and Payment

How to recognize Medicare Advantage members Medicare Advantage members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card.

These images illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

To verify eligibility and benefits for an out-of-area Medicare Advantage member, you can initiate a Secure Message via Availity®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at 800-676-BLUE (2583). Be sure to ask if Medicare Advantage benefits apply.

Note: Please be sure to have the member's 3-character prefix in order to obtain eligibility information.

Medicare Advantage Claims Submission

Medicare Advantage is a separate program from BlueCard and delivered through its own centrally-administered platform. However, claims for all out- of-area Blue Plan Medicare Advantage members are still submitted to your local Highmark plan under your current billing practices. You will receive payment from your local Highmark plan.

Important! Medicare should not be billed for any services rendered to a Medicare Advantage member.

NAIC Codes For Medicare Advantage Claims Submission

Claims for all out-of-area Blue Plan Medicare Advantage members can be submitted to your local Highmark plan via an electronic HIPAA 837 transaction using the applicable NAIC code for the Highmark plan with which you participate.

Please reference the following tables for NAIC codes for claim submission for Highmark Medicare Advantage products and for Medicare Advantage claims for out-of-area Blue Plans:

Pennsylvania

NAIC Code	Provider Type	Products

54771W	Western Region facility type providers (UB-04/837I)	• Medicare Advantage Security Blue HMO- POS, Together Blue Medicare HMO, and Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company; and • All Medicare Advantage claims for any other Blue Plans.
54771C	Central Region facility type providers (UB-04/837I)	• Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company. • All Medicare Advantage claims for any other Blue Plans.
54771	All other provider types (1500/837P)	• Medicare Advantage Security Blue HMO- POS, Together Blue Medicare HMO, (Western Region only) and Medicare Advantage Community Blue Medicare HMO, all administered by Highmark Choice Company.

		• All Medicare Advantage claims for any other Blue Plan.
15460	All provider types	• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes **HRT** and **HRF**). • Medicare Advantage Community Blue Medicare PPO (prefixes **QLS, QMV, QJS, QKS**) and Community Blue Medicare Plus PPO (prefixes **FYO**, **FZO**).

Delaware

NAIC Code	Provider Type	Products
00070	Facility provider types (UB-04/837I)	• All Medicare Advantage claims for any Blue Plan.
00570	All other provider types (1500/837P)	• All Medicare Advantage claims for any Blue Plan.

West Virginia

NAIC Code	Provider Type	Products
54828	All provider types	• All Medicare Advantage claims for any other Blue Plan.
15459	All provider types	• Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix **HSR**).

For More Information

For complete information on all Highmark NAIC payer codes, please see the section of this unit titled "NAIC Codes."

Medicare Advantage Paper Claims Submission Addresses

Submit paper claims for Highmark Medicare Advantage products and out-of-area Blue Plan Medicare Advantage members to your local Highmark plan as follows:

Pennsylvania	Delaware	West Virginia
Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062	Highmark Blue Cross Blue Shield (DE) P.O. Box 8830 Wilmington, DE 19899	Highmark Blue Cross Blue Shield (WV) P.O. Box 7026 Wheeling, WV 26003

Reimbursement for Medicare Advantage HMO, POS, and PPO – With a Plan Contract

For providers in Pennsylvania and West Virginia

If you are a Medicare participating provider in Pennsylvania or West Virginia and have a Medicare Advantage contract with Highmark, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount when you render services to out-of-area Blue Plan Medicare Advantage HMO and POS members. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

However, if you provide services to an out-of-area Medicare Advantage PPO Network Sharing member, you will be reimbursed in accordance with your contracted rate under your Freedom Blue PPO contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by Highmark. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service and may not otherwise charge or balance bill the member. Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Note: Out-of-area Medicare Advantage HMO members are generally covered only for emergency services; however, please see below for the transplant services exception effective January 1, 2018.

Medicare Advantage HMO Network Sharing for Transplant Services

For providers in Pennsylvania

Blue Cross Blue Shield Association (BCBSA) policy, effective January 1, 2018, requires Blue Plans that offer Medicare Advantage HMO products to participate in network sharing for transplant services. Under the policy, Blue Plans with Centers for Medicare & Medicaid Services (CMS) approved transplant facilities included in their Medicare Advantage HMO networks are required to share contracted rates for transplant services with out-of-area Blue Plan Medicare Advantage HMO members.

Medicare Advantage HMO Network Sharing for Transplant Services will provide in- network access to all Blue Plans' Medicare Advantage HMO provider networks for Blue Plan Medicare Advantage HMO members who may require a transplant service outside of their home Plan's licensed service area.

Beginning January 1, 2018, transplant facilities participating in Highmark's Medicare Advantage HMO networks in Pennsylvania will be reimbursed according to their contracted Medicare Advantage HMO rate for approved transplant services for out-of-area Blue Plan Medicare Advantage HMO members. If you are a contracted Highmark Medicare Advantage HMO provider, you must provide the same access to transplant services for members of other Blue Plan Medicare Advantage HMO plans as you do for Highmark's Medicare Advantage HMO members.

These members will receive in-network benefits for approved transplant services in accordance with their plan's in-network benefits, with any applicable member cost sharing applied.

Reimbursement for Medicare Advantage HMO,POS, and PPO - With No Plan Contract

Based on the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a Medicare participating provider who accepts Medicare assignment and you render services to a Medicare Advantage member but do not have a Medicare Advantage contract with Highmark, you will generally be considered a non-contracted provider and will be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Reimbursement for Medicare Advantage PFFS Members

If you have rendered services for a Blue out-of-area Medicare Advantage Private- Fee-For-Service (PFFS) member, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the

amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms and Conditions under the member's Blue Plan.

Medicare Advantage PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan. We advise that you review them before servicing Medicare Advantage PFFS members.

A link is provided on the Provider Resource Center to access the Medicare Advantage PFFS Terms and Conditions for all Blue Plans-select **Provider Network** from the main menu and then **Inter-Plan-Programs**.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member. Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

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2.6 Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is the primary payer, submit claims to your local Medicare carrier or intermediary.
- Most Blue Plan claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

How to Submit Medicare Primary/Blue Plan Secondary Claims

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from Highmark. Check the member's ID card for the correct Blue Plan name.

Include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

Review the Remittance Advice for Confirmation

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the member's Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **Do not submit the claim to Highmark.**
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Highmark with the Medicare remittance advice.
- In some cases, the member identification card may contain a Coordination of Benefits Agreement (COBA) ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact Highmark.

Claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed. This process may take up to 14 business days.

This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.

What to Do if You Have Not Received a Response

If you submitted the claim to the Medicare intermediary/carrier, and have not received a response to your initial claim submission, do not automatically submit another claim. You should:

- Review the automated resubmission cycle on your claim system
- Wait 30 days
- Check claim status before resubmitting

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Questions? If you have questions, please contact Highmark Provider Service.

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2.6 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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About Highmark

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Chapter 3 - Provider Network Participation

Highmark pays claims for services performed by licensed, eligible health care providers. Eligible providers may sign an agreement to participate in one or more of Highmark's provider networks. Providers who choose not to participate in Highmark's networks must register with Highmark prior to submitting claimsfor covered services.

Unit 1: Introduction to Network Participation

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

READ MORE

Unit 2: Professional Provider Credentialing

Where the Highmark professional provider networks are utilized to support managed care products,Highmark must credential providers. Providers are initially credentialed prior to network admission and recredentialed at least every three years.

READ MORE

Unit 3: Professional Provider Guidelines

CMS requires Highmark to have the most current information on our network providers and requires ongoing review of all physician information listed in the Provider Directory. It is crucial to your practice to ensure your information is always accurate and up-to-date for the Provider Directory.

READ MORE

Unit 4: Organizational Provider Participation (Facility/Ancillary)

Highmark credentials organizational providers (facility and ancillary) in order to ensure they are in good standing with all regulatory and accrediting bodies. Highmark's participation and credentialing requirements derive from internal business decisions as well as the standards set by those agencies.

READ MORE

Unit 5: Ohio Healthcare Simplification Act (PA and WV Only)

This unit sets forth provisions of, and procedures and policies resulting from, the Ohio Healthcare Simplification Act (“OHSA”).

READ MORE

Disclaimer

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Unit 1: Network Participation Overview

3.1 Introduction to Network Participation

Highmark pays claims for services performed by licensed, eligible health care providers. Eligible providers may sign an agreement to participate in one or more of Highmark's provider networks. Providers who choose not to participate in Highmark's networks must register with Highmark prior to submitting claims for covered services.

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

All providers who submit claims to Highmark must obtain an individual National Provider Identifier (NPI) number. Highmark will only make payments for eligible services rendered by a provider with a valid NPI. To learn more about obtaining an NPI, please see the section in this unit titled **National Provider Identifier (NPI).**

Non-Discrimination Policy

In selecting and credentialing providers for the associate networks, Highmark does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Highmark does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If Highmark declines to include a provider in its networks, Highmark will furnish written notice of the reason for its decision to the affected provider.

Compliance with the Mental Health Parity and Addiction Equity Act

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Highmark applies the same network admission and provider credentialing standards to all providers in comparable manner regardless of whether the provider renders medical services, behavioral health services, or substance abuse treatment services.

Eligible Organizational Providers (Facility and Ancillary)

Highmark holds contracts with organizational providers (facility and ancillary) and credentials them to ensure they are in good standing with all regulatory and accrediting bodies.

- Eligible facility type providers include, but are not limited to, acute care hospitals, psychiatric facilities, substance abuse treatment centers, skilled nursing facilities, ambulatory surgical centers, hospice, and home health.
- Eligible ancillary providers include freestanding and facility-based providers including, but not limited to, independent laboratories, durable medical equipment, home infusion, and ambulance.

For more information specifically on organizational provider participation, please see the manual's **Chapter 3 Unit 4: Organizational Provider Participation.**

Who is an Eligible Professional Provider?

Eligible professional providers include:

- Certain certified registered nurses
- Doctors of Chiropractic (DC)
- Doctors of Dentistry (DDS/DMD)
- Doctors of Medicine (MD)
- Doctors of Optometry (OD)
- Doctors of Osteopathy (DO)
- Doctors of Podiatry (DPM)
- 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

Additional Providers Eligible in West Virginia

For providers in West Virginia

Highmark Blue Cross Blue Shield (WV) also contracts with the following provider types for networks and/or programs as indicated:

- Acupuncturists – for Federal Employee Program (FEP) members and Medicare Advantage members only
- Massage Therapists – for commercial networks only
- Certain diabetic educators – for all provider networks*
- Licensed Physician Assistants – for all provider networks*

**Including Medicare Advantage*

Additional Providers Eligible in Delaware

For providers in Delaware

Highmark Blue Cross Blue Shield (DE) also contracts licensed Physician Assistants in all networks.

Additional Providers Eligible in New York

For providers in New York

Licensed Mental Health Counselors (LMHC) are eligible in all commercial networks.

Effective January 1, 2024, LMHCs are also eligible in Medicaid and Medicare Advantage networks.

Effective January 1, 2024, Psychoanalysts with a Psychoanalyst license are eligible in all commercial networks.

Acupuncturists

For providers in Delaware and Pennsylvania

Practitioners who are not eligible to contract with Highmark to participate in Highmark's networks in Delaware and Pennsylvania may be eligible to provide services for certain government programs only (e.g., FEP and Medicare Advantage).

Although acupuncturists are not eligible to contract with Highmark for our commercial networks in Delaware and Pennsylvania, they are fully credentialed and contracted to provide services to FEP and Medicare Advantage members only.

Acupuncturists

For providers in New York

Acupuncturists in New York are eligible for Medicare Advantage, FEP, and commercial networks.

Physician Assistants

Physician Assistants (PA-Cs) in Pennsylvania and New York are not eligible to participate in Highmark's commercial or Medicare Advantage networks as independent practitioners; however, PA-Cs can bill as a rendering provider once they enumerate within Highmark's systems.

PA-Cs in West Virginia and Delaware can independently bill if they have met Highmark's credentialing requirements. Providers who have not met Highmark's credentialing requirements are not eligible to participate in Highmark's commercial or Medicare Advantage networks as independent practitioners; however, PA-Cs can bill as a rendering provider once they enumerate within Highmark's systems.

For more information on Physician Assistants billing as a rendering provider, review Reimbursement Policy 010: "Incident To" Billing.

Practitioners Who May Serve as PCPs

A physician (MD or DO) who is a family practitioner, general practitioner, internal medicine practitioner, Geriatricians, Adolescent Medicine, Obstetrics/Gynecologists, or pediatrician is entitled to participate as a primary care physician (PCP). The physician must complete the credentialing process.

In addition, certified registered nurse practitioners (CRNPs) have the opportunity to offer their clinical expertise as a primary care CRNP to Highmark members. Qualified CRNPs must complete a credentialing application and meet credentialing requirements to receive designation as a primary care

CRNP with Highmark. CRNPs cannot be dual credentialed and serve as both a CRNP specialist and a PCP within the same group practice. However, a CRNP can be dual credentialed for different group practices, serving as a CRNP specialist in one group and as a PCP in another group practice.

In West Virginia and Delaware only, physician assistants (PAs) may also participate as PCPs.

Practitioner Availability Monitoring

Since Highmark requires members to utilize a designated practitioner network, Highmark must ensure that there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs. Highmark monitors practitioner availability annually against its standards and initiates action, as needed, to improve member access to covered services.

Practitioner availability monitoring is completed for primary care practitioners, high-volume specialty care practitioners, and behavioral health practitioner types. All behavioral health practitioner types (not just high-volume types) are assessed on an annual basis.

General Conditions of Participation

In order to participate in Highmark's networks, a provider must:

- Execute the appropriate network participation agreement(s), which include the terms of payment, and complete fully any required application or information forms;
- Abide by the terms and conditions of such agreement(s), including any amendments;
- Satisfy and remain in compliance with applicable Highmark credentialing and recredentialing standards;
- Cooperate and comply with Highmark's health services management programs, including but not limited to: precertification, prior authorization, care and case management, disease management, clinical quality improvement, and other programs and initiatives that may be adopted;
- Provide timely written responses to complaints or clinical quality issues upon request from Highmark;
- Follow Highmark's appeals processes and other dispute resolution mechanisms; and
- Adhere to Highmark's billing, claims submission, and other administrative guidelines and requirements, including this *Highmark Provider Manual.*

Open/Closed Networks

Highmark accepts applications in any of its networks, with only a limited area closed to new practitioners of specific provider types. Highmark reserves the right, however, to close one or more of its networks to specific types of providers or to additional service locations if:

- Highmark determines that it has contracted with a sufficient number and distribution of providers to serve its members adequately; or
- Highmark determines that closing the network would otherwise be in the best interests of its members, the company, and network providers.

If Highmark elects in the future to close a network, notice of such policy will be communicated.

Mutual Roles and Obligations for Network Participating Providers and Highmark

As a participant in any of Highmark's networks, providers agree to a set of regulations that outline their obligations to Highmark members. Highmark has obligations to its network participants as well. The agreements and regulations that providers execute when joining the network contain the mutual obligations.

Key contractual provisions include:

- Network providers will accept the network allowance as payment-in-full for covered services, less any applicable copayments, deductibles, and/or coinsurance.
- Highmark will make payment directly to network providers and will notify members of any responsibility they may have (such as non-covered services, coinsurance, and/or deductibles).
- Network providers will handle basic claims filing paperwork for the member.
- Highmark will encourage members to obtain health care services from network providers which could increase the provider's patient base.
- Network providers will recommend their patients see other network providers when necessary.
- Providers participating in any of Highmark's professional provider networks are eligible to become actively involved with Highmark as corporate professional members and as members of the company's various professional committees and advisory councils.

Equal Access and Non-Discrimination in Treatment of Members

In addition to requirements contained in your provider agreement and in any other applicable administrative requirements, network providers agree to requirements of equal access and non-

discrimination of Highmark members within this manual. Complaints will be investigated as appropriate and referred to the Credentialing Committee for appropriate action.

Providers will give members equal access at all times to provider services. Providers agree not to discriminate in the treatment of Highmark members, or in the quality of services delivered, on the basis of place of residence, health status, race, color, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment. Further, providers shall not deny, limit, discriminate or condition the furnishing of provider services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

Meeting Cultural and Linguistic Needs

Network providers must ensure that services, both clinical and non-clinical, can meet the cultural and linguistic needs of all members, including those with limited English proficiency, disabilities, reading skills, diverse cultural and ethnic backgrounds, sexual orientation, and the homeless; and are responsive to member needs and preferences.

Highmark may be able to assist a provider to locate translator or interpreter services for members who are non-English speaking or hearing impaired. The provider or member should call the Highmark Member Service telephone number on the back of the member's ID card.

Non-Retaliation for Exercise of Rights and Remedies

Providers are encouraged to become knowledgeable of the rights and remedies available to them under their agreement(s) with Highmark, this *Highmark Provider Manual,* and other administrative policies and procedures.

It is our policy to treat providers courteously, professionally, and fairly in all circumstances. Providers can be assured that they will not be subject to discriminatory treatment or retaliation in any form of exercising rights and remedies afforded them pursuant to their agreements with Highmark.

3.1 PROMISe Enrollment Required for Pennsylvania CHIP

For providers in Pennsylvania

The Pennsylvania Department of Human Services (DHS) implemented the Affordable Care Act (ACA) Provider Enrollment and Screening provisions that require all providers who render, order, refer, or prescribe items or services to Children's Health Insurance Program (CHIP) enrollees to have a valid PROMISe™ ID.

Providers who provide services to Highmark Healthy Kids (CHIP) enrollees must complete a Provider Reimbursement and Operations Management Information System (PROMISe) enrollment application for their provider type for each service location where they see CHIP enrollees. Once enrolled, the provider is issued a PROMISe ID, which is required to provide services to CHIP enrollees and receive reimbursement.

PROMISe ID Enrollment Requirements

PROMISe enrollment is required to provide services to Highmark Healthy Kids (CHIP) enrollees and receive payment for claims. The enrollment requirements apply to all providers who provide services to CHIP enrollees covered under the Pennsylvania CHIP program. The Pennsylvania Office of CHIP requires every provider servicing CHIP enrollees to have a PROMISe ID assignment for each service location and for each provider NPI (includes practitioner, group, vendor, and billing NPI).

To enroll, you must complete an enrollment application appropriate for your provider type and for each service location. A **service location** is defined as a physical street address where a practitioner: 1) maintains an office; 2) holds office hours/sets appointments; and 3) renders services. Once enrolled, you will receive a 13-digit PROMISe ID unique to each service location.

If you are already enrolled in PROMISe ID for the Pennsylvania Medical Assistance Program (also called "Medicaid"), you do not need to enroll again for CHIP. However, if you are enrolled with another state's Medicaid or CHIP program or are enrolled in Medicare, you must enroll with Pennsylvania's DHS to service CHIP enrollees in Pennsylvania.

Note: Most providers are not required to pay the application fee, which typically applies to larger facilities.

Important! Avoid Claim Denials

Highmark is required to deny claims if we are unable to match the provider's NPI reported on the claim to a PROMISe enrollment record for the service location where the services were performed. To avoid claim denials, ensure that you have enrolled and received a PROMISe ID for all service locations prior to that date. In addition, always report any changes to your practice in a timely manner to avoid any future claim denials.

Service Location Enrollment Guidelines

The following explains how specific types of providers are to enroll service locations.

Individual Providers

Individual providers must enroll every service location where they provide services to Highmark Healthy Kids (CHIP) enrollees, except as noted below. This results in each service location having its own unique service location number. Providers who work at multiple locations or offices must enroll each location at which they provide services.

Institutional Locations

Individual providers who have clinical privileges at an institutional location do not need to enroll these places of service. The institutional locations are those using the following Place of Service (POS) codes:

POS Code	Place of Service Name
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility

32	Nursing Facility

However, if the individual provider is employed by the institution and the only place they provide services is the institutional location, the individual provider must enroll at the institutional location.

Radiologists and Anesthesiologists

Individual providers enrolled with the following provider types and specialties, who may have enrolled previously at only one service location, must enroll at every service location where they provide services, unless they are providing services at an institutional location as described above.

	Provider Type	Specialty
Radiologist	31	341
Anesthesiologist	31	311
Certified Registered Nurse Anesthetist (CRNA)	32	320

Provider Groups

Provider groups must enroll all of their service locations and receive a separate service location number for each location. Additionally, each group member must enroll as an individual provider at each service location where the individual provider practices.

Highmark Healthy Kids (CHIP) Promise ID Enrollment Application

Providers can complete a PROMISe ID application to enroll in Highmark Healthy Kids (CHIP) and/or Pennsylvania Medical Assistance. If completing an application for CHIP only, you would not be enrolled

as a Medical Assistance provider and you would not be required to service Pennsylvania Medical Assistance beneficiaries.

CHIP PROMISe ID enrollment information and applications, both electronic and printable PDF versions, are available on the DHS website.

How the PROMISe ID is Determined

The PROMISe ID is a 13-digit number based on the Federal Tax ID Number, provider type and specialty (s), and the physical location where services are provided. The first nine digits are assigned for a given Federal Employer Identification Number (FEIN) or Social Security number (SSN). The last four numbers reflect a 4-digit Service Location Code that is based on provider type, specialty, and physical location. Click on the link to access the list of provider types/specialties that are reflected in Service Location Codes.

Your PROMISEe ID is Automatically Added to Highmark's Provider File

Highmark receives a listing of the PROMISe IDs for Highmark-affiliated providers electronically from the Pennsylvania Department of Human Services, and these IDs are automatically uploaded into Highmark's Provider Information Management system for each individual provider.

Reporting Changes

Any changes to your practice must be reported to DHS in a timely manner. Information and forms for various types of changes are available on the DHS website.

Revalidation

All providers must revalidate their PROMISe enrollment for each service location every five years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found here.

Frequently Asked Questions

We have developed frequently asked questions to help you understand more about PROMISe ID enrollment requirements and the importance of enrolling in order to receive reimbursement for the services you provide to Highmark Healthy Kids (CHIP) enrollees.

For More Information

For more information about the CHIP program in Pennsylvania, please see the *Highmark Provider Manual's* **Chapter 2 Unit 3: Other Government Programs.**

3.1 Network Compliance

Providers participating in Highmark's provider networks must comply with the terms and conditions of their provider agreement(s) and meet acceptable standards for quality of clinical care, resource utilization, and administrative compliance to ensure that the networks operate in an effective and efficient manner. This also ensures that members receive high quality, medically appropriate, and cost-effective care.

Providers who are not compliant are subject to the network corrective action policy providing for corrective action, sanctioning, suspension, and termination of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, resource utilization, and/or administrative compliance.

Categories of Non-Compliance

Non-compliance can be divided into three categories:

1. Quality-of-care concerns
2. Unacceptable resource utilization
3. Administrative non-compliance

Quality-of-Care Concerns

A quality-of-care concern arises when an episode of care deviates from accepted medical standards. The occurrence of an adverse outcome does not, in and of itself, indicate a breach of accepted medical standards and/or warrant action.

Examples of Quality-of-Care Concerns

Examples of quality-of-care concerns include, but are not limited to:

- Actions or omissions that result or may result in an adverse effect on a patient's well-being
- Delayed services/referrals
- Missed diagnoses
- Medication errors
- Delayed diagnosis/treatment
- Unexpected operative complications
- Invasive procedure complications
- Inappropriate procedures
- Unanticipated, unexplainable death
- Actions requiring a report to the National Practitioner Data Bank (NPDB) or other adverse actions

Unacceptable Resource Utilization

Unacceptable resource utilization is defined as a pattern of utilization that is at variance with recognized standards of clinical practice or with specialty-specific aggregated data.

Examples of Unacceptable Resource Utilization

Examples of patterns of unacceptable resource utilization include but are not limited to:

- Inappropriate or unnecessary admissions
- Inappropriate utilization of emergency services
- Inappropriate or unnecessary inpatient hospital stay days
- Patterns of inappropriate utilization of outpatient surgery
- Patterns of inappropriate PCP encounters per member per year
- Patterns of inappropriate utilization of referrals
- Under-utilization (i.e., withholding) of necessary and appropriate medical services

Administrative Non-Compliance

Administrative non-compliance is defined as behavior that does not comply with applicable laws, regulations, or Highmark policies or procedures, or that is detrimental to the successful functioning of Highmark as a health plan or to its members' rights or benefits under their plan.

Examples of Administrative Non-Compliance

Examples of administrative non-compliance include but are not limited to:

- Direct or unauthorized billing for services

- Balance billing a member for services
- Failure to cooperate/comply with Highmark's administrative quality improvement, utilization review, credentialing, member service, reimbursement, and other procedures
- Conduct that is unprofessional toward members, family members, and/or staff of Highmark
- Failure to comply with any contractual obligation
- Failure to comply with policies and procedures of Highmark
- Failure to comply with or violation of state or federal laws or regulations

Use of Information and Data for Quality Improvement and Transparency and Compliance Requirements

Providers acknowledge and will cooperate with Highmark's quality improvement and transparency programs and initiatives, which include, but are not limited to, programs developed to support Highmark's member and provider initiatives, and satisfy the compliance requirements of the National Committee for Quality Assurance (NCQA), other accreditation entities, and any applicable regulatory body (collectively, "Quality Initiatives").

In connection with Quality Initiatives, Highmark may use the Provider Data for such purposes, including but not limited, as follows:

- Utilize, publish, disclose, and display any information and data related directly or indirectly to the Provider's delivery of health care services, such as, but not limited to, performance or practice data, information relating to Provider's costs, charges, payment rates and quality, utilization, outcome and other data ("Provider Data");
- Disclose the Provider Data to Highmark's contracted vendors and agents to assist in the review, analysis, and reporting of the Provider Data;
- Report the Provider Data to other providers to assist such providers in the management of care costs, quality outcomes, and other efficiencies;
- Report the Provider Data to Members and customers (including third parties who supply information and analysis services to group customers); and
- Use the Provider Data to support Provider's participation in certain benefit value levels (such as network tiers).

Providers acknowledge and agree that any Provider Data is proprietary to Highmark, a highly confidential trade secret of Highmark, and is entitled to protection as such. In the event that a provider receives any Provider Data (which may be the provider's own Provider Data or the Provider Data of a provider other than the provider), the provider agrees to maintain the Provider Data as confidential and to use it for the

purpose or purposes for which the Provider Data was provided by Highmark or its contractor or agent and agrees to not publish or publicly share the Provider Data, except as expressly permitted by Highmark in writing.

Without limiting the foregoing, any provisions in the provider's participating agreement or Administrative Requirements that address the confidentiality of information and data, such as the Provider Data, shall remain in full force and effect and such provisions shall govern the Provider Data in addition to this section of Chapter 3.1 of the *Highmark Provider Manual.*

3.1 Electronic Transaction Requirements

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark has taken steps to eliminate paper transactions with our contracted providers. Because of the inherent speed and cost-effectiveness, electronic and online communications are integral in today's business world and Highmark requires that all network providers participate in electronic programs sponsored or utilized by Highmark now or in the future.

Enrollment in Availity, EFT, & Paperless EOBs/Remittances Required for All Participating Providers

All Highmark network participating providers are required to enroll in Availity®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements and Remittance Advices. All new assignment accounts must sign up for Availity and also enroll in EFT and paperless EOBs/remittances.

Availity is an easy online solution linking physician offices and facilities with Highmark and other health plans. Availity integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available at no cost to Highmark network participating providers.

Participating providers are also required to enroll to receive electronic funds transfers and paperless EOB statements/ remittances.

- EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account as directed by your office. Payments are typically in the designated bank account by Wednesday of each week. For Delaware, Pennsylvania, and West Virginia providers, this information is also available for viewing within PNC's Healthcare's ECHO Health platform.
- Paperless EOB statements and remittances reduce the amount of paper flowing into the provider's office. They are available for viewing on Monday morning via Availity – which is two days earlier than receiving them by mail. For Delaware, Pennsylvania, and West Virginia providers, this information is also available for viewing within PNC's Healthcare's ECHO Health platform.

How to Sign Up for Availity

Providers who are not currently registered to use Availity should go to the Register and Get Started with Availity Essentials webpage.

Enrolling in EFT and Paperless EOBs

For providers in Delaware, Pennsylvania, and West Virginia

Claims payments are generated by PNC-ECHO Health Trust. Electronic Remittance Advices (ERAs) are distributed using the ECHO Payer ID 58379. Providers may elect to receive EFT only or 835/EFT through the ECHO Health platform. To sign-up to receive EFT on the ECHO Health platform, visit their EFT/ERA enrollment page.

Virtual Credit Cards: Providers who have not registered to accept payments electronically will receive virtual credit card payments with their EOBs. Offices opted in to virtual credit cards (VCC) will receive notification for each payment via mail or fax, which will include a unique virtual credit card number and instructions for processing. Providers may opt out of VCC by visiting/calling ECHO Health at **800-890-4124.**

Additional payment options: ECHO also offers payments via Medical Payment Exchange (delivers payments and EOBs electronically and gives providers the option to print a check at no cost, receive a virtual card payment, or enroll for EFT) or paper check. Explore more details about these options on ECHO Health's platform.

Once providers are enrolled and start receiving EFT payments, providers will no longer receive paper EOB statements or remittances. Providers will still be able to view the claims status and a copy of the EOB

through Highmark's provider portal. However, providers will need to visit ECHO's provider platform to manage/change payment information.

Enrolling in EFT and Paperless EOBs

For providers in New York

After becoming Availity-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless Explanation of Benefits (EOB) statements. To do this, please contact the Provider Service Center.

Health Information Exchange Programs

Network providers are also required to participate in any Highmark, Highmark-sponsored, and/or Highmark-designated state or community-sponsored health information exchange program, which supports and/or facilitates the availability and exchange of claims-based information and clinical information for the treatment and ongoing management of Highmark members and/or other patients of network providers.

Any requirements relating to participation in such health information exchange program shall be provided through Highmark communications and/or administrative requirements in advance of such participation requirement and shall be binding on network providers and Highmark.

3.1 Provider Networks

Overview of Pennsylvania Networks

For providers in Pennsylvania

This section provides brief descriptions of Highmark's professional provider networks in the state of Pennsylvania and contiguous counties.

Commercial networks in Pennsylvania include:

- Participating Provider Network
- Premier Blue Shield statewide provider network
- Keystone Health Plan West (KHPW) managed care network (Western Region only)
- Community Blue select network

Medicare Advantage networks in Pennsylvania:

- Freedom Blue PPO
- Community Blue Medicare PPO/Plus PPO
- Medicare Advantage HMO (Western Region only)
- Community Blue Medicare HMO

Participating Provider Network

For providers in Pennsylvania

Highmark has agreements with thousands of Participating Providers representing every major specialty. Any eligible professional provider licensed to practice in Pennsylvania may apply for participating status by completing the *Participating Provider Agreement With Highmark Blue Shield.*

This is not a credentialed network – a professional provider's admission to the network is based solely on Pennsylvania licensure and the execution of a Participating Provider Agreement. This network services our traditional Highmark Blue Shield programs, including traditional BlueCard® as well as BlueCard Point of Service (POS) and Health Maintenance Organization (HMO) programs.

Premier Blue Shield Network

For providers in Pennsylvania

The Premier Blue Shield Network is Highmark's statewide selectively contracted preferred provider network in Pennsylvania. Any eligible facility and professional provider licensed to practice medicine in Pennsylvania may apply for the Premier Blue Shield network. You must meet the network's credentialing criteria to be accepted into the network.

Because Premier Blue Shield supports managed care products, Highmark must ensure the network complies with the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 PA Code, Chapter 9). These regulations require that we ensure network providers meet certain standards. As a result, Highmark staff conducts site visits and medical record reviews of primary care practitioners, obstetricians/gynecologists, high-volume behavioral health provider offices, and facilities.

This network supports a variety of coverage programs. Premier Blue Shield also supports the BlueCard Preferred Provider Organization (PPO) programs in Pennsylvania's Central Region and is used by other carriers who have an arrangement with Highmark. The Federal Employee Program (FEP) is the largest customer that utilizes this network in the Central, Eastern, and Northeastern Regions of Pennsylvania.

Western Region KHPW Managed Care Network

For providers in Pennsylvania

The Keystone Health Plan West (KHPW) managed care network in the 29-county Western Region of Pennsylvania supports the managed care products in Highmark's Western Region only. These include health maintenance organization (HMO) coverage plans and the Children's Health Insurance Program (CHIP). This network also supports the Federal Employee Program (FEP) in the western part of Pennsylvania. In addition, this network supports BlueCard PPO programs in the 29-county Western Region.

The network is comprised of highly qualified PCPs, leading medical specialists, and facilities offering a broad range of care. Eligible licensed professional providers practicing medicine in Highmark's Western Region may apply for participation in the network. Professional providers must meet credentialing criteria and sign a Highmark Choice Company Professional Provider Agreement.

Since it supports Highmark's managed care products in the Western Region, this network must also comply with Pennsylvania Department of Health regulations governing managed care organizations. Therefore, Highmark also conducts site visits and medical record reviews of network participating providers' offices and facilities to ensure they meet necessary standards.

Highmark Healthy Kids (CHIP)

For providers in Pennsylvania

The PA CHIP Network supports the CHIP health maintenance organization (HMO) product in all 62 counties of Pennsylvania's service areas. The network is comprised of providers who have enrolled in PROMISe ID with the Pennsylvania Department of Human services.

Community Blue Commercial Network

For providers in Pennsylvania

The Community Blue networks, located in Pennsylvania's Western and Central Regions, are select networks that support the commercial Community Blue PPO and EPO products. These products were designed to provide an affordable choice for customers seeking lower cost coverage while still being able to receive high quality, cost-efficient care from highly reputable health care providers.

The Community Blue hospital networks include community and world-renowned hospitals while the physician network includes primary care physicians and specialists who are also part of the larger managed care networks in each region.

Members can locate participating Community Blue providers by using the applicable regional Provider Directory accessible on MyHighmark.com by selecting **Find Doctors and RX.**

First Priority Health Network

For providers in Pennsylvania

The First Priority Health managed care network in the 13-county Northeastern Region of Pennsylvania supports the health maintenance organization (HMO) products in this service area. This includes, but is not limited to, BlueCare® HMO, BlueCare® HMO Plus, and the Children's Health Insurance Program (CHIP).

The First Priority Health network of professional providers and facilities spans throughout the 13-county service area and includes several hospitals and their participating physicians in contiguous counties in Pennsylvania, New Jersey, and New York. To be included in the network, practitioners and facilities must maintain high-quality standards and meet strict credentialing criteria.

Medicare Advantage Networks

For providers in Pennsylvania

The networks are the cornerstones of the Medicare Advantage HMO and PPO programs in Pennsylvania. Medicare Advantage HMO members are required to obtain services from providers participating in the applicable Medicare Advantage network – *except* for urgent or emergent care. Members with Medicare Advantage PPO plans have both in-network and out-of-network benefit options.

The Medicare Advantage preferred provider network supporting Freedom Blue PPO spans a 62-county service area, including all Pennsylvania counties except Bucks, Chester, Delaware, Montgomery, and Philadelphia in the Eastern Region.

The Medicare Advantage network supporting Security Blue HMO members (in Pennsylvania's Western Region only) includes an expansive network of professional and facility providers in the 28-county service area.

Community Blue Medicare HMO and PPO networks are select, high-value networks in select counties throughout Highmark's regions supporting the Community Blue Medicare products. Community Blue Medicare PPO has a broader network of providers than Community Blue Medicare HMO, while the Community Blue Medicare Plus PPO network is limited to Clinton, Lycoming, Sullivan, and Tioga counties with exclusive access to Geisinger Danville facilities and doctors.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself. For more information on Medicare Advantage, please visit **Chapter 2 Unit 2: Medicare Advantage Products & Programs.**

Note: The Community Blue Medicare HMO network differs from the network associated with the commercial Community Blue products.

ACA Select Network

For providers in Pennsylvania

The ACA Select Network supports Highmark Affordable Care Act (ACA) my Direct Blue HMO and EPO products that are available in certain counties in Pennsylvania. The ACA Select Network is comprised of select local physicians and hospitals that provide quality outcomes at an affordable cost for my Direct Blue ACA members in those counties.

Physician practices employed by a hospital or health system in the ACA Select Network will also participate in the network. Network participating providers can be located by using the online Highmark Provider Directory.

Note: Highmark continues to offer ACA PPO plans in most regions that use the broader networks, as applicable.

Delaware

For providers in Delaware

The Delaware Provider Network spans all three counties in the state of Delaware and also contiguous counties of neighboring states. Highmark Blue Cross Blue Shield (DE) has participating provider contracts with more than 90 percent of Delaware's physicians and health care providers and includes all hospitals in Delaware.

As the leading health benefits company in the state, Highmark Delaware strives to provide members access to leading health care professionals in all specialties. All physicians and practitioners requesting network status with Highmark Delaware are required to complete and participate in the application and credentialing process.

Highmark Delaware's Participating Provider Network supports all products available from Highmark Delaware, including Blue Classic traditional, Blue Choice PPO, Simply Blue EPO, Blue Select POS, the MedicFill Medicare supplemental program, and the Blue Care Independent Practice Association (IPA) managed care HMO product. The network also supports FEP and BlueCard.

West Virginia

For providers in West Virginia

Highmark Blue Cross Blue Shield (WV) contracts with providers who have service locations within either the state of West Virginia or a contiguous county. Highmark West Virginia uses provider networks for all of its health benefits lines of business.

Highmark West Virginia professional provider networks include the following:

- Indemnity
- Preferred Provider Organization (PPO)
- Point of Service (POS)
- Medicare Advantage Freedom Blue PPO

Providers sign a Network Agreement, which includes an Addendum I to Network Agreement for Super Blue PPO and POS Participants. The Network Agreement includes an Addendum II to Network Agreement for Super Blue Select Primary Care Physicians for those primary care physicians who act as care coordinators for members in Highmark West Virginia POS products.

Participation in the Freedom Blue network is governed by an Amendment to Network Agreement for Medicare Advantage PPO Program(s); for certain providers not participating in Highmark West Virginia's commercial networks, this may be a standalone agreement.

New providers contracting with Highmark West Virginia are required to participate in the indemnity, PPO, and POS commercial networks. New providers are encouraged but not required to participate in the Medicare Advantage Freedom Blue PPO network. Network providers may elect to opt out of the Freedom Blue network by providing written notice to Highmark West Virginia pursuant to the Medicare Advantage amendment/agreement.

The West Virginia Small Business Plan (WVSBP) uses the Highmark West Virginia commercial PPO network. Providers may opt out of the WVSBP but remain in the Highmark West Virginia PPO network through an annual opt-out process administered by the West Virginia Public Employees Insurance Agency (PEIA).

3.1 Select DME Network (PA Only)

For providers in Pennsylvania

To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

Select DME Network

The Select DME Network is the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

For Highmark commercial benefit plans, the Select DME Network applies to the highest tier level of Pennsylvania tiered health plans. For example, for a 3-tiered plan such as Connect Blue in western Pennsylvania, the Select DME Network applies to the Preferred tier level. In a two-tiered plan such as Community Blue Flex, Community Blue Premier Flex, and Alliance Flex Blue, the Select DME Network applies to the Enhanced tier level. Highmark commercial members with tiered plans have the option of choosing other DME participating providers not in the Select DME Network; however, receiving services or supplies from non-Select DME Network providers may result in higher out-of-pocket costs for members.

For More Information

Highmark provides two versions of the current list of providers in the Select DME Network. You can select a list of all participating providers or a list organized by category, which includes telephone numbers. These lists of providers in the Select DME Network are also available on the Provider Resource Center. From the main menu at the top of the page, select **Provider Network**, then **High-Performance Networks** and then choose **Select Durable Medical Equipment Network.**

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

Referring Highmark Members to DME Providers

Providers should refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

Highmark commercial members can continue to use providers from the broader DME network; however, you should refer Highmark commercial members to Select DME Network providers to receive the highest level of benefits possible.

3.1 Directing Care to Network Providers

Highmark network providers must refer members who need additional, non-emergent services to other providers who participate in the network associated with the member's benefit plan (i.e., PPO, POS, Medicare Advantage). This protects the member from higher costs that may be incurred if services are received from a out-of-network provider.

Background

Many of Highmark's products have a requirement that members have all their care rendered by providers who hold a contract with the appropriate Highmark network.

- Health Maintenance Organization (HMO), Independent Practice Association (IPA), and Exclusive Provider Organization (EPO) products provide no benefits for non-emergent services rendered by out-of-network providers. An HMO, IPA, or EPO member is responsible for the entire cost of out-of-network services unless in rare cases where a service is not available in the network.
- Preferred Provider Organization (PPO), Point of Service (POS), and open access products feature a lower level of payment when non-emergent services are rendered by an out-of-network provider. A PPO, POS, or open access member who receives a service from an out-of-network provider is

responsible for out-of-network deductible and coinsurance amounts before the insurance begins to cover the expense unless in rare cases where the service is not available in the network.

For additional program and product information, please see the *Highmark Provider Manual's* **Chapter 2: Product Information.**

Participating Provider Responsibilities

It is the obligation of providers who participate in a managed care network to provide services at the most appropriate level and to protect Highmark members from business practices that expose them to unnecessary out-of-pocket expenses. This means, among other things, that when your Highmark members require services that you are not able to provide, you are obligated to direct those members to other providers who participate in the network associated with their benefit program.

You are not permitted to direct Highmark members to out-of-network providers unless the member elects to use an out-of-network provider, has out-of-network coverage, and/or the use of such providers has been authorized by Highmark's Clinical Services or, in some cases, by a Highmark Medical Director.

Locating Network Providers

The online Highmark Provider Directory allows providers to search for Highmark network participating providers. It can be accessed from the footer on the home page of each of Highmark's regional Provider Resource Center websites:

- https://hbcbs.highmarkprc.com/ - serving the 29 counties of western Pennsylvania.
- https://hbs.highmarkprc.com/ - serving the 21 counties of central Pennsylvania, 5 counties of southeastern Pennsylvania, the Lehigh Valley, and the 14 counties of Northeastern Pennsylvania,
- https://hdebcbs.highmarkprc.com/ - serving the three counties of Delaware.
- https://hwvbcbs.highmarkprc.com/ - serving the entire state of West Virginia.
- https://hwnybcbs.highmarkprc.com/ - serving eight counties in Western New York.
- https://hnenybs.highmarkprc.com/ - serving 13 counties in Northeastern New York.

Providers can also search for participating providers through Availity.

Out-of-Network Services

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 Highmark's Clinical Services for assistance.

Highmark care management staff will attempt to identify one or more in-network providers who perform the service in question. If we cannot locate an in-network provider, we will work with other sources to identify out-of-network providers who may perform the service. If the services are medically necessary, Clinical Services will authorize the use of an out-of-network and approve in-network benefits.

Type of Provider Choice

When more than one type of provider can furnish a particular service or item covered by the member's benefit plan, Highmark generally does not restrict a member's or referring provider's choice of what type of provider to use.

Consistent with provider anti-discrimination law, Highmark plans do not impose limitations or conditions on services, diagnoses, or treatment by a particular type of provider that do not apply equally to all types of licensed providers that customarily provide such services.

Highmark's benefit plans do generally provide services that must be:

- Furnished by licensed (or certified, where applicable) providers practicing within the scope of their license;
- Rendered according to generally accepted medical standards and practices;
- Provided by someone other than an immediate family member; and
- The most appropriate supply or level of service which can be safely and adequately provided to the member in the most cost-effective setting.

3.1 How to Register with Highmark

To be registered on Highmark's files and submit claims to Highmark, eligible providers who are not participating in Highmark's networks must submit their rendering and billing National Provider Identifiers (NPIs).

Information on obtaining an NPI is provided in the section within this unit titled "National Provider Identifier (NPI)."

Submit NPIs to Highmark

To be registered on Highmark's files in these service areas, eligible providers must submit their rendering and billing NPIs to Highmark.

Fax to: 800-236-8641

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

3.1 How to Become a Participating Provider (PA Only)

For providers in Pennsylvania

Highmark's Participating Provider Network (Par Network) in Pennsylvania — which services Highmark's traditional programs as well as BlueCard® traditional, point of service (POS), and health maintenance organization (HMO) programs — is not a credentialed network. A professional provider's admission to the network is based solely on Pennsylvania licensure and the execution of a Highmark Professional Agreement.

Participating Providers agree to perform services for members according to the applicable Participating Provider provisions (Part I and Part II) of the Highmark Blue Shield Regulations for Participating Providers and Premier Blue Shield Providers, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield, and master contracts.

Highmark Professional Agreement Form

A provider who completes the credentialing process to participate in Highmark's Pennsylvania credentialed networks will automatically be sent a **Highmark Professional Agreement** and be eligible to participate in the Par Network. However, if a provider would like to forego credentialing and participate

only in the Par Network, a provider must complete a “Highmark Professional Agreement” by submitting the completed agreement. A solo practitioner is entering into the agreement as both “Participating Provider” and “Practitioner”. In a group practice, the Participating Provider is entering into the agreement on its own behalf and on behalf of each of its employed practitioners.

The “Highmark Professional Agreement” can be requested through the Request for Assignment Account form or, if not setting up a new Assignment Account, through the Request to be a Highmark Professional Pennsylvania Participating Provider form under the **Provider Information Management Forms** section on the Provider Resource Center. You will also find the **Regulations for Participating Providers** in this section.

Facility and Ancillary providers can use the Initial Application for Facility and Ancillary Providers under the **Credentialing** section of the Provider Resource Center.

The completed **Highmark Professional Agreement** can be sent to Highmark along with a copy of your current license if a solo practitioner. If a group practice, submit a copy of the license of each practitioner. The Participating Network Agreement and license(s) can be sent by using the Contract Upload Form under the **Provider Information Management Forms** section on the Provider Resource Center.

Once the completed agreement is received and processed, you will be notified in writing of the effective date of your participation.

3.1 Participation in Highmark Credentialed Networks

To participate in Highmark’s credentialed networks, the professional provider begins the application process through CAQH ProView™ – the online credentialing database developed by the Council for Affordable Quality Healthcare (CAQH). The CAQH ProView national standardized online system eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Practitioners complete one standard application that meets the needs of Highmark and other participating health plans and health care organizations.

Highmark uses CAQH ProView as the exclusive provider credentialing system for all applicable networks. All Highmark network providers in the Pennsylvania and Delaware service areas must use CAQH for credentialing and recredentialing.

Once CAQH ProView registration is completed, the provider will receive additional information for completing the application process for participation in the networks within our service areas.

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

Important: Mandated WV Uniform Credentialing Form

For providers in West Virginia

To initiate the credentialing process, Highmark Blue Cross Blue Shield (WV) physicians and allied health practitioners must complete the most recent version of the State of West Virginia Uniform Credentialing Form (application), preferably by entering information into the CAQH database, as long as it is printed on the mandated West Virginia Uniform Credentialing Form (application).

For More Information

For complete details on CAQH ProView and the credentialing process, please see **Chapter 3 Unit 2: Professional Credentialing.**

3.1 Dual Networks (PA Only)

For providers in Pennsylvania

Some customers choose to have more than one professional provider network support their managed care coverage program in Pennsylvania. These programs have both a primary provider network and a

secondary network comprised solely of Highmark Blue Shield's Participating Provider network. The Pennsylvania Insurance Department and Pennsylvania Department of Health have approved these dual-network programs.

Dual-network managed care programs use a separate, supplemental member contract. This contract applies when a member chooses to receive services from a participating provider not in the primary network. Payment under the supplemental contract is based on Usual, Customary, and Reasonable (UCR). Service benefits apply when a Highmark Blue Shield participating provider renders the services.

The Explanation of Benefits form that accompanies the UCR payment states that a Participating Provider must accept the UCR allowance as payment in full for covered services, in accordance with the terms of the Participating Provider agreement. The participating provider may collect any applicable coinsurance or deductibles from the member.

3.1 Assignment Accounts

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

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

Eligible Entities and Arrangements

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

- The billing entity must be arranged in one of these manners:
    - **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number to receive payment from Highmark.
    - **Sole proprietorship** – A sole proprietorship is unincorporated, owned by one individual, and its liabilities are the sole proprietor's personal liabilities. The sole proprietor takes the risks

of the business for all assets owned. For legal and tax purposes, the business does not exist separately from the owner.

- **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
  - Two or more providers practice as a partnership;
  - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
  - A provider employs one or more other providers as associates in his or her practice.

- A provider not participating in a Highmark provider network may not be included in a Highmark assignment account which also contains participating providers.

How to Establish an Assignment Account

To establish an assignment account, complete the Request for Assignment Account electronic form. This form can also be found on the Provider Resource Center – select **Resources & Education**, then **Provider Information Management Forms.**

Note: To establish a Medicare assignment account, call Medicare Provider Enrollment Services at 866-488-0549.

Important: Assignment Account Regulations

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

The regulations are also available on the Provider Resource Center under **Forms,** and then **Provider Information Management Forms.**

Electronic Transactions Required

All Highmark network participating providers are required to enroll in Availity®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements. All new assignment accounts must sign up for Availity and also enroll in EFT and paperless EOBs.

Availity is Highmark's provider portal, which integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). EFT is a secure process that directs Highmark claim payments to the provider's checking or

savings account as directed by your office. Paperless EOB statements reduce the amount of paper flowing into the provider's office.

For information on enrolling in Availity, EFT, and paperless EOBs, please see the **Electronic Transaction Requirements** section of this unit.

Keeping Assignment Account Information Up-to-Date

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

Please notify Highmark immediately when any of the following changes:

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

Notification of New or Departing Practitioners

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

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

Availity is the preferred method for notifying Highmark of practitioner changes. Please continue reading this unit for additional information on making changes to an existing assignment account.

Restrictions

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

How to Make Changes to an Existing Assignment Account

You can notify Highmark of any changes to your existing assignment account quickly and easily by using Availity, Highmark's preferred method for updating your assignment account information. Select **Provider Data Maintenance** or **Provider File Management (Delaware, Pennsylvania, and West Virginia only)** in Availity's Payer Spaces.

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

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

- **Practitioner Updates:** For practitioner changes, use the Addition to Existing Assignment Account electronic form.
- **Address Updates:** For adding new practice locations or to make changes to an existing location, complete the Provider Directory Update Form.

These forms can also be accessed on the Provider Resource Center – select **Resources & Education,** and then **Provider Information Management Forms.**

The completed **Provider File Maintenance Request** form can be faxed or mailed as follows:

Fax to: 800-236-8641

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

Note:

New York: After becoming Availity-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless Explanation of Benefits (EOB) statements. To do this, please contact the Provider Service

Center.

Delaware, Pennsylvania, and West Virginia: Changes to your electronic funds transfer (EFT) can be done through the ECHO portal. Please see the **Electronic Transaction Requirements** section of this unit for more information on how to contact ECHO/change your EFT preferences.

Important!

If going from a solo practice to a group practice and adding practitioners, you will need to create a new assignment account.

3.1 Provider Tax Identification Numbers

Highmark's Use of Provider Tax Identification Numbers

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

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

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

How to Obtain a Federal Employer Identification Number (EIN)

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

To obtain an EIN, please visit irs.gov.

3.1 National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans.

The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

What is The “NPI”?

The National Provider Identifier (NPI) is a 10-digit numerical identifier for providers of health care services. The NPI is a result of the CMS mandate which supports the HIPAA simplification standards. All eligible health care providers receive one standard number which they are required to use when submitting health care transactions. It is intended to improve the efficiency of the health care system and to help reduce fraud and abuse.

Individual practitioners receive one NPI even when they are dual licensed under multiple provider types (e.g., a practitioner holds both an MD and DMD license). Organizational providers (group practices and facilities) receive one NPI for the legal entity and any subpart that meets the covered health care provider definition if it were a separate legal entity. Organizations may request additional NPIs for subparts as long as the identifying data is unique.

How to Obtain an NPI

NPPES is the central electronic enumerating system in place for assigning NPIs. Health care providers can apply for NPIs in one of three ways:

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

3.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 2: Professional Provider Credentialing

3.2 Introduction to Credentialing

Where the Highmark professional provider networks are utilized to support managed care products, Highmark must credential providers and utilize procedures to comply with National Committee for

Quality Assurance (NCQA); the Centers for Medicare & Medicaid Services (CMS); State of Delaware Regulation 1403 Managed Care Organizations; New York State Department of Financial Services and New York Department of Health; Commonwealth of Pennsylvania Department of Health (DOH) regulations; and State of West Virginia regulations.

Providers are initially credentialed prior to network admission and recredentialed at least every three years. Highmark conducts verification of the practitioners as defined by their policies, state and federal regulations, and in accordance with accrediting standards.

This unit focuses on the credentialing process and presents a general description of Highmark's credentialing criteria and process. This is not intended to be a complete description of all credentialing requirements and procedures.

Note: Throughout this unit, the use of "Highmark" implies the Highmark service areas of Delaware; New York's Northeastern and Western regions; Pennsylvania's Central, Northeastern, and Western regions; and West Virginia, unless otherwise noted.

Purpose

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

Online Process Utilized

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

Initial Credentialing

Highmark staff follows an established process to credential professional providers for the Commercial Exclusive Provider Organization (EPO) and Independent Practice Association (IPA) networks in Delaware; the Point of Sale (POS) and Health Maintenance Organizing HMO networks in Western and Northeastern New York; the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; and the Commercial Preferred Provider Organization (PPO) and Point of Service (POS) networks and the Medicare Advantage network in West Virginia.

In addition, we have delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

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

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

To be considered a participating practitioner and support Highmark managed care products, including Medicare Advantage, all new practitioners must complete the CAQH online credentialing application, be approved by Highmark through a routine assessment process or by the Highmark Network Quality and Credentials Committee, as applicable, and then sign a contract.

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

Recredentialing

Highmark completes the recredentialing process at least once every three years with any applicable physicians and allied health professionals in the Commercial EPO and IPA networks in Delaware, the Point of Sale (POS) and Health Maintenance Organizing HMO networks in Western and Northeastern New York; the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; and the PPO and POS networks and the Medicare Advantage network in West Virginia. Our internal policies require recredentialing for the protection of our members. Additionally, Highmark's three-year credentialing cycle is consistent with NCQA, CMS, State of Delaware, New York Department of Health, New York State Department of Financial Services, Pennsylvania Department Of Health, and State of West Virginia standards.

The recredentialing process includes most of the same components as initial credentialing with some added components. At the time of recredentialing, a quality review is conducted. This review includes, when available, member satisfaction, member complaints related to both administrative and quality of

care issues, malpractice history, medical record reviews, and office site information. Information regarding clinical quality actions or sanction activity will also be considered for continued network participation.

Ongoing Monitoring

Highmark's Provider Information Management Department routinely monitors the ongoing compliance of network providers with credentialing/recredentialing criteria. Such monitoring includes, but is not limited to:

- U.S. Department of Health and Human Services, Office of Inspector General (OIG), List of Excluded Individuals/Entities (providers excluded from participation in Medicare, Medicaid program in all states, and other federal or governmental health programs) (monthly);
- Licensing Board queries (monthly); and
- Medicare Part B Opt-Out List (monthly).

If it is determined or suspected that a provider no longer complies with credentialing, recredentialing, or contracting requirements (e.g., revocation or suspension of a license, state or federal government program sanction), the matter will be investigated and presented to the Highmark Network Quality and Credentials Committee (or the medical director in urgent situations) for appropriate action including termination of provider agreements and participation in credentialed networks (as necessary).

Network Quality and Credentials Committee

The Highmark Network Quality and Credentials Committee (DE/NY/PA/WV) consists of practitioners from the applicable regions who are practicing physicians of various specialties who participate in Highmark's network in those regions. The Committee meets monthly to allow expeditious processing of exception practitioners.

The Committee is chaired by Highmark medical directors, who oversee the clinical aspects of the credentialing program. Other Highmark executive staff members serve on the Committee as non-voting members.

The primary responsibilities of the Network Quality and Credentials Committee are:

- Review and make recommendations regarding credentialing/recredentialing exception cases;
- Request additional information if needed to review a provider;
- Review and make recommendations regarding credentialing policies and procedures;

- Recommend corrective action or termination if a provider fails to meet reasonable standards of care or to comply with credentialing or contracting requirements; and
- Consult with appropriate specialists if needed to review a credentialing application or issue.

Note: The Highmark Network Quality and Credentials Committee is a formally constituted peer review body, which meets the definition of review organization under West Virginia Code §S30-3C-1. As such, their proceedings and records are confidential and privileged as provided by WV Code §S30-3C-3.

3.2 Highmark Network Credentialing Policy

Physicians and any applicable allied health professionals must be credentialed by Highmark to participate in the Commercial EPO and IPA networks in Delaware; the HMO POS networks in Western and Northeastern New York, the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; and the Commercial PPO and POS networks and the Medicare Advantage network in West Virginia.

Types of Professional Providers Credentialed

Highmark currently credentials the following types of professional providers:

Physicians	Allied Health Professionals
Doctors of Chiropractic (DC)	Occupational Therapists
Doctors of Dental Surgery/Dental Medicine (DDS/DMD): • General dentists who provide covered medical/surgical services	Optometrists Physical Therapists *Acupuncturists** *Certified Diabetic Educators*** Certified Midwife****

	Clinical Nurse Specialists Licensed Dietitian – Nutritionist***** *Licensed Physician Assistants** *Licensed Psychoanalysts****** *Massage Therapists*** Registered Nurse Practitioners Speech Pathologists & Therapists
• Oral and maxillofacial surgeons	Psychologists
• Oral and maxillofacial radiologists	Registered Dieticians
• Oral and maxillofacial pathologists	Registered Nurse Anesthetists
• Orthodontists	Registered Nurse Midwives
Doctors of Osteopathic Medicine (DO)	Clinical Social Workers
Podiatrists (DPM)	Counselors and Therapists
Medical Doctors (MD)	Audiologists

**Medicare Advantage and FEP networks in Delaware, Pennsylvania, and West Virginia.*

Commercial, Medicare Advantage, and FEP in New York.

***New York and West Virginia only.*

****Delaware and West Virginia only.*

*****Delaware and New York only.*

*****Not eligible for New York Medicaid.*

******New York only.*

When are Practitioners Credentialed?

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

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

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

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

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

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

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

When Credentialing is Not Required

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

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

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

Availity-enabled providers can make those changes through **Provider Data Maintenance** or **Provider File Management (Delaware, Pennsylvania, and West Virginia only)** in Payer Spaces. For those providers not Availity-enabled, click here for an electronic form that can be used to notify us. This form is also available on the Provider Resource Center – select **Forms** from the left menu, click **Provider Information Management Forms,** and then click:

- **DE, PA, and WV:** Addition Request to Existing Assignment Account
- **NY:** Request to Add a New Practitioner to an Existing Participating Practice

General Credentialing Criteria

The following is a general summary of Highmark's credentialing criteria for all practitioners.

- Active state license in each state where the practitioner provides services;
- Acceptable five-year work history for initial credentialing;
- Professional liability insurance in compliance with regulations in state(s) in which the physician practices (please see the section in this unit on malpractice insurance requirements);
- Acceptable malpractice history;
- Have not opted out of the Medicare Part B program for the Medicare Advantage network(s); and
- No Medicare, Medicaid, or other state or federal government program sanctions.

In addition, physicians (MDs, DOs, DDSs/DMDs, and DPMs), Physician Assistants (West Virginia and Delaware only), CRNPs, Clinical Nurse Specialists (West Virginia and Delaware only), and Nurse Midwives must furnish proof of the following:

- Active Drug Enforcement Agency (DEA) certificate in each state where the practitioner is prescribing controlled substances or a plan of action listing an in-network provider who could prescribe on their behalf, if applicable;
- Privileges at a network or participating Blue Cross Blue Shield hospital, as applicable; and
- Availability to see Highmark members at least 20 hours a week (for primary care practitioners).
- Physician Assistants:
    - West Virginia: must have a Practice Agreement in place and practice location must be within West Virginia.

- Delaware: must be practicing within Delaware and must have a Physician Assistant license issued by the state licensing board.

Additional criteria for Non-Physician Acupuncturist must meet the following requirements:

- A Masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)
- A current, full, active, and unrestricted License to practice acupuncture

Additional criteria for allied health practitioners include:

- Evidence of appropriate education and training (licensure often verifies education);
- Registered nurses (RNs) must have an active advanced practice certification by an entity approved by the state licensing board; and
- Physician Assistants (West Virginia and Delaware only) must have a collaborating agreement with a physician who is credentialed and contracted in the same network.

Please see the applicable sections in this unit for criteria specific to Emergency Medicine, Facility-Based, and Behavioral Health providers.

Mid-Level and Advanced Practice Provider (APP) Enumeration

To submit an enumeration request, please complete the Advanced Practice Provider (APP) Enumeration Form.

Providers Eligible for Enumeration

Below are the providers eligible for enumeration by state, provider type, and line of business (LOB).

Provider Type	PA Commercial	PA Medicare Advantage	DE Commercial	DE Medicare Advantage	NY Commer
Clinical Nurse Specialist	X	X	X	X	X

Certified Registered Nurse Practitioner	X	X	X	X	X
Licensed Clinical Social Worker	X	X	X	X	
Physician Assistant	X	X	X	X	X
Licensed Marriage and Family Therapist	X	X	X	X	
Licensed Professional Counselor	X	X	X	X	
Licensed Social Worker	X	X	X	X	
Licensed Associate Marriage	X		X		

and Family Therapist					
Licensed Associate Professional Counselor	X		X		

More Information

For more information for advanced practice providers, please see **Medical Policy Z-27: Eligible Providers and Supervision Guidelines** and **Reimbursement Policy 068 (RP-068): Mid-Level Practitioners and Advanced Practice Providers**.

Physician Education and Training

All physicians must furnish proof of graduation from an American Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited training program. MDs and DOs may possess current Educational Commission for Foreign Medical Graduation (ECFMG) certification and have passed the Federation Licensing Examination (FLEX) or United States Medical Licensing Exam (USMLE).

Oral and maxillofacial surgeons, general dentists, and orthodontists must have completed training accredited by the Commission on Dental Accreditation (CODA). Podiatrists must have completed an accredited program recognized by the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS).

Specialty Training and Provider Directory Listing

MDs and DOs may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) if they have completed an ABMS or AOA accredited residency program in that specialty.

Oral and maxillofacial surgeons may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Oral and Maxillofacial Surgery (ABOMS) if they have completed an accredited residency program in that specialty.

Podiatrists may be credentialed and listed in the provider directories in specialties recognized by either the ABPM or the ABFAS if they have completed an accredited residency program in that specialty. If ABPM or ABFAS boards are not available to the practitioner, the American Board of Medical Specialties in Podiatry (ABMSP) will be recognized.

Completion of Applications

For practitioners who fail to complete the credentialing or recredentialing process, or fail to supply all required information, this action **will be deemed as a practitioner's intention** to voluntarily withdraw from the applicable network(s) or result in discontinuation of the credentialing process for initial applicants.

The provider will be able to reapply for credentialing once he/she is able to comply with all initial credentialing requirements. For recredentialing practitioners, you will be notified in writing and your members may receive notification that you no longer participate in the network(s).

Malpractice Information

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

Medicare Opt-Out

Practitioners who have opted out of Medicare are not eligible to see Medicare Advantage members.

24/7 Availability Requirements

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

An answering service, pager, or direct telephone access whereby the practitioner or his/her designee can be contacted is acceptable.

For Behavioral Health providers, a referral to a crisis line/center is acceptable if prior arrangement has been made whereby the crisis line/center can reach the provider (or his/her designee), if needed.

The following specialties are exempt from this requirement:

- Audiologists
- Certified Diabetic Educators
- Dermatopathologists
- Dietitians/nutritionists
- Massage therapists
- Occupational therapists
- Pathologists (only if working outside of the acute care setting)
- Oral and maxillofacial pathologists (only if working outside of the acute care setting)
- Physical therapists
- Psychologists who perform neuropsychological testing or psychological evaluations only
- Preventive medicine specialists
- Read-only practitioners
- Speech/language pathologists

Availability for Urgent and Routine Care

At the time of initial credentialing, Primary Care Practitioners (PCPs) applying for Pennsylvania networks and not joining an existing group must provide office hours accessible to members a minimum of 20 hours a week. (Only applies to networks in Pennsylvania.)

PCP practices in Pennsylvania not meeting this requirement will be subject to an on-site review every three years and will be noted in the provider directory as having limited hours.

Admitting and Clinical Privilege Requirements

Primary care physicians (family practitioners, pediatricians, internists, Geriatricians, Adolescent Medicine, Obstetrics/Gynecologists, and general practitioners) and Primary Care Physician Assistants (Delaware and West Virginia only) are required to have admitting privileges in good standing at a network participating hospital. Applicable physician specialists and physician assistant specialists (Delaware and West Virginia only) are required to have clinical privileges in good standing at an in-network hospital. Primary care certified registered nurse practitioners (CRNPs) must have full admitting privileges or a plan of action with a network participating primary care physician.

The hospital clinical privilege requirement is waived for the following specialties:

- Anesthesiology
- Dental anesthesiology

- Emergency medicine
- Nuclear medicine
- General dentistry
- Hospice and palliative medicine
- Oral maxillofacial surgery
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Non-surgical podiatry
- Physiatry/physical medicine
- Physician assistant specialist
- Psychiatry
- Radiology

Clinical privilege requirements, including admitting, will be waived for all physicians who, on the application, document arrangements that are acceptable to Highmark for adequate coverage through another credentialed in-network practitioner.

The practitioner must have privileges at an in-network hospital or belong to a credentialed in-network group of the same specialty. The name(s) of the covering physician(s) must be provided on the application (a co-signed document from the covering physician[s] is not required.)

First Priority Health Network Admitting and Clinical Privilege Requirements

For providers in Pennsylvania

Primary care physicians and specialists who are in the First Priority Health (FPH) network in northeastern Pennsylvania must meet the following admitting and clinical privilege requirements:

- Each FPH primary care physician applicant shall have hospital privileges in the specialty for which they are applying at a FPH participating hospital or have an alternative arrangement for admitting a member, approved by the Plan.
- Each FPH specialist applicant shall have hospital privileges in the specialty for which they are applying at a FPH participating hospital or have an alternative arrangement for admitting a member, approved by the Plan.

Important!

Highmark practitioners are required to use participating practitioners for all coverage arrangements, including ambulance.

Confidentiality and Anti-Bias Statements

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

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

Time Frame

Highmark is required to verify all completed application information within 180 days from the date the practitioner signs the attestation statement.

The Network Quality and Credentialing area will not submit any application for the Network Quality and Credentials Committee's review that is signed and dated more than 180 days prior to the Committee date for initial or recredentialing providers. These time frames also apply to any primary or secondary source verification information. In such cases, the provider may be asked to re-sign the application and information may need to be re-verified.

Ohio Healthcare Simplification Act

Highmark's credentialing procedures are designed to facilitate prompt review and decision regarding a provider's completed credentialing application. In accordance with the Ohio Healthcare Simplification Act, all practitioners who participate with West Virginia and/or Pennsylvania and whose primary site of service is located in Ohio are required to be credentialed and notified of their credentialing status within 90 days of Highmark receiving a complete or incomplete credentialing application.

New York

For providers in New York

Highmark will notify a provider of the following within 60 days of receiving a completed application:

- Credentialing determination; or
- Information regarding additional time/documentation that is necessary to make a determination because of a failure of a third party

A final determination will be made within 21 days of receiving additional documentation.

Credentialing applications are not considered “complete” until all necessary documentation has been received by Highmark’s Credentialing Department.

Massachusetts

All providers will be initially credentialed within 60 days following the submission of the provider’s completed credentialing application. Notification with the status of the application will be sent to the provider within 75 days.

West Virginia

For providers in West Virginia

A credentialing decision must be made within four months of a completed application for West Virginia providers. The timeframe may be extended an additional three months due to delays in obtaining primary source verification.

Locum Tenens

Highmark credentials locum tenens physicians based on the length of time the physician will be providing care in Highmark network service areas. Locum tenens physicians who will be providing services for 60 days or longer will be required to undergo initial credentialing and, if applicable, recredentialing at least every three years.

3.2 Practitioner Credentialing Rights

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

Primary Sources

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

- State Licensing Bureau
- Drug Enforcement Agency
- Educational program(s) the practitioner completed
- American Board of Medical Specialties, or American Osteopathic Association, if applicable
- National Practitioner Data Bank
- Office of the Inspector General participation/sanction data
- Applicable State of Federal Program Administration for participation/sanction data
- Federation of Chiropractic Licensing Board, if applicable
- Federation of Podiatric Medical Board, if applicable

Additional Sources

Highmark will review and may also take into consideration the following types of information (among others) in credentialing or recredentialing decisions for all provider types:

- Convictions, criminal and civil proceedings;
- Substance abuse impairment;
- Fraud, inappropriate or excessive billing;
- Complaints;
- Non-cooperation/non-compliance with Highmark contract terms, administrative requirement, or health services management programs;
- Completeness, timeliness, and accuracy of credentialing information; and
- Quality-of-care or utilizations issues.

Right to Review Information

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

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

Fax to: 800-236-5907

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

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

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

Notification of Discrepancy

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

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

Right to Correct Erroneous Information

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

Fax to: 800-236-5907

Mail to:
Highmark Blue Shield
Provider Information Management

P.O. Box 898842
Camp Hill, PA 17089-8842

Email to: Address provided by staff assigned

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

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

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

Right to be Informed of Credentialing Status

Providers can view network status and effective dates via **Provider Data Maintenance** or **Provider File Management (Delaware, Pennsylvania, and West Virginia only)** in Payer Spaces in the Availity provider portal..

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

Communication of Practitioner Rights

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

Annual notifications of the availability of this information in the *Highmark Provider Manual* are published in the *Provider News* newsletters. Providers are notified when *Provider News* is published online via e-Subscribe email notifications.

3.2 The Credentialing Process

Highmark uses CAQH ProView™, the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) for initial credentialing because it greatly improves processing times. CAQH ProView eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Through this online service, practitioners complete one standard application that meets the needs of Highmark and other participating health plans and health care organizations.

Highmark uses CAQH ProView as the exclusive provider credentialing system for all applicable networks. All Highmark network providers in the Delaware and Pennsylvania service areas must use CAQH for credentialing and recredentialing.

Important: Mandated West Virginia Uniform Credentialing Form

For providers in West Virginia

To initiate the credentialing process, Highmark West Virginia physicians and allied health practitioners must complete the most recent version of the State of West Virginia Uniform Credentialing Form (application), preferably by entering information into the CAQH database, as long as it is printed on the mandated West Virginia Uniform Credentialing Form (application). Please continue reading this unit for CAQH instructions.

The most current versions of the West Virginia Uniform Credentialing Form and recredentialing forms are also available on the West Virginia Insurance Commissioner's website at wvinsurance.gov. All initial credentialing applications for practitioners are to be returned to Highmark's Provider Information Management area for primary source verification by faxing to 800-236-5907.

Providers without access to a fax machine can mail the application to:

Mail to:

Provider Information Management
Highmark
P.O. Box 898842
Camp Hill, PA 17089-8842

Important!

For an overview of the Highmark credentialing process, select **Provider Network** from the main menu on the Provider Resource Center, and then click on **Professional.** The process is also explained in the coming sections of this unit.

If You Already Have a CAQH ID

If you are already a CAQH participating practitioner with a CAQH ID, please visit https://proview.caqh.org. Log into CAQH ProView to review and re-attest to your CAQH application. Be sure to add Highmark as an authorized plan or grant global authorization.

In addition, you must complete Highmark's online Initial Credentialing Request Form, which is available in the **Credentialing** section of Highmark's Provider Resource Center.

Complete the required fields on the form, including your CAQH ID, and then click **Submit.** Highmark will retain an electronic copy of your CAQH ProView profile in its database and send you a confirmation email.

If You Are Not Yet Registered with CAQH

If you have not yet registered with CAQH ProView, you will first need to visit https://proview.caqh.org to obtain a CAQH ID and complete the application. Resources to help you navigate the system are available through links on the login page. Although the initial application may take several hours to complete, the process allows you to save your information and return later to complete the application. **Please be sure to select Highmark as a plan authorized to receive your information.**

Once you have obtained your CAQH ID, please complete Highmark's **Initial Provider Credentialing Request Form,** which is available in the Credentialing section of Highmark's Provider Resource Center.

Complete the required fields on the form, including your CAQH ID. After the form is successfully submitted, Highmark will retain an electronic copy of your CAQH ProView profile and will send you a

confirmation email.

Check the Status of Your Request

To ensure your application has been received, please visit Availity and follow these steps:

- Go to Payer Spaces and then click on **Provider Data Maintenance** or **Provider File Management (Delaware, Pennsylvania, and West Virginia only).**
- Select the **Review credentialing status** link; the **Case Status** field will indicate the progress of the practitioner's credentialing application.
- Click on the arrow before the practitioner's name to view details.

By selecting **Expand All,** you can view credentialing details for all practitioners in the group.

If You Do Not Have Internet Access...

If you are not yet registered with CAQH and do not have internet access, please call the toll-free **CAQH Help Desk** at **888-599-1771** for other options for completing the CAQH credentialing application. You can then call Highmark's Provider Service Center once you receive your CAQH ID.

Steps in the Initial Credentialing Process

During initial credentialing, practitioners also participate in the process of contracting with Highmark. The initial credentialing and contracting process is as follows:
Step 1: To begin the process, the practitioner must submit all information requested through CAQH ProView. Highmark will then provide additional information and instructions.

Step 2: The Highmark Credentialing Department representative reviews the application. If the application is incomplete, the representative contacts the practice to request the missing information.

Step 3: The credentialing process will include, but is not limited to, verification or confirmation of the following:

- Unrestricted licensing in the state(s) where practicing*
- Drug Enforcement Agency (DEA) certificate issued by each state where practicing* or a plan of action listing an in-network provider who could prescribe on their behalf, if applicable
- Medical education and training (as applicable)*
- Board certification (if applicable)*
- History of liability claims

- Malpractice coverage amounts
- Work history
- Medicare participating status
- National Practitioner Data Bank (NPDB)*
- Office of the Inspector General (OIG) Medicare and Medicaid sanction lists*

Note: Primary source verification of hospital clinical privileges and medical liability insurance coverage is no longer required. A signed attestation statement is all that is needed.

**These elements are verified through primary sources.*

Step 4: The Credentialing Department will also review the application for the following:

- Ability to provide urgent/routine care
- 24/7 coverage (if applicable)
- Laboratory Services: If yes, will need to supply CLIA Certificate

Step 5: A Credentialing Department Specialist verifies that all information required for National Committee for Quality Assurance (NCQA) and/or State and Federal Regulatory Agencies is complete.

Note: If verification cannot be completed within the required 180 days, the applicant will be asked to re-sign and re-date the attestation page of the application and provide valid, current information. Electronic signatures are accepted on the application.

Step 6: If the credentials file elements meet all Highmark credentialing criteria, the Medical Director will review the application and render a decision.

If an initial application does not meet the routine credentialing requirements, the application must be denied and the process will be discontinued for the following reasons:

- Lack of an unrestricted license
- Lack of 24/7 coverage
- Lack of appropriate liability coverage
- Lack of board certification, if applicable
- Lack of DEA certificate or Plan of Action, if applicable
- Lack of appropriate education and training
- Lack of hospital privileges or appropriate hospital cover
- Any current government program sanctions

If the recredentialing application does not meet Highmark credentialing criteria, the Highmark Medical Director and/or the Network Quality and Credentials Committee reviews the application. In some instances, the Committee may request additional information before rendering a decision.

Step7:

- Upon approval of the Highmark Network Quality and Credentials Committee or the Medical Director, practitioners will receive written notification.
- If denied initial credentialing status, the practitioner will receive written notification within 60 calendar days.

Step 8:

- In Delaware, a copy of the contract will be mailed to the practitioner for a signature. The practitioner will send the contract back and Highmark Delaware will counter execute it. The practitioner will then receive a fully executed contract and a welcome letter with the effective date of the new provider or group, as applicable.
- In Pennsylvania, a copy of the executed contract and a welcome letter stating the effective date is mailed to the new practitioner or group, as applicable. The practitioner or authorized representative signs the contract and the original contract is returned to Highmark. A Highmark representative signs the contract for validation. A copy of the executed contract and a welcome letter stating the effective date is then mailed to the new network practitioner or group, as applicable.
- In West Virginia, a copy of the executed contract and a welcome letter stating the effective date is mailed to the new practitioner or group. The practitioner or authorized representative signs the contract and the original is returned to Highmark. The contract is signed and validated by a Highmark representative, and then a copy of the executed contract and welcome letter confirming the effective date is mailed to the new practitioner or group, as applicable.

Effective Date

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

Important!

Please note that Highmark strongly discourages the use of Social Security numbers in lieu of business tax identification numbers whenever it requests a provider's tax identification number.

Highmark's Use of Provider Tax Identification Numbers

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

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

How to Obtain A Federal Employer Identification Number (EIN)

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

To obtain an EIN, please visit irs.gov.

3.2 The Recredentialing Process

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

Notification to Complete Online Process

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

All Highmark network providers must use CAQH ProView™ for recredentialing. Paper applications and provider portal functionality for recredentialing have been eliminated.

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

- **For Practitioners Registered with CAQH:** Highmark will send a letter to notify the practitioner that it is time for recredentialing. The practitioner will then log into CAQH ProView at https://proview.caqh.org to review and re-attest to their CAQH application.
- **For Practitioners Not Yet Registered with CAQH:** Highmark will send you a notification to log into CAQH ProView at https://proview.caqh.org. Complete the online application. Be sure to add Highmark as an authorized plan or grant global authorization.
- **For West Virginia Practitioners Not Registered with CAQH:** Generally, six months prior to the recredentialing due date, an application will be mailed to Highmark West Virginia practitioners for completion. Physicians and allied health providers must complete the West Virginia Uniform Recredentialing Form (application), or other state mandated recredentialing application.

If You Do Not Have Internet Access...

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

Assessment of Clinical Quality

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

Office Site Reviews

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

These evaluations will be based on the following:

1. Member dissatisfactions received about the quality of any practitioner office where care is delivered that is related to physical accessibility, physical appearance, or adequacy of waiting room and examining/treatment room space;
2. Annual random sampling with practice sites selected using a statistically valid sampling methodology; or
3. Problems that were identified during Risk Adjustment Data Validation (RADV) audits.

The overall evaluation process may include the following:

- Practitioner office site quality evaluation;
- Medical/treatment record evaluation; and
- Process improvement evaluation.

The office site evaluations include, but are not limited to, an assessment of the following:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Member access to services and availability of appointment;
- Policies and procedures;
- Adequacy of equipment;
- Confidentiality of member information; and
- Adequacy of medical/treatment-record keeping/documentation.

The on-site review nurse will mail a comprehensive, written report to the practice outlining the results of the evaluation and a corrective action plan if necessary.

Practices not meeting the compliance standards are expected to correct deficiencies and are subject to a re-evaluation six months after the initial visit. Failure to correct deficiencies could impact the practice's credentialing or network status.

For more detailed information on this process, please refer to the applicable section of **Chapter 5.6: Quality Management.**

Assessment of Data Completeness

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

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

- **Year One:** If a Data Completeness deficiency or deficiencies are noted by one of Highmark's Clinical Transformation Consultants during a HEDIS or RADV chart audit, a feedback sheet(s) will be left on each member's medical record detailing the deficiencies found. If the individual practice

receives five or more unique feedback sheets in the first year, the practice will be “flagged” in Highmark’s database.

- **Year Two:** If five or more feedback sheets are left with the same practice in the subsequent year, the practice will receive a letter that explains that the credentialing decisions for all practitioners in the practice could be impacted if five or more feedback sheets are given to the practice for a third consecutive year.
- **Year Three:** If a practice receives five or more feedback sheets **for three *consecutive* years,** the practitioners at that office will be evaluated as “exceptions” at the time of their next recredentialing review, which could potentially lead to termination from the network(s).

For the basic elements reviewed during this assessment, please see the measures related to documentation in the Professional/Facility Medical Record Evaluation tables in the Clinical Quality section of **Chapter 5.6: Quality Management.**

Step-By-Step Process

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

Step 1: Notification is sent to the practitioner that the recredentialing application is due several months prior to the end of the three-year credentialing period.

- CAQH registered practitioners receive a letter from Highmark, and then log into CAQH ProView to review and re-attest to their CAQH application.
- Practitioners not yet registered with CAQH ProView will receive a letter from Highmark notifying you to log into CAQH ProView at https://proview.caqh.org. Complete the online application and add Highmark as an authorized plan or grant global authorization.

Step 2: A Credentialing Department representative conducts primary source verification. If additional documents are required, they should be emailed, faxed, or mailed. Highmark is required to verify all completed application information within 180 days from the date the practitioner signs the attestation statement.

Step 3: The Credentials Committee or the Medical Director reviews the practitioner’s qualifications and renders a decision.

Step 4: The practitioner is notified of any adverse decision through a letter within 60 calendar days.

3.2 Credentialing Requirements for Facility-Based Providers

Facility-Based Practitioner Credentialing Policy

Important!

If a practitioner begins to provide medical services to members **outside** of a network-participating facility — including acute care facility, skilled nursing facility, ambulatory surgery center, inpatient hospital, and inpatient freestanding facility setting — the practitioner will be required to complete the initial credentialing and contracting processes.

Determination of In-Network Status

The provider must be currently credentialed by an in-network skilled nursing facility, ambulatory surgery center, inpatient hospital, and/or inpatient freestanding facility setting. This includes, but is not limited to, the following provider types:

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

The practitioner must:

- Provide 100% of his or her services to members exclusively in an in-network skilled nursing facility, ambulatory surgery center, inpatient hospital, and/or inpatient freestanding facility setting.
- Have a current, valid unrestricted license (i.e., absence of a current Prothonotary report or consent order) to practice in the state(s) where he/she provides care for the organization's members. For participation in the Premier Blue Shield Network in Pennsylvania, a practitioner must have a

current, valid, unrestricted license in the Commonwealth of Pennsylvania regardless of the state(s) where the practitioner provides care.
- Have current active malpractice insurance that meets or exceeds Delaware, New York, Pennsylvania, and/or West Virginia state requirements.
- Actively participate with Medicare/Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs.
- Sign an *Affirmation of Medical Practice Statement* (Form No. 282). *(See PARE Attestation information below.)*

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

PARE Attestation

The Pathologist – Anesthesiologist – Radiologist – Emergency Providers (PARE) Attestation, or Facility-Based Provider Affirmation Statement form, can also be accessed from the Provider Resource Center — select **Resources & Education** then **Provider Information Management Forms.**

3.2 Emergency Medicine Credentialing Requirements

Board Certification Requirements

Emergency Medicine providers must be board certified in Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or General Surgery.

Exception To Board Certification

Providers who are in the Highmark defined board eligibility period must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete the board certification by December 31 of the sixth year of completing approved, applicable residency training or a contiguous subsequent fellowship training program in the specialty in which he/she practices. The intent of this exception is to allow time for the provider to become board certified.

If board certified/eligible in Family Medicine, Internal Medicine, Pediatrics, or General Surgery, the provider must maintain current Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certification. If working in an Emergency Department, the provider must have ACLS, PALS, and Advanced Trauma Life Support (ATLS) certification.

General Practice Specialist

For providers in West Virginia

Effective December 1, 2012, Highmark West Virginia participating physicians practicing in an emergency department can no longer be credentialed as a General Practice Specialist with the exception of those practitioners who are currently credentialed under this specialty who were “grandfathered” in under this specialty listing.

To maintain the recredentialing status as a General Practice Specialist, the practitioner must maintain ATLS, ACLS, and PALS certifications and obtain 10 Pediatric CMEs (continuing medical education credits) per year (for a total of 30 Pediatric CMEs per credentialing cycle).

3.2 Credentialing Requirements for Behavioral Health

Behavioral health practitioners considered for participation must provide evidence of a current license in their specialty at the highest level in the state where they practice. Licensure must be for independent practice, if applicable.

A behavioral health practitioner must carry professional liability insurance in compliance with regulations in the state(s) where he/she practices. Please see the section in this unit titled “Malpractice Insurance Requirements” for additional information on requirements in Delaware, New York, Pennsylvania, and West Virginia.

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 where they practice. LCSWs can either be credentialed or enumerated.

Note: For West Virginia only, licensed social workers with a bachelor's degree are eligible for credentialing and can be enumerated for Medicare Advantage.

Licensed Social Workers in Delaware and Pennsylvania are not eligible for credentialing and should follow the process for enumeration. Please refer to the **Mid-Level and Advanced Practice Provider (APP) Enumeration** section in this manual's Chapter 3.2 Highmark Network Credentialing Policy.

Licensed Psychoanalyst* (Effective January 1, 2024)

Provider must be licensed as a psychoanalyst.

Clinical Nurse Specialist Requirements

Clinical nurse specialists (CNSs) in Delaware and West Virginia must be licensed as a registered nurse (RN) and have an Advanced Practice License as a CNS in the state where they practice. Clinical nurse specialists (CNSs) in Pennsylvania and New York require an RN license and state issued CNS license/certification. National Certification is verified through licensure.

Psychiatric-Certified CRNP Requirements

Psychiatric certified registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state where they practice.

Additional Behavioral Health Specialties Criteria

Additional behavioral health specialties must hold licensure or certification in the state where they practice. Specialties include the following:

- Licensed professional counselor (LPC)
- Marriage and family therapists (MFT)
- Licensed Mental Health Counselor (LMHC)*
- Behavioral Analysts/Behavioral specialists licensed or certified per state regulation

**New York only*

3.2 Dual Credentialing/Recredentialing as Both PCP and Specialist

Physician Categories

Highmark contracts with network physicians as either:

- Primary Care Physicians (PCPs) – family practitioners, general practitioners, internists, geriatricians, adolescent medicine specialists, obstetrics/gynecologists, and pediatricians; or
- Specialists – all other MDs or DOs.

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

Criteria

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

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

Recredentialing

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

Recredentialing applicants requesting to add dual credentialing must be board certified/meet exception in each additional specialty requested. If not board certified/meets exception in additional specialty requested, the file will be “Process Discontinued” for that specialty only.

Note: Recredentialing applicants without board certification who were approved for dual credentialing prior to August 15, 2016, will be “grandfathered” into the network.

Provider Directory

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

3.2 Practitioner Quality and Board Certification

To be credentialed in Highmark networks, primary care practitioners (PCPs) and specialists — including podiatrists — are required to be board certified in the specialty in which they practice or meet one of the exceptions to board certification. Our online provider directories will indicate that a physician is board certified if he/she is currently certified in a specialty category.

Note: Effective Aug. 15, 2016, the board certification and exception policy requirements will be applicable to West Virginia practitioners. Board certification is required in each specialty for which the practitioner is requesting to be credentialed. Practitioners in the network prior to Aug. 15, 2016, will be grandfathered and processed as routine. Please note that these exceptions do not apply to practitioners practicing in Emergency Departments or Urgent Care Centers/Medical Aid Units (MAUs); board certification is required.

Highmark Recognized Boards for Certification

Highmark recognizes the following boards for certification:

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

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

Exceptions To Board Certification Requirements

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

Exception 1: Completed training prior to December 31, 1987

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

Exception 2: Board eligibility period

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

Exception 3: Rural ZIP Code

ZIP Code class is updated several times a year. If a provider's practice location ZIP Code is classified as rural and they have completed an Accreditation Council for Graduate Medical Education (ACGME)/American Osteopathic Association (AOA) residency or fellowship for MD/DO, then they meet the rural exception.

If it is determined that there is not a rural ZIP Code class at any of the provider's locations, initial applicants will be "Process Discontinued." Recredentialing applicants will be reviewed by the Medical Director.

Note: These exceptions do not apply to practitioners being credentialed as Emergency Medicine.

Dual Credentialing Criteria

Initial applicants requesting to be dual credentialed must be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded or meeting exception will be finalized as "Process Discontinued."

Recredentialing applicants requesting to add dual credentialing must be board certified/meet exception in each additional specialty requested. If not board certified or meets exception in additional specialty requested, the file will be finalized as “Process Discontinued” for that specialty only.

Note: Recredentialing applicants without board certification who were approved for dual credentialing prior to August 15, 2016, will be “grandfathered” into the network.

New York In-Network Providers

For providers in New York

Providers who were credentialed prior to August 1, 2022, will be grandfathered into the board certification status.

Providers who are credentialed with these plans after August 1, 2022, will need to be board-certified or meet one or more of the board exceptions.

3.2 Malpractice Insurance Requirements

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

Network Malpractice Insurance Criteria

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

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

Pennsylvania Requirements: If You are Mcare Fund Eligible

For providers in Pennsylvania

Medical doctors, doctors of osteopathy, podiatrists, and nurse midwives are required by Pennsylvania law to participate in the Pennsylvania Medical Care and Reduction of Error Fund (“Mcare Fund”).

By law, these providers must maintain primary medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate in addition to the limits provided by the Mcare Fund of $500,000 per medical incident and $1.5 million in the annual aggregate (for a combined total of $1 million per incident and $3 million in annual aggregate).

Providers outside of Pennsylvania are eligible to have Mcare coverage. Providers outside of Pennsylvania who do not have Mcare must have no less than $1 million per claim and $3 million aggregate coverage, or whichever is higher according to the state law requirements.

Pennsylvania Requirements: If You are Not Mcare Fund Eligible

For providers in Pennsylvania

All Pennsylvania network practitioners who are not required to participate in the Mcare Fund must carry minimum medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate.

These practitioners include, but are not limited to, the following:

- Audiologists
- Doctors of chiropractic
- Optometrists
- Oral maxillofacial surgeons
- Physical therapists

Exception: Certified registered nurse practitioners (CRNPs) and Clinical Nurse Specialists (CNSs) are required to carry $1 million per incident and $3 million in annual aggregate.

Delaware Requirements

For providers in Delaware

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

West Virginia Requirements

For providers in West Virginia

In West Virginia, physicians (MDs, DOs, DDSs/DMDs, DPMs and DCs) and Physician Assistants are required to carry professional liability insurance in the amount of $1 million per occurrence, $3 million aggregate, or compliance with WV Code §55-7B-12.

Allied health practitioners must carry coverage of $500,000 per occurrence, $1.5 million aggregate. The exceptions to this requirement are CRNPs and nurse midwives who are required to maintain $1 million per occurrence, $3 million aggregate in professional liability coverage.

New York Requirements

For providers in New York

In Western and Northeastern New York plans, all physicians, podiatrists, dental specialists, primary care CRNPs, midwives, and CNS are required to carry $1 million per medical incident and $3 million in annual aggregate.

Chiropractors, optometrists, and all other Allied health practitioners must carry coverage of $500,000 per occurrence, $1.5 million aggregate.

3.2 Termination From the Networks

Decisions to terminate a practitioner may be made by the Highmark Network Quality and Credentials Committee or, in urgent situations, by the Medical Director. A practitioner shall be provided with a written decision to terminate with the specific reason for the decision and any reconsideration/appeal rights.

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

Note: It is recognized that Highmark's provider agreements automatically terminate, or may be terminated immediately or upon specified notice, under certain specified circumstances. Nothing in this *Highmark Provider Manual* shall be deemed to abrogate or modify any such provisions or rights.

Valid Reasons for Termination

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

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

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

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

Invalid Reasons for Termination

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

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

Continuation of Care Throughout a Contract Termination

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

Continuation of care (COC) is a process followed to permit a member to continue an ongoing course of treatment with a primary care physician (PCP), a specialist, or a facility whose contract has been terminated by Highmark for reasons other than for cause, to be provided and paid in accordance with the

terms and conditions of the agreement. Continuation of care also covers a member in the second or third trimester of pregnancy; the transition period shall last through post-partum care related to the delivery.

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

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

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

Member Notification

If you are terminated from a Highmark network, that will trigger automatic letters via U.S. Mail to Highmark members, who are your patients, notifying them you have been terminated and are no longer in network.

3.2 Reconsiderations and Appeals

Reconsideration of a Credentials Committee Decision

For providers in Pennsylvania

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

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

The practitioner must request the reconsideration in writing within 30 days of notice of the termination. The provider shall be given the opportunity to present information to the Highmark NQCC by one or any of the following options:

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

Reconsiderations for practitioners who participate in Highmark commercial and Medicare Advantage networks will be presented before the Highmark NQCC.

After the meeting, the provider shall receive written notice of the final decision of the Highmark NQCC, which will include the basis for the decision. The Pennsylvania practitioner has the right to an appeal to the Medical Review Committee within 30 days if the decision is upheld. The provider will remain in the network until the Highmark Network Quality and Credentials Committee's final decision to terminate and an effective date of termination is established.

Appeals of Credentials Committee Decisions

For providers in Pennsylvania

An appeal of a Highmark Network Quality and Credentials Committee (NQCC) decision is available to a professional network practitioner if the Credentials Committee upholds a denial or termination action

following a reconsideration hearing. The written notice issued following the reconsideration hearing advises the practitioner of the right to appeal as well as the appeal process and states the following:

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

Pennyslvania practitioners have the right to appeal the decision to the Highmark Medical Review Committee (comprised of professional peers). Highmark's Medical Review Committee decisions are final and not subject to further appeal.

For providers in Delaware and West Virginia

An appeal hearing is available to a professional network practitioner who participates in Highmark's commercial and/or Medicare Advantage when a denial or termination action or a limited or modified decision is made by the Highmark Network Quality and Credentials Committee (NQCC) due to:

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

The practitioner must request the appeal in writing within 30 days of notice of the termination. Providers will be given the opportunity to present information to the Highmark NQCC by one of the following options:

1. In writing, to the Credentials Committee for consideration, which will take place during a Credentials Committee meeting.
2. Participating via a telephone conference call at a Credentials Committee meeting.

After the meeting, the provider will receive written notice of the final decision. The NQCC subcommittee decision is final and not subject to further appeal.

For providers in New York

An appeal hearing is available to a professional network practitioner who participates in Highmark's commercial and/or Medicare Advantage when a denial or termination action or a limited or modified decision is made by the Highmark Network Quality and Credentials Committee (NQCC) due to:

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

The practitioner must request the appeal in writing within 30 days of notice of the termination. Providers will be given the opportunity to present information to the Highmark NQCC subcommittee by one of the following options:

1. In writing, to the Credentials Committee for consideration, which will take place during a Credentials Committee meeting.
2. Participating via a telephone conference call at a Credentials Committee meeting.

After the meeting, the provider will receive written notice of the final decision. The NQCC decision is final and not subject to further appeal.

Reporting of Actions

When a final determination has been made concerning a proposed corrective action that adversely affects the clinical privileges or network status of a practitioner for a period longer than 30 days, or a final decision notification of termination has been rendered, Highmark shall report such corrective action to the appropriate parties, including the state licensing agency, the National Practitioner Data Bank (NPDB),

and/or the Healthcare Integrity and Protection Data Bank (HIPDB) pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Once a final decision has been issued, a Highmark medical director and the Provider Information Management (Credentialing Compliance) area will review the action and report to appropriate authorities if required.

3.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 3: Professional Provider Guidelines

3.3 Provider Data Updates for the Provider Directory

Highmark is committed to ensuring that the information in the Highmark Provider Directory meets Centers for Medicare & Medicaid Services (CMS) regulations and National Committee for Quality Assurance (NCQA) standards, as well as our own standards of quality.

In addition, Highmark members use the Highmark Provider Directory to make informed decisions when selecting a provider; therefore, it is also crucial to your practice to ensure your information is always accurate and up-to-date for the Provider Directory.

CMS Requirements

CMS requires Highmark to have the most current information on our network providers and requires ongoing review of all physician information listed in the Provider Directory to confirm:

- The provider's name is correct.
- The practice name is correct.
- The provider's practicing specialties are correctly listed.
- Providers are not listed at practice locations where they do not actually accept appointments and see patients.
- The provider is accepting new patients, or not accepting new patients, at the location.
- The provider's street address and phone number are correct.

NCQA Requirements

NCQA also requires the Provider Directory to include, and Highmark to confirm, the same physician information as listed above for CMS, as well as the physician's hospital affiliation. Hospital affiliation means the hospital(s) in Highmark's networks where physicians have admitting or attending privileges.

Policy

Providers are required to review and update their information as soon as a change occurs. All data should be reviewed once a quarter, at a minimum, to ensure accuracy. **Providers who do not verify or update their data in a timely manner will be removed from the Highmark Provider Directory**. In addition, your status within Highmark's networks may be impacted.

Provider Data Maintenance & Provider File Management

You may review your detailed, real-time billing provider information in Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only) in Availity. Once you log into Availity, go to Payer Spaces and then select **Provider Data Maintenance or Provider File Management** (Delaware, Pennsylvania, and West Virginia only).

Please see the section of this unit on **Reporting Changes in Your Practice** for additional information on reviewing your information and instructions for making necessary changes via Availity or forms, if necessary.

3.3 Medical Records Documentation and Maintenance

Network providers are required to maintain current, detailed, comprehensive, and accurate medical records for each member to whom they provide services. The medical record is critical to ensuring the quality, coordination, and continuity of care.

Each record must support the service billed and the level of care provided on each unique date. **Records that contain cloned documentation, conflicting information, or other such irregularities may be disallowed for reimbursement**. Reimbursement for any record containing such questioned documentation will be represented in overpayment calculations with zero reimbursement allowed.

Standards of Documentation

Each medical record should contain:

- Biological, demographic, and other personally identifying information for the member;
- Patient-identifying information on each page to ensure pages are not lost or misfiled;
- Identification of the treating provider and the services he/she provided on each entry;
- Date of each provider/patient encounter and date of each entry;
- Information on allergies and adverse reactions or, if none, notation that the patient has no known allergies or history of adverse reactions;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Problem list, including significant illnesses and medical and psychological conditions;
- Presenting complaints, working diagnoses, and treatment plans;
- History and physical examination for each encounter appropriate to the reason for the particular encounter;

- Past medical history, examinations, treatments, social history, and risk factors pertinent to developing a treatment plan;
- Documentation that laboratory tests, other studies ordered, and consultations are appropriate to the member's symptoms or condition, and that results have been reviewed and acted upon;
- Documentation of required follow-up, including any diagnostic testing, treatment, or education;
- Documentation that information received from another provider has been reviewed and, where appropriate, acted upon;
- Tracking and review of problems from previous visits, including management of chronic conditions;
- Documentation sufficient to demonstrate the medical necessity and appropriateness of each service;
- Copies of advance directives or documentation of discussions with adult patients about such directives;
- Immunization records (for PCPs);
- Documentation of tobacco or alcohol use, or substance abuse;
- Documentation of member input into treatment plans and decisions;
- Preventive services, referrals, or counseling, where appropriate;
- Copies of consents or releases, where required, for release of confidential health information; and
- Legible entries.

Note: These standards have been approved by the Highmark Credentialing Committees, the voting members of which are practicing physicians in the applicable Highmark networks.

Important! Signature Required

All entries in the record must contain a valid, legible author's signature, which may be a handwritten signature with credentials, printed name and credentials accompanied by handwritten provider initials, or unique electronic identifier with credentials.

Maintenance of Records

Medical records must be maintained in accordance with the following requirements:

- Each chart is labeled to allow for easy and timely retrieval by the provider or provider's staff to meet the patient's clinical needs;
- Records are systematically and timely prepared, filed, and stored; and
- Safeguards are in place to protect the confidentiality of patient records and information.

Monitoring Compliance

Highmark will monitor compliance with medical record documentation and maintenance standards in a number of ways. These may include: site visits in connection with credentialing, collection of HEDIS or other data; or monitoring compliance with contract, regulatory, or accreditation requirements; review of records in connection with billing audits or other provider monitoring activities; review of records in connection with investigation of quality of care concerns; investigation of complaints; and as part of quality improvement initiatives.

Providers whose records are not in compliance may be subject to written counseling, corrective action including repayments and follow-up reviews.

3.3 Medical Records Review

Highmark periodically engages in the review of members' medical records as well as inspection of network providers' offices. Highmark reviews medical records for a number of reasons pertaining to the administration of high-quality managed care benefit programs. The reasons include, but are not limited to:

- To evaluate the appropriateness of billing or level of utilization of services
- To determine the medical necessity and appropriateness of a claim when we have insufficient information
- For credentialing and recredentialing network providers (does NOT apply to Pennsylvania's Participating Provider Network)
- To evaluate the clinical quality of care provided to members
- To determine possible pre-existing conditions
- For conducting condition management for the benefit of members

- To investigate complaints
- For verifying immunization of pediatric and adult patients
- For risk adjustments
- For appeals and audits

Medical Records Requests

Network providers are required to cooperate with and timely respond to requests for medical records from Highmark. Regulatory standards require health plans to make medical necessity determinations, request and review additional information, and process claims within strict time frames. For this reason, it is important for providers to provide all relevant medical records within the time frame stipulated in the written request. No response or a late response may result in a denial of payment.

Clinical quality of care issues are reviewed by the plan's clinical staff and, if necessary, a medical director. Failure to provide records requested may result in disciplinary action, up to and including termination from Highmark network participation.

Billing reviews may determine whether services billed are documented and supported by the medical record. Highmark reimburses only for medically necessary covered services. Failure to furnish requested medical records may result in Highmark recouping prior payments.

Highmark's procedures for requesting and using medical records are designed to avoid multiple requests for the same records, request only the minimum necessary records, and protect the confidentiality of information and the privacy of individuals.

Network providers are not reimbursed for supplying requested medical records to Highmark.

Member Consent

As a HIPAA covered entity, Highmark has established as its policy that we will not request or obtain consent of our members in connection with the use or disclosure of protected health information (PHI) for treatment, payment, or health care operations. Highmark has received a general consent from our members. Each member completes and signs an enrollment form that provides for the release of most

information relating to past, present, or future health care examinations or treatments for anyone covered under the enrollment form. Such consent is necessarily broad to enable Highmark to administer high-quality benefit programs.

Information collected is handled with a high level of security and respect for privacy. However, member records that include information relating to behavioral health, human immunosuppressant virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases (STDs), and/or substance abuse could be subject to extra protections regarding disclosure under state laws. In such cases, providers asked to submit medical records are responsible for obtaining member consent and should submit it to Highmark along with the requested documents, as payment for services provided are specifically conditioned upon receipt of supporting documentation.

Alternatively, providers may choose to delete the personally identifying details from those records containing any such protected information prior to submitting the medical records to Highmark for review.

Provider Cooperation

The terms of the network agreement require the full cooperation of network providers with all office reviews. Failure to supply requested copies of medical records or failure to cooperate with office inspections of medical records may result in termination from Highmark network participation.

3.3 Locum Tenens Policy

Highmark requires all physicians who provide services to our members to be credentialed and contracted. However, under certain circumstances, Highmark allows for locum tenens arrangements.

A **locum tenens**, or “substitute physician,” is defined as a practitioner who is covering for another physician when they are absent for reasons of illness, medical leave, vacation, military leave, or continuing medical education, or in the event of a practitioner’s retirement or death.

Service Time Frame

Locum tenens service time frames **may not exceed 60 consecutive days** for Medicare Advantage or Commercial networks.

If a regular physician is absent longer than 60 days without returning to work and is covered by one locum tenens, the locum tenens must be credentialed and enrolled as if he or she were joining your practice as a new physician. It is recommended that the credentialing process be started as soon as possible to help reduce any gaps in services.

For credentialing requirements, please see **Chapter 3 Unit 2: Professional Provider Credentialing**.

Requirements

Highmark does not enumerate substitute physicians. A physician may bill and receive payment for the substitute physician's covered services as though he/she performed them. With respect to physicians, the term "covered visit service" includes not only those services ordinarily characterized as a covered physician visit but also any other covered items and services furnished by the substitute physician or by others as "incident to" the physician's services.

A physician may submit a claim and, if assignment is accepted, receive payment for covered visit services of a substitute physician if:

- The regular physician is unavailable to provide the services;
- The member has arranged or seeks to receive the services from the regular physician;
- The regular physician pays the substitute physician for his/her services on a per diem or similar fee-for-time basis;
- The substitute physician does not provide the services to members over a continuous period of longer than 60 days. **Exception**: If the regular physician is called to active duty in the Armed Forces, services provided by a substitute physician may be billed under a fee-for-time compensation arrangement for longer than the 60-day limit; and

- The regular physician indicates on the claim that the services were provided by a substitute physician under a fee-for-service compensation arrangement by including the Q6 Modifier, which designates services were performed by a substitute physician.

Note: If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services would not be identified on the claim as services furnished by a substitute physician.

Billing Guidelines

Claims for the services of a substitute physician are billed as though the regular physician performed the services; the regular physician on whose behalf the services were furnished by a substitute is identified as the rendering provider on the claims (Item 24J on the 1500).

To receive payment for a substitute physician's covered services, the regular physician must include the Q6 modifier after the procedure code(s) (Item 24D on the 1500).

A record of each service provided by the substitute physician must be kept on file along with the substitute physician's NPI. This record must be made available to Highmark upon request. Claims submitted with a Q6 modifier will be subject to ongoing monitoring and auditing.

3.3 Requesting a Contract Copy

Highmark allows participating providers to request copies of their participating physician contract, as required. Highmark will provide a copy of the contract with participating physicians, including certain contracts with physician organizations or physician groups where participating physicians participate. Highmark is restricted, however, to provide contracts to requesters if the terms of the contract restrict the request.

How to Request a Copy of Your Contract

Providers must direct a written request for a copy of their contract to:

Fax to:	800-236-8641
Mail to:	Highmark Blue Shield Provider Information Management P.O. Box 898842 Camp Hill, PA 17089-8842

Upon receipt of the request, Highmark's Provider Information Management will provide the requestor one copy of their participating physician contract, unless otherwise requested. Requests generally take 15 business days to process. Please allow ample time for processing before checking the request status.

3.3 Reporting Changes In Your Practice

Policy for Changing Practice Information

The provider database maintained by Highmark contains vital information regarding each network practitioner. By keeping your practice information updated, you help Highmark do the following:

- Maintain compliance with federal regulations and National Committee for Quality Assurance (NCQA) standards
- Process claims correctly
- Notify members of the names and addresses of network practitioners
- Notify primary care practitioners of available specialists to whom they may refer

Most changes will require Highmark to revise existing provider files. In most cases, membership or claims payment will be affected by changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information, claims, and/or claims payments. Certain changes may necessitate the issuance of a new contract.

Note: Your up-to-date information must include your current address, phone number, and fax number, and any and all required data elements set forth in your provider contract(s) with Highmark.

Type of Changes to Report

The following is a list of changes in your practice that must be communicated to Highmark:

- Practice location change
- Billing/mailing address change
- Telephone number change
- Fax number change
- Hospital affiliation change
- Medical group affiliation change
- Office hours change
- New tax identification number
- Practice name change
- Practitioners joining the practice
- Practitioners leaving the practice (including through retirement or death)
- Changes in malpractice insurance coverage levels (10 days in advance of any reduction or termination of coverage)
- Practice mergers
- Practice acquisitions
- Addition or closure of a practice site
- Changes in acceptance of new patients
- Changes in practice locations where practitioners see and treat patients
- Languages spoken by the physician or clinical staff
- Board certification change
- Specialty change

Using Availity® to Report Updated Practice Information

All Availity-enabled practitioners should make their practice information changes via Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only) in

Highmark's Payer Spaces in Availity. This function can be used to update the practice information such as contact information, practitioners affiliated with a location, office hours, age range the practice serves, etc.

Once in Payer Spaces, click Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only), and then select the location for which updates are needed. Click on the Edit button next to the information that requires change.

Detailed instructions are available in the Provider Data Maintenance Guide and the Provider File Management Guide (Delaware, Pennsylvania, and West Virginia only). The guides are available on the Provider Resource Center under **Resources & Education**, then **Provider Data Accuracy Compliance**.

How to Use Availity to Add or Delete Practitioners

Availity-enabled practices can use Provider Data Maintenance or Provider File Management (Delaware, Pennsylvania, and West Virginia only) to add practitioners or remove practitioners from their assignment accounts.

The addition of an individual practitioner to a group or the deletion of an individual practitioner from the group, via this real-time function, requires only one electronic signature. The Authorized Representative of the Group is able to complete both additions and deletions. If a new practitioner has never completed an *Initial Credentialing Application* with Highmark, they must do so before being added to your group.

Note: Your Availity Security Officer can generate a username for a practitioner new to your assignment account.

How to Update Practice Information for Non-Availity Enabled Practitioners

Practitioners who are not Availity-enabled must notify Highmark of any change to their practices. The Addition Request to Existing Assignment Account form can be completed electronically for practitioner changes.

For additional practice addresses or for address changes, complete the Provider Directory Update Form.

These forms can be accessed on the Provider Resource Center – under **Resources & Education** in the main menu select **Forms**, and then **Provider Information Management Forms**.

Important!

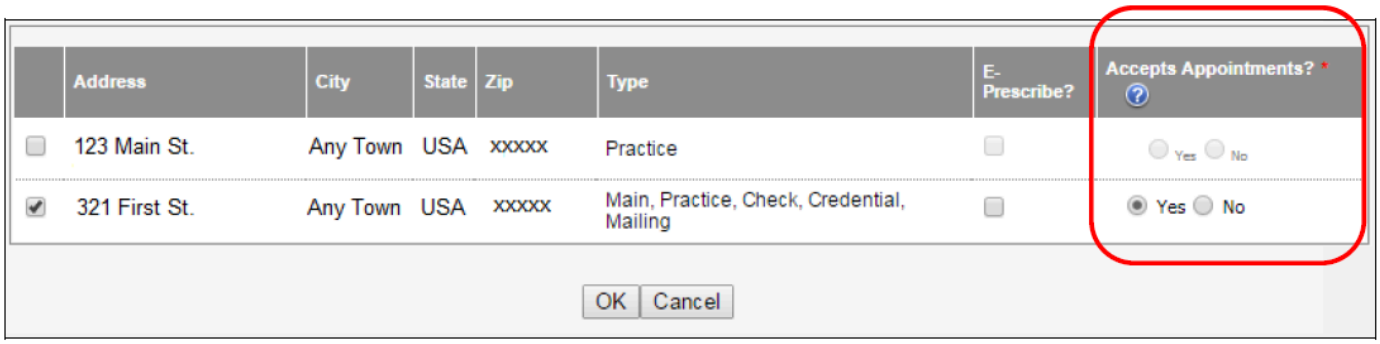
All practitioners joining or leaving an established practice or leaving a Highmark network must notify Highmark 60 days before the event.

Updating "Accepts Appointments?"

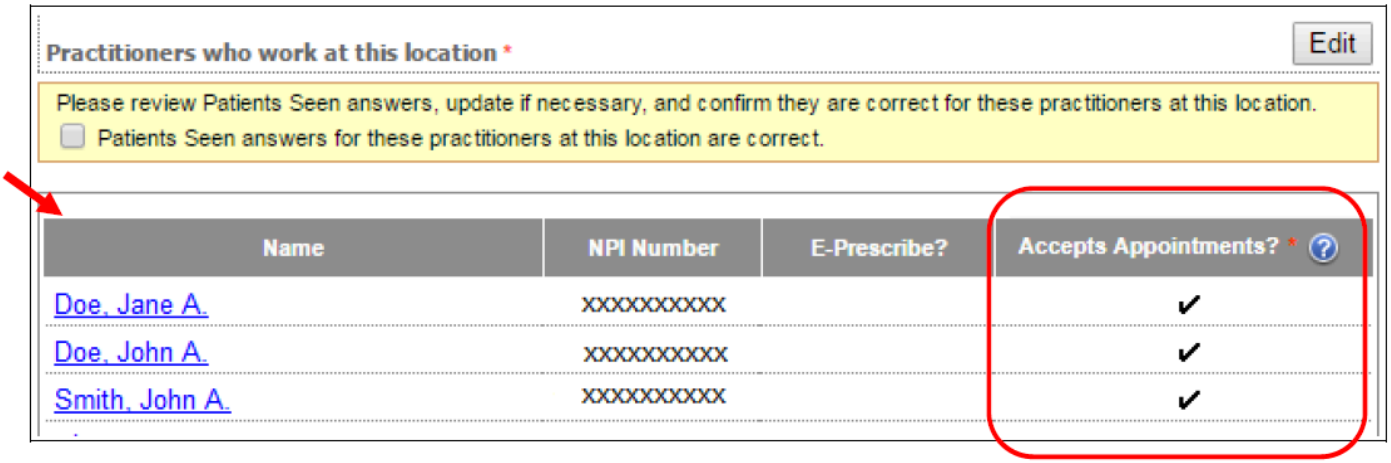
For providers in Delaware, Pennsylvania, and West Virginia

The "Accepts Appointments?" question requires a response in Provider File Management, which is available in Payer Spaces in Availity. When adding a new practice address, affiliating a new practitioner to an existing address, and adding a new practitioner to an existing address, you must indicate either YES or NO for each practitioner at a location. If a practitioner accepts appointments at a location at least one day per week on a regular basis, then the response is "YES"; otherwise, the response is "NO."

The "Accepts Appointments?" responses can be viewed once established and modified through the **Edit** function:



Practices must also confirm the “Accepts Appointments?” answers are accurate when submitting any of these location-related changes. The changes cannot be saved until this statement is confirmed.



Written Notification Required for Mergers and Acquisitions

The provider agreement between Highmark and network practitioners is not assignable. In cases of practice mergers, acquisitions, etc., it is necessary to send written notification, on practice letterhead, to Highmark.

For additional information, please see the next section of this unit on Mergers and Acquisitions.

Immediate Notification of Certain Actions

Providers of all types must provide immediate written notification to Highmark in the event of any of the following:

- Termination, suspension, or limitation of license or certification;
- Exclusion, withdrawal, sanctions, or other change in status regarding participation in federal health programs (Medicare, Medicaid, Federal Employee Health Benefit Plan, other programs);
- Change in accreditation status;
- Felony conviction;
- Labor strike or work stoppage; and
- Change in credentialing information.

Notification can be faxed or mailed to Provider Information Management at:

Fax to: 800-236-8641

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

3.3 Mergers and Acquisitions

Notification to Highmark

You must send written notification on your practice letterhead of anticipated mergers, acquisitions, etc., at least 45 days before the change(s) occur. The managing partner of the practice must sign the written notification. Include the following information:

- Effective date of the change
- Highmark provider number, NPI, new tax identification number* (if applicable)
- Changes to physician staffing
- Changes to physician location

The written notification can be faxed or mailed to Highmark.

Fax to: 800-236-8641

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

New assignment account paperwork will need to be completed – please use the Request for Assignment Account form. The form can also be found on the Provider Resource Center under **Resources & Education**, then **Forms**, and then **Provider Information Management Forms**.

*When reporting a new tax identification number, include the Internal Revenue Service (IRS) Tax Notification as evidence.

Consequences to Not Giving 60 Days' Notice

Most changes will require Highmark to revise existing provider files. In most cases, membership or claims payment will be affected by major changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information and/or claims payments.

Sample Change Notification

If sending written notification on your practice letterhead, please include information in your letter as shown below:

XYZ Medical Associates
1000 Main Street
Somewhere, PA 15000
1-717-555-4000

10/1/2014

Re: Highmark Provider Number 999999 and NPI

To: Provider Information Management (if western, central or eastern PA; Delaware; or West Virginia provider)
OR
To: Provider System Support (if northeastern PA provider)

The following changes are occurring in our practice:

Old information was as follows:

Phone number 1-717-555-3900

New information is as follows:

Phone number 1-717-555-4000

New information effective as of:

January 1, 2015

Signature of Managing Partner,

John Smith, MD

3.3 How To Resign From Network Participation

To resign from participation in Highmark's credentialed network(s) in all service areas, fill out the electronic Request to Terminate a Contracted Network form. This form can also be accessed on the Provider Resource Center – select **Resources & Education**, then **Forms**, and then **Provider Information Management Forms**.

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

IMPORTANT: If you decide to resign from the Highmark network(s) by submitting the form above, the resignation will trigger automatic letters to Highmark members, who are your patients, via U.S. Mail, notifying them you have terminated and are no longer in network. Please take this into account before completing the electronic form.

3.3 Corrective Action

A network provider who engages in practices inconsistent with reasonable standards of care or professional conduct or who does not comply with Highmark contractual or administrative requirements may be subject to corrective action.

Determining Need for Corrective Action

For providers in Delaware, Pennsylvania, and West Virginia

Certain circumstances, acts, or omissions of a professional network provider may result in a requirement that the provider engage in a corrective action or a series of corrective actions to continue participation in the network.

Treatments, procedures, and services that are subject to corrective action include any treatments, procedures, or services that indicate a professional provider is practicing in a manner that is not consistent with reasonable standards of care (including, when applicable, accepted standards of medical care) and service, ethical expectations, contractual obligations, or the administrative requirements of the plan.

Examples of such circumstances, acts, or omissions which may be subject to corrective action include, but are not limited to, the following:

- Clinical quality of care
- Administrative non-compliance
- Unacceptable resource utilization
- Service-related issue

Providers identified with one of these issues will be reported to a Highmark Medical Director. The determination to take corrective action shall be made by a Medical Director.

Determining Need for Corrective Action

For providers in New York

For New York providers, a corrective action plan can be initiated by any department or corporate committee. The Health Care Quality Improvement (HCQI) team is responsible to coordinate efforts amongst the Senior Medical Director and appropriate teams that will be integral in the review.

Once Provider Correspondence is reviewed and approved, it is sent out from the HCQI team with instructions, requested materials and a time frame when it is due back.

Forms of Corrective Action

Corrective action may vary according to the situation and may include, but is not limited to, one or more of the following actions as they relate to the circumstance, action, or omission that requires corrective action:

- Sending a written warning to the provider
- Engaging in a discussion or a series of discussions with the provider
- Monitoring the provider's performance
- Expedited recredentialing
- Requiring that the provider complete a continuing medical education course regarding the treatment, procedure, or service in question
- Limiting the provider's authority to perform certain procedures
- Requiring that the provider enter a preceptor relationship with another provider
- Monitoring and observing the provider subject to corrective action
- Termination or suspension

Highmark may immediately suspend the network participation status or restrict the clinical privileges of a provider who, in the opinion of the medical director, is engaged in conduct or is practicing in a manner that appears to pose a significant risk or imminent danger to the health, welfare, or safety of a patient or other individual. In such cases, Highmark will investigate the circumstances on an expedited basis.

If the suspension or restriction will last longer than 14 days, the provider will be notified that he/she can request a hearing. The request must be made in writing within 30 days of receipt of the notification.

Corrective Action on Clinical Quality of Care Issues

The determination to take corrective action on a clinical quality of care issue shall be based on an assessment of the severity level of the action based on the judgment of a Highmark Medical Director. The following are general guidelines used by the Medical Directors when assigning severity levels:

Severity Level	Guideline

Minor – low	Deviation from the standard of care without harm to the member.
Moderate – medium	Deviation from the standard of care with temporary harm to the member.
Severe – high	Deviation from the standard of care with harm to the member resulting in permanent sequelae or death.

Sanctioning

For providers in Delaware, Pennsylvania, and West Virginia

Sanctioning of a provider will occur whenever an assessment of the severity level of action is moderate or severe, and/or the corrective action was a result of an administrative non-compliance circumstance, act, or omission. Sanctioning may result in a provider's practice not being eligible for participation in certain programs.

Corrective Action Appeals

For providers in Delaware, Pennsylvania, and West Virginia

An appeal shall be made available to a professional network provider before the Highmark Network Quality and Credentials Committee (NQCC), if the practitioner is placed under corrective action.

If an appeal is available, the procedure will be as follows:

Step	Action
1	The provider will be given written notice of the proposed action including: (a) the action that has been proposed to be taken against the provider; (b) the reason(s) for the action; (c) that the provider may request an appeal on the proposed action; (d) that the practitioner may participate via phone or in person; and (e) that the provider will waive any appeal rights if an appeal is not requested within 30 days of receipt of the notice of the action.
2	If the provider requests an appeal on a timely basis, Highmark will notify the provider of the time and date of the NQCC meeting.
3	The appeal shall be held before the NQCC, which is comprised of network practicing providers who will review the information presented and render a decision. The members of the NQCC shall not be in direct economic competition with the provider. The provider has the right during the meeting to have a representation by an

	attorney or other person of the provider's choice.
4	After completion of the appeal, the provider has the right to receive the written decision of the Credentials Committee from the Medical Director, including a statement of the basis for the decision. The decision of the Credentials Committee is not subject to further appeal.

Corrective Action Appeals

For providers in New York

Corrective Action is discussed with the Senior Medical Director and team who were responsible for the review prior to notification to the provider.

Any Corporate Credential Committee initiated requests for Corrective Action would be determined by the Senior Medical Director and team prior to being discussed with the NY Corporate Committee team for re-credential consideration.

If the provider requests an appeal on a timely basis, Highmark will notify the provider of the time and date of the appeal meeting.

3.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 4: Organizational Provider Participation (Facility/Ancillary)

3.4 Participation and Credentialing

Highmark credentials organizational providers (facility and ancillary) in order to ensure they are in good standing with all regulatory and accrediting bodies. Highmark's participation and credentialing requirements derive from internal business decisions as well as the standards set by those agencies.

Requirements

All organizational providers are required to have a license, certificate, registration, or permit, as applicable, in the state where they do business. It must be maintained and in good standing with that particular state. Participation with Medicare/Medicaid may be required for providers. All organizational providers must submit their current certificate of liability insurance.

In addition, providers that are eligible for accreditation must also maintain an active accreditation status. Organizational providers that perform laboratory services must submit a current Clinical Laboratory Improvement Amendments (CLIA) certificate.

For requirements for specific organizational provider types, click on the link below:

Organizational Provider Participation, Credentialing, and Contracting Requirements

This document is also available on the Provider Resource Center within the **Provider Network** section, then **Credentialing**.

Facility Provider Types

Highmark defines “facilities” as those providers billing services in the UB-04/837I format. Highmark holds contracts with facility provider types including, but not limited to:

- Acute care hospitals
- Psychiatric facilities
- Substance abuse treatment centers
- Skilled nursing facilities (SNFs)
- State-owned psychiatric hospitals
- Ambulatory surgical centers (ASCs)
- Renal dialysis facilities
- Hospice
- Home health
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Rehabilitation hospitals
- Long-term acute care facilities (LTACs)
- Long-term services and supports (LTSS)/home and community-based service options (HCBS)

Ancillary Provider Network

Ancillary providers are credentialed by Highmark as organizational providers; however, ancillary providers bill services in the 1500/837P format.

The ancillary provider network includes freestanding and facility-based providers in the specialties including, but not limited to:

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

Availability

Facility services must be available to members on a 24-hour-per-day, seven-day-per-week basis when medically necessary and in accordance with industry standards of care. Care should be provided in the most appropriate setting, in the most efficient manner, offering the most appropriate plan of treatment for the member.

Report Changes

Please inform Highmark of any changes as required by your contract. Failure to keep this data current may lead to an incorrect listing in the provider directories, missed mailings or checks, and possibly incorrect payments.

The following list includes, but is not limited to, important informational changes that will require immediate written notification to Highmark:

- Change to hours of operation
- Address (physical location) change
- Mailing and/or billing address change
- Tax Identification Number (TIN) change

- Ownership/Corporation/Organizational changes
- Additions/deletions of Assignment Account members, if applicable
- Telephone number change, including area code (member access telephone number)
- Fax number change

Please see the section in this unit on **Reporting Mergers**, **Acquisitions**, **and Changes** for additional information.

For More Information

Please refer to Highmark's Provider Manual **Chapter 3 Unit 1: Network Participation Overview** for additional information on Highmark network participation.

3.4 Applications

Facilities and Ancillary Providers

To begin the process for credentialing and participation in Highmark's networks, facilities and ancillary providers must complete and submit the Initial Application for Facility and Ancillary Providers. This application is also available on the Provider Resource Center within the **Credentialing** section, under **Provider Network** in the main menu.

Note: Certain ancillary provider networks, such as durable medical equipment and laboratories, may be closed to new applicants. Highmark most often performs outreach in the provider community when it is determined that such services are needed. If an application is received for a closed network, a response may not be provided. Closed network status will be noted on the Organizational Provider Participation, Credentialing, and Contracting Requirements document.

Urgent Care Centers/Medical Aid Units and Retail Clinics

The Urgent Care Center/Medical Aid Unit and Retail Clinic Application is required to begin the process for participation in Highmark networks for Urgent Care Centers, Medical Aid Units (in Delaware), and Retail Clinics. This application is also available on the Provider Resource Center under **Provider Network** then **Credentialing**.

For more information on participation requirements for Urgent Care Centers and Medical Aid Units, please see the Urgent Care Centers/Medical Aid Units section of this unit.

Behavioral Health

The Application for Behavioral Health Providers is to be used for freestanding behavioral health facilities/centers. This application is also available on the Provider Resource Center within the Credentialing section, under Provider Network in the main menu.

3.4 Reporting Mergers, Acquisitions, and Changes

Highmark requires advance notification of the following events: mergers, acquisitions, changes of ownership, legal name changes, new or changed locations, or services or related events (individually or collectively, referred to as a "Facility Event").

Facilities are instructed to initiate the change notification process to notify Provider Contracting 30-60 days prior to the effective date of a Facility Event. A facility is also required to comply with any applicable notification requirements set forth in its facility agreement.

After determining all information and notices are complete, Provider Contracting will initiate internal processes as appropriate with respect to Highmark’s approval and file modifications.

Required Form

Highmark provides a standard form that is required for providing appropriate notification of significant changes as identified above. To view and print the form, please click on the link below:

Change of Ownership Form

The **Change of Ownership Form** is also available on the Provider Resource Center – select **Provider Network** then **Organizational Credentialing**.

This form should be used to report any changes in ownership which may include the Legal Name, Doing Business As name, NPI, or Tax ID information.

Highmark Approval Required

New facility locations cannot be billed under the Highmark facility agreement until Highmark has received proper contractual notice and given its prior approval, as set forth in the applicable facility agreement.

The approval requirement applies to all new facility locations, whether the location is brand new, the result of the movement of services or combination of services, or addition of services through a merger, acquisition, change of ownership or some other legal event of an existing health care entity or practice (e.g., acute care facility, ambulatory surgery center, or physician practice).

If a facility bills for services at a new location prior to notification and approval by Highmark, this may result in the following occurrences and/or as may be provided for in the facility agreement and related agreements and documents, a breach of contract:

- Denial of payment
- Denial of authorization
- Decreased payment
- Increased audit activity

Highmark's approval of a Facility Event is for the purpose of recognizing an event in terms of the provider's contract(s) with Highmark, and the rights and obligations of each party thereunder.

Address & Phone Number Changes

Providers should update their address, phone numbers, and/or contact information to existing locations for UB Facility Billers, Urgent Care Centers/Medical Aid Unit/Retail Clinics, or for Organizational Behavioral Health Billers, using the Highmark Facility/Ancillary Change Form.

This form is also available on the Provider Resource Center – select **Resources & Education**, and then **Provider Information Management Forms**.

3.4 Electronic Transaction Requirements

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark has taken steps to eliminate paper transactions with our contracted providers. As part of this initiative, all facilities are required to enroll in Availity and Electronic Funds Transfer (EFT) and will receive paperless Remittance Advices.

Due to their inherent speed and cost-effectiveness, electronic and online communications are integral in today's business world and Highmark requires that all network providers participate in electronic programs sponsored or utilized by Highmark now or in the future.

Availity® and EFT Enrollment Required

All Highmark network participating providers are required to enroll in Availity® and Electronic Funds Transfer (EFT).

Availity integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available at no cost to Highmark network participating providers.

Participating providers are also required to enroll to receive electronic funds transfers and paperless remittances.

- EFT is a secure process which directs Highmark claim payments to the provider's checking or savings account as directed by your facility. Payments are typically in the designated bank account by Wednesday of each week. For Delaware, Pennsylvania, and West Virginia providers, this information is also available for viewing within PNC's Healthcare's ECHO Health platform.
- Paperless Remittance Advices reduce the amount of paper flowing into the facility's office. Remittance Advices are available for viewing via Availity, which is earlier than receiving them by mail. For Delaware, Pennsylvania, and West Virginia providers, this information is also available for viewing within PNC's Healthcare's ECHO Health platform.

For More Information

For guidance on enrolling in Availity and EFT and paperless remittances, please see the section on **Electronic Transaction Requirements** in Highmark's Provider Manual **Chapter 3 Unit 1: Network Participation Overview**.

3.4 Urgent Care Centers/Medical Aid Units

Urgent care is care for an illness, injury, or condition serious enough that it requires care right away, but not so severe as to require emergency room care.

When urgent care is needed, Urgent Care Centers and Medical Aid Units provide Highmark members with a convenient option for non-life-threatening injuries and illnesses when their personal physicians are unavailable.

Urgent Care Centers (UCCs)

An Urgent Care Center (UCC) generally provides immediate care for acute, non-life-threatening illnesses and injuries outside of a hospital emergency department. Services are provided on a walk-in basis without a scheduled appointment.

Urgent care medicine differs from emergency medicine in that its primary focus is on acute medical problems at the lower end of the severity spectrum. Individuals who present to an Urgent Care Center and are judged to need emergency care are transferred to a hospital emergency department.

Delaware Regulations for UCCs and MAUs

For providers in Delaware

There is significant variation among states regarding regulation of urgent care facilities. Delaware law limits the use of the terms “emergency” or “urgent” by a facility if that facility is not able to handle life-threatening emergency care.

Delaware law defines “Free Standing Emergency Center” as a facility that is:

- Physically separate from a hospital
- Using the words “emergency,” “urgent care,” or parts of those words or other language or symbols which imply or indicate to the public that immediate medical treatment is available to individuals suffering from a life-threatening medical condition in its title or in its advertising
- Capable of treating all medical emergencies that have life-threatening potential
- Not a trauma center
- Open 24 hours a day, seven days a week
- Generally able to treat most emergencies

In Delaware, a facility is considered to be an “Urgent Care Center (UCC)” and credentialed as such only if they are licensed as a Freestanding Emergency Center. Facilities providing urgent care that are not licensed are called and credentialed as “Medical Aid Units (MAUs).”

Application Process for Highmark Network Participation

To begin the application process for participation in Highmark's networks, complete the Urgent Care Center/Medical Aid Unit and Retail Clinic Application. Each location will require a separate application. This application is available on the Provider Resource Center. Select **Provider Network**, and then **Organizational** under **Credentialing**.

You will be contacted by Highmark Provider Information Management if additional information is needed. Please allow up to 180 days for the application to be processed.

A GEO access analysis will be completed to determine the number of members and existing Urgent Care Centers within a reasonable radius of the provider's ZIP Code. Highmark may approve or deny provider network participation based on the results of the GEO access analysis.

If Highmark approves network participation, a contract is sent to the provider to sign and return to Highmark. When Highmark receives the signed contract, a new provider number is assigned and a welcome letter and the executed contract, with the effective date indicated, is sent to the provider. **No claims should be billed until all steps are completed; claims submitted prior to completing all steps will reject**.

Credentialing Requirements

Highmark credentials Urgent Care Centers and Medical Aid Units at the facility level as part of the application and contracting process.

Although Highmark does not require in-network practitioners participating Urgent Care Centers and Medical Aid Units to credential, practitioners are still required to submit the Request for Addition/Deletion to Existing Assignment Account electronic form as they join or leave the group. The form is also available on the Provider Resource Center. Select **Resources & Education**, then **Forms**, and then **Provider Information Management Forms**.

Accreditation Requirements

Highmark requires that Urgent Care Centers/Medical Aid Units have accreditation from one of the following organizations:

- Joint Commission (JC)
- National Urgent Care Center Accreditation (NUCCA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Urgent Care Association of America (UCAOA)

Initial applicants that are not accredited must pass a Highmark Health Services Site Visit and obtain accreditation by a Highmark recognized accrediting organization within 18 months after they are credentialed. If accreditation is not obtained within that time frame, the contract may be terminated.

License Requirements

Licensing is not required for Urgent Care Centers in Pennsylvania and West Virginia.

In Delaware, Urgent Care Centers are required to be licensed as a Freestanding Emergency Center. Medical Aid Units do not require licensing.

In New York, a license is required for Urgent Care Centers.

Additional Participation Requirements

Additional requirements for Urgent Care Center and Medical Aid Unit participation in Highmark networks includes, but is not limited to, the following:

- Medical Director who is a Highmark network participating physician with a valid license in the state(s) where the Urgent Care Center(s) is located. The Medical Director maintains responsibility for all medical personnel within the Urgent Care Center.

- Services provided on a walk-in basis with no appointment required.
- Hours of operation must be as follows:
    - Monday-Friday: Minimum 12 hours per day
    - Saturday and Sunday: Minimum eight hours per day
- Post-services coverage, which at a minimum shall include access to a physician by telephone, should be available 24 hours a day, seven days a week to all members who have received services.
- Claim submission via 1500/837P.
- Inspect, calibrate, service, and ensure equipment is in optimal working condition and meets all federal, state, and local safety standards.
- Compliance with federal and state requirements regarding the dispensing, recording, and controlling of medications.
- Store pharmaceuticals and medical supplies under proper and secure conditions.
- The provider should participate in, cooperate with, and abide by the decisions of Highmark's peer review, utilization review, and quality improvement programs; medical record audits; and other activities deemed appropriate by Highmark for assuring quality care, cost-effectiveness of care, and patient satisfaction.

Urgent care does not replace the member's PCP. Communication with the member's PCP regarding the care rendered to the member is essential.

On-Site Services Required

The following services must be available during all hours of operation:

- X-ray (routine plain film) and phlebotomy services
- Licensed provider on-site with the appropriate state license and resources to obtain and read X-rays
- Administration of intramuscular, oral, and IV medication/fluids on-site
- Minor procedures such as suturing, cyst removal, incision and drainage, splinting, etc.
- Staff trained in equipment located on-site (i.e., automated external defibrillator (AED), oxygen)
- Working telephone to contact 911 if necessary

Verify Eligibility and Benefits for Urgent Care

Providers are advised to verify a member's eligibility and benefits via Availity® Eligibility and Benefits Inquiry or a 270/271 HIPAA electronic transaction. Member benefit plans vary and urgent care may not be a covered service for certain members.

Important! Verifying Highmark Delaware UCC Benefit

For providers in Delaware

To verify a Highmark Delaware member's benefits for services in an Urgent Care Center (a "Freestanding Emergency Center"), go to Availity's Eligibility and Benefits Inquiry.

Please note that member cost-sharing may be different for services at Urgent Care Centers and Medical Aid Units.

Billing Guidelines

Highmark will only accept claims from Urgent Care Centers and Medical Aid Units that are billed electronically via an **837P transaction** or **1500 claim form**. This applies to all services provided, including diagnostic services.

All claims should include the following:

- S9088 – services provided in an Urgent Care Center (list in addition to code for service)
- Evaluation and Management procedure code, as applicable
- All other eligible services provided during the visit (i.e., X-rays)

Note: Medicare Advantage and Federal Employee Program (FEP) members do not have coverage for code S9088. Additionally, service(s) designated with S9088 are not eligible for payment when reported with place of service telemedicine (02) for Highmark commercial members. The code may be billed;

however, claims will reject as non-billable to the member. In addition, self-funded groups may choose to not provide coverage for this code.

Supplies and oral medications are considered an integral part of the Evaluation and Management or procedure performed. No additional reimbursement is provided for supplies or oral medications.

If a member is referred/transferred to an emergency room, the Urgent Care Center/Medical Aid Unit may bill for services that were provided and collect any applicable member responsibilities, including copayments, coinsurance, and deductible. If the member was directed to an emergency room without treatment, a claim should not be submitted to Highmark.

3.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 5: Ohio Healthcare Simplification Act (PA and WV Only)

3.5 Introduction

For providers in Pennsylvania and West Virginia

This unit sets forth provisions of, and procedures and policies resulting from, the Ohio Healthcare Simplification Act (“OHSA”).

This unit applies exclusively to providers located in the State of Ohio and participating with Highmark Plans in West Virginia and/or Pennsylvania.

Applicability

This unit does not apply to self-funded Employee Retirement Income Security Act (ERISA) plans.

Who Should Read This Unit

This unit is intended to act as a reference point for Highmark's network participating professional and facility providers located in the state of Ohio, *excepting* pharmacists.

3.5 Products and Network

For providers in Pennsylvania and West Virginia

In accordance with the Ohio Healthcare Simplification Act (OHSA), Highmark will not require network providers to provide services for all current or future products offered.

However, if all existing products are not accepted, the OHSA permits a plan to refuse to contract and allows for contract termination if a future product is refused.

Networks

Except as permitted by OHSA, Highmark will not rent or sell networks involving Ohio providers.

3.5 Termination for Cause Contract Provisions

For providers in Pennsylvania and West Virginia

Termination for Cause Contract Provisions

Termination “for cause” contract provisions are permitted only for:

1. Any lawful reason;
2. If a party objects to a material amendment for which there is no resolution, either party may terminate not later than 60 days prior to the effective date of the amendment; or
3. Any reasonable provision agreed to by both parties.

For More Information

Please see the termination provisions of your provider contract for additional information.

3.5 Amendments

For providers in Pennsylvania and West Virginia

Notification of Material Changes to Terms of Agreement

Highmark shall furnish providers with 90 days’ notice if it intends to make a material change to the terms of the agreement.

Material changes, as defined by the Ohio Healthcare Simplification Act (OHSA), are amendments that decrease the provider’s payment, change the administrative procedures in a way that may reasonably be expected to significantly increase provider’s administrative expenses, or add a new product.

3.5 Credentialing

Applicability

For providers in Pennsylvania and West Virginia

This section on credentialing applies to all providers subject to the Ohio Healthcare Simplification Act (OHSA).

Forms

For providers in Pennsylvania and West Virginia

Highmark accepts the Council for Affordable Quality Healthcare (CAQH) credentialing application form.

In addition, Highmark West Virginia will accept the State of West Virginia *Uniform Credentialing Form* and the State of Ohio *Uniform Credentialing Form*.

Incomplete Information

Highmark will notify providers of missing or incomplete information within 21 days of receipt of application.

Time Frames

For providers in Pennsylvania and West Virginia

All providers who participate with Highmark and whose primary site of service is located in Ohio are required to be credentialed and notified of their credentialing status within 90 days of Highmark receiving a complete or incomplete credentialing application.

State Medical Board

For providers in Pennsylvania and West Virginia

Highmark *may* accept information from the State Medical Board's website to the extent that the Board has verified medical education, graduate medical education, and examination history of a physician (or the physician's status with the educational commission for foreign medical graduates).

For More Information

For providers in Pennsylvania and West Virginia

Please see **Units, 1, 2, and 4** in Chapter 3 of this *Highmark Provider Manual* for additional credentialing information.

3.5 Most Favored Nation Clauses Prohibited

For providers in Pennsylvania and West Virginia

Highmark may not include most favored nation clauses in professional provider and non-hospital facility provider contracts.

Most Favored Nation Clause as Defined by OHSA

As defined by the Ohio Healthcare Simplification Act (OHSA), a "most favored nation clause" is one that:

1. Prohibits the provider from contracting with another contracting entity to provide health care services at a lower price; or
2. Requires the provider to accept a lower payment if the provider agrees to provide health care services to any other contracting entity at a lower price; or

3. Requires termination or renegotiation of the existing contract if the provider agrees to provide services to another contracting entity at a lower price; or
4. Requires the provider to disclose the provider's contractual reimbursement rates with other contracting entities.

3.5 Arbitration

Arbitration Available For Certain Contract Disputes

Arbitration for contract disputes for the enforcement of certain rights conferred by the Ohio Healthcare Simplification Act (OHSA) is available for:

1. Termination for "for clause" provisions;
2. Information required by the OHSA to be included in the contract;
3. Material amendments; and
4. Sections that:
    a. Prohibit renting or selling networks;
    b. Require the provider to provide services for all products offered;
    c. Require the provider to accept any future product offering;
    d. Waive the provider's rights under state or federal law; and
    e. Prohibit the provider from entering into a contract with any other contracting entity.

3.5 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Search Keyword or Code

Chapter 4 – Provider Responsibilities and Guidelines

Highmark requires certain responsibilities of providers, and offers guidelines for doing business with us. We commit to announcing changes to administrative or reimbursement policies with adequate notice. Consult these units for all provider responsibilities.

Unit 1: PCPs and Specialists

While primary care physicians/practitioners (PCPs) play an important role in managing all aspects of health care for members who select their practice, specialists in Highmark's networks play an equally important role of providing specialty services to Highmark members.

READ MORE

Unit 2: Behavioral Health Providers

Behavioral health benefits vary by product and by group. In some instances, a group may purchase medical
health care coverage through Highmark, but behavioral health care coverage through another company.

READ MORE

Unit 3: Facility-Specific Guidelines

This unit includes facility-specific guidelines for facility providers and applies to Commercial and Medicare Advantage, unless otherwise noted. Section headings will help to identify if the information in the section is applicable to a specific facility type.

READ MORE

Unit 4: Ancillary Services

Ancillary care refers to the wide range of health care services provided to support the work of physicians. To supplement the professional provider and facility networks, Highmark contracts with a network of ancillary providers that provide health care related equipment or services.

READ MORE

Unit 5: Outpatient Radiology and Laboratory

These units offer guidelines on advanced imaging, cardiology, outpatient laboratory services, laboratory management, diagnostics and cost sharing.

READ MORE

Unit 6: Prescription Drug Programs

The prescription drug program offers pharmacy networks that include national chains and many local independent pharmacies. Drug benefits may vary slightly depending on the member's group program.

READ MORE

Unit 7: Medical Records Overview

Highmark makes every effort to provide resources to assist providers in servicing our members and working with us. This unit of the manual was developed to provide guidelines for documenting members' medical records that will help you to have the appropriate documentation readily available for medical necessity reviews.

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Unit 1: PCPs and Specialists

4.1 Primary Care/Specialist Essentials

While primary care physicians/practitioners (PCPs) play an important role in managing all aspects of health care for members who select their practice, specialists in Highmark's networks play an equally important role of providing specialty services to Highmark members.

Primary Care/Specialist Communication

Highmark network primary care physicians, primary care CRNPs, and specialists, including medical, surgical, and behavioral health, must communicate with one another to assure continuity and coordination of care for members. Where the networks support managed care products, Highmark will monitor compliance of the communication procedure as part of the medical record review program.

For additional information, please see the PCP and Specialist Communication section in this unit.

New Member

For providers in New York

The Medical Director, the Director of Utilization Management, or a nurse reviewer may issue an administrative referral for continuity of care or as medically necessary under the following conditions:

- A new member requires specialty care, but the PCPs office cannot accommodate a new member visit immediately.
- A new member changes PCPs and current referrals are terminated, but continued specialty care is required.
- Continuation of active care occurs under the following circumstances:
    - If the provider's participation terminates, the member may continue to receive care for up to 90 days. The 90 day transitional period begins on the date the provider's contractual obligation with the health plan to provider services terminates.
    - If the member is in the second or third trimester of pregnancy, she may continue receiving care from a terminated provider through delivery and the postpartum period.
    - New members in the second or third trimester of pregnancy may continue to see out-of-network providers for delivery and postpartum care.
    - New members who are disabled or have degenerative and/or life-threatening conditions or diseases, may continue to see out-of-network providers for up to 60 days from the date of enrollment.

Involving Members In Health Care Decisions

Highmark and providers must continually work together to encourage and support members taking an active role in their health care by:

- Providing consideration for member input when developing treatment plans;
- Informing members of appropriate follow-up care;
- Arranging or providing training in self-care and other measures that impact health status; and
- Addressing barriers to member compliance with prescribed treatments or regimens.

Advising Members of Treatment Options Policy

Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel and to freely communicate with patients on all medically necessary viable treatment options available, including medication treatment options, regardless of benefit coverage limitations, that may be appropriate for the member's condition or disease, regardless of benefit coverage limitations. Therefore, we do not penalize and have never penalized physicians for discussing medically appropriate care with the patient.

Some managed care plans may include a “gag clause” in their provider contracts that limits a network physician’s ability to provide full counsel and advice to enrollees. Highmark’s network contracts for all products do not (and never did) contain such a “gag clause” relating to treatment advice (complies with Pennsylvania Act 68 requirements).

Highmark does not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Highmark plan, about:

- The patient’s health status, medical care, or treatment options (including any alternative methods of treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Reminder: In cases where the care, services, or supplies are needed from a provider who does not participate with Highmark, authorization must be requested.

Voluntary or Involuntary Specialist Termination from the Networks

In the event of the voluntary or involuntary termination of a Highmark provider agreement, the specialist/specialty group must cooperate with Highmark in its efforts to obtain information regarding those members enrolled in managed care products that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of the specialist/specialty group. Such information includes the name, address, and identification number of the affected managed care members.

This information must be provided timely so that affected members may be notified prior to the effective date of the termination. Highmark has a process in place to notify these members as obligated by state regulation and federal law.

Highmark’s Communication Policy

From time to time, Highmark will announce changes to administrative or reimbursement policies. In cases where such changes have a direct impact on the provider, it is Highmark’s policy to give providers adequate notice regarding these changes. Informational changes will be announced in no less than thirty (30) days in advance, unless the change decreases reimbursement in an adverse way in which there will

be written notice ninety (90) days in advance, or it changes our credentialing/recredentialing policies in which case written notice will be given sixty (60) days in advance, unless required by law or regulation.
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4.1 Treatment of Immediate Relatives

Charges imposed by immediate relatives of the patient or members of the patient's household:

General

These are expenses that constitute charges by immediate relatives of the patient or by members of their household. The intent of this exclusion is to bar Highmark reimbursement for items and services that would ordinarily be furnished gratuitously because of the relationship of the patient to the person imposing the charge.

This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s) of the corporation that employs the provider. It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s) of the supplier.

Payment may be made for charges imposed on immediate relatives or household members by a professional provider to recover expenses incurred in furnishing covered items or supplies, such as drugs and biologicals, prosthetic devices, etc.

Immediate Relative

The following degrees of relationship are included within the definition of immediate relative:

- Spouses
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild

Members of Patient's Household

These are persons sharing a common abode with the patient as a part of a single-family unit, including those related by blood, marriage or adoption, domestic employees, and others who live together as part of a single-family unit. A mere roomer or boarder is not included.

Charges for Provider Services

Payment will not be made by Highmark for items and services furnished by providers to immediate relatives of the owner(s) of the corporation that employs the providers. This exclusion applies whether the provider is a sole proprietor who has an excluded relationship to the patient, or a partnership in which even one of the partners is related to the patient.

Charges for Physician and Physician-Related Services

This exclusion applies to physician services, including services of a physician who belongs to a professional corporation, and services furnished incident to those services (for example, by supervised services incident to their services has an excluded relationship to the beneficiary).

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by state law. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

Charges for Items Furnished by Nonphysician Suppliers

This exclusion applies to charges imposed by a nonphysician supplier that is not incorporated, whether the supplier is owned by a sole proprietor who has an excluded relationship to the patient, or by a partnership in which even one of the partners is related. It does not apply to charges imposed by a corporation (other than a professional corporation), regardless of the patient’s relationship to any of the stockholders, officers, or directors of the corporation or to the person who furnished the service.

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4.1 PCP and Medical Specialist Accessibility Expectations

Accessibility Expectations for Providers

To stay healthy, members must be able to see their physicians when needed. To support this goal, Highmark's expectations for accessibility of primary care physicians (PCPs), medical specialists, and obstetricians are outlined below. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see patients with scheduled appointments within fifteen (15) minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

Note: Standards for Highmark Healthy Kids/Pennsylvania Children's Health Insurance Program (CHIP) enrollees are available in the *Highmark Provider Manual* Chapter 2 Unit 3: Other Government Programs and may differ from the expectations noted below.

PCP and Medical Specialist Accessibility Expectations

Patient's Need:	Performance Standard:
Emergency/life-threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)…	Immediate response.
Urgent care appointments • An urgently needed service is a medical condition that requires rapid clinical intervention due to an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)…	Immediate response.

Routine care appointments • Routine wellness appointments (e.g., asymptomatic/adult preventive care, well child/patient exams, physical exams)…	• Must be scheduled within three weeks. • Subsequent routine wellness appointments must be scheduled within seven days of member request.
Non-urgent, regular care appointments • Patient's condition is considered to be stable • Non-urgent, regular care, but in need of attention appointment (e.g., sick visit, headache, cold, cough, rash, joint/muscle pain)…	• Office visit within 48-72 hours (three days).
Follow-up visit • After an emergency or hospital discharge for a medical condition.	• Care within five days of discharge or as clinically indicated.
After-hours care • Access to practitioners after the practice's regular business hours…	Acceptable coverage in place to respond to members 24 hours per day, seven days a week which may be either directly or through an on-call arrangement with another Highmark credentialed participating practitioner of the same or similar specialty and of the same network(s). An answering service, pager, or direct telephone (landline or cellphone) access whereby the practitioner or his/her designee can be contacted is acceptable.
In-office waiting times	Within 15 minutes.

• Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays…	

Maternity Care Expectations (Obstetrics)

Patient's Need:	Performance Standard:
Maternity Emergency…	Immediate response.
Maternity 1st Trimester…	Within 3 weeks of first request.
Maternity 2nd Trimester…	Within 7 calendar days of first request.
Maternity 3rd Trimester…	Within 3 calendar days of first request.
Maternity High Risk…	Within 3 days of identification of high risk.

Acceptable After-Hours Methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

Answering Process	Response/Message	Comments

Answering Service or Hospital Used as an Answering Service	Caller transferred directly to provider or clinical staff person covering for the provider.	
	Service pages the provider on call (see comments).	A provider or clinical staff person is expected to return the call within 30 minutes.
Answering Machine	Message must provide the caller with a way to reach the provider on call by telephone or pager.	Provide clear instructions on how to record a message on a pager (i.e., “you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up”). A provider or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment).	A provider or clinical staff person is expected to return the call within 30 minutes.

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4.1 Primary Care Practitioner Overview

Highmark managed care members may select a primary care physician or practitioner (PCP) in accordance with their managed care program requirements. PCPs play an important role in managing all aspects of health care for members who select their practice.

Definition of PCP

A PCP is the medical professional who provides a patient's care and helps them access a range of services. The PCP provides, coordinates, and/or authorizes the health care services covered by the managed care program.

Practitioners Who May Serve as PCPS

A physician (MD or DO) who is a family practitioner, general practitioner, internal medicine practitioner, or pediatrician is entitled to participate as a PCP. The physician must complete the credentialing process.

In addition, certified registered nurse practitioners (CRNPs) may offer their clinical expertise as a primary care CRNP to Highmark members. Qualified CRNPs must complete a credentialing application and meet credentialing requirements to receive designation as a primary care CRNP with Highmark. CRNPs who receive primary care CRNP designation with Highmark can only participate in Highmark's provider networks in that capacity; they cannot serve as both a CRNP specialist and a primary care provider.

How PCPS are Reimbursed

PCPs in most Highmark networks are paid fee-for-service; however, PCPs participating in the First Priority Health (FPH) managed care network in Pennsylvania's Northeastern Region receive capitation, unless otherwise set forth in your participating provider agreement.

Please see the section in this unit on **First Priority Health Network PCP Payment Methodology** for more information on FPH network payment methodology.

PCP Selection Requirements

Highmark members enrolled in the following products are required to select a PCP to manage their care:

Pennsylvania:

- Commercial HMO plans in the Western and Northeastern Regions
- Medicare Advantage HMO plans -- Security Blue HMO, offered only in the Western Region, and Community Blue Medicare HMO

- Highmark Healthy Kids (CHIP) HMO plan

Delaware:

- Independent Practice Association (IPA) and Point of Service (POS) products require the selection of a PCP.

West Virginia:

- Members in Super Blue Select POS plans are required to select a PCP at the time of enrollment.

Traditional indemnity products and PPOs do not require PCP selection. In Pennsylvania, EPO products do not require PCP selection but it is recommended.

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4.1 Primary Care Practitioner Role and Responsibilities

Highmark managed care members may select a primary care physician/practitioner (PCP) in accordance with their managed care program requirements. The PCP provides, coordinates, and/or authorizes the health care services covered by the managed care program.

PCPs play an important role in managing all aspects of health care for members who select their practice. The information to follow serves as an introduction to the roles and responsibilities of the PCP.

For providers in New York

Managed care members are required to select a PCP from our directory of participating providers. The PCP is responsible for monitoring his/her patients and coordinating the delivery of all health care services, including preventive and routine medical care, hospitalization, and specialized care within the network. If an enrollee is using a behavioral health clinic that also provides primary care services, the enrollee may select lead provider to be PCP.

PCP Responsibilities

Responsibilities specific to primary care physicians and primary care CRNPs, if within the scope of their license, include, but are not limited to:

- Office visits
- Inpatient hospital, emergency room, skilled nursing, and home visits
- Routine pediatric and adult immunizations
- Maintenance allergy injections
- Routine diagnostic procedures
- Minor surgeries performed in office (as applicable)
- Lab services performed in the office
- Preventive and early detection interventions
- Most acute and chronic services
- Other services as necessary
- Maintaining organized medical record keeping practices and ensuring accurate medical records
- Maintaining active staff privileges at a minimum of one Highmark contracted hospital*
    - Risk Adjustment Data Verification (RADV)
- Providing 24-hour telephone availability year round
- Providing 24/7 physician coverage
- Obtaining authorization for services as required
- Informing Medicare Advantage members about advance directives (applicable in Pennsylvania and West Virginia)
- Cooperating with Highmark quality management programs to the extent permitted by federal and state law including, but not limited to, the following:
    - Clinical initiatives
    - Condition management and shared decision making
    - Credentialing
    - Clinical studies
    - Health Plan Employer Data and Information Set (HEDIS®)
- Providing access to members' medical records

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

**Primary care CRNPs must have full admitting privileges or a plan of action with a network participating primary care physician with admitting privileges, with consideration to the age range of patients (e.g., a general practitioner who sees patients age 13 years and older should not cover hospital admissions for a CRNP with a pediatric practice who sees patients under 13 years of age).*

Primary Care Physician

For providers in New York

A primary care physician's role is that of a medical manager, providing and coordinating medical care for Highmark members. A primary care physician is responsible for determining the health care needs of his/her patients, for directly providing many of these needs and for coordinating the services of other providers. Primary care specialties include family practice, general practice, internal medicine, geriatrics, adolescent medicine, and pediatrics.

To remain in compliance with New York State laws, primary care physicians must make arrangements with other participating providers to ensure that Highmark members have access to health care 24 hours per day, seven days per week. An "on-call provider" covers for another. The name of the on-call provider should be indicated on the provider application form at the time of credentialing and re-credentialing. Providers should follow the guidelines below when selecting providers to cover their practices:

1. Individual provider practices are limited to five on-call providers.
2. All providers of the same specialty within a group can be on call for each other.
3. Specialists cannot be on call for PCPs.
4. Specialists can only be on call for specialists in the same field.
5. All on-call providers must be participating providers with Highmark.

It is the responsibility of the provider to notify the File Data Management Department of any changes to who is covering for his/her practice. If a provider is covering on a temporary basis only, Provider File Data Management should be notified of the specific dates that he/she will be covering. The following criteria explain that family practice physicians must have a coverage agreement for each major component of their active practice with a physician that has an active practice in the same component (adult medicine, pediatrics, and OB-GYN). It may be necessary for the family practice physician to have more than one practitioner for coverage agreement(s) for their active practice(s) as described in the table below. Pediatric practice physicians must have coverage agreement(s) with physicians that have an active pediatric component within practice(s).

Adult medicine physicians must have coverage agreement(s) with physicians that have an active adult medicine component within their practices.

Organizational Provider Communication

Highmark network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities, must promote continuity and coordination of care for network members by communicating with primary care physicians and primary care CRNPs when care is delivered to their patients.

Primary care physicians and primary care CRNPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

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4.1 How Members Select and Change PCPS

How Members Select a PCP

Managed care members with coverage requiring a PCP selection are asked to select a PCP at the time of enrollment.

- Pennsylvania: Members with coverage under commercial health maintenance organization (HMO) plans in the Western Region, Medicare Advantage HMO plans in the Western Region, and Highmark Healthy Kids (CHIP) HMO plan.
- Delaware: Members with Independent Practice Association (IPA) and Point of Service (POS) plans are required to select a PCP.
- West Virginia: Members in Super Blue Select POS plans must select a PCP and are informed that benefits will be paid at the lower, self-referred level if they do not select a PCP.

Managed care members who are required to select a PCP may select any network PCP listed in the provider directory they receive at enrollment as long as the following conditions are met:

- The PCP practice is open to new members.
- The member fits into the PCP's patient age range as specified by specialty, e.g., pediatrics.

Members in PPO/EPO and traditional indemnity plans, including Medicare Advantage Freedom Blue PPO plans in Pennsylvania and West Virginia, are not required to formally select a PCP. These members may select or switch PCPs as they choose without notifying Highmark.

How Members Change PCPS

Highmark members may call into Member Service and select a new PCP at any point after enrollment.

If The Member Calls In...	PCP Changes Are Effective...
from the 1st through the 15th day of the month,	the first of the next month following the date of the call.
after the 15th day of the month,	the first of the second month following the date of the call.

Transfer of Medical Records

When a member chooses a new PCP, the original PCP must transfer the member's complete medical record to the new PCP in a timely manner (at no charge to the member).

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4.1 Arranging for PCP Absence

The purpose of this section is to explain what the PCP needs to do before leaving for vacation or other time off.

Making the Necessary Arrangements

Prior to leaving for an extended period of time off, the PCP should:

1. Find a PCP who participates in the same network(s) as you to provide medical treatment to members during your absence.
2. Resolve payment arrangements, including copayments.
3. Inform office staff of the above arrangements and ask that the covering physician inform his/her office staff of the arrangements.
4. Be sure that your answering service informs patients of the arrangement.

PCP Back-Up Physician Form

For providers in West Virginia

PCPs in Highmark West Virginia's Point of Service (POS) network select a back-up physician at the time of contracting with Highmark West Virginia by completing the Primary Care Physician Back-Up Physician Information Form.

The PCP may change his/her designated covering physician by submitting a new form. However, use of a non-network physician for coverage must be authorized by Highmark West Virginia. Please contact Highmark Provider Information Management at **800-798-7768**

Appointments

Most members will be able to wait for their regular PCP's return. However, there will be some cases when a member will require an office visit during his/her PCP's absence. For such cases, the covering PCP's office staff should make an appointment or arrangements and give the member clear directions.

Authorization Requests During the PCP'S Absence

If the PCP is planning to be away for a short duration (less than five days), the covering PCP can request authorizations and advise members to go to specialists or the emergency room during the PCP's absence.

The covering physician may keep a list of these incidents which he/she then shares when the member's PCP returns. For the treatment that took place during the absence, the member's PCP should submit any authorization requests expediently to avoid payment delays.

Reimbursement and Copayments

We advise physicians to work out their own payment arrangements prior to covering for one another. We do not provide additional reimbursement to practitioners who are covering for other PCPs.

The collection of copayments works the same way. The two physicians involved should come to an agreement as to how this will be handled.

Informing the Office Staff

It is imperative that both the regular and the covering physicians' office staff be aware of any temporary coverage arrangements. Failing to notify the office staff may decrease continuity of care to members.
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4.1 Member Removal Policy and Procedure

Policy

All Highmark members have a responsibility to maintain a cooperative physician/patient relationship. Documented occurrences of members not fulfilling their responsibilities may result in a practitioner requesting discharge of the member from his/her practice.

Background

The relationship between a PCP and his/her members is crucial in the managed care environment. However, sometimes problems can occur which cause a serious rift in the doctor/patient relationship. In such cases, we ask the PCP to attempt to resolve the matter directly with the member. If this does not correct the problem, the PCP is supported in his/her effort to remove the member from the practice.

Invalid Reasons for Removing a Member

Invalid reasons for removing a member include:

- Race.
- Sexual orientation.
- Age (unless the member's age is outside of the scope of the practice, e.g., an adult patient in a pediatric practice).
- National origin.
- Diagnosis.
- Physical disability.
- Religion.
- Gender.
- Health status factors (e.g., medical condition, claims experience, receipt of health care medical history, genetic information, or evidence of insurability).

- Health care insurance coverage.

Before You Request Removal...

Removing a member from your practice should be used as a last resort. You must make a sincere attempt to resolve the situation with the member prior to requesting his/her removal. Your efforts must be documented in the member's chart.

Procedure for Removing a Member from Your Practice

If a problem is identified, the practitioner must communicate the problem to the member or the member's legal representative and document the problem in the member's medical record.

When a PCP has exhausted his/her best efforts to establish an effective relationship and has documented situation(s), the PCP may apply to Highmark to have the member transferred from the PCP's practice. Written requests for physician/patient relationship termination should be submitted to:

Pennsylvania and Delaware	West Virginia
Highmark Member Disenrollment Fifth Avenue Place, Suite 721 120 Fifth Avenue Pittsburgh, PA 15222-3099 Fax: 717-635-4219	Highmark West Virginia Provider Services Department 614 Market Street Parkersburg, WV 26102

Note: It is not necessary to send a written request for members with coverage that does not require a PCP selection.

The request must contain the following information:

- Member name.
- Member ID number and insurance product.
- Member address.
- Member telephone number.

Also included with each request should be statements which document:

- Specific documentation of the nature and timing of the incident(s) which gave rise to the request as evidenced in the medical record.
- The steps which the PCP has taken to resolve the situation and/or to establish an acceptable relationship with the member.
- Other relevant information pertinent to the request for terminating the physician/patient relationship.

A practitioner or designee from the practice must sign the request. A copy of the request should also be sent to the member.

The PCP must provide access to service until the termination date and provide urgent care if necessary. If requested to do so by the member or Highmark, the practitioner must, at no cost to the patient, forward medical records to the new PCP within 30 days.

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4.1 How to Close and Re-Open Your Practice to Members

This section is intended to explain how to close and re-open your practice to new members.

Definition: Closed Practice

When a practice is “closed to new members,” it means that the PCP practice is temporarily not available for selection by new members.

Definition: New Member

A new member is one who has:

- Never been seen by a physician of the practice.
- Not been seen by a physician of the practice within the past 36 months.

Rationale

By closing to new members, your practice can limit the number of new members. This can be especially helpful to practices that are new to managed care, or to practices that have a shortage of physicians or office staff.

Guidelines

- Your practice must provide written notice to Highmark 60 days prior to the anticipated closing date and/or re-opening date.
- Closure takes place on the first day of the month following the 60-day period.
- You must continue to accept new members up to the end of the 60-day period when closure is in place. You must accept existing members who choose you as their PCP.
- You must close to all new Highmark plan members.

How to Close or Re-Open Your Practice

To close or to re-open your practice to new members, simply mail or fax written notification on practice letterhead, including practice name, address, vendor number, effective date, and authorized signature for the requested change, to:

- Fax: 800-236-8641
- Mail: Highmark Blue Shield
    - Provider Information Management
      P.O. Box 898842
      Camp Hill, PA 17089-8842

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4.1 First Priority Health Network PCP Payment Methodology (PA Only)

For providers in Pennsylvania

The First Priority Health (FPH) managed care provider network supports the health maintenance organization (HMO) products in the 13-county Northeastern Region of Pennsylvania. Highmark also uses FPH for the Highmark Healthy Kids (CHIP) program. There are several reimbursement methodologies available to primary care physicians (PCPs) participating in the FPH network. These include capitation, billables, copayments, and fee-for-service reimbursement as more specifically set forth in your FPH participating provider agreement.

FPH PCP Capitation

For providers in Pennsylvania

Capitation is a prepaid dollar amount, determined actuarially, which is paid to the PCP for each patient who has chosen his/her office. It is calculated to average a fee-for-service equivalent. The dollar amount is based on a predetermined rate per age group, regardless of any one patient's use of services. The dollar amount varies based on copayment, age category, and provision of venipuncture.

Capitation checks are issued on the first of the month and the dollars paid are for services provided during that month. Capitation services are not prorated. The date on which additions or deletions to your office are effective determines whether your office will receive or repay a full month's payment.

Changes effective from the first through the fifteenth of the month are calculated for capitation purposes for the entire current month. Changes which are effective from the sixteenth through the end of the month are effective on the first day of the following month.

If you do not have a copy of the capitation rates, please contact Provider Services.

Some examples of services covered under capitation include, but are not limited to:

- Office visits and outpatient services rendered at the PCP's office.
- Drawing of blood and other laboratory specimens (if the office is located in a laboratory program region, these specimens should be sent to the assigned laboratory provider – please see the Highmark Provider Manual Chapter 4 Unit 5: Outpatient Radiology and Laboratory for more information).
- Physical examinations, including routine, camp, college, scouts, driver's license, or school physicals, are covered under capitation once every 12 months. If the member has had a physical examination within less than twelve (12) months and requests another exam for non-medical reasons, it is not a covered service because it is not considered medically necessary and, therefore, the member is responsible for payment.
- EKGs (electrocardiograms).
- Services not listed on the billable list are considered covered under capitation.

Foreign service physical exams, pre-employment physicals, or exams required by insurance companies are not covered; the member is responsible for payment of these services.

Important: It is critical that ALL services rendered to members are submitted for payment or adjudication as pre-paid. This includes capitated (prepaid) services in addition to the PCP billable procedures, which are paid fee-for-service. Highmark requires this billing/encounter information to monitor clinical activities, comply with accrediting bodies, and provide PCPs with fair capitation payments and accurate reports. All payments for non-medically necessary services and/or non-covered benefits are the member's responsibility.

Capitation Roster

For providers in Pennsylvania

The capitation roster is a monthly financial statement intended for use by the provider's business office. In the roster's heading, totaled capitation information for the provider practice is provided, including total number of members, total capitation rate for all members, the total amount of adjustments (if applicable), and the total capitation payment for the month for all members.

The capitation roster also lists, alphabetically, all members enrolled with your practice. Due to the time required to process new members or PCP selection changes, sometimes there is a delay of one to two months before a new member may appear on the roster. The following information is included on the roster for each member:

- Member Name/Member ID.
- Date of Birth/Age.
- Sex.
- Effective Date with PCP.
- Copay Amount.
- Capitation Rate.
- Adjustment Amount/Date, if applicable.
- Capitation Payment.

The capitation roster is available at the beginning of every month via Availity. It is accessed by going to Payer Spaces and then clicking Quality Blue and navigating to Quality Blue reports.

- The roster is generated by "provider group," not by "physicians within the group."
- The roster can be downloaded to a PDF or text file.
- A history of rosters will be available at all times within Quality Blue.

- Providers receiving Highmark capitation via electronic funds transfer (EFT) will only receive the roster via Quality Blue.
- Providers receiving a paper check will receive the roster by mail in addition to the ability to access the roster via Quality Blue.

FPH PCP Billables

For providers in Pennsylvania

Billables are certain services the PCP may submit for fee-for-service reimbursement consideration in addition to his/her capitation payments. The PCP must submit claims with all the required information via an 837P electronic claim transaction or a paper claim using an original 1500 Health Insurance Claim Form, Version 02/12 (photocopies, discontinued, or outdated versions will not be accepted).

Please refer to the PCP Billable Services list for procedures that are billable for fee-for-service reimbursement.

FPH PCP Copayments

For providers in Pennsylvania

For any office visit where a member seeks “professional medical attention,” the patient is responsible for a copayment at the time services are rendered. Copayments should be collected **only** for office visits billed with an evaluation and management code. Highmark follows the current year evaluation and management codes as published in the American Medical Association CPT Manual.

Please refer to the member’s current ID card or Availity’s Eligibility and Benefits Inquiry for the correct copayment amount to be collected. **A member’s copayment cannot exceed the allowed amount (contracted rate). If the allowed amount is less than the member’s designated copayment, providers should only collect up to the allowed amount.**

Please check your remittance advice for the appropriate member liability (copayment, deductible, and/or coinsurance). If you collected the copayment at the time services were rendered and the remittance advice indicates a lower copayment, the member must be reimbursed the difference.

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4.1 Risk Score Accuracy (RSA) Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

The goal of the Risk Score Accuracy (RSA) Program is to help ensure that quality health care is provided to Highmark Medicare Advantage and Inter-Plan Medicare Advantage members with complex chronic health conditions by assisting provider practices to accurately identify, treat, document, and report appropriate ICD-10-CM and Hierarchical Condition Category (HCC) diagnosis codes to Highmark.

Program Overview

For providers in Delaware, Pennsylvania, and West Virginia

Analytics are used to identify persistent (previously reported) and/or suspected diagnosis condition(s) of Program Members, and Participants are asked to address these diagnosis condition(s) during office visits using an Electronic Medical Record (EMR)-based or desktop-based, system-generated form (RSA Tool). Participants must respond to the RSA Tool, document the condition in the Member's medical record, and submit any confirmed condition(s) via claim as indicated in the instructions and Program training materials.

Evaluating each Program Member for the diagnosis condition(s) listed on the RSA Tool helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each Program Member to the Centers for Medicare & Medicaid Services (CMS).

The Program is available to Participants that have Program Members with diagnosis condition(s) that need to be evaluated during the current year. Participants have the potential to receive program compensation by taking steps toward providing quality health care through assessment of the Program Members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this Program. It is important that every office visit with the Program Member be precisely

documented in the medical record to provide a complete picture of the Program Member's health for purposes of appropriate treatment and follow-up care.

The information presented in the RSA Tool is derived from diagnosis codes reported in previous years by multiple sources, including PCPs, Specialists, and clinical data, facilities, chart reviews, and other sources. The RSA Tool will only appear for a Program Member who has not been evaluated for the specific diagnosis condition(s) listed on the RSA Tool in the current year.

For More Information

For providers in Delaware, Pennsylvania, and West Virginia

Complete program information is available on the Provider Resource Center. Select **Resources & Education.** You'll find **Risk Adjustment Programs** under **Clinical Quality & Education.** You'll need use your Availity login credentials to gain access to the information.

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4.1 Unconfirmed Diagnosis Code (UDC) Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

The Unconfirmed Diagnosis Code (UDC) Program is a clinically-based program that promotes provider/Highmark collaboration to evaluate previously reported and/or suspected diagnosis conditions. These conditions require annual evaluation and/or treatment but may not have been reported to Highmark in the current year. This improves continuity, quality, and timely coordination of care for chronic conditions.

The goal of the UDC Program is to ensure that quality health care is provided to Highmark Medicare Advantage and Commercial Affordable Care Act (ACA) members with complex chronic health conditions

by accurately identifying, treating, documenting, and reporting the appropriate ICD-10-CM diagnosis codes to Highmark.

Program Overview

For providers in Delaware, Pennsylvania, and West Virginia

Using analytics, the program will identify and list persistent (previously reported) and/or suspected diagnosis condition(s) of program members. In-network primary care physicians (PCPs) and physicians with select specialties (“participants”) are asked to address the diagnosis condition(s) with the program member during their scheduled visit within the current program period.

Participants will be provided with the diagnosis condition(s) in various formats and tools (“UDC Forms”). Participants must complete and return the UDC Forms as indicated in the instructions and program materials. Evaluating each program member for the diagnosis condition(s) listed on the form helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each program member to the Centers for Medicare & Medicaid Services (CMS).

The program is available to all participants who have program members with diagnosis conditions that need to be evaluated during the current program period. Participants will have the potential to receive additional compensation (“program compensation”) by taking steps toward providing quality health care through assessment of the program members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this program.

For More Information

For providers in Delaware, Pennsylvania, and West Virginia

Complete program information is available on the Provider Resource Center. Select **Resources & Education**. You'll find **Risk Adjustment Programs** under **Clinical Quality & Education**. You'll need use your Availity login credentials to gain access to the information.

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4.1 PCP and Specialist Communication

Network personal physicians and specialists, including medical, surgical, and behavioral health, must communicate with one another to assure continuity and coordination of care for members. The communication procedure is documented below.

The goal is to ensure the exchange of information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.

Requirements

PCPs and specialists, including medical, surgical, and behavioral health specialists, must communicate in each of the following ways to ensure continuity of patient care:

- Before the member's visit to the specialist, the PCP must provide relevant clinical information to the specialist. Acceptable forms of communication are formal letters and/or copies of relevant portions of the patient's medical chart. The Patient Treatment Summary Communication Form is available on the Provider Resource Centers in Pennsylvania and West Virginia – select **Forms,** and then **Miscellaneous Forms.**
- Within 10 business days of the first visit, the specialist must provide the PCP with information about his/her visit with the member. Acceptable methods of communication are standardized form, formal letter, and/or copies of relevant portions of the patient's medical record.
- In the case of behavioral health, the member's consent may be needed for the behavioral health specialist to release information to the PCP. If a patient refuses to give consent, the behavioral health specialist must document this refusal in the patient's behavioral health treatment record.
- The PCP must document his/her review of the reports, lab, X-rays, and other diagnostic tests received from the specialist or facility in the patient's chart. The PCP must also indicate any subsequent action necessary. The PCP should indicate that he/she has reviewed the information (e.g., by initialing each page).

Member Role in Communication

Highmark members should not be asked by PCPs or specialists to communicate findings, reports, lab results, etc. to another practitioner.

PCP/Behavioral Health Form

For providers in Pennsylvania

Behavioral health providers in Pennsylvania may use the Communication Document for Behavioral Health Specialist to Primary Care Physician to communicate with the member's PCP. This form can also be found on the Provider Resource Centers in Pennsylvania – select **Forms,** and then **Behavioral Health Forms.**

Copying and Transferring Medical Records

Providers must ensure members are guaranteed timely access to their medical records, X-rays, and other information that pertains to them. The following requirements apply to the transfer and copying of medical records for Highmark members:

- PCPs must transfer sufficient medical records (or copies thereof) and information to Specialists without charge to the member or Highmark, as is necessary for the Specialist to appropriately treat the member.
- Specialists must provide PCPs, without charge to the member or Highmark, written documentation regarding medical care given or being given to the member. (Additional restrictions may apply to information regarding certain medical conditions such as mental health, substance abuse, and HIV/AIDS).
- PCPs must transfer, without charge to the member or Highmark, sufficient medical records and information to another if the member requests to change his/her PCP.
- In general, practitioners must transfer to each other appropriate medical information as necessary to ensure quality care for all members. The transfer of medical records must be completed in a timely fashion and without charge to the member or Highmark to ensure continuity of care.
- When releasing records directly to the patient, at the patient's request, the practitioner may charge a reasonable fee to cover copying and postage costs, up to the amount set by state law and as permitted by federal law.

Compliance Monitoring

Where the network supports managed care products, Highmark will monitor compliance of the communication procedure as part of the medical record review process. During medical record review, Highmark representatives will check for the provider's initials on the member's chart and ensure that any necessary follow-up actions are addressed.

The goal is to ensure the exchange of information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.

Organizational Provider Communication

Highmark network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities, must promote continuity and coordination of care for Highmark members by communicating with personal physicians when care is delivered to their Highmark members. Personal physicians should expect a written description of the care given to their Highmark members any time services have been rendered by these providers.

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4.1 Specialist Basics

As a specialist, you play the important role of providing specialty services to our Highmark members.

In New York, the specialty care physician is responsible for responding to the referral from the primary care physician.

How Specialists are Reimbursed

Network specialists are paid fee-for-service. For more information on reimbursement methods, see the *Highmark Provider Manual* Chapter 6 Unit 7: Payment/EOBs/Remittances.

How Auxiliary Personnel are Reimbursed

When physicians employ auxiliary personnel (e.g., non-physician such as a certified registered nurse) to assist in rendering services to their Highmark members and include the charges for those services in their own bills, the services of such personnel are considered to be “incident to” the physician’s services. Services of auxiliary personnel are covered when there is a physician’s service rendered to which the services of such personnel are an incidental part and there is direct personal supervision by the physician.

More detailed information about supervision guidelines of ancillary personnel and employment guidelines can be found in Medical Policy Bulletin Z-27: Eligible Providers and Supervision Guidelines.

Highmark's Medical Policies are available on the Provider Resource Center under **Policies & Programs.**

If Network Participation is Terminated

In the event of voluntary or involuntary termination the specialist or specialty group from any of Highmark's networks, upon request, are required to cooperate with network policies in obtaining a list of members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active plan members. The list must include name, address, and identification number.

Highmark will use the member list to initiate its member notification process to alert them that the specialist or group will no longer be a part of the network.

Directing Care to Network Providers

As a provider who participates in a managed care network, it is your obligation to provide services at the most appropriate level and to protect Highmark members from business practices which expose them to unnecessary out-of-pocket expenses. This means, among other things, that when your Highmark members require services that you are not able to provide, you are obligated to direct those members to other providers who participate in the network associated with their benefit program.

For more information on directing care to network providers, please see the *Highmark Provider Manual* Chapter 3 Unit 1: Network Participation Overview.

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4.1 Preventive Care Responsibilities for All Network Physicians

Network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Benefits are provided for prevention, early detection, and minimization of ill effects and causes of disease.

Highmark charges its PCPs and specialists with promoting and helping to maintain the health of members through the HEDIS® measures and other preventive services as noted below.

PCP and Specialist Responsibilities

- Adhere to nationally accepted preventive health guidelines as approved by Highmark.
- Provide or recommend beta-blocker treatment after heart attack and promoting long-term therapy.
- Recommend and promote timely and age-appropriate preventive services, e.g., screening for breast, cervical, colorectal, and prostate cancers.
- Recommend a follow-up behavioral health visit within seven days and no later than 30 days after hospitalization for mental illness and ensuring compliance with medication and long-term follow-up.
- Evaluate members to determine tobacco use. Advise and assist members to cease tobacco use.
- Recommend the Baby Blueprints® program to members who could benefit from participating in this program.
- Provide or recommend adequate care for diabetics, including foot and eye exams.
- Use recommended depression screening tools to identify depression in members and initiate appropriate, ongoing treatment.
- Recommend members to condition management programs when appropriate and available under their benefit plan.
- Provide appropriate and comprehensive care for members with hypertension.
- Prescribe appropriate medications for members based on current national standards of care.
- Promote exercise and physical activity to all members, especially the senior population.

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

Clinical Practice and Preventive Health Guidelines

On an annual basis, Highmark's Quality Management, along with participating network physicians, review and update the *Clinical Practice and Preventive Health Guidelines*.

These guidelines are available online to the provider community as a reference tool to encourage and assist you in planning your patients' care. The guidelines can be found under **Resources & Education** on the Provider Resource Center.

Additional Information Related to OB/GYN Care

- Provide or recommend screening mammograms, cervical cancer screenings, and Chlamydia screenings.

- Recommend Baby Blueprints® to expectant Highmark members so that they may better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.
- Provide or recommend prenatal care, especially in the first trimester.
- Provide or recommend post-partum exams 4-6 weeks after delivery.
- Provide appropriate counseling for menopause.
- Evaluate the risk of child abuse, domestic violence, and elder abuse.
- Evaluate the risk of post-partum depression.

Documentation

Network physicians should submit accurate encounters/claims and document their preventive care services and recommendations in the member's chart.

If performed by a specialist, the intervention, including dates they were performed and their results, should be communicated in writing to the PCP.

Likewise, information about such interventions performed by the PCP should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.

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4.1 OB/GYN Requirements and Procedures

Obstetricians and gynecologists (OB/GYNs) in Highmark's networks play a very important role by providing health care to our female members. Women have direct access to any network OB/GYN for their health care needs.

Direct Access

Direct access to women's health care means that no members in need of gynecological or obstetrical services need to obtain referrals from their primary care physicians/practitioners (PCPs).

Direct access offers the following advantages for members seeing a credentialed network OB/GYN:

- No referral for annual routine gynecological exam.

- No referral for sick visits.
- No referral for follow-up care.
- No referral for maternity services.

Direct access does not extend to services provided by OB/GYN residents or to gynecological services provided in a hospital clinic setting.

For providers in New York

Members have access to two annual routine gynecological exams.

Communication Procedure

Direct access enables members to have contact with their OB/GYNs without going through their PCPs. While this enhances member satisfaction, communication between OB/GYNs and PCPs is still vital, especially when routine annual gynecological exams and mammograms are provided.

The following should be faxed or mailed within 30 days to the member's PCP for each office visit:

- Clinical findings.
- Test results.
- Treatment plans.
- A summary report at the conclusion of the treatment period.

Acceptable formats include typed letters, physician forms, and progress notes.

OB/GYN Referrals

For providers in Delaware, Pennsylvania, and West Virginia

If an OB/GYN sees a member and determines that the member may need the services of another specialty practitioner, the OB/GYN should recommend that the member return to their PCP. OB/GYNs are not authorized to refer members to other specialty practitioners.

If a member requests a visit for symptoms that do not appear to be gynecological in nature, the OB/GYN should refer the member back to her PCP.

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4.1 Obstetrical Services

Highmark members have direct access to women's health care and are not required to obtain referrals from their primary care physicians/practitioners (PCPs) for maternity care.

Verifying Benefits

Highmark recommends that you always verify benefits prior to providing service to our members because member benefits can vary. Ensure you do so for each of these special circumstances:

- Dependent daughter's eligibility for maternity benefits.
- Coverage for tubal ligation.
- Hospital employees and their dependents – some may have coverage or high-level coverage only at their employer hospitals.

To verify benefits, please use the **Eligibility and Benefits** feature in Availity®. If you do not have access to Availity, please call Provider Services for your service area to speak to a customer service representative.

Note: Maternity authorizations are not necessary unless the care is provided out-of-network.

Case Management Available

Case management is a systematic, proactive, and collaborative approach to effective assessment, monitoring, and evaluation of options and services required to meet an individual member's health needs. Case management is a collaborative process involving the physician, the patient and support system, the case manager, and other health care service providers to encourage and assist patients to achieve their optimum level of wellness, self-management, and functional capability.

In cases where the obstetrician feels there is a need for case management due to a high-risk pregnancy, please contact case management staff to discuss your patient's needs.

- Pennsylvania: **800-596-9443**
- Delaware: **800-572-2872**
- West Virginia: **800-344-5245**

Baby Blueprints® Program Available!

Baby Blueprints® is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through multiple printed and online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes, and many others.

For more information on this program, please visit the *Highmark Provider Manual* **Chapter 2 Unit 4: Benefit Plan Programs.**

Spontaneous Abortion

In the case of a spontaneous abortion, the obstetrician should retrospectively bill for all prenatal visits.

Directing Members for Appropriate Care

If a member requests a visit for symptoms that do not appear to be obstetrical or gynecological in nature, please direct the member to contact her PCP.

OB/GYN Network Participation

For Highmark network participation requirements and procedures, please see the *Highmark Provider Manual* **Chapter 3 Unit 3: Professional Provider Guidelines.**

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4.1 Gynecological Services

Highmark members have direct access to women's health care and are not required to obtain referrals from their primary care physicians/practitioners (PCPs) for gynecological services. Direct access offers the following advantages for members seeing a credentialed network OB/GYN:

- No referral for annual routine gynecological exam.
- No referral for sick visits.
- No referral for follow-up care.

Annual Routine Gynecological Exams

Annual routine gynecological exams include, but are not limited to, the following services:

- Pelvic exam.
- Pap test.
- Clinical breast exam.
- Interval history.

Follow-Up Visits

Follow-up visits may include the following services:

- Screening mammography.
- Diagnostic mammography.
- Selected diagnostic and surgical procedures, **only** if not on the list of procedures requiring pre-authorization.
- Lab services referred by the OB/GYN.
- Additional office visits, if necessary.

Mammography

A prescription is required to order a mammogram.

Mammography Screening vs. Diagnostic Mammography

A **screening mammogram** is an ordinary check-up intended to detect any problems. A **diagnostic mammogram** is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis.

Infertility Services Require a Benefit

Not all members have a benefit to cover testing and/or treatment for infertility and/or assisted fertilization. To verify coverage, please use the **Eligibility and Benefits** feature in Availity. For inquiries that cannot be handled via Availity, please call the Provider Service Center for your service area.

Directing Members for Appropriate Care

If a member requests a visit for symptoms that do not appear to be gynecological in nature, please direct the member to contact her PCP.

OB/GYN Network Participation

For Highmark network participation requirements and procedures, please see the *Highmark Provider Manual* **Chapter 3 Unit 3: Professional Provider Guidelines.**
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4.1 Breast Pumps and Lactation Counseling

Under the Affordable Care Act of 2010 (ACA), specific women's preventive health care services are required to be covered for eligible health plan members without cost sharing to members. Such services include breastfeeding support, supplies, and lactation counseling services.

Coverage at a Glance

Breastfeeding support, counseling, and supplies are covered ACA Women's Preventive Health Services Mandate with no cost sharing to the member when performed by **in-network** providers.

- Out-of-network coverage is pursuant to the terms of the member's individual benefits.
- Out-of-network cost sharing and balance billing may apply.
- Only durable medical equipment (DME) providers can bill for breast pumps and supplies.

Verify Eligibility and Benefits

You can verify whether a Highmark member is covered under the federal Women's Preventive Health Mandate via Availity or the applicable HIPAA electronic transactions.

Breastfeeding Pumps and Supplies

Breastfeeding pumps and supplies are covered without cost sharing for women covered under the ACA Women's Preventive Health Services Mandate. Eligible members are entitled to one breast pump per pregnancy when supplied by any network participating durable medical equipment supplier.

Eligible Highmark members can order high-quality breast pumps directly from two of the leading manufacturers in the industry: Ameda and Medela. Members can call the selected manufacturer or place an order online in advance of their delivery. The manufacturer will confirm a member's eligibility and submit claims to Highmark for processing. Eligible members can be directed to contact the manufacturers as follows:

Manufacturer	Pump	Website	Phone/Hours
Ameda	Purely Yours Electric Breast Pump with Dual Collection Kit	www.insured.amedadirect.com	**Phone:** 877-791-0064 **Hours:** 8 a.m. - 6 p.m.
Medela	Pump in Style Advanced Breast Pump Starter Set	www.medeladelivers.com	**Phone:** 800-866-2825 **Hours:** Monday – Friday, 9 a.m. - 6 p.m.

Breastfeeding Supplies Procedure Codes

For eligible members whose coverage falls under the ACA women's health mandate, breast pumps and supplies are covered without member cost sharing when provided by participating DME providers. The following are eligible procedure codes for breastfeeding pumps and supplies:

Procedure Code	Description
E0602	Manual breast pump
E0603	Electrical breast pump
A4281	Tubing for breast pump replacement
A4282	Adapter for breast pump replacement

A4283	Cap replacement for breast pump bottle
A4284	Breast shield and splash protector
A4285	Polycarbonate bottle
A4286	Locking ring

Lactation Counseling/ Support

Based on the ACA mandate, lactation services are eligible with no member cost sharing as follows:

- When provided by credentialed physicians who can employ lactation consultants or use their nursing staff to provide support. (This includes services provided by a physician assistant [PA] or certified registered nurse practitioner [CRNP] when under the supervision of a credentialed physician. Lactation consultants are not credentialed and cannot receive direct payment for their services.)
- When billed using the appropriate procedure codes — **99401, 99402,** and **99403** — and the appropriate diagnosis code of **Z39.1.**

Additionally, breastfeeding counseling/support is eligible with no age limit or frequency restrictions, and lactation counseling/support is considered to be a preventive service.

Please also note the following:

- When the service is provided by the pediatrician, then it is integral to the baby exam.
- When a lactation consultant provides the service in the pediatrician office, the billing is for the mother.
- When the services are provided as part of the maternity hospitalization, the payment is bundled and paid per the facility contract and integral to that admission.
- The service is part of the standard preventive schedule for non-grandfathered groups (NGF); please check Availity for benefit coverage.

For More Information

Highmark **Medical Policy E-37** includes medical guidelines not outlined in the ACA mandate; however, these medical policy guidelines would apply to those groups that do not follow the Women's Health Federal Mandate. The policy addresses:

- Newborns who are detained in the hospital after the mother is discharged.
- Babies who have congenital anomalies that interfere with feeding.

Highmark Medical Policy can be accessed from the Provider Resource Center by selecting **Policies & Programs** from the main menu.

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4.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the "manual" or "Highmark Provider Manual") are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 2: Behavioral Health Providers

4.2 General Information

Verify Benefits

Behavioral health benefits vary by product and by group. In some instances, a group may purchase medical health care coverage through Highmark, but behavioral health care coverage through another company.

To determine whether a member has behavioral health care coverage through Highmark and if authorization is required, always verify the member's benefits prior to providing services. Eligibility and benefits can be verified via Availity® or the applicable HIPAA electronic transaction. If you do not have electronic access, call Highmark Behavioral Health Services or the benefits telephone number on the member's identification card.

Eligibility and Benefits Inquiry

To verify behavioral health benefits via Availity, click **Patient Registration** and then select **Eligibility and Benefits Inquiry** from the task bar.

Contact Information

To reach Highmark's Behavioral Health Services, please call:

- Delaware (DE), New York (NY), Pennsylvania (PA), and West Virginia (WV): **800-258-9808**
    - Fax for DE and PA: **877-650-6112**
- New York (NY) Behavioral Health Utilization Management: **844-946-6264**

- Fax: Behavioral Health UM Outpatient: **833-581-1867** or Behavioral Health UM Inpatient: **833-581-1866**

DE, PA, and WV – standard business hours for the Behavioral Health Services department are:

- Monday through Friday from 8:30 a.m. to 7 p.m.
- Saturday from 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

NY standard business hours for the Behavioral Health Services departments are:

- Monday through Friday 8:15 a.m.to 5 p.m.
- After these hours, there is a prompt if you want to speak to a nurse. When you press the prompt, the call is forwarded to the On Call Service (Answer Phone).

Medical Management Services

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

Utilization Management

For most Highmark products, authorization is required to receive coverage for **all inpatient behavioral health services**. Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission.

Highmark Behavioral Health Services provides timely utilization management determinations for all members and providers based on established medical necessity criteria. Each utilization management determination is handled in a manner consistent with the clinical urgency of the situation and with legal and regulatory compliance requirements.

For more information, please see **Chapter 5 Unit 4: Behavioral Health.**

Virtual Behavioral Health

Highmark participating behavioral health providers have the option of providing “virtual” behavioral health visits for Highmark members via telecommunications technology. The services performed must fall under the scope of the provider’s license, and the sessions must be conducted following Highmark’s recommended service and security guidelines.

For more information, please see **Chapter 2 Unit 5: Telemedicine Services.**

Referrals to In-Network Providers

When recommending inpatient services, be sure that the member is to receive care from a provider that participates in the network associated with the member’s program and, when applicable, is in the highest benefit tier.

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4.2 Levels of Care

Least Restrictive Setting

Highmark Behavioral Health Services operates from the foundational principle that optimal, high-quality care occurs when the member receives the services that meet his or her needs in the least intensive, least restrictive setting safely available within the scope of his or her benefit plan.

Levels of Care

Highmark Behavioral Health Services has defined the following levels of care for mental health and substance abuse treatment services:

- Inpatient Hospitalization:
  - Psychiatric
  - Withdrawal Management (ASAM Level 4)
- Residential Treatment:
  - Psychiatric
  - Substance Use Disorder (ASAM Level 3.5 or 3.7)
  - Withdrawal Management
- Outpatient Treatment:
  - Medication Management
  - Outpatient Therapy
- Intensive Outpatient, including:
  - Psychiatric
  - Substance Use Disorder
- Partial Hospitalization Program, including:
  - Psychiatric
  - Substance Use Disorder

Coverage and Requirements May Vary by Product and Benefit Plans

Behavioral health benefits may vary by product and may also vary by the specific contract under which the member has coverage. All levels of care may not be covered by the member's benefit plan. In addition, pre-certification and concurrent review requirements apply and may vary by benefit type.

Always verify a member's plan-specific benefits via Availity® or by calling Highmark Behavioral Health Services **prior to providing services.**

Inpatient Hospitalization

Inpatient hospitalization is the highest level of skilled psychiatric and substance-abuse treatment services. It is provided in facilities such as freestanding psychiatric hospitals or distinct-part psychiatric or detoxification units of an acute care hospital.

Settings eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.

Residential Treatment Centers

The residential treatment center level of care is defined as a non-hospital setting that provides twenty-four (24) hour residential care to persons with long-term or severe mental disorders and persons with substance-related disorders. These programs feature the following:

- Treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs
- Training in the basic skills of living, as determined necessary for each patient

Licensure requirements for this level of care vary by state.

Partial Hospitalization Programs (PHPS)

Partial hospitalization programs (PHPs) are defined as structured and medically supervised outpatient day or evening treatment programs. Although the patient is not considered a resident, the services provided are of essentially the same nature and intensity as those provided in an inpatient setting.

Highmark treats partial hospitalization as a professional service and, if eligible, is considered part of a member's outpatient mental health or substance abuse treatment benefit.

Partial hospitalization services are designed to address a mental health or substance abuse disorder

through an individualized treatment plan provided by a coordinated multidisciplinary team. Highmark defines partial hospitalization programs as providing, at a minimum, the following treatment:

- Psychosocial assessment within the first program day
- Substance abuse evaluation within the first two program days
- Clinical assessment once daily
- Individual/group/family therapy at least four hours per day, three or more days per week
- Psychiatric/medication evaluation once per week
- Toxicology screen/self-help or education groups as needed

Note: School-based programs must also adhere to the hourly requirements regardless of the number of days a member is treated per week (e.g., three hours per day, five days per week **does not** meet criteria).

Intensive Outpatient Programs (IOPs)

Intensive outpatient programs (IOPs) provide planned and structured services to address mental health and/or substance-related disorders.

Highmark defines intensive outpatient programs as providing, at a minimum, the following treatment:

- Psychosocial assessment within the first visit
- Substance abuse evaluation within the first two visits
- Individual/group/family therapy at least 2.5 hours per day, two or more days per week
- Psychiatric/medication evaluation as needed
- Toxicology screen/self-help, 12-step, or education groups as needed

The coordinated and integrated multidisciplinary services provided by an intensive outpatient program may include the services listed below:

- Group, individual, family, or multi-family group psychotherapy
- Multiple or extended treatment/rehabilitation/counseling visits
- Professional supervision and support
- Crisis intervention, psychiatric/psychosocial rehabilitation, or day treatment models
- Psycho-educational services

- Adjunctive services such as medical monitoring

Note: These services are provided by an intensive outpatient program-contracted facility or agency.

IMPORTANT: Self-Help Programs

While treatment for substance abuse typically involves participation in self-help programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), these programs are offered without charge by community volunteers and cannot be included as billable time in an intensive outpatient program.

Medical Director Required for PHPS & IOPs

All facilities providing partial hospitalization and/or intensive outpatient programs **and** submitting claims via 1500 must have a Medical Director.

The Medical Director must be a medical doctor (MD) or doctor of osteopathic medicine (DO) with a board certification in psychiatry in good standing who is credentialed and participating with Highmark.

Facilities contracting for substance abuse only can alternatively have a medical doctor (MD) or doctor of osteopathic medicine (DO) who is also certified in addiction medicine by a Member Board of American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or American Society of Addiction Medicine (ASAM).

Traditional Outpatient Treatment

Traditional outpatient treatment is typically individual, family, and/or group psychotherapy and consultative services, including nursing home consultation and psychiatric home health visits.

Service duration ranges from 15 minutes (e.g., medication checks) to 50 minutes (e.g., individual or family psychotherapy) and can extend as long as two hours (e.g., group psychotherapy).

SUPERVISED LIVING IS NOT A COVERED SERVICE

Supervised living services, which provide assistance but not medically necessary care, are **not covered** under Highmark benefit plans.

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4.2 Opioid Treatment Program Benefit

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 is aimed at addressing the nation's opioid overdose epidemic.

As required by the SUPPORT Act, the Centers for Medicare & Medicaid Services (CMS) will pay Medicare-enrolled Opioid Treatment Programs (OTPs) through bundled payments for Opioid Use Disorder (OUD) treatment services provided to Medicare beneficiaries in an episode of care. OTPs must enroll in the Medicare program to receive reimbursement when these services are provided to Medicare patients.

Medicare Advantage plans are also required to include the OTP benefit, and can contract with Medicare-enrolled OTP providers in their service area.

Opioid Treatment Programs Defined

Opioid Treatment Programs provide medication-assisted treatment for people diagnosed with OUD. The programs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body.

For SAMHSA certification, OTPs must comply with all pertinent state laws and regulations and all regulations enforced by the Drug Enforcement Administration.

Services Covered Under the OTP Benefit

As defined by CMS, the following services used for the treatment of OUD are covered under the OTP benefit:

- Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- The dispensing and administering of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing, which includes both presumptive and definitive testing
- Intake activities
- Periodic assessments

OTP Services HCPCS Codes

Highmark's OTP benefit for our Medicare Advantage plans is similar to the CMS OTP benefit that pays for bundled services under Medicare Part B for Medicare beneficiaries. A bundled payment for the overall management, care coordination, individual and group psychotherapy, and substance use counseling for OUD creates an avenue for clinicians to bill for a group of services in the office setting.

Codes that have been created describe a weekly bundle (HCPCS codes G2067-G2075), with one week defined as seven (7) contiguous days. Additional codes for add-on services (HCPCS codes G2076-G2080) for evaluation/assessment, take-home supplies of medication, or for billing counseling/therapy services that substantially exceed the amount specified in the member's individualized treatment plan. The member's medical records must be documented to show the medical necessity for these add-on services.

These codes are specifically for use by OTPs for OUD treatment services. These codes can only be billed by Medicare-enrolled OTP providers.

Per Medicare guidelines, the individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as telehealth services using communication technology as clinically appropriate.

Provider Enrollment

To provide OUD treatment services to Highmark Medicare Advantage members under the OTP benefit, OTP providers must meet the same requirements as those providing services under Medicare Part B (including enrollment with Medicare). Medicare-enrolled OTPs can submit an application to contract with Highmark to provide these services to Highmark Medicare Advantage members.

Please refer to the MLN Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet for more information about the Medicare enrollment requirements and process.

Claim Submission

Opioid Treatment Program providers must submit all claims for OUD treatment services covered under the OTP benefit via an 837P electronic transaction or the 1500 Health Insurance Claim Form. Include the following information:

- HCPCS codes associated with the OTP service provided to the member
- OTP's NPI in the Rendering Provider Identifier section in Box 24J of the 1500 form or its equivalent on the electronic 837P
- Prescribing or other eligible professional provider's NPI in Box17 (the ordering/referring/other field) of the 1500 form or the equivalent field on the electronic 837P

For More Information

For additional information, please see the Opioid Treatment Programs page on the CMS website.

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4.2 Delaware Senate Bills 41 and 109 - Drug and Alcohol Dependency Treatment

For providers in Delaware

Delaware Senate Bill 41 was written in an effort to reduce overdose deaths related to the growing opioid epidemic. The bill was enacted into law on May 30, 2017, amending Title 18 of the Delaware Code relating to coverage for serious mental illness and drug and alcohol dependency (Del. Code tit. 18 §§ 3343, 3578).

The law requires coverage for medically necessary inpatient and residential drug and alcohol dependency treatment and immediate access to a 5-day emergency supply of prescription medications. It also prohibits insurers from imposing precertification, prior authorization, pre-admission screening, and referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies, and does not allow concurrent utilization review for the first 14 days of inpatient and residential treatment.

Delaware Senate Bill 109, signed into law on September 29, 2017, also amends Title 18 and further extends the restriction on concurrent utilization review to include 30 days of intensive outpatient treatment and five days of inpatient withdrawal management.

Applicability

For providers in Delaware

These statutes are applicable to all Highmark Delaware fully-insured individual and group health benefit plans. Self-insured employer groups will be offered the opportunity to adopt the mandate and may or may not elect to follow the mandate. Medicare supplemental plans are exempt from this law.

Definition

For providers in Delaware

Drug and alcohol dependencies are defined as a substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16 of the Delaware Code.

Inpatient and Residential Treatment Requirements

For providers in Delaware

Under this legislation, health plan coverage for drug and alcohol dependencies must include:

- Inpatient coverage; and
- Unlimited medically necessary treatment provided in residential settings as required by the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

Prescription Drug Coverage for a 5-Day Emergency Supply

For providers in Delaware

If a health plan's coverage includes prescription drugs, the plan must provide immediate access, without prior authorization, to a five day emergency supply of prescription medications for treatment of serious mental illness and drug and alcohol dependencies, including a prescribed drug for opioid withdrawal, stabilization, or overdose reversal, except where otherwise prohibited by law.

The 5-day emergency supply may be subject to copayments, coinsurance, and annual deductibles if consistent with those imposed on other benefits within the health benefit plan. However, a plan **may not impose an additional copayment or coinsurance** on a covered person who receives a subsequent 30-day supply of the same medication in the same 30-day period in which the person received the emergency supply.

Benefit Management Restrictions

For providers in Delaware

As per the legislation, Highmark Delaware may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies at a Highmark Delaware network participating facility.

In addition, concurrent utilization review is prohibited during the first 14 days of medically necessary inpatient and residential treatment by a network participating facility approved by a nationally recognized health care accrediting organization or the Division of Substance Abuse and Mental Health; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management.

However, the facility must comply as follows:

- The facility must notify Highmark Delaware of both the admission and the initial treatment plan **within 48 hours** of the admission.
- The facility must perform daily clinical review and periodically consult with Highmark Delaware to ensure that the facility is using the evidence-based and peer-reviewed clinical review tool used by Highmark Delaware and designated by ASAM or, if applicable, any state-specific ASAM criteria and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

Retrospective Review

For providers in Delaware

Highmark Delaware may perform retrospective review for medical necessity and appropriateness of all services provided during an inpatient stay or residential treatment, including the initial 14 days of treatment; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management.

Highmark Delaware may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer-reviewed clinical review tool used by Highmark Delaware and designated by ASAM or any state-specific ASAM criteria.

The Highmark Delaware member does not have any financial obligation to the facility for inpatient and residential treatment other than any applicable copayments, coinsurance, or deductible amounts required under their benefit plan.

Reminder: Verify Benefits

For providers in Delaware

You can verify benefits, including whether the member's benefit plan follows the mandate, via Availity's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

If Availity is not available, please call the Highmark Provider Service Center.

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4.2 Highmark Behavioral Health Programs

The need for more access to behavioral health resources is a growing trend among health care consumers. To meet the needs of our members, Highmark is taking a hands-on approach to enhancing various behavioral health programs available to our members. Professionally trained staff are available to members, their families, significant others, and providers to coordinate the services needed to meet our members' needs.

Case and Condition Management Programs

Highmark offers health coaching through behavioral health case management and chronic condition management approaches. The objective of the programs is to facilitate the member's self-management plans for lifestyle improvement and activities relative to their specific circumstances or diagnosis, address potential barriers to goal achievement, and assist in referrals to providers, community, and/or other resources and support.

For example, the condition management services specific to depression help members identify symptoms of depression; overcome the reluctance that many people have to getting help; decide if formal treatment is indicated and, if so, what the right treatment may be; locate services; manage barriers; and assist in tracking progress.

Role of the Behavioral Health Specialist

The behavioral health specialist plans, implements, coordinates, monitors, and evaluates the preferences and services to meet the member's behavioral health care needs. The behavioral health specialist assesses the member throughout the case management or condition management process, working with the member to identify short and long-term goals that address the member's specific needs.

Highmark's behavioral health specialists are licensed behavioral health professionals who receive formal training in motivational interviewing and other behavior change approaches. This training enables behavioral health specialists to communicate effectively with members via telephone and other approved technologies to establish and monitor both short and long-term goals for improved health management.

Utilization Management Team's Role

The utilization management team assists in applying medical necessity criteria to avoid variation in the delivery of services, recommends clinically appropriate alternative levels of care, and assists in discharge planning. Highmark behavioral health utilization management has become an integral part of ensuring timely and appropriate discharge planning and triaging referrals to other programs in Highmark. The care managers on the team promote continuity of care.

Recommending a Member to a Behavioral Health Program

Providers are encouraged to recommend members who may benefit from these programs. To verify patient eligibility, please check the Eligibility and Benefits Inquiry selection in Availity®.

To recommend patients to Highmark behavioral health programs, providers should call Highmark Behavioral Health Services at:

- Pennsylvania Western & Northeastern Regions: **800-258-9808**
- Pennsylvania Central Region: **800-628-0816**
- Pennsylvania Southeastern Region: **800-628-0816**
- Delaware: **800-421-4577**

- West Virginia: **800-344-5245**
- New York: **877-878-8785, Option #2**

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4.2 Accessibility Expectations for Behavioral Health

Accessibility Expetations

To stay healthy, members must be able to see their providers when needed. To support this goal, we are sharing Highmark's expectations for accessibility of behavioral health providers. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Note: Standards for Pennsylvania Children's Health Insurance Program (CHIP) enrollees are available in Chapter 2 Unit 3: Other Government Programs and may differ from the expectations noted below.

Behavioral Health Provider Expectations

Patient's Need:	**Performance Standard:**
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response
Urgent care appointments	Immediate response

Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within six hours
Non-urgent, regular care office visit • Patient's condition is considered to be stable • Non-urgent, regular care, but in need of attention	Office visit within 48-72 hours (three days)
Routine or initial office visit • Routine care, initial visit	Appointment within seven business days
Follow-up visit • After an emergency or hospital discharge for medical, behavioral health, or substance abuse condition	Care within five days of discharge or as clinically indicated
After-hours care • Access to providers after the practice's regular business hours	Acceptable coverage in place to respond to members 24 hours per day, seven days a week, which may be either directly or through an on-call arrangement with another Highmark credentialed participating practitioner of the same or similar specialty and of the same network(s). An answering service, pager, or direct telephone access whereby the practitioner or his/her designee can be contacted is acceptable.

	A referral to a crisis line/center is acceptable if prior arrangement has been made whereby the crisis line/center can reach the provider (or his/her designee), if needed.
In-office waiting times • Providers are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes

Acceptable After-Hours Methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

Answering Process	Response/Message	Comments
Answering Service or Hospital used as an Answering Service	Caller transferred directly to provider or clinical staff person covering for the provider	
	Service pages the provider on call (see comments)	A provider or clinical staff person is expected to return the call within 30 minutes.
		Provide clear instructions on how to record a message on a pager (i.e., “you will hear a

Answering Machine	Message must provide the caller with a way to reach the provider on call by telephone or pager	series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A provider or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment)	A provider or clinical staff person is expected to return the call within 30 minutes.

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4.2 Treatment Information and Patient Privacy

Consent is Required for Release of Treatment Information

Under federal and state laws, providers of substance abuse and mental health treatment may be required to obtain members' written consent before releasing certain mental health and substance abuse information to insurers and/or to other health care providers for the management of patient care.

As a contracted provider, it is your responsibility to obtain appropriate consent for release of information.

Restrictions On Substance Abuse Information

For providers in Pennsylvania

Pennsylvania Code Subsection 255.5(b) limits the substance abuse treatment information providers can release to an insurer, even with written member consent. Providers practicing in Pennsylvania are advised to ensure that the information they communicate to Highmark Behavioral Health Services is compliant with these regulations.

Restrictions On Substance Abuse Information

When practicing in any of Highmark's service areas, contracted providers are expected to be compliant with any applicable federal or state regulations.

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4.2 Behavioral Health Provider and PCP Communication

Patient care and clinical outcomes are enhanced when health care professionals share information and coordinate patient care. Communication between behavioral health providers and PCPs is vital, especially when medications are prescribed or changed or when counseling is provided.

Open and timely communication is particularly important considering that members may contact their behavioral health providers without coordinating care with PCPs.

Member Consent

The member's consent may be required to permit the behavioral health provider to release certain information to the PCP. The member should be informed of your policy about sharing information with other health care professionals involved in coordinating treatment.

If a patient refuses to give consent, the behavioral health provider should document this refusal in the patient's behavioral health treatment record.

Member's Role in Communication

Neither PCPs nor behavioral health providers should require members to take responsibility for communicating findings, reports, lab results, etc. to another provider.

Behavioral Health Provider and PCP Communication Procedure

Highmark's network participating behavioral health providers and PCPs are encouraged to communicate with one another to ensure continuity and coordination of care for members.

PCPs and behavioral health providers should communicate in the following ways to ensure continuity of patient care, provided patient consent has been granted:

- If the PCP has referred (or directed) the member to a behavioral health provider, the PCP should provide relevant clinical information to the behavioral health provider before the member's visit to the provider. Acceptable forms of communication are formal letter and/or copies of relevant portions of the patient's medical chart.
- Within one week after the second visit and/or after changes in the member's treatment or condition, the behavioral health provider should provide the PCP with information about his or her visit with the member, with the member's consent if applicable, using the same forms of communication.

What Should be Communication?

The following list indicates the type of information that may be communicated:

- Clinical findings/diagnosis (include written description in addition to diagnosis code)
- Test results
- Treatment plans
- A summary report at the conclusion of the treatment period

Form Available for PCP Communication

For providers in New York and Pennsylvania

The Communication Document for Behavioral Health Specialists to Primary Care Physician has been developed to help the behavioral health provider communicate clinical information to the PCP. This form is also available on the Provider Resource Center. Select **Resources & Education**, then **Forms**, and then **Behavioral Health Forms.**

The form is not required. Behavioral health providers can choose to communicate all the information included on the form via another written format. Acceptable formats include typed letters, physician forms, and progress notes.

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4.2 Documentation Standards for Outpatient Services

When providing outpatient behavioral health services to Highmark members, progress notes must be documented for each office visit or encounter. Clinical documentation should be created at the time of services and/or before a claim is submitted to Highmark.

Initial Evaluations

Initial evaluations must have a comprehensive history, full mental status exam, and a treatment plan documented. If the services are performed by a licensed or certified therapist under the supervision of an

eligible professional provider, the initial evaluation must include the signature of the supervising provider.

Minimum Documentation Standards for Outpatient Office Visits

The provider's progress notes for outpatient office visits should, at a minimum, include the following information:

- Member's name
- Date of service
- Length of session (if billing code submitted is time-dependent)
- Therapy/modality utilized
- Appropriate subjective and objective data
- Assessment
- Treatment plan

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4.2 Inpatient Consultations for Patients on Medical Units

Determining Whether Authorization is Required

Some patients admitted to a medical unit may require a psychiatric consultation. Whether authorization is required for an inpatient consultation depends on the credentials of the performing provider:

If the inpatient consultation is performed by...	Then...
Psychiatrist	Authorization is **NOT** required

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4.2 Follow-Up Appointments After Hospitalization

Ensuring that behavioral health patients receive appropriate care after an inpatient stay can be challenging. Patient failure to keep an initial outpatient appointment following discharge has been linked to a high risk of relapse and re- admission.

Therefore, Highmark has been working to help members who receive such treatment stay connected to the behavioral health care network following discharge in an effort to improve their health and quality of life.

Discharge Planning

Discharge planning should begin prior to or upon admission to an inpatient facility. At the time of precertification, the behavioral health care manager discusses discharge planning barriers and assists with any discharge needs.

Follow-Up Appointment Important

To increase the likelihood that a member being discharged from inpatient behavioral health services will receive appropriate aftercare, it is very important that the member leave the hospital with a follow-up outpatient appointment.

Member Contact After Inpatient Discharge

Upon a mental health inpatient discharge, a Highmark behavioral health specialist will attempt to make a post-discharge call to the member. When post-discharge contact is made, the behavioral health specialist will verify that a follow-up appointment has been made or, if necessary, assist the member in obtaining an appointment.

The behavioral health specialist will provide education about the importance of adhering to scheduled appointments and will work with the member to resolve any barriers. They will also discuss any questions the member may have regarding discharge instructions, medication changes, and/or any other issues of concern to the member.

When Medication is Prescribed

The follow-up appointment is particularly important when a patient is discharged with a prescription for psychotropic medication. Follow-up care should be arranged with a behavioral health provider.

If a Follow-Up Appointment is Not Made

If a member leaves an inpatient facility without an appointment for any reason, the Highmark behavioral health specialist will assist the member with obtaining follow-up services.

Continuing Care Coordination

Highmark is committed to working with providers to support members in maintaining the gains made during their inpatient treatment. If the member does not keep the scheduled follow-up appointment, please make every effort to reschedule as soon as possible.

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4.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 3: Facility-Specific Guidelines

4.3 Overview of Facility-Specific Guidelines

A facility provider is a hospital, ambulatory surgery center, home health agency, hospice, home infusion agency, skilled nursing facility, an alcohol or drug treatment center, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided.

This unit includes facility-specific guidelines for facility providers and applies to Commercial and Medicare Advantage, unless otherwise noted. Section headings will help to identify if the information in the section is applicable to a specific facility type.

Medicare Advantage

For guidelines related to care management of Medicare Advantage members, please see Chapter 5.3: Medicare Advantage Procedures.

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4.3 Member Access to Facilities

Availability of Facility Services

Facility services need to be available to Highmark members on a twenty-four (24) hour per day, seven (7) day per week basis when medically appropriate and in accordance with industry standards.

Access to Physician Services

Access to physician services is an integral component of the facility services provided to members. Physician services are provided by either hospital-based physicians or physicians employed by a facility.

If physician services are provided to Highmark members on behalf of a facility, the facility must verify that he physician has the appropriate training, education, and licensure to provide such services.

Equal Access and Non-Discrimination in Treatment of Members

In addition to those requirements contained in your facility agreement and in any other applicable administrative requirements, network facilities agree to requirements of equal access and non-discrimination of Highmark members within this manual.

Facilities will provide members with equal access at all times to facility services. Facilities shall not deny, limit or fail to admit a member based on any factors related to race, color, national origin, ancestry, religion, sex, marital status, sexual preference, disability, age, source of payment, cost, anticipated cost, membership in a Product of Highmark or Health Plan or a member's health status. Facilities may also not refuse to render facility services based on the assumption that the anticipated cost that will be incurred will be in excess of Highmark's payment for covered services. Further, facilities shall not deny, limit, discriminate or condition the furnishing of facility services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

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4.3 Status of Patient vs. Place of Service

Policy

When a member who is an inpatient or outpatient of a hospital is taken outside of the hospital (e.g., MRI or CT mobile unit or doctor's office) for a procedure and is then returned to the hospital without being discharged, the service should be classified as inpatient or outpatient based on the status of the patient at the hospital versus the place where the service was performed.

Patient Status Definitions

The definition of the status of the patient is as follows:

Inpatient – A patient is considered an inpatient if formally admitted as an inpatient in a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed.

Outpatient – A patient, other than inpatient, who is treated in a hospital, on hospital grounds, or in a hospital-owned or controlled satellite. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital-owned building, and when the practice is not affiliated or controlled, in any way, by the hospital or related entity.

Reminder: Observation status is an **outpatient** care option that can be used when a member's condition must be evaluated promptly, but appropriateness of an inpatient admission has not yet been confirmed. For more information, please see the applicable section on **Observation Services** in this unit.
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4.3 Guidelines of Billing Ambulance Transports Between Hospitals

The guidelines below are for billing ambulance transports between hospitals, including one-way transports and transports with return to the original facility.

One Way Transports

When a member must be transported from Hospital A to become an inpatient of Hospital B, that member has in effect been discharged from Hospital A. Since the member is no longer an inpatient at the time of

transport, this service can be provided and billed by a network participating ambulance provider or any other licensed ambulance transport provider (including a hospital-based ambulance service).

Assuming that the member has coverage and the necessary benefit and that the claim is billed appropriately, payment will be made to the ambulance provider in accordance with the member's benefit plan and, if applicable, the provider's Highmark contract.

Note: If a member arrives in the emergency room, is stabilized, and then transferred to another hospital without being admitted, the claim would also be billed by the ambulance transport provider.

Emergent Situations Arising While an Inpatient

There may be situations in which a member who is an inpatient at one facility is transported on an emergency basis to another facility. In these instances also, any licensed ambulance transport provider, including a network participating ambulance provider or a hospital-based ambulance service, may transport the member.

Unless the member is later returned to the original facility, which would be unusual in these circumstances, he or she would **not** be considered an inpatient at the time of transport. Therefore, the services must be billed to Highmark by the ambulance transport provider.

Again, assuming that the member has coverage and the necessary benefit and the claim is billed correctly, payment will be made to the ambulance transport provider in accordance with the member's benefit plan and, if applicable, the provider’s Highmark contract.

Transport with Return

There are situations in which the member is admitted to Hospital A but must be transported via ambulance to Hospital B to receive specialized services (e.g., an MRI) not available at Hospital A. After the services have been provided, the member is returned to Hospital A.

In such situations, the member is considered an inpatient of Hospital A throughout this sequence of events, including the roundtrip transport. As a result, the ambulance transport services are considered to be part of Hospital A's inpatient claim. The services can be provided by a network participating ambulance provider or any licensed ambulance provider, which must then bill the hospital for the transport.

Hospital A must include the ambulance charge on the corresponding inpatient claim to Highmark. The services will be reimbursed within the hospital's DRG or per-diem payment for the inpatient stay, in accordance with the member's benefit plan. No separate payment (apart from the DRG or per-diem payment to the hospital) will be made to the hospital or the ambulance provider by Highmark for the ambulance transport services. The hospital is responsible for reimbursing the ambulance provider.
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4.3 Observation Services

Observation status is an outpatient care option that can be used when a member's condition must be evaluated promptly but appropriateness of an inpatient admission has not yet been confirmed.

Highmark encourages hospitals to perform the appropriate diagnostic services promptly so the determination can be made on an expedited basis.

Definition: Outpatient Observation Services — From Centers for Medicare & Medicaid Services (CMS)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning

their admission or discharge.

Hospitals may also bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department visit.

Time Frame for Observation Services

Highmark recognizes that most observation services do not exceed one day and in rare instances span beyond 48 hours. For purposes of reimbursement, Highmark will not reimburse for observation services that exceed **48 hours.**

Note: Observation services begin at the time the physician writes the order for outpatient observation. The reason for observation must also be stated in the orders.

Goal of Observation

Observation status does not replace or extend outpatient ambulatory diagnostic or therapy services, nor is it to be used in conjunction with elective outpatient surgery, including post-procedure observation.

Observation is meant to be used for making a diagnosis and/or treating a patient in an acute-care facility **prior to or instead of** an inpatient admission.

Medicare Outpatient Observation Notice (Moon)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients

for more than 24 hours. The written notice must include the reason the individual is receiving observation services, and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The **Medicare Outpatient Observation Notice (MOON)** was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Beginning March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice **no later than 36 hours** after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS-approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website.

Typical Uses for Observation

Although Highmark does not restrict coverage of observation services to particular medical conditions, observation services are for **urgent or emergent** medical conditions. Observation is only medically necessary when the patient's current condition requires outpatient hospital services, or when there is a significant risk of deterioration in the immediate future such that continued observation in a non-hospital environment is inadvisable.

The following circumstances typically warrant the use of observation:

- The hospital expects that the patient will be stabilized and released within 48 hours.
- The clinical diagnosis and necessity of inpatient admission are unclear, but the hospital expects to determine these in less than 48 hours.

Inappropriate Uses for Observation Status

It is inappropriate to place a patient in observation status for any of the following reasons:

- Patient, physician, or hospital convenience
- Respite care
- Pre-operative preparations or evaluations that do not meet criteria for acute-care facility admissions
- Pre-procedure care for diagnostic procedures that do not meet criteria for acute-care facility admission
- Post-procedure care for diagnostic procedures

Medical Policy V-3

For additional information on medical necessity and documentation requirements, please see **Highmark Commercial Medical Policy V-3: Billing of Observation Services.**

Outpatient Cost-Sharing Applies

Many Highmark benefit plans currently include member cost-sharing for outpatient hospital services, including those received in the emergency room. Under most benefit plans, this cost-sharing requirement is waived if the member is admitted as an inpatient.

When members come into a hospital through the emergency room, it often is not immediately clear whether they need to be admitted as an inpatient and the member may be placed in observation status. If a member is not truly admitted as an inpatient to the hospital, then the member **is responsible** for any applicable outpatient cost-sharing amounts indicated by their benefit plan.

EXAMPLE: The member is placed in observation status after being treated in the emergency room. After treatment in observation, the member is discharged to his or her home the following afternoon. The member has a $50 emergency room copayment. Since the member was not admitted as an inpatient, he or she would be responsible for the $50 emergency room copayment.

Because observation services can be provided in any room or bed in a hospital, and because the member often stays in the facility overnight and may be served a meal, it may seem to the member and family that he or she is receiving inpatient care. If it is eventually determined that the member's condition does not meet MCG Care Guidelines and he or she can safely be discharged to home, the member or family may be surprised to learn that the services received throughout the time spent in the hospital were actually classified as outpatient in nature. Because of this confusion, members may dispute their obligation to pay the cost-sharing amounts for which they are in fact responsible.

The most important step that hospitals can take to assist their own facility in collecting member cost-sharing amounts is to inform the member, and/or the family, that the services received were observation services -- not an inpatient admission. In an effort to educate members, Highmark has published articles about observation services in its member newsletters.

Hospitals are welcome to use the article as they choose to help Highmark members understand that observation services are classified as outpatient in nature and that if they receive such services and are not formally admitted as inpatients, they are responsible for the outpatient cost-sharing amounts required by their benefit plan.

EXCEPTION: Please note that this request is not applicable to situations in which the member is in fact admitted as an inpatient following observation.

Requesting an Inpatient Admission

The hospital can request authorization of an inpatient admission as soon as clinical findings indicate that the admission would be appropriate. **This can occur at any point during the observation period.** There is no need to wait until 48 hours have elapsed.

The request for the inpatient authorization should ordinarily be made using Availity. If Availity is unavailable, contact Highmark Clinical Services at:

- In the PA Western Region, call **800-242-0514.**
- In the PA Central & Northeastern Regions, call **866-803-3708.**
- In the PA Southeastern Region, call **800-628-0816.**
- In the Delaware, call **800-572-2872.**
- In the West Virginia, call **800-344-5245.**

Important! Always Confirm Benefits

Availability of benefits under the member's benefit plan is required in order for a service to be reimbursed by Highmark. Be sure to confirm the specific member cost-sharing responsibility for outpatient services for each member.

Availability of benefits can be verified through the Eligibility and Benefits Inquiry function in Availity. If Availity is unavailable, providers may contact the appropriate Highmark Provider Service unit by telephone.

Reporting Observation Services

For providers in Pennsylvania and West Virginia

Observation services are reported in Pennsylvania and West Virginia using the following revenue and procedure codes:

REVENUE CODE	PROCEDURE CODE
0762	G0378 (Hospital Observation Services, per hour)

0762	G0379 (Direct Referral to Observation) -- as applicable

When the patient was admitted directly to Observation, the hospital should report procedure code G0379 (Direct Referral to Observation), in addition to procedure code G0378. In such situations, payment for the services will be made on the basis of the presence of procedure code G0378 on the claim. No payment will be made based on the presence of procedure code G0379.

As required by the definition of the procedure code, **units** must equal the **hours of observation services provided.** Observation hours should be rounded to the nearest minute, as directed below:

MINUTES	UNITS
0 – 30 minutes	0 units
31 – 59 minutes	1 unit

The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- Type A or Type B emergency department visit (CPT codes 99281-99285 or HCPCS codes G0380-G0384); or
- Clinic visit (HCPCS code G0463); or
- Critical care (CPT code 99291); or
- Direct referral for observation care reported with HCPCS code G0379 (APC 5013) must be reported on the same date of service as the date reported for observation services.

Hospitals are reminded that observation services resulting in an inpatient admission are to be reported on the inpatient claim and are reimbursed via the payment for the inpatient stay. **No separate reimbursement will be made for the observation services.**

Important !

For providers in Delaware

Highmark Delaware providers need to follow their current reimbursement method and continue to submit claims according to their contract.

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4.3 Purchased Services Provided to Members Registered as Inpatients or Outpatients

When a Highmark member is registered as an inpatient or an outpatient at a participating facility, **the facility is responsible to provide or arrange for all of the care and services the member receives during that stay or visit.** This section is meant to clarify Highmark's policy and procedure for providing services and/or dispensing supplies and/or equipment to Highmark members when they are registered as inpatients or outpatients

Purchased Services Defined

If a participating facility is not able to provide (or chooses not to provide) a particular service or supply to Highmark members when they are registered as inpatients or outpatients, then the facility must make the appropriate arrangements with another entity/vendor to provide those services.

The key to understanding this requirement is not the type of service — but the entity providing the service. If a facility does not have the proper equipment or expertise to provide a given service, and engages with an outside vendor to render it, then that service by definition is called a **purchased service.**

Examples of purchased services include, but are not limited to, the following:

- Durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS)
- Laboratory and pathology services
- Cardiac event monitors

Limited Reimbursement

Additional reimbursement is very limited, and **most services, supplies, and equipment are not eligible for separate payment and are considered to be inclusive of your consolidated payment from Highmark**. It is important to reference your Highmark contract to determine your specific reimbursement methodology and continue to submit claims accordingly.

Using Vendors

If a vendor has been engaged by your facility to provide certain services or supplies to a Highmark member registered as an inpatient or outpatient at your facility, and the services or supplies are not eligible for separate payment, then it is your responsibility to enter into a financial arrangement to pay this vendor for the services or supplies provided.

The vendor may not bill Highmark — or the member — directly, and your facility is obligated to reimburse the vendor according to the financial arrangement made between your facility and the vendor. Highmark is not responsible and will not make a separate payment to the vendor.

Note: Contracted facilities may bill the member for cost-sharing amounts (deductible, coinsurance or copayment) as required by the member's benefit plan.

Certain Supplies Billable to Highmark

When a Highmark member is registered as an inpatient or outpatient at a participating facility, c**ertain supplies are considered billable and eligible for separate payment ONLY when one of the following**

apply:

- The equipment or supplies requires approval and authorization by Highmark's Clinical Services; *or*
- The equipment or supplies are customized specifically for the individual member's use in the home setting (e.g., customized power wheelchairs, customized splints or braces provided to the member for use in the home).

Note: In this instance, DMEPOS providers may bill Highmark directly, but only for the equipment/supplies as outlined above. Any other DMEPOS provided are not eligible for separate reimbursement, and claims should not be submitted directly to Highmark.

Exceptions for Medicare Advantage

For providers in Pennsylvania and West Virginia

When a Medicare Advantage member is registered as an inpatient or outpatient at a participating facility, certain clinical laboratory services are considered billable. **Chemotherapy sensitivity tests performed on live tissue are the only laboratory services billable and eligible for separate payment from Highmark.** In this instance only, reference laboratories are permitted to bill and seek payment from Highmark directly.

Highmark's purchased service policy does not apply in the case of DMEPOS items provided to Medicare Advantage members residing in a SNF **who have exhausted their 100-day skilled nursing benefit or are receiving a non-skilled level of care.** Under these circumstances only, the billing process should be treated as if the member is living in his or her own residence. Therefore, the DMEPOS provider would bill the claim to Highmark directly.

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4.3 Post-Exposure Rabies Treatment

The Centers for Disease Control and Prevention (CDC) recommends the following regimen for post-exposure rabies treatment:

- **Wound Cleansing:** All post-exposure prophylaxis should begin with immediate thorough cleansing of the wound.
- **Rabies Immune Globulin (RIG):** RIG is administered to provide immediate antibodies until the body can respond to the vaccine; this is given only once on the day of exposure (day 0) and should **not** be administered to previously immunized individuals.
- **Vaccine:** Injections of the rabies vaccine are given on days 0, 3, 7, & 14; a fifth dose on day 28 may be recommended for immunocompromised persons. Previously vaccinated individuals should receive two doses, one immediately and one three days later.

Place of Service

Post-exposure rabies treatment can be sought from a hospital, PCP, urgent care centers, or the Health Department. However, rabies immune globulin (RIG) and rabies vaccine may not be readily available at physicians' offices or locations other than hospitals. Because of the need for timely treatment, individuals most often will seek initial treatment in a hospital emergency room and return to the hospital to complete the vaccine series.

Reporting Services

Hospitals are to report post-exposure rabies treatment as indicated below.

Initial Visit in the Emergency Room

- Revenue Codes: **450** (Emergency Room); **250** (Pharmacy)
- Procedure Codes:
  - Rabies Immune Globulin (RIG)
    - **90375** – Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use; ***or***
    - **90376** – Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use
  - Rabies Vaccine
    - **90675** – Rabies vaccine, for intramuscular use; ***or***

        - **90676** – Rabies vaccine, for intradermal use
- Appropriate ICD-10 diagnosis code(s) for the exposure.

Follow-Up Visits for Rabies Vaccine

- Appropriate revenue codes, such as:
    - **510** (Clinic – general)
    - **761** (Treatment Room)
    - **771** (Preventive care services vaccine administration)
- Procedure Codes:
    - **90675** – Rabies vaccine, for intramuscular use; ***or***
    - **90676** – Rabies vaccine, for intradermal use
- Appropriate ICD-10 diagnosis code(s) for the exposure.

Reimbursement and Member Cost Sharing

Reimbursement is subject to medical necessity and the benefits available under the member's benefit plan at the time of service. Providers are reminded to always confirm a member's eligibility and benefits prior to rendering services.

Contracted facilities may bill the member for cost-sharing amounts (copay, deductible, coinsurance) as applicable under the member's benefit plan.

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4.3 Early Maternity Discharge and Home Health Evaluation

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth.

Group and individual health plans subject to NMHPA may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If the baby is delivered in the hospital, the 48-hour or 96-hour period starts at the time of delivery. If the baby is delivered outside the hospital and later admitted to the hospital in connection with childbirth (as determined by the attending physician) the period begins at the time of admission.

If the attending physician, in consultation with the mother, determines that the mother or the newborn child can be discharged before the 48-hour or 96-hour period, the health plan does not have to continue covering the stay for the one ready for discharge.

The federal NMHPA does not require follow-up visits. Some states, however, mandate expanded coverage for shorter lengths of stay.

Pennsylvania Health Security Act 85 of 1996

For providers in Pennsylvania

The General Assembly of the Commonwealth of Pennsylvania enacted the Health Security Act in 1996 (Act 85). This Act applies only to Highmark health insurance policies that provide maternity benefits and are issued through Highmark plans located in Pennsylvania.

As in the NMHPA, Pennsylvania's Act 85 also requires that every health insurance policy that provides maternity benefits to provide coverage for a minimum of 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following cesarean delivery. Act 85 also provides for a shorter length of stay if the treating or attending physician determines that the mother and newborn meet medical criteria for safe discharge.

In addition to minimum maternity stay requirements, Act 85 provides coverage for at least one home health care visit within 48 hours after discharge when discharge occurs prior to 48 hours following a vaginal delivery or 96 hours following cesarean delivery. The visit must be provided by a licensed health care provider whose scope of practice includes postpartum care.

The initial home health visit following discharge should be used to verify the condition of the infant and

the mother. The initial visit does not require authorization. **Any additional visits, if needed, require authorization and should be coordinated by the home health agency (HHA)**

Eligibility and Benefits

For providers in Pennsylvania

When coordinating a home health visit following an early maternity discharge, providers should first check the member's eligibility and benefits using Availity's **Eligibility and Benefits Inquiry** to determine if their coverage follows the mandate.

Pennsylvania's Act 85 is tied directly to the maternity benefit.

Authorization Requirements

For providers in Pennsylvania

HHAs are reminded that authorization is not required for the initial evaluation of the mother and baby when the group has elected to follow the mandate and meets the criteria for early discharge. Any additional visits, if needed, require authorization and should be coordinated by the HHA.

If the member's coverage does not follow Act 85 or the length of stay does not fall within the designated time frames, the HHA must check for the availability of home health benefits. If coverage is available for home health care, each visit may require authorization.

Scenarios

For providers in Pennsylvania

The table below reviews several scenarios and clarifies when authorization is required for home health visits following a maternity stay:

Does this group follow the PA Act 85 Mandate?	Discharged prior to 48 hours for vaginal delivery or 96 hours for cesarean?	Is auth required for this group?	Scenario
No	Yes	Yes	Although the member was discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section, the group does not follow Act 85. Since the member does have a benefit for home health care visits, the services are eligible. These visits require authorization.
No	Yes	No	This group does not follow the mandate but also does not have an authorization requirement for home health care visits. As long as the member has the benefit for home health care

			visits, the services would be eligible if they are medically necessary or appropriate. No authorization is necessary.
Yes	Yes	Initial visit - No Additional visits - Yes	If the member is discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section, the initial visit does not require authorization since the member's coverage follows Act 85. All subsequent visits require authorization.
Yes	No	Yes	Although the member's coverage follows Act 85, the member was not discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section. Authorization is required for all visits.

Claims Rejected for Auth in Error

For providers in Pennsylvania

If a claim is rejected for no authorization when an authorization is **not** required based on the scenarios above, the HHA should submit a Secure Message via Availity.

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4.3 Breast Pumps and Lactation Counseling

Under the Affordable Care Act of 2010 (ACA), specific women's preventive health care services are required to be covered for eligible health plan members without cost sharing to members. Such services include breastfeeding support, supplies, and lactation counseling services.

Coverage at a Glance

Breastfeeding support, counseling, and supplies are covered ACA Women's Preventive Health Services Mandate with no cost-sharing to the member when performed by **in-network** providers.

- Out-of-network coverage is pursuant to the terms of the member's individual benefits.
- Out-of-network cost sharing and balance billing may apply.
- Only durable medical equipment (DME) providers can bill for breast pumps and supplies.

Verify Eligibility and Benefits

You can verify whether a Highmark member is covered under the federal Women's Preventive Health Mandate via Availity's Eligibility and Benefits Inquiry or the applicable HIPAA electronic transactions.

Breastfeeding Pumps and Supplies

Breastfeeding pumps and supplies are covered without cost sharing for women covered under the ACA Women's Preventive Health Services Mandate. Eligible members are entitled to one breast pump per pregnancy when supplied by any network participating durable medical equipment supplier.

Eligible Highmark members can order high-quality breast pumps directly from two of the leading manufacturers in the industry: Ameda and Medela. Members can call the selected manufacturer or place an order online in advance of their delivery. The manufacturer will confirm a member's eligibility and submit claims to Highmark for processing. Eligible members can be directed to contact the manufacturers as follows:

Breastfeeding Supplies Procedure Codes

For eligible members whose coverage falls under the ACA women's health mandate, breast pumps and supplies are covered without member cost sharing when provided by participating DME providers. The following are eligible procedure codes for breastfeeding pumps and supplies:

PROCEDURE CODE	DESCRIPTION
E0602	Manual breast pump
E0603	Electrical breast pump
A4281	Tubing for breast pump replacement
A4282	Adapter for breast pump replacement
A4283	Cap replacement for breast pump bottle

A4284	Breast shield and splash protector
A4285	Polycarbonate bottle
A4286	Locking ring

Lactation Counseling/Support

Based on the ACA mandate, lactation services are eligible with no member cost sharing as follows:

- When provided by credentialed physicians who can employ lactation consultants or use their nursing staff to provide support. (This includes services provided by a physician assistant [PA] or certified registered nurse practitioner [CRNP] when under the supervision of a credentialed physician. Lactation consultants are not credentialed and cannot receive direct payment for their services.)
- When billed using the appropriate procedure codes — **99401, 99402,** and **99403** — and the appropriate diagnosis code of **Z39.1.**

Additionally, breastfeeding counseling/support is eligible with no age limit or frequency restrictions, and lactation counseling/support is considered to be a preventive service.

Please also note the following:

- When the service is provided by the pediatrician, then it is integral to the baby exam.
- When a lactation consultant provides the service in the pediatrician office, the billing is for the mother.
- When the services are provided as part of the maternity hospitalization, the payment is bundled and paid per the facility contract and integral to that admission.
- The service is part of the standard preventive schedule for non-grandfathered groups (NGF); please check Availity for benefit coverage.

For More Information

Highmark **Medical Policy E-37** includes medical guidelines not outlined in the ACA mandate; however, these medical policy guidelines would apply to those groups that do not follow the Women's Health Federal Mandate. The policy addresses:

- Newborns who are detained in the hospital after the mother is discharged
- Babies who have congenital anomalies that interfere with feeding Highmark Medical Policy can be accessed from the Provider Resource Center by selecting **Policies & Programs** from the main menu.

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4.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the "manual" or "Highmark Provider Manual") are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not

be relied upon for any purpose.

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Unit 4: Ancillary Services

4.4 Introduction

Ancillary care refers to the wide range of health care services provided to support the work of physicians. To supplement the professional provider and facility networks, Highmark contracts with a network of ancillary providers that provide health care related equipment or services. These include freestanding and facility-based providers in specialties including, but not limited to:

- Durable medical equipment and supplies
- Orthotics/prosthetics
- Home infusion
- Ambulance
- Diagnostic services (radiology and laboratory)
- Therapeutic services (i.e., physical and occupational therapy, chiropractic services, and speech therapy)

In this Unit

This unit provides information and guidelines for providers of ancillary services such as durable medical equipment and supplies, orthotics, prosthetics, home infusion, therapy services, and more.

For diagnostic services, please see **Chapter 4.5: Outpatient Radiology and Laboratory.**

Network Participation

For information on applying to participate in Highmark's facility and ancillary networks, please see **Chapter 3.4: Organizational Provider Participation.**

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4.4 West Virginia Senate Bill 273 – Alternative Treatments for Management of Chronic Pain

For providers in West Virginia

West Virginia Senate Bill 273 (the “Act”), effective June 7, 2018, was enacted in an effort to reduce opioid addiction by requiring health care insurers licensed in West Virginia to provide coverage for certain alternative treatments for management of chronic pain. The Act, in relevant part, amends Chapter 16 of the West Virginia Code relating to Public Health to add §16-54-1 et seq. (Treatment of Pain).

Requirements Under the Act

For providers in West Virginia

The following is a summary of the Act’s requirements:

- A health care practitioner can refer or prescribe any of the following treatment alternatives when a patient seeks treatment for chronic pain, based on their clinical judgment and the availability of the treatment, before starting a patient on an opioid: physical therapy, occupational therapy, acupuncture, massage therapy, osteopathic manipulation, chronic pain management program, and chiropractic services.
- All of these treatment alternatives do not need to be exhausted before prescribing an opioid.
- A practitioner may simultaneously prescribe an opioid along with any of the alternative treatments listed above.
- An insurer must provide, at a minimum, coverage for twenty (20) visits per event of physical therapy, occupational therapy, osteopathic manipulation, a chronic pain management program, and chiropractic services to treat conditions that cause chronic pain when ordered by a health care practitioner.
- A provider referral is not required as a condition of coverage for patients seeking these services.
- Any deductible, coinsurance, or copayment for these services may not be greater than the deductible, coinsurance, or copayment required for a primary care visit.

Applicability

For providers in West Virginia

Beginning with benefit plans renewing July 1, 2018, the Act will apply to Highmark West Virginia fully-insured large group and small group products, as well as Medicare supplemental group (Medifil) and individual (Medigap Blue) plans, upon renewal. The group products will continue to renew with the change through June 1, 2019.

Self-insured employer groups will be offered the opportunity to opt in and may or may not elect to follow the requirements of the Act.

The Act becomes effective on January 1, 2019, for individual Affordable Care Act (ACA) products, both on and off the Exchange.

Verify Benefits

For providers in West Virginia

To determine whether a member has coverage for alternative treatments for managing chronic pain as indicated under the Act, please be sure to verify the member's benefits via Availity's Eligibility and Benefits Inquiry prior to providing services.

If the Act applies to a member's benefit plan, it will indicate "Yes" for **WV Mandate – Opioid Reduction Act (SB 273)** under Product Wide Provisions. Benefit categories with special guidelines for visit limits per event for chronic pain include physical medicine, occupational therapy, and spinal manipulations.

WV Mandate - Opioid Reduction Act (SB 273)	Yes Special Guidelines Apply to Certain Services for Treatment of Chronic Pain Conditions

Definitions

For providers in West Virginia

Chronic pain is defined as a non-malignant, non-end-of-life pain lasting more than three months or longer than the duration of normal tissue healing. Pain is considered chronic if it persists longer than expected after an illness or injury, if it is associated with a chronic pathological process, or if it flares up periodically over months to years.

Chronic pain may be caused by physical, psychological, and environmental factors. Chronic non-malignant pain encompasses many painful disorders including but not limited to back pain, migraine headaches, diabetic neuropathy, dental and orofacial pain, and arthritic pain.

An **event** is defined as an adverse or damaging medical occurrence resulting in an acute exacerbation of an existing chronic pain condition.

Chronic Pain Management Services

For providers in West Virginia

For following guidelines apply for chronic pain management services:

- The services must be provided in an outpatient setting, and
- The patient must have a diagnosis of chronic pain, and
- The patient must have an adverse or damaging medical occurrence resulting in an acute exacerbation of an existing chronic pain condition.

Applicable Diagnosis Codes

For providers in West Virginia

The Act applies to the following ICD-10-CM Primary Diagnosis Codes:

- G89.21 – Chronic pain due to trauma
- G89.28 – Other chronic post-procedural pain
- G89.29 – Other chronic pain
- G89.4 – Chronic pain syndrome

How Visit Limits Apply Per Event

For providers in West Virginia

The chronic pain visit limit per event is applied as a combination of physical therapy, occupational therapy, chiropractic services, osteopathic manipulation, and chronic pain management programs (and not as a visit limit per each service per event). Any combination of these services will fulfill the “per

event" visit limit. In addition, the visit limits are combined for services provided in-network and out-of-network.

Note: Services received for diagnoses other than chronic pain will not apply to a member's visit limit per event coverage for chronic pain. Please review the member's benefits via Availity's Eligibility and Benefits Inquiry for these services when they are provided for diagnoses other than chronic pain.

Highmark West Virginia Medical Policy

For providers in West Virginia

Please refer to the following Highmark West Virginia medical policies for physical and occupational therapy and manipulation services:

- **Y-1** Physical Medicine
- **Y-2** Occupational Therapy (OT)
- **Y-9** Manipulation Services

In addition, please see Highmark West Virginia Medical Policy **Y-23 Chronic Pain Management**, effective September 17, 2018. This policy is applied on a post-payment basis and services will be subject to retrospective review.

Highmark West Virginia Medical Policy can be accessed under **Policies & Programs** from the main menu.

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4.4 Ground Ambulance Services

The purpose of this section is to provide Highmark's guidelines for billing ground ambulance services for all **commercial** products. When used here, the term "ambulance transport services" includes all medically necessary ambulance services, **except** wheelchair van transport.

Medical Necessity

To be eligible for approval and payment, ambulance transport services must be medically necessary and appropriate. Medically necessary ambulance services are those rendered when the patient's clinical condition is such that the use of any other method of transportation, such as a taxi, personal car, or other type of vehicle, would be contraindicated (e.g., it would endanger the member's health).

Benefits

Although many Highmark benefit plans provide benefits for medically necessary ambulance transport services, benefits vary widely. The coverage available to any particular member is determined by the member's specific benefit plan.

For medically necessary ambulance transport services provided to Highmark members, payment is made in accordance with the member's benefit plan and, if applicable, the provider's contract if the required benefit is available and the claim is billed appropriately.

Highmark's determination on which entity is to bill for ambulance transport services is based on the Medicare program's distinction between Part A and Part B services as in the table below. This standard applies to all Highmark products:

When the Medicare beneficiary is...	The service falls under this program... AND	Transportation is billed by... via this process...	AND is reimbursed...
An inpatient of a facility	Medicare Part A	The facility in which the beneficiary is an inpatient via the UB-04/837I claim	As part of the DRG or per-diem payment for the inpatient stay
Not an inpatient of a facility	Medicare Part B	The ambulance transport provider via the 1500/837P claim	Via separate outpatient payment

Emergent Situations

In the case of an emergency, any licensed ambulance transport provider (including a hospital-based service) may transport a Highmark member with coverage under any product from the scene of an accident or other initiating event to the closest facility that can provide the needed services.

- When the member is not an inpatient of any facility at the time of transport, the services must be billed to Highmark by the ambulance provider.
- If a member is an inpatient at one facility and is transported to another facility on an emergency basis, any licensed ambulance transport provider may transport the member. Unless the member is later returned to the original facility (which would typically be unusual in these circumstances), the member would not be considered an inpatient at the time. Therefore, the services must be billed to Highmark by the ambulance provider.

Assuming the member has coverage and the necessary benefit and that the claim is billed appropriately, payment will be made in accordance with the member's benefit plan.

Non-Emergent Situations: To and From Hospitals

When a member must be transported from Hospital A to Hospital B, that member has been discharged from Hospital A. Since the member is no longer an inpatient at the time of transport, this service can be provided and billed by any licensed ambulance transport provider (including a hospital-based ambulance service). Assuming that the member has coverage and the necessary benefit and that the claims is billed appropriately, payment will be made in accordance with the member's benefit plan and, if applicable, the provider's Highmark contract.

Non-Emergent Inter-Hospital Transports with Return

If a member is transported from Hospital A to Hospital B to receive specialized services not available at Hospital A, and then returns to Hospital A, the member is considered an inpatient of Hospital A throughout the events, including the transport.

The ambulance transport services are part of Hospital A's inpatient claim. The services can be provided by any licensed ambulance provider, which then must bill the hospital for the transport.

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4.4 DME/Respiratory Supplies Management Program

Under the Durable Medical Equipment (DME)/Respiratory Supplies Management Program, specific DME and supply items require authorization. Managed care plans typically require authorization -- PPO, EPO, HMO, IPA, POS, including Medicare Advantage PPO and HMO plans. However, benefits can vary and certain employer groups may choose to opt out of this requirement; **always confirm DME authorization requirements under the member's coverage.** You can use the Availity® *Eligibility and Benefits Inquiry* transaction or the applicable HIPAA electronic transaction for benefit verification.

Highmark is responsible for claims processing, utilization management, and authorization functions for DME, prosthetics, orthotics, and supplies provided to Highmark members. Please verify benefits via Availity for a member's specific coverage.

DME Requiring Authorization

Highmark maintains a **List of Procedures/DME Requiring Authorization**. This list is available on the Provider Resource Center under **Claims & Authorization.**

The authorization process for DME and supplies furnished through a stand-alone, Highmark participating ancillary DME suppliers for the items on the list is managed by Highmark's Clinical Services. Ordering physicians may initiate authorization requests. Availity-enabled providers must submit the authorization request via Availity.

Important!

DME that does not require authorization simply requires a prescription written by the ordering physician.

Medicare Advantage

For providers in Pennsylvania and West Virginia

For Medicare Advantage members in Pennsylvania and West Virginia, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims that do not require authorization will process according to indications and limitations of Medicare Advantage Medical Policy. **Items and services that are not considered to be medically necessary may not be billed to Medicare Advantage members**

without a *Notice of Denial of Medical Coverage* from Highmark (obtained through a preservice organization determination).

For information on preservice organization determinations for Medicare Advantage, please see **Chapter 5.3: Medicare Advantage Procedures.**

Claim Submission

Electronic claims submission is the preferred, most efficient, and most cost-effective method of submitting claims. If you are not yet submitting claims to Highmark electronically, visit the **Electronic Data Interchange (EDI) Services** website, which can be accessed from the Reimbursement Resources page on the Provider Resource Center. Or call EDI Operations toll-free at **800-992-0246**, Monday through Friday, 8 a.m. to 4:30 p.m. EST.

You can also submit claims electronically through Availity's HIPAA-approved claims submission transaction. Once your claims are submitted to Highmark, whether through Availity or a HIPAA 837 electronic transaction, you are able to view the claim status and perform a Secure Message in Availity.

DMEPOS Refills

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the member or caregiver/designee prior to dispensing refills. Highmark does not support or endorse auto-shipping; if the member is enrolled in or gives approval for auto-shipment of their supplies, **the provider should not automatically ship the item(s)**. This is to ensure that the refilled item remains medically necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order.

A refill request must be obtained from a member prior to delivery of any refill items. Refill requests are to be obtained on a monthly basis; refill requests for supplies should not extend beyond thirty (30) calendar days. The member’s refill request, including date of request and supplies requested, must be documented in the provider’s records and provided to Highmark upon request.

Documentation of Trial/Rental Period on CMN/LMN

If a Certificate of Medical Necessity (CMN) or Letter of Medical Necessity (LMN) indicates that a required trial/rental period for a DME item has occurred in the office, the provider must document the dates in which the trial occurred on the CMN/LMN.

If the dates of the in-office trial/rental are not indicated, the DME company is required to proceed as if the trial did not occur and must fulfill the trial/rental period prior to purchase.
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4.4 Authorizing Durable Medical Equipment

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory supplies. Ordering physicians may initiate the authorization request.

This process applies to PPO, EPO, HMO, IPA, POS, and PPO Plus plans (including Medicare Advantage HMO and PPO plans in Pennsylvania and West Virginia).

Step 1: The requesting provider determines whether the request must be authorized by Highmark's Clinical Services. **Please gather all pertinent information, including a Certificate of Medical Necessity (CMN) if required, prior to submitting the request.**

Step 2: If required, the requesting provider submits the request for authorization to Clinical Services through one of the following methods:

- If Availity-enabled, the request **must** be submitted via Availity.
- For those practices not yet Availity-enabled, **fax** an authorization request form to **412-544-2921** or **888-236-6321.**

Step 3: Clinical Services will review the request.

- If benefits are not available, go to Step 4.
- If medical appropriateness cannot be determined, go to Step 5.
- If the request meets criteria, Clinical Services will approve the authorization request and notify the requester.

Step 4: If benefits are not available for the requested item or service, Clinical Services will deny the authorization request and notify the requesting provider.

A denial letter from Highmark will be sent to the ordering physician, vendor, and the member. Information regarding appeal/complaint rights will be detailed in the denial letter.

Step 5: If medical appropriateness cannot be determined from the documentation provided, Clinical Services will contact the requesting provider for additional information.

This information must be returned to Clinical Services in a timely manner, preferably within 48 hours, as regulatory time frames must be met.

Proceed to Step 6.

Step 6:

- If medical necessity cannot be determined, the authorization request is pended and sent to a Highmark physician reviewer for review. Proceed to Step 7.
- If the documentation substantiates the request, the service will be approved and the requesting provider will be notified.

Step 7: If the Highmark physician reviewer determines that the authorization:

Is medically appropriate…

Clinical Services will approve the pended authorization request and notify the requester.

Is not medically appropriate…

A physician will deny the pended request and send a denial letter to the ordering physician, vendor, and the member. A Clinical Services care manager will inform the requester of the denial.

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4.4 Select DME Network (PA Only)

For providers in Pennsylvania

To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

Select DME Network Effective January 1, 2017

For providers in Pennsylvania

Effective January 1, 2017, the Select DME Network will be the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

For Highmark commercial benefit plans, the Select DME Network applies to the highest tier level of Pennsylvania tiered health plans. For example, for a 3-tiered plan such as Connect Blue in western Pennsylvania, the Select DME Network applies to the Preferred tier level. In a two-tiered plan such as Community Blue Flex, Community Blue Premier Flex, and Alliance Flex Blue, the Select DME Network applies to the Enhanced tier level. Highmark commercial members with tiered plans have the option of choosing other DME participating providers not in the Select DME Network; however, receiving services or supplies from non-Select DME Network providers may result in higher out-of-pocket costs for members.

For More Information

For providers in Pennsylvania

Highmark provides two versions of the current list of providers in the Select DME Network. You can select a list of all participating providers or a list organized by category, which includes telephone numbers. These lists of providers in the Select DME Network are also available on the Provider Resource Center. Select **Provider Network** from the main menu, and then **Select Durable Medical Equipment Network**.

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

Referring Highmark Members to DME Providers

For providers in Pennsylvania

Providers should refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

Highmark commercial members can continue to use providers from the broader DME network; however, you should refer Highmark commercial members to Select DME Network providers to receive the highest level of benefits possible.

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4.4 Billing For DMEPOS Provided to Members Registered as Inpatients or Outpatients at a Facility

Providers who supply durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) to Highmark members when they are registered as inpatients or outpatients at a Highmark-contracted facility may bill Highmark for a very limited scope of equipment and supplies.

Billing Guidelines

If a Highmark member is registered as an inpatient or outpatient of a hospital or skilled nursing facility (SNF), DMEPOS providers may bill Highmark for equipment or supplies provided to the member ONLY when one of the following apply:

- The equipment or supplies require approval and authorization by Highmark's Clinical Services.
- The equipment or supplies are customized specifically for the individual member's use in the home setting (e.g., customized power wheelchairs, customized splints or braces provided to the member for use in the home).

For any other DMEPOS supplies or equipment furnished to members who are registered as inpatients or outpatients of a facility, it is the responsibility of the Highmark-contracted hospital or SNF to provide the

supplies or equipment and to seek payment from Highmark, as appropriate. Other DMEPOS supplies or equipment include, but are not limited to, items such as crutches, walkers, canes, and soft goods.

These requirements apply to all Highmark products, including Medicare Advantage HMO and PPO products available in Pennsylvania.

Exceptions for Medicare Advantage Members Residing in SNFS

For providers in Pennsylvania and West Virginia

These requirements do not apply in the case of DMEPOS items provided to Medicare Advantage HMO or PPO members residing in a SNF who have exhausted their 100-day skilled nursing benefit or are receiving a non-skilled level of care.

Under these circumstances, the billing process should be treated as if the member is living in his or her own residence. Therefore, the DMEPOS provider would bill the claim to Highmark.

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4.4 Home Infusion Therapy Guidelines

Home infusion therapy (HIT) is the administration of medically necessary fluids or drugs through a central line or peripheral vein to Highmark members in their homes or places of residence.

Drug therapies commonly administered by infusion include antibiotics, chemotherapy, pain management, and parenteral nutrition.

Here are examples of certain conditions that commonly require infusion therapy:

- Infections that are unresponsive to oral antibiotics
- Cancer and cancer-related pain
- Gastrointestinal diseases or disorders that prevent normal functioning of the gastrointestinal system
- Immune disorders

Home nursing services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home.

Provider Guidelines

Home infusion therapy providers must possess a current pharmacy license from the state in which they provide services. They must also maintain accreditation from one of the following: The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations); Accreditation Commission for Health Care, Inc.; Community Health Accreditation Program, Inc.; The Compliance Team, Inc.; or Healthcare Quality Association on Accreditation.

Provider agrees to submit claims to Highmark for all Highmark members (must use best efforts to submit claims electronically). Providers also agree to accept Highmark's payment for covered services they perform. The provider will not charge the member for covered services the provider has agreed to provide except for applicable copayment, coinsurance, and deductible amounts.

In Pennsylvania, the provider agrees to provide:

- Dedicated customer service personnel
- A toll-free telephone number
- Twenty-four hour availability for service and delivery
- Twenty-four hour turnaround time to accept patient to service except for customized, specialized, or significantly customer-specific product

Nursing Services for Home Infusion Therapy

Per diem rates are all-inclusive rates for medically necessary services. They include all ancillary services and supplies (e.g., durable medical equipment or supplies as needed, educational materials, basic solutions, administrative supplies, and the defined nursing hour increment).

Daily maintenance and a flush kit are integral components to the per diem allowance regardless of the mode of access. Since daily maintenance and flush kits were considered in the development of the fee schedule, Highmark will not provide separate payment for these services.

Multiple Infusion Therapies

Multiple infusion therapies apply to patients who require multiple concurrent infusion treatments including, but not limited to, multiple antibiotics, hydration, chemotherapy, and enteral feeding therapy.

Highmark will not reimburse separately for each therapy. Instead, the provider must bill and will be reimbursed for the most costly per diem that applies plus the drug(s) administered.

When billing for multiple therapies on the same claim, bill only for the most costly procedure. Do not report zero dollar charges for the remaining therapies.

Exception: The only exception to this is aerosolized AIDS drug therapy. It is the only therapy that must be billed in conjunction with another mode of home IV therapy administration. It is also the only drug therapy that, while provided as part of a multiple-therapy treatment, can be billed as a separate service. Use procedure code S9061 to report aerosolized AIDS drug therapy.

Billing and Reimbursement for Drugs Administered

Follow these guidelines when reporting drugs administered by home infusion therapy:

- If the patient administers the drugs, and the home infusion provider provides the drugs but no nursing services, bill for the supplies or drugs but not a per diem nursing visit.
- Report the correct procedure code according to the date of service and the effective date of your contract.
- When billing for drugs administered through home therapy infusion, bill the amount of drug based on the smallest available commercial size.
- Drug claims billed under Highmark medical benefits **require** the submission of National Drug Code (NDC) information. Please see the List of Procedures Requiring NDC Information. This list is also available under **Policies & Programs** then **Pharmacy Programs** on the Provider Resource Center.

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4.4 DME Provided in a Physician's Office for Medicare Advantage (PA Only)

PA For providers in Pennsylvania

Highmark has always maintained a list of durable medical equipment (DME), prosthetics, orthotics, and supplies incidental to a physician or facility that can be furnished to members for their convenience in the physician office setting. **This list applies only to Medicare Advantage products with DME benefits.**

The list includes minor DME items, prosthetics, orthotics, and supplies incidental to a physician or facility that can be furnished to members for their convenience in the physician office setting.

These items do not require authorization and can be billed to Highmark for reimbursement at fee-for-service. Member cost-sharing may apply.

Physician Office DME Supply List for Medicare Advantage

For providers in Pennsylvania

For the complete list of DME, prosthetics, orthotics, and supplies that can be provided to Medicare Advantage members in the physician's office, click here.

Note: For items not on this list, please direct members with Medicare Advantage HMO and Freedom Blue PPO to a participating network vendor.

Important! Always Verify Benefits

For providers in Pennsylvania

Please verify the member's benefits through Availity® prior to providing any of these items. Member cost-sharing in the form of deductible or coinsurance may apply to DME and supplies under the member's Medicare Advantage plan.

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4.4 Medicare Advantage Guidelines for DMEPOS Upgrades (PA and WV Only)

For providers in Pennsylvania and West Virginia

Generally, upgrades to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are defined as items that go beyond what is medically necessary. An upgrade may be from one Healthcare Common Procedure Coding System (HCPCS) code to another HCPCS code, or it may be from one item to another within the same HCPCS.

The payment for an item must be consistent with what is considered reasonable and medically necessary to serve the intended purpose. In cases where an item is considered to be medically necessary and covered, and a member wishes to obtain an item with upgraded features, payment is based on the allowance for the item normally used for the intended purpose.

Claim Submission and Reimbursement

For providers in Pennsylvania and West Virginia

Highmark requires providers to bill these services as they do for Medicare fee-for-service beneficiaries. The items should be billed as two (2) separate line items, one for the upgraded item and one for the standard item.

If it is determined that the upgrade was not medically necessary, payment is made on the standard item and the line item for the upgraded item will be denied. Liability will be set based on which modifiers were billed on the line.

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4.4 Medicare Advantage Capped Rentals (PA and WV Only)

For providers in Pennsylvania and West Virginia

Highmark adopted the Centers for Medicare & Medicaid Services (CMS) payment methodology on capped rental items for all Medicare Advantage products. These items are denoted as payment class "CR" (Capped Rental) on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Under the CMS payment methodology, items denoted as payment class CR are paid for as rentals only. Generally, they cannot be purchased upfront, except in certain situations (e.g., electric wheelchairs meeting certain criteria). Upon reaching the final monthly payment on items and services in this category, ownership will transfer to the member.

Note: Claims for rental items not designated as CR will continue to be paid at the monthly allowable fee until the purchase price is met at which time ownership of the item will transfer to the Highmark patient.

Payment Methodology and Required Modifiers for Capped Rentals

For providers in Pennsylvania and West Virginia

The following chart outlines the payment schedule and required modifiers for capped rental items for Medicare Advantage:

Schedule	Payment	Required Modifier
Month 1	10% of purchase price paid	KH
Months 2-3	10% of purchase price paid	KI
Months 4-13 (4-15 for PEN pumps)	7.5% of purchase price paid	KJ

Exception: Power wheelchairs pay at 15% for months 1-3 and 6% for months 4-13. Modifiers are the same as above.

List Of Capped Rental Items

For providers in Pennsylvania and West Virginia

For a complete list of procedure codes for DMEPOS items that fall into this capped rental classification, click here.

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4.4 Medicare Advantage Home Oxygen Therapy (PA and WV Only)

For providers in Pennsylvania and West Virginia

Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

Oxygen Equipment Limited to 36-Month Rental Period

For providers in Pennsylvania and West Virginia

Reimbursement for oxygen equipment is limited to 36 monthly rental payments to mirror the Centers for Medicare & Medicaid (CMS) payment methodology.

Payment for accessories (e.g., cannula, tubing, etc.), delivery, back-up equipment, maintenance, and repairs will be included in the rental allowance. Payment for oxygen contents (stationary and/or portable) will also be included in the allowance for stationary equipment (E0424, E0439, E1390, E1391).

After the 36-month rental period ends, according to CMS policy, Highmark will pay for oxygen contents monthly and for maintenance once every six months. Ownership of the oxygen delivery equipment will remain with the equipment supplier.

Supplier Responsibilities

For providers in Pennsylvania and West Virginia

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment, and all related items and services, through the 36-month rental period unless one of the following exceptions is met:

- The beneficiary relocates temporarily or permanently outside of the supplier's service area;
- The beneficiary elects to obtain oxygen from a different supplier; or
- Highmark makes individual case exceptions.

Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, transfilling equipment) is not permitted unless one of the following requirements is met:

- The supplier replaces the equipment with the same or equivalent item;
- The physician orders different equipment;
- The member chooses to receive an upgrade and signs a Pre-Service Denial Notice; or
- Highmark determines that a change in equipment is warranted.

Reasonable Useful Lifetime (RUL)

For providers in Pennsylvania and West Virginia

After 36 rental payments have been made, there will be no further payment for oxygen equipment during the 5-year reasonable useful lifetime (RUL) of the equipment. The RUL is not based on the chronological age of the equipment. It starts on the initial date of service and runs for five years from that date.

If use of portable equipment (E0431, E0433, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until 36 rental payments have been made for the portable equipment.

The supplier who provided the equipment during the thirty-sixth rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5-year RUL of the equipment.

Any time after the end of the 5-year RUL period for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.

Payment for Oxygen Content

For providers in Pennsylvania and West Virginia

Payment for stationary and portable contents is included in the fee schedule allowance for stationary equipment. **No payment can be made for oxygen contents in a month in which payment is made for stationary equipment.**

If the patient was using stationary gaseous or liquid oxygen equipment during the thirty-sixth rental month, payment for stationary contents (E0441 or E0442) begins when the rental period for the stationary equipment ends.

Conditions for Which Coverage is Available

For providers in Pennsylvania and West Virginia

Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy.
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

Conditions for Which Coverage is Not Available

For providers in Pennsylvania and West Virginia

Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable Oxygen Systems

For providers in Pennsylvania and West Virginia

Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, please check both the “portable” box and the “stationary” box.

Spare Tanks Or Emergency Inhalators

For providers in Pennsylvania and West Virginia

Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

Blood Oxygen Determinations

For providers in Pennsylvania and West Virginia

Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO2) in arterial blood. **The study must be performed within 30 days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician.
- Ordered and evaluated by the attending physician and performed under his or her supervision.

- Performed by a qualified provider of laboratory services.

Note: Highmark does not consider suppliers as qualified to perform blood gas studies and will not pay for a qualifying blood gas study if performed by a supplier.

Conditions of Blood Gas Studies

For providers in Pennsylvania and West Virginia

The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include: at rest, while sleeping, while exercising, on room air, on oxygen, etc.

Note: If the study is performed while the patient is receiving oxygen, indicate the amount, body position during testing, and any additional information required for interpretation.

Blood Gas Level Criteria

For providers in Pennsylvania and West Virginia

The table below describes three groups of blood gas levels for which coverage is provided.

Group	Blood Gas Level Criteria
GROUP 1: Medically necessary	Arterial PO2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO2 at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake.

	OR A greater than normal fall in oxygen level during sleep (arterial PO2 decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, “P” pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis). OR Arterial PO2 is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO2 at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.
GROUP 2: Medically necessary	Arterial PO2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF)

	• Erythrocythemia with a hematocrit greater than 56%
GROUP 3: Not medically necessary	Home use of oxygen is not medically necessary for members with PO2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional Studies

For providers in Pennsylvania and West Virginia

Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient's initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO_2 was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

Certificate Of Medical Necessity (CMN)

For providers in Pennsylvania and West Virginia

A Certificate of Medical Necessity (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

Obtaining Authorization

For providers in Pennsylvania and West Virginia

Highmark's Clinical Services must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization:

STEP	ACTION
1	If Availity-enabled, the vendor or physician must enter an authorization request for oxygen into Availity. **A Certificate of Medical Necessity (CMN) must be completed for the situations indicated above.** If not Availity-enabled, the vendor or physician should fax a CMN form to Clinical Services at 412-544-2921 or 888-236-6321.
2	If a required CMN form has not been submitted, Clinical Services will contact the provider and request that one be completed.
3	Once all information has been received, the DMEPOS authorization process will be followed (as detailed on earlier in this unit).

Recertification

For providers in Pennsylvania and West Virginia

Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO2 was 56 mm HG or greater at the initial certification.
- If the patient's oxygen saturation was 89% or greater at the initial certification.
- If the physician initially estimated that oxygen was needed for one to three months.

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

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4.4 Diabetic Testing Devices for Medicare Advantage Members (PA and WV Only)

For providers in Pennsylvania and West Virginia

Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips, and lancets under the durable medical equipment (DME) benefit. Insulin pens and insulin pumps are also covered under the DME benefit.

Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

Purchasing Diabetic Testing Devices

For providers in Pennsylvania and West Virginia

Members are able to purchase diabetic testing devices from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage. Supplies obtained from an in-network DME supplier are covered in full after coinsurance.

Although Medicare Advantage PPO members have out-of-network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions for Multiple, Daily Diabetic Testing

For providers in Pennsylvania and West Virginia

If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written clearly to state the correct frequency of testing (e.g., "to be tested three times daily"). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies, the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail-Order Diabetic Testing Supplies

For providers in Pennsylvania and West Virginia

Members are able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long-term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long-term supplies.

For More Information

For providers in Pennsylvania and West Virginia

If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact the Provider Service Center.

4.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 5: Outpatient Radiology and Laboratory

4.5 Advanced Imaging and Cardiology Services Program

Highmark partners with eviCore healthcare (eviCore) for Highmark's Advanced Imaging and Cardiology Services Program. This program incorporates a comprehensive, evidence-based clinical review, including predictive intelligence, clinical decision support, and peer-to-peer discussions.

Advanced Imaging Component

The following outpatient, non-emergent, elective advanced imaging procedures require authorization under the program:

- Computerized tomography (CT)
- Computerized tomography angiography (CTA)
- Magnetic resonance angiogram (MRA)
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Positron emission tomography (PET)
- Positron emission tomography-computed tomography (PET-CT)

Cardiology Services Component

The following outpatient, non-emergent, elective cardiology services require authorization under the program:

- Cardiac CT and MRI
- Diagnostic heart catheterization
- Myocardial perfusion imaging (single-photon emission computerized tomography [SPECT] and PET)
- Nuclear cardiac imaging
- Stress echocardiogram
- Transesophageal echocardiogram
- Transthoracic echocardiogram

List of Procedure Codes Requiring Authorization

The list of all procedure codes that require prior authorization under the Advanced Imaging and Cardiology Services Program is available on Highmark's Provider Resource Center. On the Provider Resource Center, select **Policies & Programs** and look under **Care Management.**

The list is also available on eviCore's website.

Authorization Not Required

eviCore does not manage prior authorization for advanced imaging or cardiology services that are performed during an inpatient stay, in an emergency room setting, or during an observation stay.

Members Impacted

eviCore manages the prior authorization process for advanced imaging and cardiology services for the following Highmark members:

- Fully insured commercial
- Medicare Advantage (in Pennsylvania and West Virginia)
- Affordable Care Act (ACA)
- Children's Health Insurance Program (CHIP) in Pennsylvania
- Select self-insured (Administrative Services Only) groups

Since some employer groups may choose to opt out of the program, please be sure to always verify a member's eligibility and benefits via Availity® to confirm whether the member's coverage requires authorization.

Note: The Federal Employee Program (FEP) is excluded from this program.

Highmark Medical Policy and eviCore Clinical Guidelines

Highmark Medical Policy applies to services under the program. You can quickly access Highmark Medical Policy by clicking on **MEDICAL POLICY SEARCH** on the Quicklinks bar at the top of the Provider Resource Center.

You can access eviCore's clinical guidelines at evicore.com/resources/healthplan/highmark. Scroll down to the **eviCore Evidenced-Based Clinical Guidelines** section on the right, click **ACCESS GUIDELINES** and then select **Radiology & Cardiology.**

Responsibility for Requests

It is the ordering provider's responsibility to request prior authorization from eviCore under the Advanced Imaging and Cardiology Services Program.

Methods for Requesting Prior Authorizations

AVAILITY: Prior authorization requests for the program can be submitted to eviCore electronically via Availity, the preferred method for submitting requests.

Telephone: eviCore can accept requests by phone at **888-564-5492** from **7a.m. to 7p.m. EST**, **Monday through Friday**. Outside of these normal business hours, you can leave a message for a return call the next business day.

Fax: To fax your request to eviCore, first obtain the appropriate condition-specific form from the eviCore website at eviCore.com. From **RESOURCES** on the menu bar, select **Providers**, and then **Online Forms**

& Resources. Complete the form and fax it to **800-540-2406**. When the authorization review is completed, eviCore will respond by fax with the decision.

Prior to submitting your request, please be sure to have all pertinent information at hand, including:

- Patient's name, address, and current Member ID
- Diagnosis and procedure codes
- Office notes related to the current diagnosis
- Recent clinical information, including imaging studies and prior test results related to the diagnosis

Urgent Care Requests

An **urgent care request** is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

When a service is required due to a medically urgent condition, the ordering provider can request authorization by calling eviCore at **888-564-5492.**

An urgent request can also be submitted online via Availity by selecting **No** on the urgency indicator screen in the submission process. However, please note that **clinical documentation must be uploaded for urgent requests**. You are able to upload up to five Word or PDF documents. Your case will only be considered urgent if there is a successful upload.

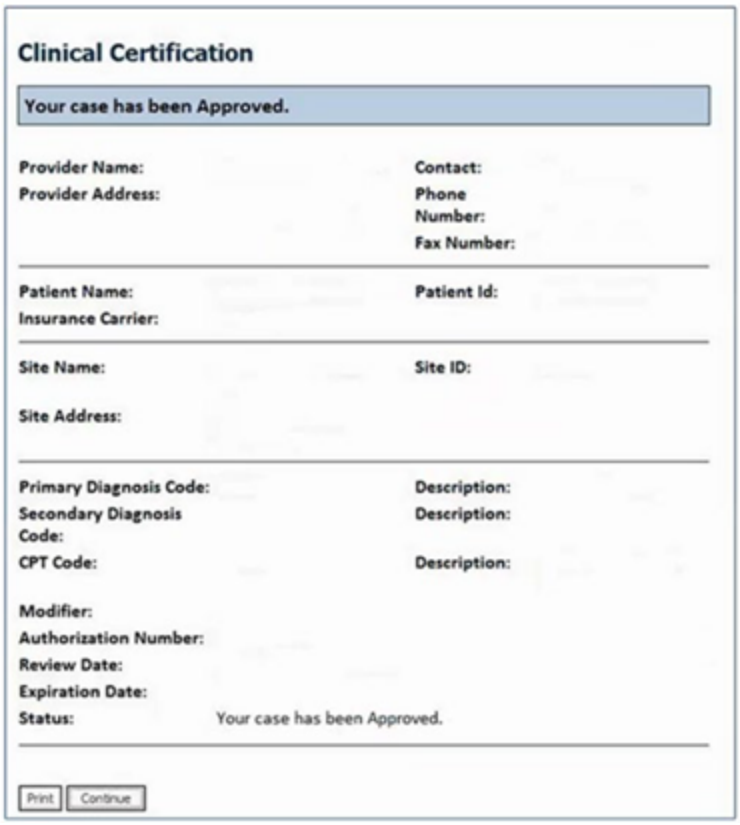
eviCore will make a good faith effort to render a decision for an urgent request within 24 hours and not to exceed 72 hours of receipt of all necessary information.

Approval Notification

Once the clinical pathway questions are answered and you have submitted the case, an approval is issued if the answers you have provided have met the clinical criteria. The approval page can be printed for the member's file.

An authorization number will be assigned. All authorization numbers will begin with the letter “A” followed by nine digits. The authorization is valid for 60 days.

Here is an image that illustrates the approval page:



Clinical Certification

Your case has been Approved.

Provider Name:
Provider Address:
Contact:
Phone Number:
Fax Number:

Patient Name:
Insurance Carrier:
Patient Id:

Site Name:
Site Address:
Site ID:

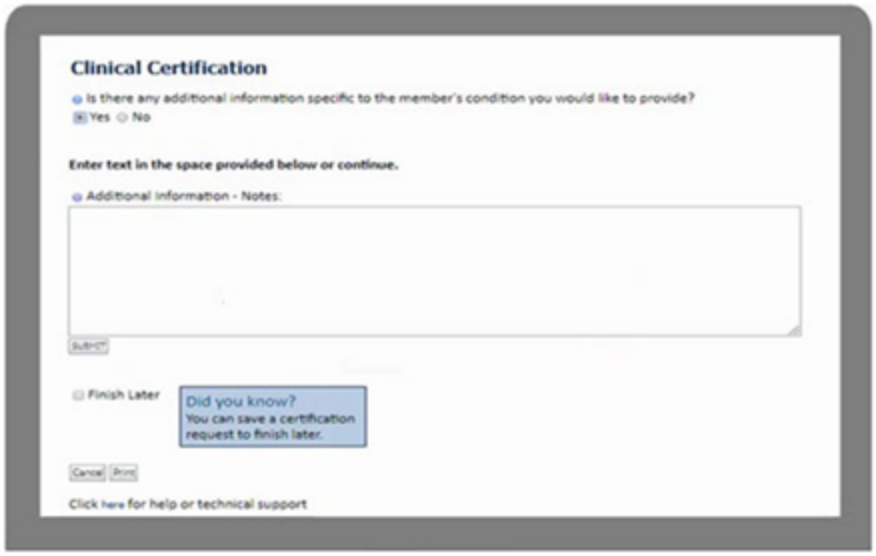
Primary Diagnosis Code:
Secondary Diagnosis Code:
CPT Code:
Description:
Description:
Description:

Modifier:
Authorization Number:
Review Date:
Expiration Date:
Status: Your case has been Approved.

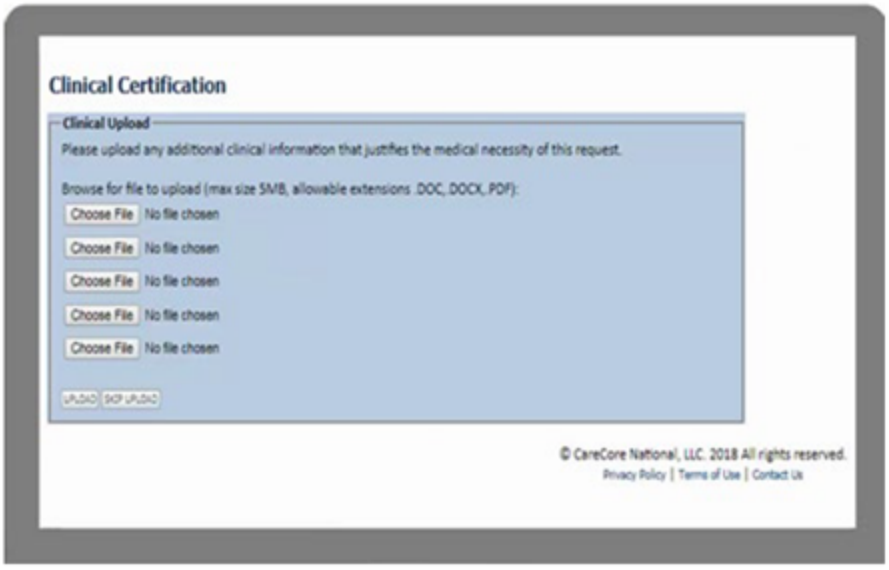
Print Continue

Medical Review Required

If additional information is required for medical review, you will have the option to upload documentation, enter information into the text field, or contact eviCore by phone. **REMINDER: For urgent care requests, documentation must be uploaded.**



Continue to the next screen to upload documents. You can upload up to five documents (maximum size 5MB; .doc, .docx, .pdf extensions only).



Authorization requests are reviewed and processed within two business days of eviCore's receipt of all requested information. Requests are first reviewed by a nurse reviewer who can approve a request if it is determined that criteria is met. If the nurse reviewer is not able to make a determination, the case is reviewed by an eviCore Medical Director. Only an eviCore Medical Director can deny a request.

eviCore will notify the ordering provider of the decision via fax. A determination letter is mailed to the member.

If a request is approved, an authorization number is assigned. An authorization number will begin with the letter “A” followed by nine digits. The authorization is valid for 60 days.

Reconsiderations and Peer-to-Peer

Reconsiderations and peer-to-peer discussions will be available for commercial members only.

For Medicare Advantage members in Pennsylvania and West Virginia, consultations will be made available prior to a decision if requested. Once an authorization request has been denied, the decision cannot be overturned.

Providers Rendering Services

To avoid any unnecessary delay in payment, those providers rendering the specific advanced imaging or cardiology service should verify that the necessary authorization has been obtained prior to performing the service. Failure to do so may result in non-payment of your claim, and you may not seek reimbursement from the member.

Claims Adjudication

Under the terms of the agreement between Highmark and eviCore, Highmark will oversee the eviCore program and will continue to be responsible for claims adjudication. All claim inquiries should be directed to Highmark.

Retrospective Reviews

Retrospective requests must be submitted by phone or fax **within 730 business days** following the date of service. Requests submitted after 730 business days will be denied. All retrospective requests are reviewed for medical necessity with determinations made within 30 calendar days.

Note: Retrospective requests for dates of service prior to January 1, 2019, must be submitted to National Imaging Associates (NIA).

Medical Necessity Appeals

eviCore will process first-level provider appeals for commercial members. Highmark will process first-level provider appeals for all other members.

Requests for appeals for commercial members must be submitted to eviCore within the applicable time frames below:

- Delaware and West Virginia: **365 days** of the initial determination
- Pennsylvania: **180 days** of the initial determination

The procedure request and all clinical information provided will be reviewed by a physician other than the one who made the initial determination. A written notice of the appeal decision is mailed to the member and faxed to the provider.

Note: Appeals for services denied under the previous program for dates of service prior to January 1, 2019, must be submitted to NIA.

For More Information

Additional information about the program is available on Highmark's Provider Resource Center. Select **Policies & Programs** and then look under **Care Management.**

eviCore provides a variety of resources at evicore.com/resources/healthplan/highmark. In addition to their clinical guidelines, you will find online forms, educational tools, helpful blogs, and more.
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4.5 Outpatient Laboratory Overview

Providers must refer members to participating laboratory vendors when lab services are needed and are not performed in the provider's office.

Prescription Necessary

PCPs and specialists need only give their members a prescription for the necessary lab tests and direct them to a network-participating lab.

Communication Between the PCP and Specialist

Specialty practitioners should communicate with a member's PCP after a consultation visit so that laboratory services can be appropriately coordinated.

Pass-Through Billing Not Permitted

For providers in Delaware and Pennsylvania

Pass-through billing occurs when ordering practitioners bill for clinical laboratory tests that were not performed in their offices. In Pennsylvania and Delaware, Highmark does not permit pass-through billing.

Practitioners should bill only for the component of the laboratory service they perform in their offices. Independent laboratories should bill for any clinical lab tests referred to them by practitioners.

Highmark will reimburse practitioners for drawing or handling when the specimen is sent to a laboratory other than the practitioner's office lab and the clinical lab test is billed by the independent laboratory. However, if the clinical lab test is performed in the practitioner's office and the practitioner bills for the test, an additional charge for drawing or handling will not be reimbursed. The handling or drawing of the specimen is considered part of the laboratory procedure.

Participating Independent Laboratory Lists

Availity is the preferred Highmark tool for inquiring about participating providers; however, if you are not Availity-enabled, please click the links below for a list of designated independent lab providers. Please select the appropriate region-specific link below:

- Delaware Independent Labs
- Pennsylvania Central Region Independent Labs
- Pennsylvania Northeastern Region Independent Labs
- Pennsylvania Western Region Independent Labs
- West Virginia Independent Labs

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4.5 Laboratory Management Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Highmark has partnered with eviCore healthcare ("eviCore") to ensure our members are receiving the most clinically appropriate genetic laboratory testing. eviCore has a team of 14 genetic counsellors and medical geneticists with national experience in genetic testing utilization management using evidence-based policies developed with trained genetic experts.

Under Highmark's Laboratory Management Program, eviCore will perform medical necessity reviews for select molecular and genomic tests performed in an outpatient setting. In addition, all claims associated with molecular and genetic procedure codes will be reviewed for accuracy and medical necessity, based on eviCore's policies.

Procedures Requiring Authorization

Prior authorization is required for certain outpatient, non-emergent molecular, and genomic testing, such as:

- Hereditary cancer screening
- Carrier screening
- Tumor marker/molecular profiling
- Hereditary cardiac disorders testing
- Cardiovascular disease and thrombosis risk variant testing
- Pharmacogenomics testing
- Neurologic disorders testing
- Mitochondrial disease testing
- Intellectual disability/developmental disorders testing

A complete list of impacted procedure codes is available at www.evicore.com/resources/healthplan/highmark. Once there, select **SOLUTION RESOURCES**, choose **Laboratory Management**, and then click **CPT CODES.**

Any services performed without prior authorization may be denied, and providers may not seek reimbursement from members.

Exclusions

Prior authorization is not required for the following:

- Inpatient genetic testing;
- General lab testing; or
- Genetic testing for CPT codes not included on eviCore's prior authorization list.

Applicable Products

Highmark's Laboratory Management Program applies to Highmark members with fully insured commercial, Affordable Care Act (ACA), and Medicare Advantage products.

The program is not applicable to traditional indemnity products, ASO (Administrative Services Only) accounts, National accounts, the Federal Employee Program (FEP), or BlueCard.

If you are uncertain whether a member's benefits require authorization for genetic testing under the Laboratory Management Program, you can call eviCore at **888-564-5492** for confirmation of prior authorization requirements for the member.

Requesting Authorizations

Highmark recommends that ordering physicians secure authorizations and pass the authorization numbers to rendering facilities at the time of scheduling. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different from what is authorized, contact eviCore for review.

Availity-enabled providers should use Availity to submit authorization requests. If you attempt to submit a request and receive a message to call eviCore, authorization may not be required under the member's benefit plan; the eviCore representative will assist in identifying the member and determining if authorization is needed.

If you are not Availity-enabled for authorization submission, you may use the eviCore Web Portal, available 24/7 at evicore.com, to request authorizations.

Authorizations are valid for 180 days. If the approved procedure is not completed by the Last Assigned Covered Day, a new request must be submitted.

Urgent Requests

If services are required in less than forty-eight (48) hours due to medically urgent conditions, please call eviCore at **888-564-5492** for authorization. Be sure to tell the representative that the authorization is for medically urgent care.

eviCore will make every effort to render a decision within one (1) business day of receipt of all necessary information.

Claim Submission & Reimbursement

Claims are submitted to Highmark following normal claim submission procedures, and you will receive reimbursement for eligible services from Highmark.

Claims Review Requirements

All claims associated with molecular and genomic procedure codes will be reviewed prior to payment for accuracy and medical necessity, based on eviCore's policies, and matched against the authorization, if applicable. **This review is not limited to those codes for which authorization is required**. A list of codes subject to claims review is available at evicore.com.

For More Information

For complete program information, please see the Laboratory Management Program page on the Provider Resource Center – select **Policues & Programs** then look under **Care Management.**
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4.5 Reporting Place of Service

Inpatient vs. Outpatient

When you submit claims to Highmark for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician's office, and is then returned to the hospital, the physician must report services according to the patient's status, in this case, inpatient. Therefore, you must report only "inpatient" as the place of service, rather than the place, such as "office" or "outpatient hospital," where the service actually was performed.
- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds, or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital-owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved to be recognized as an office practice.

For example, if a mobile ultrasound, MRI, or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

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4.5 Cost Sharing on Outpatient Diagnostic Services

Highmark offers optional benefit designs that include cost-sharing provisions specific to outpatient diagnostic services.

Services Affected

Cost sharing on outpatient diagnostic services will be applied to:

- Routine/preventive diagnostic services (with the exception of all mammograms and the annual routine Pap test), and
- Non-routine diagnostic services, including pre-admission testing.

Impacted Products

Products that may have a cost-sharing benefit design include Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) plans, including Medicare Advantage PPO.

Note: Cost-sharing provisions will not be noted on Member ID cards. Please review member benefits accordingly through Availity® or by contacting Provider Services if you are not an Availity-enabled provider.

Five Categories of Outpatient Diagnostic Services

Advanced Imaging Services:

- Advanced Imaging Services – include, but are not limited to, computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), and positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services:

- Standard Imaging Services – procedures such as skeletal X-rays, ultrasound, and fluoroscopy.
- Diagnostic Medical Services – procedures such as stress echocardiography, myocardial perfusion imaging (MPI), electrocardiograms (ECG), pulmonary studies, echocardiograms, electroencephalograms (EEG), regular treadmill stress tests, and audiology tests.
- Laboratory and Pathology Services – procedures such as non-routine Papanicolaou (Pap) smears, blood tests, urinalysis, biopsies, and cultures.
- Allergy Testing Services - allergy testing procedures such as percutaneous tests, intracutaneous tests, and patch tests.

How Coinsurance is Applied

If a member has coinsurance, it is applied to all line items identified as outpatient diagnostic services either on Advanced Imaging only or also on the four categories of Basic Diagnostic Services depending on the benefit design selected. The coinsurance amount (e.g., 80%) for the four categories of Basic Diagnostic Services is the same. Coinsurance for outpatient diagnostic services is applicable to the total component, technical component, and/or professional component only.

The member may be responsible for both a copayment and coinsurance when a service, such as an office visit or therapy service, and an outpatient diagnostic service are performed on the same date of service.

How Copayments are Applied

If a member has copayments on outpatient diagnostic services, they are applied per date of service and per type of diagnostic service. If services fall in more than one of the five diagnostic service categories (see above chart), multiple copayments can be applied. Please review the member's benefit program to determine if a copayment is owed on multiple services.

Copayments may be applicable to only the advanced imaging services or also to all four categories of basic diagnostic services. The copayment amount for the advanced imaging services would usually be a higher amount (e.g., $100). The copayment amount for the four categories of basic diagnostic services is the same (e.g., $25 for each type of service).

Copayments are applied to the total component or technical component claims for outpatient diagnostic services. Copayments are not applied to professional component only claims (26 modifier).

Please Note: For Medicare Advantage products with outpatient diagnostic copayments, copayments are applied per date of service, per type of diagnostic service, and per provider.

Examples of Multiple Copayments and/or Coinsurance

- If a PPO member sees his cardiologist and receives an EKG during the visit, he would be responsible for two copayments: an office visit copayment and an outpatient diagnostic service copayment for the EKG (diagnostic medical service).
- If a PPO member receives an MRI (advanced imaging service), then has a spinal X-ray (standard imaging service) and lab work (laboratory/pathology service) on the same day – all as outpatient services – she would be responsible for three outpatient diagnostic copayments.
- If an EPO member sees his cardiologist and receives a regular treadmill stress test (basic diagnostic medical service) while there, he would pay an office visit copayment, and then would be responsible for any applicable coinsurance when the stress test claim is processed.
- If a Medicare Advantage member with outpatient diagnostic copayments sees her cardiologist and receives an EKG (basic diagnostic medical service) while there and on the same day goes to another physician and receives a regular treadmill stress test (also a basic diagnostic medical service), she would be responsible for two copayments, one for each provider.

Cost Sharing Exceptions

- All mammograms (routine and medically necessary) and the annual routine Pap tests are generally unaffected by the cost sharing benefit designs.

- Diagnostic services performed in conjunction with an emergency room visit would not be impacted in most cases.
- There may be situations where cost sharing may apply in the first two situations, especially for self-insured employer groups. Please be sure to review each service on a case-by-case basis.

Determining if Members have Cost-Sharing

More information on outpatient radiology and other diagnostic services cost sharing can be easily accessed through Availity by selecting the appropriate service type, or by contacting the Provider Service Center if you are not a Availity-enabled provider.

To verify outpatient diagnostic benefits in Availity, select **Additional Benefit Notes** from the Eligibility and Benefits detail page.

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4.5 Disclaimers

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Unit 6: Prescription Drug Programs

4.6 Pharmaceutical Overview

Pharmacy Networks

The prescription drug program offers pharmacy networks that include national chains and many local independent pharmacies. Drug benefits may vary slightly depending on the member's group program. Pharmacies have point-of-sale technology that confirms a member's eligibility, benefit design, and copayment information at the time of dispensing.

Under most prescription drug programs, members must use one of the participating pharmacies in Highmark's pharmacy network associated with their benefit plan. To find a network pharmacy that is conveniently located to them, members may consult the pharmacy directory by visiting highmark.com or calling Highmark Member Service at the phone number shown on their identification cards.

Highmark also offers a home delivery mail service option to most members. Under this option, members can get a 90-day supply of medication through the mail.* For most prescriptions, the member can save on the cost of the medication when it is obtained via the mail service pharmacy.

**Under the Children's Health Insurance Program (CHIP) in Pennsylvania, members receive a 34-day day supply at the pharmacy and also through home delivery mail service.*

How to Use Highmark's Formularies

Highmark's drug formularies include a list of FDA-approved prescription drug medications reviewed by our Pharmacy and Therapeutics (P&T) Committee. The formularies are designed to assist in maintaining the quality of patient care and containing cost for the patient's drug benefit plan. Our P&T Committee approves revisions to the drug formularies on at least a quarterly basis; updates will be provided to reflect such additions.

After a minimum of thirty (30) days notification is given to providers, products are removed from the formularies at least twice per year -- on January 1 and July 1 and after brand medications become generically available. Practitioners are requested to prescribe medications included in the formulary whenever possible. Our Clinical Pharmacy Strategies department will monitor provider-specific formulary prescribing and communicate with providers to encourage use of formulary products.

The drug formularies are divided into major therapeutic categories for easy use. Products that are approved for more than one therapeutic indication may be included in more than one category. Drugs are listed by brand and generic names.

Providers can access Highmark's formularies on the Provider Resource Center. Select **PHARMACY PROGRAM/FORMULARIES** from the main menu.

Provider Appeal Rights

If you are a participating provider with Highmark and you disagree with the decision to deny authorization or payment of a prescription drug, you have a right to appeal that decision. Please see **Chapter 5.5: Denials, Grievances, and Appeals** for additional information.

Telephone Contact

For pharmacy benefit questions, the Delaware, Pennsylvania, and West Virginia Prescription Drug Department can be contacted at **800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.

Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York providers can reach the Pharmacy Call Center for pharmacy benefit questions at **866-264-4685** between 8:00 a.m. and 8:00 p.m., Monday through Friday.

For More Information

This unit provides a brief overview of Highmark pharmacy benefit programs. To access all policies and updates, select **Policies & Programs** from the main menu on the Provider Resource Center.
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4.6 Pharmaceutical Home Delivery

Home delivery service is a standard component of our prescription drug benefit. Members may call the Member Service telephone number on their identification card to obtain a mail order form.

Advantages of Home Delivery

Members may prefer to use the home delivery prescription service. This service enables most members to obtain up to a 90-day supply* at a discounted copayment compared to retail prescriptions.

**34-day supply for CHIP members in Pennsylvania.*

How to Assist Members with Home Delivery

If a member must begin taking a new maintenance drug immediately, you may need to write two prescriptions. The member can have one of the prescriptions filled at a local pharmacy to begin taking the medication immediately. The member can send the other prescription to the home delivery service.

How Members Can Enroll in-Home Delivery

Members can obtain mail-order forms for maintenance drugs by calling the Member Service telephone number on their identification card or by visiting their Highmark member website. They can reach their member website through our corporate website at Highmark.com. They would click on the orange **Consumers/Members/Providers** box, and then the appropriate link for their Highmark service area under **for Members**

Once a member places an order, the member's information remains on file. Any subsequent refills do not require an order form. For refills, the member can call the toll-free number, send in the refill form with the applicable copayment, or visit their Highmark member website.

As a convenience to patients, practitioners may fax prescriptions directly to Express Scripts. For details regarding how to fax a prescription to the mail-order pharmacy, please call Express Scripts at **800-903-6228.**

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4.6 Prescriptive Prescriber Authority

The Centers for Medicare and Medicaid Services (CMS), as well as various states, require that providers have the appropriate prescribing authority for any prescriptions they write. Prescribing authority is based on providers' data in the National Plan and Provider Enumeration System (NPPES).

Review, Certify, and Update your Data in NPPES

At least annually, review your NPPES data, make any necessary updates, and certify its accuracy to ensure your patients don't experience unnecessary delays and rejections on otherwise valid prescriptions.

To review your data in NPPES:

- Go to https://npiregistry.cms.hhs.gov/ and enter your NPI in the **NPI field**.
- Click on your **NPI number** to access your data record.
- Review your data for accuracy, and scroll to the bottom to the **Taxonomies** section to review your prescribing authority information, including your taxonomy code for your provider type.
- CMS provides a list of accepted taxonomy codes based on provider type. Note: If your taxonomy code is not one of the accepted codes for your provider type, prescriptions will be rejected at the point of sale.

To update and certify your data in NPPES:

- Go to https://nppes.cms.hhs.gov/ and log in using your user ID and password.
- Update your information as needed. This includes ALL address locations for where you practice and your taxonomy code for your provider type.
- Finalize any changes and follow the instructions to certify your information.

Prescriptive Authority Logic Applied for Medicare Part D Claims

Effective September 11, 2018, Express Scripts®, the pharmacy benefit management company that processes Highmark prescription drug claims, implemented state prescriptive authority logic within their pharmacy claims processing system for Medicare Part D claims.

If the Medicare Advantage prescribing practitioner does not meet the criteria determined by state law regarding assignment of correct taxonomy code(s) to their National Provider Identifier (NPI), Express Scripts will leverage the National Council for Prescription Drug Programs state-level prescriptive authority rejection reason code, 876.

This may mean that your patient's prescription will not be filled at the pharmacy if your NPI is not within compliant taxonomy code requirements. Highmark recommends that providers review taxonomy codes assigned to their NPIs and update taxonomy codes, if necessary. It is also recommended that you review this information annually and make updates as frequently as required.

Express Scripts Prescriber Taxonomy FAQ

To ensure continued member access and data accuracy, it is crucial that you be familiar with what taxonomy is, how it works, and that your NPI is associated with a valid taxonomy code that correctly reflects what you do.

Express Scripts' Prescriber Taxonomy FAQ provides the information you need to know about taxonomy codes, including instructions for updating your taxonomy code(s), if necessary. This document is also available on the Provider Resource Center— select **Policies & Programs** and look under **Pharmacy Programs.**

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4.6 Drug Management

Prescription Drug Management

The Pharmaceutical Management Programs (Clinical Management Programs) are designed to safeguard patients from potentially harmful drug interactions and side effects, optimize clinically appropriate therapy, promote appropriate prescription drug utilization, and promote compliance with recommended drug quantity, dosage, and intended use of product.

These programs bring together every individual or entity involved in the management and delivery of pharmaceutical care: plan sponsor, practitioners, members, and pharmacists. The programs are administered across all lines of business and are seamless across both retail and home delivery prescription drug benefit programs. These programs achieve this by:

- Identifying specific prescribing situations that may represent inappropriate utilization based on nationally recognized clinical practice guidelines or manufacturer's recommended dosages.
- Providing the appropriate clinical interventions and follow-up necessary with physicians and patients to foster more appropriate and effective use of prescription therapy.

Pharmaceutical Management Programs

Highmark's Pharmaceutical Management Programs include the following:

- Drug Utilization Review
- Quantity Level Limit Program
- Prior Authorization Program
- Managed Prescription Drug Coverage (MRxC) Program
- Formulary Management

Highmark's Pharmacy and Therapeutics Committee has approved all of these program policies. This committee is composed of network physicians and pharmacists who consider the safety, efficacy, and appropriate use of medications when reviewing these policies. Changes and updates to these criteria are distributed quarterly to all network providers via a formulary update.

Please select **Policies & Programs** from the main menu on the Provider Resource Center to access all policies and updates.

Medical Nesessity Criteria for Drug Management

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity," or such other comparable term in any provider contract shall mean health care services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
3. not primarily for the convenience of the patient or the provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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4.6 Medical Injectable Drugs Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Highmark has a streamlined program through which network physicians must obtain certain medical injectable drugs. Highmark has engaged Free Market Heath and their innovative technology platform to match each prescription with the best fit in-network pharmacy for the referral.

Drugs Included in The Program

Highmark provides a list of drugs included in the program that is reviewed regularly and updated as needed.

This list is also available on the *Provider Resource Center* by selecting **Policies & Programs** from the main menu, click the **Free Market Health** link, and then select the **List of Eligible Drugs in the Program** link. On the program page, you will also find additional information, including a list of in-network Free Market Health pharmacies and guidance on how the program works.

Certain Drugs Require Authorization

Certain drugs on the Medical Injectable Drugs Program list require authorization. To determine if a drug from the program's list of drugs requires authorization, please refer to Highmark's List of Procedures/DME Requiring Authorization.

This list is also available on the Provider Resource Center under **Claims & Authorization.**

Ordering Drugs

Once an approved authorization is submitted for a drug on the List of Eligible Drugs Included in the Program, Free Market Health receives the patient referral for management* Free Market Health then orchestrates Highmark's program configuration, including ensuring referrals are assigned to participating

specialty pharmacies to maintain continuity of care, based on specific patient care needs and health plan program design.

Once a specialty pharmacy is assigned the referral, they will reach out to obtain the prescription. This pharmacy is assigned by Highmark to service the referral, and prescribers should provide the prescription as requested.

***NOTE:** If the authorization request is approved to be administered via a "Buy & Bill" scenario (drug procured and billed to Highmark by prescriber for outpatient/office administration), the member's drug referral will not be assigned through the Free Market Health program.

BlueCard® Patients

When treating out-of-area BlueCard® patients, providers can order certain injectable drugs for office administration for these patients. You may also choose to purchase and bill Highmark directly for injectable drugs for BlueCard patients, in which case you will receive reimbursement based on your contracted rate.

Obtaining Authorization

Authorizations must be obtained by the prescribing physician. Authorizations can be sent through Availity or faxed to Highmark for approval. To fax an authorization, go to the Provider Resource Center under **Resources & Education** and look under **Forms**. If a prescriber has access to the Real Time Auth (RTA) tool, Free Market Health accepts authorizations through RTA. If you do not have access to RTA and believe you are eligible, email RTA-enrollment@freemarkethealth.com

Hospital Guidelines

In circumstances where the ordering physician directs the member to the hospital for the drug and/or its administration, the following must be considered by the facility:

- Some drugs on the Medical Injectable Drug Program list require authorization. Only the ordering physicians, who have access to the member's clinical information, can obtain the authorization

through Highmark, regardless of where the drug is administered. Physicians are instructed to identify if the drug is to be administered at a facility in the outpatient setting so that the facility name can be added to the authorization record.

- If the facility receives an order/request to administer a drug to a Highmark member that is included in the Medical Injectable Drugs Program and requires authorization, the facility should verify that an authorization exists for the facility to provide the drug and/or the administration. Please check Availity to determine if the physician has obtained authorization.
- If an authorization is not present, please contact the ordering physician who must contact Highmark to obtain an authorization.
- The facility is not expected to obtain authorization for either the drug or its administration. However, if the facility administers and/or provides a procedure that requires authorization and an authorization does not exist, the facility claim will reject. If the facility claim is denied, a retrospective authorization request must be initiated by the ordering physician.
- Highmark will reimburse the facility for the drug and/or the administration when the authorization has been granted.

For More Information

Please refer to the **Free Market Health** page on the Provider Resource Center for additional information.
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4.6 Prescription Drugs for Medicare Advantage Hospice Patients

For providers in Pennsylvania and West Virginia

On March 10, 2014, the Centers for Medicare & Medicaid (CMS) issued guidance on payment for drugs under the Medicare Part A Hospice Benefit and Part D Prescription Drug Benefit for beneficiaries enrolled in hospice.

The goal of this guidance was to ensure that the hospice and Part D programs correctly pay for prescription drugs covered under each respective Medicare benefit while ensuring timely access to

needed prescription medications.

Drugs and/or Biologicals Covered Under Mediare Part A Hospice Benefit

For providers in Pennsylvania and West Virginia

The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. Drugs and/or biologicals that are necessary for the palliation and management of the terminal illness and related conditions are the responsibility of the hospice provider. They are appropriately covered under the Medicare Part A Hospice Benefit rather than the Part D Prescription Drug Benefit.

Drugs that were used prior to a Medicare Advantage member's hospice election will be covered under the Medicare Part A Hospice Benefit only if those drugs will continue as part of the hospice plan of care and are necessary for the palliation and management of the terminal illness or related condition.

If any of a member's existing medications are determined unreasonable or unnecessary for the palliation of pain and/or symptom management by the hospice interdisciplinary team, these medications would not be covered under the Medicare Part A Hospice Benefit. If the member still chooses to have these medications filled at the pharmacy, the medications are not covered by Part D and payment for these medications becomes the member's responsibility.

Maintenance Drugs

For providers in Pennsylvania and West Virginia

After hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis. These maintenance drugs would be the responsibility of the hospice provider and covered under the Part A Hospice Benefit.

Drugs Eligible Under Part D

For providers in Pennsylvania and West Virginia

For prescription drugs to be eligible under the Part D Prescription Benefit when a member elects hospice, the drug(s) must be for the treatment of a condition that is completely unrelated to their terminal illness and/or related conditions. These drugs continue to be subject to standard Part D formulary management practices, including quantity limitations, step therapy, and prior authorization.

Authorization Requirements for Select Part D Drugs

For providers in Pennsylvania and West Virginia

When a Medicare Advantage member is in a hospice election period, Highmark requires prior authorization for six categories of drugs to determine coverage eligibility under the Part D Prescription Benefit:

• Analgesics	• Antieoplastics
• Anticonvulsants	• Anxiolytics (antianxiety)
• Antiemetics (antinauseants)	• Laxatives

The prescription medications must be for the treatment of a condition that is completely unrelated to the member's terminal prognosis or related condition. Hospice providers are expected to maintain a record of the clinical basis for the statement that the drug is unrelated and provide it upon request. In documenting Part D coverage of the drugs designated to require authorization, a statement indicating that the drug is unrelated to the terminal illness and related conditions is sufficient.

Highmark's **Medicare Part D Hospice Authorization Information Form** can be completed by a member's representative or the prescribing physician to initiate the prior authorization process. Per CMS guidelines, a hospice provider cannot request a coverage determination on behalf of the member.

This form can be accessed on the Provider Resource Center by selecting **Policies & Programs** then **Pharmacy Programs.**

Highmark Pharmacy Policy J-30

For providers in Pennsylvania and West Virginia

Please see Pharmacy **Policy J-30: Administrative Prior Authorizations for Medicare Part D Plans** – Medicare for Highmark's policy on Part A vs. Part D coverage determinations for members in hospice.

To access Highmark Pharmacy Policy on the Provider Resource Center, select **Policies & Programs** from the main menu, and then **Pharmacy Programs.** You'll find a link to the search on the landing page.

Hospice Termination or Revocation

For providers in Pennsylvania and West Virginia

In the event of hospice termination or revocation, documentation is to be submitted to Highmark by the hospice facility, member, or prescriber to confirm that the member is no longer receiving the hospice benefit. Highmark will accept any of the following documentation:

- Written statement of revocation
- Notice of Medicare Non-Coverage
- Copy of the Hospice Discharge Summary

Upon receipt of this documentation, Highmark will remove the Part D prior authorization requirement for the member (unless a new hospice period start date is reported).

Auto-Shipment Under Part D

For providers in Pennsylvania and West Virginia

If a member is receiving Part D prescriptions through auto-shipment prior to electing hospice, auto-shipment is required to be promptly discontinued after the member has elected hospice.

Coordination Between Hospice and Part D Plan

For providers in Pennsylvania and West Virginia

Coordination of benefits between hospice providers and the Part D plan is required to further ensure appropriate payment for drugs under either the Medicare Part A Hospice Benefit or the Part D Prescription Drug Benefit.

Due to delays in notification of a member's hospice election, Part D plans may pay for a hospice drug claim prior to knowing that hospice coverage was in effect for the date of service. Hospice providers are expected to cooperate with the Part D plan when seeking recovery for claims paid incorrectly under Part D.

For More Information

To learn more about hospice benefit election, please see the *Highmark Provider Manual's* **Chapter 2.2: Medicare Advantage Products and Programs.**

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4.6 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc.,

Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

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Unit 7: Medical Records Documentation Requirements

4.7 Medical Records Overview

Highmark makes every effort to provide resources to assist providers in servicing our members and working with us. This unit of the manual was developed to provide guidelines for documenting members' medical records that will help you to have the appropriate documentation readily available for medical necessity reviews. This will help us to ensure accuracy of billed claims data and, therefore, prevent delays in reviews and payment.

The content herein provides minimum standards for medical record detail necessary to document and support claims for services rendered to members. It is the provider's responsibility to adhere to professional standards, as well as applicable laws, regulations, and directives, with respect to medical recordkeeping and when such obligations are not addressed in this Unit.

Please note that examples included within this Unit are general in nature.

Purpose of a Medical Record

A medical record must clearly document the medical care provided to a member. Medical record documentation is necessary to record applicable observations and findings regarding the member's history, examinations, diagnostic tests and procedures, diagnoses, treatments and treatment plan, necessary follow-up care, and outcomes or responses to care per date of service or encounter.

Additionally, the medical record serves as a formal document and a communication tool between providers, vendors, and Highmark. All medical documentation must be maintained in the member's medical record and, if requested, made available to Highmark or its contracted vendor by the requested date.

Benefit Applictaion

Coverage guidelines are determined according to individual or group customer benefits. All services reported for Highmark members must be supported within the medical record and all claims may be subject to medical review.

You should not routinely submit this documentation with your claims, except in circumstances when required. However, if requested, medical documentation must be made available to Highmark or its contracted vendor.

The medical record is expected to include such information as noted above and defined in the provider requirements within this Unit. Reimbursement may be denied for services that are not clearly documented within the member's medical record.

Medical Record Retention

Providers are required to retain all records, including medical records, in accordance with the provider's participation agreements and Highmark's administrative requirements, as well as all applicable state and federal laws, Regulations, and governmental program requirements.

Important!

For providers in New York

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) providers are required to maintain records in accordance with prudent record-keeping procedures and as required by practice standards and law, but in no event shall any medical records be retained for less than six years for audit covered per and, with respect to minor covered persons, three years from majority or six years from the date of majority, as applicable, following termination or for such longer period as may be required by law.

Audits

All claims submitted, including those for risk adjustment and quality review purposes, are subject to internal and/or federal audit.

- Audits may be initiated by Highmark, the Centers for Medicare & Medicaid Services (CMS), National Committee on Quality Assurance (NCQA), or Health & Human Services (HHS) to determine accuracy and completeness of documented medical records.

- Providers are required to respond to all medical record requests in a timely manner and provide identified records.
- Providers are required to notify Highmark or file a corrected claim for any submissions they identify as erroneous.

Reminder: Refer Members to Network Participating Providers

Highmark contracted providers are strongly encouraged to refer members to providers participating in the member's network. This protects the member from higher costs that may be incurred if services are received from a non-network provider.

If an out-of-network referral is necessary, the reason for the referral to an out-of-network provider must be documented in the member's medical records.

For More Information

Please refer to Highmark's Medical Policies and Reimbursement Policies for additional information. These can be accessed by selecting **Policies & Programs (Medical Policies)** or **Claims & Authorization (Reimbursement Policies)** on the Provider Resource Center.

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4.7 Electronic Health Records

Electronic health records (EHRs) can help providers better manage care by enabling quick access to accurate, up-to-date, and complete information about their patients at the point of care. They also promote complete and legible documentation to improve productivity and efficiency in coding and billing.

Cloning and Copying Forward Not Permitted

Providers must ensure that every entry is accurate and unique to the individual member. Functions such as cloning, copy and paste, cookie cutter, copy forward, and carrying forward are similar in that using

these features has the potential to create inaccuracies in documentation by using the same language from member to member.

Highmark strongly discourages cloning and copying forward because utilization of canned statements within the EHR may not reflect accurate clinical determinations if not reviewed carefully, as they may lead to the following issues:

- Potential for a false description of services rendered to the member
- Potential for medical errors by using outdated or inaccurate information
- Coding from old or outdated information may result in inaccurate coding

Inconsistencies as a result of cloning, copying, or pasting found during the review of a member's medical record may result in denial of the claim.

Authenticate Records

Providers must authenticate records that have been written by others, especially when another individual (such as a scribe) types the documentation into the EHR. Errors may not be identified when the responsible providers signs the record without reading the content thoroughly.

Use of Addenda

Delayed entries within reasonable time frames may be appropriate for clarification, error correction, or for the addition of information not available at the time of the initial entry.

However, addenda are not to be used to add services reported at the time of the initial service or to retrospectively add information to justify medical necessity. In addition, using addenda to enhance documentation can cause medical records to be altered inappropriately.

Amending The Medical Record

If it is necessary to amend a medical record, the **original documentation should not be deleted.** Retain and clearly identify all original content.

Any edits to the medical record must be clearly and permanently identified as such – as an amendment, delayed entry, or correction.

- Document whether the edit is an amendment, delayed entry, or correction.
- Indicate the date and author of all changes, corrections, and delayed entries.

Signatures

Legible dates, times, signatures, and credentials are required from each person (physicians, scribes, residents, nurses, etc.) who updates, reviews, and/or approves the medical record. Signatures are also required for the addition of any other pertinent information to ensure the validity of the data.

In addition, signatures must include the credentials of the performing provider. Hard-copy records must be signed (electronic signature is also acceptable) on each page by the person providing the service.

Audits

For audit purposes, ensure all required documentation is sent in by the request date and ensure the EHR software is identified.

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4.7 Documentation Requirements for All Providers

All providers are required to comply with the following requirements and include the information below, as applicable, in a member's medical records in order to support a claim for reimbursement of services.

Failure to comply with the requirements and provide the requested information may result in a denial of authorization or reimbursement for services.

Confidentiality

Medical records must be stored and maintained to fully protect the confidentiality, integrity, and safety of the member's information.

For providers in New York

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) will preserve the confidentiality of the member's health and medical records consistent with the requirements of applicable New York State and federal law.

Medical Record Orgnization

Sections within the medical record must be organized in a consistent manner.

- All entries are legible.
- All entries are dated and timed.
- All entries must be signed or initialed by the author, with his/her title, credentials, and specialty.
- Member identifiers must be included on every page of documentation.
- All member encounters, including telephone, fax, and electronic message exchanges, are documented.

Medical History

The initial physical examination and the member's medical history are to be recorded at the initial visit for new members. For members younger than six years old, medical record birth history must be included in the child's medical records.

Prior medical history is documented to include any serious accidents, operations, and illnesses. In addition, family medical history is to be included in the medical record.

Medications,Allergies,and Problems

The following must be documented prominently in the member's medical record and updated as necessary:

- Medications currently taken and all newly prescribed medications
- Allergies and/or adverse reactions; or display “None” or “NKA” if no allergies are known
- Current and updated problem list

FDA Label Restrictions

Medical records must include documentation of weight and date of birth for prescribed medications as required by the Food and Drug Administration (FDA).

Member Encounters

For all member encounters, including telephone, fax, and electronic message exchanges, ensure that the following are clearly documented:

- Member’s chief complaint or purpose for each visit/encounter
- Clinical assessment and/or physical findings (ensure working diagnoses are consistent with these findings)
- Treatment plans and goals (ensure treatment plans are consistent with the recorded diagnosis code/s)
- Any unresolved problems from prior visits are addressed
- Follow-up instructions and necessary follow-up appointments

Treatment Options

All treatment options, conservative or alternative, are to be documented in the member’s medical record as required by Highmark Medical Policies.

Coordination of Care

Primary care physicians and specialists, including medical, surgical, and behavioral health, must communicate with one another. The exchange of information in an effective, timely, and confidential manner promotes appropriate diagnosis and treatment.

The coordination of care between primary care and specialty care providers or other practitioners is to be documented within the member's medical record.

Coordintion of Care Timefrmes

For providers in New York

Time frames for this information exchange shall be within 30 calendar days of initial assessment; annually if concurrent care continues for more than 12 months, or more frequently if the member's clinical condition or treatment changes significantly and within 7 calendar days of medication change. The guidelines are supported by New York State Mental Health Law, New York State Public Health Law, Centers for Medicare & Medicaid Services (CMS) standards, and the National Committee for Quality Assurance (NCQA) Standards for Accreditation and HIPAA regulations.

Diagnostic Testing and Results

When services are provided by an external provider (e.g., radiologists, labs, referrals, consultations), the documentation they provide, including follow-up letters, are to be included in the member's medical record.

Laboratory and diagnostic testing results must be signed by the practitioner to acknowledge that they have been reviewed. Review of diagnostic services must include the CPT codes of the diagnostic test(s) reviewed.

In addition, the documentation must confirm that the member was notified of diagnostic testing/laboratory results and the practitioner's follow-up recommendations.

Time-Based Codes

Start and stop times and total time must be documented within the medical record when time is a required factor for reporting services.

Examples include, but are not limited to: anesthesia services, physical medicine services, screening services, prolonged services, observation services, critical care, discharge day, etc.

NOC CPT/HCPCS Codes

When a Not Otherwise Classified (NOC) CPT or Healthcare Common Procedure Coding System (HCPCS) code is billed:

- The service provided cannot have an exclusive CPT or HCPCS code, which defines the service rendered.
- A detailed description of the service or item provided must be included within the medical record.

All Codes on Claim Must Be Substantiated

All CPT, HCPCS, and ICD-10 codes reported on the claim must be substantiated within the member's medical record.

Amending the Medical Record

If it is necessary to amend a medical record, **the original documentation should not be deleted.** Retain and clearly identify all original content.

Any edits to the medical record must be clearly and permanently identified as such — as an amendment, delayed entry, or correction.

- Document whether the edit is an amendment, delayed entry, or correction.
- Indicate the date and author of all changes, corrections, and delayed entries.

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4.7 Additional Requirements to Support E/MService

Coding Guidelines for E/M Services

As of Jan. 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time. Since January 2021, this change has been in effect for New Patient or Other Outpatient Services, and Established Patient or Other Outpatient Services.

Please access the Highmark Provider Resource Center's (PRC's) Documentation Guidelines for Evaluation and Management Services page, which provides guidance based on the date of service as well as the type of E/M service rendered. Auditor's Scoring Worksheets utilized by Highmark are also available on this PRC page.

All services performed and the diagnosis(es) related to the visit must be documented in the member's medical record.

Seperately Billed E/M Services

Separately billed E/M services following a procedure within a global surgical period must be supported in the member's medical record.

Critieria That Must Be Documented

To ensure accuracy of diagnosis coding, the following criteria, as applicable to the visit, must be documented in the medical record:

- Laterality (left vs. right)
- Specific location of injury, pain, or disease
- Condition status (acute, chronic, chronic intractable, recurrent, controlled, uncontrolled, etc.)
- Date of occurrence of injury or symptoms
- Fracture type (e.g., open or closed, displaced or non-displaced)
- Stage of condition (e.g., decubitus ulcer stage)
- Weeks/trimester of pregnancy
- Congenital conditions
- Illness phase (e.g., dysphagia, pharyngeal phase)
- Encounter status (initial, subsequent, sequela)

This list is not an all-inclusive list; additional criteria may be necessary based on the reason for the visit.

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4.7 Hospital/Facility Services

This section provides medical records documentation guidelines for services provided to members at a hospital or other facility as an inpatient, outpatient, or for emergency department care.

Hospital Medical Record

Documentation in the member's hospital medical record for inpatient, outpatient, and emergency department visits must include the intake of the member's history and physicals performed at the time of admission or visit.

The medical record should also include, but is not limited to, the following as applicable:

- Physician orders
- Provider's progress notes
- Consultative physician notes and records
- Laboratory and diagnostic imaging
- Medications ordered and administered
- Immunization records
- Diagnosis codes consistent with laboratory or diagnostic services
- Critical or preventable serious adverse events (PSAE)
- Documentation of restraint usage
- Risk of treatment outcomes
- Member responsibility of services (e.g., Notice of Denial of Medical Coverage)
- Authorization requests such as, but not limited to, Availity® with information to justify admission
- Referrals to other providers
- Reason(s) why a service was discontinued or not started

Attending Physician's Progress Notes

Countersignatures by the attending physician of another physician's orders or notes are not acceptable documentation of the attending physician's services. A countersignature must be supplemented by the attending physician's own progress notes.

Visit on Day of Discharge

When a claim for a hospital visit is billed on the same day as discharge, inpatient progress notes must support the reason for the visit.

Discharge Summary

The hospital discharge summary must contain the following:

- Reason for hospitalization
- Significant findings
- Procedures
- Treatments provided
- Member discharge condition
- Discharge orders
- Member education
- Discharge planning notes, including all options and/or facilities discussed with member and/or caregivers
- A written plan of care that is multi-disciplinary and is updated throughout continuum of care

Acute Care Transfers

If an acute care transfer, the rationale for the transfer must include:

- Name of facility/hospital
- Arrangements to facilitate transfer
- MD orders and updates for actual services rendered with time and dates for all inpatient and/or observation stays
- A written plan of care that is multi-disciplinary and updated throughout the continuum of care

Post-Acute Provider Referrals

Documentation for post-acute provider referrals must include MD orders and updates for actual services rendered. The MD's orders must include time and dates for all inpatient and/or observation stays.

In addition, a written multi-disciplinary plan of care must be included and updated throughout the continuum of care.

Consultations

Requests for consultations must be documented within the member's medical record. Consultations must be ordered and documented by the attending physician.

The consultation reports must be dictated and typed or handwritten, and they must contain the signature of the physician who performed and reported the consultation.

Services Renderd By Hospital Interns and Residents

Services rendered by interns, residents, or any other hospital/facility employee under the supervision of the attending physician may be reported by the attending physician. The care must be documented and signed by the attending physician in the progress notes, or other pertinent records, reflecting the level of medically necessary care.

Surgical Procedures

The medical record must contain all relevant information related to performing the surgical procedure, including but not limited to:

- Pre- and post-operative diagnosis(es) codes
- Implant/device make and model numbers
- Comprehensive list of procedure(s) performed
- Any techniques used to perform the procedure(s)

The performing physician's name and all assistants' names are to be recorded in the operative report. When a procedure(s) requires the services of two surgeons or a surgical team, documentation must clearly establish that each surgeon performed distinct and separate components in a team fashion.

The operative report must indicate the name of the anesthesiologist(s), certified registered nurse anesthetist(s) (CRNAs), and/or anesthetists who performed the anesthesia services.

Please refer to Highmark's medical policies and reimbursement policies for more information. Highmark **Medical Policy and Reimbursement Policy** are both available on the Provider Resource Center**.**

Global Obstertical/Surgical Care

When a global service is reported, all pre- and post-operative/obstetrical care must be recorded in the member's medical record.

Minor surgical procedures can be described in the progress/office notes and must be signed by the provider reporting the service.

Evidence of conservative measures taken should be noted, if applicable.

Anesthesia

The operative and anesthesia reports both must indicate the name of the anesthesiologist(s), CRNA(s), and/or anesthetists who performed the anesthesia services.

Start and stop times and number of units provided must be clearly documented.

Pre-and post-operative evaluations or other encounters with the member must be documented in the medical record. This is important when monitoring members who are in active labor or who post-operatively require additional anesthesia services.

When an anesthesiologist is supervising one or more anesthetists, the supervising physician's presence and interventions must be recorded on the anesthesia record.

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4.7 Ancillary Services

Ambulance

When transporting a Highmark member by ambulance, the following information must be documented and maintained in the member's medical records:

- Member identifying information (name, Member ID, address)
- Date of service
- Point of origin/destination
- Total mileage
- Beneficiary or authorized representative signature
- Records from hospital/facility noting need for ambulance and medical necessity of transport
- Legible documentation signed by the primary attendant which includes, but is not limited to, a detailed trip sheet

If the member was transported beyond the closest facility, the reason for doing so must be contained in the medical record. In addition, the reason for transport by air ambulance instead of ground ambulance must be documented.

For additional information about ambulance services, please see Highmark Medical Policy. Medical Policy can be accessed on the Provider Resource Center by selecting **Policies & Programs.**

Diagnostic X-Rays and/or X-Ray Reports

Relevant and/or current records from the prescribing physician's office (e.g., office notes, history and physical, labs, etc.) can serve as supporting documentation of medical necessity for the service provided by a radiology provider.

The radiology provider must also document the following in the member's medical record:

- Member name, Member ID, date of service
- Name of provider performing and interpreting the study
- Clear directional markers
- Specific description and diagnosis of X-ray findings

- Radiology reports for all services billed
- Overall treatment plan

When billing for travel allowance, documentation pertaining to travel expenses should also be included.

Dialysis

For dialysis services, the member's medical record should include the member's name, Member ID, and the date of service.

In addition, the records should include the following:

- Dialysis Flow Sheets
- Medication Record(s)

Hospice

For hospice care, the documentation must include the following:

- The date the plan of care is established, which must occur prior to the member beginning hospice
- The date the hospice plan is initiated

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4.7 Psychiatric Care, Psychotherapy, and Counseling

When psychiatric care, psychotherapy, and counseling services are provided, medical records documentation must include the requirements identified below.

Note: Psychotherapy notes should not be included in the medical records.

Date of Service and Provider Information

The date of service must appear prominently within the member's medical record. The documentation must include the identity and legible signature of the person administering the service on that date. The

provider's certification(s) must also be documented. If applicable, the referral source must be indicated.

History

The member's psychiatric hospitalizations and associated diagnosis(es) must be included in the medical records along with the treatment obtained and the results of each hospitalization.

In addition, a family psychiatric history, including any hospitalizations and associated diagnosis(es) codes, should also be included. Family history should also include successes with specific medications.

Observations and Type of Therapy

Observations of the member during the intake should be noted in the medical records. The type of therapy must be contained in the medical records for each session, along with content of the session and the therapeutic techniques and approaches used.

For interactive therapy, the member record must indicate the adaptations utilized in the session and the rationale for using a specific technique.

In addition, an assessment of the member's ability to adhere to the treatment plan, as well as any treatment failures, should also be documented.

The time spent during an encounter with the member, informant, and/or the family must be legibly documented in the member's medical records. Also, start/stop times must be documented within the medical records for all time-based codes.

Diagnoses

The diagnosis(es) must be clearly documented and the clinical presentation, which supports the diagnosis, noted.

Documentation supporting a multiaxial diagnosis must be included, if applicable.

Medications

Any medications that the member is currently taking and all newly prescribed medications must be documented.

If there are any changes in medications or an adjustment in dosage of a medication already prescribed, the rationale for the change or adjustment needs to be clearly documented.

Progress and Follow-up

Note(s) indicating the member's status and/or progress must be contained within the medical records documentation. In addition, follow-up instructions provided during the encounter must be included.

When E/M is Provided

When evaluation and management (E/M) is provided:

- Providers are to clearly separate and document the time spent for the E/M service and time spent for psychiatric, psychotherapy, and/or counseling services.
- E/M documentation guidelines apply as outlined in the E/M section of this Unit.
- The psychotherapy service must be "significant and separately identifiable."

When psychotherapy is performed in addition to an E/M, the level of the E/M chosen must reflect the work performed and not the amount of time spent providing counseling and coordination of care.

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4.7 Opioid Addiction Management

Controlled Substance Programs

Prior to dispensation of a controlled substance, dispensing providers are required to enroll or query the member in a controlled substance program for their respective service area. The enrollment must be documented in the member's medical record.

Click on the appropriate link below to access the login page for the program for the member's service area:

- **Pennsylvania:** Prescription Drug Monitoring Program (PDMP) at: https://pdmp.health.pa.gov/PDMPSystemApp/
- **West Virginia:** Controlled Substance Automated Prescription Program (CSAPP) at:https://www.csappwv.com/Account/Login.aspx?ReturnUrl=%2f
- **Delaware:** Delaware Prescription Monitoring Program (DPMP) at: https://dpr.delaware.gov/boards/pmp/
- **New York:** Office of Addiction Services and Supports at:
  - https://oasas.ny.gov/
  - https://commerce.health.state.ny.us

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4.7 Diagnostic and Therapeutic Testing

When tests are performed, all reasons for the testing as well as test results/findings must be documented in the member record and signed by the ordering physician. This applies to laboratory, pathology, radiology, cardiology, and other ancillary or machine testing services.

Medical Record Documentaion

All diagnostic and therapeutic services for which a member was referred by a practitioner must be maintained in the member's medical record records. This includes, but is not limited to:

- Home health nursing reports
- Specialty physician reports
- Hospital discharge reports
- Physical therapy reports
- All computer-generated test data results

For diagnostic testing, including laboratory and radiology, the ordering provider must maintain a copy of the request as part of the member's permanent medical record. Additionally, the performing provider must also have a copy of the request on file in the member's medical records.

Highmark does not permit standing orders for diagnostic testing.

Testing Interpretation

When a testing interpretation code is used, the medical record must contain a documented report signed by the physician who reported the service.

Travel Expenses

Travel expenses may be billed for some diagnostic services. Documentation pertaining to all travel expenses must be included in the member's medical records.

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4.7 Therapy Services

This section provides medical records documentation guidelines for therapy services, including: physical therapy; occupational therapy; speech therapy; chiropractic care; and acupuncture.

Requirements

The following items must be documented within the member's medical record when treatment, manipulation, or therapy is provided:

- Member name
- Member ID number
- Date of service
- Member's complaint
- Diagnostic studies and results
- Results of previous treatments
- Planned treatments and/or diagnostic studies

A clear description of the type of treatment provided, including the body region(s) treated, must be included in the documentation. In addition, an assessment or physical findings to support the therapeutic treatment or manipulation provided must also be included.

Associated updates to the treatment plan based on changes in the member's condition must be noted. The medical records documentation should also include a post-treatment evaluation of the member's response to the treatment or manipulation.

Physical Exams

When physical exams are performed, document the exams separately from the therapy or manipulation and indicate whether the exam is one of the following:

- Initial examination of a new member or condition;
- Re-examination of a new member within an episode of care to assess member progress, current clinical status, and determine the need for further medically necessary therapeutic level of care; or
- Acute exacerbation of symptoms or significant changes in the member's condition, which are distinctly different indications from original treatment plan.

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4.7 Durable Medical Equipment, Prosthetics, Orthotics, & Supplies

Highmark-contracted providers are strongly encouraged to refer members to providers participating in the member's network. This includes referrals for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Reasons for referrals to out-of-network providers should be documented in the medical record.

Highmark Medical Policy

Providers are reminded to refer to the pertinent Highmark Medical Policies when referring members for DMEPOS or submitting claims for DMEPOS.

BOTH the referring physician and the DMEPOS supplier are to comply with Highmark Medical Policies (e.g., the supplier should ensure that the referring physician's order is appropriately completed by the physician).

Dispensing Prescriptions

When dispensing prescriptions, the following requirements must be met:

- Must comply with all state prescribing and/or other laws.
- A copy of the physician order must be maintained in the medical record and contain a description of the item to be dispensed.
- The supplier may write the Detailed Written Order (DWO) or Written Order Prior to Delivery (WOPD), however, the prescribing physician must review, sign, and date prior to delivery/billing of services.
- Prescription must be dated prior to delivery date.
- Length of time item is indicated for use and updated every six months.
- Standing orders are not permitted and should be written specific to the member's condition, unless otherwise stated in relevant medical policy.

Prescriber

The ordering physician must document the member's medical record, at a minimum, with the information below. Additional policy requirements may apply for certain DMEPOS.

- Description of DMEPOS prescribed
- Length of time DMEPOS is indicated for use and updated every six months
- Documentation to support why item continues to remain reasonable and customary for ongoing supplies
- Date of face-to-face examination
- Date and results of trial period when required by Medical Policy
- A copy of the prescribing physician's order, including NPI
- Indication of laterality

- Risks and benefits of use

Supplier

The DMEPOS supplier's documentation must contain, at a minimum, the information below for all billed DMEPOS. Additional policy requirements may apply for certain DMEPOS.

- Description of DMEPOS prescribed
- Copy of the physician's written order
- Indication of laterality
- Indication of trial period, if required (see additional information below)
- Documentation referencing the actual DME dispensed; the packing slip is to include the following information:
    - Member's name
    - Description of the DMEPOS or the full HCPCS description code
    - Quantity
    - Brand name of item
    - Model and serial numbers
    - Date dispensed

Manufacturer Order Forms

If a prescribing provider or a supplier orders from a manufacturer for a specific type of DMEPOS, the manufacturer order form must be included with the medical records and complete with all pertinent patient information:

- Patient name, date of birth, address, date of order, laterality of prosthetic/orthotic ordered;
- All pertinent practitioner information:
    - Name, credentials, address, facility (if applicable); and modifications/customizations to be clearly documented and detailed related to item ordered.

Customization and Modifications

- Documentation within the medical records of the clinician's and/or DME, prosthetic, or orthotic fitter's notes to list all modifications made based on the member's condition.

- Documentation within the medical records of the clinician's and/or DME, prosthetic, orthotic fitter's notes is required to state how the DME, prosthetic, or orthotic was customized to meet member need as indicated by the prescriber's order.

Supplier's Proof of Delivery

Proof of delivery documentation must be maintained in the supplier's records and include the information below:

- Member's name
- Laterality, where applicable
- Detailed description to sufficiently identify the item(s) being delivered
- Quantity delivered
- Delivery date or shipping date if a delivery service is used (will be the official date of service for the claim)

The member or the member's representative (e.g., relative, neighbor, nursing home, etc.), who does not have a financial interest in the company supplying the DMEPOS, must sign to indicate the DMEPOS was received.

The member's medical record must include the printed name and signature of the member or the member's designated recipient. If the recipient is someone other than the member, the designated recipient's relationship to the member must also be noted.

Trial Periods

Please note that DMEPOS suppliers are NOT permitted to have providers and/or members attest that a trial period has occurred. If the supplier is relying on a trial period performed by another provider, the supplier is to document the name of the provider and the dates of service when the trial period occurred.

If the supplier is unable to discern whether or not a trial period occurred, the DMEPOS supplier is required to perform a trial period prior to submitting a claim for a purchase.

Refills to the Original Order

The following apply for refills to the original order:

- Supplier is required to contact the member prior to dispensing the refill to ensure the refill is necessary and document the member requested supplies.
- Suppliers must have documentation, available upon request, to demonstrate contact with the member to ensure the refill remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order prior to delivery or shipment of the product.
- Contact must be made and documented within the member's record no sooner than two weeks (14 calendar days) prior to the delivery/shipping date.
- Supplier shall deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.
- Suppliers must not dispense a quantity of supplies exceeding the member's expected utilization.
- Suppliers must stay attuned to changed or unusual utilization patterns; suppliers are required to contact, verify, and document any changes or unusual utilization patterns with the prescribing physician.

Additional Prosthetics Guidelines

For prosthetics, the expected member functional ability information must be clearly documented and retained in the prosthetist's records and made available upon request.

The following information must be included within the member's medical record for all prosthetics:

- Member name
- Member ID number
- Date of serviceMember's past history
- Member's current condition to support the designation of the functional level
- Member's expected functional capabilities to support the use of modifiers K0-K4
- Amputation side (laterality) clearly and consistently identified — especially for bilateral members
- Member's desire to use the new prosthesis, or ambulate (if for lower extremity)
- Recommendation for the new prosthesis/component(s) and rationale for decision\

Microprocessor-Controlled Prosthetics

Documentation within the member's medical record must show functional need for the technologic or design feature of the microprocessor-controlled prosthetic (e.g., knee).

Relevant Physical Exams

Any recent physical examinations that are relevant to the member's functional deficits and the need for a prosthetic must be documented in the member's medical records.

The focus is to document body systems impacting the member's functional ability and ambulatory difficulties:

- Weight and height, including recent weight gain or loss
- Cardiopulmonary examination
- Musculoskeletal examination
- Arm and leg strength and range of motion
- Neurological examination
- GaitBalance and coordination

Replacements

If the prosthetic will be a replacement, the status of the current prosthesis/component(s) and reason for replacement must be documented.

In addition, past experience with related items [previous prosthesis/component(s)], if pertinent, should be included in the member's medical record.

Additional Orthotics Guidelines

Relevant Physical Exams

Any recent physical examinations that are relevant to the member's functional deficits and the need for an orthotic must be documented in the member's medical records.

The focus is to document body systems impacting the member's functional ability and ambulatory difficulties:

- Weight and height, including recent weight gain or loss
- Musculoskeletal examination
- Arm and leg strength and range of motion
- Neurological examination
- Gait
- Balance and coordination

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4.7 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Chapter 5 – Care and Quality Management

Care management incorporates a comprehensive integrated solution that encompasses all aspects of engagement and self-management by providing information, support, and interventions across the continuum of care.

Unit 1: Introduction to Care Management

The Highmark Care Management Program focuses on the integration of the delivery of health care services with our members, their employers or groups, and our network providers. It is designed to comply with all federal, state, and external review body regulations and standards.

READ MORE

Unit 2: Authorizations

Highmark requires authorization of all inpatient admissions, medical and behavioral health. In addition, authorization is required for certain outpatient services, procedures, and durable medical equipment and supplies prior to performing the services or providing the supplies.

READ MORE

Unit 3: Medicare Advantage Procedures

This unit outlines Highmark and Centers for Medicare & Medicaid Services (CMS) procedures and processes specifically for Medicare Advantage members.

READ MORE

Unit 4: Behavioral Health

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

READ MORE

Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

This unit outlines Highmark's procedures for handling denials, adverse benefit determinations, grievances, and appeals.

READ MORE

Unit 6: Quality Management

The Highmark Quality Management Program is designed to ensure that members receive the best quality health care, in the most appropriate setting, in the most cost-effective manner.

READ MORE

Unit 7: Value-Based Reimbursement (VBR) Programs

Highmark's network management methodology utilizes value-based reimbursement models, performance, and high-value networks and products. This strategy emphasizes efficiency and appropriateness over volume and waste, encourages provider/payer collaboration, and increases quality and cost improvement potential.

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Unit 1: Care Management Overview

Last Updated: Thursday, August 29, 2024

5.1 Disclaimers

5.1 Introduction to Care Management

Care management incorporates a comprehensive integrated solution that encompasses all aspects of engagement and self-management by providing information, support, and interventions across the continuum of care.

The Highmark Care Management Program focuses on the integration of the delivery of health care services with our members, their employers or groups, and our network providers. It is designed to comply with all federal, state, and external review body regulations and standards.

Employer groups and individuals receive a core set of services including:

- Utilization Management (medical, behavioral health, and pharmacy)
- Wellness
- Condition Management
- Case Management/Care Transitions
- Care Coordination

The activities and functions are used to optimize appropriate utilization of health care resources within the appropriate settings, including acute inpatient, outpatient, outpatient imaging, home health care, skilled nursing, and rehabilitation.

Various Departments Involved in Coordination of Services

Highmark's Clinical Services is directly responsible for implementation of the Care Management Program through its Utilization Management (UM) and Medical Management and Quality (MM&Q) departments. The staff consists of clinical, non-clinical, and administrative personnel who support the coordination and seamlessness of the services provided to the member. Highmark Behavioral Health Units are included within the scope of Clinical Services.

Within Clinical Services, the physician reviewers provide direction and oversight to the overall care planning process. They support the functions of the physician staff as well as the clinical staff.

Clinical Services' goal is to deliver a comprehensive and integrated care management program that positively impacts both members' health and medical benefit costs. Care managers may also manually refer members to case and condition management based on individual member needs.

Behavioral Health

Additional information on the utilization processes and procedures specific to behavioral health can be located in *Highmark's Provider Manual* **Chapter 5 Unit 4: Behavioral Health**. For requirements and guidelines for behavioral health providers, please see **Chapter 4 Unit 2: Behavioral Health Providers**.

5.1 Components of the Care Management Program

Scope of Services

There are numerous components of the Care Management Program. These components are inclusive of both medical and behavioral health services.

The services listed below are integrated into Highmark's total Care Management Program. They include, but are not limited to:

- Health Information and Support
- Utilization Management
- Significant Medical Decision and Treatment Support
- Condition Management
- Maternity Education and Support
- Case Management
- Behavioral Health Case Management
- Coordination between Medical and Behavioral Health Management

- Prevention and Wellness
- Radiology Management
- External Review Services
- Medical Technology Assessment Reviews

Customized Care Management Programs

Employer groups may select from a set of core services or increase their depth of services by adding programs such as wellness coaching or by intensifying their condition/disease management program.

This allows employers to address their specific population, whether they have employees who will benefit from chronic illness intervention and education or employees who are interested in participating in wellness programs beyond what may be provided in a traditional worksite wellness program.

5.1 Partnership Vendors

Partnerships Enhance Services

By partnering with vendors who provide expertise in specific care management services, Highmark enhances the services provided to members. These vendors work in coordination with Highmark to provide a seamless, integrated program for Highmark members.

eviCore Healthcare

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for several of Highmark's care management programs. These include:

- Radiation Therapy Authorization Program (DE, PA, and WV Only)

- Laboratory Management Program (DE, PA, and WV Only)
- Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program (DE, PA, and WV Only)
- Advanced Imaging and Cardiology Services Program (DE, PA, and WV Only)

Additional information on all programs managed by eviCore can be found on the Provider Resource Center by selecting **Policies & Programs** then **Care Management** from the main menu.

In addition, information on the eviCore Advanced Imaging and Cardiology Program is available in the *Highmark Provider Manual's* **Chapter 4 Unit 5: Outpatient Radiology and Laboratory.**

Home & Community Care Transitions

For providers in Pennsylvania and West Virginia

Highmark has partnered with Home & Community Care Transitions to manage post-acute care services for Highmark's Medicare Advantage members. This will include long-term acute care (LTAC) services, inpatient rehabilitation, and skilled nursing facility (SNF) services.

Additional information on Highmark's partnership with Home & Communicty Care Transitions can be located on the Provider Resource Center – select **Policies & Programs** from the main menu at the top of the home page, then **Care Management**, and then **Post-Acute Care Management for Medicare Advantage Members**.

Davis Vision

For providers in New York

Davis Vision is our partner for routine vision exams, glasses, and contacts for Highmark members in New York. Routine vision benefits may vary by plan.

Coverage for problem eye services is considered a medical benefit and will not be managed by Davis Vision. Medical claims (for care including but not limited to infection, macular degeneration, glaucoma, detached retina) will continue to be submitted to Highmark electronically through Administrative Services of Kansas, Inc. (ASK) for all members.

Davis Vision Pediatric Exchange Vision Coverage

For providers in New York

Pediatric (up to age 19) Affordable Care Act (ACA) members who are covered by our Individual and Small Group plans must see Davis Vision providers for routine eye exams, and eye care accessories (frames, lenses, contact lenses) as these benefits are embedded in the medical benefit.

If you care for pediatric ACA members, you will need to be in the Davis Vision network. Providers already contracted with Davis Vision can send claims to Davis Vision directly for routine eye exams and eye care accessories for these Highmark pediatric members.

Davis Vision Medicare Advantage Vision Coverage

For providers in New York

All covered Medicare Advantage vision services and products claims must be processed through Davis Vision. This includes routine vision exams, glasses, contacts, and post-cataract benefits for glasses or contacts.

Members with Medicare Advantage HMO plans must use a Davis Vision participating provider to receive benefits for vision services. Members with Medicare Advantage PPO plans can see a non-participating Davis Vision provider; however, the claims must be submitted to Davis Vision using the Davis Vision's Out of Network Claim form.

Filing Vision Claims with Davis Vision

For providers in New York

If you are contracted with Davis Vision, you will be able to provide and bill Davis Vision directly for covered routine vision services to Highmark Commercial and Medicare Advantage members.

Non-Participating Davis Vision providers should not submit claims directly to Highmark using ASK for routine vision services including routine exam, glasses, contacts, or Medicare Advantage required post-cataract benefits.

Any problem or diagnosis-focused eye services that are considered medical claims (including but not limited to infection, macular degeneration, glaucoma, detached retina) should be submitted and billed directly to Highmark electronically through ASK.

Contacting Davis Vision

For providers in New York

If you are already a part of the Davis Vision network and have a general inquiry, you can reach them at **800-773-2847**. Call center hours of operation are Monday – Friday: 8 a.m. to 8 p.m. (Eastern time), and Saturday: 9 a.m. to 4 p.m.

Providers who are not currently part of the Davis Vision network and would like to join, can contact Davis Vision here.

5.1 Utilization Management

Utilization management activities focus on opportunities to reduce clinically unnecessary variation in the delivery of services, to utilize clinically appropriate alternative levels of care, to assist with timely and effective discharge planning, to facilitate the appropriate use of benefits, and to proactively identify members who may benefit from other services such as health promotion and disease prevention programs, treatment decision support, chronic condition support, depression management services, and/or case management services.

The utilization management process incorporates a rules engine that automatically triggers referrals to case management and condition management based on a select group of diagnoses and procedures that are entered. Care managers may also manually refer members to case and condition management based on individual member needs. Components of the utilization management process are described below.

Authorization

An **authorization** is a determination by Highmark that a health care service proposed for or provided to a member is “medically necessary” as that term is defined by the member’s contract.

Prior Authorization

Prior authorization (also known as preservice review or precertification review) is the process by which services requiring authorization are evaluated against criteria for medical necessity and appropriateness prior to the receipt of services.

Predetermination

Predetermination is the process in which members or providers may request that selected services that do not require authorization, such as potentially cosmetic procedures, selected drugs, behavioral health treatment, and high-cost medical equipment, are reviewed prospectively in order to determine medical necessity, benefit availability, and financial responsibility.

In Pennsylvania, predeterminations are available for members with commercial benefit plans. Highmark Delaware will accept requests for predeterminations for Highmark Delaware members only from providers located outside of Delaware. Predeterminations are not available for Highmark West Virginia members.

Medicare Advantage members in Pennsylvania and West Virginia have a right to an advance determination by their health plan to verify whether services are covered prior to receiving them. A provider must advise the member to request a "preservice organization determination," or the provider can request the determination on the member's behalf. For more information, please see the Preservice Organization Determinations section in the *Highmark Provider Manual* **Chapter 5 Unit 3: Medicare Advantage Procedures**.

Inpatient Admissions

Requests for inpatient services are evaluated according to criteria for medical necessity, appropriateness, the most appropriate setting, and benefit availability. Authorization is required for all in-network and out-of-network inpatient services and required under all Highmark products whenever a member is admitted as an inpatient to any of the following facilities:

- Acute Care
- Long-Term Acute Care (LTAC)
- Inpatient Rehabilitation Facility
- Mental Health or Substance Abuse Treatment Facility
- Skilled Nursing Facility (SNF)

Concurrent Review

Concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized. Outpatient requests should be made at least 24 hours prior to the expiration of the original authorization period (last day of treatment).

Concurrent review is also conducted for all inpatient settings after the initial authorization has been obtained, including acute inpatient, LTAC, SNF, and inpatient rehabilitation. Requests for continued stay should be made no later than the last covered day.

Concurrent review is conducted for all behavioral health inpatient services, for medical care for select facilities based on the reimbursement structure, for medical services reimbursed by the visit, or for accounts with specific contract provisions.

Retrospective Review

Retrospective review (also known as post-service review) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.

Network providers have an obligation to cooperate with preservice authorization review procedures. If the provider fails to comply, Highmark has the right to review the service retrospectively. If the service is deemed not medically necessary, then payment may be denied or recovered from the provider. Providers who consistently fail to request authorizations on a preservice basis may be subject to corrective action by the Credentials Committee.

Clinical Review Process

Initial reviews of authorization requests are performed by registered nurse reviewers with clinical experience. They utilize MCG Care Guidelines, Highmark or Medicare Advantage medical policies, and

other clinical criteria to review the medical necessity of the requested services.

The nurse reviewer may authorize a service that meets criteria. Reviewers have access to consult with a medical director. If an initial reviewer is unable to approve a service, the case is referred to a physician medical director or other physician reviewer. The physician will evaluate the request using Highmark's criteria and considering the specific clinical aspects of the individual case. Only a physician may determine that a service is not medically necessary.

Medical necessity reviews by Highmark medical directors and other clinical staff do not constitute medical advice or treatment, nor do they create any provider-patient relationship. Such reviews are solely for the purpose of determining whether services meet Highmark criteria for medical necessity, which is a condition for services to be covered and reimbursable.

Peer-to-Peer Conversation

Highmark provides the opportunity for a treating physician to discuss the denial of an authorization with the medical director or other physician reviewer who made the determination. The purpose of the **peer-to-peer conversation** is to allow the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide any additional information or perspective that may be helpful, prior to initiating a formal appeal.

This discussion may help resolve the issue and spare the time and expense of an appeal. Highmark will advise the treating provider of the availability of this process when verbally notifying the provider of an authorization denial (if a peer-to-peer conversation has not already occurred).

The provider may initiate the peer-to-peer discussion by calling Clinical Services.

For More Information

For additional information on initiating a peer-to-peer conversation, please see the *Highmark's Provider Manual* **Chapter 5 Unit 5: Denials, Grievances, and Appeals**.

Discharge Planning

Discharge planning is a proactive and collaborative process between the provider and the Care Manager or Health Coach and is an integral part of the inpatient review process, often beginning prior to a scheduled admission and continuing throughout the course of treatment. Members receiving inpatient acute, rehabilitation, and skilled nursing services are followed at specific intervals throughout the admission to anticipate and identify needs, quality of care concerns, gaps in care, and/or barriers to care.

Behavioral Health

Highmark has a dedicated behavioral health unit staffed by behavioral health professionals and registered nurses with significant clinical behavioral health experience. The behavioral health case managers review authorization requests and referrals for behavioral health services. Case managers have access to Highmark medical directors and consulting psychiatrists (except in New York) for consultation on individual cases.

For more information on behavioral health authorizations, please see *Highmark's Provider Manual* **Chapter 5 Unit 4: Behavioral Health**.

5.1 Access to Medical Management Services

For providers in all regions, Predictal, accessible via Availity, is key to Highmark's utilization management services. It is provided cost-free to Highmark network participating providers and can be used for submitting most authorization requests. Other functionality available in Predictal related to utilization management includes discharge planning, referrals to Case Management, and inquiry functions to confirm status of your authorization requests.

When Availity and/or Predictal is not available or for non-routine inquiries that cannot be handled through Availity and/or Predictal, Clinical Services may be contacted.

Clinical Services Fax Availability

For providers in New York

- Medical outpatient: **833-619-5745**
- Medical Inpatient: **833-581-1868**
- Behavioral health outpatient: **833-581-1867**
- Behavioral health inpatient: **833-581-1866**

Hours of Availability:

- Monday through Friday, 8:15 a.m. to 5 p.m.

5.1 Criteria for Medical Management Decisions

When rendering a medical necessity determination, Clinical Services uses medical necessity criteria that are based on sound medical and clinical evidence. The criteria used are formally reviewed annually and revised as necessary.

In addition to nationally recognized evidence-based criteria, Highmark medical policies are used that consider regional and local variations in medical practice. Procedures are also in place for applying criteria based on individual needs.

Definition: Medically Necessary

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, Highmark's Healthy Kids [CHIP], Centers for Medicare &

Medicaid Services [CMS] as to the Medicare Advantage program, etc.), Highmark has adopted a universal definition of medical necessity.

The term medically necessary, medical necessity, or such other comparable term shall mean health care services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services, or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury, or disease, the severity of the patient's symptoms, or other clinical criteria.

Generally Accepted Standards of Medical Practice

For these purposes, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Specialty Society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors.

Request for Criteria

Highmark uses resources such as nationally recognized clinical review criteria, medical policy, and Medicare guidelines in determining whether a requested procedure, therapy, medication, or piece of equipment meets the requirements of medical necessity and appropriateness. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

To assess a request for medical necessity and appropriateness, relevant clinical information is reviewed. When the clinical information is incomplete, the Utilization Management department attempts to obtain the relevant clinical information from the provider and/or facility or by obtaining the member's medical record. A medical necessity determination is made by either a Utilization Management Clinician, Pharmacist, or Medical Director after the available clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical necessity determinations by calling Highmark at:

- **800-421-4744** for Medical/Surgical related criteria/guidelines
- **800-258-9808** for Behavioral Health related criteria/guidelines
- Pharmacy-related criteria/guidelines
    - Delaware, Pennsylvania, and West Virginia: **800-600-2227**
    - New York: **877-698-0793**

Criteria Used

The Medical Utilization Management staff uses the following criteria, guidelines, and policies:

- MCG Care Guidelines
- Highmark Medical Policy
- Medicare Advantage Medical Policy
- American Society of Addiction Medicine (ASAM) criteria
- New York Only: Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) criteria

MCG Care Guidelines

The MCG Care Guidelines provides criteria for settings ranging from acute through outpatient. Care managers base medical necessity decisions for adult and pediatric acute, long-term acute, sub-acute and

skilled nursing facility (SNF), rehabilitation, and home care services on the MCG Care Guidelines. The MCG Care Guidelines are embedded in Predictal, accessible via Availity.

Utilization Decision Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. Such reviews are solely for the purpose of determining whether services meet Highmark criteria for medical necessity and are being delivered in the most appropriate setting, which are conditions for services to be covered and reimbursable.

They do not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.

Highmark Medical Policy

Highmark's Medical Policy guidelines address both clinical and claim payment reimbursement issues. These policies are developed and maintained in accordance with national standards such as those set by the National Committee for Quality Assurance (NCQA).

The Medicare Advantage Medical Policy guidelines are based on national coverage determinations issued by the Centers for Medicare & Medicaid Services (CMS) and local coverage determinations established by Novitas Solutions, Inc. in Pennsylvania and Palmetto GBA in West Virginia.

Highmark Medical Policies are available on the Provider Resource Center under CLAIMS, PAYMENT & REIMBURSEMENT. Medicare Advantage Medical Policies are available on CMS' Medicare Coverage Database website.

Additional information regarding Medical Policy may also be found in the **Highmark Medical Policy** section of this unit.

Clinical Judgement

Please note that the use of these and other guidelines requires, and never replaces, clinical judgment.

Criteria Review

All criteria are reviewed, approved, and/or revised at least once annually by the Care Management & Quality Committee (CMQC). The CMQC is comprised of practicing physicians in the community and physicians in hospital administrative positions who are involved in care management functions.

Important! FEP Medical Policies

Federal Employee Program (FEP) medical policies are specific to FEP benefits and may differ from Highmark's medical policies; however, in the absence of FEP medical policy, consult Highmark medical policy for guidance.

To view FEP medical policies in their entirety, please refer to the Federal Employee Program's website. From the homepage, scroll down to the footer and select **Policies & Guidelines.**

Policies are not intended to be prescriptive; thus, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefit eligibility and application are determined by the Federal Employee Program.

5.1 Criteria for Behavioral Health Services

Basis of Authorization Decisions

Highmark's Behavioral Health Unit bases its decisions to authorize care on available clinical information, availability and appropriateness of less restrictive treatment settings, appropriate medical necessity criteria, the member's benefits, and the safety of the patient and others.

Criteria

With the exception of substance abuse treatment, Highmark's Behavioral Health Unit applies MCG Care Guidelines in DE, PA, and WV and InterQual® criteria in NY for Behavioral Health when reviewing the medical necessity and appropriateness of behavioral health services.

Highmark's Behavioral Health Unit uses the current version of the American Society of Addiction Medicine (ASAM) Criteria when reviewing the medical necessity of substance abuse treatment.

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) Criteria

For providers in New York

New York State Office of Addiction Services and Supports (OASAS), in partnership with National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), developed the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0, a web-based tool to assist substance abuse treatment providers, Medicaid Managed Care plans, and other referral sources in determining the most appropriate level of care (LOC) for a client with a substance use disorder and/or problem gambling disorder. This tool enables the referral source to identify the most appropriate treatment setting closest to the client's community.

For More Information

Please see the *Highmark Provider Manual* **Chapter 5 Unit 4: Behavioral Health** for additional information on medical necessity criteria for behavioral health services.

5.1 Highmark Medical Policy

Medical policies are documents that provide medical necessity and coverage guidelines for all our medical-surgical products, including managed care. These guidelines address hundreds of medical issues including diagnostic and therapeutic procedures, injectable drugs, and durable medical equipment. Highmark's Medical Policy guidelines have been integrated into the claims processing system, which allows for cost-effective claims processing and ensures accurate administration of our members' health care benefits.

In addition to medical policies for our commercial products, Highmark also maintains medical policy guidelines for our Medicare Advantage products. Please see *Highmark's Provider Manual* **Chapter 5 Unit 3: Medicare Advantage Procedures** for additional information.

Policy

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are merely intended to reflect Highmark's coverage and reimbursement guidelines. Coverage for services may vary for individual members based on the terms of the benefit contract.

Highmark retains the right to review and update the medical policy guidelines in its sole discretion. These guidelines are the proprietary information of Highmark. Any sale, copying, or dissemination of the medical policies is prohibited; however, limited copying of medical policies is permitted for individual use.

Medical Policy Development

Highmark continually reviews its existing medical policies to ensure that they reflect evidence-based medicine, the current standard of care, and the appropriate place of service. Highmark's Medical Policy Department ensures that medical policies are developed and maintained in accordance with national standards such as NCQA and the Blue Cross and Blue Shield Association. For Highmark Medicare Advantage products, the Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage insurers use CMS national policy and the regional Medicare B Carrier's local policy.

To begin the process of adding or revising its policy guidelines, Highmark's Medical Policy department reviews published, peer-reviewed medical literature along with information and determinations from multiple sources — including the Food & Drug Administration (FDA) and professional medical societies.

After the Medical Policy department has performed its initial research, it may solicit opinions from appropriate Highmark Professional Consultants. If the procedure in question is performed by a particular specialty, consultants within that specialty may be contacted, or the issue may be referred to one of four specialty subcommittees for review and recommendation regarding a medical policy coverage position. The specialty subcommittees are made up of external practicing physicians in the areas of Cardiology, Hematology/Oncology, Musculoskeletal, and Neurosciences. To develop a draft policy, the Medical Policy department utilizes input from all these sources.

For providers in Delaware, Pennsylvania, and West Virginia

Once the policy is drafted, the Medical Policy department then collaborates with the Clinical Policy Management Committee (CPMC) in making a final determination on the policy prior to publication. The CPMC consists of staff Medical Directors working under the direction of Highmark's Chief Medical Officer.

For providers in New York

Once the policy is drafted, the Medical Policy department then collaborates the New York Medical Management Clinical Committee (MMCC) for review and voting and then to the QMC and Board of Directors for approval.

Provider Involvement

Health care professionals play an important role in Highmark's Medical Policy development. They provide medical expertise that helps in the development of coverage and reimbursement guidelines.

Over 500 independent health care professionals are active in a variety of positions that influence the core of Highmark's operations. They make up the majority of committees that help to define medical policy, resolve claims disputes, and promote the delivery of quality medical care to Highmark members.

Place of Service Requirements

Highmark develops medical policy as the foundation for determining coverage eligibility for certain health care services rendered to its members. Highmark continually reviews its existing medical policies to ensure that they reflect evidence-based medicine, the current standard of care, and the appropriate place of service. Place of service requirements are indicated on select commercial medical policies to clearly define the most appropriate setting for specific services.

If place of service requirements apply, the medical policy will include a **Place of Service** section. Additional policy guidelines are also listed under this heading, if applicable.

Note: Place of service requirements do not apply to Highmark's Medicare Advantage business, which is governed by regulations and policies developed and promulgated by CMS.

Determining Medical Policy Criteria

Facilities must coordinate with the ordering and/or performing provider before the date of service. The facility should work with the ordering and/or performing provider, as necessary, to ensure medical policy criteria are met. Alternatively, the facility can initiate an inquiry through the Provider Service Center if there are concerns about whether the facility services to be performed meet applicable Highmark medical policy criteria.

Accessing Highmark's Medical Policies

Highmark's commercial medical policies are accessed on the Provider Resource Center under **Policies & Programs** then **Medical Policies**.

Medical policy may differ in service areas based on state regulatory requirements. Please be sure to access the appropriate medical policies from the Provider Resource Center for your service area and/or based on the member's coverage.

Note: Highmark medical policies online are considered to be current; however, users can access and review terms of previous versions of a policy prior to the effective date of the current version.

Notification of New Policies and Updates to Existing Policies

Our Medical Policy Update newsletter, published monthly, provides advance notification of new policies and upcoming changes to existing medical policies. You can find current and past issues of Medical Policy Update by selecting **Latest Updates** then **Medical Policy Update** on the Provider Resource Center. In addition, you can sign up for our mailing list and receive a monthly email notification when the latest issue of Medical Policy Update is published. To subscribe, select **Join Our Mailing List** from the top right-hand corner of the Provider Resource Center and complete the form.

IMPORTANT!

New medical policies and updated versions of existing medical policies are not available for viewing until the effective date of the policy, or the following Monday if that date falls on a weekend or holiday.

Claim Impacts Based on Application of Medical Policy

Although claims for services impacted by Highmark medical policy may be paid when submitted, Highmark reserves the right to review such cases retrospectively to ensure that payments made were appropriate based upon the applicable medical policy requirements. Complete and careful

documentation must be maintained in the member's medical record in case of any such post-payment review.

If it is determined that Highmark medical policy requirements were not met in a particular case and, therefore, a service is not eligible for coverage, the payment Highmark has made for the services will be retracted. As always, if the facility disagrees with the result of such a review, it can appeal the decision. ConflictsIn the event of a conflict between the requirements of the *Highmark Provider Manual* and Medical Policy, the following order of control should apply: a) First, Medical Policy; (b) Second, the *Highmark Provider Manual*.

IMPORTANT! FEP Medical Policies

Federal Employee Program (FEP) medical policies are specific to FEP benefits and may differ from Highmark's medical policies; however, in the absence of FEP medical policy, consult Highmark medical policy for guidance.

To view FEP medical policies in their entirety, please refer to the Federal Employee Program's website. From the homepage, scroll down to the footer and select **Policies & Guidelines.**

Policies are not intended to be prescriptive; thus, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefit eligibility and application are determined by the Federal Employee Program

5.1 Non-Covered Services

Non-covered services include services ineligible under the member's plan documents, deemed experimental or investigational, or deemed not medically necessary by Highmark.

Except otherwise stated herein, a provider may always bill a commercial member for non-covered services if the provider has given the member advance written notice that the service(s) may not be eligible for coverage and an estimate of the cost thereof. Thereafter, the member must agree in writing to

assume financial responsibility for the service(s) in advance of receiving such service(s). The signed agreement shall be kept in the provider's records.

Member Desire to Obtain Medically Unnecessary Services

On occasion, situations may arise where Highmark determines, in advance of a service being provided, that the service is not medically necessary, yet the member still desires to obtain the service and is willing to bear the cost. The provider may bill the member for such services only if:

1. The provider has requested a determination of medical necessity from Highmark **in advance** of providing the service and Highmark determines **in writing** that the proposed service is not medically necessary;
2. The provider informs the member of Highmark's determination in writing and **in advance** of providing the service; and
3. The member indicates **in writing** that he or she understands and agrees that he/she will be totally responsible for paying for the service and is waiving all rights to submit a claim to Highmark.

The documentation for requirements two and three above cannot be a general form in which the patient agrees to be financially responsible for any charges not paid by insurance. The documentation must: (i) describe the specific service in question; (ii) state clearly that Highmark has determined that the service is not medically necessary; and (iii) clearly document the patient's agreement to be personally responsible for payment and not to submit a claim to Highmark.

By this process, Highmark acknowledges that, in limited circumstances, a member may want to enter a private arrangement with a network provider to obtain and pay for a service, knowing that the service is not reimbursable under the member's coverage with Highmark. Highmark will not preclude the provider from billing the member in these special circumstances as long as the written documentation is prepared in advance of the service to demonstrate that the member entered into the arrangement knowingly and with full knowledge of the financial consequences.

5.1 Medical Records Requests

Medical records are requested by Highmark when it does not have the information needed to determine the medical necessity and appropriateness of the services being provided.

When Medical Records Are Requested

If Highmark does not have sufficient information to determine whether services are medically necessary and appropriate, medical records will be requested. Medical records can be requested for either medical or behavioral health services, and for either inpatient or outpatient services.

The medical record requests are made in writing. The request is addressed to the attention of the hospital's Medical Records Department.

Minimum Necessary Standards

Medical record requests will be limited to only the minimum necessary amounts of personal health information (PHI) needed to accomplish the intended purpose for which the PHI is being requested, used, or disclosed.

Confidentiality

In accordance with applicable regulatory and accrediting body requirements, as well as Highmark corporate policy, all personally identifiable confidential information obtained to manage a member's care is maintained in such a manner as to protect the privacy of all individuals.

Provider Responsibility for Timeliness

Regulatory standards require health plans to make medical necessity decisions within strict time frames. In some cases, the regulatory standard does not provide additional time for obtaining medical records.

For this reason, it is important for providers to provide all relevant medical records within the time frame

stipulated in the written request. **Lack of response or a late response to the request for medical records may result in a denial of payment**.

Non-Reimbursement Policy

According to Highmark policy, Highmark does **not** reimburse participating network providers for supplying medical records to Highmark.

BlueCard® Requests

On occasion, Highmark may request medical records for an out-of-area member in the BlueCard Program who has received services from you. The request is made in writing via a standard Medical Records Request Form.

Please respond to these requests as quickly as possible. The Blue Cross Blue Shield Association (which sponsors the BlueCard Program) encourages a response time frame of **ten days or less**. Your prompt return of medical records helps to expedite the review process and avoid unnecessary claim denials.

When mailing medical records, please attach/enclose the original Medical Record Request Form. This helps to ensure that the records reach the individual who requested them.

Note: For additional information for medical record requests for out-of-area BlueCard members, please refer to *Highmark's Provider Manual* **Chapter 2 Unit 6: The BlueCard Program**.

5.1 Member Consent for Release of Medical Records

Routine Situations

As a HIPAA-covered entity, Highmark has established the following policy regarding routine member consent:

Highmark's policy is that it will not request or obtain consent of its members in connection with the use or disclosure of protected health information (PHI) for treatment, payment, or health care operations. Under certain limited situations, Highmark may elect to obtain consent from a member.

Non-Routine Situations

For certain situations, a member may be asked to sign an authorization to use or disclose specific PHI. This includes information related to any of these topics:

- Psychotherapy notes
- Substance abuse
- Sensitive diagnoses such as HIV, STDs, or AIDS

When asked for medical records of this nature, the facility is responsible for obtaining the authorization from the member and submitting it to the Clinical Services department with the requested records.

5.1 Case Management

Highmark's Clinical Services department is responsible for case management services, offered at no cost to Highmark members. Case management is a systematic, proactive, and collaborative approach to effective assessment, monitoring, and evaluation of options and services required to meet an individual member's needs for health care services.

Case management is a collaborative process involving the physician, the patient and his or her support system, our Case Managers, and other health care service providers to encourage and assist patients to achieve their optimum level of health, self-management, and social and occupational functioning. Case management usually, but not always, follows a significant health-related event, such as hospitalization.

Purpose

Case management is offered to assist members who have complex or high-cost health care needs. Its purposes are:

- To help determine the health care needs of the patient; and
- To help plan for and coordinate the provision of needed services through communication, education, and the use of available resources, to achieve jointly established short and long-term goals.

Activities include assessment, planning, facilitation, advocacy, communication, and education to help the member meet his or her health care needs. Case managers can also help protect the welfare and safety of members through identifying and reporting risks of abuse, violence, and suicide. Case management can also assist members to understand their benefits and other consumer protections including medical directives and power of attorney.

Provider Referrals for Case Management

Highmark encourages providers to identify members who could benefit from coordinated case management services. To discuss your patient's needs, please contact the Clinical Services Case Management staff at:

- Pennsylvania: **800-596-9443**
- Delaware: **800-572-2872**
- West Virginia: **800-344-5245;**
    - Medicare Advantage Freedom Blue PPO: **800-269-6389**
- New York: **877-878-8785 option 2**

Please consider the following conditions for case management referral:

- Patients with multiple medical or behavioral health concerns or services
- Patients who lack a consistent caregiver, have financial concerns, and require community resources
- Patients with a life-altering diagnosis or condition such as brain trauma, cancer, or debilitating neurological condition
- Patients with difficulty achieving self-management resulting in frequent emergency room visits or hospital admissions

Identifying Members for Case Management

Highmark's Case Management staff uses clinical, utilization, and predictive modeling/Member Listening System (MLS) indicators to identify members who could benefit from case management. The indicators include, but are not limited to, the following:

- High-risk diagnoses
- Complex disease processes
- Catastrophic medical events
- High-cost cases
- Complications of care
- Situational and discharge planning needs
- Psycho-social issues
- Financial issues
- Complex care coordination needs
- Multiple admissions and readmissions
- Health risk assessment screening

Screening and Consent

If it is determined that a member would benefit from case management and the member accepts case management, his or her case is assigned to a Highmark Case Manager. Case management is a voluntary program and requires the member's consent. If the member is accepted into the program, the assigned Case Manager will contact the member and/or the member's family, when necessary, to obtain permission for case management (except in New York where the member is not required to provide permission to be enrolled in case management).

The case management program recognizes that a patient's condition is dynamic and changes over time. If a member is not accepted into the program when initially referred, he or she may be referred again at a later date if there is a change in his or her clinical condition.

Case Manager Responsibilities

The Case Manager is responsible for the following:

- Contacting the member and his/her providers when appropriate
- Conducting a comprehensive assessment of the member's needs
- Identifying the issues and/or barriers affecting the member's care
- Developing, implementing, coordinating, and evaluating a plan of care in collaboration with the member and his/her providers

Case Managers have access to Highmark physician medical directors and other consulting physicians who can assist in the review of and planning for individual cases, conditions, and services.

Case Management Services

Highmark Case Managers are licensed registered nurses (RNs) or licensed behavioral health professionals able to assist your patient by providing services including, but not limited to, the following:

- Assessment of knowledge deficits regarding their condition, treatment, or benefit issues;
- Reinforcement of educational information as directed by the physician or service provider;
- Evaluation and reinforcement of medication use and adherence which is particularly important in polypharmacy situations;
- Evaluation and reinforcement of adherence with treatment regime, including development of short- and long-term goals;
- Intervention to assist with obtaining medical supplies or equipment;
- Coordination of services among providers;
- Communication of adverse situations to the physician or service provider;
- Evaluation and assistance with financial concerns;
- Assessment and assistance with advanced care planning; and/or
- Information related to available community resources such as self-help support groups and other similar services.

5.1 Condition Management

Condition Management Overview

Condition management programs focus on creating better outcomes of members identified with chronic illnesses by improving their self-management skills and understanding of their illness and treatment options.

Once members choose to participate, they are enrolled in a program specific to their needs. Members may provide consent to allow the Case Manager to discuss their condition with their caregivers.

Available Programs

Members may be identified for one of the following condition management programs:

- Asthma
- Baby Blueprints
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High-Risk Pregnancy
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Metabolic Syndrome
- Migraine
- Musculoskeletal Pain
- Osteoporosis
- Pediatric Obesity
- Upper GI
- Wellness

Availability of Case Managers

Case Managers are available to receive inbound calls 24 hours a day, seven days a week.

For providers in Delaware, Pennsylvania, and West Virginia

Case Managers are available for outbound calls to members from 8:30 a.m. until 9:00 p.m. Monday through Friday, and on weekends when requested by the member.

For providers in New York

Case Managers are available for outbound calls to members from 8:30 a.m. until 6:00 p.m. Monday through Friday, and on weekends when requested by the member.

Primary Goals of Condition Management

Highmark's condition management programs focus on the following goals:

- Improving the quality of care and outcomes for members with chronic illnesses by addressing and closing gaps in care and improving their self-management skills;
- Improving member decision-making skills, including understanding of their treatment options in the context of their personal values, preferences, and priorities;
- Promoting dialogue and communication between the provider and member;
- Reducing clinical progression of conditions by encouraging preventive screenings and immunizations; and
- Reducing potentially avoidable healthcare costs and enhancing the provider's ability to provide high-quality, evidence-based care.

5.1 Enhanced Community Care Management (ECCM) (DE and PA Only)

For providers in Pennsylvania and West Virginia

Enhanced Community Care Management (ECCM) is a non-billable service currently offered for Highmark Medicare Advantage, Highmark Individual ACA, Highmark Small Group, and HealthWay (Highmark employees with Highmark insurance) members to support the most complex and vulnerable members. The goal of the program is to help our members live their best lives possible while maintaining their independence in the community.

What is the ECCM Program?

For providers in Pennsylvania and West Virginia

ECCM's interdisciplinary care team, including physicians, advanced practice providers (Nurse Practitioners or Physician Assistants), nurses and social workers, are all trained in motivational interviewing, health literacy, and serious illness conversations.For members who have advanced illness and need Supportive and Palliative Care, the interdisciplinary team will:

- Create and document a whole-person-advance care plan (centered on the member and their family)
- Help with pain and symptom management through medical and non-medical interventions in coordination with the member's Primary Care Physician (PCP)
- Provide more frequent check-ins
- Help with care plan support, including monitoring of conditions and when to take medications
- Provide the family caregiver with education, counseling, and/or respite
- Assist with decision making, clarifying care priorities, and helping to match treatment and services to the member's goals
- Assist with social determinants of health

- Attend to palliative care needs and help to relieve the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and their family.

ECCM is a free, flexible program that reduces disruption for the member, family, and caregiver by streamlining communication across health care settings to ensure the member's needs are matched with the appropriate resources. The team also provides closer oversight of the member and their illness (through virtual and in-home care – including nursing facilities) while working with the member's doctor and health care providers.

How Does ECCM Differ from Hospice?

For providers in Pennsylvania and West Virginia

Palliative care strives to alleviate discomfort and pain to improve the quality of life for members. Palliative care can be provided during any stage of an illness and most frequently to members with life-limiting illness. It can be provided at the same time as curative care.

The table below outlines the differences between the palliative care services provided by hospice and services provided through ECCM.

Hospice...	ECCM...
Focuses on controlling pain and symptoms for those who no longer seek curative treatment or for whom treatment to prevent the progression of illness is no longer appropriate.	Are primarily consultative with focus on controlling pain and symptoms, providing emotional support, facilitating decision-making related to care, and coordinating services while the member may still be receiving curative treatment.
Is available when life expectancy is **six months or less**.	Is available whenever the member needs it.

Is a Medicare benefit. Medicare-covered services related to the member's terminal condition and also medical services unrelated to the terminal condition are paid under Medicare when the member is in an active hospice election period. **While in an active hospice election period, the member is not eligible for ECCM**.	Services are covered under the member's benefits. Members are not eligible for ECCM if they are in an active hospice election period. **If a member revokes a hospice election, the member would then be eligible for ECCM**.

Note: While a member is in an active hospice election period covered under traditional Medicare, the member's benefit will continue to cover supplemental or extra benefits, such as vision and dental, which are not covered by Medicare.

Hospice Services

For providers in Pennsylvania and West Virginia

All Medicare-certified hospice providers will be able to continue providing hospice care to Highmark members. The ECCM program does not provide hospice services; however, the program refers its members who elect hospice services to local hospice providers. Members and their caregivers will continue to have their choice of hospice providers when they elect hospice care.

Additional Information And Referrals

For providers in Pennsylvania and West Virginia

Additional information on the ECCM Program is available on the Provider Resource Center – select **Care Management Programs** from the main menu.

Providers can refer members to the ECCM Program services through one of the channels below:

- **Epic**: Ambulatory Referral to ECCM
- **Phone**: **844-438-3226** (844-GET-ECCM)
- **Fax**: **844-978-2756**
- **Email**: eccmreferrals@highmark.com

Members may contact Member Services at the number on the back of their ID cards for information on ECCM participation.

5.1 High-Risk Maternity (NY Only)

For providers in New York

Benefits for Physicians, Mothers, and Their Babies

Pregnant women need care, support, and education from the first signs of pregnancy, through birth and after the baby is born. To ensure all our pregnant members receive the services they need, we recommend our High-Risk Maternity Program. This program covers moms and their babies from the time the pregnancy is identified to six months after birth.

The High-Risk Maternity Program begins with our prenatal assessment form. Registered moms will receive prenatal education and interventions when identified as high-risk.

The High-Risk Maternity clinical practice guidelines are included in the Prenatal/Perinatal Care Preventive Health Guidelines, which are available on the Preventive Health Guidelines page of the Provider Resource Center.

Newborn Education Component

For providers in New York

New mothers may not recognize the basic signs of illnesses in their babies, simply because they lack the necessary education, experience, and materials. As a result, these moms frequently take their newborns to the emergency room when home care was all that was needed.

By providing newborn care information to new moms, we hope to:

- Teach moms how to recognize signs of illness in their babies.
- Help them to better communicate with their baby's pediatrician.
- Avoid unnecessary trips to the emergency room.
- Reinforce proper preventive care and immunization schedules with moms.

Fact Sheet

For providers in New York

All pregnant patients should be enrolled in the High-Risk Maternity Program and should be registered during their first trimester. Registered members will receive educational support and materials. If identified as high-risk, members will also receive case management services that reinforce the physician's care instructions and offer additional patient education.

After the birth of their babies, new moms will receive newborn education to help them care for their babies.

The Four Major Components of the High-Risk Maternity Program

For providers in New York

The High-Risk Maternity Program's four major components are:

- Enrollment of pregnant patients in the program
- Prenatal education for all patients
- Interventions for high-risk patients (including care coordination)
- Health education for newborn care

Enrollment by Physician

For providers in New York

Physicians who serve members in Western New York need to complete a prenatal assessment form for each pregnant patient at the time of her first prenatal visit. It's important that we receive a form for every member, not just those who may be high-risk. Please fax or mail the completed forms to us at the number or address on the form.

Prenatal Education

For providers in New York

The program emphasizes the importance of early and ongoing prenatal care. Women will also be encouraged to attend one of our many prenatal education classes. Additionally, education regarding importance of postpartum care and follow-up are reviewed.

Interventions for High-Risk Patients

For providers in New York

Patients who are identified as high-risk on the prenatal assessment form will be evaluated. The nurse will act as a liaison between you and your patient by reinforcing your care instructions and offering patient education.

After a total of no more than two missed prenatal visits or one post-partum visit by the member, providers can call for Case Management assistance to request active member outreach at **877-878-8785** Monday through Friday 8 a.m. to 5 p.m. EST.

HIV Services

For providers in New York

HIV pretest counseling should be provided to all prenatal clients. If a woman is found to be HIV positive, the clinician ordering the HIV test is responsible for arranging for a follow-up appointment to an HIV specialist or designated Al DS Center.

Department of Health Memorandum DOHM (Al 99-01) is the standard of care for HIV services and will:

1. Provide all pregnant women with HIV counseling and education;
2. Offer the pregnant woman confidential HIV testing; and
3. Provide the HIV positive woman and her newborn infant the following services or make the necessary referrals for these services:
    a. Management of the HIV disease.
    b. Case management to assist in coordination of necessary medical, social, and addictive services.

Universal Recommendation for Testing of Pregnant Women

For providers in New York

New York's regulatory framework for preventing mother-to-child transmission (MTCT) of HIV has proven highly effective and remains unchanged, except for the 2017 update that removed the requirement to obtain written or oral consent for HIV testing.

All pregnant women must be offered HIV testing as a clinical recommendation as early as possible during pregnancy. Third trimester testing is recommended for all pregnant women in New York State

(NYS) who tested negative for HIV earlier in their pregnancy.

When being offered HIV testing, the woman should be provided the key points of information and informed of her right to decline the test. Pregnant women who are diagnosed as living with HIV should be linked to treatment as soon as possible to protect their health and prevent transmission of HIV to the newborn.

Women who present to the labor/delivery setting with no history of HIV testing during their current pregnancy should be counseled with the recommendation for HIV testing. If the mother declines testing in labor/delivery, the mother should be informed that her newborn will be tested immediately at birth without her consent. All newborns, including those tested at birth, are routinely tested for HIV through the New York State Newborn Screening Program.

Documentation of the woman's prenatal HIV testing should be forwarded to the delivering hospital and a copy of the mother's HIV test history results should be placed in the newborn's medical record to ensure administration of medications during labor/delivery and initiation of medication to the infant for the first four-six weeks of life or until the infant is definitively excluded from HIV infection.

To access the latest regulations, visit:

- Section 69-1.3 - Responsibilities of the CEO of a Hospital
- Section 405.21 - Perinatal services

Acute HIV Infection During Pregnancy

For providers in New York

The acute HIV infection in pregnancy guidelines recommend the following:

- Confirmation of preliminary positive expedited HIV test results.
- Vigilance for acute HIV infection in pregnant women who present with a compatible clinical syndrome, even if a previous HIV antibody test during current pregnancy was negative.
- Evaluation for acute HIV infection in pregnant or breastfeeding women who present with a febrile "flu" or "mono" like illness, or rash that is not otherwise explained.

- Immediate screening for suspected acute HIV infection by obtaining an HIV serologic screening test in conjunction with a plasma HIV RNA assay (a fourth-generation HIV antigen/antibody combination test is the preferred serologic screening test, if available).
- Repeat HIV RNA testing from a new specimen to confirm the presence of HIV RNA if HIV RNA or antigen was detected in the absence of HIV antibody.
- Baseline genotypic testing and initiation of ART while waiting for the results of resistance testing.

For HIV-positive women, documentation should reflect receipt of appropriate care.

Labor and Delivery

For providers in New York

- Testing should be offered during labor and delivery for those who do not have documented third trimester HIV test results.
- Expedited testing of pregnant women who present for delivery without documentation of a negative HIV test should be made available.

Partner Services and the Role of Partner Services Programs

For providers in New York

Medical providers or their designee must explain to all newly diagnosed patients the importance of notifying any sexual or needle-sharing partners that they may have been exposed to HIV. Partner services is a cornerstone of HIV prevention efforts that provides an opportunity for sexual or needle-sharing contacts of a person living with HIV to be offered testing in a timely manner, and if diagnosed with HIV infection, be linked into care. Every physician or other person authorized to order diagnostic testing is required to report HIV and AIDS diagnoses to the health department. This report must include identifying information about any contacts known to the clinical provider or provided to the clinical provider by the patient.

The HIV/AIDS Provider Portal may be used to report cases (including partners) and to request assistance from the health department with partner notification. As part of post-test counseling, the following must

be provided to the patient:

1. An explanation of the importance of notifying sexual or needle-sharing partners to prevent further transmission, and to promote early access of exposed persons to HIV testing, health care, and prevention services;
2. A description of notification options and assistance available to the protected individual;
3. A discussion about the risk of domestic violence and screening for domestic violence prior to partner notification in accordance with New York State Department of Health (NYSDOH) domestic violence screening protocol;
4. The fact that known contacts, including a known spouse, will be reported to the health department. That protected persons will also be requested to cooperate in contact notification efforts of known contacts and that protected persons may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials; and
5. An explanation that the name and other information about the person living with HIV will be protected during the contact notification process.

The NYSDOH Partner Services Program and the New York City (NYC) Health Department Contact Notification Assistance Program (C-NAP) provide a wide range of services including performing notifications; assisting patients with decision-making; and consulting with health care providers.

In some situations, Partner Services Specialists can meet with the patient at the same time that the laboratory results are given to assist with post-test counseling and development of a partner notification plan. Additional NYSDOH/NYC Department of Health and Mental Hygiene (NYCHMH) services may be available such as assistance in locating persons who test positive but who do not return for their results.

For more information about partner services and how to contact partner services programs throughout NYS, click here.

Important!

For providers in New York

In recognition of the need for ongoing partner services beyond the time of initial diagnosis of HIV, the 2016 updates to the NYSDOH Regulations formally prioritized partner services for people previously

diagnosed with HIV who are at elevated risk of transmitting the virus to others. Several factors are considered as evidence of elevated risk of transmitting the virus to others. Those factors include that the individual:

1. is not engaged in health care services
2. is not virally suppressed
3. has had a recent STD or
4. has recently moved back to NYS from another jurisdiction.

In addition, the updated NYS DOH Regulations remove the requirement that data on the partners of HIV cases be destroyed after three years. The NYS DOH or local health department will establish a new policy for record retention and disposition.

Health Care Provider HIV Reporting Requirements

For providers in New York

New York State Public Health Law Article 21 requires the reporting of persons with HIV infection and AIDS to the NYS DOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the patient wishes to have notified. Under the federal HIPAA Privacy Rule, public health authorities have the right to collect or receive information "for the purpose of preventing or controlling disease" and in the "conduct of public health surveillance ... " without further authorization. This provision of HIPAA regulations authorizes medical providers to report HIV/AIDS cases to the NYS DOH or NYC Health Department without obtaining patient permission.

The Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF) (DOH-4189) must be completed within 14 days of diagnosis for persons with the following diagnoses or with known sex or needle-sharing partners:

- **Initial/New HIV diagnosis** – First report of testing documenting HIV diagnosis
- **Previously diagnosed HIV (non-AIDS)** – Applies to a medical provider who is seeing the patient for the first time
- **Initial/New diagnosis of AIDS** – Including <200 CD4 cells/µL or an opportunistic infection (AIDS-defining illness)

- **Previously diagnosed AIDS** – Applies to a medical provider who is seeing the patient for the first time
- **Known sex or needle-sharing partners of persons with diagnosed HIV infection**

Clinicians seeing for the first time a patient previously diagnosed with HIV or AIDS should report to the NYS DOH using the PRF. The rationale is that this is often the only indication the NYS DOH receives of a patient new to New York, but not newly diagnosed, and perhaps not in need of extensive Health Department Partner Services. Additionally, particularly for the well suppressed patient who moves into NYS, the report by the clinician can be the only indication that the person is in fact HIV positive.

Information regarding electronic reporting via the HIV/AIDS Provider Portal (see below) or paper forms are available from the NYS DOH at **518-474-4284**; clinicians located in NYC, call **212-442-3388**. To protect patient confidentiality, faxing of reports is not permitted.

HIV/AIDS Provider Portal

For providers in New York

The HIV/AIDS Provider Portal is an electronic system that enables clinicians to:

1. Meet their reporting requirements electronically
2. Provide a mechanism for clinicians statewide to notify the NYS DOH that a patient needs linkage to Health Department Partner Services and
3. Submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care.

A NYS DOH Health Commerce System (HCS) Medical Professionals account is required. After logging into the Health Commerce Systems, select **Refresh My Applications List** on the left side and then under **My Applications** select **HIV/AIDS Provider Portal**. Follow the prompts to set up an account.

Laboratory Reporting Requirements

For providers in New York

Laboratory reporting of suspected or confirmed positive findings or markers of HIV infection is mandated under New York State Public Health Law. Guidance has been prepared to assist permitted clinical laboratories and blood banks in meeting their obligations to report HIV-related laboratory test results, as well as other communicable disease markers. The guidance is available on the Wadsworth Laboratory website.

HIV laboratory reporting is an essential source of information for New York's HIV surveillance efforts and maintaining high-quality, complete data is critical to tracking progress toward National HIV/AIDS Strategy retention and care measures and New York's effort to end the epidemic. To keep pace with advances in HIV care, testing technologies and disease monitoring, there have been some important changes to HIV laboratory reporting requirements. Laboratories and blood/tissue banks performing tests for screening, diagnosis or monitoring of HIV infection for NYS residents and/or NYS health care providers (regardless of patient residence) shall report the following laboratory tests or series of tests used in the diagnosis of HIV infection:

- All reactive/repeatedly reactive initial HIV immunoassay results AND all positive, negative, or indeterminate results from all supplemental HIV immunoassays performed under the second or third step in the diagnostic testing algorithm, including HIV-1/2 antibody differentiation assay, HIV-1 Western blot, HIV-2 Western blot, or HIV-1 immunofluorescent assay
- All HIV nucleic acid (RNA or DNA) detection tests (qualitative and quantitative), including tests on individual specimens for confirmation of nucleic acid-based testing (NAT) screening results
- All CD4 lymphocyte counts and percentages, unless known to be ordered for a condition other than HIV
- HIV genotypic resistance testing via the electronic submission of the protease, reverse transcriptase, and integrase nucleotide sequence
- Positive HIV detection tests (culture, P24 antigen)

All HIV-related laboratory reporting, including by NYC providers and for NYC residents, should be made directly to the NYS DOH, submitted electronically via the NYS DOH Electronic Clinical Laboratory Reporting System (ECLRS).

To improve the quality of data, and in keeping with changes that allow for enhanced use of surveillance data to improve linkage and retention in care, laboratories are required to report results using patient

identifying, demographic and locating information, as well as the requesting provider and facility ordering the lab test. The 2016 update requires that when labs report HIV-related test results, the following information should be included:

- Patient identifying, demographic, and locating information
- Provider ordering the test and facility name
- Complete provider and facility address and telephone number
- Provider and facility National Provider Identification

For a complete list of this information and instructions on how to report required data elements, please call **518-474-4284** or contact BHAELab@health.ny.gov

In Labor and Delivery Settings, recommendations are:

- Adoption of point-of-care rapid HIV testing in labor and delivery settings
- Availability of expedited HIV test results prior to delivery to allow maximum benefits of intrapartum ARV prophylaxis for the fetus
- Steps to follow when expedited HIV testing yields a preliminary positive result
- Steps to follow when definitive test results indicate HIV infection is present
- Steps to follow when HIV infection has been definitely excluded in the mother

Pregnant women and exposed infants lost-to-care require immediate action for re-engagement. HIV-positive pregnant women and their exposed infants are a priority when identified as lost-to-care and require immediate action for reengagement. Reengagement in care is especially important for HIV-positive pregnant women who are in their third trimester due to possible increasing viral loads from being non-adherent to ART, leading to increased risk of transmitting HIV to their infants. Ensuring exposed infants are engaged in care is critical during the first 4-6 months to ensure appropriate antiretroviral and opportunistic infection prophylaxis, as well as definitive documentation of the infant's HIV infection status.

If routine attempts for re-engagement of the HIV-positive pregnant woman or her exposed or infected infant(s) are not successful, please contact the NYS DOH Perinatal HIV Prevention Program at **518-486-6048** or submit a request via the NYS DOH HIV/AIDS Provider Portal for assistance. New York City providers should call the NYC DOHMH Field Services Unit at **347-396-7601** for assistance with re-engagement of pregnant women.

Records and Reports

For providers in New York

- Create and maintain records and reports that are complete, legible, retrievable, and available for review; such records and reports shall include: a comprehensive prenatal care record for each pregnant woman that documents the provision of care and services required by this section and is maintained in a manner consistent with medical record confidentiality requirements
- A comprehensive prenatal care record should be maintained on each client. Entries should be complete, legible, and accurately reflect any of laboratory testing and special procedures
- Records should be maintained in a manner that safeguards confidentiality requirements
- Develop/implement system to track trimester of entry, low birth weight (LBW) infants, number of prenatal visits, postpartum rate of return, number of c/sections, vaginal births after cesarean sections (VBACs), number of women choosing to breastfeed, and number of teen pregnancies
- An annual report should be accurately completed and submitted within the expected time frame

Internal Quality Assurance

For providers in New York

- Develop and implement written policies and procedures establishing an internal quality assurance (IQA) program to identify, evaluate, resolve, and monitor actual and potential problems in patient care
- Implement IQA activities focusing on prenatal care within system-wide QA program
- Develop policies/procedures establishing internal quality assurance plan for prenatal care program
- Recommend IQA should be multidisciplinary and review issues such as nutrition, psychosocial, educational methods, care coordination, risk assessment, and HIV services

Have periodic IQA meetings to discuss prenatal issues:

- A documented and filed prenatal chart audit performed periodically on a statistically significant number of current prenatal client records
- An annual written summary evaluation of all components of such audits

- A system for determining patient satisfaction and for resolving patient complaints
- A system for developing and recommending corrective actions to solve identified problems
- A follow-up process to assure that recommendations and plans of correction are followed

Prenatal chart audits should be performed using 85-40 indicators.

A tool to conduct chart audit should be developed.

Prepare written summary evaluation of audit findings on an annual basis. Maintain audit summary on file. Develop system for determining patient satisfaction with prenatal program and resolving patient complaints. Recommend administering patient satisfaction survey during client's third trimester or at the postpartum visit.

Documentation should include summary reports of chart audit findings; analysis of outcome statistics; analysis of patient satisfaction survey results with recommendations to correct identified problems. All follow-up is done in a timely manner.

Postpartum Services

For providers in New York

Coordinate with the neonatal care provider to arrange for the provision of pediatric care services and patient services.

Stress importance of postpartum/pediatric visit to the mother during third-trimester visits. Develop strategies to encourage client to return for postpartum visit (i.e., incentives). Implement missed visit policy for 'no shows'.

A postpartum visit with a qualified health professional shall be scheduled and conducted in accordance with medical needs, ideally between 7-84 days after delivery. For the interim, furnish each woman with a means of contacting the provider in case postpartum questions or concerns arise.

Provide home visits to assess needs (e.g., adjustment to parenting, feeding, etc.) as indicated. Refer to **Care Coordination** section for additional guidance. Contents of home visit should be documented in the record.

Develop arrangements for client to contact provider between delivery and scheduled postpartum visit.

Postpartum Visit Components

For providers in New York

- Identify any medical, psychosocial, nutritional, alcohol treatment, and drug treatment needs of the mother or infant that are not being met;
- Refer the mother, or other infant caregiver to resources available for meeting such needs and provide assistance in meeting such needs where appropriate;
- Assess family planning needs and provide advice and services or referrals where indicated;
- Provide preconception counseling as appropriate and encourage a preconception visit prior to subsequent pregnancies for women who might benefit from such visit;
- Refer infants for preventive and special care;
- Establish a protocol to provide all postpartum components of care (i.e., identify the needs of woman/infant, necessary referrals, family planning, etc.).

Postpartum documentation should include delivery outcome, maternal physical exam, health status of mother/infant including medical, nutritional, and psychosocial needs with referrals.

Use a standardized medical record with postpartum section or separate postpartum visit tool outlining indicated components of care. If you have questions about the High-Risk Maternity Program, please call **800-871-5531**.

Supporting documentation is found here:

- https://www.health.ny.gov/prevention/nutrition/wic/breastfeeding
- https://www.health.ny.gov/health_care/medicaid/standards/perinatal_care

Medicaid Prenatal Guidelines

For providers in New York

The New York State Department of Health worked with internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. Additionally, Highmark has adopted these guidelines for all other lines of business for the maternity program.

These comprehensive changes will improve the quality of prenatal/postpartum care provided to pregnant women. View the Medicaid Prenatal Care Standards for more information.

5.1 Practice Guidelines and Standards of Care for HIV (NY Only)

For providers in New York

Highmark has adopted the New York State Department of Health AIDS institute's guidelines and criteria for medical care of adults, children, and adolescents with HIV infection.

For HIV Guidelines, review hivguidelines.org or nyhealth.gov/diseases/aids.

Confidentiality of HIV-Related Information

For providers in New York

Each health care provider is required to develop policies and procedures (P&P) to assure confidentiality of HIV-related information.

P&P must include:

- Initial and annual in-service education of staff and contractors.
- Identification of staff allowed access and limits of access.
- Procedure to limit access to trained staff (including contractors).
- Protocol for secure storage (including electronic storage).
- Procedures for handling requests for HIV-related information.
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

NYS DOH Requirements for HIV Counselling and Testing, and Care of HIV Positive Individuals

For providers in New York

Early identification of Human Immunodeficiency Virus (HIV) infection and entry into care can help HIV-infected persons live longer, healthier lives. In addition, identifying infection can help prevent the spread of the disease through education.

The NYS DOH has requirements regarding HIV counseling, testing, and reporting. Established guidelines help increase HIV testing, ensure entry into care, and expand laboratory reporting.

An HIV test is the only way to determine whether someone has HIV. The decision to have an HIV test is voluntary.

All practitioners and providers must comply with the HIV confidentiality provisions of Title 27-F of the New York State Public Health Law.

Routine HIV Testing in Medical Settings

For providers in New York

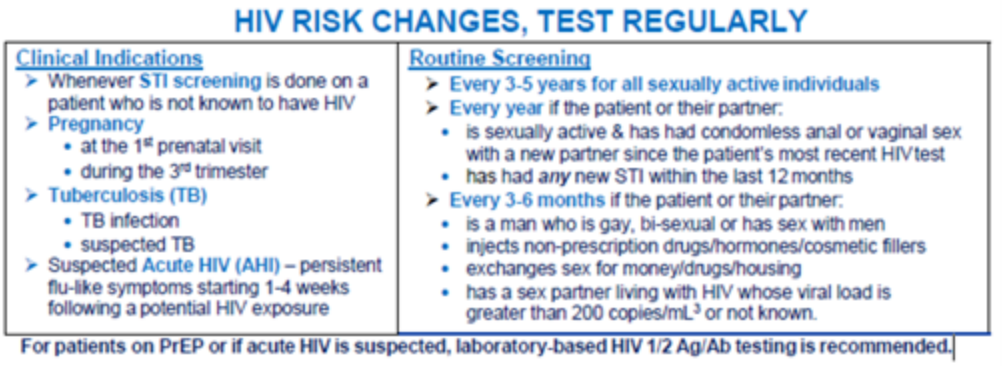
HIV testing should be a routine part of medical care and other services. Recent data indicate that routine HIV testing may be cost effective, even in areas with seroprevalence lower than one percent.

HIV testing MUST be offered to all persons over the age of 13 receiving hospital or primary care services, with limited exceptions noted in the law. The offering must be made to those inpatient persons seeking services in emergency rooms, and persons receiving primary care as an outpatient at a clinic, or from a physician, physicians' assistant, nurse practitioner, or midwife.

Health care providers in NYS are encouraged to routinely discuss HIV with their patients, regardless of their perceived risk. Since many patients may not be comfortable disclosing risk, providers should adopt a low threshold for recommending testing.

There are three exceptions to the requirement to offer HIV testing:

- If the individual...
  - is being treated for life-threatening emergency;
  - has previously been offered or has previously been tested for HIV (unless otherwise indicated due to more recent risk behavior);
  - has been determined by the attending provider to lack mental capacity to consent.



HIV RISK CHANGES, TEST REGULARLY

Clinical Indications	Routine Screening
➢ Whenever STI screening is done on a patient who is not known to have HIV ➢ Pregnancy • at the 1st prenatal visit • during the 3rd trimester ➢ Tuberculosis (TB) • TB infection • suspected TB ➢ Suspected Acute HIV (AHI) – persistent flu-like symptoms starting 1-4 weeks following a potential HIV exposure	➢ Every 3-5 years for all sexually active individuals ➢ Every year if the patient or their partner: • is sexually active & has had condomless anal or vaginal sex with a new partner since the patient's most recent HIV test • has had *any* new STI within the last 12 months ➢ Every 3-6 months if the patient or their partner: • is a man who is gay, bi-sexual or has sex with men • injects non-prescription drugs/hormones/cosmetic fillers • exchanges sex for money/drugs/housing • has a sex partner living with HIV whose viral load is greater than 200 copies/mL^3 or not known.

For patients on PrEP or if acute HIV is suspected, laboratory-based HIV 1/2 Ag/Ab testing is recommended.

Documentation Requirements

For providers in New York

According to the Public Health Law, the following elements pertaining to HIV testing should be documented in the patient medical record:

- The patient was advised that HIV testing is being done;
- If the patient declines the HIV test; and

- For patients with confirmed HIV infection, the name of the provider/facility with whom the follow-up appointment was made.

How Often Does the Offer of HIV Testing Need to be Repeated?

For providers in New York

In addition to offering HIV testing once in the course of routine care, testing should be offered annually to patients whose behavior indicates elevated risk. To promote early identification, HIV testing may be offered as frequently as every three months to patients with identified risk behaviors. Since many people choose not to disclose their risk behaviors, providers should consider adopting a low threshold for recommending HIV testing.

Requirement for Written or Oral Patient Informed Consent to HIV Testing

For providers in New York

Effective November 28, 2016, amendments to the New York State Public Health Law removed the requirement for written or oral informed consent prior to ordering an HIV-related test, including elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms. The objective of the update is to eliminate barriers to HIV testing and make HIV testing comparable to the manner in which other important laboratory tests are conducted. HIV testing remains voluntary and patients have the right to refuse an HIV test, but obtaining written or oral consent for testing is no longer required in any setting. Patients must be advised orally that an HIV test is going to be performed. If the patient objects to the HIV test, this should be noted in the patient's medical record. HIV test requisition forms submitted to laboratories do not require provider certification of informed consent.

Important!

For providers in New York

Prior to conducting diagnostic HIV testing, information about HIV must be provided orally, in writing, through signage, or in any other patient-friendly, audio-visual format. Placing the NYS DOH HIV testing clinic poster in a visible location or providing patients with the NYS DOH patient brochure on HIV testing are simple ways of conveying this information to patients. The key points of information that must be provided are:

- HIV testing is voluntary, and all HIV test results are confidential (private).
- HIV can be transmitted through unprotected sex, sharing needles, childbirth, or breastfeeding.
- Treatment for HIV is very effective, has few or no side effects, and may involve taking just one pill once a day.
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment or taking HIV pre-exposure prophylaxis (PrEP). Not sharing needles and practicing safer sex will help protect against HIV, hepatitis C, and other STDs.
- It is illegal to discriminate against a person because of his or her HIV status and services are available to help address discrimination.
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- HIV testing is a routine part of health care, but you have the right to decline an HIV test; testing will not be performed if you object; if you wish to decline HIV testing, inform the health care provider.
- If the patient declines the offer of an HIV test, this should be noted in the patient's medical record. For patients diagnosed as living with HIV, the health care provider administering testing must arrange, with the consent of the patient, an appointment for HIV medical care; simply providing the name of a care provider is not sufficient; a specific appointment with a provider who offers HIV care should be provided.

These new provisions apply to all HIV testing in New York State and not just for testing as offered to people over the age of 13 in clinical settings.

For additional information, please visit the Department's website by clicking here.

Questions may be sent to hivtestlaw@health.ny.gov

Expansion of Minor Consent for HIV Treatment and Preventive Services

For providers in New York

The 2017 amendments to NYS DOH's regulations allow minors to consent to their own HIV treatment and HIV preventive services such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) without parental/guardian involvement (10 NYCRR Part 23). Part 23 has long established the legal capacity of minors to consent to treatment and preventive services for sexually transmitted diseases (STDs). Provisions in Part 23 require that the Commissioner of Health promulgate a list of sexually transmitted diseases. The 2017 amendments to 10 NYCRR Part 23 added HIV to the list of STDs, thereby bringing minor capacity to consent to HIV treatment and preventive services on par with other STDs. In addition, under Part 23, medical or billing records may not be released or made available to the parent or guardian without the minor patient's permission.

After being diagnosed, young people currently face barriers that can prevent or delay access to care, including denial and fear of their HIV status, misinformation, HIV-related stigma, low self-esteem, lack of insurance, homelessness, substance use, mental health issues, and lack of adequate support systems. Because of these factors, many young people need the ability to consent to their HIV treatment. Updates to regulation help ensure that more young people have optimal health outcomes and prevent transmission of HIV to others. In addition, minors will now have the ability to consent to HIV-related preventive services, including PrEP and PEP just as they can consent for other reproductive or sexual health-related services.

Post-Test Counseling and Requirements to Link Newly Diagnosed Patients to HIV Care

For providers in New York

When testing indicates a diagnosis of HIV infection, the person ordering HIV testing or their representative must provide the patient the final interpretation of diagnostic testing, and, with the patient's consent, schedule an appointment for follow-up HIV medical care.

Important!

For providers in New York

A person with laboratory evidence of acute or early HIV infection (i.e., detectable HIV antigen and virus, but no evidence of HIV antibodies) has a high likelihood of passing the virus to sexual or needle-sharing partners and should be counseled about how to avoid passing the virus to others.

Patient Education That Should be Provided

For providers in New York

Patients should be educated on the following:

- That the diagnosis means the person is living with HIV, a lifelong health condition.
- That people can live a healthy life with HIV; HIV treatment is effective, has few or no side effects, and may involve taking just one pill once a day.
- That financial assistance is available, if needed, for HIV medical care and HIV medications.
- That the patient can pass HIV to sexual or needle-sharing partners and strategies for avoiding transmission, including information about mother-to-child transmission.
- The importance of notifying sexual or needle-sharing partners to prevent further transmission and to promote access of exposed persons to HIV testing, health care, and prevention services.
- The range of partner notification options and available partner services programs.
- That names and other information about the patient is not shared during the partner notification process.
- That known contacts, including a known spouse, are reported to the health department.
- The risk of domestic violence and performance of domestic violence screening using the NYS DOH-approved domestic violence screening protocol.
- That HIV-related information is confidential; information may be shared with medical providers to provide needed care but may not be shared with others without patient authorization to release confidential HIV-related information.

- That a minor who has been diagnosed with HIV may consent to their own HIV treatment (if applicable).
- That patient authorization to release confidential HIV-related information may be revoked at any time.
- That discrimination against persons with HIV in the areas of employment, housing, public accommodations, health care, and social services is prohibited by law.
- That all cases of HIV infection are reported to the health department.
- That if a person with HIV appears to be out of care, he or she may be contacted by the medical provider or health department staff to address barriers to entry into care and promote engagement in care.

Important!

For providers in New York

Undetectable equals Untransmittable (U=U): There are many important reasons to start HIV treatment as soon as possible. In addition to getting treatment to support their own health, a person living with HIV who is on HIV treatment and virally suppressed for 6 months or longer has effectively no risk of passing HIV to a partner through sex.

Persons Who Test Negative for HIV Infection

For providers in New York

A person who tests negative for HIV infection must be informed of the result and provided information concerning the risk of acquiring HIV through sexual and needle-sharing activities. Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) should be discussed as prevention options. This information may be in the form of written materials such as the NYS DOH document titled Information on Non-reactive (Negative) HIV Test Results.

The negative test result and required information do not need to be provided in person. Other mechanisms such as email, mail, and phone may be used as long as there is an established protocol. Alternative methods of delivering results must be discussed with the patient. It is not appropriate to tell patients that if they are not contacted, they may assume their test was negative.

Patients with potential recent exposure to HIV present diagnostic challenges due to the "window period," or the length of time after infection that it takes for antibodies or the virus to be detected by HIV diagnostic tests. More information about the window period for various types of tests can be found here. Clinicians should be familiar with the testing process used by the laboratory conducting testing for their patients because recommendations for retesting patients with recent exposure will vary depending on the test used.

Persons With Inconclusive or Incomplete HIV Diagnostic Testing Results

For providers in New York

A person with inconclusive or incomplete HIV diagnostic testing results, i.e., when the HIV Diagnostic Testing Algorithm did not produce an overall valid or conclusive result, shall be informed that the test result was inconclusive or incomplete and have an additional specimen collected as soon as possible. In these cases, the entire algorithm should be repeated. More information is available at: Information for Clinicians on a New Diagnostic Testing Algorithm for Human Immunodeficiency Virus (HIV) Infection

The New York State Health Department may be able to assist if you have difficulty locating a patient in need of additional testing to resolve inconclusive HIV diagnostic testing through Information on Partner Services.

Universal Recommendation for Testing of Pregnant Women

For providers in New York

New York's regulatory framework for preventing mother-to-child transmission (MTCT) of HIV has proven highly effective and remains unchanged. The only exception is that the 2017 updates to HIV testing do remove the requirement to obtain consent for HIV testing in writing or orally. All pregnant women must be offered HIV testing as a clinical recommendation as early as possible during pregnancy. Third-trimester testing is recommended for all pregnant women in NYS who tested negative for HIV earlier in their pregnancy. When being offered HIV testing, the woman should be provided the key points of information and informed of her right to decline the test. Pregnant women who are diagnosed as living with HIV should be linked to treatment as soon as possible to protect their health and prevent transmission of HIV to the newborn.

Women who present to the labor/delivery setting with no history of HIV testing during their current pregnancy should be counseled with the recommendation for HIV testing. If the mother declines testing in labor/delivery, the mother should be informed that her newborn will be tested immediately at birth without her consent. All newborns, including those tested at birth, are routinely tested for HIV through the New York State Newborn Screening Program. Documentation of the woman's prenatal HIV testing should be forwarded to the delivering hospital and a copy of the mother's HIV test history results should be placed in the newborn's medical record to ensure administration of medications during labor/delivery and initiation of medication to the infant for the first four-six weeks of life or until the infant is definitively excluded from HIV infection. To access the latest regulations visit:

Title: Section 69-1.3 - Responsibilities of the CEO of a Hospital

Title: Section 405. 21 - Perinatal services

Acute HIV Infection During Pregnancy

For providers in New York

The acute HIV infection in pregnancy guidelines recommend the following:

- Confirmation of preliminary positive expedited HIV test results;
- Vigilance for acute HIV infection in pregnant women who present with a compatible clinical syndrome, even if a previous HIV antibody test during current pregnancy was negative;

- Evaluation for acute HIV infection in pregnant or breastfeeding women who present with a febrile "flu" or "mono" like illness, or rash that is not otherwise explained;
- Immediate screening for suspected acute HIV infection by obtaining an HIV serologic screening test in conjunction with a plasma HIV RNA assay (a fourth-generation HIV antigen/antibody combination test is the preferred serologic screening test, if available);
- Repeat HIV RNA testing from a new specimen to confirm the presence of HIV RNA if HIV RNA or antigen was detected in the absence of HIV antibody; and
- Baseline genotypic testing and initiation of ART while waiting for the results of resistance testing.

Rapid Test Technology

For providers in New York

Rapid HIV antibody tests that can provide a preliminary* result during a single appointment are recommended. Individuals may be more likely to be tested for HIV if they know that the appointment, inclusive of counseling, consent, and testing, will be relatively brief.

*Further testing is always required to confirm a reactive (preliminary positive) screening test result.

Consent for rapid HIV testing can be oral and noted in the medical record, including:

- Offering of testing during labor and delivery for those who do not have documented third trimester HIV test results; and
- Availability of expedited testing of pregnant women who present for delivery without documentation of a negative HIV test.

In Labor and Delivery Settings, recommendations are:

- Adoption of point of care rapid HIV testing in labor and delivery settings;
- Availability of expedited HIV test results prior to delivery to allow maximum benefits of intrapartum ARV prophylaxis for the fetus;
- Steps to follow when expedited HIV testing yields a preliminary positive result;
- Steps to follow when definitive test results indicate HIV infection is present; and
- Steps to follow when HIV infection has been definitely excluded in the mother.

Additional information about rapid testing is available at the Department of Health's: HIV Testing

Additional Material:

- Medicaid Prenatal Care Standards
- Maternal-Pediatric HIV Prevention and Care Program Test History and Assessment

AIDS Institute NYS DOH Counseling and Testing Resources

For providers in New York

The following numbers are available to call for HIV information, referrals, or information on how to obtain a free HIV test without having to give the client's name and without waiting for an available appointment:

- Counseling/Testing: **800-541-AIDS**

Special initiatives are available to providers who want to arrange for a program presentation or possible anonymous HIV counseling and testing at their sites. Providers should contact the regional coordinator of the Anonymous HIV Counseling and Testing Program at the appropriate toll-free number listed above.

NYSDOH AIDS Institute Resource Directory

For providers in New York

The NYS DOH AIDS Institute has a resource directory intended for use by individuals seeking services and as a referral tool for providers. This directory is arranged by region, with each organization listed under the region it services, and then by the service(s) it provides. This directory can be found at the Department of Health.

About the AIDS Institute

Partner Services and the Role of Partner Services Program

For providers in New York

Medical providers or their designee must explain to all newly diagnosed patients the importance of notifying any sexual or needle-sharing partners that they may have been exposed to HIV. Partner services is a cornerstone of HIV prevention efforts that provides an opportunity for sexual or needle-sharing contacts of a person living with HIV to be offered testing in a timely manner, and if diagnosed with HIV infection, be linked into care. Every physician or other person authorized to order diagnostic testing is required to report HIV and AIDS diagnoses to the health department. This report must include identifying information about any contacts known to the clinical provider or provided to the clinical provider by the patient. The HIV/AIDS Provider Portal may be used to report cases (including partners) and to request assistance from the health department with partner notification. As part of post-test counseling, the following must be provided to the patient:

1. An explanation of the importance of notifying sexual or needle-sharing partners to prevent further transmission, and to promote early access of exposed persons to HIV testing, health care, and prevention services.
2. A description of notification options and assistance available to the protected individual.
3. A discussion about the risk of domestic violence and screening for domestic violence prior to partner notification in accordance with NYS DOH domestic violence screening protocol.
4. The fact that known contacts, including a known spouse, will be reported to the health department; that protected persons will also be requested to cooperate in contact notification efforts of known contacts and that protected persons may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials.
5. An explanation that the name and other information about the person living with HIV will be protected during the contact notification process.

The NYS DOH Partner Services Program and the New York City (NYC) Health Department Contact Notification Assistance Program (C-NAP) provide a wide range of services, including performing notifications; assisting patients with decision making; and consulting with health care providers. In some situations, Partner Services specialists can meet with the patient at the same time that the laboratory results are given to assist with post-test counseling and development of a partner notification plan. Additional NYS DOH/NYC Department of Health and Mental Hygiene (NYCHMH) services may be available, such as assistance in locating persons who test positive but who do not return for their results.

For more information about partner services and how to contact partner services programs throughout NYS, visit: Information on Partner Services.

Important!

For providers in New York

In recognition of the need for ongoing partner services beyond the time of initial diagnosis of HIV, the 2016 updates to the NYS DOH Regulations formally prioritized partner services for people who were previously diagnosed with HIV and who are at elevated risk of transmitting the virus to others. Several factors are considered as evidence of elevated risk of transmitting the virus to others. Those factors include that the individual:

1. Is not engaged in health care services;
2. Is not virally suppressed;
3. Has had a recent STI; or
4. Has recently moved back to NYS from another jurisdiction.

In addition, the updated NYS DOH Regulations remove the requirement that data on the partners of HIV cases be destroyed after three years. The NYS DOH or local health department will establish a new policy for record retention and disposition.

Health Care Provider HIV Reporting Requirements

For providers in New York

New York State Public Health Law Article 21 requires the reporting of persons with HIV infection and AIDS to the NYS DOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the patient wishes to have notified. Physicians and others authorized to order HIV testing are required to report any determination or diagnosis of HIV infection, including primary HIV infection, acute retroviral syndrome, and early HIV infection, within one day (24 hours) of such determination or diagnosis. Insurance institutions, insurance support

organizations, and health care providers associated with or under contract to a health maintenance organization or other medical services plan are subject to these regulations, except as noted in section 63.6(a)(9), (10), and (12).

The Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF) (DOH-4189) must be completed no later than seven days after the provider's receipt of a positive laboratory result or after diagnosis, whichever is sooner, for persons with the following diagnoses:

- Initial/New HIV diagnosis – First report of HIV antigen/antibody positive test results;
- Previously diagnosed HIV infection (non-AIDS) – Applies to a medical provider who is seeing the patient for the first time;
- Initial/New diagnosis of AIDS – Including <200 CD4 cells/µL or an opportunistic infection (AIDS-defining illness);
- Previously diagnosed AIDS – Applies to a medical provider who is seeing the patient for the first time;
- Known sex or needle-sharing partners of persons with diagnosed HIV infection.

Medical providers must complete the NYS Medical Provider HIV/AIDS and Partner/Contact Report Form (DOH-4189) for all reportable cases. For information regarding electronic reporting or paper forms, please call the NYS DOH at **518-474-4284.** Completed paper Provider Report Forms for practitioners outside of NYC can be mailed to:

Division of Epidemiology, Evaluation, and Partner Services
P.O. Box 2073, ESP Station
Albany, NY 12220-0073

For clinicians located in NYC, please call **212-442-3388.** To protect patient confidentiality, faxing of reports is not permitted.

HIV/AIDS Provider Portal

For providers in New York

The HIV/AIDS Provider Portal is an electronic system that enables clinicians to:

- Meet their reporting requirements electronically
- Provide a mechanism for clinicians statewide to notify the NYS DOH that a patient needs linkage to Health Department Partner Services and
- Submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care.

After logging into the Health Commerce Systems, select **Refresh My Applications List** on the left side and then under **My Applications** select HIV/AIDS Provider Portal. Follow the prompts to set up an account.

Laboratory Reporting Requirements

For providers in New York

Laboratory reporting of suspected or confirmed positive findings or markers of HIV infection is mandated under New York State Public Health Law. Guidance has been prepared to assist permitted clinical laboratories and blood banks in meeting their obligations to report HIV-related laboratory test results, as well as other communicable disease markers. The guidance is available here.

HIV laboratory reporting is an essential source of information for New York's HIV surveillance efforts and maintaining high quality, complete data is critical to tracking progress toward National HIV/AIDS Strategy retention and care measures and New York's effort to end the epidemic. To keep pace with advances in HIV care, testing technologies and disease monitoring, there have been some important changes to HIV laboratory reporting requirements.

Laboratories and blood/tissue banks performing tests for screening, diagnosis, or monitoring of HIV infection for NYS residents and/or NYS health care providers (regardless of patient residence) shall report the following laboratory tests or series of tests used in the diagnosis of HIV infection:

- All reactive/repeatedly reactive initial HIV immunoassay results AND all positive, negative, or indeterminate results from all supplemental HIV immunoassays performed under the second or third step in the diagnostic testing algorithm, including HIV-1/2 antibody differentiation assay, HIV-1 Western blot, HIV-2 Western blot, or HIV-1 immunofluorescent assay.

- All HIV nucleic acid (RNA or DNA) detection tests (qualitative and quantitative), including tests on individual specimens for confirmation of nucleic acid-based testing (NAT) screening results.
- All CD4 lymphocyte counts and percentages, unless known to be ordered for a condition other than HIV.
- HIV genotypic resistance testing via the electronic submission of the protease, reverse transcriptase, and integrase nucleotide sequence.
- Positive HIV detection tests (culture, P24 antigen).

All HIV-related laboratory reporting, including by NYC providers and for NYC residents, should be made directly to the NYS DOH, submitted electronically via the NYS DOH Electronic Clinical Laboratory Reporting System (ECLRS).

To improve the quality of data, and in keeping with changes that allow for enhanced use of surveillance data to improve linkage and retention in care, laboratories are required to report results using patient identifying, demographic and locating information, as well as the requesting provider and facility ordering the lab test. The 2016 update requires that when labs report HIV-related test results, the following information should be included:

- Patient identifying, demographic, and locating information
- Provider ordering the test and facility name;
- Complete provider and facility address and telephone number; and
- Provider and facility National Provider Identification.

For a complete list of this information and instructions on how to report required data elements, please call **518-474-4284** or contact BHAELab@health.ny.gov

Care of HIV Positive Individuals

For providers in New York

The NYS DOH AIDS Institute's clinical guidelines pertaining to HIV prevention and the medical management of adults, children, and adolescents with HIV infection can be found on the Department of Health AIDS Institute website.

All clinical care settings should be prepared, either on-site or with a confirmed referral, to support patients in initiating antiretroviral therapy (ART) as rapidly as possible after diagnosis.

A new HIV diagnosis is an immediate call to action for every provider who engages with that individual, to assure the rapid initiation of antiretroviral treatment (RIA). New York State Department of Health (NYS DOH) HIV Clinical Guidelines state that treatment is recommended for all patients with a confirmed HIV diagnosis regardless of their CD4 cell count or viral load. All providers serving persons with HIV should establish systems which strive for the same-day initiation of HIV treatment, even while initial lab work is pending. While same-day initiation of treatment may not always be possible, it is ideal that patients be started on treatment within three days. In the outpatient setting, in no instance should treatment initiation take longer than 30 days.

On April 1, 2014, Public Health Law Section 2135 was amended to promote linkage and retention in care for HIV-positive persons. The law allows the NYS DOH and New York City Department of Health and Mental Hygiene (NYC DOHMH) to share information with health care providers for the purposes of patient linkage and retention in care. The NYS DOH AIDS Institute recommends that health care providers take a multi-pronged approach to support their patients' retention in care, including but not limited to the following:

- Have a proactive patient plan: do not wait for a lapse in care to discuss what to do if the patient becomes lost-to-care.
- Create a patient-centered atmosphere, where all members of the medical care teams (e.g., reception staff, phlebotomists, medical providers) promote patient engagement, linkage, and retention in care.
- When acceptable to patients, expand authorization dates on *Authorization for Release of Health Information and Confidential HIV-Related Information* forms (DOH-2557) to at least two years. Extending consent timeframes allows collaboration across sectors. Have DOD-2557 consent forms on file for every patient. This will permit you to contact community-based organizations (CBOs) and others in the event of a lapse in care. Examples of CBOs that can help return patients to care include but are not limited to: HIV/AIDS CBOs: Health Homes and their downstream providers; food and nutrition programs; shelters; substance use treatment facilities; housing providers; mental health providers; prenatal care providers, etc.
- Encourage patients to add your practice's name to any releases they sign with other organizations.
- Work with patients to update releases prior to when the releases expire (if applicable).

- Become a member of your area's Health Home network(s) if you have not already done so, visit Find A Health Home.

Leverage Existing Resources for Patient Re-Engagement

For providers in New York

- Use information from the Regional Health Information Organization (RHIO), if available, to determine if the patient is in care with another provider or if updated personal contact information is available.
- Conduct a health insurance benefits check, if available, on the patient to determine if he/she changed insurance or is in care with another provider.
- If the patient is in a Managed Care plan, the plan will have updated contact information, recent use of care, and medications on file. If this is a Medicaid Managed Care Plan, the plan can identify which Health Home the patient may be enrolled in as this information may be useful to your follow-up efforts.
- If your patient is enrolled in a Health Home and has signed a release, contact the Health Home to determine whether the patient is actively enrolled. If yes, request assistance to contact or re-engage the patient in care.
- If your patient has Medicaid but has not been enrolled in a Health Home, contact the Health Home to make an "upstream referral." The patient will be referred to a provider who may conduct outreach to the patient's home.
- Try multiple modes of contact (phone, text, letter, email, and social media) at varying times of the day/week to reach the patient (special consideration for social media sites - contact patient from an agency social media account and not a staff person's personal account).
- If your patient uses other services within the facility (e.g., WIC, dental, child's provider), place an alert on the Electronic Medical Record (EMR) to reconnect to the HIV Primary Care Provider and, if pregnant, to her prenatal care provider.
- As authorized in patient releases and/or medical charts, work with emergency contacts and other agencies/providers to determine whether they have had recent patient contact.
- Conduct a home visit if resources allow. If you have a peer program, utilize peers to provide outreach to the patient's home.

Use External Systems to Expand Your Search When You Cannot Find a Patient

For providers in New York

Review public records such as:

- New York Free Public Records Directory (property tax rolls, municipal tax rolls, etc.)
- Parole Lookup
- NYS County Jail Inmate Lookup
- NYC Department of Corrections Inmate Lookup
- NYS Department of Corrections and Community Supervision Inmate Lookup
- Consider using people search engines, local newspapers, and police blotters.
- National Program of Cancer Registries
    - A user ID and password are required to access the site and may be obtained by calling 301-572-0502.

Pregnant Women and Exposed Infants Lost-to-Care Require Immediate Action for Re-Engagement

For providers in New York

HIV-positive pregnant women and their exposed infants are a priority when identified as lost-to-care and require immediate action for re-engagement. Re-engagement in care is especially important for HIV-positive pregnant women who are in their third trimester due to possible increasing viral loads from being non-adherent to ART, leading to increased risk of transmitting HIV to their infants. Ensuring exposed infants are engaged in care is critical during the first 4-6 months to ensure appropriate antiretroviral and opportunistic infection prophylaxis, as well as definitive documentation of the infant's HIV infection status.

If routine attempts for re-engagement of the HIV-positive pregnant woman or her exposed or infected infant(s) are not successful, please contact the NYS DOH Perinatal HIV Prevention Program at **518-486-6806** or submit a request via the NYS DOH HIV/AIDS Provider Portal (see below) for assistance. NYC

providers should call the NYC DOHMH Field Services Unit at **347-396-7601** for assistance with re-engagement of pregnant women.

Providers in NYS Based Outside of NYC

For providers in New York

After exploring the investigation tools and strategies listed above and if patient follow-up is warranted, the Bureau of HIV/AIDS Epidemiology (BHAE) may be able to provide information regarding a patient's care status through the NYS DOH HIV/AIDS Provider Portal. The HIV/AIDS Provider Portal is an electronic system which enables clinicians to:

1. Meet their reporting requirements electronically;
2. Provide a mechanism for clinicians statewide to notify the NYS DOH that a patient needs linkage to Health Department Partner Services; and
3. Submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care.

A NYS DOH Health Commerce System (HCS) Medical Professionals account is required. To apply for an HCS Medial Professions account, visit NYS Department of Health.

Pre-Exposure Prophylaxis (PReP)

For providers in New York

In May 2014, the Centers for Disease Control and Prevention (CDC) released its guidelines for the use of daily pre-exposure prophylaxis (PrEP) for the prevention of HIV infection. The following CDC PrEP documents are available:

- Pre-exposure Prophylaxis for HIV Prevention in the United States - 2014. A Clinical Practice Guideline

- Pre-exposure Prophylaxis for the Prevention of HIV in the United States - 2017 Update

The New York State Health Department urges providers to adhere to CDC and New York State guidelines with their patients on PrEP by:

- Testing for HIV every three months using a laboratory-based, ideally 4th generation HIV test;
- Assessing for signs of acute HIV infection at every visit;
- Having a low threshold for testing for acute HIV and STIs; and
- Encouraging patients on PrEP (or on HIV treatment) to use condoms as often as possible.

Visit Pre Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) for more information.

Reporting Suspected Seroconversion

For providers in New York

Providers who manage patients on PrEP are strongly encouraged to immediately report any cases of suspected PrEP/PEP breakthrough HIV infection as follows:

1. **NYC**: Report cases to the New York City Department of Health and Mental Hygiene by calling **212-442-3388**
2. **Remainder of state**: Report cases to New York State Department of Health by calling **518-474-4284** or using DOH-4189 and contacting the local Partner Services Program to discuss the case.

State law requires that providers report all cases of HIV infection as soon as possible but no later than seven days after diagnosis. Rapid case reporting is critical, because it allows health departments to investigate the case and engage field staff to:

1. Conduct outreach to the patient's social network;
2. Make HIV testing available to exposed partners; and
3. Reduce secondary transmission by expediting linkage to care and PrEP/PEP referrals.

5.1 Tuberculosis (NY Only)

For providers in New York

Tuberculosis Facts and Internet Resources

Tuberculosis (TB) is a bacterial disease usually affecting the lungs. TB is spread through the air and can affect anyone of any age. Treatment can be complicated and often includes taking medication for three to nine months.

More Information About Tuberculosis (TB)

5.1 Blue Distinction Programs

Blue Cross and Blue Shield companies work with more than 90 percent of all doctors and hospitals nationwide and, therefore, have a unique perspective on doctors and hospitals that are effective in improving patient care and health. This perspective is the foundation of Blue Distinction®, the Blue Cross and Blue Shield national doctor and hospital recognition program. These recognized doctors and hospitals are changing health care to be more patient-focused, coordinated, and in many cases, affordable.

Blue Distinction designations are based on strict performance criteria formulated through insights and recommendations from the medical community to be consistent with medical advances and current clinical practices, guidelines, and measurement. The aim of the Blue Distinction designation is to help Blue Plan members find the highest quality care available in their area. The Blue Distinction portfolio includes three programs:

- **Specialty Care** recognizes providers that demonstrate proven expertise in delivering effective and cost-efficient care for select specialty areas. The program targets procedures and episodes of care in areas of high or increasing demand, yet with variations in quality and cost.
- **Total Care** recognizes providers participating in locally tailored programs (Patient-Centered Medical Homes, Accountable Care Organizations, or similar programs) designed to lower cost trend through better coordinated care and performance-based payment.

- **Flexible Network** is the nation's largest custom-tiered network solution, enabling accounts to achieve the optimal balance of savings and employee access via customizable benefit levels.

Blue Distinction Specialty Care

The Specialty Care Program relies on objective, nationally-consistent quality and affordability criteria, enabling Blue Cross and Blue Shield Plans to recognize providers that demonstrate expertise in delivering quality specialty care effectively and cost-efficiently.

The foundation of Specialty Care is the quality-focused Blue Distinction Center designation. An additional and more select value-based designation, Blue Distinction Center+, further distinguishes providers delivering quality, cost-efficient specialty care. Quality is key: only those providers that first meet Blue Distinction Centers' objective, nationally-consistent quality criteria are considered for designation as a Blue Distinction Center+.

The Blue Distinction Specialty Care Program includes two levels of designation:

- Blue Distinction Centers are health care facilities recognized for their expertise in delivering quality specialty care safely and effectively.
- Blue Distinction Centers+ are health care facilities recognized for their expertise and efficiency in delivering specialty care. To earn this designation, hospitals must meet the same quality criteria as Blue Distinction Centers, and then go an extra step to demonstrate they do so efficiently (i.e., cost of care measures).

Blue Distinction Specialty Care has seven areas of specialty care:

- Bariatric surgery
- Maternity care
- Cardiac care
- Spine surgery
- Cancer care
- Transplants
- Knee and hip replacement
- Fertility care

- Gene therapy

Blue Distinction Total Care

Blue Distinction Total Care is a national program that recognizes doctors who spend more time on prevention, holistic (“total”) care, and personalized care planning for their patients. Total Care encourages a focus on health care instead of sick care. The program is designed to encourage strong relationships between doctors and their patients that can lead to better health.

Designation as a Blue Distinction Total Care provider means this provider has met the established national criteria and has been designated by the local plan. Blue Cross and Blue Shield companies nationwide use the same criteria to select programs for Blue Distinction Total Care.

Blue Distinction Specialty Care Benefit Designs

Highmark offers health plans that may include a benefit for Blue Distinction Specialty Care. Members may be able to reduce their out-of-pocket costs by receiving quality care in any one of five specialty areas at Blue Distinction Center and/or Blue Distinction Center+ providers.

These Blue Distinction service-based plans recommend Blue Distinction Centers/Centers+ for the following specialty care: bariatric surgery, cardiac care, knee and hip replacement, spine surgery, and transplants. These benefit plans may also include a travel and lodging benefit for members who may have to travel beyond a specified mileage limit to access a Blue Distinction Center.

To assure Highmark members receive the highest quality specialty care, professional providers are encouraged to recommend facilities that have received Blue Distinction designation. As you verify a member’s eligibility and benefits prior to rendering services and making recommendations for specialty care, please be sure to verify if the member’s coverage includes a benefit for Blue Distinction Specialty Care.

Locating Blue Distinction Recognized Providers

Information on Blue Distinction designations for participating physicians and hospitals is available in the Highmark Provider Directory. The Provider Directory is accessible on the home page of Highmark.com. Click on **Accreditations** on the provider's profile page to determine if a physician has received the Blue Distinction Total Care designation or the facility has received Blue Distinction Center and/or Blue Distinction Center+ designation(s) for any of the seven types of specialty care.

BCBSA Blue Distinction Center Finder

To locate Blue Distinction Centers and Blue Distinction Centers+ near you or in other locations, you can also use the Blue Cross and Blue Shield Association's Blue Distinction Center Finder.

5.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 2: Authorizations

5.2 Introduction

Highmark requires authorization of all inpatient admissions, medical and behavioral health. In addition, authorization is required for certain outpatient services, procedures, and durable medical equipment and supplies prior to performing the services or providing the supplies.

Authorization must be requested prior to the initiation of these services in accordance with the member's plan and Highmark administrative requirements. When requesting an authorization, be sure that the member receives care from a provider who participates in the network associated with the member's benefit plan. If the member has more than one in-network benefit level, select a provider who participates in the network for the member's highest in-network benefit level.

If a provider fails to obtain authorizations as required, the member cannot be billed for charges for services that are denied for lack of authorization. However, a provider may bill the member if, prior to service or care, the provider informs the member of failure to obtain authorization and the member agrees in writing to pay for such service or care.

Definition

An **authorization** is a determination by Highmark that a health care service proposed for or provided to a member is "medically necessary" as that term is defined by the member's contract. If a service requires authorization, then the provider, and in some cases the member, must contact Highmark to request the medical necessity review. Authorization may also be called precertification, preauthorization, prior authorization, prospective review, preservice review, prior approval, or other similar terms.

Authorization does not guarantee payment. A service or supply will be reimbursed by Highmark only if it is medically necessary, a covered service, and provided to an eligible member.

Medical Necessity means health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity,

interfere with such person's capacity for normal activity, or threaten some significant handicap.

We will reimburse for medically appropriate care that is not more costly than alternative services or supplies at least as likely to produce equivalent results for the person's condition, disease, illness, or injury.

Products Requiring Authorization

All Highmark products, including Medicare Advantage, require that certain services be authorized as a condition of coverage. **However, benefits can vary; always confirm authorization requirements under the member's coverage prior to providing services.**

Utilization Decision Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. Highmark does not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor does the company provide any financial incentives to utilization management decision makers to encourage denials of coverage.

5.2 Authorization Guidelines

Authorization review is the process by which services are evaluated according to benefit availability and criteria for medical necessity and appropriateness. Ordinarily, authorization should be in place before services are rendered; therefore, this process is often called "precertification" or "prior authorization."

Medical appropriateness reviews are conducted to determine the appropriateness of a service. A pre-admission review is performed prior to admission on the elective surgical procedure being performed (NOT level of care), concurrently during an episode of care, and retrospectively to determine that procedures are medically necessary and appropriate for a specific condition. If health services are approved, Highmark will not modify standards or criteria during the same course of treatment.

Provider-Driven Process

The authorization process is **provider-driven for all in-network care.** This means that it is the network provider's responsibility to obtain authorization for an inpatient admission or for any outpatient services requiring approval.

If services are delivered and authorization is required but not obtained timely, the corresponding claim may be rejected and the member must be held harmless. In order for such a claim to be considered for payment, the provider will need to request a retrospective review and submit the applicable medical records, if applicable.

For HMO, IPA, and POS products, the PCP is responsible for obtaining authorizations for services needed by the PCP's designated members. If a referral is made to a specialist, the specialist can request an authorization for a service he or she will provide.

Criteria Used

Highmark Medical Policy and Medicare Advantage Medical Policy* are used to assess the medical necessity and appropriateness of health care services.

For inpatient care, Highmark also uses MCG Care Guidelines in the processes for assessing medical necessity and appropriateness of services. The MCG Care Guidelines are applied to assess acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing, and home health services. These criteria are applied in conjunction with applicable Highmark Medical Policy and CMS Medicare Advantage Medical Policy.

For more information on Highmark's commercial and Medicare Advantage medical policies and criteria used for medical management decisions, please see **Chapter 5.1: Care Management Overview.**

Electronic Authorization Requests

Availity® is the preferred method for submitting authorization requests to Highmark. Authorizations may be requested through Availity or by submitting a HIPAA 278 electronic transaction. Electronic authorization requests are the preferred method and are quick and easy to perform.

For a HIPAA 278 transaction, refer to the **Provider EDI Reference Guide** accessible from the Provider Resource Center:

- Select **Claims & Authorization,** then **Reimbursement Resources.** There, you'll find **Electronic Data Interchange (EDI) Services.**

- Select **Resources** from the menu on the Highmark EDI Trading Partner Business Center home page.

Important! Authorization is Not a Guarantee of Payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; **it is not a guarantee of payment.** Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan.

It is the provider's responsibility to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service. Some benefit plans may also impose deductibles, coinsurance, copayments, and/or maximums that may impact the payment. Providers may consult Availity to obtain benefit information.

When Highmark is Not Primary

Authorization requirements apply if a claim will be submitted to Highmark for any portion of payment. Therefore, if the member's primary insurance is with a commercial carrier other than Highmark, any authorizations required under the member's Highmark benefit plan are required if a claim will be submitted to Highmark for services requiring authorization.

However, if traditional Medicare is primary, an authorization is required only if:

- The member exhausts his/her Medicare benefit and desires to continue the service;
- The service is not covered by Medicare (e.g., home infusion); or
- The member is admitted to a Veteran's Administration (VA) facility (applicable to West Virginia only).

Behavioral Health Benefits

Behavioral health benefits vary by group. In some instances, a group may purchase medical health care coverage through Highmark, but behavioral health care coverage through another company.

To be sure a member has behavioral health care coverage through Highmark, verify eligibility and benefits through Availity® or perform the applicable HIPAA electronic transaction. If you do not have electronic access, call the benefits telephone number on the member's identification card.

The member's benefit program must provide the specific benefit for the service the member is scheduled to receive. **If the member's benefit program does not provide the benefit, the facility will not be**

reimbursed for the services.

Disclaimer

An authorization is a determination of medical necessity only and does not guarantee coverage or payment. Payment is based on the member's coverage and eligibility at the time of service.

A service that has been authorized may nonetheless be denied payment if:

- The member is no longer eligible when the service is provided;
- The service is not a covered benefit under the member's contract; or
- The service actually provided is different from the service authorized.

Medical necessity determinations are not a substitute for the medical judgment of the treating provider. They are for reimbursement purposes only. They do not constitute medical advice or treatment or establish any provider/patient relationship.

Providers must exercise their own independent medical judgment regarding the treatment of their patients who are Highmark members. Highmark encourages providers to communicate openly with patients about their treatment options, regardless of benefit coverage limitations. Responsibility for medical treatment and decisions remains with the member and his or her physician.

Medical Record Review

Highmark reserves the right to request and review medical records for visits whether or not authorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the provider may not bill the member for the services.

If the Authorization is Not in Place at the Time of Service

Ordinarily, the member's attending physician should have requested a required authorization prior to the member receiving the services. However, if a Highmark member arrives for an appointment for non-emergency services and the required authorization does not appear to be in place, the provider should perform an authorization inquiry in Availity. If not Availity-enabled, call Clinical Services at the phone number for your service area.

Failure to Obtain an Authorization

Failure to preauthorize or pre-certify a service or admission may result in a retrospective review. Highmark has the right to review the service retrospectively for medical necessity and appropriateness, and to deny payment when necessary.

If a retrospective review is performed, and Highmark's Medical Management & Quality (MM&Q) department determines that the service was medically necessary and appropriate, the claim will be paid.

If MM&Q determines that the service was not medically necessary and appropriate, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).

Vendor Delegation and Oversight

For providers in New York

Highmark delegates specific Utilization Management functions to a number of vendors. Highmark seeks to align with vendors who are an expert in their field and have attained national certifications.

Our vendors maintain their own UM Program, which is approved by Highmark's Vendor Joint Oversight Team and reports to the Quality Management Committee. Vendor physicians are involved in our clinical committees upon request.

Utilization Management conducts yearly audits that include a review of policies, procedures, and operational functions of the Utilization Management Department.

File audits are conducted on a quarterly basis.

5.2 Services Requiring Authorization

Highmark commercial and Medicare Advantage products require authorization for all inpatient admissions and select outpatient services, drugs, and equipment. The following circumstances are representative of those services that require an authorization. **This is not an all-inclusive list.** Benefits can vary; always confirm a member's coverage prior to providing services.

- Inpatient hospital admissions
- All other inpatient admissions (e.g., skilled nursing facility, rehabilitation, behavioral health, long-term acute care facility)
- Home health care
- Clinical trials
- Hospice
- Transplantation services
- Highmark's List of Procedures/DME Requiring Authorization

Important! Delaware Mandate

For providers in Delaware

Delaware legislation, effective January 1, 2018, puts restrictions on imposing authorization and review requirements on drug and alcohol dependency treatment. Please see **Chapter 5.4: Behavioral Health for information.**

For complete details of the Delaware mandate, please see **Chapter 4.2: Behavioral Health Providers.**

Inpatient Admissions

Authorization is required for all inpatient medical services and inpatient levels of behavioral health care. Authorization is required under all Highmark products whenever a member is admitted as an inpatient to any of the following facilities:

- Acute care hospital
- Long-term acute care hospital (LTAC)
- Rehabilitation hospital
- Skilled nursing facility (SNF)
- Mental health or substance abuse treatment facility

Exception: Maternity Care

An authorization is not required for a normal inpatient delivery for maternity care unless clearly designated in a member’s benefit. Normal inpatient delivery in 48 hours for vaginal delivery and 96 hours for caesarean section.

If the mother and/or baby require an inpatient stay that exceeds these time frames, authorization would be required. In addition, the Clinical Services department should be contacted for any non-routine or emergency admissions for maternity care, such as admissions for hyperemesis, preterm labor, placenta previa, and preeclampsia.

List of Procedures/ DME Requiring Authorization

Highmark maintains a list of outpatient procedures/services that require authorization. Throughout the year, procedures are added and/or deleted and these changes are communicated to the provider community. The list includes services such as:

- Behavioral health intensive outpatient and partial hospitalization (except in New York where a prior authorization is not required for outpatient services)
- Potentially experimental, experimental, and cosmetic procedures
- Select durable medical equipment (DME)
- Select injectable drugs covered under the member's medical plan
- Some oxygen services
- Select Not Otherwise Classified (NOC) procedure codes, i.e., unlisted, miscellaneous, Not Otherwise Specified (NOS)
- Certain outpatient procedures, services, and supplies

To obtain additional information about authorization requirements and to view the all-inclusive and most up-to-date list, please visit the Provider Resource Center. Select **Claims & Authorization** from the main menu, and then **Authorization Guidance.**

Note: Certain employer groups may choose to opt out of this requirement. In addition, self-funded accounts, government programs, and other groups with non-standard benefits may have their own lists of services requiring authorization. You must confirm if the requirement is applicable to the member. You can use the Availity® **Eligibility and Benefits Inquiry** or the applicable HIPAA electronic transaction for benefit verification.

Outpatient Services Provided by Out-Of-Area Blue Plan Providers

As of November 1, 2020, Highmark expanded our prior authorization requirements for outpatient services to include those services provided by out-of-area providers participating with their local Blue Plan. This assures that the care our members receive while living and traveling outside of the Highmark service areas is medically necessary and managed consistently as it is throughout our service areas.

Out-of-area Blue Plan providers will be required to contact Highmark for prior authorization for services on our List of Procedures/DME Requiring Authorization. Highmark's provider portal, Availity, is enabled to accept authorization requests for outpatient services from out-of-area Blue Plan providers when submitted via their local portals.

Claims for services on the prior authorization list received without authorization will deny and a request for medical records will be sent to the provider's local Blue Plan.

Authorization Requirements for Out-Of-Network Services for Commercial Products

Effective January 1, 2020, Highmark requires prior authorization for inpatient admissions **and** also for outpatient services on Highmark's List of Procedures/ DME Requiring Authorization when a Highmark member with commercial coverage seeks those services from an out-of-network provider. Members seeking services from out-of-network providers will be responsible for working with their provider to assure they are obtaining the necessary authorizations.

An "out-of-network provider" is a provider that is within Highmark's service area but not participating in the member's network **or** an out-of-area provider located outside of Highmark's service area who is not participating with their local Blue Plan.

The authorization requirements for outpatient services are effective January 1, 2020, for all Affordable Care Act (ACA) individual products. Beginning January 1, 2020, these requirements will also be applied to fully insured small and large groups upon the group's renewal.

These authorization requirements for outpatient services **do not apply** to self-insured groups (ASO), the Federal Employee Program (FEP), Pennsylvania's Children's Health Insurance Program (CHIP), Medicaid, student health insurance plans (SHIP), and indemnity and comprehensive benefit plans.

Note: These requirements do not apply to outpatient services managed by our partner vendor eviCore.

Medicare Advantage Out-Of-Network Requirements

Effective January 1, 2020, Highmark requires that out-of-network inpatient and outpatient services be deemed medically necessary prior to payment. Providers or members may contact Highmark to request precertification of coverage from the plan prior to performing or receiving a service to determine whether or not it would be considered medically necessary.

Note: These requirements do not apply to outpatient services managed by our partner vendor eviCore.

Speech Therapy

Speech therapy services, including those for Medicare Advantage, require prior authorization. For additional information for Medicare Advantage members, please see **Chapter 5.3: Medicare Advantage Procedures.**

Physical Medicine Management Program

Information about physical medicine services that require prior authorization can be found on the Provider Resource Center. Select **Policies & Programs** and then look under **Care Management.**

Advanced Imaging and Cardiology Services

For providers in Delaware, Pennsylvania, and West Virginia

Highmark requires authorization for select advanced outpatient diagnostic imagining procedures. Highmark partners with eviCore healthcare (eviCore) for Highmark's Advanced Imaging and Cardiology Services Program. This program incorporates a comprehensive, evidence-based clinical review, including predictive intelligence, clinical decision support, and peer-to-peer discussions.

Additional information is available in the *Highmark Provider Manual's* **Chapter 4.5: Outpatient Radiology and Laboratory.** And you can find details of the program on the Provider Resource Center under **Policies & Programs** and then **Care Management.**

Radiation Therapy Authorization Program

For providers in Delaware, Pennsylvania, and West Virginia

Additional information on radiation therapy services that require prior authorization can be found on the Provider Resource Center. Select **Policies & Programs** and then look under **Care Management.**

Post-Acute Care Management for Medicare Advantage Members

For providers in Pennsylvania and West Virginia

Highmark has a partnership with Home & Community Care Transitions, a national post-acute care management company, to bring a personalized approach to support its Medicare Advantage members. According to patient needs, Home & Community Care Transitions will utilize decision-support technology and its post-acute analytics capabilities to coordinate long-term acute care, inpatient rehabilitation, and skilled nursing facility utilization and will oversee proper care transitions to and from these facilities.

For more information, please see the program page on the Provider Resource Center — select **Policies & Programs** and look under **Care Management.**

Laboratory Management Program for Molecular and Genomic Testing

For providers in Delaware, Pennsylvania, and West Virginia

Highmark contracts with eviCore to manage molecular and genomic testing to ensure that the genetic lab services provided to Highmark's members support clinically appropriate care and are medically necessary, in accordance with their benefit policy.

Additional information on authorization requirements is available on the Provider Resource Center — select **Policies & Programs** and look under **Care Management.**

MSK and IPM Services

For providers in Delaware, Pennsylvania, and West Virginia

Effective October 1, 2018, musculoskeletal surgical (MSK) procedures and interventional pain management (IPM) services require prior authorization under the **Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program** managed by eviCore. Additional information is available on the Provider Resource Center under **Policies & Programs** then **Care Management.**

5.2 Federal Employee Program (FEP) Prior Authorization Requirements

The Federal Employee Program (FEP) has precertification and prior authorization requirements for the longstanding Standard and Basic options and also for the new FEP Blue Focus product, which is effective January 1, 2019.

Inpatient Admissions

Precertification is required for inpatient hospital, residential treatment center (RTC), and skilled nursing facility admissions. FEP applies a $500 penalty if an authorization is not obtained for inpatient hospital admissions. However, the penalty is imposed on the provider — in the form of reduced payment. The provider may not bill this amount to the member.

Note: Precertification requirements are not applicable to skilled nursing facility admissions for the Basic Option and for FEP Blue Focus since the plans do not have a benefit for skilled nursing facility.

Other Services Requiring Prior Authorization

Prior authorization or notification is also required for certain services for FEP members, as indicated in the table located here.

For the FEP Blue Focus product, FEP applies a $100 penalty if an authorization is not obtained for any of the services listed below. The penalty is imposed on the provider in the form of reduced payment if a claim is received and the service is determined to be covered and medically necessary based on Medical Review. The provider may not bill this amount to the member.

For a full list of services that require prior authorization, go the **Provider Resource Center** click **Claims & Authorization** and then **Authorization Guidance.**

Confirming Member Benefits

You can confirm FEP member eligibility and benefits, including prior authorization requirements, via Availity®. You can also call the **FEP Provider Service Department** for your service area as follows:

- Pennsylvania: **800-258-8809**
- Delaware: **800-572-2872**
- West Virginia: **800-344-5245**
- New York: **800-234-6008**

Requesting Authorization

Please follow the guidance below for calling the FEP Provider Service department for authorizations for FEP members.

- For **outpatient/professional services** that require authorization, please contact your local Highmark plan.
- For **inpatient admissions,** medical and behavioral health, the services should be authorized by the Blue Cross plan where the services are being received as follows:
    - **Pennsylvania's Western & Northeastern Regions, Delaware, and West Virginia –** Highmark participating providers should contact their local Highmark plan for authorization for inpatient admissions.
    - **Pennsylvania's 21-county Central Region –** providers participating with Capital Blue Cross or Independence Blue Cross would request authorization for inpatient admissions from Capitol Blue Cross.

For More Information

You can find a wealth of information to assist you in servicing FEP members at fepblue.org.

Additional information related to the Federal Employee Program is also available in the following units of the *Highmark Provider Manual*:

- **Chapter 2.3: Other Government Programs** for background information, FEP products, and membership
- **Chapter 5.1: Care Management Overview** for information on accessing FEP Medical Policy (under section titled "Criteria for Medical Management Decisions")
- **Chapter 6.4: Professional (1500/837P) Reporting Tips** for special tips on claim submission for FEP members

5.2 Authorization Request Process

Authorization requests should be submitted at least 14 days in advance prior to a planned admission or service, when possible, or as soon as the intended admission or service is known.

For emergency (urgent, unplanned) admissions, the hospital is asked to obtain an authorization within 48 hours of the admission or as soon as the necessary clinical information is available.

For admissions related to childbirth, the provider must contact Highmark within 48 hours after an emergency admission or for lengths of stay longer than 48 hours after a vaginal delivery or 96 hours after a cesarean section (C-section) delivery.

Reminder: Verify Eligibility & Benefits

Providers are reminded to always verify a member's eligibility and benefits, including the authorization requirements, prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

You can verify benefits electronically quickly and easily via Availity's **Eligibility and Benefits Inquiry** or by submitting a HIPAA 270 transaction.

Before You Begin...

Prior to submitting an authorization request, whether electronically or by telephone, please have the following information available:

- Patient's general information (name, age, gender, etc.)
- Member ID number
- Medical history
- Any comorbidity
- All pertinent medical information (test results, prior treatment, etc.)
- Presenting symptoms
- Acuity
- Diagnosis
- Service to be performed, including admission or procedure dates and location
- Name of any other health care providers involved in the care
- Proposed length of stay and frequency or duration of services
- Treatment plan and goals

- Psycho-social issues impacting care
- Discharge plan

Note: The Highmark reviewer may request additional information. Requests may be denied for lack of information.

Electronic Submission Preferred

Electronic submission is the preferred method for requesting authorization. If Availity®-enabled, the request must be submitted via Availity.

Process

The authorization request process is as follows:

Step	Action
1 **Submission**	Submit the required information via Availity or HIPAA 278. • **Availity:** The user is guided through the steps. • **HIPAA 278 transaction:** For information about using the transaction, refer to the **Provider EDI Reference Guide.***
2 **Review**	The request is reviewed by Highmark's Clinical Services department. The decision-making period begins once Clinical Services has received the request. All decisions are made in accordance with DOL and NCQA requirements.

3 **Decision**	Following review, Clinical Services either authorizes or denies coverage for the request. • If the request is approved, you will be notified through Availity or through your practice's software. If you do not have access to Availity, you will receive a paper report through the mail. • If the request is denied, you will be advised of your appeal rights and, for Commercial members, the option of requesting a peer-to-peer conversation with the physician advisor who made the decision.

The EDI Reference Guide is accessible from the Provider Resource Center. Select **Claims, Payment & Reimbursement, and then **Electronic Data Interchange (EDI) Services.** Select **Resources** from the EDI Training Partner Business Center home page.*

Home Health Authorization Requests

For providers in Delaware, Pennsylvania, and West Virginia

Home health care providers must use Availity® to submit authorization requests. Please see the next section of this unit — **Home Health Authorization Submissions.**

If you are not Availity-enabled, home health care providers can fax requests using the Home Health Precertification Worksheet or make their requests by calling Clinical Services.

The worksheet is also accessible on the Provider Resource Center — select **Resources & Education** and then **Medical Authorization Forms.**

Telephone Requests

You may contact Clinical Services by calling the applicable phone number for your service area.

Pennsylvania:

- Western Region:
  - Facilities: **800-242-0514**
- PA Central Region:
  - Facilities: **866-803-3708**
- PA Northeastern and Southeastern Regions:
  - Facilities: **800-452-8507**
- Medicare Advantage:
  - PA Medicare Advantage Freedom Blue PPO: **866-588-6967**
  - Community Blue Medicare HMO: **888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **866-588-6967**
  - Security Blue HMO (Western Region only): **866-517-8585**

Note: Professional providers should call the appropriate Medicare Advantage program number.

Delaware:

- Medical Services: **800-572-2872**

West Virginia:

- Highmark West Virginia Products for Medical: **800-344-5245**
- Medicare Advantage Freedom Blue PPO: **800-269-6389**

New York:

- Utilization Management: **844-946-6263**
- After hours expedited appeals or urgent access to medical issues: **844-946-6263***

Behavioral Health Services:

- PA Northeastern and Western Regions: **800-258-9808**
- PA Central and Southeastern Regions: **800-628-0816**
- Delaware: **800-421-4577**
- West Virginia: **800-344-5245**; Freedom Blue PPO: **800-269-6389**
- New York: **844-946-6264**

***Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) Business Hours:**

- A nurse or physician is available to take your call from 8:15 a.m. until 5 p.m.
- A staff member will identify themselves by name, title, and organization name when initiating or returning calls regarding Utilization Management issues.
- Calls regarding inquiries will only be received during normal business hours

Out-Of-Network Providers

To determine the authorization requirements under a member's benefit plan, out-of-network providers may contact Highmark by calling the Member Service phone number on the back of the member's identification card.

To obtain authorizations for Highmark members with commercial coverage, out-of-network providers are directed to contact Highmark Clinical Services at the Utilization Management phone number on the back of the member's identification card.

Important! Federal Employee Program (FEP)

Please see the Federal Employee Program (FEP) Prior Authorization Requirements section of this unit for guidance for calling for authorizations for FEP members.

5.2 West Virginia Gold Card Program

For providers in West Virginia

Highmark Blue Cross Blue Shield's Gold Card Program is an exemption-based program established to recognize providers identified as consistently following medical necessity guidelines through review of past performance by rewarding them with a greater level of self-management.

Effective January 1, 2024, West Virginia providers can qualify for the Gold Card Program for specific procedures that require prior authorization if they meet the requirements as outlined below. Providers meeting the requirements will not be required to submit prior authorizations in the specified calendar year. During this period, Highmark Blue Cross Blue Shield will only require a pre-notification (no clinical information required) for the qualifying procedure(s), unless requested for retrospective audits.

Background

For providers in West Virginia

The Gold Card Program was developed in accordance with West Virginia Senate Bill 267, which was passed on March 8, 2023. The purpose of the bill is to establish universal guidelines related to prior authorizations.

How to Qualify

For providers in West Virginia

A provider can qualify for the Gold Card Program if the following requirements are met:

- The provider performs an average of 30 procedures per year; **and**
- In a six-month time period during that year, the provider receives a 90% final prior approval rating.

The procedures are counted toward the 30-procedure threshold only when rendered by a West Virginia health care practitioner for Highmark Blue Cross Blue Shield West Virginia commercial fully insured, ACA, or ASO Opt-in members. Please utilize Highmark's provider portal, Availity, to readily identify the member's coverage.

Notification of Qualifying Status

For providers in West Virginia

The Gold Card Program is a calendar year program. If you qualify for the program, you will be notified by letter, which will be delivered via U.S. Mail. The letter will provide additional details pertaining to your exemption or "Gold Card" status.

Note: If you do not receive a notification letter by the end of December and believe you qualify for the program, please contact Highmark at GoldCardInquiries@highmark.com.

Requirements for Program Participants

For providers in West Virginia

While participating in the program, you must continue to adhere to Highmark Blue Cross Blue Shield medical policy and medical necessity requirements, which are periodically assessed for ongoing compliance.

Although you will not be required to submit clinical information for the qualifying procedure(s) while a program participant, you are still required to pre-notify Highmark Blue Cross Blue Shield of upcoming procedures by submitting base-level demographic information, including:

- Patient name, date of birth, ID/Unique Member Identifier (UMI) — with prefix
- Start of care date
- Procedure code(s)
- Primary diagnosis code
- Blue Shield ID
- NPI

This information is submitted to Highmark Blue Cross Blue Shield using Availity. When you submit the information, you will receive a reference number for qualifying procedures as long as you remain qualified for the Gold Card Program.

Important!

This exemption to submission of clinical information for services requiring authorization **only** applies to the specific procedure(s) for which you qualified under the Gold Card Program. **You are still required to submit prior authorization requests, as usual, for all other procedures and Highmark members, as applicable.**

Services Not Included in the Program

For providers in West Virginia

The following services are not included in the Gold Card Program:

- Unplanned inpatient stays
- Pharmaceuticals (including medical injectable drugs)
- Durable medical equipment
- Home health
- Post-acute care, including:

    - Skilled nursing facilities
    - Long-term acute care
    - Inpatient rehabilitation facilities
- Other considerations
    - Some services must undergo a review to determine if the service is a covered benefit. Non-covered services are out of network services or procedures, experimental treatment, or non-covered benefits.

Retrospective Audits

For providers in West Virginia

Program participants must adhere to Highmark's medical policy and medical necessity requirements to remain eligible for the Gold Card Program. This exemption is subject to internal auditing at any time by Highmark.

Providers will be notified which cases have been selected for audit. These audits are conducted to ensure continued adherence to medical necessity criteria in accordance with medical policy.

This exemption may be rescinded if the health care practitioner is not performing services or procedures in conformity with Highmark Blue Cross Blue Shield's benefit plan, if there is substantial variance in historical utilization, or if other anomalies are identified on internal audit. Highmark will notify you of the outcome of internal audits. If applicable, a letter detailing the rationale for revocation of an exemption will be provided.

5.2 Home Health Authorization Submissions (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Participating home health care providers in Delaware, Pennsylvania, and West Virginia must use the home health care authorization request submission process through Availity®, Highmark's provider

portal. This process is applicable **for all commercial and Medicare Advantage products.**

Requirements

For providers in Delaware, Pennsylvania, and West Virginia

Using Availity, the following is required to be submitted:

- An Outcome and Assessment Information Set (OASIS) File upload
- The CMS-485 form

Important! Always Verify Eligibility and Benefits

When an authorization is obtained, it is not a guarantee of payment. The member must have active coverage at the time of service and must also have the benefit for the service to be provided. Therefore, it is important to verify the member's eligibility and benefits through Availity or through the applicable HIPAA electronic transactions.

Provider Service Center

For providers in Delaware, Pennsylvania, and West Virginia

For general questions and inquiries about the new home health care authorization process, please contact the Provider Service Center.

5.2 Inpatient Admissions

The purpose of the authorization review is to determine whether the services being requested are medically necessary and appropriate and are being delivered in the most appropriate setting. Authorization review assists Care and Case Managers in identifying potential candidates for post-discharge case management or the Blues On Call condition management programs.

Authorization Request Time Frames

Authorization is required for all in-network inpatient medical services and inpatient levels of behavioral health care. Authorization requests should be submitted at least 14 days in advance prior to a planned admission, when possible, or as soon as the intended admission is known. Authorization for planned admissions must occur no later than the date of admission.

Emergency Inpatient Admissions

For emergency (urgent, unplanned) admissions, the facility is asked to obtain an authorization within 48 hours of the admission or as soon as the necessary clinical information is available (except in New York where notification is required by an authorization is not).

Submitting a Request for Authorization

Facilities should submit authorization requests for medical and behavioral health inpatient admissions via Availity®. **Please see the next section of this unit for information.**

If either Availity or the authorization request application is unavailable, facilities may make their requests by contacting Clinical Services via telephone at the applicable phone number.

Out-of-Network Services

Some members have coverage under a benefit plan (e.g., PPO) that provides benefits for services received from a provider outside of the network associated with their Highmark product.

The authorization requirement **does not apply** to such services, except for inpatient admissions to a hospital, skilled nursing facility, rehabilitation hospital, and long-term acute care. These services are reimbursed according to the terms of the member's benefit plan, including any applicable member liability.

Reminder: Benefit Verification Required

While not all services require authorization, availability of benefits under the member's benefit plan is required in order for a service to be reimbursed by Highmark. Availability of benefits can be verified through Availity.

Transfers Between Hospitals

Transfer of a member from one facility to another requires authorization from Clinical Services. The table below identifies which facility has responsibility for obtaining authorization for transfers between

hospitals:

If...	Then...
A member is an inpatient in one hospital and is being transferred to another hospital where he or she will be admitted as an inpatient,	the hospital initiating the transfer would contact Clinical Services for authorization.
A member who has been evaluated in the emergency department of one hospital must be transferred to another hospital for the necessary inpatient services,	the hospital receiving the patient for inpatient services would contact Clinical Services for authorization.

Behavioral Health

Some processes vary slightly for behavioral health services. For additional information specific to behavioral health services, please see **Chapter 5.4: Behavioral Health.**

In addition, information on submitting behavioral health authorization requests via Availity are available.

Special Process for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (CMS) requires that members with coverage under original Medicare or a Medicare Advantage plan are fully aware of their right to appeal a discharge decision. Therefore, a special process will apply to these members. These processes begin when **a Medicare Advantage member is admitted** to an inpatient level of care in an acute care hospital, long-term acute care hospital, skilled nursing facility, inpatient psychiatric hospital/unit, or acute rehabilitation hospital/unit.

For more information on these special processes for Medicare Advantage members, please refer to **Chapter 5.3: Medicare Advantage Procedures.**

5.2 Auth Submission

Authorization Submission

Highmark provides an automated process via Availity which allows facilities to submit authorization requests for medical and behavioral health inpatient care and inpatient/post-acute transfers using interactive MCG Care Guidelines. Availity can also be used for submitting behavioral health intensive outpatient and partial hospitalization authorization requests.

Important: Observation Services

Availity is not used for observation services since observation services do not require authorization.

However, if it becomes clear that the member requires inpatient admission, the hospital is asked to obtain an authorization within 48 hours of inpatient admission or as soon as the necessary clinical information is available.

Highmark's Expectation of Facilities

Highmark expects that Availity-enabled facilities will submit all medical and behavioral health inpatient authorization requests, inpatient/post-acute transfer requests, and behavioral health intensive outpatient and partial hospitalization authorization requests for Highmark members via Availity.

Facilities are also expected to provide consistent and timely completion of the admission and discharge surveys, including entry of the discharge date.

Monitoring the Process

Based on monitoring patterns of the facility's use and submissions, Highmark has the right to perform on-site educational audits and discuss findings with the appropriate hospital staff.

Admission Questions

Admission questions are incorporated into MCG Care Guidelines. The facility should be prepared to provide the following information during the initial request for authorization of an inpatient admission:

- Patient history and any co-morbid conditions
- Re-admissions within 30 days
- Social situation or Social Determinants of Health to be aware of

- Any special needs
- Any assistance needed from Clinical Services in discharge planning

Important Benefit Reminder

An authorization means that the requested service has been determined to be medically necessary and/or appropriate.

It does **not** mean that the requested service is covered under the member's benefit plan. Payment is contingent on the availability of benefit coverage for the services rendered and the eligibility of the patient.

Discharge Planning Information Survey

Hospitals are also responsible for completing the Discharge Planning Information Survey during an inpatient admission of five or more days, the survey can also be completed at or immediately following discharge.

For more information, please see the “Discharge Planning” section of this unit.

Post-Acute Transfers

Acute care facilities also submit authorization requests via Availity for **post-acute transfers** to long-term acute care hospitals, acute rehabilitation hospitals, and skilled nursing facilities.

Submitting authorization requests through Availity for these transfers follows a similar process to the steps which are used for acute inpatient hospital admissions.

Discharge Survey

The Discharge Planning Information survey for the acute care stay **must** be completed at discharge.

Time Frames for Post-Acute Transfer Requests

Post-acute transfer requests may be entered according to the following schedule:

If transferring to...	Then the time frame will be...

Skilled Nursing Facilities	From the current date through 2 days in the future
Acute Rehabilitation Hospitals	From the current date through 2 days in the future
Long-Term Acute Care Hospitals	From the current date through 2 days in the future

Continuity of Care

To ensure continuity of care, facilities are asked to notify the member's primary care or preferred physician about any services that he or she receives during the inpatient stay.

This step taken by the facility enables the primary care or preferred physician to make any subsequent treatment decisions on a more fully informed basis.

Special Procedures for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (CMS) has established procedures to ensure any member with coverage under original Medicare or Medicare Advantage plans has the opportunity to appeal a discharge decision with which he or she disagrees. This process begins when a Medicare Advantage member is admitted to an inpatient level of care and requires additional action prior to discharge.

Note: For more information on these special processes for Medicare Advantage members, please see **Chapter 5.3: Medicare Advantage Procedures.**

Additional Resource for Behavioral Health

Some processes vary slightly for behavioral health services. For additional information specific to behavioral health services, please see **Chapter 5.4: Behavioral Health**.

In addition, information on submitting behavioral health authorization requests via Availity is available by going to “Help & Training” in Availity.

5.2 Concurrent Review

When is Concurrent Review Conducted?

Highmark may conduct **concurrent review,** also known as **continued stay review,** for any services as determined by Highmark, including, without limitation, all behavioral health services and medical care at hospitals, skilled nursing facilities, long-term acute care facilities, rehabilitation facilities, and any other facilities as noted by Highmark regardless of whether a per diem or DRG facility.

Components of Concurrent Review

The concurrent review process for medical services can be initiated by either the facility or by the Clinical Services department. The process for medical services involves three components:

1. Contact between Clinical Services and the facility
2. Sharing of relevant clinical information
3. Application of the appropriate clinical standards to determine whether the member's inpatient services should be extended

During the concurrent review conversation, the facility should be prepared to provide relevant information about the member's clinical signs and symptoms, continuing treatment, and discharge plans.

The Decision Process

Based on the information provided by the facility, the Clinical Services nurse reviewer applies the relevant criteria and determines whether to extend the member's care or to offer an alternative level of care. Concurrent review cases that meet criteria will be approved.

If the clinical staff cannot approve the case, it is referred to a physician reviewer to determine the need for the continuation of services.

Approval Notification

The requesting entity is notified verbally of the approval decision by the care manager or physician reviewer within designated regulatory time frames.

In addition, approval notifications are provided electronically to all Availity-enabled providers. Approval letters are sent to commercial and indemnity members as well as providers without electronic connectivity.

Denial Notification

If the member does not meet the criteria for continued stay, the Clinical Services staff will contact the entity requesting the review to explore and facilitate alternative care as appropriate. The member's needs, as well as the local delivery system, will be considered in making a determination.

In accordance with legal and regulatory requirements, the member and/or facility will be notified of a denial both verbally and in writing. The verbal notification will include information about the right to appeal the decision. The written notification will also include the member's appeal rights.

Medicare Advantage: When Continued Stay is Not Approved

When a concurrent review results in a denial and a Medicare Advantage member **disagrees with the decision to be discharged** from inpatient care, the member may request a review.

Highmark delegates responsibility to the facility to issue the ***Detailed Notice of Discharge*** (or *"Detailed Notice"*) form to the member. This form gives a detailed explanation of the discharge decision as well as a description of any applicable Medicare and/or Medicare Advantage coverage rules, policies, or rationales which support the decision.

Note: For more information, please refer to **Chapter 5.3: Medicare Advantage Procedures.**

Time Frame

Decisions regarding inpatient concurrent review are made **within 24 hours** of receipt of the request in order to comply with strict decision-making time frames imposed by regulatory/accreditation standards.

All relevant information **must** be provided by the facility at the time of the request. Timely submission of the relevant clinical information will avoid any unnecessary denials due to lack of information.

Additional Components of Concurrent Review

Medical necessity, quality, utilization review, and utilization management requirements, as well as all other applicable administrative requirements as determined by Highmark, as applicable to all payment

methodologies including, without limitation, DRG-based payments, are also applicable to all outlier determinations and outlier payments.

If the member does not meet the applicable criteria as determined by Highmark for a continued stay based on such aforementioned criteria, then those days not meeting the concurrent review requirements for a continued stay will not be included:

- in the count for day outlier status.
- in the calculation for cost outlier status for charges related to tests, procedures, room and board, etc.

Also, is the admission is determined by Highmark to not be medically necessary and appropriate for acute care, the admission will be downgraded and paid at the observation rate or the outpatient methodology, as applicable.

Note: Highmark will apply the applicable criteria as determined by Highmark for a continued stay against review of the entire length of stay to ensure outlier payments are not made for care that is not medically necessary and appropriate, and/or at the appropriate level of care.

Retrospective Review

Facilities are reminded that Medical Management & Quality (MM&Q) may conduct a retrospective review whenever authorization or continued stay certification was required but not obtained. A retrospective review may also be conducted when Highmark receives a claim that includes outlier days.

Behavioral Health

For more information on concurrent review for behavioral health, please see **Chapter 5.4: Behavioral Health.**

5.2 Retrospective Review

Retrospective review is the assessment of the appropriateness of health care services after the services have been rendered to a member and completed without prior authorization from Medical Management & Quality (MM&Q). Retrospective review is also known as “post-service review.”

How to Request

To request a retrospective review of an inpatient admission or an outpatient medical service provided without the appropriate authorization, a facility should follow these steps:

Step	Action
1	Submit a claim for the service, according to normal procedures. Because no authorization is on file for the service, Highmark's claims processing system **will reject** this claim.
2	When the claim denial notification is received (via the remittance advice), submit pertinent clinical information with a cover letter explaining the circumstances to the applicable address below:
	Pennsylvania: Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392 PA Central Region outpatient claims only: Medical Review P.O. Box 890035 Camp Hill, PA 17089-0035
	Delaware: Highmark BCBSDE, Inc. Medical Management

	Retrospective Reviews P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991
	West Virginia: Highmark West Virginia Attn.: Medical Review P.O. Box 1948 Parkersburg, WV 26102
	Behavioral Health (all service areas): Retro Reviews/Standard Commercial Appeals: Utilization Management Attention: Review Committee 120 Fifth Avenue, Suite P4104 Pittsburgh, PA 15222 **Note:** This address is also to be used for behavioral health retrospective review requests for Federal Employee Program (FEP) members.

Time Frame

Retrospective reviews are completed **within 30 calendar days** of receipt of the facility's request. If MM&Q requires additional information, the request will be made within 48 hours after receiving the request for retrospective review.

Behavioral Health

For more information on retrospective review specific to behavioral health services, please refer to **Chapter 5.4: Behavioral Health.**

5.2 Time Frames for Authorizations

Preservice Determinations

For providers in Delaware, Pennsylvania, and West Virginia

For preservice authorization requests, Highmark will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- Pennsylvania and Delaware:
  - 72 hours after receipt of the request in cases involving urgent care; or
  - 14 calendar days after receipt of the request in non-urgent cases.
- West Virginia:
  - Two calendar days after receipt of the request in cases involving urgent care; or
  - Seven calendar days after receipt of the request in non-urgent cases.

A case involving urgent care is one in which making a determination under standard time frames could seriously jeopardize the member's life, health, or ability to regain maximum function; or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case is one involving urgent care, it would be handled as such.

For non-urgent cases, Highmark may extend the time frame one time by up to 14 days (except in West Virginia where an extension of 7 business days will be offered). For products other than Medicare Advantage, if the extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least 45 days to provide the specified information.

Preservice Determination

For providers in New York

Non-Urgent Care Claims:

When a pre-service claim is submitted for non-urgent care services, a decision is made within three business days of obtaining all necessary information for pre- service claims

Urgent Care Claims:

When a pre-service claim is submitted for urgent care services, a decision is made 72 hours after receipt of request.

The member or the member's designee and the member's health care provider will be notified about all approvals or denials for either urgent care or non-urgent care claims by telephone and in writing.

Concurrent Review Determinations

For providers in Delaware, Pennsylvania, and West Virginia

For requests to extend a current course of treatment previously authorized, Highmark will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- 24 hours after receipt of the request in cases involving urgent care, provided that the request was received at least 24 hours before the expiration of the currently authorized period or treatments; or
- Within the time frames for preservice determinations in non-urgent cases.

If Highmark reduces or terminates authorization for a previously authorized course of treatment before the end of the period or number of treatments originally authorized, we will issue the determination early enough to allow the member to appeal and receive a decision before the reduction or termination occurs.

Concurrent Review Determinations

For providers in New York

A decision is made within 24 hours or one business day (whichever occurs first) after receipt of request for concurrent review determinations.

Notification for approvals and denials are made to the member or the member's designee, which may be satisfied by notice to the member's health care provider, by telephone and in writing.

Retrospective Review Determinations

For retrospective reviews, Highmark will provide notification of our determination within 30 calendar days of receipt of the request. If Medical Management & Quality (MM&Q) requires additional information, the request will be made within 48 hours after receiving the request for retrospective review.

This 30-day time frame may be extended one time for up to 15 days. If this extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least 45 calendar days to provide the specified information.

Notification

If an authorization is granted, Highmark will notify the member and requesting provider within the required time frame for the type of review requested. The notification will include a reference number that the provider can use in referencing the authorization.

In concurrent review cases, notification of the authorization to extend services will include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

If the authorization is denied, Highmark will issue written notification to the member and requesting provider (except in New York where verbal and written notification will be sent to the member and requesting provider). The written notification will include:

- The principal reason(s) for the denial;
- Reference to the plan provision on which the determination is based;
- In the case of denials for lack of information, a description of any additional information necessary to make the determination and an explanation of why it is necessary;
- A description of procedures and time frames for appealing the denial internally and externally, as applicable;
- A statement that a copy of the clinical review criteria relied upon will be provided free of charge upon request; and
- A statement that an explanation of the scientific or clinical basis for the determination as it relates to the member’s medical condition (clinical rationale) will be provided free of charge upon request.

5.2 Faxable Authorization Request Forms

Highmark is continuously taking steps to improve our internal processes to provide quick and efficient service when processing authorization requests.

While the preferred method to submit authorization requests continues to be through Availity®, there are certain instances when Highmark allows requests to be made via fax.

Forms

To locate faxable precertification/authorization forms, select **Resources & Education** from the main Provider Resource Center menu and look under **Forms.**

Fax Forms One Time

An authorization request form should be faxed to Highmark only once. Because of the high volume of requests being submitted into Highmark, the request form may not be immediately loaded and viewable in our system. Re-faxing an original authorization request form will only add to the overall volume of requests being received, which can result in longer overall response times.

Use The Appropriate Form

If you are faxing an authorization request to Highmark, please be sure to use the appropriate authorization request form. The forms vary based on the type of clinical services being requested.

Time Frames: Urgent Vs. Non-Urgent

Highmark remains committed to handling authorization requests within the required regulatory time frames. It is important for providers to submit timely requests well **in advance of the patient's anticipated date of service** to allow for adherence to the following regulatory time frames:

- **Urgent concurrent** requests are completed within 24 hours of receipt.
- **Pennsylvania and Delaware:**
  - **Urgent** requests are completed within 72 hours of receipt.
  - **Non-urgent** requests are completed within 14 days of receipt.
- **West Virginia:**
  - **Urgent** requests are completed within two calendar days of receipt.
  - **Non-Urgent** requests are completed within seven calendar days of receipt.

- **New York:**
  - **Urgent** requests are completed within 72 hours of the receipt of the request
  - **Non-Urgent** requests are completed within three business days of obtaining all necessary information for pre-service claims

Tips

Wait times for authorization requests can either be eliminated or reduced by adhering to the following guidelines:

- Always ensure that the authorization submission includes **all** required information, including applicable diagnoses and procedure codes.
- When calling Highmark, please have all necessary member and clinical information available to allow for the fastest completion of the call.
- Authorization requirements have been suspended for certain procedure codes. Before submitting an authorization request, check Availity first to see if an authorization is still required.
- Outpatient authorization requests have a 60 day window. Service date changes do not need to be communicated to Highmark as long as they are within the original 60-day time frame.

Use Availity for Status Updates!

Please use Availity to check on the status of your authorization request, as the most up-to-date status will be viewable there.

If you are not yet Availity-enabled, go to the Register and Get Started with Availity Essentials webpage .

5.2 Preservice Denials

At times, providers may encounter situations in which a claim for services provided to a Highmark member is denied because medical necessity criteria were not met. Guidelines have been developed to identify when a Highmark commercial member can be billed for services rendered in such situations.

Guidelines

When services are denied in advance of being rendered, the member must be notified and given the option to cancel the services or proceed with the services as planned.

The Highmark member cannot be billed for the denied services unless the provider has given advance written notification informing the member that the specific service may be deemed not medically necessary or not covered by the member's benefit plan and providing an estimate of the cost. The member must agree in writing to assume financial responsibility before receiving the service.

Note: Medical policy allows a provider to bill the member for services that are deemed to be experimental or investigational. In these cases, providers need to ensure that the member understands that he or she is personally liable for the cost of services that are considered to be experimental or investigational.

Preservice Denial Defined

A **preservice denial** occurs when a provider informs a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the provider's decision, a preservice denial is not necessary. If the member continues to request the service after being informed that is it non-covered, a preservice denial notification is needed.

This conversation must occur before the service is provided and the claim is submitted. A preservice denial notification cannot be issued for services already received.

Specific to Service to be Provided

The preservice denial notification is **specific to the service** to be provided and may not be used to secure a routine or "blanket" acceptance of financial responsibility by the Highmark member.

Requirements

The member must agree in writing to assume financial responsibility in advance of receiving the service. Each of the following conditions must be met:

- Written notification was provided to the member **before the service was rendered,** indicating the specific service to be received may be denied
- The notification included an estimate of the cost

- The member agreed in writing, **before the service was rendered,** to assume financial liability for the services
- The signed agreement is maintained in the provider's records

No Specific Form Required

No specific form is required or recommended for documenting such a conversation with a member. However, the form must do all of the following:

- Identify the proposed services **specifically;**
- Inform the member that the services are not deemed to be medically necessary or are experimental/investigational;
- Provide an estimate of the cost; and
- Require the member to agree in writing, in advance of receiving a service, to assume financial responsibility for the service.

Purpose of The Preservice Denial Notification

The purpose of a signed agreement is to document that: (a) a provider has had a conversation with the member regarding lack of coverage and the estimated out-of-pocket expense the member will incur; and (2) the member agrees in writing to be financially responsible for the cost of the service.

Appealing Preservice Denials

If the Highmark member has questions about the preservice denial notification or questions about his or her appeal rights, please tell them to call Highmark Member Services at the telephone number listed on their Member ID card.

Member Later Reconsiders

If the member agrees with the provider's decision not to supply the service at the time of the visit **but later reconsiders** and decides that he or she wants to have the service, this is a preservice denial.

Important! Medicare Advantage Requirements

The preservice denial requirements for Highmark's Medicare Advantage members differ from the requirements for Highmark commercial members.

For information specific to Medicare Advantage members, please refer to the section on "Preservice Organization Determinations" in **Chapter 5.3: Medicare Advantage Procedures.**

5.2 Emergency Services

Introduction

For providers in New York

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) do not preauthorize emergency services or deny emergency care on a retrospective basis. However, we may identify specific diagnosis to pend for medical review to determine if rationale to seek care in an emergency room setting meets the intent of the New York State Prudent Layperson Law. After review by a physician, Highmark New York will treat identified non-emergency care as an adverse determination and all provisions of Adverse Determination Policy will be applied.

Emergency services, including Comprehensive Psychiatric Emergency Program (CPEP), Office of Mental Health/ Office of Alcoholism and Substance Abuse Services (OMH/OASAS), Crisis Intervention, and OMH/OASAS specific non-urgent ambulatory services are not subject to prior approval.

Emergency Care Defined

"Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

a. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

b. Serious impairment to such person's bodily functions;

c. Serious dysfunction of any bodily organ or part of such person; or

d. Serious disfigurement of such person.

e. Any condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act, including with respect to a pregnant woman who is having contractions — that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Definition: Prudent Layperson

A **prudent layperson** is one who is without medical training and who draws on his or her practical experience when deciding whether emergency medical treatment is needed.

Reimbursement of Emergency Services

Emergency services are reimbursed without authorization in cases where a prudent layperson believed that an emergency medical condition existed.

If the emergency condition results in an inpatient admission, the hospital is asked to obtain an authorization within 48 hours of the admission or as soon as the necessary clinical information is available (except in New York where a notification is required but an authorization is not).

Emergency Transportation

Emergency transportation and the related medical emergency services provided by a licensed ambulance service are considered to be emergency care and, therefore, are covered without authorization.

5.2 Experimental/Investigational and Cosmetic Services

Highmark maintains policies and procedures to ensure that all services identified as or potentially considered experimental/investigational or cosmetic are reviewed and analyzed on an individual basis.

Definition: Experimental/Investigational

The term **experimental/investigational** applies to the use of any treatment, service, procedure, facility, equipment, drug, device, or supply (intervention) which is determined by Highmark or its designated agent not to be medically effective for the condition being treated.

Highmark Medical Policy

Highmark determines an intervention to be **experimental/investigational** based on one or more of the following reasons:

- The service does not have FDA approval;
- Based on scientific evidence, the service does not impact or improve health outcomes;
- Scientific evidence does not demonstrate the efficacy of the service; and/or
- The service is still being performed in a clinical trial setting with no long-term outcomes available.

Note: Providers need to always follow Highmark Medical Policy.

Definition: Cosmetic

The term **cosmetic** applies to procedures performed to improve an individual's appearance and not to improve or restore bodily function.

Precertification Requirements

All services or procedures identified as or potentially considered as experimental/investigational or cosmetic are to be sent to Clinical Services for review. This should occur prior to beginning the treatment.

Physician Review

The care managers refer all requests for potentially experimental/investigational or cosmetic services to the Physician Advisor Office. This step is undertaken to ensure individualized clinical analysis of the requested service and to ensure that every case is reviewed by a physician reviewer.

Questions regarding these services or this process can be directed to Clinical Services by calling the Provider Service Center phone number for your service area.

Appeal Rights

If the physician reviewer determines that a request is either cosmetic or experimental/investigational, a care manager will verbally or electronically notify the provider of the determination and the availability of appeal rights. A denial letter is sent to the member (or the member's representative), the provider and/or facility. The denial letter will include the member and provider appeal rights.

Both the member and the provider can appeal a denial decision regarding services which are determined to be experimental/investigational or cosmetic in nature.

Note: For information about appeals, please see **Chapter 5.5: Denials, Grievances, and Appeals.**

5.2 Clinical Trials

Definition

Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types.

Verify Benefits

Certain clinical trials may be covered under a member's benefit plan. Others are covered under the Medicare program.

To determine if benefits are available for a particular clinical trial, providers should check the member's benefits through Availity. If Availity is unavailable, facilities should contact the Provider Service Center.

Provider Responsibility

When requesting services connected to a clinical trial, it is the responsibility of the provider participating in the trial to furnish Clinical Services with all the necessary information concerning the clinical trial itself as well as the clinical status of the member.

If appropriate, the Clinical Services reviewer will notify the provider about whether the service should be billed to Highmark (i.e., when the member's benefit plan covers it) or to the Medicare program (i.e., the member's benefit plan does not cover it).

5.2 PCP Referral Authorizations (DE Only)

DE **For providers in Delaware**

Under Highmark's Independent Practice Association (IPA) and Point of Service (POS) plans in Delaware, members are required to select a PCP who will work with them to coordinate their health care needs.

When the PCP or treating specialist determines that a referral to another provider is medically necessary, he or she initiates the referral authorization process. Referrals should be made only to network participating providers.

Process

For providers in Delaware

Requests for referral authorizations must be submitted to Highmark's Medical Clinical Services department.

- Telephone: **800-572-2872**
- Fax: **800-670-4862**

When Highmark authorizes a referral to a network provider, the medical management staff will enter the authorization into Highmark's system. Payment for claims received for services requiring a referral authorization will be denied without the required authorization.

Non-Network Referral Authorization

For providers in Delaware

In rare, extenuating circumstances, if a referral must be made to a non-network provider, Highmark may grant authorizations.

- PCPs or referral specialists generally initiate non-network referral authorizations.
- These requests usually involve special or unique circumstances where the most appropriate course of action may be to authorize patient care from a non-network provider.

If a member with a plan requiring referral authorization sees a non-network provider without a non-network referral authorization, Highmark will deny payment for services.

To obtain a non-network authorization, the provider must call Highmark's Clinical Services department and provide the following information:

- The details concerning the patient and his or her condition;
- The non-network provider's name, address, phone number, and specialty; and
- The reasons why a network provider is not adequate.

The Highmark Medical Director will review the request and notify the requesting provider as soon as the review is completed.

Additional Services

For providers in Delaware

If the referral provider determines that additional services are required, the following guidelines apply:

- If the original authorization from the referring PCP was for consultation only, the referral provider must request additional services from the PCP or contact Highmark's Clinical Services department directly.
- If the original authorization from the referring PCP was for consultation and treatment, the referral provider is approved to render limited services without requiring additional authorization from the PCP. Any changes or additional requests for services require authorization by Highmark. The referral provider must contact Highmark's Clinical Services department directly to request the authorization. Examples of such services include:
    - Surgery, diagnostic testing, or other treatment for the same condition as the original referral.
    - Treatment, such as physical therapy, that is for the same condition as the original referral.
    - Referral to another specialist for the same or related condition.

If the original authorization from the referring PCP was for consultation and treatment, the referral provider is **not** approved to render the following services without going back to the PCP for additional authorization:

- Surgery, diagnostic testing, or other treatments that is not for the same condition as the original referral.
- Referral provider identifies new or different condition requiring consultation by another specialist.

5.2 Prior Authorizations for Non-Participating Providers (PA-FPH)

For providers in Pennsylvania

There may be occasions when an HMO member in the 13-county Northeastern Region in Pennsylvania requires services that cannot be provided by a specialist or facility within the First Priority Health (FPH) network. If services are not available through a FPH network participating provider, prior authorization must be obtained for any services provided by a non-participating specialist or facility.

General Information

For providers in Pennsylvania

The following guidelines apply to non-participating provider prior authorizations for services not available from a FPH network participating specialist or facility:

- If a member receives care without a prior authorization from his/her referring participating provider and approval from Highmark, the member may be responsible for payment for all services rendered.
- All prior authorizations for services by non-participating providers should be issued prior to the member receiving the services.
- Covering PCPs may request prior authorizations for another PCP's patient(s).
- Prior authorizations are not a guarantee of payment by Highmark. The non-participating prior authorization is void for services that are not medically necessary or not covered.
- Non-participating provider prior authorization guidelines apply to all products using the FPH network (i.e., fully insured, Plus, self-funded, CHIP).
- Prior authorizations for elective services by non-participating providers are required at least two weeks prior to the member's target service date.

Requesting Prior Authorization

For providers in Pennsylvania

Prior authorization for all non-participating outpatient physician and/or outpatient facility services may be requested by completing the Outpatient Non- Participating Provider Request Form and faxing it to the fax number for migrated business for Highmark indicated on the form.

Prior authorization/precertification can also be requested for non-participating provider services by contacting the Clinical Services Department by calling the Provider Service Center phone line for your service area.

5.2 New York Regulations (NY Only)

For providers in New York

Out-of-Plan Referral Process

Out-of-plan (OOP) referrals for urgent care are made to providers or facilities not participating with Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) when:

- The member is outside the Highmark Blue Cross Blue Shield (WNY)/Highmark Blue Shield (NENY) service area
- Participating providers in the area cannot provide the necessary services

OOP referrals are made by the PCP or specialist and require review by the Utilization Management Department. If you believe that the service is materially different then what is available in-network, we require:

1. A written statement from the enrollee's attending physician, who must be a board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service requested, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and
2. Two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the enrollee than the alternate recommended in-

network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

If you believe that there is not an appropriate in-network doctor who can provide the service needed, we require a written statement from you explaining:

1. Why in-network doctors do not have the appropriate training and experience to meet particular needs; and
2. Why you recommend an out-of-network doctor who has the appropriate training and experience and is able to provide the service.

You must be licensed and board certified or board eligible and qualified to practice in the specialty area appropriate for the treatment needed.

The member's care should be directed to an in-network provider as soon as his or her condition(s) permits it.

Out-of-Plan referrals cannot be backdated.

Examples of Out-of-Plan Coverage

For providers in New York

OOP referrals are not made for patient convenience. The following circumstances must apply:

1. The covered service is not available from a participating in-network provider
2. A specialty provider is not available in-plan
3. Possible access issues

If the services are deemed necessary and are a covered service to a member in-network, the plan will adequately and timely cover these services for as long as the plan is unable to provide the service in-network.

Second opinions will also be arranged for a member should an appropriate professional not be available in-network. This will occur at no more cost to the member than if the service was obtained in-network.

Travel Time and Distance Standards:

For providers in New York

- 30 minutes or 30 miles for PCPs.
- For all other providers, it is preferred that they satisfy the 30-minute or 30-mile standard (not required).

This does not apply for patient convenience.

The above 30 miles/30 minutes travel time rule does not apply to a specialty M.D.

Specialty Care Coordinators

For providers in New York

Certain medical conditions require a specialist or specialty-care center to provide and/or coordinate the member's primary and specialty care. In these cases, a specialty care coordinator (SCC) may be designated. The Medical Director must approve the designation of SCC.

The SCC does not require a referral from the primary care physician (PCP) and may authorize referrals, procedures, and other medical services to the same extent the primary care provider would be able.

Such referral shall be made pursuant to a treatment plan developed by a specialty care center and approved by the HMO, in consultation with the primary care provider, if any, or specialist. Among other things, the treatment plan may set time limits on the SCC's authority or may establish the scope of services that may be provided or authorized by the SCC.

To be eligible for care by a Specialty Care Center, the member must be afflicted with the following, which will require specialized medical care over a prolonged period of time:

- A life-threatening condition or disease, or;
- A degenerative and disabling condition or disease.

Diagnoses that may be classified as degenerative and disabling conditions may include but are not limited to:

- Cancer
- Cerebral Palsy

- Conditions necessitating an organ transplant
- Cystic fibrosis
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis
- Sickle Cell Anemia

A Specialist Care Coordinator may be requested by:

- the member (upon enrollment)
- the member's current PCP
- the member's specialist

A Specialist Care Coordinator who is not a participating provider will only be approved if the Medical Director determines that we do not have a provider in the network with the appropriate training and expertise to provide the care necessary, and that a Specialist Care Coordinator is required and appropriate.

Members receiving care by a Medical Director-approved Specialty Care Center that is a non-participating provider, cannot be required to pay any more out-of- pocket expense than they would have when treated by a participating provider.

Summary of Specialty Care Coordination Process

1. Request for Specialist Care Coordinator (SCC).
2. Utilization Management (UM) reviews patient history and discusses request with patient, PCP, specialist, and Medical Director.
3. Decision is rendered with one of the following options:
    a. Maintain PCP, but allow one year referral to specialist
    b. Request new PCP with appropriate sub-specialty
    c. Request SCC for patient
4. Letter sent to member, provider, and specialist with decision determination.

Specialty Care Centers

For providers in New York

A Specialty Care Center is a center accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the disease or condition for which it has been accredited or designated. If we determine that our provider network does not have a Specialty Care Center with the appropriate expertise to treat a member's disease or condition, the member's PCP may request a referral to a non- participating provider. To request a referral, the PCP may contact our Utilization Management Department at **844-946-6263.**

Summary of Specialty Care Coordination Process

1. Request for Specialist Care Coordinator.
2. Utilization Management (UM) reviews patient history and discusses request with patient, PCP, specialist, and Medical Director.
3. Decision is rendered with one of the following options:
    a. Maintain PCP, but allow one year referral to specialist
    b. Request new PCP with appropriate sub-specialty
    c. Request SCC for patient
4. Letter sent to member, provider, and specialist with decision determination.

If we determine that a member's disease is life-threatening, or degenerative and disabling, and will require specialized medical care over a prolonged period of time, we will authorize an in-network referral to a Specialty Care Center that has the expertise to treat the member's disease or condition.

5.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark

Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 3: Medicare Advantage Procedures

5.3 Introduction and Overview

This unit outlines Highmark and Centers for Medicare & Medicaid Services (CMS) procedures and processes specifically for Medicare Advantage members.

CMS Requirements Overview

CMS requires specific procedures for Medicare Advantage member notification and appeal processes to ensure that beneficiaries with coverage under a Medicare Advantage plan have adequate notice of appeal rights when coverage of their health care services is denied, reduced, or terminated.

When it has been determined that it is no longer medically necessary for a member to continue receiving care in a hospital, skilled nursing facility (SNF), from a home health agency (HHA), or from comprehensive outpatient rehabilitation facilities (CORFs), CMS requires the provider to notify that member of the termination of services and provide a statement of appeal rights.

In addition, CMS requires notification when it is deemed that services may be denied prior to the services being rendered and when Medicare beneficiaries, including Medicare Advantage, are receiving observation services as outpatients for more than 24 hours.

Compliance Terms

The regulations governing the Medicare Advantage program set forth required terms for both Medicare Advantage plans and contracted providers. To make contracted providers aware of such terms, CMS has created a contracting checklist for Medicare Advantage plans to follow in developing providers' contracts and related policies and procedures.

In certain cases, regulatory language must be included in the actual contractual document governing the relationship between the Medicare Advantage plan and the provider. In other cases, CMS allows a Medicare Advantage plan to include required terms in its policies and procedures that are made available to contracted providers.

Highmark maintains a complete listing of the required Medicare Advantage compliance terms that may be included in Highmark's policies and procedures. Highmark's providers are required to comply with all such provisions.

Medicare Advantage compliance language can be found in the **Appendix** of the *Highmark Provider Manual.*

For More Information

To learn more about Highmark's Medicare Advantage products, please see the Highmark Provider Manual **Chapter 2 Unit 2: Medicare Advantage Products and Programs.**

In addition, Member Evidence of Coverage (EOC) Booklets for Highmark Medicare Advantage plans are made available in the **Appendix** of the *Highmark Provider Manual* to assist you in servicing our Medicare Advantage members. The EOCs explains their rights, benefits, and responsibilities as a member of our Plan. The Appendix is available in the main *Highmark Provider Manual* in Chapter 7.

5.3 Expedited Review of Initial Determinations and Appeals

Providers should be knowledgeable about the expedited review of initial determinations and appeals for Highmark's Medicare Advantage products. Although these processes are largely member-driven, the physician may represent the member and initiate the expedited review. Also, the physician is responsible for the crucial role of providing requested medical records on a timely basis.

When asking for an expedited review, the enrollee or the physician must submit either an oral or written request directly to the organization responsible for making the determination. The physician may also provide oral or written support for an enrollee's own request for an expedited determination.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determinations and appeals. For its Medicare Advantage programs, Highmark has processes in place for expedited review of initial determinations and appeals for members with all Medicare Advantage products.

Highmark must automatically provide an expedited determination to any preservice or continued services request made or supported by a physician. The physician must indicate either orally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.

Expedited Review Rights

Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process. In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

Highmark reserves the right to determine whether the request meets the criteria for an expedited review. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

Not Applicable to Claim Denials

The processes for expedited review of initial determinations and appeals do not apply to claim denials if services have already been received. Members or providers may appeal claims denials through their respective standard appeal processes.

Your Role

You may be contacted by a Highmark staff member or physician advisor to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately.

Additionally, if you are contacted for information by a Highmark physician advisor about an expedited appeal, you must return his/her call. Failure to do so could result in corrective action and/or sanctioning.

Appealing on Behalf of a Member

You or a treating physician may wish to initiate an appeal on behalf of a Medicare Advantage member if you believe services are medically necessary and covered under the member's benefit plan.

If a Denial Decision is Upheld

If a denial decision is upheld on appeal, Highmark is required to forward the case to the CMS appeals contractor within 24 hours of the decision for Medicare Advantage (Part C).

The appeals contractor may request additional information. In such cases, a Highmark Medicare Advantage appeals staff member may contact your office for additional information. If you are contacted, please respond to the request immediately.

Note: For Part D prescription drug coverage, the member or provider must request an appeal through the CMS appeals contractor.

Expedited Review or Appeal Process

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members.

Note: Appeal administrators will automatically forward member appeals that do not meet expedited review criteria through the standard appeal process.

Step	Who Does It...	What Happens...
1	Member or treating physician	Decides to pursue an expedited initial determination or expedited appeal.
2	Member	Does member want to pursue the review or the appeal or appoint someone as a representative? • If the member is pursuing the review, go to **Step 4.** • If the member is appointing a

		representative, go to **Step 3.**
3a	Member or Physician	3a. For expedited appeals the member or the physician does not require a representative statement to make a request. Members or physicians may request an expedited review or appeal by phone, fax, or by mail. If an appeal request does not meet expedited criteria, it will be processed as a standard appeal.
	Or	
3b	An appointed representative	3b. The appointed representative may submit an Appointment of Representative (AOR) form by following instructions located on the form directly or sending a written equivalent. Both member and representative must sign the document. Fax or mail the signed document to

		the contact information in **Step 4.**
4	Member or appointed representative	Contacts the Expedited Review department at: • DE, PA, and WV: **800-485-9610.** • NY: **844-946-6326** May send a physician's statement supporting the urgent need for services to: Fax: • DE, PA, and WV: **800-894-7947** • NY Medical and Medical Injectables: **833-619-5750** • NY Pharmacy: **833-619-5749** Mail: • Expedited Review Department • P.O. Box 534047 • Pittsburgh, PA 15253-5073
5	Clinical Services care manager and/or physician reviewer	Investigates the review (the 72-hour period begins upon receipt of this request). Is there enough information to render a decision?

		• If yes, go to **Step 7.** • If no, request additional information from provider of care and go to **Step 6.**
6	Care provider	Forwards member's medical records to a Highmark staff member or physician advisor.
7	Highmark care manager, medical appeals staff, and/or physician reviewer	• Renders decision. • Notifies member by telephone and letter. • Notifies physician.

Where Can I Get Forms?

A current copy of the Appointment of Representative form (#CMS 1696) is always available under the CMS' forms section of the CMS website here

5.3 Medicare Advantage Medical Policy

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage plans utilize National and Local Coverage Determinations (NCDs/LCDs) when providing indications and limitations of coverage.

NCD/LCD guidelines have been integrated into the claims processing system, allowing for cost-effective claims processing and ensuring consistent, accurate administration of our customers' health care

benefits.

Plan Exclusions and Restrictions

The following exclusions and restrictions apply to Highmark's Medicare Advantage plans:

1. Services considered not reasonable and necessary according to the standards of Original Medicare, i.e., Local and National Coverage Determinations (LCD/NDC), Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and Current National Correct Coding Initiatives (NCCI), and/or other CMS guidance.
2. Experimental medical and surgical procedures, equipment, and medication unless covered by Original Medicare, i.e., LCD/NDC, HCPCS, CPT, NCCI, and/or other CMS guidance.

Accessing Medicare Advantage Medical Policy

Prior to rendering service, it is important to review medical necessity criteria outlined in the Medicare Advantage Medical Policies that are available on CMS' Medicare Coverage Database website.

5.3 Advising Members of Their Inpatient Rights at Discharge

Medicare Advantage plans must notify their members of their Medicare appeal rights at or near the time of a hospital or facility admission and discharge. The Centers for Medicare & Medicaid Services (CMS) policy requires acute care facilities to give all Medicare and Medicare Advantage inpatients the **Important Message From Medicare** ("*Important Message*") **no later than two days after admission** to the inpatient level of care. A follow-up copy must also be delivered to the patient **no more than two days prior to discharge.**

The member will need to sign and date the *Important Message* to indicate that he/she received and understood it. The acute-care facility must then provide the member with the signed *Important Message* and retain a copy of the signed document in the member's medical record.

Important Message

The *Important Message* explains the member's rights as an inpatient as well as his/her right to appeal a discharge decision. It also indicates the circumstances under which the member will or will not be liable for charges for continued stay in the acute-care facility. CMS requires facilities to maintain a copy of the signed *Important Message* in their files. This can be done electronically or via paper, according to each facility's standard record retention policy.

Process

The following steps are required for both medical and behavioral health services:

Step	Action
1	Give all Medicare Advantage inpatients the *Important Message From Medicare* at or near the time of admission, but no later than two days after admission to the inpatient level of care.
2	Provide a follow-up signed copy of the Important Message *From Medicare* to all Medicare Advantage patients (or, if necessary, to their representative) prior to discharge, but no more than two days before discharge. Retain a copy of the signed document in the member's medical record or in some other location/format to demonstrate that the requirement was met.

Member Must Comprehend

The member must be able to understand the purpose and contents of the notice to be able to sign indicating receipt. The facility is responsible to explain the *Important Message* and to ensure that the member understands its content. Members who do understand must sign and date the form to indicate receipt and understanding.

If the facility determines that the patient does not understand that he/she can appeal the discharge decision, the facility must provide the *Important Message* document to another individual acting as the patient's representative. The representative must then sign and date it to indicate receipt and understanding.

If the member decides to accept the discharge, he/she leaves the facility and goes home or to an alternative level of care.

Member Disagrees with Discharge Decision

If the member disagrees with the discharge decision, he/she has until midnight on the day of the scheduled discharge (while he/she is still an inpatient) to decide to pursue an expedited review (appeal). If the member decides to pursue the appeal, additional steps are necessary.

This procedure applies only to patients who disagree with the discharge decision and wish to initiate an expedited review of the discharge decision:

Step	Action
1	If the patient disagrees with the discharge decision, no later than midnight on the day of discharge the patient or authorized representative contacts the Quality Improvement Organization (QIO) as directed on the *Important Message* From Medicare.
2	The QIO notifies the facility and Highmark that the request was received. The QIO will notify the facility to forward relevant records and complete and deliver the **Detailed Notice of Discharge.**
3	The facility will deliver the **Detailed Notice of Discharge** to the member no later than noon

	of the day the facility is notified of the review request. This notice provides the member with the clinical and coverage reasons why the member's physician has determined that the level of care is no longer reasonable or medically necessary. The member is not required to sign this document.
4	No later than one day after receiving all the necessary information, the QIO completes its review and communicates its decision to the member, facility, and the health plan.

Timeline for Discharge Notification Process

For a detailed timeline for the delivery of the *Important Message* and Detailed Notice of Discharge, click here. The timeline outlines the responsibilities of each individual who has a role in the process.

If Member Disagrees with QIO Decision

If the Medicare Advantage member disagrees with an adverse QIO review decision, the member may request reconsideration while still an inpatient in the hospital.

Locating Forms

Current copies of the *Important Message From Medicare and the Detailed Notice of Discharg*e are available on the CMS website.

In addition, a Highmark branded *Detailed Notice of Discharge* is available. This form can also be found on the Resource Center – select **Resources & Education,** then **Miscellaneous Forms**. Scroll to **DETAILED NOTICE OF DISCHARGE.**

For More Information

Beneficiary and Family Centered Care QIOs (BFCC-QIOs) handle case reviews. The BFCC-QIO for the region that includes Pennsylvania and West Virginia is Livanta.

Quality Innovation Network QIOs will offer health care quality improvement learning opportunities, technical assistance, and free resources to support providers. Quality Insights is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) that services Pennsylvania and West Virginia. For more information, please visit their website.

In addition, you may call Highmark's Provider Service Center at:

- **Delaware:** Freedom Blue PPO: **800-346-6262**
- **New York**: **800-329-2792**
- **Pennsylvania**:
  - Freedom Blue PPO: **866-588-6967**
  - Community Blue Medicare HMO: **888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **866-588-6967**
  - Security Blue HMO (Western Region only): **866-517-8585**
- **West Virginia**: Freedom Blue PPO: **888-459-4020**
- **New York: 800-329-2792**

Procedure for SNFs, HHAs, and CORFs

The CMS also requires skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) to follow special procedures to ensure that Medicare Advantage patients are given adequate notice of discharge and appeal rights.

5.3 Notice of Medicare Non-Coverage (NOMNC)

The Centers for Medicare & Medicaid Services (CMS) requires skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) to follow special procedures to ensure that Medicare Advantage patients are given adequate notice of discharge and appeal rights. The member must be given appropriate notice when it has been determined that coverage of their health care services is denied, reduced, or terminated.

CMS has issued a *Notice of Medicare Non-Coverage* (NOMNC) form that providers must use to notify both Medicare beneficiaries and enrollees of Medicare Advantage plans that Medicare coverage for

specific services currently being received will end.

The CMS is requiring that insurers, including Highmark, collect additional documentation from facilities for Quality Improvement Organization (QIO) program audits, **effective January. 1, 2024.**

For these audits, facilities will now be required to submit the following forms to the health plan when they are issued:

- Notice of Medicare Non-Coverage (NOMNC)
- Detailed Explanation of Non-Coverage (DENC)

The NOMNC form is available on the Provider Resource Center . See the “Locating the Form” section below. The DENC form is available on the CMS website by clicking here. Completed forms should be faxed to Highmark at this number: **888-740-4318.**

Time Frame

The NOMNC form should be issued **no later than two days before** the proposed end of services.

Valid Delivery

Valid delivery means that the member or appointed or authorized representative* must be able to understand the purpose and contents of the notice to sign for receipt of it. The member, or appointed or authorized representative, must be able to understand that he/she may appeal the termination decision. If the member, or appointed or authorized representative, is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.

**An appointed or authorized representative requires an AOR (Appointment of Representative Form) or a POA (Power of Attorney).*

Valid Delivery Methods

The NOMNC form can be delivered using the following methods:

- In person to a member, or appointed or authorized representative; or
- Via telephone when unable to provide the NOMNC form to the member, or appointed or authorized representative, in person.

If the NOMNC form is delivered by telephone, then the facility must confirm the telephone contact by acknowledging the conversation in writing and mailing it on the same day.

Important!

Providers **cannot** leave any of this information in a voicemail message. CMS considers only direct verbal notifications to be valid.

Provider Information Required

The provider must document the name, address, and telephone number of the provider delivering the notice at the very top of the first page of the form. The field for this information is located immediately below the logo of the product under which the member has coverage. The form is not considered valid without this information.

Providers choosing to use a NOMNC form that is not specifically branded for Highmark products must add their name, address, and telephone number in this same location on the first page of the form.

Additional Information Section

Highmark has chosen to add fields in the "Additional Information" section for the provider to document the details supporting the valid delivery of the notice. This documentation is designed to protect the provider, the member, and the health plan, especially when the notice must be delivered to a member's representative who is not physically present in the facility. The facts required in the Additional Information section of the form are as follows:

- Details of the conversation with the member or representative;
- The name and telephone number of the Quality Improvement Organization (QIO);
- The date and time by which the QIO must be contacted;
- The name and title of the individual delivering the NOMNC to the member or representative on behalf of the facility;
- The date and time of the conversation during which the NOMNC was delivered to the member or representative;
- The method of delivery (verbal, telephonic, etc.);
- If delivered by telephone, also include the telephone number called; and
- The date on which written confirmation was sent as follow up to telephone delivery.

Note: Although some of these fields are most immediately applicable to situations in which the NOMNC is delivered to a member or representative not present in the facility, the relevant information should be documented in all cases.

Telephone Delivery: Obtaining the Member's Signature

When the NOMNC form is delivered via telephone, the member's signature can be obtained as follows:

- The member or representative may come to the facility to sign the NOMNC form at a later date; or
- The facility should make a copy of the NOMNC form for the facility's records, and then send the original to the member or representative via certified mail requesting that a receipt be returned to the facility if the member or representative is unable to come to the facility for signature.

Retain Copy

Facilities should retain a copy of the completed and signed NOMNC form in their records.

SNFS Managed by Home & Community Care Transitions

For providers in Pennsylvania and West Virginia

For skilled nursing facilities managed by Home & Community Care Transitions, a copy of the completed and signed NOMNC form should **also** be faxed to Home & Community Care Transitions at **844-496-7209.**

Locating Form

The **Notice of Medicare Non-Coverage** form applicable to Highmark Medicare Advantage plans is located on the Provider Resource Center. Select **Resources & Education** then **Miscellaneous Forms.** Scroll to the **Notice Of Medicare Non-Coverage** heading to access the form.

5.3 Medicare Outpatient Observation Notice (MOON)

Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than 24 hours. The written notice must include the reason the individual is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-

sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

Medicare Outpatient Observation Notice (MOON)

The Medicare Outpatient Observation Notice (MOON) was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. The MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted. The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

To Access the MOON Form

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website.

5.3 Preservice Organization Determinations

The Medicare Advantage member has a right to an advance determination by their health plan to verify whether services are covered prior to receiving the services. In circumstances where there is a question whether or not an item or service is covered under a member's Medicare Advantage benefit plan, a provider **must** advise the member to request a preservice organization determination from their health plan, or the provider can request the determination on the member's behalf.

If coverage for the item or service is denied, the health plan must provide the member with a standard written denial notice that states the specific reasons for the denial and informs the member of his/her appeal rights.

Note: *The Advance Beneficiary Notice of Noncoverage (ABN) used for the Original Medicare program is not applicable to Medicare Advantage plans.*

Notification of Non-Coverage Determinations

Giving a preservice denial notice to members in advance of performing a service is not compliant with CMS regulations for Medicare Advantage plans.

The notification of a non-coverage determination must be issued to the member by Highmark. **If you believe that a service or item is not covered or may not be covered for a Highmark Medicare Advantage member, you must advise the member that a written coverage decision ("preservice organization determination") is required from Highmark before the service or item can be provided.**

Exceptions to Preservice Organization Determination Requirements

Preservice organization determinations **are not required** for Highmark Medicare Advantage members receiving the services listed below. These services are clearly listed as exclusions for Medicare Advantage members in Highmark's Evidence of Coverage (EOC) booklets.

1. Private duty nurses.
2. Personal items in member's room at a hospital or a skilled nursing facility, such as a telephone or television.
3. Full-time nursing care in the member's home.
4. Custodial care provided in a nursing home, hospice, or other facility setting when the member does not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps the member with activities of daily living, such as bathing or dressing.
5. Homemaker services including basic household assistance, including light housekeeping or light meal preparation.
6. Fees charged by member's immediate relatives or members of the member's household.
7. Meals delivered to the member's home.
8. Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids.
9. Reversal of sterilization procedure and non-prescription contraception supplies.
10. Naturopath services (uses natural or alternative therapies).
11. Services provided to veterans in Veterans Affairs (VA) facilities.
12. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
13. Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.

14. Medical determination of refractive state (Medical Refraction).

The services listed above are not eligible for payment and can be billed to the member.

Important! Providers are required to direct members to obtain or request a preservice organization determination prior to the receipt of all non-covered services other than those listed above. **Failure to obtain a Notice of Denial of Medical Coverage will result in the member being held harmless from any payment liability.**

Requesting Preservice Organization Determinations

Highmark members can be directed to call the Member Service phone number on the back of their identification card to initiate a preservice organization determination. Or, if you prefer to act on behalf of the member, you should call Highmark Provider Services as follows:

- **Delaware:** Freedom Blue PPO: **800-346-6262**
- **New York: 800-329-2792**
- **Pennsylvania:**
  - Freedom Blue PPO: **866-588-6967**
  - Community Blue Medicare HMO: **888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **866-588- 6967**
  - Security Blue HMO (Western Region only): **866-517-8585**
- **West Virginia:** Freedom Blue PPO: **888-459-4020**

Note: This process is not applicable to services or items that require prior authorization. Requests for prior authorization are to be submitted via Availity®.

Time Frame for Reviews (PA Only)

For providers in Pennsylvania

Upon receipt of a request for a coverage determination, Highmark will review the request and provide notification of the decision as quickly as the member's health condition requires.

For a **standard non-urgent request**, Highmark will notify the member of the determination **within 14 calendar days** after receiving the request. Highmark will extend the time frame up to 14 calendar days if the member requests an extension, or if Highmark can justify a need for additional information and can

document how the delay is in the best interest of the member. For example, the receipt of additional medical evidence from a noncontracting provider may change Highmark's decision to deny.

In cases involving the need for **urgent care**, Highmark will provide notification of the decision **within 72 hours** after receipt of the request. A case involving urgent care is one in which making the determination under the standard time frames could seriously jeopardize the member's life, health, or ability to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case as one involving urgent care, it will be handled as such.

For non-participating providers, Highmark will extend the urgent case turnaround time of 72 hours or the non-urgent case turnaround time of 14 calendar days up to an additional 14 calendar days if the member requests the extension. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

For non-participating providers, Highmark may also extend the urgent 72 hour or non-urgent 14 calendar time frames up to an additional 14 calendar days if a need for additional information can be justified and it is documented that the delay is in the interest of the member. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

Time Frame for Reviews

For providers in West Virginia

Upon receipt of a request for a coverage determination, Highmark will review the request and provide notification of the decision as quickly as the member's health condition requires.

For a **standard non-urgent request**, Highmark will notify the member of the determination **within seven calendar days** after receiving the request. Highmark will extend the time frame up to seven business days if the member requests an extension, or if Highmark can justify a need for additional information and can document how the delay is in the best interest of the member. For example, the receipt of additional medical evidence from a noncontracting provider may change Highmark's decision to deny.

In cases involving the need for **urgent care**, Highmark will provide notification of the decision **within two calendar days** after receipt of the request. A case involving urgent care is one in which making the determination under the standard time frames could seriously jeopardize the member's life, health, or ability to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case as one involving urgent care, it will be handled as such.

For non-participating providers, Highmark will extend the urgent case turnaround time of two calendar days or the non-urgent case turnaround time of sevencalendar days. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

For non-participating providers, Highmark may also extend the urgent two calendar day or non-urgent seven calendar day timeframes. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

Notice of Denial of Medical Coverage

If a review results in a non-coverage determination, Highmark will issue a *Notice of Denial of Medical Coverage*. This standardized written notice will state the specific reasons for the denial and inform the member of his/her appeal rights.

When a provider initiates a coverage determination on behalf of a member, the provider will receive a copy of the *Notice of Denial of Medical Coverage* that is issued to the member.

If the member initiated the coverage determination, the *Notice of Denial of Medical Coverage* will be issued to the member. The provider will receive a copy of the notice issued to the member, provided that Highmark is able to obtain the provider's information at the time the request is made.

5.3 Non-Emergency Ambulance Transport

Prior authorization from Highmark is required for non-emergent ambulance transports for Highmark Medicare Advantage plan members in Delaware, Pennsylvania, and West Virginia.

All non-emergent ambulance transportation, whether a one-time trip or scheduled repetitive transports, require prior authorization from Highmark, with the exception of non-emergent transports originating at a hospital (inpatient discharge, ER discharge).

When non-emergent ambulance trips originate at a hospital (i.e., inpatient discharge, ER discharge), the hospital/facility may serve as a delegate and authorize the transport without having to obtain prior authorization from Highmark.

Note: This exception does not apply to hospital-based treatments, such as dialysis and cancer treatment; **transports to and from ongoing hospital-based treatment (e.g., dialysis, chemotherapy) require prior authorization from Highmark.**

Medical Necessity Criteria

Non-emergent ambulance transportation is covered under Highmark's Medicare Advantage plans if it meets the Centers for Medicare & Medicaid Services (CMS) medical necessity guidelines. Non-emergent transportation by ambulance is appropriate if the member (beneficiary) is bed-confined. This means he/she meets **all three** of the following CMS criteria for bed confinement:

- the member is unable to get up from bed without assistance;
- the member is unable to ambulate; **and**
- the member is unable to sit in a chair or wheelchair.

Or

The member's condition is such that other means of transportation (Access, wheelchair/stretcher vans, taxi, personal vehicle) could endanger the member's health and, therefore, ambulance transport is medically necessary.

Available Procedure Codes

The following HCPCS codes for non-emergent ambulance transports are subject to prior authorization as per the requirements above:

- A0426 – Ambulance service, Advanced Life Support (ALS), nonemergency transport, Level 1
- A0428 – Ambulance service Basic Life Support (BLS), non-emergency transport

Required Prior Authorization Form

The Non-Emergent Ambulance Prior Authorization for Medicare Advantage Members form must be completed and signed by the treating provider. The form contains fields to enter member, ambulance, and transport information such as:

- Member Name/Date of Birth/Highmark Member ID;
- Ambulance Provider Name/NPI/Address;
- Start Date of Service;
- Origin and destination of transports; and/or
- Number of transports requested (to and from destination are **two trips**).

This form also serves as the Certificate of Medical Necessity (CMN). The second page is completed to certify that the services are medically necessary and must be signed and dated by the treating physician or authorized person. Medical records must support the documentation entered on the form. The completed form must be kept on file and made available upon request.

Requesting Authorization

The treating provider is responsible for obtaining prior authorization, and the ambulance provider is responsible for verifying that the service was authorized. Requests for prior authorization can be submitted by the following methods:

- Availity®;
- Fax: **888-236-6321**; or
- Telephone: **800-547-3627**.

The request form is required when submitting requests by fax. It is recommended that you complete this form prior to submitting requests via Availity or calling Highmark. The completed form will provide the information needed during the Availity submission process or when requesting authorization by phone.

Decision Notification

Highmark will make a determination **within 48 hours** of receiving the request. The ordering/treating provider will be notified of the decision by the method used to submit the request (phone/fax/Availity). Decision letters are sent via mail to the ambulance provider and to the member.

Authorizations will provide confirmation of the ambulance provider, transport origin and destination, number of transports approved, and start/end dates. If authorization is denied, the decision letter will provide a detailed written explanation outlining which specific policy requirements were not met.

Prior Authorization Not Required

- Prior authorization is not required for:
  - Commercial lines of business/plans.
  - HCPCS codes for ambulance services not noted above.
  - Emergent transportation
  - Transports originating from a hospital setting (i.e., inpatient discharge, ER discharge). This does not include hospital-based treatments (i.e., dialysis, cancer treatment) that do require prior authorization from Highmark.

5.3 Authorization Requests For Outpatient Therapy Services

Speech Therapy

For Medicare Advantage members, speech therapy requires authorization to begin treatment. The authorization requests for speech therapy are reviewed by Highmark's Clinical Services department. Your authorization requests for speech therapy services can be submitted to Highmark via Availity.

Note: Clinical Services reserves the right to request a full plan of treatment as deemed necessary.

Telephone Requests

If you are not yet Availity-enabled, authorization requests for speech therapy for Medicare Advantage members can be submitted to Highmark by contacting Clinical Services at:

Delaware Freedom Blue PPO: **800-346-6262**

New York: **800-329-2792**

Pennsylvania:

- Freedom Blue PPO: **866-588-6967**
- Community Blue Medicare HMO: **888-234-5374**

- Community Blue Medicare PPO and Plus PPO: **866-588-6967**
- Security Blue HMO (Western Region only): **866-517-8585**

West Virginia Freedom Blue PPO: **800-269-6389**

The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.

5.3 Medical Record Documentation Requirements

Highmark participating providers are expected to maintain a single standard medical record in such form and containing such information as required by all applicable federal and state laws that govern operations and all applicable Highmark policies and procedures.

Documentation Requirements

For each encounter, Medicare Advantage medical records must include, but not be limited to, all the following:

- Documentation that is appropriate and legible to someone other than the writer.
- Appropriate, timely, and legible provider signatures and credentials on the documentation.
- Date of service (or review for consultation, laboratory, or testing report) clearly documented in the medical record which correlates to the date of reported claim.
- Documentation supporting the need for the service reported on the claim.
- The member's name (on each page) and date of birth.

CMS Signature and Credentials Requirements

CMS has stated that stamped signatures are not acceptable on any medical records. The prohibition applies to all providers who bill the Medicare Program. CMS will accept handwritten signatures, electronic signatures, or facsimiles of original written or electronic signatures.

CMS also requires that the provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician credentials.

Compliance

If a provider fails to comply with these documentation requirements, remedial actions such as rejection of claims, review of claims on a retrospective basis and collection of any overpayments, and/or termination of provider agreements as noted in the provider contract may be initiated as appropriate.

Acceptable Provider Signatures

Valid provider signatures include:

1. electronic signatures which include credentials;
2. handwritten signatures including credentials;
3. printed name including credentials accompanied by provider initials; and
4. facsimiles of original written or electronic signatures that include credentials.

Type and Acceptable:

Hand-written signature including credentials

- Mary C. Smith, MD; or MCS, MD
  Examples:

Electronic signature, including credentials

- Requires authentication by the responsible provider

Examples include but are not limited to:

"Approved by," "Signed by,"
"Electronically signed by"

- Must be password protected and used exclusively by the individual provider

Printed name including credentials, accompanied by handwritten initials

- **Mary C. Smith MD** *MCS*

Facsimile

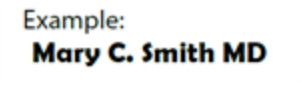
- Other than an original signature, such as included on medical record copy

Invalid Provider Signatures

The following table provides information on invalid provider signatures:

Type

- Typed name with credentials



Unacceptable Unless..

- The provider includes a written signature or initials plus credentials

Type

- Non-physician or non-physician extender signature (e.g., medical student)

Unacceptable Unless..

- Co-signed by supervising physician

(Refer to acceptable examples in the preceding table.)

Type

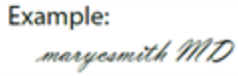
- Provider of services signature without credentials

Unacceptable Unless..

- Name is linked to provider credentials or name with credentials on practitioner stationery

Type

- Signature stamp, including credentials



Unacceptable Unless..

- Prior to 2008

(Stamped signatures are not permitted on medical records after 2008.)

5.3 Record Retention Policy

Highmark complies with, and requires its contracted providers to comply with, CMS policies and procedures including inspection of records.

Record retention is required to ensure efficient availability in case of immediate need. Compliance with CMS' requirements is paramount for continuing participation in the Medicare Advantage program and the ability to service our Medicare Advantage members.

Policy

CMS revised its regulations with respect to records retention and access to records, increasing the period from six to ten years. Therefore, network providers must maintain records and information in an accurate and timely manner in accordance with 42CFR §422.504(d) and provide access to such records in accordance with 42CFR §422.504(e)(2).

42CFR §422.504(d) states Medicare Advantage organizations are to maintain records and allow CMS access to them for **ten years** from the termination date of the contract or the date of the completion of any audit.

42CFR §422.504(e)(2) states:

"HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the Medicare Advantage organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract."

If you wish to read the entire context of the requirement please visit The Code of Federal Regulations, Title 42, Volume 2, Chapter 1V – Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 422, Medicare Advantage Program, Subpart K, Contracts with Medicare Advantage Organizations.

5.3 Chronic Care Management Services

CMS recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

Under the Medicare Physician Fee Schedule (PFS), Medicare pays separately for CCM services furnished to Medicare patients with multiple chronic conditions.

Definition

CCM services encompass the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Highmark Reimbursement Policy Bulletin RP-043

Highmark follows CMS published guidelines for chronic care management services for Medicare Advantage as per Highmark Reimbursement Policy RP-043: Care Management.

These guidelines are available in the CMS MLN Matters booklet on Chronic Care Management Services.

5.3 Advance Directives

Network providers are required to comply with the requirements of this section with respect to their Highmark Medicare Advantage patients. Providers are urged to adhere to these same standards with respect to their other Highmark patients in all types of plans.

Definitions

An **advance directive** is written instructions, such as a living will and medical (or durable) power of attorney, recognized under state law and signed by a patient, that explains the patient's wishes concerning the provisions of health care if the patient becomes incapacitated or is unable to make those decisions known.

An advance directive can tell physicians and family members what life-sustaining treatments one does or does not want at some future time if one becomes incapable of making or communicating treatment decisions. An essential component of the advance directive is the selection of a person to make health and personal care decisions for one who lacks sufficient capacity to make or communicate choices.

A **living will** is a witnessed, notarized statement by which an individual specifies in advance what life-prolonging measures or other medical care he/she wants, or does not want, in the event the individual:

1. is certified by one or more examining physicians to have a terminal condition or to be in a persistent vegetative state; and
2. is unable to communicate his/her wishes.

A **medical (or durable) power of attorney** is a witnessed, notarized statement by which an individual appoints someone (typically a family member or trusted friend) to make health care decisions on the individual's behalf in the event that the individual becomes unable to make such decisions. If called to act, the appointed representative is to make decisions consistent with the wishes and values of the incapacitated individual, and to act in the individual's best interest where such wishes are unknown.

Some advance directives combine the functions of both a medical power of attorney and a living will.

Policy

Primary care physicians/practitioners (PCPs) must ask Medicare Advantage program members whether they have executed an advance directive and selected a surrogate. PCPs must then review the advance directive and determine their role as described in the procedure below.

Advance directive discussions must be documented in a prominent place in the medical record. A copy of the executed advance directive must be placed in a prominent part of the medical record.

If a provider cannot implement an advance directive, in whole or in part, as a matter of conscience, then the provider must:

- Issue a clear and precise written statement of this limitation, describing the range of medical conditions or procedures affected by the conscientious objection; and
- Discuss this with the patient and document the discussion in a prominent part of the individual's medical record; and assist the member in locating another network provider, if the member so desires, or contact Highmark Customer Service at the telephone number located on the back of the member's ID card so that we may assist in locating another network provider.

A provider may not condition the provision of care or otherwise discriminate against a Medicare Advantage member based on whether or not the individual has executed an advance directive.

Monitoring

During an office site visit, a nurse from Quality Management will review medical records to determine whether:

- Discussion of the advance directive with the member is documented in a prominent part of the medical record; and
- A copy of the advance directive, signed by the member and physician, is on file, if applicable.

Clinical studies may also be conducted to evaluate ongoing use and discussion of advance directives.

Procedure

Step	Action
1	Ask the member whether he/she has executed an advance directive. Document the response in the member's chart. • If the member *has completed* an advance directive, go to Step 2.

	• If the member *has not completed* an advance directive, initiate a discussion about completing an advance directive and selecting a surrogate decision-maker. Document the discussion in the member's chart. Process complete.
2	Review the advance directive. • If you **are willing** to honor the request as it is written, document the discussion and place a copy of the advance directive in a prominent part of the member's medical record. Process complete. • If you **are not willing** to honor the request as it is written, document the discussion in a prominent part of the member's chart and go to Step 3.
3	If possible, notify the member of the decision not to honor the advance directive. Member Service will make every effort possible to place the member with another provider who is able to honor the member's wishes.

Highmark West Virginia Responsibilities

For providers in West Virginia

Highmark Senior Solutions Company, through Highmark West Virginia, provides Freedom Blue Medicare Advantage members, at the time of initial enrollment, written information on their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Members are informed that complaints alleging denial of care or provision of care not authorized by an advance directive, or discrimination based on the existence of a directive, may be filed with the West Virginia Bureau of Public Health, Office of Health Facility Licensure and Certification at **304-558-0050.**

Highmark West Virginia may monitor compliance with this section by review of a provider's medical records during a site visit.

WV Forms and Additional Information

For providers in West Virginia

Select the appropriate link for copies of forms recognized under West Virginia law:

- State of West Virginia Medical Power of Attorney
- State of West Virginia Living Will
- State of West Virginia Combined Medical Power of Attorney & Living Will

For additional copies or more information about advance directives in West Virginia, providers may contact the following:

- West Virginia Bureau of Senior Services at **304-558-3317**; or
- West Virginia Center for End-of-Life Care at **877-209-8086**.

Providers may direct their patients who request additional information about advanced directives to the West Virginia Bureau of Senior Services or the West Virginia Center for End-of-Life Care at the numbers listed above or to similar other state agencies for members residing outside of West Virginia.

Additional Information About Advance Directives

Providers should contact their state health department, professional licensing board, health facility licensing agency, Medicare survey and certification agency, or legal counsel to learn the requirements for advance directives in their state and to obtain forms, if available.

Providers can direct their Highmark members to contact **Blues on Call** at **888-258-2428** for general (not state-specific) educational information on advance directives.

5.3 Unconfirmed Diagnosis Code (UDC) Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

The Unconfirmed Diagnosis Code (UDC) Program is a clinically-based program that promotes provider/Highmark collaboration to evaluate previously reported and/or suspected diagnosis conditions. These conditions require annual evaluation and/or treatment but may not have been reported to Highmark in the current year. This improves continuity, quality, and timely coordination of care for chronic conditions.

The goal of the UDC Program is to ensure that quality health care is provided to Highmark Medicare Advantage and Commercial Affordable Care Act (ACA) members with complex chronic health conditions by accurately identifying, treating, documenting, and reporting the appropriate ICD-10-CM diagnosis codes to Highmark.

Program Overview

For providers in Delaware, Pennsylvania, and West Virginia

Using analytics, the program will identify and list persistent (previously reported) and/or suspected diagnosis condition(s) of program members. In-network primary care physicians (PCPs) and physicians with select specialties (“participants”) are asked to address the diagnosis condition(s) with the program member during their scheduled visit within the current program period.

Participants will access the diagnosis information via the UDC portal. Providers must complete and return the UDC information as indicated in the instructions and program materials. Evaluating each program member for the diagnosis condition(s) listed in the portal helps Highmark improve overall health

care quality while reducing future health care cost. It also allows Highmark to report the accurate health status of each program member to CMS.

The program is available to all participants who have program members with diagnosis conditions that need to be evaluated during the current program period. Participants will have the potential to receive additional compensation (“program compensation”) by taking steps toward providing quality health care through assessment of the program members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this program.

For More Information

For providers in Delaware, Pennsylvania, and West Virginia

Complete program information is available on the Provider Resource Center **Education & Resources** from the main menu and then **Risk Adjustment Programs**.

5.3 Identifying Members with End Stage Renal Disease

End stage renal disease (ESRD) is permanent kidney failure that requires kidney dialysis or a transplant to maintain life. Medicare beneficiaries generally cannot join a Medicare Advantage plan if they have this condition. However, if they develop this condition while they are a Medicare Advantage member, they will continue to be enrolled. It is important to identify all members with ESRD as soon as possible to ensure adequate treatment. Your role in identifying members with ESRD is crucial.

Policy

When a Medicare Advantage patient is determined to have chronic kidney failure and receives treatment in a Medicare-approved dialysis center or receives a kidney transplant, the attending physician should help the dialysis center complete an ESRD Medical Evidence Report, CMS-2728-U3.

It takes approximately four months for the CMS-2728-U3 forms to be processed through all systems to set up the initial record and pay appropriate reimbursement rates for members with ESRD. **However, it is**

the responsibility of the patient's dialysis center to send completed CMS-2728-U3 forms to the ESRD Network Organizations in a timely manner.

Procedure

Step	Action
1	The physician ordering dialysis contacts the dialysis center.
2	The dialysis center is responsible for submitting the original copy of the completed CMS-2728-US to the servicing Social Security office. The dialysis center also submits copies of and is responsible for verifying the information on the form and resolving any questionable items before sending the information to the ESRD networks that transmit the information to CMS.
3	The information that CMS receives from the ESRD Network Organizations is documented in CMS's Group Health Plan system (GHP) which is responsible for assigning ESRD status.

5.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 4: Behavioral Health

5.4 General Information

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

The key objectives of Highmark's Behavioral Health Care Management Program are as follows:

- Ensure timely access to appropriate quality outpatient specialty services
- Encourage adherence to evidence-based treatment standards.

- Support behavioral health care needs of members in active treatment with primary care providers.
- Increase communication and coordination of care between primary care providers, psychiatrists, and other behavioral health professionals.
- Work closely with health care providers to coordinate all aspects of services for its members with both medical and behavioral health needs, especially members with chronic medical conditions complicated by conditions such as depression and anxiety.

Reminder: Verify Eligibility

To determine whether a member has behavioral health care coverage through Highmark and whether an authorization is required, always verify the member's benefits prior to providing services. Eligibility and benefits can be verified via Availity® or the applicable HIPAA electronic transaction.

In addition, the member's benefit program must provide the specific benefit for the service the member is to receive. **If the member's benefit program does not provide the benefit, the provider will not be reimbursed for the services.**

Referrals to In-Network Providers

When recommending inpatient services, be sure that the member is to receive care from a provider who participates in the network associated with the member's program and, when applicable, is in the highest benefit tier.

Timely Utilization Management Determinations

Highmark's Behavioral Health Services department provides timely utilization management determinations for all members and providers. Each utilization management determination is handled in a manner consistent with the clinical urgency of the situation and with legal and regulatory compliance requirements.

Contact Information

When Availity® is not available and/or for medical management questions/issues that cannot be handled through Availity, Highmark Behavioral Health Services can be reached by calling the telephone number for your service area:

- Delaware (DE): **800-421-4577**
- New York: 844-946-6264
- Pennsylvania (PA) Western & Northeastern Regions: **800-258-9808**

- Pennsylvania (PA) Central & Southeastern Regions: **800-628-0816**
- West Virginia (WV): **800-344-5245**
- Fax for PA, DE, and WV: **877-650-6112**
- Fax for NY: **833-581-1866**

Delaware, Pennsylvania, and West Virginia Hours of Availability:

- Monday through Friday – 8:30 a.m. to 7 p.m.
- Saturday – 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

New York Hours of Availability:

- Monday-Friday – 8:15 a.m. to 5 p.m.
- After hours: When utilization management is called outside of normal availability, a prompt is available to speak to a nurse. If the prompt is selected the call will be forwarded to an On-Call Service called Answer Phone.

Important! Privacy Reminder

When calling a behavioral health care manager directly, your call may be answered by voicemail. To uphold a member's right to privacy and in consideration of HIPAA regulations and the importance of documentation, **please do not leave clinical information about members on voicemail.**

Consent Required for Release of Treatment Information

Providers are reminded that under federal and state laws, providers of mental health and substance abuse treatment services may be required to obtain members' written authorization to release certain mental health and substance abuse treatment information to insurers and/or to other health care providers for the management of patient care.

As a contracted provider, it is your responsibility to obtain appropriate consent for release of information.

Restrictions for Substance Abuse Treatment

Pennsylvania Administrative Code Subsection 255.5(b) limits the information providers can release to insurers and/or other providers about substance abuse treatment, even with member written consent. Providers practicing in Pennsylvania are advised to ensure that the information they communicate to Highmark Behavioral Health Services is compliant with these regulations.

When practicing in any of Highmark's service areas, contracted providers are expected to be compliant with any applicable federal or state regulations.

For More Information

For additional information for providing behavioral health services to Highmark members, please see **Chapter 4 Unit 2: Behavioral Health Providers.**

5.4 Medical Necessity Criteria

Basis of Authorization Decisions

Highmark Behavioral Health Services bases its decisions to authorize care upon the following:

- Clinical information available to the care manager or physician reviewer at the time of review
- The safety of the patient and, when applicable, the safety of others
- Availability of other effective but less restrictive treatment settings
- Availability to the member of the appropriate behavioral health benefit
- Application of the appropriate medical necessity criteria

Medically Necessary Definition

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, Children's Health Insurance Program [CHIP], Centers for Medicare & Medicaid Services [CMS] as to the Medicare Advantage program, etc.), Highmark has adopted a universal definition of medical necessity:

The term medically necessary, medical necessity, or such other comparable term shall mean health care services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice; and

b. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and

c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services, or site of service at least as likely to

produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury, or disease, the severity of the patient's symptoms, or other clinical criteria.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Specialty Society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors.

Medical Necessity Criteria for Substance Abuse Treatment

For providers in Delaware, Pennsylvania, and West Virginia

Highmark's Behavioral Health Services department uses the current version of the American Society of Addiction Medicine (ASAM) criteria when reviewing the medical necessity of substance abuse treatment.

Copies of these criteria can be purchased by visiting the ASAM website, or by contacting ASAM at **301-656-3920.**

Medical Necessity Criteria for Substance Abuse Treatment

For providers in New York

NYS Office of Addition Services and Supports (OASAS), in partnership with National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), developed the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0, a web-based tool, to assist substance abuse treatment providers, Medicaid Managed Care plans, and other referral sources in determining the most appropriate level of care (LOC) for a client with a substance use disorder and/or problem gambling disorder. This tool enables the referral source to identify the most appropriate treatment setting closest to the client's community.

Medical Necessity Criteria for All Other Behavioral Health Services

Highmark's Behavioral Health Services department applies MCG Care Guidelines in DE, PA, and WV and InterQual Criteria in NY for Behavioral Health when reviewing the medical necessity of behavioral health services.

Facilities are able to view the MCG Care Guidelines/InterQual Criteria in Predictal, which is accessible via Availity. If for any reason Availity and/or Predictal is not available, facilities can call Highmark Behavioral Health Services for medical necessity criteria applicable to a particular case.

Criteria Reviewed Annually

All criteria are reviewed, approved, and/or revised at least once annually by the Care Management Committee (CMC). The CMC is comprised of practicing physicians in the community and in hospital administrative positions, including psychiatrists, who are involved in care management functions.

Prudent Layperson Laws for Emergency Services

Highmark adheres to state “prudent layperson” laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson laws. An emergency department physician can make a decision regarding admission or physical or chemical restraints.

Highmark adheres to state “prudent layperson” laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson laws. An emergency department physician can make a decision regarding admission or physical or chemical restraints.

Highmark agrees that where a physician has not entered into a different agreement with Highmark or the hospital or other mental health care facility where services are rendered, and where Highmark has not entered into a different agreement with such hospital or mental health care facility, in the event of an emergency, Highmark will pay for medically necessary emergency care mental health covered services provided by such physician in accordance with applicable prudent laypersons standards, the definition of medical necessity as defined above, and the terms and conditions of the plan member’s plan and Highmark will pay for medically necessary mental health covered services provided by physicians resulting from the admission in accordance with the definition of medical necessity and the terms and conditions of the member’s plan.

5.4 Services Requiring Authorization

Behavioral Health Authorization

Authorization (or “preauthorization”) is the process whereby the behavioral health provider must contact Highmark Behavioral Health Services to determine the eligibility of coverage for and/or the medical necessity or appropriateness of behavioral health services.

Inpatient Services

For most Highmark products, authorization is required to receive coverage for all inpatient behavioral health services, or “higher levels of care.” The term “higher levels of care” applies to the levels listed below:

- Inpatient mental health services
- Inpatient detoxification services
- Inpatient rehabilitation (substance abuse treatment and mental health treatment)

Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission.

Inpatient Psychiatric Admissions for Under Age 18

For providers in New York

No preauthorization or concurrent review is required for the initial 14 days of medically necessary inpatient psychiatric admissions for those who have not yet reached the age of 18, in a facility that is licensed by the NY State Office of Mental Health and is participating in the Blue Cross Blue Shield network. Although preauthorization is not required, facilities **are** required to provide the health plan with notification of the admission, and the initial treatment plan, within two business days of admission and participate in periodic consultation with the plan.

- If the facility fails to notify the health plan of either the inpatient admission or the initial treatment plan within two business days of the admission, the health plan may begin concurrent review immediately upon learning of the admission, even if it is during the initial 14 day period.
- All care may be reviewed retrospectively and may be denied if not medically necessary. If coverage is denied retrospectively, the member is held financially harmless, except for allowable co-pay and deductible amounts.

New York State Opioid Legislation SUD/OUD Inpatient/Facility Admissions

For providers in New York

No preauthorization or concurrent review is required for the initial 28 days of medically necessary inpatient treatment for Substance Use Disorder/Opioid Use Disorder (SUD/OUD) in New York State Office of Alcoholism and Substance Abuse Services (OASAS) licensed facilities that are participating in the Blue Cross Blue Shield network.

Levels of care include detoxification, inpatient rehabilitation, and residential treatment. Although preauthorization is not required, facilities are required to provide the health plan with notification of the admission and the initial treatment plan within two business days of admission.

- The facility is also required to perform daily clinical review, including "periodic consultation" with the plan to ensure the facility is using the OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool.
- If the facility fails to notify the health plan of either the inpatient admission or the initial treatment plan within two business days of the admission, the health plan may begin concurrent review immediately upon learning of the admission, even if it is during the initial 28-day period.
- All care may be reviewed retrospectively and may be denied if not medically necessary. If coverage is denied retrospectively, the member is held financially harmless, except for allowable co-pay and deductible amounts.

Request for Inpatient SUD/OUD prior to discharge from inpatient admission.

For providers in New York

The Plan will make a determination regarding a request for inpatient SUD/OUD treatment within 24 hours of receiving the request (if required per contract), provided the request is submitted to the Utilization Review (UR) agent at least 24 hours before discharge from the inpatient admission.

The Plan will provide coverage for the inpatient treatment while the determination is pending. Expedited review process is not limited to discharges from an inpatient hospital, and applies to all inpatient facilities, transfers between, and continued stay requests covered under the contract.

Making A Determination of Coverage Based on Medical Necessity

For providers in New York

When making a determination of coverage based on medical necessity, Highmark considers the following factors when applying criteria to a given individual:

- Age
- Co-morbidities
- Complications including risk factors and functional status
- Progress of treatment
- Psychosocial factors
- Home environment/availability and adequacy of supports (when applicable)

Highmark also considers characteristics of the local delivery system that are available for the member, such as the availability of inpatient rehabilitation, residential treatment facilities, outpatient services, or home care and community supports in the service area to support the member after discharge.

If medical necessity criteria fail at the primary review, a secondary review with a Highmark Medical Director is required. Additional information is obtained and provided to the Medical Director for second level review with consideration of:

- Whether or not support systems are local and accessible/adequate to meet member/parent-child needs
- Availability of stable housing/homelessness
- Living environment, changes in job/school, domestic violence, high-risk drug use, illegal or unsanitary conditions
- Prior attempts at living independently
- Recent death or health status of immediate family member or caretaker
- Prior treatment history including episodes of care, successful treatment episodes, impulse control, and ability to self-manage
- Member/caregiver engagement and acceptance, understanding of illness and functional limitation, participation in treatment and recovery plan, ability to assist/implement interventions, and acceptance of own responsibility to participate in recovery process

Important! Exceptions

For providers in Delaware

For important changes in Delaware legislation affecting authorization requirements for drug and alcohol dependency treatment in Delaware, please see the next section of this unit.

If Authorization is Not Obtained

When the behavioral health provider is required to obtain authorization but provides covered services without obtaining authorization, the member will not be responsible for payment.

5.4 Delaware Drug and Alcohol Dependency Treatment Mandate

For providers in Delaware

Policy

Per Delaware legislation (Del. Code tit. 18 §§ 3343, 3578), Highmark Blue Cross Blue Shield Delaware may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies at a Highmark Delaware network participating facility.

Definition

For providers in Delaware

Drug and alcohol dependencies are defined as a substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16 of the Delaware Code.

Concurrent Utilization Review

For providers in Delaware

Concurrent utilization review is prohibited during the first 14 days of medically necessary inpatient and residential treatment by a network participating facility approved by a nationally recognized health care accrediting organization or the Division of Substance Abuse and Mental Health; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management, provided that the facility notifies Highmark Delaware of both the admission and the initial treatment plan within 48 hours of the admission.

The facility must perform daily clinical review and periodically consult with Highmark Delaware to ensure that the facility is using the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by the American Society of Addiction Medicine (ASAM) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

Retrospective Review

For providers in Delaware

Highmark Delaware may perform retrospective review for medical necessity and appropriateness of all services provided during an inpatient stay or residential treatment, including the initial 14 days of treatment; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management.

Highmark Delaware may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by ASAM or any state-specific ASAM criteria.

Applicability

For providers in Delaware

These statutes are applicable to all Highmark Delaware fully insured individual and group health benefit plans. Self-insured employer groups will be offered the opportunity to adopt the mandate and may or may not elect to follow the mandate. Medicare supplemental plans are exempt from this law.

Member Liability

For providers in Delaware

The Highmark Delaware member does not have any financial obligation to the facility for inpatient and residential treatment other than any applicable copayments, coinsurance, or deductible amounts required under their benefit plan.

For More Information

For providers in Delaware

For additional information on this mandate, please see *Highmark's Provider Manual* **Chapter 4 Unit 2: Behavioral Health Providers.**

5.4 Authorization Requests

Provider-Driven Process

Authorization of behavioral health services is a provider-driven process. This means that it is the provider's responsibility to obtain the required authorization for all behavioral health services.

In the absence of required authorizations, claims for behavioral health services are not reimbursed and the member must be held harmless.

Complete Clinical Assessment Prior To Initiating Authorization Request

Before initiating the authorization request (either via Availity® or through telephone contact with Highmark Behavioral Health Services), please complete the clinical assessment and be prepared to provide the information below:

- The member's name and ID number, including alpha prefix
- The events precipitating the call
- The member's symptoms and mental status
- The degree of impairment in function
- The potential for harm to self and/or others
- The degree of distress
- The member's treatment history, including medications
- Axis I-III Diagnoses
- The treatment plan or suggested treatment plan

Authorization Request Submission Required

For providers in Delaware, Pennsylvania, and West Virginia

Authorization requests must be submitted through Highmark's provider portal, Availity®, for the following behavioral health services:

- Inpatient Admissions
- Inpatient Transfers

Requests for authorization of inpatient behavioral health services are submitted via Availity® by the facility providing services. However, if Availity is unavailable or the facility is not Availity-enabled, authorization reviews can be initiated by calling Highmark Behavioral Health Services at **800-258-9808** or faxing **877-650-6112**.

Time Frames for Review

Highmark Behavioral Health Services renders authorization decisions within the time frames required by law and the applicable regulatory agencies. For a routine review, Highmark Behavioral Health Services will render a decision within two business days from the receipt of the request.

Important! New York Behavioral Health Services will have three business days from the receipt of the request to render a decision.

5.4 Potential Outcomes of Authorization Review

Medical Necessity Criteria Used

In making authorization decisions, the Highmark behavioral health care manager reviews the information submitted and makes a determination based on the medical necessity criteria.

If Criteria Are Met

If the medical necessity criteria **are** met, an internal Highmark system authorization is generated, as well as a notification to the provider.

- If providers are Availity®-enabled, they can retrieve the authorization notice by accessing Predictal. (Select the authorization in question to view it.)
- If providers are not Availity-enabled, the authorization notice is sent to the provider as a letter through U.S. Mail, with a copy to the member. (The exception to this process is that Medicare Advantage members do not receive a copy of the letter.)

If Criteria Are Not Met

If the behavioral health care manager determines that the criteria have not been met, he or she may recommend alternative levels of care and treatment options for which the criteria have been met.

If no alternative level of care can be arranged, the case is sent to a Highmark physician reviewer. The physician reviews the clinical information and has the option to contact the attending provider (or designee) to discuss the case. The physician reviewer then renders a decision.

If the decision is made to not authorize the requested care, a verbal nonauthorization notice is given to the provider. A written notice follows within one business day after the verbal notice. Information about appeal rights is also communicated.

Peer-To-Peer Conversation

If the treating or ordering provider did not have an opportunity to discuss a case with the clinical peer reviewer before a utilization management decision was made, he or she may request a peer-to-peer conversation after the decision has been rendered for a commercial member.

To initiate the request, the provider should call the dedicated peer-to-peer tollfree phone number: **866-634-6468.** Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday (except in New York where you can call from 8:15 a.m. until 5:00 p.m.). A live agent will take the necessary information and forward the request to a Highmark clinical peer reviewer.

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- CASE/REQ# (e.g., REQ-1234).
- Patient's name and Member ID.
- Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.

The clinical peer reviewer who made the determination (or an appropriate designee) will contact the provider **within one business day** to discuss the case. If the provider still does not agree with the non-authorization decision after the peer-to-peer conversation, an appeal can be initiated.

Note: The peer-to-peer conversation option is not available for Medicare Advantage members.

Appeal of Adverse Decisions

Attending providers and facilities can appeal a utilization management decision that results in non-authorization of reimbursement for health care services. Please see **Chapter 5 Unit 5: Denials, Grievances, and Appeals** for more information on appeal rights

5.4 Concurrent Review

Concurrent review, also known as continued stay review, is an assessment that determines medical necessity and appropriateness for an extension of previously authorized services.

Plan-Specific Requirements

The need for concurrent review of higher levels of care varies based on the product and the specific benefit plan under which the member has coverage. As for all behavioral health services, **always verify plan-specific requirements** via Availity®, or by contacting Highmark Behavioral Health Services.

When is Review Completed?

Concurrent reviews for behavioral health services must be completed on or before the "Last Covered Day" (LCD) of the previous authorization.

Time Frames

Concurrent review decisions for behavioral health services are communicated to the provider **within one business day,** or no later than 24 hours, from receipt of the request.

In view of the short turnaround time imposed by regulating bodies, providers are reminded to **forward all relevant clinical information as quickly as possible** to avoid denials based on lack of clinical data.

Who Initiates?

The provider is ultimately responsible for initiating the concurrent review process; however, it can be initiated by the behavioral health care manager as well.

Initiating the Review

Concurrent review requests for inpatient care are normally submitted via Availity® (Availity can be used even if the original case was initiated by telephone contact with Highmark Behavioral Health Services). However, if Availity is unavailable or the facility is not Availity-enabled, concurrent reviews can be initiated by calling Highmark Behavioral Health Services.

When preparing for a concurrent review dialogue with the behavioral health care manager, please plan to provide clinical information that is new or updated since the previous review or authorization.

Types of Information to be Provided

The information below should be provided to the behavioral health care manager for a concurrent review:

- Presenting problem/proximal event
- Current mental status
- Progress since the last review

- Barriers to progress and modifications to the treatment plan
- Psychiatric and substance abuse history and response
- Current substance abuse
- Vital signs, withdrawal, blood alcohol level
- Axis I-V diagnosis
- Family/social support involvement since last review
- Risk related to functional impairment/inadequate support system
- Risk related to self and/or others
- Medications, including start date, dosage, and frequency, as well as PRN medications ordered and given
- Current medical status, complications, consultations, medications, plans of care
- Treatment plan addressing targeted symptoms
- Treatment plan changes based on progress or newly identified problems
- Patient response to and compliance with treatment
- Coordination of care for patients with co-existing medical and/or substance-related disorders
- Discharge planning, including scheduling of appointments
- Any additional assistance needed
- Any other information which may be useful in assessing the medical necessity of the patient's continuing to remain at this level of care

Important! Privacy Reminder

When working directly with a particular behavioral health care manager, it is possible that a provider may occasionally reach a voicemail line. In consideration of the member's right to privacy and the importance of documentation, you are asked to **never leave clinical information about your patient on the voicemail system.**

Compliance

Information for concurrent review should be provided in accordance with the limits imposed by federal or state law, including but not limited to Pennsylvania Administrative Code Subsection 255.5(b).

Outcomes of the Decision Process

After all the relevant clinical information has been gathered, the behavioral health care manager will make a clinical determination based on the appropriate medical necessity criteria.

- If **criteria are still met,** the continued stay may be authorized.

- If **criteria are not met,** an alternative level of care may be discussed.
- If **criteria are not met and an alternative level of care is not accepted,** the case is referred to the physician reviewer. The physician reviewer then contacts the attending provider. A decision will be rendered within the appropriate time frame based on the urgency of the request.

Medicare Advantage: When Continued Stay is Not Approved

The Centers for Medicare & Medicaid Services (CMS) requires the issuance of the *Important Message From Medicare* (*"Important Message"*) to the Medicare Advantage patient **within two days of admission** as well as a follow-up notice again prior to discharge. This *Important Message* explains the member's rights as an inpatient as well as his or her right to appeal a discharge decision.

When a concurrent review results in a denial and a Medicare Advantage member **disagrees with the decision to discharge** him or her from inpatient care, the member may request a review as instructed in the Important Message. Highmark delegates responsibility to the facility to then issue the required Detailed Notice of Discharge (*"Detailed Notice"*) form to the member. This form gives a detailed explanation of the discharge decision as well as a description of any applicable Medicare and/or Medicare Advantage coverage rules, policies, or rationales which support the decision.

Note: For more information about the *Important Message* and *Detailed Notice* requirements for Medicare Advantage members, please see **Chapter 5 Unit 3: Medicare Advantage Procedures.**

5.4 Retrospective Review

A **retrospective review,** also known as post-service review, is an evaluation of the medical necessity and appropriateness of services *after* they have been provided.

Information Needed

To demonstrate that the treatment that had been provided was medically necessary, Highmark Behavioral Health Services will need the same type of information as that required for a concurrent review.

Note: For a list of the specific types of information needed for both the concurrent and retrospective reviews, please see the preceding content regarding concurrent review.

Compliance

For providers in Pennsylvania

When requesting a retrospective review of substance abuse treatment services, please provide information regarding the member's substance abuse history in a manner compliant with Pennsylvania Administrative Code 255.5.

Mailing Address

Information for retrospective reviews of mental health or substance abuse treatment services can be mailed to the addresses below.

Delaware, Pennsylvania, and West Virginia	New York
Retro Reviews/Standard Commercial Appeals: Utilization Management P.O. Box 890392 Camp Hill, PA 17089-0392	Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208

Note: This address is also to be used for behavioral health retrospective review requests for Federal Employee Program (FEP) members.

Outcomes of the Decision Process

After all the relevant clinical information has been gathered, the behavioral health care manager will make a clinical determination, based on the appropriate medical necessity criteria, on the services provided prior to notification or without authorization.

- If **criteria are met,** an authorization is issued.
- If **criteria are not met,** the case is referred to a physician reviewer.

Review Results in Approval

If an authorization is issued, the rendering provider can obtain the authorization number from Predictal, which is accessible via Availity®. To have a previously denied claim adjusted, the provider can then open a Secure Message, reporting the newly obtained authorization number. Providers who are not Availity-enabled can call the Highmark Provider Service Center for your service area to request the adjustment with the new authorization number.

5.4 Provider Appeal Process

Non-Authorization Decision

When it is determined that a member's case does **not** meet medical necessity criteria, alternative levels of care may be discussed. If these suggestions are not acceptable to the provider or facility, the case is sent to a physician reviewer.

If the physician reviewer makes a decision to not authorize the requested services, a verbal non-authorization notice is given to the provider or facility, and a written notice follows within the required time frames. The applicable appeal rights are provided both verbally and in writing.

Peer-to-Peer Conversation

If the treating or ordering provider did not have an opportunity to discuss the case with the clinical peer reviewer before a utilization management decision was made, he or she may request a peer-to-peer conversation for commercial members (the peer-to-peer option is not available for Medicare Advantage members).

To initiate the request, the provider should call the dedicated peer-to-peer phone line: **866-634-6468.** A live agent will take the necessary information and forward the request to a Highmark clinical peer reviewer.

Delaware, Pennsylvania, and West Virginia Hours of Operation:

- Monday through Friday from 8:30 a.m. to 4:30 p.m. (EST)

- After business hours: If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:
    - Patient's name and Member ID.
    - Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.

New York Hours of Operation:

- Monday through Friday from 8:15 a.m. to 5 p.m. (EST)

The clinical peer reviewer who made the determination (or an appropriate designee) will contact the provider **within one business day** to discuss the case. If the provider still does not agree with the non-authorization decision after the peer-to-peer conversation, an appeal can be initiated.

Note: If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.

Initiating An Appeal

Either the attending provider or the facility may initiate an appeal verbally or in writing at the time of the initial non-authorization decision.

When requesting a provider appeal, the provider or facility should provide the name and telephone number of the individual who will be able to discuss the clinical aspects of the case with the physician reviewer.

Two types of appeals are available for providers of behavioral health services -- **expedited appeals** and **standard appeals**

Expedited Appeals (DE, PA, WV)

For providers in Delaware, Pennsylvania, and West Virginia

An expedited behavioral health provider appeal is a formal appeal of a decision denying one of the following on the basis of medical necessity:

- An imminent or ongoing service; or
- The admission or continued stay of a patient who has received emergency services but has not been discharged from a facility.

Expedited Appeals (NY)

For providers in New York

Eligibility for an Expedited Appeal process is available to members appealing adverse determinations involving:

- Continued or extended health care services.
- Procedures, treatments, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider.
- Situations in which a health care provider believes an immediate appeal is warranted, except post service adverse determinations.
- Any situation that would increase risk to the member's health.
- Denial for home health care services following a discharge from a hospital admission.

If Blue Cross Blue Shield requires information necessary to conduct an expedited appeal, Blue Cross Blue Shield shall immediately notify the member and the member's health care provider by telephone or fax to identify and request the necessary information followed by written notification. The clinical peer reviewer will be available within one business day, or sooner.

Time Frame: Expedited Appeals

For an expedited appeal, a decision is rendered **within one business day** of receipt of complete information, not to exceed 72 hours of receipt of the request.

Note: For Pennsylvania Act 68 expedited appeals, the decision time frame is not to exceed 48 hours. Please refer to **Chapter 5 Unit 5: Denials, Grievances, and Appeals,** section titled "Expedited Grievance: Filing On Behalf of a Member (PA Act 68)," for additional information.

Potential Outcomes of The Expedited Appeal

Either of the following could occur as the outcome of an **expedited** appeal:

If ...	Then ...

The denial is overturned upon expedited appeal,	an authorization is provided for the service.
The denial is upheld upon expedited appeal,	a statement of appeal rights is provided, both verbally and in writing. The provider can request a standard appeal.

Standard Provider Appeals

A standard behavioral health provider appeal is a formal appeal of a denial decision that does not meet the criteria for an expedited appeal.

It is also used as a secondary appeal level when a denial is upheld under the expedited appeal process.

As is necessary for an expedited appeal, the facility must provide the name and telephone number of the facility contact who will be prepared to discuss the clinical aspects of the case with a physician reviewer for a standard provider appeal.

Time Frame: Standard Provider Appeals

For a standard provider appeal, a decision is rendered and communicated in writing **within 30 days** of receipt of the request.

Potential Outcomes of Standard Appeal Process

Either of the following could occur as a result of the standard appeal process:

If ...	Then ...
The denial is overturned at standard appeal,	an authorization is provided.
The denial is upheld at standard appeal,	the decision is final, no further appeals can be initiated.

Appealing on Behalf of A Member

Upon request by the member or the member's family, a facility may file an appeal on behalf of a member as his or her representative.

If appealing on behalf of the member, the facility must provide Highmark with the name and address of the facility and a written consent form signed by the member, which specifies the services to be performed. A copy of the appropriate form is attached to every denial letter.

Note: For more detailed information about appealing on behalf of a member, please see *Highmark's Provider Manual* **Chapter 5 Unit 5: Denials, Grievances, and Appeals.**

5.4 Discharge Planning and Post-Discharge Follow-Up Care

Discharge planning should begin prior to or upon admission to an inpatient facility. At the time of precertification, the behavioral health care manager discusses discharge planning barriers and assists with any discharge needs.

Encourage Follow-Up Appointment

To increase the likelihood that a member being discharged from inpatient behavioral health services will receive appropriate aftercare, it is very important that the member leave the hospital with a follow-up outpatient appointment.

Contact Following Discharge

Upon a mental health inpatient discharge, a Highmark behavioral health specialist will attempt to make a post-discharge call to the member. When post-discharge contact is made, the behavioral health specialist will verify that a follow-up appointment has been made or, if necessary, assist the member in obtaining an appointment.

The behavioral health specialist will provide education about the importance of adhering to scheduled appointments and will work with the member to resolve any barriers. They will also discuss any

questions the member may have regarding discharge instructions, medication changes, and/or any other issues of concern to the member.

Continuing Care Coordination

Highmark Behavioral Health Services is committed to working with providers to support members in maintaining the gains achieved during inpatient treatment.

It is very important that the member leaves the facility having scheduled a follow-up appointment with a psychiatrist or other behavioral health provider **within seven days** post-discharge. If the appointment was not kept, the behavioral health specialist will work with the member to resolve any barriers and assist in rescheduling the appointment.

When Medication is Prescribed

The follow-up appointment is particularly important when a patient is discharged with a prescription for psychotropic medication. Follow-up care should be arranged with a behavioral health provider.

Discharge Summary

Facilities are reminded to complete the Discharge Summary Fax Template at, or immediately following, discharge of a Highmark member from inpatient behavioral health care admission.

Special Requirements for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (CMS) requires that people with coverage under traditional Medicare or a Medicare Advantage plan to be fully aware of their right to appeal a discharge decision. Therefore, a special process applies to these members. This process begins when a Medicare Advantage member is admitted to an inpatient level of care and requires additional action prior to discharge.

Note: For information on these special requirements for Medicare Advantage members, please see **Chapter 5 Unit 3: Medicare Advantage Procedures.**

5.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

5.5 Medical Necessity Denials

When a determination is made to not authorize a service, the denial could be either for medical necessity ***or*** benefit related. This section includes information on medical necessity denials. Please see the applicable section in this unit for benefit denials.

Medical Necessity Definition

Medical Necessity means health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

We will reimburse for medically appropriate care that is not more costly than alternative services or supplies and is likely to produce equivalent results for the person's condition, disease, illness, or injury.

Physician Reviewer

When a provider requests authorization for an admission or a service, but it is determined that the applicable medical necessity criteria are not met, the case is forwarded to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact **medically necessary**, an authorization is issued.
- If the physician reviewer agrees with the initial assessment that the service is **not medical necessary**, a medical necessity denial is issued. Only a physician can render a denial as not medically necessary.

This process applies whether the authorization request was submitted through Availity® or initiated by telephone contact with Clinical Services.

Behavioral Health Review Process

When Highmark Behavioral Health Services makes the initial assessment that a member’s case does not meet the applicable medical necessity criteria, alternative levels of care may be discussed with the requesting provider. If these suggestions are not acceptable to the treating physician or the facility, the behavioral health care manager refers the case to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact **medically necessary**, an authorization is issued.
- If the physician reviewer's decision is to **not authorize the services**, a verbal notice of non-authorization is given to the provider, and a written notice follows within one business day after the verbal notice.

Written Notification of Denial

Providers are notified verbally, as well as formally by letter, when the decision is made to not authorize a service. Providers also receive denial notifications through Predictal, which can be accessed via Availity.

Content of Denial Letter

As required by regulatory and accrediting agencies, denial letters contain very specific information, including the following:

- Identification of the denied service(s) and service date(s), when applicable
- Clinical rationale that provides a clear and precise reason for the decision
- Utilization criteria, medical policy, or benefit provisions used in making the adverse determination
- A statement that a copy of any policy, criteria, guideline, or other information referenced is available upon request (not applicable to Medicare Advantage)
- Suggested alternative level of care, if appropriate
- Suggested alternatives for treatment if benefits are exhausted
- Information about member and provider appeal rights and the process to initiate an appeal
- A description of appeal rights (standard and expedited appeals) including the right to submit written comments, documents, or other information relevant to the appeal.

Financial Responsibility Agreement

In accordance with Highmark's policy on denials for medical necessity reasons (including clinical appropriateness as to site of service) or any non-covered services, the member cannot be billed unless he or she has specifically agreed in writing, **in advance of the service,** to be financially responsible for the entire expense. This financial responsibility agreement must specify the procedure to be performed and include an estimate of the cost of the procedure.

Note: The general waiver document routinely signed by patients at admission or registration is not sufficient for this purpose.

5.5 Benefit Denials

Benefit Verification is Provider Responsibility

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits before rendering a service. Availity's **Eligibility and Benefits Inquiry** provides the information needed to make this determination.

If Availity is unavailable, providers can contact the Highmark Provider Service Center for information about benefits for medical services, or Highmark Behavioral Health Services for information about benefits for behavioral health services.

Notification of Denial

When authorization requests are submitted by telephone contact, the care manager can assist the provider by verifying whether the member's benefit plan provides the specific benefit for the service to be rendered.

If, in fact, the member does **not** have the benefit, the care manager notifies the provider verbally and follows up with a benefit denial letter.

Member's Right to Appeal

Although the provider is not permitted to appeal a benefit denial, the member can do so. The benefit denial letter addressed to the member provides the information needed to initiate the appeal.

5.5 Peer-to-Peer Conversation

The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss a medical necessity denial determination. This process is typically initiated when a peer-to-peer conversation did not occur prior to the initial denial determination.

Peer-to-Peer Option Offered at Time of Denial Notification

Highmark will advise the treating provider of the availability of this process for commercial members when verbally notifying the provider of an authorization denial (if a peer-to-peer conversation has not already occurred). This discussion may help resolve the issue and spare the time and expense of an appeal.

Note: If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.

Important!

The peer-to-peer conversation option is not available for Medicare Advantage members.

Process

For commercial members, the provider may request a peer-to-peer conversation prior to the start of the appeal and upon receipt of the initial denial determination via verbal, electronic, or written notice.

If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case. In the event the peer-to-peer conversation does not result in an authorization, the provider and member will be informed of their appeal rights and procedures.

Initiating A Peer-to-Peer Conversation

To initiate a peer-to-peer conversation, the provider should call the dedicated peer-to-peer toll-free phone number: **866-634-6468.** Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday.

Providers are encouraged to call during hours of operation to speak with a live intake agent who will gather the necessary information and answer any questions. When speaking with a live intake agent, providers will have the following options:

- **Warmline transfer** to the first available Highmark Clinical Peer Reviewer to conduct the peer-to-peer conversation.
- **Schedule a peer-to-peer conversation** with the Highmark clinical peer reviewer who made the determination (or an appropriate designee), at the requesting provider's convenience.

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- CASE/REQ# (e.g., REQ-1234)
- Patient's name and Member ID
- Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider

The Highmark clinical reviewer will contact the provider within one business day from the time of the request.

Outcomes of Peer-to-Peer Conversation

If the peer-to-peer conversation or review of additional information **results in an approval,** the physician reviewer informs the provider of the approval.

If the conversation **does not result in an approval,** the physician reviewer informs the provider of the right to initiate an appeal and explains the procedure to do so.

Home & Community Care Transitions Peer-to-Peer Conversations

For providers in Pennsylvania and West Virginia

Peer-to-peer conversations should be requested directly from Home & Community Care Transitions for authorization requests for skilled nursing, long-term acute care, and inpatient rehabilitation services for Medicare Advantage members.

To initiate the process, the provider should contact Home & Community Care Transitions via their toll-free telephone number **844-838-0929.**

Reconsideration Appeal

For providers in New York

If attempts to discuss with the provider an initial adverse determination by the Plan's Medical Director are unsuccessful, the provider may request reconsideration. Except in cases of retrospective reviews, such reconsideration shall take place within one business day of the request. The provider is expected to share information via telephone and fax to provide the reviewer with complete information regarding the case. Once the necessary clinical information is received, reconsideration is conducted by the member's health care provider and clinical peer reviewer.

Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY) may reverse a preauthorized treatment, service, or procedure on retrospective review when:

- Relevant medical information presented upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The information existed at the time of the preauthorization review but was withheld or not made available; and
- The clinical reviewer was not aware of the existence of the information at the time of the preauthorization review; and
- Had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

5.5 Provider Appeals

Highmark follows an established appeals/grievance process as a mechanism for providers to appeal an adverse benefit determination. This section will describe the specific processes as they apply to providers appealing on their own behalf for services provided to Highmark members. Please see the **Medicare Advantage: Provider Appealing on Own Behalf** section of this unit for Medicare Advantage members.

A provider may appeal a medical necessity denial decision, including decisions to deny experimental/investigational cosmetic procedures, or in certain cases, out-of-network. At the time of a denial determination, the provider is informed of the right to appeal and the process for initiating an appeal.

Note: In Delaware, the provider appeal processes outlined here apply only to providers participating in Highmark Delaware's provider networks.

Applicable Products

The provider appeal processes described here apply to all Highmark members **except** those with coverage under Highmark's Medicare Advantage products or products sold on the Marketplace

Exchange.

- For the provider appeal processes applicable to Medicare Advantage products, please see content later in this unit.
- For information regarding appeals in Delaware, Pennsylvania, and West Virginia related to Affordable Care Act (ACA) regulated, under 65 on-exchange products, please call the customer service phone number on the back of the member's identification card.

Initiating an Appeal

Requests for appeals may be submitted either by telephone or in writing.

A provider has **180 days** from the date of the initial denial of coverage in which to file an appeal in all of Highmark's service areas in Delaware, New York, Pennsylvania, and West Virginia (PA CHIP exception below).

Highmark Healthy Kids (CHIP) Filing Time Frame

For providers in Pennsylvania

For the Highmark Healthy Kids/Children's Health Insurance Program (CHIP) in Pennsylvania, a provider has **60 days** from the date of the initial denial of coverage in which to file an appeal.

Types of Provider Appeals

There are two types of appeals available to the provider following a medical necessity denial – **expedited appeal** or **standard appeal.** The type of appeal is determined by the urgency of the situation, as well as the physician's assessment of the situation.

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member's representative and the physician and/or facility, as appropriate. This process involves a verbal or written request initiated by the provider to review a determination that denied payment of a health care service for medical necessity. A clinical peer reviewer who was not involved in the original denial must conduct the review.

Expedited Appeal

An **expedited appeal** is used when a member is receiving an ongoing service or a member is scheduled to receive a service for which coverage has been denied, but the treating provider believes that a delay in

service will adversely affect the member's health. This process may be used when any of the following circumstances exist:

- A delay in decision making might jeopardize the member's life, health, or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or
- In the opinion of the practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or
- Concerning the admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; or
- Concerning a concurrent review; or
- Situations in which a health care provider believes an immediate appeal is warranted, except post-service denials; or
- Denial for home health care services following a discharge from a hospital admission; or
- You are asking for home care services after you leave the hospital (New York only); or
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged (New York only); or
- You are asking for mental health or substance abuse services that may be related to a court appearance (New York only).

Standard Appeal

A **standard appeal** is used for preservice denials in non-urgent situations **and** for appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.

It is also used as a secondary appeal level when a denial is upheld under the expedited appeal process. In West Virginia and Delaware, provider appeal rights are exhausted after the standard appeal.

Highmark's Appeal Review Process Follows All Applicable Accreditation Requirements

Highmark's process for reviewing appeals follows all applicable accreditation requirements. These include the following components:

- Review by a clinical peer reviewer who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.
- Reviewer is neither the individual who made the original decision nor the subordinate of such individual.
- Review of the appeal is within time frames established by the applicable regulations and standards.
- Verbal (as applicable) and written communication of the decision is sent within time frames established by the applicable regulations and standards.

Responsibility For Medical Treatment and Decisions

Under all circumstances, the member and the physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care. Providers and Highmark employees involved in utilization management decisions are not compensated for denying coverage nor are there any financial incentives to encourage denials of coverage.

Out-of-Network Appeals

For providers in New York

A member or the member's designee may appeal an out-of-network denial by submitting

1. A written statement from the member's attending physician, who must be a licensed, board certified, or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the member's health care needs; and
2. Two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the member than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

Full and Fair Review Process

For providers in New York

This is for all lines of business except Medicare Advantage and Administrative Services Only (ASO) that are grandfathered per HR3590H.R. Patient Protection and Affordable Care Act (PPACA).

The purpose is to provide the claimant with all the new or additional evidence that the plan considers, relies upon, or generates in connection with an appeal that was not available when the initial adverse determination was made. The claimant will be provided any and all additional information submitted during their appeal process which resulted in a final adverse determination.

5.5 Pre-Payment Coding Dispute Resolution

The pre-payment coding review dispute resolution process is a second-level appeal process that is intended to address a multitude of pre-payment coding or claim content disputes. Highmark will use this process to resolve any pre-payment coding or claims contents disputes for claims that have already undergone a standard appeal. Providers who initiate a second-level appeal process for pre-payment coding will be bound to the final resolution of the Pre-Payment Dispute Resolution.

Any provider has the right to dispute claims payment decisions related to coding or claim contents made by Highmark. All disputes related to coding or claim contents will be governed by the terms of the provider agreement and not under the member's benefit plan. Requests for payment of services will be made directly to Highmark rather than the member's benefit plan. This includes plans governed by either the Employee Retirement Income Security Act of 1974 (ERISA) or the Patient Protection and Affordable Care Act of 2010 (PPACA).

Important!

This process is distinct from the post-payment Coding Audit Dispute process which is discussed in further detail in **Chapter 6 Unit 8: Payment Review.** The post-payment dispute process is only for coding disputes related to post-payment audits.

Pre-Payment Coding Dispute

A pre-payment coding review dispute is a dispute that arises due to one or more claim reviews conducted by Highmark and/or its designated agents. Pre-payment review disputes include, but are not limited to dispute(s) that arise after one or more pre-payment claims coding reviews have been conducted by Highmark and resulted in:

- A disagreement between Highmark and the provider on the appropriate procedure code(s) assigned to the diagnosis and/or service rendered
- A disagreement between Highmark and the provider about a diagnosis code assigned to a claim
- A disagreement between Highmark and the provider about claim contents including but not limited to; revenue codes, place of service, or modifiers
- A resolution not being resolved by the parties through informal means

Appeal Rights

Providers who do not agree with Highmark pre-payment coding review findings must request a first-level appeal in accordance with the instructions provided on the applicable pre-payment review determination letter. This letter may come from Highmark or a designated agent of Highmark.

If providers are not satisfied with the appeal determination, they may have the right to request a second level appeal to have the dispute reviewed by an independent review organization (IRO). **Second level appeal determinations made by the IRO are final and binding on both the provider and Highmark except for providers located in Delaware (see below).**

Delaware Department of Insurance

For providers in Delaware

Providers in Delaware who are not satisfied with Highmark's final appeal decision have a right to request arbitration through the arbitration program administered by the Delaware Department of Insurance, except when the arbitrations involve disputes related to primary care or chronic care management providers reimbursement pursuant to 18 Del. C. §§3342B and 3556A.

Determinations made by the Delaware Department of Insurance are binding on both the provider and Highmark. However, the losing party has a right to trial de novo in the Delaware Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within 30 days of the date of the arbitration decision being rendered.

Use of an Independent Review Organization

When a provider disputes a pre-payment coding decision made by Highmark or its designated agent, the provider and Highmark shall make a good faith effort to resolve the dispute by first exhausting available appeal options and must discuss the matter with the appropriate representative(s).

Following the exhaustion of available appeal option(s), the provider may request a second-level appeal which results in a review by an Independent Review Organization (IRO) to perform a review and conclusively resolve the dispute. To initiate an external pre-payment coding review by an IRO, the provider must send an email request to the following email address:

- IROAppealRequest@highmark.com

The following must be included in the email:

- Claim number
- Member name
- Date of service
- Reason for dispute
- Supporting documentation/records
- Selection of the IRO for external review:
    - Advanced Medical Reviews (AMR)
    - National Medical Reviews (NMR)
- Contact name, email address, and phone number

Response will be provided within 30 days from date of request for external review. Once started, this process will be the sole means for resolving pre-payment coding disputes.

Independent Review Organization Fees and Costs

When the IRO's decision on a second-level pre-payment coding review is fully in favor of one party, the losing party must pay the entire fees and costs associated with the IRO's review and decision. If the IRO's decision is partly in favor of each party, the parties will share the cost of the review.

Limitation Time Period

All pre-payment coding disputes not resolved by negotiation as described in this section must be submitted to an IRO for a second-level appeal within the time frame outlined in the provider agreement, or where applicable, federal or state law.

5.5 Expedited Provider Appeal Process

Expedited Appeal Process

This process applies in situations where decisions need to be made in an urgent manner prior to services being rendered ***or*** for continued stay decisions following a concurrent review denial. All concurrent service appeals are considered urgent.

Note: The expedited appeal process is **not applicable** when the service has already been rendered.

How to Initiate

Contact Clinical Services to initiate an expedited appeal. Clinical Services may request additional information to be faxed, if needed.

When to Initiate

Prior to the member's discharge from the facility or before rendering services, but within the applicable time frame from receipt of the denial notification.

The expedited appeal must be initiated within **180 days** from receipt of the denial notification in all of Highmark's service areas in Delaware, New York, Pennsylvania, and West Virginia.

Note: The time frame is within **60 days** of receipt of the denial notification for Highmark Healthy Kids (CHIP).

Decision Time Frame

As expeditiously as the member's health requires, but **not to exceed 72 hours (except in New York where you have two business days or 72 hours, whichever is less)** from receipt of the appeal request, a decision is rendered to uphold or reverse the original denial.

Note: For Acts 68 and 146 expedited appeals in Pennsylvania, the decision time frame is **not to exceed 48 hours.** Please refer to the section later in this unit titled "Expedited Appeal: Filing On

Behalf of a Member (PA Acts 68 and 146)" for additional information.

Important!

For providers in New York

If Highmark requires information necessary to conduct an expedited appeal, Highmark shall immediately notify the member and the member's health care provider by telephone or fax to identify and request the necessary information followed by written notification.

A decision will be rendered no later than two business days or 72 hours, whichever is less, after receipt of appeal request. Immediate notification of the decision will be given by telephone, followed by written notice, which will be sent within 24 hours of the appeal decision, but not to exceed two business days or 72 hours, whichever is less. Failure to comply with time frames for an internal appeal of a utilization review determination is deemed a reversal of the initial determination.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process. The member is not required to exhaust the standard appeal process to be eligible for an external appeal.

Notification of Decision

The appropriate parties will be notified of the determination by telephone, followed by written notification. Written notification will include, but not be limited to, the following information:

- Reason/clinical rationale for an adverse determination
- Source of the criteria used to make the determination
- Right to file a standard appeal and the procedure to initiate it (except in New York where only group plans have a right to file an appeal)

5.5 Standard Provider Appeal Process

This process applies to preservice denials in non-urgent situations **and** to appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the

required authorization.

Requests for standard appeals may be submitted either by telephone or in writing.

When to Initiate

A provider must file an appeal within **180 days** from receipt of the denial notification in all of Highmark's service areas in Delaware, New York, Pennsylvania, and West Virginia.

Note: The time frame is within **60 days** of receipt of the denial notification for Highmark Healthy Kids (CHIP).

Appeal Process

The following process is followed for standard provider appeals:

1. The provider submits a request to appeal an adverse medical necessity decision either by calling Clinical Services or in writing to the applicable mailing address (indicated below).
2. Additional Information:
    a. **Delaware, Pennsylvania, and West Virginia:** A Clinical Services care manager will contact the provider if any additional information is needed to conduct the review and the provider sends it to the Clinical Services care manager.
    b. **New York:** if additional information is needed, the member and member's provider are to be notified, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information. If only some of the requested information is provided, Highmark will make a second request for the missing information in writing, within five business days of receiving the incomplete information.
3. A clinical peer reviewer who was not involved in the original denial decision reviews the case.
4. The provider is notified of the decision by telephone **within 30 calendar days** (except in New York where written notice will be given within **15 calendar days**) of receipt of the request and all pertinent information. Written notification is sent to the provider and the member.

To Initiate by Telephone

To initiate a standard provider appeal by phone, contact Clinical Services by calling the applicable telephone number for your service area:

Mailing Addresses

Submit all pertinent information to the applicable address below for Commercial appeals. Please see the **Medicare Advantage: Provider Appealing on Own Behalf** section of this unit for Medicare Advantage members.

	Preservice Appeals	Post-Service Appeals	FEP Provider Appeals
Pennsylvania: **Western Region** (all providers)	Highmark 120 Fifth Avenue Suite P4301 Pittsburgh, PA 15222	Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392	FEP Customer Service P.O. Box 890035 Camp Hill, PA 17089-0035
Pennsylvania: Central, Eastern, & Northeastern Regions	**Professional Providers:** Highmark Blue Shield Attn: Appeals P.O. Box 890035 Camp Hill, PA 17089-0035 **Facilities:** Highmark 120 Fifth Avenue Suite P4301	**Professional Providers:** Highmark Blue Shield Attn: Appeals P.O. Box 890035 Camp Hill, PA 17089-0035 **Facilities:** Highmark Medical Review P.O. Box 890392	FEP Customer Service P.O. Box 890035 Camp Hill, PA 17089-0035

	Pittsburgh, PA 15222	Camp Hill, PA 17089-0392	
Delaware (all providers)	Highmark BCBSDE, Inc. Medical Management Appeals P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991	Highmark BCBSDE, Inc. Medical Management Appeals P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991	FEP Customer Service-Federal Employee Program Service Benefit Plan P.O. Box 1991 Wilmington, DE 19801
West Virginia (all providers)	Highmark West Virginia Attention: Appeals Committee P.O. Box 535095 Pittsburgh, PA 15253-5095	Highmark West Virginia Attention: Medical Review P.O. Box 1948 Parkersburg, WV 26102	WV FEP Customer Service P.O. Box 1948 Parkersburg, WV 26102
Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY) (All providers)	Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208	Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208	Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208

Behavioral Health Services (all service areas)	Highmark Clinical Services Attn: Behavioral Health 120 Fifth Avenue, Suite P4205 Pittsburgh, PA 15222	Retro Reviews/Standard Commercial Appeals: P.O. Box 890392 Camp Hill, PA 17089-0392	Retro Reviews/Standard Commercial Appeals: P.O. Box 890392 Camp Hill, PA 17089-0392

Time Frame Compliance

For providers in New York

A decision will be rendered no later than 30 calendar days of receipt of appeal request for pre-service appeals and 60 calendar days of receipt of appeal request for post-service appeals. For Commercial, Indemnity, and Exchange plans, a decision will be rendered no later than 30 calendar days of receipt of appeal request (preservice and post service appeals). Written notice to enrollee, the enrollee's designee, and provider will be sent within two business days of the appeal decision. Highmark maintains files on all appeal requests and decisions.

5.5 Filing an Appeal on Behalf of the Member

Any Highmark member has the right to appeal an adverse determination if they are not satisfied with decisions made by Highmark regarding the coverage of services. There are specific federal and state laws and regulations that guide the member appeal process.

As outlined in this section, Highmark will resolve member appeals in a thorough, appropriate, and timely manner in accordance with the Department of Labor (DOL) Claims Procedure Rule under the Employee

Retirement Income Security Act of 1974 (ERISA) and the requirements imposed under the Affordable Care Act (ACA). There are separate sections for member appeals under New York law, Pennsylvania law (Acts 68 and 146), and the Children's Health Insurance Program for PA (Act 146). Please refer to those sections for content on member appeals for members covered by those products.

The DOL appeal process **applies to all group health plans governed by ERISA regardless of whether the group is fully insured or self-funded.** Highmark also applies this process to all non-ERISA group accounts.

Definition of a Member Appeal

A **member appeal** is a request from a member, or member's authorized representative or a provider (with the member's written consent), to review an adverse benefit determination.

This includes services related to coverage, such as decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

This process applies to both pre-service and post-service appeals.

Submitting an Appeal on Behalf of the Member

For providers in Delaware, Pennsylvania, and West Virginia

The appeal may be submitted verbally or in writing and should include supporting documentation. Unless requesting an expedited appeal, the appropriate **Designation of a Representative** form must be completed to submit an appeal request in writing.

These forms can be found on the Provider Resource Center under **Resources & Education** then **Forms**.

If the member appoints a provider as his personal representative, the member may not submit his own appeal concerning the services listed in the Designation form. The member may rescind his/her Designation (must be in writing) at any time during the process.

Filing Time Frame

The appeal must be filed no later than **180 days** after receipt of the original denial notification.

Verbal Requests

To submit an appeal request verbally, please contact Highmark by calling the Member Service telephone number on the back of the member's ID card.

Written Requests

Written appeal requests for Commercial members can be mailed to the appropriate address below. Please see the **Medicare Advantage: Appeals On Behalf of A Member** section of this unit for Medicare Advantage members.

Pennsylvania:

Western & Northeastern Regions Member Grievance & Appeals Attn: Review Committee P.O. Box 535095 Pittsburgh, PA 15253-5095	**Central Region** Highmark Blue Shield Attn: Review Committee P.O. Box 890178 Camp Hill, PA 17089-0178	**FEP** FEP Customer Service P.O. Box 890035 Camp Hill, PA 17089-0035

Delaware:

Highmark Blue Cross Blue Shield Delaware Attn: Customer Service Appeals Team P.O. Box 8832 Wilmington, DE 19899-8832	**FEP** Customer Service-Federal Employee Program Service Benefit Plan P.O. Box 1991 Wilmington, DE 19801

West Virginia:

Highmark West Virginia P.O. Box 1988 Parkersburg, WV 26101	**FEP** FEP Customer Service P.O Box 1948 Parkersburg, WV 26102

New York:

Highmark Blue Cross Blue Shield (WNY) Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208	**Highmark Blue Shield (NENY)** Utilization Management Appeals Unit P.O. Box 4208 Buffalo, NY 14240-4208	**Federal Employee Program** FEP Customer Service P.O. Box 4208 Buffalo, NY 14240-4208

Letter Acknowledging Receipt

An acknowledgement letter will be sent to the member or to the provider filing on behalf of the member **within five business days** (except in New York where the written notification will be sent **within 15 business days** of filing the appeal) from receipt of the request. The letter will include:

- A description of the appeal process.
- A statement affording the opportunity for the member to submit written comments, documents, or other information relating to the appeal.
- A statement advising that the member, or the member's representative filing on behalf of the member, may have access to information related to the appeal upon request or may submit additional material to be considered.

Medical Necessity Appeals

Any appeals related to medical necessity issues are reviewed by a licensed provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment of the service being appealed. The health care provider will not have been involved in any previous adverse benefit determination regarding the subject of the appeal or be a subordinate of any individual who was involved in the adverse benefit determination.

Benefit Related Appeals

Appeals regarding benefit denials do not require clinical review. The appeals analyst will determine whether the benefit was applied correctly under the applicable benefit program.

Decision Time Frame

With a Pennsylvania plan, for non-urgent reviews, the member and the provider filing on behalf of the member will be notified of the decision in writing **within 30 calendar days** from receipt of the request for post-service appeals.

With a West Virginia plan, for non-urgent reviews, the member and the provider filing on behalf of the member will be notified of the decision in writing **within 10 business days** for pre-service appeals, and **within 30 calendar days** from receipt of the request for post-service appeals.

In Delaware, the member and the provider filing on behalf of the member will be notified of the decision in writing **within 30 calendar days** from receipt of the request for preservice appeals, and **30 to 60 calendar days** for post-service appeals.

Decision letters will provide information on any additional appeal rights that are available.

Urgent Appeals

A request for an **urgent review** of a previous adverse benefit determination for medical, pharmaceutical, or behavioral health services on the basis of medical necessity and appropriateness may be filed by a member, member's authorized representative, or a provider (member written consent is not required; however, physician certification is required).

An urgent request will be considered when any or all of these conditions apply:

- A delay in decision-making might jeopardize the member's life, health, or ability to regain maximum function, or when supported by a provider with knowledge of the claimant's medical condition;
- A delay in decision-making will subject the member to severe pain that cannot be managed without the care or treatment that is the subject of the appeal;
- A determination that a service is experimental/investigative and, based on the written certification of the treating provider, would be significantly less effective if not promptly initiated;
- The request concerns admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; and/or
- The request is concerning a concurrent review.

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests. If a member submits the request, Highmark requires the provider to submit a *Physician Certification for Expedited Review* form. The Highmark Member Service Representative will send the form directly to the provider and it should be returned to Highmark immediately.

The appeals analyst will notify the provider and member of the decision by telephone and follow up with a written notification to the member and the provider **within 72 hours** of receipt of the request. The expedited appeal decision letter will provide any additional appeal rights that are available.

Note: When an urgent appeal is filed, no additional internal appeals are available; this applies even if the member's benefit plan has a two-level internal standard appeal process.

Additional New York Urgent Appeal Guidance

For providers in New York

An urgent request will also be considered when:

- Situations in which a health care provider believes an immediate appeal is warranted, except post service denials; or
- Denial for home health care services following a discharge from a hospital admission.

If Highmark requires information necessary to conduct an expedited appeal, Highmark shall immediately notify the member and the member's health care provider by telephone or fax to identify and request the

necessary information followed by written notification. The clinical peer reviewer will be available within one business day, or sooner.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process. The member is not required to exhaust the standard appeal process to be eligible for an external appeal.

A decision will be rendered no later than two business days or 72 hours, whichever is less, after receipt of appeal request. Immediate notification of the decision will be given by telephone, followed by written notice, which will be sent within 24 hours of the appeal decision, but not to exceed two business days or 72 hours, whichever is less. Failure to comply with time frames for an internal appeal of a utilization review determination is deemed an adverse determination subject to appeal.

Final Adverse Determination of an Internal Appeal Process

For providers in New York

Each final adverse determination of an appeal is sent to the member or their designated representative and provider, and must include the following information:

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial and instructions for requesting the clinical review criteria used.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol, or similar criterion was relied upon in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
3. The provisions of the policy, contract, or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. The health care plan's contact person and his/her telephone number.
6. The member's coverage type.
7. The name and full address of the health care plan's utilization review agent.
8. The utilization review agent's contact person and his/her telephone number (for example the manager responsible for the utilization review agent).
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment, and/or the

developer/manufacturer of the health care service.

10. A statement that the member may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that the member is entitled to receive, upon request and free of charge:
    a. Reasonable access to and copies of all documents, records, and other information relevant to the claim.
    b. A copy of each internal rule, guideline, protocol or similar criterion that was relied upon in making the determination on appeal.
    c. A list of titles and qualifications (including specialist of individuals participating in the appeal review)
12. The information supplied by the Superintendent of the New York State Department of Financial Services (NYSDFS) describing the external appeal process.
13. A statement that the claimant may have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA)
14. That Highmark will maintain files on all appeal requests and decisions made. A member must receive standard appeal rights with the expedited internal appeal decision
15. A clear statement in bold that the enrollee has 45 days from the final adverse determination to request an external appeal and that if he/she chooses a 2nd level of internal appeal time to file external appeal may expire.
16. An attachment with the standard description of the external appeals process

New York State (NYS) External Appeal

For providers in New York

A member has the right to an external appeal of certain coverage determinations made by Highmark or our vendors. An external appeal is a request by a member to the New York State Department of Financial Services (NYSDFS) for an independent review by a third party known as an external review agent. External review agents are certified by New York State and may not have a prohibited affiliation with any health insurer, HMO, medical facility, health care provider, or member associated with an appeal. The determination of the external review agent is binding for both the member and Highmark.

Eligibility for a New York State External Appeal

For providers in New York

A member cannot request an external appeal unless we have issued a final adverse determination of an Internal Appeal Process. However, if Highmark disagrees with the admission of a provision or continuation of care by a facility for an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the member's attending health care practitioner), Highmark shall initiate an expedited external appeal. Until a decision is rendered, the admission of, provision of, or continuation of care for the enrollee by the facility shall not be denied and Highmark shall provide continued coverage. If Highmark does not initiate an expedited external appeal, then Highmark shall reimburse that facility for services provided. An expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment. Highmark must include an application for an external appeal in the Final Appeal Determinations (FAD) to the member for all denials. Providers may obtain an application on the NYS Department of Financial Services website.

To be eligible for a NYS external appeal, the final adverse determination must be made on the basis that the service is not medically necessary, or the requested service is experimental or investigational, not materially different (out-of-network service request), training and experience (out-of-network referral request) or treatment of rare disease, as explained below:

1. Medical Necessity

The service or treatment is denied, in whole or in part, on the grounds that the service or treatment is not medically necessary and the service would otherwise be covered under the member's contract.

2. Experimental or Investigational

- The service or treatment is denied on the basis that it is experimental or investigational; and
- The denial is upheld on appeal or both Highmark and the member have jointly agreed to waive any internal appeal
- The member's attending practitioner has certified that the member has a life-threatening or disabling condition or disease (i) for which standard treatment or services have been ineffectual or would be medically inappropriate, or (ii) for which there does not exist a more beneficial, standard service or treatment that is covered, or (iii) for which there exists a clinical trial; and
- The member's attending practitioner (who must be a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-

threatening or disabling condition or disease) must have recommended either (i) a health service or treatment or procedure including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B) that, based on at least two documents from the medical or scientific evidence, is likely to be more beneficial to the member than any covered, standard service or treatment; or (ii) a clinical trial for which the member is eligible. Any physician, certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation; and

- The service or treatment would otherwise be covered except for the determination that it is experimental or investigational.

3. Out-of-Network Denials

There are two types of out-of-network denials that are eligible for external appeal:

- **Out-of-network service denial**. The member's preauthorization request was denied because, while the service is not available in-network, the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service.
- **Out-of-network referral denial.** The member's out-of-network referral request was denied because the health plan has an in-network provider with the appropriate training and experience to meet the particular health care needs of the member.

4. Rare Disease

An enrollee with a life-threatening condition who may require "rare disease treatment" may seek an external review for an adverse determination. Treatments of "rare diseases" would be approved, upon external review, if they contain all of the following;

- A physician certification and evidence presented by the insured or the insured's physician
- The treatment for the rare disease would be "likely to benefit" the enrollee, and
- The benefit of such treatment outweighs the risk of said service or procedure.

Agreeing to a New York State (NYS) External Appeal

For providers in New York

New York members can request an external appeal even if the initial appeal process is not completed when:

- They have coverage of a health care service which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, that was denied on appeal, in whole or in part, on the grounds of medical necessity, and
- Highmark has rendered a final adverse determination or
- Both Highmark and the member jointly agree to waive any internal appeal.

Highmark is under no obligation to agree to this request. The Manager of Utilization Management Appeals, in conjunction with the Medical Director, considers all requests for waiving the initial appeal process on an individual basis. If Highmark agrees to waive the internal process, Highmark must provide a written letter with information regarding filing an external appeal to the member within 24 hours of the agreement to waive the Highmark internal appeal process.

New York State (NYS) External Appeal Procedure

For providers in New York

Members or their designees must send an external appeal application to the Department of Financial Services within four months from the date of the final adverse determination OR the waiver of the internal appeal process. Providers appealing a concurrent or retrospective adverse determination on their own behalf must request an external appeal within 60 days of the final adverse determination. If you do not send your application to the Department of Financial Services within the required time frame (with an additional eight days allowed for mailing), you will not be eligible for an external appeal. If a member files an external appeal, the member's claim will be reviewed by an External Appeal Agent **whose decision will be binding on Highmark and the member.**

Providers have their own right to an external appeal when health care services are denied concurrently or retrospectively and must request an external appeal within 60 days. For provider requested external appeals of concurrent adverse determinations: the provider is responsible for the cost if the external appeal is upheld, and both the provider and the plan are responsible for this cost (evenly divided) if the external appeal is upheld in part (partial overturn).

5.5 Adverse Benefit Determination Appeal: Filing on Behalf of a Member (PA Acts 68 And 146)

For providers in Pennsylvania

The Pennsylvania Quality Health Care Accountability Protection Act (Acts 68 and 146) is legislation enacted to protect the rights of enrollees in fully insured health plans. These acts contain provisions that require health plans to establish procedures for member dissatisfactions, complaints, adverse benefit determinations, and grievances according to the legislative guidelines.

Any Highmark fully insured member has the right to file an adverse benefit determination appeal for a medical necessity issue or a complaint for a benefit issue, as applicable, if they are not satisfied with decisions made by Highmark. Acts 68 and 146 give the provider the option of filing an adverse benefit determination on behalf of the member as long as the provider obtains the member's written consent. An Act 68 and/or Act 146 appeal can be submitted by or on behalf of a member even in situations in which the member is not financially liable for the services in question.

Definitions

For providers in Pennsylvania

A **dissatisfaction** is when a member expresses to the health plan, either verbally or in writing, that he or she is not satisfied with some aspect of the health care plan or delivery of health care services. A dissatisfaction that concerns the network, benefits, quality of care, etc. becomes a formal **complaint** if the member, or the member's authorized representative, requests a review of the matter.

A dissatisfaction becomes an **adverse benefit determination** when the member, or the member's authorized representative, files a written or verbal request for review of adverse benefit determination (ABD).

The Act 146 definition of an Adverse Benefit Determination is:

1. a decision by the Plan that, based upon the information provided and upon application of utilization review, a request for a benefit does not meet the Plan's requirements for Medical Necessity and Appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/ Investigative, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. the denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on the Plan's determination of a person's eligibility for coverage under this Agreement or noncompliance with an administrative policy; or
3. a rescission of coverage determination by the Plan.

Applicable Products

For providers in Pennsylvania

The Acts 68 and 146 adverse benefit determination process described here applies to Highmark fully insured products in Pennsylvania.

Children's Health Insurance Program

For providers in Pennsylvania

Although Acts 68 and 146 apply to the Highmark Healthy Kids/Pennsylvania Children's Health Insurance Program (CHIP) managed care plans, the Commonwealth of Pennsylvania Department of Human Services (DHS) provisions include variations on these processes for CHIP.

Please refer to the **Pennsylvania CHIP Complaints, Grievances, and External Review** section of this unit for details of these processes for CHIP.

Definition of an Adverse Benefit Determination

For providers in Pennsylvania

There are two types of adverse benefit determination (ABD) appeal processes — those for Administrative Denials and those for ABDs subject to external review.

The definition of Administrative Denial is a decision based on prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information, or other failure to comply with an administrative policy.

ABDs subject to external review are those that involve

i. Medical Necessity and Appropriateness;

ii. Health care setting;

iii. Level of care;

iv. Effectiveness of a Covered Service; or

v. Relates to a Claim regarding the Plan's compliance with the surprise billing and cost-sharing protections under the federal No Surprises Act.

Member's Written Consent Required

For providers in Pennsylvania

A valid written consent, signed by the member, is required before a provider may proceed with the Acts 68 and 146 adverse benefit determination appeal process. The appropriate **Designation of an Authorized Representative** form must be completed in its entirety. This form is available on the Provider Resource Center – select **Resources & Education**, then **Forms**, then **Miscellaneous Forms**.

The member may not submit a separate appeal on the same issue without rescinding the consent in writing. The member may rescind consent at any time during the appeal process.

Filing Time Frame and Address

For providers in Pennsylvania

The appeal must be filed no later than **180 days** after receipt of the original denial notification.

The appeal may be submitted verbally or in writing with supporting documentation and the completed three-page **Designation of an Authorized Representative** form. Verbal appeals can be initiated by calling

the Member Service telephone number on the back of the Member ID card. Written grievances can be sent to:

Western & Northeastern Regions:

Highmark

Member Grievance & Appeals Department

P.O. Box 2717

Pittsburgh, PA 15230-2717

Central Region:

Highmark Blue Shield

Attention: Grievance Committee

P.O. Box 890174

Camp Hill, PA 17089-0174

The **Designation of an Authorized Representative** forms are available on the Provider Resource Center – select **Resources & Education,** then **Forms,** and **Miscellaneous Forms.** There is a section with Appeals forms.

Billing Restrictions

For providers in Pennsylvania

Once a health care provider assumes responsibility for filing an appeal, the provider may not bill the member or the member's legal representative for services that are the subject of the appeal until the appeal process has been completed or the member rescinds consent.

Letter to Acknowledge Receipt

For providers in Pennsylvania

An acknowledgement letter will be sent to the member and the provider filing on behalf of the member **five business days** from receipt of the appeal request.

The acknowledgement letter will include the following information:

- The right to submit additional information to support the appeal.
- 30 days for resolution.
- Confirmation that Highmark considers the matter to be an adverse benefit determination rather than a complaint, and that the member, member's representative, or provider may question the classification of complaints and adverse benefit determinations by contacting the Pennsylvania Department of Health.
- Description of the adverse benefit determination appeal process.
- Member may appoint a representative to act on his or her behalf at any time during the adverse benefit determination appeal process.
- The member, the member's representative, or the provider filing on behalf of the member may review information related to the adverse benefit determination upon request and submit additional material to be considered by Highmark.
- A statement advising that the member or the member's representative may request the assistance of a Highmark employee to assist in preparing the first level appeal.

Adverse Benefit Determination Review Process – Internal Level of Review

For providers in Pennsylvania

A provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will be assigned to review the documentation. The physician reviewer will be an individual who was not involved in any previous adverse benefit determination regarding the appeal and is not a subordinate of any individual involved. The physician reviewer will decide whether to uphold or overturn the initial determination.

The member and the provider filing on behalf of the member will be notified of the decision in writing **within 30 calendar days** from receipt of the request. The decision letter will contain:

- A statement of the issue under review;
- The basis for the decision;
- The specific reasons for the decision;
- The scientific and clinical rationale for making the decision applying the terms of the plan to the member's medical circumstances;
- Specific references to the plan's provisions on which the decision is based or instructions on how to obtain the specific plan provisions; and
- An explanation of how to file a request for a second-level review of the decision and the time frames for requesting a second-level review.

Requesting an External Review

For providers in Pennsylvania

It is not necessary for written member consent for each level of the appeal process. A request to have an adverse benefit determination eternally reviewed by the Insurance Department must be made **within four months** from receiving notice of the adverse benefit determination decision at the internal level.

Second-Level Review (Independent External Review)

For providers in Pennsylvania

Independent external review requests must be submitted to the Insurance Department **within four months** from receipt of the decision letter. **Within five business days** from Highmark's notification of the external review request from the Department, a preliminary review will be conducted to determine whether:

- The member is or was covered at the time the health care item or service was requested or, in the case of retrospective review, was covered at the time the service was provided.
- The adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the plan.

- The member has exhausted the plans internal appeal process, unless the member is not required to exhaust the internal appeal process.
- The service, which is the subject of the denied Claim, is not covered because it does not meet the Plan's requirements as to Medical Necessity and, Appropriateness, health care setting, level of care or effectiveness of a Covered Service, or because the plan determined the service to be Experimental/Investigative for a particular medical condition;
    - with respect to denials based on the experimental and investigational nature of the service, whether the treating Provider has certified that: (1) standard health care services have not been effective, are not medically appropriate or that no alternative Covered Service is more beneficial than the service that is the subject of the denial; and (2) that the recommended service is likely to be more than available standard health care services, or that scientifically valid studies using accepted protocols demonstrate that the requested service requested is likely to be more beneficial to the Member than any available standard health care services.
- The member/member's representative has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, Highmark will issue a written notification to the Department. If the request is not complete, the notification will describe the necessary information needed to proceed.

The Department will assign an Independent Review Organization (IRO) who will review all information and make a decision **within 45 days** after the IRO receives the request. The IRO will provide a written decision to the member, the provider filing on behalf of the member, Highmark, and the Department.

5.5 Expedited Adverse Benefit Determination Appeal: Filing on Behalf of a Member (PA Acts 68 and 146)

For providers in Pennsylvania

A member may request an expedited review at any stage of the Acts 68/146 adverse benefit determination process if the member's life, health, or ability to regain maximum function would be placed

in jeopardy by delay under the time frames of the standard review process.

As in the standard adverse benefit determination process, the member has **180 days** from the notification of an adverse benefit determination to file an expedited appeal. Acts 68/146 also gives the provider the option of filing an expedited appeal on behalf of the member.

Expedited Review

For providers in Pennsylvania

A member may request an expedited external review of the Plan's decision if the initial decision of the Plan or the denial resulting from the Plan's Internal Adverse Benefit Determination Process involves:

i. an Urgent Care Claim;

ii. an admission, availability of care, continued stay or service for which the Member received Emergency Care Services but has not been discharged from a facility; or

iii. a determination the service is experimental or investigational and, based on the written certification of the treating provider, would be significantly less effective if not promptly initiated.

An expedited external review may not be provided for retrospective adverse benefit determinations.

The Department requires the provider to submit a **Physician Certification for Expedited Review Form** for verification that the service requires an expedited review. The form should be returned to the Department immediately.

Expedited appeals will follow the Second-Level review process (see previous section on the standard adverse benefit determination process), with written notification of the decision to the member and provider **within 72 hours** from receipt of the request.

It is the responsibility of the member, or the provider filing on behalf of the member, to provide information to the Department in an expedited manner to allow the parties to conform to the requirements of the expedited process.

A request for an expedited external review must be submitted to the Insurance Department. Upon receipt of a request for an expedited external review, the Insurance Department shall, within 24 hours, send a

copy of the request to the Plan.

The Member may choose to request expedited external review at the same time of filing a request for expedited internal review of an adverse benefit determination. If the IRO determines that an expedited internal review is first required, the IRO must notify the Member within 24 hours. Additionally, the Plan may agree to waive the expedited internal review exhaustion requirement.

Within 24 hours of receipt from the Department of the request for an expedited external review, the Plan shall determine whether the request is timely, complete, and eligible for expedited review.

Within 24 hours following completion of this preliminary review of the expedited external review request, the Plan shall notify the Department and the Member, of its determination. The Plan's determination that the request is not eligible for expedited external review may be appealed to the Department.

Within 24 hours from receipt of the notification that the request is complete and eligible for expedited external review, the Insurance Department shall assign an Independent Review Organization (IRO) to conduct the external review and notify the Plan of the assignment.

Upon receipt of the notification of IRO assignment, the Plan or its Designated Agent shall transmit documents and information considered in making the adverse benefit determination to the assigned IRO in an expeditious manner. Decisions or conclusions reached during the Plan's initial determination or the Plan's Internal Adverse Benefit Determination Process are not binding on the IRO.

The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but in no event more than 72 hours following receipt by the IRO of the request for expedited external review.

If notice of the decision by the IRO is not provided in writing, the IRO must provide within 48 hours following initial notice of its final external review decision written confirmation of that decision to the Plan, the Member, and the Insurance Department. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO.

Upon receipt of notice that the Plan's decision was reversed by the IRO, the Plan shall within 24 hours approve coverage of the service that was the subject of the expedited external review request.

5.5 Grievances and Appeals (NY Only)

For providers in New York

If a member encounters any concerns, they can usually be resolved with a call to the Member Services Department.

Unresolved complaints or requests to change **contractual** determinations that are not regarding medical necessity determinations or experimental/investigational determinations can be reviewed through the grievance and appeal procedures. Adverse medical necessity determinations or experimental/investigational determinations are reviewed through the Utilization Management appeals process.

Our grievance and appeal procedure is designed to ensure a timely review of:

- Our members' concerns regarding our policies and procedures; or
- Any decision that we have made regarding a service that they believe is covered by Highmark or should be provided to them as part of their coverage.

A grievance can be requested for any determination made by Highmark other than a decision that a service is **not** medically necessary or is experimental or investigational in nature. Examples of concerns that may be reviewed under our grievance and appeal procedure include, but are not limited to, the following:

- denial of a referral to a specialist,
- denial of coverage for a referred service,
- denial because a benefit is not covered according to the terms of the member's contract(s),
- denial of a benefit because it was provided by an ineligible provider or at an ineligible place of service, and
- a determination that they were not a member of Highmark at the time services were rendered.

Traditional Indemnity members and individual market products sold on or off the exchanges have a one level grievance process with the following timeframes for response:

- Urgent cases: 72 hours

- Pre-service: 30 calendar days
- Post-service: 60 calendar days

There is a two-level grievance and appeal process for HMO, POS, EPO, and PPO members, as well as for small group products sold on or off the exchanges.

As always, you may file a grievance at your discretion. Highmark will not take any discriminatory action against you because you have filed a grievance or an appeal.

Designating a Representative

For providers in New York

Members may designate someone to represent them with regard to their grievance or appeal at any level. If a representative is designated, we will communicate with the member and their representative, unless directed otherwise. To appoint a representative, the member must complete, sign, and return the Appointment of Authorized Representative Form. This form can be requested by calling Member Services at **800-544-2583.**

In cases involving urgent care, a health care professional with knowledge of their medical condition may act as their authorized representative without the need to complete the Appointment of Authorized Representative Form.

Initiating a Grievance (Level 1)

For providers in New York

Any time Highmark denies a referral or determines that a benefit is not covered under the member's contract(s), the member will receive notification of our grievance procedures. A written or oral grievance may be filed up to 180 days after the receipt our original determination. Requests for a grievance should state the name and identification number of the member for whom the benefit or referral was denied. It should also describe the facts and circumstances relating to the case. Oral or written comments, documents, records, or other information relevant to the grievance may be submitted.

A grievance may be initiated by calling our Member Service Department at **800-544-2583.** Our Member Services Department hours are 8 a.m. - 7 p.m., Monday through Friday. When our offices are closed, the

member may notify us about the grievance by leaving a detailed message with our answering service. We will acknowledge receipt of the oral grievance by telephone within one business day of receipt of the message. You may contact Customer Service for language assistance free of charge or if you have special needs.

Please send all written requests for a grievance to:

Grievance Department

Highmark Blue Cross Blue Shield (WNY) or Highmark Blue Shield (NENY)

PO Box 15068

Albany, NY 12212

We will send a written acknowledgment of receipt of a member's grievance within 15 calendar days. This letter will include the name, address, and telephone number of the department that is handling the grievance. It may be necessary to ask for additional information before we can review the grievance. If this is necessary, we will contact the member.

A Member Services Representative who was not involved in the initial determination and who is not a subordinate of the initial reviewer, will thoroughly research the case by contacting all appropriate departments and providers. The Member Service Representative will review all relevant documents, records, and other information including any written comments, documents, records, and other information the member or their representative have submitted.

If the issues involved are of a clinical nature, it will be reviewed by a health care provider who was not involved in our initial determination and who has appropriate training and experience in the field of medicine involved in the medical judgment. Clinical matters would be those that require appropriate medical knowledge and experience to make an informed decision. The member will be contacted within the following time frames:

In urgent cases, when a delay would significantly increase the risk to the member's health, a decision will be made and communicated to the member by telephone within 48 hours after receipt of the grievance. The member will also be contacted in writing within two business days of the notice by telephone.

In cases involving requests for referrals or disputes involving contract benefits and all other non-urgent cases, a decision will be made and communicated to the member as follows:

- Pre-Service Claims: In writing within 15 calendar days after receipt of the grievance.
- Post-Service Claims: In writing within 30 calendar days after receipt of the grievance

Our response to our member will include the detailed reasons for our determination, the provisions of the contract, policy, or plan on which the decision was based, a description of any additional information necessary for the member to perfect their claim and why the information is necessary, the clinical rationale in cases requiring a clinical determination, the process to file an appeal, and an appeal form.

Appealing an Upheld Denial (Level II)

For providers in New York

If a member remains dissatisfied with the outcome of their grievance, they may file an appeal. A request for an appeal should include any additional information the member feels is necessary. Members have 60 business days from the time they receive the grievance determination to submit an appeal to Highmark. They may submit their request for an urgent appeal verbally or in writing. For a non-urgent appeal, they may submit a written request in the form of a letter or use our appeal form. The member will receive a copy of our appeal form with the original grievance decision. They may submit any written comments, documents, records, or other additional information with their appeal.

We will send written acknowledgment of our receipt of the appeal request within 15 calendar days. This notice will include the name, address, and telephone number of the individual who will respond to the member's appeal.

Non-clinical matters will be reviewed by a panel comprised of representative staff from our Network Services, Member Services, Quality Management, and Utilization Management areas who were not previously involved in your grievance.

If the appeal involves a clinical matter, it will be reviewed by a panel of personnel qualified to review clinical matters. This includes licensed, certified, or registered health care professionals who did not make the initial determination. At least one of the health care professionals reviewing the appeal will be a Clinical Peer Reviewer (a licensed physician or a licensed, certified, or registered health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment).

We will make a decision regarding the appeal and send the member notification within the following periods:

- In urgent cases, a decision will be made and notice provided by telephone within 24 hours after receipt of the Level II grievance appeal followed by written notice within two business days after receipt of the appeal.
- For non-urgent pre-service claims, a written decision will be sent within 15 calendar days from receipt of the appeal.
- For post-service claims, a written decision will be provided within 30 calendar days from receipt of the appeal.

Our notification to the member with regards to their appeal will include the detailed reasons for our determination; the provisions of the contract, policy, or plan on which the decision was based; and the clinical rationale in cases where the determination has a clinical basis.

Member Grievance/Appeal

For providers in New York

Upon written request, and free of charge, our members have the right to have access to copies of all documents, records, and other information relevant to their claim and details regarding diagnosis/treatment. Members also have the right to request, in writing, the name of each medical or vocational expert whose advice was obtained in connection with their claim.

Upon written request, and free of charge, members have the right to an explanation of any scientific or clinical judgment for the determination to deny their claim that applies the terms of their contract, policy, or plan to your medical circumstances.

Upon written request, and free of charge, members have the right to a copy of each rule, guideline, protocol, or similar criteria that was relied upon in making the determination to deny their claim.

Members have a right to file a complaint at any time with the NYS Department of Health at **800-206-8125** or the NYS Department of Financial Services Consumer Service Bureau at **800-342-3736.**

For questions about your appeal rights or assistance you can contact the Employer Benefits Security Administration at **866-444-3272** or Community Service Society of New York, Community Health Advocates at **888-614-5400.**

Members may have the right to bring a civil action under the Employment Retirement Income Security Act of 1974 (ERISA) §502 (a) if they file an appeal and their request for coverage or benefits is denied following review. Members have this right if their coverage is provided under a group health plan that is subject to ERISA.

Quality of Care Access

For providers in New York

As a Highmark member, members have the right to ask us to look into their concern about quality of care or timely access to a provider. We closely track all complaints. If we receive similar complaints from our customers about a provider during a certain time period, we address those issues with the provider. This is our informal process.

We also have a formal process. At a member's request, we will investigate their concern by requesting records or other documentation. Our Medical Director reviews this information. If necessary, our Medical Director will meet with the provider to discuss the concern.

If a member has a concern or problem regarding their ability to see a Highmark provider in a timely fashion or the quality of care they receive, they can contact our Member Services Department at **800-544-2583.**

We will send the member a letter that explains the complaint process and gives them a number to call if they wish to file a formal complaint. It also explains the appeal process if the member disagrees with the way our staff handles their concerns.

Unresolved Disputes

For providers in New York

We always recommend that members follow our grievance or utilization review process to remedy any issues concerning their coverage. However, if they are not satisfied with any Highmark decision, members have the right to contact the New York State Department of Financial Services or the New York State Department of Health (DOH).

The addresses and telephone numbers for these agencies are:

New York State Department of Health

Corning Tower

Albany, NY 12237

800-206-8125

New York State Department of Financial Services

One Commerce Plaza

Albany, NY 12257

800-342-3736

5.5 Pennsylvania Chip Complaints, Grievances, and External Review

For providers in Pennsylvania

The Pennsylvania Quality Health Care Accountability Protection Act (Act 68) as updated and amended by Act 146 of 2022, legislation enacted to protect the rights of those enrolled in managed care health plans, applies to Highmark Healthy Kids/Pennsylvania's Children's Health Insurance Program (CHIP) managed care plans.

In addition, the Commonwealth of Pennsylvania Department of Human Services (DHS) also provides these protections for CHIP with provisions that require some variations from the processes for our other managed care plans.

At any time during the internal complaint or grievance process, a Member may choose to designate an authorized representative to participate in the complaint or grievance process on his/her behalf. The Member or the Member's authorized representative shall notify Highmark Choice Company, in writing, of the designation. Highmark Choice Company reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by Highmark Choice Company shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

For purposes of the complaint and grievance processes, Member includes authorized representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf.

At any time during the internal complaint or grievance process, at the request of the Member, Highmark Choice Company will appoint a person from its Member Service Department to assist the Member, at no charge, in preparing the complaint or grievance. The Highmark Choice Company employee made available will not have participated in any previous decisions to deny coverage for the issue in dispute.

At any time during the internal complaint or grievance process, a Member may contact the Member Service Department at the toll-free telephone number listed on his/her Identification Card to inquire about the filing or status of a complaint or grievance.

This section will outline the complaint and grievance processes for Highmark Healthy Kids (CHIP) enrollees.

Internal Complaint Process

For providers in Pennsylvania

Highmark Choice Company maintains a complaint process for the resolution of disputes or objections by a Member regarding a Network Provider or the coverage (including contract exclusions and non-covered benefits), operations or management policies of Highmark Choice Company, and the breach or termination of the Highmark Healthy Kids policy. A complaint does not include a grievance.

Members have the right to have complaints internally reviewed through the process described in this **Internal Complaint Process.**

When a complaint involves an Urgent Care Claim, a single level review process is available as provided in the section entitled **Expedited Review.**

When a complaint involves one of the following, a single-level review process is available and the decision may be appealed using the process outlined in the section entitled **Appeal of Compliant:**

- A denial because the service or item is not a covered service.
- The failure of Highmark Choice Company to meet the required time frames for providing a service or item in a timely manner.
- The failure Highmark Choice Company to decide a complaint or grievance within the required time frames.
- A denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item was provided by a health care provider not enrolled in PROMISe ID.
- A denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item provided is not a covered service or item for the enrollee.
- A denial of an enrollee's request to dispute a financial liability.

For all other complaints, members must exhaust the two-level process before seeking further administrative review of a complaint by the Pennsylvania Insurance Department.

Initial Review

For providers in Pennsylvania

The Member's initial complaint shall be directed to the Member Service Department. This complaint, which may be oral or in written form, must be submitted within 60 days from the date of the Member's receipt of the notification of an adverse decision or the occurrence of the issue which is the subject of the complaint.

Upon receipt of the complaint, Highmark Choice Company will provide written confirmation to the Member that the request has been received, and that Highmark Choice Company has classified it as a complaint for purposes of internal review. If a Member disagrees with Highmark Choice Company's classification of a request for an internal review, he/she may directly contact the Pennsylvania Insurance Department for consideration and intervention with Highmark Choice Company regarding the classification that has been made.

The Member, upon request to Highmark Choice Company, may review all documents, records, and other information relevant to the complaint and shall have the right to submit any written comments, documents, records, information, data, or other material in support of the complaint. The initial level complaint review will be performed by an Initial Review Committee which shall include one or more employees of Highmark Choice Company. The members of the Committee shall not have been involved or be the subordinate of any individual who was involved in any previous decision to deny the Member's complaint.

In rendering a decision on the complaint, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Highmark Choice Company. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the complaint.

Each complaint will be promptly investigated and a decision rendered within the following time frames:

- When the complaint involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the complaint, unless the time frame for deciding the complaint has been extended by up to 14 days at the request of the Member;
- When the complaint involves an Urgent Care Claim, within the period of time provided in the section entitled **Expedited Review;** or
- When the complaint involves a Post-service Claim, within a reasonable period of time not to exceed 30 days following receipt of the complaint, unless the timeframe for deciding the complaint has been extended by up to 14 days at the request of the Member.

Highmark Choice Company will provide written notification of its decision within fivebusiness days of the decision, not to exceed 30 days from Highmark Choice Company's receipt of the Member's complaint, unless the timeframe for deciding the complaint has been extended by up to 14 days at the request of the Member.

In the event that Highmark Choice Company renders an adverse decision on the complaint, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for either (1) requesting a second-level review where permitted or (2) appealing the decision, and a statement regarding the right of the Member to pursue legal action.

Second-Level Review

For providers in Pennsylvania

If the Member is dissatisfied with the decision following the initial review of his/her complaint and the decision is not one of the following:

- a denial because the service or item is not a covered service;
- the failure of Highmark Choice Company to meet the required time frames for providing a service or item in a timely manner;
- the failure Highmark Choice Company to decide a complaint or grievance within the required time frames;
- a denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item was provided by a health care provider not enrolled in PROMISe ID;
- a denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item provided is not a covered service or item for the enrollee; or
- a denial of an enrollee's request to dispute a financial liability,

then the member may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date an adverse decision is received and may include any written information from the Member or any party in interest.

The Second-Level Review Committee shall be comprised of three individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one individual of the Committee will not be an employee of Highmark Choice Company or of any Highmark Choice Company related subsidiary or affiliate. The Committee will hold an informal hearing to consider the Member's complaint.

When arranging the hearing, Highmark Choice Company will notify the Member in writing of the hearing procedures and rights at such hearing, including the right of the Member to be present at the review. If a Member cannot appear in person at the second level review, Highmark Choice Company shall provide the Member the opportunity to communicate with the Committee by telephone or other appropriate means.

The hearing will be held and a decision rendered within 30 days of Highmark Choice Company's receipt of the Member's request for review. This applies to both the second level review of a non-urgent care Pre-

service Claim complaint and the second level review of a Post-Service Claim complaint.

Highmark Choice Company will provide written notification of its decision within five business days of the decision, not to exceed 45 days from Highmark Choice Company's receipt of the Member's request for review. In the event that Highmark Choice Company renders an adverse decision, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for appealing the decision and a statement regarding the right of the Member to pursue legal action.

Appeal of Complaint

For providers in Pennsylvania

If a Member is dissatisfied with one of the following complaint decisions,

- a denial because the service or item is not a covered service;
- the failure of Highmark Choice Company to meet the required time frames for providing a service or item in a timely manner;
- the failure Highmark Choice Company to decide a complaint or grievance within the required time frames;
- a denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item was provided by a health care provider not enrolled in PROMISe ID;
- a denial of payment by Highmark Choice Company after the service or item has been delivered because the service or item provided is not a covered service or item for the enrollee; or
- a denial of an enrollee's request to dispute a financial liability,

the member will have 15 days from the receipt of the notice of the decision to appeal the decision to the Pennsylvania Insurance Department, as appropriate depending on the nature of the dispute. The appeal shall be in writing unless the Member requests to file the appeal in an alternative format.

Appeals may be filed at the following address:

Member Appeals & Grievances

120 Fifth Avenue, FAPHM-231B

Pittsburgh, PA 15222

If a member is dissatisfied with a decision of the Second Level Review Committee, a Member will have 15 days from the receipt of the notice of the decision of the Second Level Review Committee to appeal the decision to the Pennsylvania Insurance Department, as appropriate depending on the nature of the dispute. The appeal shall be in writing unless the Member requests to file the appeal in an alternative format.

Appeals may be filed at the following address:

Member Appeals & Grievances

120 Fifth Avenue, FAPHM-231B

Pittsburgh, PA 15222

All records from the initial review and/or the second level review shall be forwarded to the Pennsylvania Insurance Department, as appropriate. Additional material related to the complaint may be submitted by the Member, the health care Provider or Highmark Choice Company. Each shall provide to the other, copies of additional documents provided. The Member may be represented by an attorney or other individual before the appropriate Department.

Internal Grievance Process

For providers in Pennsylvania

Highmark Choice Company maintains an internal grievance process by which a Member, authorized representative, or a health care Provider, with the written consent of the Member, shall be able to file a grievance regarding the denial of payment for a health care service on the basis of Medical Necessity, and Appropriateness, health care setting, level of care or effectiveness of a health care service.

Any Member or authorized representative who consents to the filing of a grievance by a health care Provider may not file a separate grievance. This consent may be rescinded by the Member or authorized representative at any time during the grievance process. In the event that the health care Provider fails to file or pursue a grievance, the consent shall be deemed as having been automatically rescinded without further action on the part of the Member.

A grievance may be filed regarding a decision that: (a) disapproves full or partial payment for a requested health care service; (b) approves the provision of a requested health care service for a lesser scope or

duration than requested; or (c) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service. A grievance does not include a complaint.

When a grievance involves an Urgent Care Claim, a single level review process is available as provided in the section entitled **Expedited Review.**

Members must exhaust this internal process before seeking further administrative review of a grievance by the Pennsylvania Insurance Department.

The Member's grievance shall be directed to the Member Service Department. This grievance, which may be oral or in written form, must be submitted within 60 days from the date of the Member's receipt of the notification of an adverse decision or occurrence of the issue which is the subject of the grievance.

Upon receipt of the grievance, Highmark Choice Company will provide written confirmation to the Member and the health care Provider that the request has been received, and that Highmark Choice Company has classified it as a grievance for purposes of internal review. If a Member disagrees with Highmark Choice Company's classification of a request for an internal review, he/she may directly contact the Pennsylvania Insurance Department for consideration and intervention with Highmark Choice Company regarding the classification that has been made.

The Member or health care Provider, upon request to Highmark Choice Company, may review documents, records, and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data, or other material in support of the grievance.

The grievance review will be performed by an Initial Review Committee which shall include three or more individuals selected by Highmark Choice Company. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision relating to the Member's grievance. The Member or the health care Provider may specify the remedy or corrective action being sought. The initial review will include a licensed Physician or, where appropriate, an approved licensed Psychologist or licensed dentist in the same or similar specialty that typically manages or consults on the health care service at issue.

In rendering a decision on the grievance, the Initial Review Committee will take into account all comments, records, and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Highmark Choice Company. The Initial Review

Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the grievance.

Each grievance will be promptly evaluated and a decision rendered within the following time frames:

- When the grievance involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the grievance, unless the timeframe for deciding the grievance has been extended by up to 14 days at the request of the Member or Member's authorized representative;
- When the grievance involves an Urgent Care Claim, within the period of time provided in the section entitled **Expedited Review;** or
- When the grievance involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the grievance, unless the timeframe for deciding the grievance has been extended by up to 14 days at the request of the Member or Member's authorized representative.

Highmark Choice Company will provide written notification of its decision within five business days of the decision, not to exceed 30 days from Highmark Choice Company's receipt of the Member's grievance, unless the timeframe for deciding the grievance has been extended by up to 14 days at the request of the Member or Member's authorized representative.

In the event that Highmark Choice Company renders an adverse decision on the grievance, the notification shall include, among other items, the specific reason or reasons for the adverse decision including clinical rationale, the procedure for filing a request for external review and a statement regarding the right of the Member to pursue legal action.

External Grievance Process

For providers in Pennsylvania

A Member, a Member's authorized representative or a health care Provider, with the written consent of the Member or the member's authorized representative, may within 15 days from the receipt of the notification of the decision, appeal the denial resulting from the Internal Grievance Process. This can be done by filing a request for an external grievance with Highmark Choice Company. The Member should include any material justification and all reasonably necessary supporting information as part of the external grievance filing.

Within five business days of the filing of the external grievance, Highmark Choice Company will notify the Pennsylvania Insurance Department, the Member, the authorized representative, or the health care Provider, as appropriate, that an external grievance has been filed.

Within two business days of receiving the request, the Pennsylvania Department of Insurance shall randomly assign an IRO on a rotational basis from the designated list and will notify the assigned IRO and Highmark Choice Company of the assignment. Within that same two-day timeframe, the Pennsylvania Insurance Department must also notify the Member or the Member's authorized representative of the name, address, e-mail address, fax number, and telephone number of the IRO assigned under this subsection.

The notice will advise the Member and the authorized representative of the right to submit additional written information to the IRO within 20 days of the date the IRO assignment notice was mailed and will include instructions for submitting additional information to the IRO by mail, fax, and electronically. If the Pennsylvania Department of Insurance fails to select an IRO within the required time frame, Highmark Choice Company will designate and notify a certified IRO to conduct the external grievance.

Highmark Choice Company shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision to the IRO conducting the external grievance within 15 days of the receipt of notice that the external grievance was filed.

Within this same period, Highmark Choice Company shall provide the Member or the health care Provider with a list of documents forwarded to the IRO for the external review. The Member, the Member's authorized representative or the health care Provider may supply additional written information, with copies to Highmark Choice Company, to the IRO for consideration on the external review within 20 days of the date of the notice of the IRO assignment was mailed to the Member, a Member's authorized representative or health care Provider.

The IRO conducting the external grievance shall review all the information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the Member, the authorized representative, or the health care Provider.

Within 60 days of the filing of the external grievance, the IRO conducting the external grievance shall issue a written notification of the decision to Highmark Choice Company, the Member, the Member's

authorized representative if the representative requested the external review, and the health care Provider, including the basis and clinical rationale for the decision.

The external grievance decision may be appealed to a court of competent jurisdiction within 60 days of receipt of the notification of the external grievance decision.

Highmark Choice Company shall authorize any health care Service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the IRO regardless of whether an appeal to a court of competent jurisdiction has been filed.

Expedited Review Process

For providers in Pennsylvania

In those cases involving an Urgent Care Claim, there is a procedure for expedited review. In order to obtain an expedited review, the Member shall identify the particular need for an expedited review to the Member Service Department. A Member shall provide Highmark Choice Company with a certification, in writing, from the Member's Physician that the Member's life, health or ability to regain maximum function would be placed in jeopardy or in the opinion of a Physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the service requested as a result of the delay occasioned by the review process. The certification shall include clinical rationale and facts to support the Physician's opinion. Highmark Choice Company shall accept the Physician's certification and provide an expedited review.

Highmark Choice Company shall conduct an expedited internal review and notify the Member, the authorized representative, and the health care Provider of its decision as soon as possible taking into account the medical exigencies involved but not later than 48 hours following the receipt of the Member's request for an expedited review. The notification to the Member, the authorized representative, and health care Provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding the right of the Member to pursue legal action.

The Member has two business days from the receipt of the expedited internal review decision to contact Highmark Choice Company to request an expedited external review. Within 24 hours of receipt of the Member's request for an expedited external review, Highmark Choice Company shall submit a request for

an expedited external review to the Pennsylvania Insurance Department. The Pennsylvania Insurance Department will assign a CRE within one business day of receiving the request for an expedited review. The CRE shall have two business days to issue a decision.

5.5 Expedited Review Process Under the Autism Mandate (PA Act 62)

For providers in Pennsylvania

Overview of Autism Mandate

Pennsylvania Act 62 requires private insurers to provide coverage for medically necessary diagnostic assessment and treatment of autism spectrum disorders (ASD) to covered individuals under 21 years of age.

This mandate applies to any fully insured health insurance policy offered, issued, or renewed on or after July 1, 2009, to groups of 51 or more employees. The mandate also applies to any contract executed on or after July 1, 2009, by the Highmark Healthy Kids/Children's Health Insurance Program (CHIP).

Expedited Internal Review Process

For providers in Pennsylvania

If the Act 62 ASD mandate is applicable, a covered individual or an authorized representative is entitled to an expedited internal review process upon denial or partial denial of a claim for diagnostic assessment or treatment of ASD, followed by an expedited independent external review process established and administered by the Pennsylvania Insurance Department. A member or authorized representative also has the option to choose the standard appeal process.

The request for an expedited internal review may be submitted verbally or in writing. The mandated expedited review process applies to both pre-service and post-service denials for diagnostic assessment

or treatment of ASD.

The expedited internal appeal will be reviewed by the Second Level Review Committee as set forth under Article XXI (Act 68 as amended by Act 146). The Second Level Review Committee is made up of three or more individuals who did not previously participate in the decision to deny coverage or payment for health care services. The committee shall include a licensed physician or an approved licensed psychologist in the same or similar specialty as that which would typically manage or consult on the health care service in question. The members of the review committee shall have the duty to be impartial in their review and decision.

Verbal and written notification of the decision will be issued to you and the member **within 48 hours** from receipt of the request. The written decision to the member, member's representative, or provider on behalf of the member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

The member, member's representative, or provider on behalf of the member has two business days from receipt of the expedited grievance decision to request an expedited external review.

Expedited External Review

PA **For providers in Pennsylvania**

If an adverse determination is upheld by the internal review committee, the covered individual or an authorized representative is then entitled to an expedited external independent review process administered by the Pennsylvania Insurance Department.

An insurer or covered individual or an authorized representative may appeal an order of an expedited independent external review to a court of competent jurisdiction.

Verify Coverage

PA **For providers in Pennsylvania**

To determine if a member is covered under the autism mandate, you can verify the member's coverage using **Eligibility and Benefits Inquiry** in Availity® or by calling the Provider Service Center.

5.5 Medicare Advantage: Provider Appealing on Own Behalf (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Providers are entitled to appeal a medical necessity denial decision and are informed of this right at the time of the denial decision. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The processes as described here apply to members with coverage under one of Highmark's Medicare Advantage products.

When the Provider Can Appeal on His or Her Own Behalf

For providers in Delaware, Pennsylvania, and West Virginia

A provider can make use of this provider appeal process when all of the following are true:

- The provider is contracted with Highmark, and
- The member has coverage under a Medicare Advantage product, and
- The services in question have a medical necessity denial determination, including denials for services considered experimental/investigational or cosmetic in nature, and
- The member is held financially harmless, and
- The provider seeks a resolution in order to obtain payment for the services.

Types of Appeals

For providers in Delaware, Pennsylvania, and West Virginia

Expedited appeals and standard appeals are available to the provider for medical necessity denial determinations.

An **expedited appeal** is a formal review of an initial adverse medical necessity determination. It can be requested when a delay in decision-making may seriously jeopardize the member's life, health, or ability to regain maximum function. Highmark reserves the right to determine whether the request meets the criteria for an expedited appeal.

A **standard appeal** is a formal review of the initial adverse medical necessity determination in which the conditions for expedited appeal are not met. Standard appeal can also be used as a secondary appeal level when a denial has been upheld under the expedited appeal process.

Member Expedited Review Rights

For providers in Delaware, Pennsylvania, and West Virginia

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determinations and appeals. Members of all Highmark Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process. In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

Although these processes are largely member-driven, the provider may represent the member and initiate the expedited review. Highmark reserves the right to determine whether the request meets the criteria for an expedited provider appeal. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The provider must indicate either verbally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The provider need not be appointed as the member's authorized representative to make the request.

Requests For Medical Records

For providers in Delaware, Pennsylvania, and West Virginia

Providers may be contacted by a Highmark staff member or physician reviewer to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately.

Additionally, if you are contacted for information by a physician reviewer about an expedited appeal, you must return his or her call by 8 a.m. the next day. Failure to do so could result in corrective action and/or sanctioning.

Important: Appeals Related to Home & Community Care Transitions Denials

For providers in Pennsylvania and West Virginia

A denial of post-acute care services will be issued by Home & Community Care Transitions, similar to the approval of services. naviHealth generates the notification of denial of coverage to both the provider and to the patient. If requested, Home & Community Care Transitions also offers a peer-to-peer clinical conversation with the Home & Community Care Transitions Medical Director.

Any appeal of the preservice or concurrent denial of services rendered by Home & Community Care Transitions will be handled by Highmark, just as appeals are currently handled. Highmark will continue to handle appeals when the member has not yet been admitted to a post-acute care facility or when the member is still inpatient. Appeals for these situations should be initiated by contacting Highmark Medicare Advantage Expedited Appeals at **800-485-9610.**

Home & Community Care Transitions will handle appeals after the member has been discharged from the post-acute care facility and a denial has been received. Home & Community Care Transitions can be contacted for **post service** provider appeals as follows:

- Phone **844-838-0929**
- Fax **855-893-5963**
- Address for appeals:

  Home & Community Care Transitions

Attention: Provider Appeals

10 Cadillac Drive, Suite 400

Brentwood, TN 3702

Expedited Appeal Process

For providers in Delaware, Pennsylvania, and West Virginia

This provider appeal process would apply in situations when a decision needs to be made in an **urgent** manner for a member with Highmark Medicare Advantage coverage. This includes appeals of initial denial determinations prior to services being rendered **and** appeals of denial decisions for continued services following a concurrent review.

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members:

Expedited Appeals

How to Initiate

Requests for expedited review can be initiated either verbally or in writing.

Call the Medicare Advantage Expedited Review Department at

800-485-9610;

or

Fax the information to **800-894-7947;**

or

Submit all pertinent medical and other information to:

Medicare Advantage

Expedited Review Department

P.O. Box 534047

Pittsburgh, PA 15253-5073

When to Initiate

Prior to rendering services, continuing services, or prior to the member's discharge from the facility; but **within 60 days** from receipt of the denial notification.

Decision Time Frame

As expeditiously as the member's health requires, but **not to exceed 72 hours** from receipt of the appeal request. The 72-hour time frame may be extended by up to 14 calendar days if the member requests or if additional information is needed.

Standard Appeal Process

For providers in Delaware, Pennsylvania, and West Virginia

This provider appeal process applies to initial denial determinations for **services that have already been rendered,** including denials resulting from retrospective review of services rendered without the required authorization.

This process would also apply to appeals for initial preservice denial determinations in non-urgent situations and as a secondary appeal level when an initial denial has been upheld in the expedited appeal process.

The table below explains how the standard review process for Medicare Advantage members works:

Standard Appeals

How to Initiate

Call the applicable Provider Service Center number:

or

Submit all pertinent medical and other information to:

Highmark Medical Review

P.O. Box 890392

Camp Hill, PA 17089-0392

When to Initiate

Within **180 days** from receipt of the denial notification.

Decision Time Frame

Within **30 calendar days** from the receipt of the appeal request.

5.5 Medicare Advantage: Appeals on Behalf of a Member (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Members of a Medicare Advantage plan have a right to file an appeal if their plan will not pay for, does not allow, or stops or reduces a course of treatment that they believe should be covered or provided.

Ordinarily, it is the member or the member's family who files an appeal if a requested medical service is not authorized; however, the member might ask a provider or other representative to file an appeal on his or her behalf. A provider can do so **only if the member would be financially liable** for the services.

Representative Statement

For providers in Delaware, Pennsylvania, and West Virginia

The Centers for Medicare & Medicaid Services (CMS) provides an Appointment of Representative (AOR) form (#CMS 1696). This form is also available on the CMS website.

The member is not required to use the CMS form. They may write their own representative statement appointing a provider or other individual as an authorized representative. The written authorization must contain the following criteria:

- Member's name, Medicare number, address, and telephone number
- Representative's name, address, telephone number, and professional status or relationship to the member
- A statement signed and dated by the member or the individual holding the member's power of attorney authorizing the named person to act as the member's representative in appeal of the denial decision, and acknowledging that he or she understands that personal medical information may be disclosed to this representative
- A statement signed and dated by the appointed representative confirming acceptance of their appointment and agreeing to waive the right to charge a fee for representation
- A statement signed and dated by the provider waiving their right to collect payment from the member for items or services at issue

EXCEPTION: In preservice denial situations that meet the criteria for an **expedited** request, the **member's ordering provider** (either contracting or non-contracting) can act as the member's representative without a signed representative statement.

Types of Appeals

For providers in Delaware, Pennsylvania, and West Virginia

Two types of appeals are available to the member or to the facility acting as the member's appointed representative:

- Expedited appeal
- Standard appeal

Expedited Appeals

For providers in Delaware, Pennsylvania, and West Virginia

If the member or the member's authorized representative believes that following the standard appeal process would seriously jeopardize the member's life, health, or ability to regain maximum function, an

expedited appeal can be requested. The health plan reserves the right to determine whether the request meets the criteria for an expedited appeal.

Highmark will make a decision on an expedited appeal as expeditiously as the member's health requires, but no later than **72 hours** from receipt of the request.

Standard Appeals

For providers in Delaware, Pennsylvania, and West Virginia

Standard member appeals, including those filed on the member's behalf by a facility, are those that do not meet the criteria for an expedited appeal as determined by the health plan, or those in which the member's health would not be jeopardized by the standard appeal time frame.

Standard appeals are processed as expeditiously as the member's health requires, but no later than **30 calendar days** from receipt of the request.

Option for Inpatient Discharge Decisions

When an inpatient in a hospital, a Medicare Advantage member has another appeal option if he or she disagrees with a discharge decision. An immediate review by the Quality Improvement Organization (QIO) can be requested.

Note: For more information on this QIO appeal process, please see **Chapter 5 Unit 3: Medicare Advantage.**

Non-Participating Providers

For providers in Delaware, Pennsylvania, and West Virginia

A non-participating provider can file a standard appeal on behalf of a Medicare Advantage member for post-service denials only if he or she submits a *Waiver of Liability* statement with the appeal. The waiver states that the provider will not bill the member regardless of the outcome of the appeal.

Providers who do not participate with Highmark's Medicare Advantage products should follow the standard appeals process as outlined below when appealing a post-service denial.

Appeal Processes

For providers in Delaware, Pennsylvania, and West Virginia

The table on the next page explains the expedited and standard appeal processes for Medicare Advantage.

	Expedited Appeals	Standard Appeals
How to Initiate	Call the Medicare Advantage Expedited Review Department at **800-485-9610.** **or** Fax the request to **800-894-7947.** **or** Submit all pertinent information to: Medicare Advantage Expedited Appeals Department P.O. Box 534047 Pittsburgh, PA 15253-5073	Submit all pertinent information to: Highmark Appeals and Grievance Department P.O. Box 534047 Pittsburgh, PA 15253-5047 **or** **Fax** the information to the Appeals Department at **717-635-4209.**
When to Initiate	• **Prior authorization denials:** Before	**Within 60 days** from receipt of the denial notification (if good

	rendering the service. • **Concurrent review denials:**Before discharge or continuation of treatment.	cause is shown, written requests can be accepted after 60 days).
Decision Time Frame	As expeditiously as the member's health requires, but **not to exceed 72 hours** from receipt of the request.	As expeditiously as the member's health requires, but **no later than 30 calendar days** from the receipt of the appeal request.

14 Day Extension

For providers in Delaware, Pennsylvania, and West Virginia

The health plan or the facility filing on behalf of the member may request extensions of up to **14 calendar days** for rendering a decision.

Requests for extension must be in the best interest of the member. The health plan must justify the need for the extension and notify the member in writing.

If a Denial on an Appeal is Upheld

For providers in Delaware, Pennsylvania, and West Virginia

When the health plan renders an adverse decision on an appeal, Highmark automatically forwards the case to the CMS independent review agency and sends a written notification to the member for Medicare Advantage (Part C).

Note: For Part D prescription drug coverage, the member or provider must request an appeal through the CMS appeals contractor. The appeals contractor may request additional information. In such cases, a

Highmark Medicare Advantage appeals staff member may contact you for additional information. If you are contacted, please respond to the request immediately.

If the CMS independent review agency also renders an adverse decision, the member has the right to initiate further action. The denial communication from the independent review agency includes information about this option.

5.5 Provider Appeal Rights for Prescription Drug Benefits

If you are a participating provider with Highmark and you (or, in New York, the member/the member's designated representative) disagree with the decision to deny authorization or payment of a prescription drug for a Highmark Commercial member, you have a right to appeal that decision.

Note: This section does not apply to Medicare Part D prescription drug coverage.

Expedited Appeals

For providers in Delaware, Pennsylvania, and West Virginia

Expedited appeals are available when the application of the standard appeal time frame could seriously jeopardize the member's life, health, or ability to regain maximum function, or would subject the member to severe pain that cannot be managed without the care or treatment which is the focus of the appeal.

To request an expedited appeal, please contact Highmark's Prescription Drug Department **by fax** at **866-240-8123;** or by calling **800-600-2227.**

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within two business days of receipt of your appeal request.

Expedited Appeals

For providers in New York

Written acknowledgment of receipt of the appeal will be sent to the appealing party **upon receipt** of the expedited request.

If additional information is necessary to conduct the appeal, the member and the member's health care provider will be notified, in writing, upon receipt of the appeal, to identify and request the necessary information.

The clinical peer reviewer will be available within one business day, or sooner. Appeals will be conducted by a clinical peer reviewer other than the reviewer who rendered the initial adverse determination.

A decision will be rendered no later than two business days or 72 hours, whichever is less, after receipt of the appeal request. Immediate notification of the decision will be given by telephone, followed by written notice, which will be sent within 24 hours of the appeal decision, but not to exceed two business days or 72 hours whichever is less.

Failure to comply with the time frames for an internal appeal is deemed a reversal of the initial determination (except in New York where it is deemed an adverse determination subject to appeal).

Standard Appeals

If you are not eligible for an expedited appeal or your expedited appeal resulted in an adverse determination, you may initiate a standard appeal (New York may also have the right to initiate an external appeal process).

To request a standard appeal, please contact the Highmark Prescription Drug Department **by fax at 866-240-8123;** or **by calling 800-600-2227.**

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within 30 days of receipt of your appeal request.

New York:

Written acknowledgment of receipt of the appeal will be sent to the appealing party **within 15 days** of receipt. If additional information is necessary to conduct the appeal, the member and the member's health care provider will be notified, in writing, within 15 days of the appeal, to identify and request the necessary information.

If only some of the requested information is provided, Highmark will make a second request for the missing information in writing, within 5 business days of receiving the incomplete information.

Appeals will be conducted by a clinical peer reviewer other than the reviewer who rendered the initial adverse determination.

A decision will be rendered no later than 30 calendar days of receipt of the appeal request. Written notice to the enrollee, the enrollee's designee, and provider will be sent within two business days of the appeal decision.

Mailing Appeal Requests

Appeal requests can also be mailed to:

Delaware, Pennsylvania, and West Virginia	New York
Highmark P.O. Box 279 Pittsburgh, PA 15230-2717 Attn: Provider Appeal Review Committee	Utilization Management Appeals PO Box 4208 Buffalo, NY 14240

Appeals on Behalf of a Member

Providers can initiate appeals on behalf of the member with the member's written consent (except in New York where written consent from the member is not required). However, if the member gives the provider consent to file an appeal on his or her behalf, then the member is not permitted to file a separate appeal. Member appeal requests must be received within 180 of member receipt of denial.

When submitting appeal requests on behalf of a member, you will be asked to provide the following information:

- The member's name, the patient's name, and the group policy number
- The actual drug for which payment was denied and the date of service

- The reasons why you feel the drug should be provided
- Any available clinical information to support your appeal
- Signed consent of member (patient) and provider

Additional information related to member appeal rights will be provided when an appeal request is received.

Final Adverse Determination of an Internal Appeal

For providers in New York

Each final adverse determination of an appeal is sent to the member or their designated representative and provider, and must include the following information:

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial and instructions for requesting the clinical review criteria used.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol, or similar criterion was relied upon in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
3. The provisions of the policy, contract, or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. The health care plan's contact person and his/her telephone number.
6. The member's coverage type.
7. The name and full address of the health care plan's utilization review agent.
8. The utilization review agent's contact person and his/her telephone number.
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment, and/or the developer/manufacturer of the health care service.
10. A statement that the member may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that the member is entitled to receive, upon request and free of charge:
    1. Reasonable access to and copies of all documents, records, and other information relevant to the claim.

2. A copy of each internal rule, guideline, protocol, or similar criterion that was relied upon in making the determination on appeal.
3. A list of titles and qualifications (including specialist of individuals participating in the appeal review)

12. A clear statement in bold that enrollee has 45 days from the final adverse determination to request an external appeal and choosing second-level of internal appeal may cause time to file external appeal to expire.
13. An attachment with the standard description of the external appeals process.

Questions?

If you have questions about your right to appeal, or about how to file an appeal, please call the Prescription Drug Department:

- Delaware, Pennsylvania, and West Virginia Prescription Drug Department can be contacted at **800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.
- New York Prescription Drug Department can be contacted at **877-698-0793** between 8:30 a.m. and 4:30 p.m., Monday through Friday.

5.5 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 6: Quality Management

5.6 Quality Management Program Overview

The Highmark Quality Management Program is designed to ensure that members receive the best quality health care, in the most appropriate setting, in the most cost-effective manner.

Quality Management follows a Continuous Quality Improvement Process model for the ongoing monitoring and analysis of relevant clinical and service quality measures. The model focuses on the early identification of problems, with the development and implementation of interventions that focus on any issues that are identified. The member is at the heart of all activities.

The purpose of the Quality Management Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety, and service to members.

Definitions

Quality improvement processes are those activities that the health plan undertakes to improve the quality and safety of clinical care (including behavioral health care) and the quality of service to members.

Quality management is the integrative process that links knowledge, structure, and processes together throughout the organization to assess and improve quality.

Highmark Quality Management

Highmark's Health Plan Clinical Quality area, part of the Health Plan Chief Medical Officer (CMO) Organization division of Highmark, is responsible for corporation-wide coordination of clinical and service-related improvement initiatives focused on clinical care, member satisfaction, access and availability, and performance measures and outcomes for both physicians and facilities.

Quality Management is also accountable for compliance with all applicable external accrediting and regulatory entities such as the:

- Centers for Medicare & Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)
- Office of Personnel Management (OPM)
- State health and insurance departments

Organizational Structure

The organizational structure of Highmark's Quality Management divides staff responsibilities into these distinct functional areas:

- HEDIS/CAHPS/FEP
- Quality Care and Quality Audits
- Clinical Outcomes and Guidelines
- Clinical Quality Assurance

The Risk & Compliance Management area – which is part of the Enterprise Risk & Governance division – also supports the quality management program from an accreditation and regulatory compliance perspective.

These areas work together with the support of staff from other departments in Highmark, as well as external support from primary and specialty care providers to continually assess and improve the quality of clinical care, safety, and service to members.

Overall Objectives of the Quality Program

The objectives of the Quality Program are as follows:

1. Continuously improve client and member experience of care, as well as their health, by anticipating and evaluating their needs and proactively aligning those needs with appropriate programs and services that reduce and/or control clinical risk.
2. Support and promote the delivery of care by providing a high-quality network of practitioners and providers.
3. Offer data-driven, evidenced-based, and comprehensive health care services and programs that are continuously improved based on outcomes.
4. Build effective partnerships with members and their caregivers/families, clients, providers, facilities, payers, and the community to understand their objectives and needs while adapting products and/or services accordingly to create positive and lasting change and a differentiated member and provider experience.
5. Utilize advanced analytics and proven quality improvement strategies and tools to measure and improve outcomes of care and service and achieve meaningful and sustainable improvement.

6. Enhance transparency efforts to promote member engagement and customer intimacy, while supporting members in making appropriate decisions about care.
7. Continue to work toward achieving health equity through reducing health care disparities, enhancing health literacy, and providing culturally and linguistically appropriate services.

Data Sources

The Highmark Quality Program provides a framework for continuous assessment and improvement of all aspects of health care delivery and services for its membership. This involves the collection and quantitative/qualitative analyses of relevant data to identify barriers or causes for less-than-optimal performance, identification of opportunities for improvement, and implementation of interventions to improve results.

Examples of the various data sources that may be collected and analyzed include, but are not limited to, the following:

1. Medical/treatment records
2. Claims
3. Enrollment reports
4. Pharmacy data
5. Condition management reports
6. Health risk appraisals
7. Member service data
8. Healthcare Effectiveness Data and Information Set (HEDIS®) results
9. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results
10. Health Outcome Survey results
11. Utilization Management (UM) statistics
12. Member/practitioner surveys
13. Current literature

Behavioral Health

The coordination of behavioral health programs is based on an analysis of the demographic, cultural, clinical, and risk characteristics of Highmark members who utilize behavioral health services.

Highmark developed a Quality Program Description that outlines in greater detail activities to monitor and improve the quality and safety of behavioral health care and the quality of service provided to members. The document outlines the behavioral health aspects of the Quality Program and is reviewed and approved annually by the Highmark Board and appropriate Quality-related committee.

Highmark manages the inpatient utilization of behavioral health services for all members who have behavioral health care coverage through Highmark. Outpatient behavioral health services are authorized in accordance with the behavioral health benefits available for each product.

Behavioral Health Activities

Behavioral health activities have continued to include:

- Access to care and service availability for behavioral health services.
- Communication standards to improve communication between behavioral health practitioners and primary care physicians to enhance continuity and coordination of care.
- Behavioral Health Toolkit available for PCPs which includes Clinical Practice Guidelines as a resource.
- New and ongoing preventive behavioral health clinical initiatives.
- Depression Condition Management Program.

5.6 Highmark Quality Program Committees

As a way for Highmark to promote objective and systematic monitoring, evaluation and continuous quality improvement, various Highmark Program Committees have been established. The Program Committees are made up predominantly of health care professionals and are established by Highmark's Board of Directors.

Highmark Quality, Safety, and Value Committee (HQSVC)

The Highmark Quality, Safety, and Value Committee is a physician-based committee that provides clinical oversight of quality program activities on behalf of the Highmark Board of Directors. The committee reviews quality assurance and improvement activities related to the health benefits administered by Highmark and its applicable wholly owned, wholly controlled, and/or partially owned subsidiaries, and provides input and recommendations on such activities. The HQSVC reviews and approves the quality program description, action plan, and evaluation on an annual basis. The HQSVC also receives quality program reports and updates, as appropriate.

Care Management and Quality Committee (CMQC)

The Care Management and Quality Committee is a multi-disciplinary committee representing Delaware, western and northeastern New York, western, central, and northeastern Pennsylvania, and West Virginia that is dedicated to continuous improvement of quality and care management services provided to members. The Senior Medical Director chairs the CMQC and Medical Directors, actively practicing physicians including behavioral health, and physicians in administrative positions with involvement in care management functions in hospitals are active voting members.

The CMQC has responsibility for the review and approval of the quality, utilization management, and population health management program descriptions, evaluations, and action plans; relevant policies and procedures; utilization core performance indicators/trends; clinical criteria sets used by the plan and its delegates; review, leadership, and direction over Highmark's care management activities and initiatives; relevant quality improvement activities; oversight/monitoring of all delegated utilization functions, credentialing policies, and desktop procedures as revised; and quality committee reports.

The CMQC is also responsible for recommending policy decisions, analyzing and evaluating the results of quality activities, ensuring provider participation in the quality program, instituting needed actions, and ensuring follow-up, as appropriate. This includes, but is not limited to, the results of quality monitoring activities completed specific to clinical outcomes, member experience, health care equity, member

access to services, practitioner and provider availability, continuity and coordination of care, credentialing and recredentialing, delegation and business arrangement oversight, ongoing regulatory and accrediting body compliance, and review and input on clinical practice and preventive health guidelines.

Clinical Policy Management Committee (CPMC) and Specialty Subcommittees

The Clinical Policy Management Committee (CPMC) is responsible for evaluating medical and surgical procedures and techniques, developing policy guidelines for new and evolving technology and injectable drugs, determining the medical policy coverage positions, and recommending medical necessity guidelines for covered procedures.

Specialty subcommittees — made up of actively practicing physicians in the areas of Cardiology, Hematology/Oncology, Musculoskeletal, Neurosciences, and Pediatrics — evaluate existing medical policy coverage guidelines as well as new technology. The subcommittees meet quarterly and make recommendations to the CPMC regarding medical policy coverage positions.

New York Quality Improvement Program

For providers in New York

The focus of the Quality Improvement Program is to continuously assess and improve the care delivered by our participating practitioners/providers and the service delivered by Highmark staff to its members. The organization has the responsibility of designing, measuring, assessing, and continually improving its performance. The result is enhanced health and well-being of the populations we serve.

New York Quality Improvement Program Scope

For providers in New York

The scope of the Quality Improvement Program is comprehensive. It includes all Highmark members for all New York operating areas, as well as practitioners and providers who participate in the network. This includes Commercial (HMO, POS, PPO, Federal Employees Program/FEP), EPO, Medicare Advantage, ASO, Essential Plan, and Exchange/Qualified Health Plan products and oversight of Child Health Plus and Medicaid managed care.

The Health Care Quality Improvement Program includes organization-wide activities, a focus on trend analysis, and development of interventions that improve the quality of care and service provided to members. The activities include clinical, service, and patient experience.

The Health Care Quality Improvement Program monitors and evaluates a wide variety of clinical and service topics that include, but are not limited to, those listed below:

- Preventive Care
- Disease Management
- Case Management
- Population Health Management
- Utilization Management (including appropriate utilization of services)
- Patient Safety
- Behavioral Health Management
- Culturally and Linguistically Appropriate Services
- Complaint Management for Access to Care or Quality of Care Issues
- Medical Policy
- Pharmacy Management
- Continuity and Coordination of Care

5.6 Functional Areas and Their Responsibilities

The scope of the Clinical Services – Quality area's functions and responsibilities are described below. These functions are only one piece of the Quality Management Program. In addition, Clinical Services – Quality has established linkages to other areas within Highmark to expand the scope of the Quality Management Program throughout the organization.

Clinical Services Quality

HEDIS/CAHPS/FEP

1. Annual Healthcare Effectiveness Data and Information Sets (HEDIS®) reporting to meet National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), Office of Personnel Management (OPM), and state regulatory requirements used to assess member utilization of preventive/chronic care services and provider compliance with national standards of care.
2. Annual NCQA HEDIS® Compliance Tool (Roadmap) completion for all applicable products, which includes a review of administration, data management, and processes which serve to collect information about how the plan's information and management practices comply with HEDIS® reporting requirements and associated on-site audit activities.
    a. One Roadmap and audit process will be completed for the Commercial, Medicare Advantage, and Marketplace products in **Delaware, Pennsylvania, and West Virginia.**
    b. Another Roadmap and audit process is required separately by the **State of PA for the Highmark Healthy Kids (CHIP) HMO product.** This audit includes a review of the health information system that is maintained to support data collection and analysis efforts for quality improvement activities.
    c. One roadmap audit process will be completed for Commercial, Essential Plan, Medicare Advantage, and MarketPlace products in New York in addition to the oversight of the New York State Medicaid Product.
3. Annual vendor selection/management for administration and analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Enrollee Experience Survey (EES) for all applicable products are maintained for identification of improvement opportunities.
4. Clinical outcome monitoring, analysis, and planning/design initiatives focused on improving the care provided to the Federal Employee Program (FEP) membership, with targeted focus on

measures selected by the Office of Personnel Management (OPM) for its performance improvement program.

5. **New York State Quality Assurance Reporting Requirements (QARR)** QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare and Medicaid Services (CMS) Quality Rating System (QRS) Technical Specifications, and New York State-specific measures. The products that these reporting requirements apply to are Commercial PPO/POS, Essential Plan, Qualified Health Plans, and Medicaid.

To enhance its ability to monitor measure compliance, New York State continually revises its Quality Assurance Reporting Requirements, adding or modifying measures to provide more comparable and complete information. QARR measures may be modified or changed annually, to reflect both advances in the technology and methodology of measuring quality and new program priorities.

The NYS Department of Health uses the QARR measures and Medicaid encounter data to determine any patterns that may indicate that a particular health plan is not providing appropriate services. If it is determined that a health plan does not achieve an acceptable performance rate, they can be subjected to corrective measures. More specifically, any health plan that does not achieve an acceptable rate of compliance will be required to perform a root cause analysis and to develop an improvement plan approved by the New York State Department of Health.

Quality Care and Quality Audits

1. Patient safety activity monitoring through the review of all internal and external Quality of Care complaints.
2. Conduct clinical quality audits to validate appropriateness of utilization management review and approval and provider medical record documentation. Identify opportunities for improvement and collaborate with relevant department on implementing initiatives to improve.
3. Conduct inter-rater reliability testing, scoring, and reporting for UM medical, behavioral health, pharmacy, and medical reviews.

Clinical Outcomes & Guidelines

1. Clinical outcome monitoring, analysis, and planning/design of initiatives focused on improving the care provided to members, with targeted focus on the NCQA HEDIS scored measures.

   a. **New York:** Commercial including Essential Plan, FEP, Medicare Advantage, and MarketPlace QRS. This information is monitored and analyzed at the QARR HEDIS Process Improvement Team meeting.
2. Co-facilitate the Program Outcomes Evaluation and Measures Clinical Work Group (POEM-CWG): Preventive initiatives are developed and implemented by the Clinical Quality staff through the work of the POEM-CWG. HEDIS data is reviewed, barrier analysis performed, and opportunities for improvement identified to target gaps in care that need to be closed and to improve outcomes through interventions targeted toward members and providers.
3. Adoption and distribution of Preventive Health Guidelines that comprehensively address the characteristics and age range of the member population, using evidence-based sources and practitioner input, which are measured annually for guideline compliance.
4. Facilitate the Preventive Health Work Groups to ensure the health plan is compliant with mandates and regulatory guidelines and complete the annual Medicare Advantage and Commercial Preventive Schedules.
5. Member and provider interventions to improve health literacy.
6. Continuity and coordination of care monitoring of transitions within medical care to identify opportunities for improvement and act as appropriate.

Other Health Plan Clinical/Service Quality Activities (Medical and Behavioral Health)

The below functions are performed by various departments within the health plan/enterprise.

1. Vendor selection/management for administration and analysis of behavioral health experience.
2. Network adequacy plan maintenance and monitoring specific to the Marketplace products.
3. Quality Improvement Strategy (QIS) for Marketplace members.
4. Member preventive health status assessments via claims data analysis, health-risk assessment (HRA) data, PRA-Plus surveys, Medicare Health Outcomes Survey (HOS) results, Personal Health Records (PHRs), etc.
5. Behavioral Health Preventive Program management, such as those components focused on alcohol use screening and depression screening post-cardiac event.
6. Collaboration with Government Quality on the development and reporting of the Chronic Care Improvement Project(s) (CCIPs). Collaboration is also with Clinical Services on interventions that support the CCIP.
7. Practitioner/provider interventions designed to encourage participation in CMS and HHS QI initiatives as applicable.

8. Limited English Proficiency Project Management Office: Civil Rights Act compliance, including arrangements for language assistance services as needed; demographic analyses; Language Assistance Plan monitoring, identification of opportunities for improvement, implementation, and re-measurement.

Enterprise Risk & Governance Functions and Responsibilities

The scope of Enterprise Risk & Governance (ER&G) functions and responsibilities are described below. These functions support the quality program and activities.

1. Ongoing monitoring and continuous audit preparedness for all applicable regulatory and accrediting bodies:
    a. NCQA Health Plan accreditation program management for all products in Delaware, Pennsylvania, and West Virginia.
    b. New York NCQA Accreditation for Commercial and MarketPlace products in New York.
    c. CMS quality-related activities related to Quality Improvement Program components: Quality Improvement Project (QIP) selection, monitoring, and reporting; and Chronic Care Improvement Program (CCIP) selection, monitoring, and reporting in collaboration with Government Quality. The CCIP incorporates at least one activity into the Quality Program to reduce disparities in health/health care among enrollees that is broadly accessible to address relevant disparity.
    d. Pennsylvania Department of Health (PA DOH) and Pennsylvania Insurance Department (PID) annual reporting/technical advisory monitoring for assigned requirements.
    e. Delaware regulatory body monitoring and compliance for assigned activities.
    f. Division of Medicaid and Medical Assistance (DMMA) requirements (credentialing, delegation oversight, and NCQA accreditation only).
2. NCQA contract, project management, and audit coordination: coordinate, prepare, and submit documents for, and participate in, on-site and off-site quality reviews and audits conducted by applicable accrediting and regulatory bodies.
3. Delegation oversight assessment/monitoring: participate in centralized delegation oversight assessment process and ongoing monitoring specific to NCQA requirements.
4. Delegation oversight and reporting for Medicaid HMO products: conduct delegation oversight of non-Highmark affiliated legal entities performing functions on behalf of the Medicaid HMO products in Delaware and report outcomes to applicable committees.

5. Quality improvement structure, governance, maintenance, and operations to support the quality, safety, and equity of clinical care and services provided to members including compilation of an annual Quality Program Evaluation, Description, and Action Plan; reporting matrices; meeting minutes; policies and desktop procedures, etc. (Not applicable for New York. See New York Quality Improvement Program Authority and Structure for more information).
6. Quality Improvement Strategy that is aligned across the integrated delivery system with common metrics and processes (where possible) and focuses on creating a culture of quality and health.
7. Highmark Population Health Management Strategy that aligns with the Highmark Health strategy.
8. Communications to members and providers regarding Quality Program goals/objectives, progress towards achieving goals, ability to provide input, etc.
9. Health services contracting monitoring to ensure compliance with NCQA requirements.
10. Compliance audits of member notification of practitioner termination and continued access to care to ensure continuity and coordination of care for membership.
11. Oversight of Transition of Care (TOC) procedures to allow new enrollees of a managed care product who are currently in treatment with an out-of-network provider the opportunity to transition his/her care to a network provider.
12. Oversight of process to help inform members and providers of the potential for benefit exhaustion as well as to educate members about available alternatives for continuing care, as appropriate.
13. Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”): Highmark applies the same network admission and provider credentialing standards to all providers in a comparable manner regardless of whether the provider renders medical services, behavioral health services, or substance abuse treatment services. Furthermore, Highmark utilizes the same processes, standards, factors, and strategies to develop provider reimbursement rates for providers that render medical services, behavioral health services, and substance abuse treatment services.
    a. **New York Providers:** New York State has a Mental Health and Substance Use Disorder Parity Compliance Program. This program establishing corporate governance for parity compliance and ensures appropriate identification and remediation of improper practices.
14. Appointment accessibility monitoring to ensure that members have appropriate access to primary care, behavioral healthcare, and specialty care services.
15. Telephone accessibility monitoring to ensure that members have appropriate access to organizational services.
16. Member experience/satisfaction monitoring (e.g., dissatisfactions, complaints, appeals) and determination of service quality improvement opportunities to correct all problems identified through internal surveillance, complaints, or other mechanisms.

17. Provider satisfaction monitoring (e.g., Utilization Management [UM] process) through the review and analysis of provider dissatisfactions. Opportunities to improve provider satisfaction are identified and a plan of action implemented, if required.
18. Practitioner and provider availability monitoring to ensure an adequate network of primary care, behavioral health, and specialty care practitioners and providers is maintained, as well as how effectively the network meets the cultural, ethnic, racial, and linguistic needs and preferences of its membership.
19. Continuity and coordination of care monitoring of transitions between medical and behavioral healthcare, identifying opportunities for improvement, and acting as appropriate.

New York Quality Improvement Program Authority and Structure

For providers in New York

The ultimate accountability for the Health Care Quality Improvement Program rests with the Board of Directors of Highmark.

The authority and responsibilities for administration and implementation of the Health Care Quality Improvement Program are vested in the Senior Medical Director and Vice President, Health Management. The Corporate Quality Management Committee regularly submit reports to the Board of Directors of Highmark in New York.

QI Committee Structure

For providers in New York

To assure that the Health Care Quality Improvement Program is implemented appropriately, key critical responsibilities related to a successful Quality Improvement Program are the shared responsibility of a variety of the committees and subcommittees across the organization.

In support of this shared responsibility the committees, subcommittees, ad hoc committees, etc. will analyze health care-related data from monitoring activities, software program output, and formal studies as appropriate.

These committees consider a variety of actions in relation to data and a number of other activities that are defined in corporate policies. These committees include the Corporate Quality Management Committee, Network Quality and Credentials Committee, Pharmacy and Therapeutics Committee, Medical Management Clinical Committee, Vendor Process Management, Mental Health and Substance Use Disorder Parity Compliance Committee, the Behavioral Health Advisory Board Committee, Wellpoint Joint Oversight Committee, and Highmark Inc./Highmark NY Utilization Management Master Service Agreement (MSA) Joint Oversight.

Monitoring and Evaluation

For providers in New York

Results are used to compare with other local plans and regional averages, to revise goals and to target areas of improvement.

- **Healthcare Effectiveness Data and Information Set (HEDIS®)** measures are primarily clinical in nature, collected annually, audited by an approved contracted vendor, and submitted to NCQA, CMS, and the Blue Cross Blue Shield Association.
- **Consumer Assessment of Health Plan Study (CAHPS®)** survey provides a measurement of how well the plan/practitioners met members' expectations.
- **Quality Assurance Reporting Requirements (QARR)** is a set of measures for Commercial HMO, Qualified Health Plans (Marketplace), and Medicaid/Child Health Plus populations based on HEDIS-like data, that are collected annually and sent to the New York State Department of Health (NYSDOH).
- **Medicare Touchpoint Measures (MTM)** reflect non-clinical service issues (accuracy and timeliness of enrollment, claims and inquiries) and reported semi-annually to the Blue Cross Blue Shield Association.

- **Medicare Star Rating** is consistent with CMS' Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. CMS uses a Five Star Quality Rating System on a scale of 1 to 5, with 5 stars being the highest score a plan can receive and 1 star being the lowest. CMS publishes star ratings in the fall each year and the five-star rating system provides Medicare beneficiaries and their families a way to compare plan performance and quality.
- **Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey** is a measure set comprised of clinical quality measures, including National Committee for Quality Assurance (NCQA), HEDIS® and a Pharmacy Quality Alliance (PQA) measure. The measure set also includes survey-based measures based on questions from the QHP Enrollee Survey that captures member experience and plan efficiency, affordability, and management. The quality ratings Five Star rating scale is similar to Medicare Star Rating.

Population Health Management Strategy

For providers in New York

A variety of clinically based programs are in place for addressing the needs of members across the continuum of care. These include health management programs to address members with complex health care needs, those with physical or developmental disabilities, multiple chronic conditions, and severe mental illness. These programs are designed to meet the care needs of the member population through identification, participation, engagement, and targeted interventions aimed at active engagements in health care services. The goal is to maintain or improve the physical and psychosocial well-being of individuals to address health disparities through cost-effective and tailored health solutions.

Delegation

For providers in New York

Delegated entities are required to meet specific regulatory standards including NCQA, NYS DOH, and CMS standards. Delegated entities are evaluated annually and key QI and UM documents are reviewed and approved (program descriptions, policies, work plan, and annual evaluations). Joint Oversight Team meetings are conducted to ensure contractual obligations are met. Members document and follow up on operational issues while reviewing and evaluating reports based on performance metrics.

Annual Evaluation of QI Program

For providers in New York

To continuously improve the quality and effectiveness of the Health Care Quality Improvement Program, an annual evaluation of the QI program is written and submitted to the Senior Medical Director, Vice President Health Management, Quality Management Committee, and Highmark's New York Board of Directors.

QI Work Plan

For providers in New York

The QI work plan is a working document that reflects ongoing progress on QI activities and updates are noted throughout the year as priorities, needs, and goals of the organization change. A mid-year update is presented to the Quality Management Committee and to Highmark's New York Board of Directors.

Important: While the New York Quality Improvement Program Authority and Structure includes Medicaid/Child Health Plus populations, Highmark does not have members in these programs in our New York service areas.

(This is the end of NY-specific information in this section.)

Credentialing Compliance

For Credentialing Compliance functions, please see **Chapter 3 Unit 2: Professional Provider Credentialing.**

Revenue Program Management

Revenue Program Management Functions

Delaware, Pennsylvania, and West Virginia:

1. Professional reviews to determine the adequacy and safety of all professional practitioner office sites, as well as conformance to Highmark Inc. standards for medical record reviews.
2. Facility office site visits and medical record reviews in the absence of external accreditation to determine the adequacy and safety of all facility sites, as well as conformance to Highmark Inc. standards for medical record documentation in response to notification from Credentialing Review requests.
3. Chart abstraction for the annual Healthcare Effectiveness Data and Information Set (HEDIS®) hybrid (medical record) reporting requirement.
4. Educate provider offices relating to Office Site/Medical Record evaluations, HEDIS® medical record review, and/or relating to Revenue Program Management projects.

New York:

1. New providers and member complaints related to the provider office environment will be reviewed by Provider Networks. This includes, but is not limited to, an assessment of the following office site criteria: access for patients with physical and/or sensory disabilities, physical appearance, adequacy of waiting/exam rooms, organized/systematic clinical record system, confidentiality, 24/7 coverage, appointment access, assessment of medical/treatment record criteria such as: medications, allergies, signature, dated entries, preventive services flow sheet, counseling

regarding an advance directive/documentation of executed Advance Directive, etc. Assessments are in response to any of the following:

a. Specified member complaints

b. Offices with less than 20 office hours availability

c. Annual randomly chosen sample

d. Medical Director requests

2. Facility office site visits and medical record reviews in the absence of external accreditation to determine the adequacy and safety of all facility sites, as well as conformance to Highmark Inc. standards for medical record documentation in response to notification from Credentialing Review requests.

3. Educate provider offices relating to Office Site/Medical Record evaluations and/or relating to Revenue Program Management projects.

5.6 Case Review Process for Quality Concerns

Highmark's Quality Management is responsible for evaluating member dissatisfactions, concerns, and issues related to clinical quality of care.

The Clinical Performance Measures area of Quality Management becomes aware of potential issues/concerns and member dissatisfactions about clinical quality of care issues through information received from a variety of sources, including providers, members, and internal Highmark departments.

Important!

For providers in New York

Members are able to make clinical quality of care complaints to the health plan.

The Initial Review

For providers in Delaware, Pennsylvania, and West Virginia

A Clinical Quality Management Consultant (CQMC) completes the initial review of each case referred for potential quality of care issues. The CQMC, who is a registered nurse, reviews the case to determine whether there is potential for a quality issue referencing scientifically-based standards of care.

- When this initial review determines that the concern does not have the potential for an adverse outcome, the case is closed and filed for trending purposes.
- If the potential for an adverse outcome is identified, medical records are requested from the provider or facility involved in the case.

The Initial Review

For providers in New York

A Clinical Information Associate will determine if a clinical review is needed and applicable information is available (i.e., DOS, permission from member to use name, name and location of provider, HIPAA, if required) or if additional clarification is needed. The member concern is then forwarded to a Clinical Quality Registered Nurse who will request the medical record and a written response to the concerns from the provider.

Analysis of Medical Records

For providers in Delaware, Pennsylvania, and West Virginia

Once medical records are received, the CQMC performs a second assessment of the case. If the assessment dispels any concern of potential for an adverse outcome, the case is closed and filed to track the provider for any future issues.

If the potential for an adverse outcome or a Level of Harm, as defined by the Agency of Healthcare Research and Quality (AHRQ), is identified, the case is forwarded to a Medical Director for review.

Analysis of Medical Records

For providers in New York

Once all needed information is received, concerns are reviewed by a Quality Registered Nurse (RN) to determine if the member's concern is recommended to be substantiated, not substantiated, or filed and trended (for issues not typically included in medical record documentation). An acknowledgement letter of the decision regarding the clinical complaint/concerns is sent to the member.

Medical Director Review Outcomes

For providers in Delaware, Pennsylvania, and West Virginia

When the Medical Director believes that a quality issue may be present, a written request for additional information is sent to the provider involved.

If it is determined that a quality issue is indeed present following the review of any additional information, a Level of Harm is determined by the Medical Director and a corrective action plan is implemented if warranted.

Medical Director Review Outcomes

For providers in New York

If a concern is substantiated and has not already been addressed by the provider in the information previously sent, a Corrective Action Plan should be requested from the provider.

Provider Responsibilities

For providers in Delaware, Pennsylvania, and West Virginia

During the investigation of quality of care concerns, facility providers may be asked to supply any or all of the following:

- A copy of the member's medical or behavioral health record
- A response from the administrator, or the administrator's designee, to address a possible adverse outcome determined during the medical record review
- A corrective action plan (if warranted) if an adverse outcome is found during the medical record review

Provider Responsibilities

For providers in New York

Every time a concern is sent to a Clinical Quality Registered Nurse, providers must send the following information:

- A copy of the member's medical or behavioral health record
- A response from the administrator, or the administrator's designee, to address a possible adverse outcome determined during the medical record review
- A corrective action plan (if warranted) if an adverse outcome is found during the medical record review

5.6 Corrective Action and Sanctioning

Issues Leading to Corrective Action or Sanctioning

A provider or facility is placed under corrective action or sanctioning when a treatment, procedure, or service indicates a provider is not practicing in a manner that is consistent with the standards of Highmark and/or deviates from acceptable standards of care.

There are two issues when a provider can be placed under corrective action/sanctioning:

1. Clinical quality of care – occurs when an episode strays from accepted medical standards (e.g., actions or omissions resulting in an adverse effect on a patient's well-being, medication errors, missed diagnosis, delaying treatment, unanticipated and unexplained death)
2. Administrative non-compliance – occurs when a provider's behavior is not consistent with their agreement with Highmark contracts and guidelines (e.g., failure to comply with contractual obligations, medical record review deficiencies, balance billing for services, and unauthorized billing for services)

Notification of Corrective Action

Once the Medical Director makes a determination to place the provider under corrective action, the provider will be notified in writing of:

- The reason for the corrective action
- What corrective action is needed and what it entails
- The period of time the provider will remain under the corrective action

The provider can either appeal the decision of the Medical Director, elect to abide by the corrective action plan, or make the necessary improvements (if applicable).

Appeal Hearing

If an appeal is requested, a hearing with the Network Quality and Credentials Committee (NQCC) will be made available. This committee will make the decision to either uphold or overturn the original decision by the Medical Director.

Sanctioning Possible

After the corrective action time period has expired, the provider will be re-evaluated by the Medical Director. If the Medical Director is satisfied that all stipulations are met, the corrective action will be lifted.

If the stipulations are not met, sanctioning of the provider could occur which may result in a provider's inability to participate in certain programs.

5.6 Clinical Quality

Preventive Guidelines

Preventive Health Guidelines are available for the entire plan providers, which include:

- Adults ages 65 and over
- Adults ages 19-64
- Pediatric ages 0-18
- Prenatal/Perinatal
- Centers for Disease Control and Prevention (CDC) Immunization Schedules
- Women's Preventive Services

The Clinical Outcomes and Guidelines Quality team review and update the Preventive Health Guidelines on an annual basis utilizing references such as the United States Preventive Services Task Force (USPSTF), CDC, National Institutes of Health (NIH), Centers for Medicare and Medicaid Services (CMS), etc. The Preventive Health Guidelines are placed on the applicable websites via the Provider Resource Center. A notice regarding the Preventive Schedule is made available via the member website.

These guidelines are available to the provider community as a reference tool to encourage and assist providers in planning their patients' care.

The **Preventive Health Guidelines**, and many other valuable clinical resources are available online via the Provider Resource Center. To access these materials, go to the Provider Resource Center and select **Resources & Education** from the main menu at the top, then **Clinical Quality & Education**.

Condition Management Program

The Condition Management Program is designed to develop a collaborative working relationship between Highmark members, members' providers, and Highmark clinicians to support the provider's plan of care for members under their care. The purpose of the program is to identify members who are most at risk for significant care gaps and, therefore, a progression and/or worsening of their chronic condition. High-risk members are identified through a combination of inpatient and outpatient claims, pharmacy claims, and clinical risk scores that enable our clinicians to conduct outreach to those members by telephone.

Nurses providing condition management services by telephone are known as clinicians. Clinicians work collaboratively with the member and provider to establish realistic and attainable short and long-term goals and to encourage behavior and lifestyle changes that lead to better member self-management of their condition(s).

Members are eligible to receive health coaching for these chronic conditions:

- Asthma
- COPD

- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High-Risk Pregnancy
- HIV/AIDS
- Metabolic Syndrome
- Musculoskeletal Pain
- Obesity (Pediatric)
- Tobacco Use (CHIP)

Providers, members, and family members can learn about the program and refer to the program by calling the 24/7 health information line at **888-BLUE-428.**

Continuity and Coordination of Care

Highmark recognizes the importance of coordination of care as part of the quality continuum. There are programs and policies in place to ensure coordination of medical, behavioral health, or other community support for members. This process enables Highmark to inform the membership of health care needs that require follow-up, training in self-care, and other measures to promote their health.

Clinical Services – Quality facilitates the continuity and coordination of medical care across the delivery system and collaborates with behavioral health practitioners to monitor and improve coordination between medical and behavioral health care. The communication between PCPs and behavioral health specialists is regularly monitored as part of the Highmark Quality Program, specifically through an annual provider satisfaction survey.

Network organizational providers such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with PCPs when care is delivered to their patients. PCPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

Medical Record Review

For providers in New York

Any Practitioner who provides care to our members

Medical record documentation can be assessed at any time using medical record documentation standards that are based on the most recent regulatory guidelines (CMS, NYSDOH, NCQA).

OB/GYN Providers

Medical record documentation will be assessed using the most recent NYSDOH prenatal guidelines. These standards will be used to evaluate compliance in appropriate prenatal medical care for pregnant women.

Purpose

Review of these medical records will improve continuity and quality of patient care by assuring timely, legible, accurate and comprehensive documentation of patient-provider interaction. It will allow Highmark of Western and Northeastern New York to target areas of opportunity to provide education to practitioners on their documentation and areas where medical care can be improved.

Procedure

Medical record documentation standards are based on regulatory guidelines. The standards are reviewed for updates annually.

The medical records for review can be derived from any of the following sources:

- **HEDIS/QARR/QRS Review:** Healthcare Effectiveness Data and Information Set/Quality Assurance Reporting Requirements/Quality Rating System.
- **Quality Concern Review:** Records obtained in response to member concerns with access to care and provider requested focused medical reviews.
- **Internal Department Referrals:** Records identified by Clinical Services, Provider Relations and Contracting, Credentialing, and Financial Investigations and Provider Review (FIPR), as needing Clinical Quality medical record review.
- **Continuity and Coordination of Care:** Designated projects will coordinate with medical record review to obtain medical records.
- **Live Birth File:** Records are identified for inclusion in the NYSDOH prenatal medical record review.

Patient Safety Program Activities

Highmark recognizes the importance of patient safety programs; therefore, the Highmark Patient Safety Program focuses on the development of activities which assess and improve the plan's patient safety efforts.

Many activities have been developed to enhance patient safety, including development of patient-safety-focused, written educational offerings for member and provider communications.

Quality of Care Case Reviews

Clinical Services – Quality of Care is responsible for evaluating member dissatisfactions, concerns, and issues related to clinical quality of care and for initiating appropriate action in response to them.

Clinical Services – Quality of Care becomes aware of quality of care dissatisfactions through information received from a number of sources, including providers and members as well as internal Highmark departments. Tracking mechanisms enable Clinical Services – Quality to monitor the information received over time and identify improvement opportunities.

	Who Does It?	What Is Done?
Step 1	Registered Nurse from Clinical Services – Quality	Performs a preliminary review to determine whether there is potential for a quality issue. Decision made to either track the accepted case in a database of similar issues involving the provider; or requests and reviews medical records according to Clinical Services – Quality policy. • IF medical record review indicates no potential for an adverse outcome, closes the case and maintains a record of it to track the provider for similar issues. • IF potential for an adverse outcome is identified or the provider may have contributed to an adverse outcome, forwards the case to the applicable

		Medical Director for review.
Step 2	A Highmark Medical Director	Performs a case review. • IF this review indicates there is no quality issue, the case is closed and tracked by provider for similar issues. • IF this review indicates that a quality issue resulting in some level of harm has been identified, a written request is sent to the involved provider/practitioner for a response or further information pertinent to the review.
Step 3	A Highmark Medical Director	Reviews the case with any additional information provided by the involved provider. • IF this information satisfies the concern, the case is closed and a record of the case is maintained so that the provider can

		be tracked for similar issues. • IF the review still indicates the presence of a quality concern, a corrective action may be initiated by the Medical Director, depending on the severity of the issue/level of harm sustained by the member. • The involved provider is notified in writing of the decision, corrective action required, and their appeal rights.
Step 4	Provider/Practitioner	May choose to appeal (within 30 days) these actions before a subcommittee of the Highmark Network Quality and Credentials Committee.
Step 5	Clinical Services – Quality Staff	• Documents the outcome of the case via the Member Dissatisfaction Tracking Database.

		• Tracks the incident(s) and providers for similar trending patterns. • Generates confidential reports from this database on a quarterly basis for the Clinical Services – Quality Medical Director to take further action if needed.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare the performance of all managed health care plans. Each participating plan reports data for the same measures, so you know you are making comparisons based on similar information.

To ensure these measures encompass data from the entire calendar year, health plans are asked to evaluate and report their results from the prior year. The Plan may be required to report on members from distinct product lines as required to meet and/or maintain National Committee for Quality Assurance (NCQA) accreditation, Centers for Medicare & Medicaid Services (CMS), and/or Office of Personnel Management (OPM) requirements, and/or the Pennsylvania and/or Delaware Department of Health and/or New York Department of Health (PA DOH, DE DOH, NYS DOH) requirements.

Understanding the categories in which plans are rated can help members make a choice based on what is important to them. HEDIS® determines quality and value by measuring success in the following areas:

- **Effectiveness of Care:** Assesses all types of care (preventive, early detection and screening, maternity, acute, chronic, and behavioral health as well as overuse and appropriateness of care)

and populations (children, adolescents, adults, and seniors).

- **Access/Availability of Care:** Assesses our network providers' accessibility and timeliness of care.
- **Experience of Care:** Assesses current members' levels of satisfaction with the health plan.
- **Utilization and Risk Adjustment Utilization:** Assesses resource use, how efficiently care is provided, and whether needed services are being delivered.
- **Health Plan Descriptive Information:** Presents an overview of provider-related information and member demographics.

This reporting occurs on an annual basis and requires the use of administrative claims data, as well as supplemental data feeds through the use of electronic clinical data systems and medical record abstracted data.

5.6 Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations

Highmark's Office/Facility Site Review Process

Highmark continually strives to enhance the quality of care and services provided to our members. Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations are required to meet Highmark standards as well as those established by regulatory and accrediting organizations. Clinical Quality Management Analysts schedule and conduct Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations **for any practitioner within the network** based on the following:

1. **Member Dissatisfactions:** A member dissatisfaction is received when the quality of any practitioner (PCP, specialist, allied health practitioner, or facility) office where care is delivered that is related to any of the following categories:
    a. Physical accessibility
    b. Physical appearance
    c. Adequacy of waiting room and examining/treatment room space
    d. Provider accessibility

2. **Annual Random Samples:** Using a statistically valid sampling methodology, practice sites in Pennsylvania will be selected for the Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations on an annual basis.
3. **Annual Less Than 20 Hours Per Week Sites (PA Only):** In accordance with the Pennsylvania Department of Health Managed Care Organization regulations, primary care practitioners must provide office hours at each practice location accessible to members a minimum of 20 hours a week at each practice site in Pennsylvania.

   On an annual basis, sites identified as providing less than 20 primary care hours to members will have Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations performed at that site.
4. **Facility Site Quality and Medical/Treatment Record Evaluations:** Any organizational provider not accredited by a recognized accreditation agency or has not undergone a review by the Centers for Medicare & Medicaid Services (CMS) or the applicable state will have site or medical/treatment evaluations completed.
5. **Medical Director Request:** Provider/facility sites may have office/facility and medical record evaluations completed as requested by a Highmark Medical Director.

Scoring Requirements

Follow-up reviews will be conducted within six months of the previous evaluations for all sites that score below Highmark's threshold of 80% for the practitioner's office/facility site quality and medical/treatment record evaluations.

Provider office sites and facilities with continuous opportunities for improvement after three consecutive visits at six-month intervals will be presented to the Credentials Committee as exception practitioners for further recommendation. Sites with office deficiencies on repeated re-evaluations may be terminated from network participation.

Review Measures

The following tables include the measures assessed in each component of the evaluation.

Professional Office/Facility Site Quality Evaluations

Measure	Applies to Professional Office Sites	Applies to Professional Office Sites	Applies to Professional Office Sites	Applies to Professional Office Sites	App to Fac Sit
	PCP	Specialists	OB/GYN	Behavioral Health	
The office/facility is reasonably accessible (noting the ease of entry into and the accessibility of space within the building) for patients with physical and/or sensory disabilities.	X	X	X	X	X
The physical appearance of the office/facility is clean, organized, and well maintained for the safety of patients, staff, and visitors.	X	X	X	X	X
The waiting area is well lit, has adequate space and seating, and has posted office hours.	X	X	X	X	X

There is adequacy of examining/treatment room space as well as patient interview areas and each is designed to respect patients' dignity and privacy.	X	X	X	X	X
Clinical records are filed in an organized, systematic manner, easily located, and kept in a secure, confidential location and away from patient access. Only authorized persons have access to clinical records.	X	X	X	X	X
The office/facility has a written confidentiality policy to avoid the unauthorized release or disclosure of confidential personal health information including but not limited to computer screens, data disks, emails, telephone messages/calls, fax machines.	X	X	X	X	X
The medical equipment utilized in the office/facility appears to be adequate, well maintained, up-to-date, appropriate for the patients' age, and appropriate for the specialty of the practice.	X	X	X	X	X

The office has 24-hour medical coverage that is available 7 days a week.	X	X	X	X	X
The office has a process to ensure after-hours calls are returned within 30 minutes.	X	X	X	X	X
The office has a process to ensure after-hours calls are communicated to the office by the morning of the following business day.	X	X	X	X	X
The office has mechanisms to assess behavioral health disorders, alcohol and other drug dependence (i.e., screening tool or questionnaire). (Not applicable to Retail Clinic sites.)	X		X		X
No more than 6 office visits are scheduled per hour per practitioner	X	X	X	X	
Emergency, life-threatening medical situations are handled immediately.	X	X	X		

Urgent medical care appointments that require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within 1 day (e.g., high fever, persistent vomiting/diarrhea).	X	X			
Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days (e.g., headache, cold, cough, rash, joint/muscle pain, etc.).	X	X			
Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., symptomatic preventive care, well child/patient exams, physical exams, etc.).	X	X			
Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) are proactively notified by the office and encouraged to schedule an appointment.	X				

There is a process to assure that patients who either no show or cancel their appointments are contacted and encouraged to reschedule the appointments as evidenced by documentation of such in the medical record (e.g., appointment scheduled, reminder card, etc.).	X				
A reminder call is made by the practice prior to scheduled appointments to encourage attendance with the scheduled visit.	X				
There is a process confirming that laboratory, diagnostic procedures, and/or consultation appointments were performed and results were received, reviewed, and filed in the patient's medical record. The process: 1. identifies how the laboratory, diagnostic procedures, and/or consultation appointments are tracked; 2. identifies staff responsible to ensure results are	X				

returned to the office; 3. identifies when and how staff match test results with patient's chart; 4. identifies how the reviewer (practitioner) notifies how the results should be handled.					
There is a process in place to ensure patients are notified of abnormal results.	X	X	X	X	X
Urgent medical care appointments which require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within 1 day such as: 1. OB – high fever, persistent vomiting/diarrhea, bladder infection, increased swelling; 2. GYN – unusual vaginal discharge or vaginal bleeding post-menopause/hysterectomy, or detection of breast mass/breast lump.			X		
Regular and routine care appointments that are non-			X		

urgent but in need of attention are available within 2-7 days: 1. OB – small amount of swelling in ankles or hands, sciatica pain (including hip/leg pain), respiratory infection, UTI symptoms; 2. GYN – increased menstrual cramps.					
Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., regular routine obstetrical and gynecological appointments).			X		
Immediate intervention for a life-threatening emergency is required to prevent death or serious harm to patient or others.				X	
Intervention within 6 hours is required for a non-life-threatening emergency to prevent acute deterioration of the patient's clinical state that compromises patient safety.				X	
Timely evaluation (within 48 hours) is needed for urgent care				X	

to prevent deterioration of the patient's condition.					
Routine office visits are available (within 10 business days) when the patient's condition is considered to be stable.				X	
There is a fire extinguisher that is visible, easily accessible, and the expiration date is current.					X
The exits are clearly marked.					X
Used syringes, scalpels, etc. are disposed of in rigid, unpierceable, leak proof containers and the containers are accessible in the area of use.					X
Biohazard wastes are disposed in red, labeled biohazardous waste bags and contained within a labeled, rigid closeable container.					X
The facility has a contract with a licensed company to dispose of biohazard waste and/or has other adequate provisions for disposal in place. The facility					X

files manifests from the licensed biohazard waste company indicating proper disposal.					
Separate refrigerators are maintained and properly identified for each of the following: medications, food, lab specimens.					X
A thermometer is present in the medication refrigerator/freezer and the temperature is recorded daily. Refrigerator: 35-46 degrees F (2-8 C). Freezer: 5 degrees F (-5C).					X
Medical equipment and instruments are properly disinfected or sterilized: 1. Heat temperature strips and spore testing; 2. Cold disinfection (20-45 minutes); 3. Cold sterilization (10 hours).					X
All medications and prescription pads are adequately protected from patient access.					X

All medications, including samples, are checked for expiration dates on a regular basis.					X
A CPR-certified staff member is present during all hours of operation. (Current CPR cards should be on file and available for review.)					X
A system for the supply of oxygen is available in the event of a medical emergency. (Not applicable for Retail Clinic sites.)					X
Emergency equipment (airway/ambu bags) and medications (i.e., epinephrine, Benadryl, NTG tablets) are available as appropriate for the type of facility. The supplies are checked on a regular basis for expiration dates. (Not applicable for Retail Clinic sites.)					X
There is a reliable emergency electrical power source available.					X
Consent forms are utilized for invasive procedures performed in					X

the facility.					
There is an infection control plan in place.					X
There is a process in place to ensure patients are notified of abnormal test results.					X
The facility has a written policy in effect specifying how communication to the PCP or referring provider is handled in the facility.					X
There is evidence of formal job descriptions which include education/certification requirements for each specified position.					X
There is documentation of current professional licenses/certificates on file.					X

There is evidence of outcome measurements for quality improvement which targets high-volume services, consumer services, billing practices, or adverse events.					X
Patient satisfaction surveys are completed and reviewed.					X

Professional /Facility Medical Record Evaluation

	Applies to Professional Office Sites	Applies to Professional Office Sites	Applies to Professional Office Sites	Applies to Professional Office Sites	A F
Measure	PCP	Specialists	OB/GYN	Behavioral Health	
An individual clinical record is established, organized, easily located and data is easily retrievable for each patient.	X	X	X	X	
Each page in the medical record contains the patient's name and another form of patient	X	X	X	X	

identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record.					
Significant illnesses and medical and behavioral health conditions are indicated on the current problem list and are updated after each office visit and hospitalization.	X	X	X	X	
Each record indicates which medications have been prescribed, the dosages of each, the date of the initial prescription and/or refill, and the date the medication was discontinued, as applicable	X	X	X	X	
The medical record includes notes from each visit.					
Vital signs for each visit are documented.					
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	X	X	X	X	

history of adverse reactions, or relevant medical conditions.					
All entries in the record contain a valid, legible author's signature which may be a: handwritten signature with credentials; printed name and credentials accompanied by handwritten provider initials; or unique electronic identifier with credentials.	X	X	X	X	
All entries in the record are dated and are legible to someone other than the writer.	X	X	X	X	
The medical/treatment records have a notation regarding follow-up care, calls, or visits when indicated. The specific time of return is noted in weeks, months, or as needed.	X	X	X	X	
For patients 12 years and older, documentation includes past and present use of cigarettes (or other tobacco), alcohol, as well as illicit, prescribed, and over-the-counter	X	X	X	X	

drugs or other substance abuse. (Assessed at least annually.)					
If a consultation is requested from a medical specialist, behavioral health practitioner, and/or organizational provider, the medical record contains documentation of follow-up correspondence from the consultant. The consultant reports are filed in the chart and are signed/initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal results.	X	X	X	X	
Consultations, laboratory, imaging, and other studies (including mammograms and Pap smears) are ordered, as appropriate. The reports are filed in the chart and are initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal laboratory and imaging results.	X	X	X	X	
There is documentation in the medical record that patients are notified of abnormal test results.	X	X	X	X	

There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. Possible risk factors for the member, relevant to the particular treatment, were documented, as applicable.	X	X	X	X	
There is a current flow sheet for preventive services, in accordance with the health plan's guidelines, as applicable to practice specialty.	X	X	X	X	
Past medical history (patients seen 3 or more times) is updated every 3 years and includes serious accidents, surgeries, and illnesses. For patients 18 years and younger, past medical history relates to prenatal care, birth history, surgeries, and childhood illnesses.	X	X	X		
The history and physical exam identifies appropriate subjective and objective data for each visit relevant to the patient's presenting complaints.	X	X	X		

The assessments or diagnostic impressions (working diagnoses) are consistent with the findings.	X	X	X		
The treatment or therapy plans are consistent with the diagnoses.	X	X	X		
The records contain documentation that the patient/caregiver received and understood instructions regarding the plan of care.					
There is evidence of 6 well care visits in the first 15 months of life to include the following: 1. a health and developmental history (physical and mental); 2. a physical exam; 3. health education/anticipatory guidance.	X				
A lead screening test is performed prior to the child's second birthday.	X				
Children ages 3-17 have a yearly well exam which includes documentation of: 1. developmental assessment;	X				

2. anticipatory guidance; 3. BMI and BMI percentile; 4. counseling for diet/nutrition; 5. counseling for physical activity.					
Infants (starting at birth) and children up to 17 years of age should have a complete childhood immunization record with dates of service. Parental refusal of immunization is documented, if applicable.	X				
A complete adolescent immunization record with dates of service include: 1. meningococcal vaccine (prior to age 13); 2. Tdap/Td (between 10-13 years of age). Parental refusal of immunization is documented, if applicable.	X				
Adults have routine health screenings that include: 1. up-to-date recommended immunizations/vaccinations; 2. BMI documented at least every 2 years; 3. a physical exam every 1-2 years for patients 19-49	X				

years; 4. a yearly physical exam for patients 50 years and older.					
Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) were seen and the chronic illness is evaluated at least annually.	X				
Adults 65 years of age and older are assessed annually for comprehensive pain screening (i.e., Multidimensional Pain Inventory, Faces Pain Scale, etc.)	X				
Adults 65 years of age and older are assessed annually for a functional status assessment including ADL's, fall risk, and level of physical activity.	X				
Adults 65 years of age and older are assessed for medication reconciliation – medications should be reviewed at least annually and within 30 days after each hospital discharge.	X				
Adults 65 years of age and older are assessed annually for	X				

discussion of bladder control issues.					
The medical record notes colorectal cancer screening for patients 50-75 years of age by any of the following: 1. fecal occult blood test – yearly; 2. flexible sigmoidoscopy every 5 years; 3. double contrast barium enema every 5 years; 4. colonoscopy every 10 years.	X	X			
Adults with diagnosis of hypertension have their blood pressure measured at each office visit. Any blood pressure 140/90 or higher is addressed by the provider as evidenced by documentation on the medical record.	X	X			
Adults diagnosed with a cardiovascular condition receive an LDL-C screening annually. (Target LDL-C is less than 100.)	X	X			
Patients diagnosed with diabetes mellitus have yearly: 1. BP monitoring (<140/90); 2. HBA1C and lipid profile;	X	X			

3. nephropathy screening or ACE/ARB prescription; 4. dilated retinal eye exam; 5. if also diagnosed with hypertension, treated with ACE/ARB.					
Any adult 40 years of age or older that has a new diagnosis or newly active COPD had appropriate spirometry testing to confirm the diagnosis.	X	X			
Patients diagnosed with rheumatoid arthritis were prescribed a disease modifying anti-rheumatic drug.	X	X			
Female patients 65 years of age and older who suffered a fracture received either a bone mineral density test or a prescription to treat or prevent osteoporosis within 6 months of the fracture, if testing had not been done within the previous 2 years.	X	X			
The medical record has evidence of a Chlamydia screening for sexually active women ages 16-24 years of age.	X		X		

The medical record has evidence of a Pap test every 3 years for women 21-64 years of age.	X		X		
The medical record has evidence of mammogram screening every 2 years for women 40-69 years of age.	X		X		
There is documentation in the medical record that the patient 65 years of age and older was counseled regarding an Advance Directive. (Assess annually.)	X				
There is documentation in the medical record as to whether or not the patient has executed an Advance Directive and, if so, the Advance Directive or documentation is placed in a prominent part of the patient's record. (Assess annually.)	X				
If an Advance Directive is filed or documented in the medical record, a surrogate has been identified. (This question will be answered N/A in the event there is no Advance Directive in the medical	X				

record and if there is no surrogate identified.)					
There is evidence of communication and collaboration (letters, reports, etc.) from the OB/GYN or Facility site to the primary care physician, including documentation that a copy of the patient's exam with pertinent information has been sent to the primary care physician.			X		
A medical and psychiatric history is documented including: previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and peri-natal events along with a complete developmental history (physical, psychological, social, intellectual, and academic).				X	
Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, and the results of a mental status exam				X	

are documented in the clinical record.					
The mental status exam documents: 1. affect/mood; 2. speech; 3. appearance; 4. thought content; 5. judgment; 6. insight; 7. attention; 8. memory; 9. impulse control.				X	
Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.				X	
The DSM-IV diagnoses are identified and are consistent with the presenting problems, history, mental status examination, and/or other assessment data.				X	
Treatment plans are consistent with diagnoses, have both objective and measurable goals, have an				X	

estimated time frame for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.					
It is noted that the office receives communication from the specialist/organizational provider which assures continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions.				X	

Practice Site Resources

Highmark is committed to promoting quality education and care to members and practitioners. Practice Site Resources is a resource for network participating office sites to assist in promoting quality health care to their patients and members.

The resources include a variety of educational resource materials, such as age-specific progress records, preventive health records, and sample office policies to assist the practitioner in meeting Highmark standards, including medical record documentation. Member-specific educational materials are also available for physicians to assist their patients with preventive health care.

The Practice Site Resources materials are used by Highmark Clinical Quality Management Analysts to educate the practitioner office designees when performing office site and medical record documentation reviews.

The Practice Site Resources section is available on Highmark's Provider Resource Center (PRC) by selecting **Resources & Education**, then find **Practice Site Resources** under **Clinical Quality & Education.**

5.6 Service Quality

Member Satisfaction Monitoring

Annual member satisfaction surveys are conducted, using a statistically valid sample of the membership, to ensure that the plan identifies potential areas for service quality improvements.

Results of the survey are reviewed by Clinical Services - Quality and internal ad-hoc workgroups. The findings are then reported to the Care Management and Quality Committee. Member satisfaction is also monitored through review of member dissatisfactions, complaints, and appeals.

CAHPS® & QHP EES Survey Results

Highmark contracts with SPH Analytics, an independent research firm certified by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS), to conduct the annual Commercial and Medicare Advantage Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and the Qualified Health Plan Enrollee Experience Survey (EES).

The surveys are used to gather information about the overall experiences of our members and to identify areas for improvement.

The CAHPS® and QHP EES survey results are updated annually and are available on the Provider Resource Center. Select **Resources & Education** from the main menu at the top of the page, and then **Clinical Quality & Education**, then **CAHPS®/QHP EES Survey.**

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

5.6 Highmark Quality Initiatives

Shared Effort

Highmark considers the pursuit of quality improvement in health care to be a shared effort. While each facility must assess its own needs, establish meaningful goals, and monitor its own progress, Highmark can assist by providing data and opportunities for analysis. Highmark appreciates the cooperation of facilities in collecting data and making good use of it toward improvement of quality in health care services.

The initiatives described here represent just some of the efforts Highmark has made to be a partner with facilities and providers in improving quality in health care.

Medicare Advantage Quality Improvement Program

Medicare Advantage Organizations (MAOs) must have an ongoing Quality Improvement Program per the Centers for Medicare & Medicaid Services (CMS). The Quality Improvement Program includes the Chronic Care Improvement Program (CCIP). The MAO is required to complete a CCIP and attest to that completion annually in the CMS Health Plan Management System (HPMS).

Quality Management selects and implements an annual Quality Improvement Project as determined by CMS. An example of such a project is: “Improving the percentage of diabetic members who are receiving an annual diabetic retinal eye exam.” Representatives from key areas of the Plan meet throughout the year to conduct a quantitative and qualitative analysis on the selected measure. Interventions are then implemented to improve results.

Safety Initiatives

Highmark continuously works to improve the safety of clinical care and services provided to its members. A variety of safety initiatives are conducted at Highmark that focus on both members and providers. One of those initiatives is ensuring that hospitals with over 50 beds implement an evidence-based initiative that improves health care quality through the collection, management, and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmissions, and/or improves care coordination.

Hospitals with over 50 beds can comply with this initiative by meeting at least one of the following criteria:

- Hospitals in the Commonwealth of Pennsylvania must already comply with the Patient Safety Requirements of Act 13, which includes Department of Health review and approval of Patient Safety Plans to ensure compliance with State-required elements, as well as oversight on an ongoing basis. A hospital in Pennsylvania may submit verification of meeting this state requirement to Highmark to show compliance.
- Obtaining/maintaining accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accrediting agency acceptable to Highmark that includes compliance with a Patient Safety Standard as a required component for obtaining accreditation. Highmark will verify this information at the time of a hospital's initial assessment (prior to contracting) and at least every three years thereafter.
- Producing evidence of participation with a Patient Safety Organization (PSO) and/or a Patient Safety Plan to Highmark as part of the assessment site visit conducted for hospitals that are not accredited. Providing evidence of a CMS Certification Number (CCN) at the time of the assessment and renewal is also required.

Member Outreach Initiatives

The Clinical Outcomes and Guidelines team coordinates the development of member communication activities such as mailings, articles, and outreach to share health information and reminders for clinical services. Monthly mailings are sent to identified members to encourage them to schedule important preventive health screenings, such as for breast, cervical, and colon cancer.

Health Care Disparities Activities

Highmark has made reducing health care disparities a priority.

Member Health Care Education Material

Highmark identified a need for Spanish-speaking members to have access to educational materials translated into their native language. Several of Highmark's educational materials have been translated into Spanish and are available on the Provider Resource Center under **Resources & Education,** then **Educational Programs,** and then **Educational Resources – Member and Provider.**

Highmark is continuing to evaluate the need for other educational materials to be translated and will implement new translated materials as necessary.

Risk Adjustment Programs

Highmark has both prospective and retrospective coding programs in place to support correct risk scoring of its members and provides resources and education to providers to facilitate correct capture of ongoing conditions on an annual basis.

Goals of Risk Adjustment Programs:

- Support a complete and accurate health record
- Gap closure to engage members who may not be properly managing their chronic conditions
- Support providers to appropriately utilize Medicare Annual Wellness Visits and other encounters to complete health assessments and facilitate gap closure
- Support population health strategies

Provider documentation and coding information is available on the Provider Resource Center – when accessed via Availity® – by selecting **Resources & Education.** Look under **Clinical Quality & Education.**

Submitting Claims with More Than 36 Diagnosis Codes

Highmark can accept up to 36 diagnoses for a date of service. If you have more diagnosis codes than the system allows, Highmark has developed the following process to submit additional diagnosis codes:

1. Submit first claim using applicable visit CPT code(s)
2. Submit a **second claim** using 99499, $0.00. Include the additional diagnoses codes that went beyond the maximum codes allowed from original claim on this new claim. **Important:** 99499 must be the **only** CPT code on this claim.
3. If appropriate, submit remaining diagnoses using 99499 with modifier 25, $0.00 on an additional claim

Example: Billing system with a maximum amount of 12 diagnoses per claim:

1. Submit first 12 diagnoses using actual visit CPT code(s)
2. Submit 13 – 24 diagnoses using 99499, $0.00
3. Submit 25 – 36 diagnoses using 99499 with modifier 25, $0.00

If you wish to submit additional diagnosis codes beyond the count of 24 by utilizing 99499 on another separate claim, a modifier 25 must be affixed to the procedure code along with a claim charge of $0.00 to avoid a duplicate claim.

- Highmark classifies 99499 as an eligible procedure code for risk adjustment within the encounter data processing system (EDPS). EDPS filtering is set by CMS, and the government agency lists only 99499 for the submission of additional diagnosis as eligible for risk adjustment. A claim only needs to have one line with an eligible procedure code in order for the entire claim and all of its diagnosis codes to be deemed eligible for risk adjustment. However, if 99499 is billed as a separate claim with a $0.00 charge, the diagnosis codes(s) would be eligible for risk adjustment, but the separate $0.00 claim will be denied/rejected for payment as no payment can be made due to the $0 charge.
- Affix a claim charge amount of $0.00 to the procedure code. **This must be the amount recorded.**

NOTE: A denial message will show on the EOB stating that this line item could not be processed because a charge amount was not attached. Even though this line item is denied, Highmark will still capture the diagnosis codes affiliated with this procedure code. If a diagnosis code of value was omitted from the original billing, Availity® will allow you to submit the additional codes using 99499 on eligible 1500 claims.

5.6 Peer Review Protections

Protected Activities

Activities of the Highmark Quality Program, including activities of the staff, medical directors, and the Network Quality and Credentials Committee, may be afforded protections as peer review activities under state and federal law. Such protected activities include:

- Evaluating and improving the quality of health care rendered;
- Reducing morbidity and mortality;
- Evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals (including inpatient hospital and extended care facility utilization review and ambulatory care review); and
- Actions or recommendations of a professional review body, based on the competence or professional conduct of a physician, which could adversely affect the health or welfare of a patient, and which could affect the clinical privileges or plan membership of the physician.

Accordingly, network providers and other peer review bodies (such as hospital quality review committees) may furnish information requested by the Highmark Quality Program and the confidentiality of such information will be maintained and protected pursuant to applicable state and federal laws.

West Virginia Code

For providers in West Virginia

Generally, the proceedings and records of a peer review organization are confidential, privileged, are not subject to subpoena or discovery proceedings, and are not to be admitted as evidence in any civil action arising out of the matters that are subject to evaluation and review.

However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil action merely because they were presented during proceedings of such organization. Please see W.Va. Code §30-3C-1 et seq. for additional information.

5.6 Disclaimers

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All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 7: Value-Based Reimbursement Programs

5.7 Payment Innovation (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

Highmark's network management methodology utilizes value-based reimbursement models, performance, and high-value networks and products. This strategy emphasizes efficiency and appropriateness over volume and waste, encourages provider/payer collaboration, and increases quality and cost improvement potential.

Highmark's value-based reimbursement strategy evaluates providers' ability to deliver the right care at the right time and in the most appropriate setting. Our value-based reimbursement programs place intense focus on care coordination and population health management principles.

Along with our focus on member incentives and social determinants of health, these initiatives will mature the care continuum to shared quality and cost accountability, with fully capitated reimbursement methodologies launching for high performers in 2019.

Primary Care Solution

For providers in Delaware, Pennsylvania, and West Virginia

Highmark launched the True Performance value-based reimbursement program in January 2017. True Performance is a contracted program that replaced all previous pay-for-value and quality incentive PCP programs across all of our service areas and member populations. In True Performance, physicians are rewarded for their performance on quality and cost/utilization metrics and may be eligible to earn monthly care coordination reimbursement and quarterly or annual lump sum reimbursement.

This program is designed to continue to improve the quality of health care delivered to our members while working to reduce the overall cost of health for our members. For our provider partners, True Performance reduces the complexity of multiple programs, offers a higher performance-based reimbursement opportunity, and provides timely and actionable reporting.

For additional information, please see the **True Performance** Program section of this unit.

Specialist Solutions

For providers in Delaware, Pennsylvania, and West Virginia

Highmark began transitioning specialist reimbursement toward risk through the Bundled Payment and Specialist Efficiency programs in 2018.

Highmark piloted bundled payment solutions using retrospective gain shares in 2018 and will progress from retrospective gain shares to prospective payments beginning in 2019. Bundled payments are based on high-volume, high-cost episodes of care (e.g., major joint replacement) using a solid foundation of nationally recognized grouper logic, such as Symmetry® Episode Treatment Groups® (ETG®) and Procedure Episode Groups® (PEG®) and the Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI).

To assist in impactful referrals, PCPs receive information on the highest-value specialists through Specialist Efficiency, which monitors cost and detects variability in care delivery within select specialties.

These specialties are associated with the highest reimbursements and, therefore, present the best opportunity to also enhance the value of the care our members receive. These cost profiles show PCPs which specialists provide the greatest value and help PCPs make more informed referral decisions. In addition, specialists will receive scorecards to help them observe care cost, detect variability in care delivery, and monitor adherence to care protocols.

Facility Value-Based Solution

For providers in Delaware, Pennsylvania, and West Virginia

Highmark's facility-based value-based reimbursement program, Quality Blue Hospital Pay for Value, is operational in all service areas. The Quality Blue Hospital Program is designed to help providers align care with industry standards and best practices to better manage the care our members receive and improve outcomes. Under the Quality Blue Hospital Program, facilities contract with Highmark to place a portion of their reimbursement "at risk," dependent on their performance on rigorous clinical quality and cost measures that align with those advanced through national organizations, including the National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA).

Incentives are paid on a retrospective performance basis. In addition to the clinical quality measures, the program includes measures for cost and utilization evaluation on select, high-volume episodes of care based on CMS BPCI logic and reduces wasteful spending while improving care.

Please see the **Quality Blue Hospital Pay for Value Program** section in this unit for additional program information.

Post-Acute Solutions

For providers in Delaware, Pennsylvania, and West Virginia

Helion, formerly known as HM Home & Community Services, is an independent company that provides post-acute network management services on behalf of Highmark Inc. and certain of its affiliated health

plans. Helion operates in two key areas in the post-acute space — Skilled Nursing Facilities (SNF) and Home Health (HH). The value-based reimbursement (VBR) programs have been developed for the SNF and HH care settings.

In our SNF program, our first priority is to minimize readmission rates, ensuring that members receive effective care during their initial stay. In addition, there is a focus to actively manage emergency department (ED) utilization, aiming to reduce unnecessary ED visits and enhance member outcomes. Lastly, SNF providers are able to closely monitor and manage the measured cost of care, promoting best practices in market. Our SNF models are currently operational in Delaware (DE), Pennsylvania (PA), and West Virginia (WV).

In the Home Health (HH) sector, the VBR programs prioritize quality metrics as well as cost metrics. This focus on quality metrics includes timely follow-up with primary care physicians (PCPs) or specialists, as well as timely initiation of care. In addition, there is an emphasis on reducing readmissions and ED utilization while ensuring costs are aligned. The HH VBR models are currently operational in Delaware, Pennsylvania, and West Virginia.

Episodic Payment Model

In 2021, Helion introduced an episodic payment model (EPM) for both SNF and HH providers. Our EPM empowers providers to earn additional incentives by caring for and managing members efficiently and effectively. The EPM is based on 30-day episodes for SNF providers and 60-day episodes for HH providers.These initiatives represent significant steps toward improving post-acute care quality and managing costs effectively. Helion will continue working to scale these successful programs across Highmark's entire footprint.

Clinically Integrated Networks (CINS)

For providers in Delaware, Pennsylvania, and West Virginia

Highmark is supportive of Clinically Integrated Networks (CINs) and strives to partner with as many providers as possible to ensure delivery of high-quality, affordable care. We will usually encourage their formation if strategic value is created for the provider(s) involved, and will design custom arrangements for them depending on their needs and aspirations.

Highmark is currently developing advanced reimbursement models that incorporate pay-for-value, shared savings, shared risk, and capitation for entities across our multi-state service area, and expects to see more partnerships with CINs in 2019 and beyond.

5.7 True Performance Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

True Performance, Highmark's flagship primary care pay-for-value program, offers primary care practices additional funds for managing their attributed population of Highmark members. Our True Performance value-based program is one of the largest PCP-based, private, value-based reimbursement programs in the country.

Physicians are rewarded for their performance on quality and cost/utilization metrics and may be eligible to earn monthly care coordination reimbursement, as well as quarterly or annual lump sum reimbursement. Timely and actionable reports are provided to give physicians regular insight into determining which care and referral decisions contribute to optimum results for quality, outcomes, and value.

In addition, True Performance meets the nationally consistent criteria for patient-centered, value-based care to be designated as a program of Blue Distinction® Total Care, an initiative of the Blue Cross Blue Shield Association. For more information, please see the **Blue Distinction Programs** section in the manual's **Chapter 5.1: Care Management Overview.**

Participants

For providers in Delaware, Pennsylvania, and West Virginia

True Performance is a contracted program offered to entities in Highmark service areas that have at least 250 uniquely attributed members, whose providers practice primary care, and who accept placement of approximately 30% of their revenue risk based on performance cost and quality metrics.

Reimbursement Opportunities

For providers in Delaware, Pennsylvania, and West Virginia

True Performance provides PCP practices with two reimbursement opportunities – Monthly Care Coordination and Performance Lump Sum.

Care Coordination is based on achieving quality thresholds for the practice's pediatric, adult, and senior patients. It accounts for 25% of potential total program reimbursement.

Lump Sum encompasses those same quality measure, plus three cost and utilization metrics – total cost per member per month (PMPM), emergency department utilization, and all-cause readmissions. Lump Sum accounts for 75% of total program reimbursement.

Participating practices that meet or exceed a minimum level of quality performance on their attributed membership receive risk-adjusted Care Coordination Reimbursement on a PMPM basis. Performance Lump Sum Reimbursement is paid on a quarterly or annual basis and is based on performance across both program components of Quality and Cost/Utilization. Calendar year performance determines the amount of Lump Sum Reimbursement earned as a percentage of maximum potential Lump Sum Reimbursement, which is based on a practice's attributed membership.

Quality Metrics

For providers in Delaware, Pennsylvania, and West Virginia

Risk-adjusted care coordination fees are advanced monthly for each attributed member as long as a minimum quality performance on 30 quality metrics, as scored by age group (e.g., pediatric, adult, senior), is maintained.

Industry-supported quality metrics are nationally sourced from National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) Stars and align with:

1. Avoiding Inappropriate Ambulatory Antibiotic Use
2. Adolescent Well-Care Visits
3. Well-Child Visits in the First 15 Months of Life
4. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
5. Childhood Immunization Status: Combination 10
6. Development Screening in the First Three Years of Life
7. Lead Screening in Children
8. Medication Management for People With Asthma
9. Cervical Cancer Screening
10. Comprehensive Diabetes Care: Medical Attention for Nephropathy
11. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
12. Breast Cancer Screening
13. Colorectal Cancer Screening
14. Comprehensive Diabetes Care: HbA1c Control (≤ 9%)
15. Medication Adherence for Diabetes Medication
16. Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA)
17. Medication Adherence for Cholesterol (Statins)
18. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
19. Statin Therapy for Patients With Cardiovascular Disease
20. Controlling High Blood Pressure
21. Annual EKGs or Cardiac Screening
22. Statin Use in Persons With Diabetes
23. Use of Opioids at High Dosage
24. Use of Opioids from Multiple Providers
25. Screening for Future Fall Risk
26. All-Cause Readmissions 2
27. Adult BMI Assessment
28. MTM Program Completion Rate for CMR
29. Osteoporosis Management in Women Who Had a Fracture
30. Annual Wellness and Initial Preventative Physical Exam Rate

31. Medication Reconciliation Post Discharge

Opportunities for Advanced Arrangements

For providers in Delaware, Pennsylvania, and West Virginia

In 2018, opportunities for both upside and downside shared risk arrangements were offered to select providers who excelled at cost and care management. True Performance will continue to serve as the foundational value-based program and select well-performing providers will be offered more advanced arrangements to increase their reimbursement opportunities through shared savings and/or shared risk in 2019 and beyond.

5.7 Quality Blue Hospital Pay for Value Program (DE, PA, and WV Only)

For providers in Delaware, Pennsylvania, and West Virginia

The Quality Blue Hospital Pay for Value Program is a contract-based initiative in which a hospital agrees to put a portion of its Highmark reimbursement at risk, contingent upon attainment of specified objectives in the areas of quality improvement and patient safety.

Purpose

For providers in Delaware, Pennsylvania, and West Virginia

Highmark seeks to improve the health of its members by bringing to the market an innovative approach that supports providers in continuously improving the care and services delivered to their patients and

our members. Highmark understands that an efficient health care delivery system promotes and maintains a high standard of quality and rewards cost-efficient care.

Highmark also understands that hospitals provide a unique opportunity to promote health care through collaboration, coordination, and communication among all providers by aligning services and enhancing the patient experience. This can be achieved by providing resource support, data sharing, aligning objectives, and encouraging care coordination across all aspects of care delivery.

Definition

For providers in Delaware, Pennsylvania, and West Virginia

The Quality Blue Hospital Program focuses on improving quality, controlling costs, and enhancing the member/patient experience. The Program components have been carefully designed to demonstrate value for Highmark, our customers and members, and our Participants, and support Highmark's Mission, Vision, and Values.

Program Participation

For providers in Delaware, Pennsylvania, and West Virginia

Eligibility in Highmark's Quality Blue Hospital Program requires Participants to have a current contract with Highmark for the period of July 1, 2019 through June 30, 2020 (hereafter fiscal year; "FY 2020").

In order to have a current contract for FY 2020, a hospital must meet the following criteria:

- The hospital has signed one or more Highmark network participating contracts that under the terms of such contracts will be in effect during FY 2020.
- The hospital is not in default under the terms and conditions of the aforesaid network contracts at any time during FY 2020.

- The hospital has not provided a notice of termination to Highmark or Highmark's regulators with respect to any Highmark network participating contract and such notice provides for termination prior to June 30, 2020 (for avoidance of doubt, this criteria is satisfied by the notice providing for a termination date prior to June 30, 2020, whether the contract is actually terminated on June 30, 2020).

Once enrolled in the program, contracted hospitals become eligible facility partners (hereafter, "Participants"). Participants are required to complete the following component metrics:

- Quality Bundle
- Readmissions
- 3-Day Returns to the Emergency Department (ED)
- Palliative Care for Complex Patients
- Follow-up Visits for Select Episodes of Care
- Average Episode of Care Costs for select episodes metric

For calendar year 2019 ("CY 2019"), Palliative Care for Complex Patients and Average Episode of Care Costs will not be an applicable measure for Specialty Care Hospitals since they predominantly treat certain diagnoses or perform certain procedures. Hospitals with employed physician practices will be required to complete the Quality Bundle metric.

Program Components

For providers in Delaware, Pennsylvania, and West Virginia

The Quality Blue Hospital Pay for Value Program focuses on key public health topics that have been identified nationally as areas of opportunity for improvement. For CY 2019, two component categories each with specific standardized metrics have been established to address these topics and include the following:

1. Quality:
    a. Quality Bundle
    b. Clinical Quality Measures
        i. Readmissions
        ii. 3-Day Returns to the ED

iii. Palliative Care Consults for Complex Patients
iv. Follow-up Visits for Select Episodes of Care

2. Cost and Utilization:
    a. Average Episode of Care Costs
        i. Major Joint Replacement of the Lower Extremity
        ii. Chronic Obstructive Pulmonary Disease (COPD),Bronchitis, Asthma
        iii. Esophagitis, Gastroenteritis, and Other Digestive Disorders
        iv. Sepsis v. Cardiac Arrhythmia
        v. Percutaneous Coronary Intervention
        vi. Simple Pneumonia and Respiratory Infections
        vii. Major Bowel Procedure
        viii. Spinal Fusion (non-cervical)
        ix. Stroke

Program Evaluation and Scoring

For providers in Delaware, Pennsylvania, and West Virginia

Participant performance will be monitored throughout the program year and dashboard reports will be shared quarterly in an effort to provide insight for further process improvements.

Performance measurement for the CY 2019 Program begins January 1, 2019, and concludes December 31, 2019. The claims-based reporting methodology requires that the measurement period begins in advance of the program start date to allow for sufficient time for data collection and claim run-out so that comprehensive and complete results can be provided. Individual metric measurement periods and, when applicable, baseline information can be found in the Program manual.

A final three month run-out period will be used on program components to identify all claims that should be included for performance measurement and scoring purposes. Participants are scored at the end of the program year.

Participants will be measured and scored on all program components for which they qualify. Participants with accountability for participating in all program component metrics have an opportunity to receive a

maximum of 100 points (105 points with potential Quality Bundle bonus points). Participants that do not meet the criteria for inclusion in all program components (due to specific component requirements or other exclusions) will have their applicable component scores converted to a score out of 100 percent.

Ongoing Changes to the Program

For providers in Delaware, Pennsylvania, and West Virginia

The Quality Blue Hospital Program continually evolves to meet the needs of Highmark and participating network facilities. Accordingly, the Quality Blue Hospital Program will be reviewed and revised annually.

For More Information

For providers in Delaware, Pennsylvania, and West Virginia

For additional information regarding the Quality Blue Hospital Program, contact the Provider Service Center.

5.7 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark

Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

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Chapter 6 – Billing and Payment

This chapter provides guidelines that apply to both electronic and paper billings and payments and is applicable to **both professional and facility providers**.

Unit 1: General Claim and Submission Guidelines

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications have become integral to health care. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically.

READ MORE

Unit 2: Electronic Claim Submission

All it takes is a computer, the proper software, and an Internet connection for electronic claims submission. Instead of printing, bundling, and sending paper claims through the mail, simply enter and store claims data through your office computer.

READ MORE

Unit 3: Facility (UB-04/8371) Billing

Highmark requires facility providers to bill electronically via 837 Institutional (837I) electronic transactions. HIPAA-compliant UB Claim Submission is also available in Availity®. In some cases, claim submission may be necessary on UB-04 paper claim forms.

READ MORE

Unit 4: Professional (1500/837P) Reporting Tips

Highmark's claim system places higher priority on processing and payment of claims filed electronically. This unit provides general guidelines applicable to both paper and electronic 1500/837P professional claim submissions.

READ MORE

Unit 5: The 1500 Health Insurance Claim Form

The 1500 Health Insurance Claim Form ("1500 Claim Form") answers the needs of many health care payers. It is the basic claim form required by many payers for paper claims submitted by physicians and other professional providers.

READ MORE

Unit 6: Coordination of Benefits

Coordination of benefits (COB) applies when a patient is covered by two or more health insurance policies. Highmark employs several processes to ensure the services provided to our members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

READ MORE

Unit 7: Payment/EOBs/Remittances

This unit addresses payment methodology for both professional and facility provider types, Explanation of Benefits (EOBs), the Facility Remittance Advice, guidance for overpayments and refunds, and special circumstances, such as payment for Federal Employee Program (FEP) members over 65 years of age.

READ MORE

Unit 8: Payment Review

Payment review[1] is a key element of the screening process Highmark uses to assure that members receive health care services that are medically necessary and that the claims for these services are submitted properly. This process also ensures that claims are being paid in accordance with provider agreements, while at the same time addressing the integrity of the payment calculated by Highmark.

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Unit 1: General Claim Submission Guidelines

6.1 Introduction to Claim Submission

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications have become integral to health care. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically.

This unit provides guidelines that apply to both electronic and paper claim submissions and is applicable to **both professional and facility providers.**

Required Formats

Use the table below to determine the required format for submitting claims:

If you submit...		Then use these formats...
Electronically	Professional	ASC X12N 837 Health Care Claim: Professional Transaction Version 005010 ("837P")
	Facility	ASC X12N 837 Health Care Claim: Institutional Transaction
On paper	Professional	1500 Health Insurance Claim Form ("1500 Claim Form"), Version 02/12
	Facility	UB-04 (CMS 1450) Institutional Claim Form

Note: If you are using paper forms, please submit the **original** red claim form. Photocopies or outdated versions of the 1500 or UB-04 forms will not be accepted and will be returned to the provider.

Reminder: Report Appropriate Place of Service on All Claims

Providers are required to report the most appropriate place of service on claim submissions. To ensure proper processing and reimbursement for your claims, please make sure you are accurately selecting the appropriate Place of Service (POS) code for all claims submitted.

Note: Please reference **Chapter 2.5: Telemedicine Services** for guidelines for reporting place of service for virtual visits and other telemedicine services.

For More Information

For information specific to submitting claims electronically, please see **Chapter 6.2: Electronic Claim Submission.**

For claim reporting tips and guidelines specific to professional providers or facility providers, please see the applicable unit:

- Facility: **Chapter 6.3: Facility (UB-04/837I) Billing**
- Professional: **Chapter 6.4: Professional (1500/837P) Reporting Tips** and **Chapter 6.5: 1500 Claim Form Guidelines**

6.1 Clean Claims

Definitions

A **clean claim** is defined as a claim with no defect or impropriety and one that includes all the substantiating documentation required to process the claim in a timely manner. The core data required on a claim to make it clean are outlined in this section and the next section.

Unclean claims are those claims where an investigation takes place outside of the corporation to verify or find missing core data. An example of this is when a request is sent to the member for information

regarding coordination of benefits. This may require obtaining a copy of an Explanation of Benefits (EOB) from the member's other carrier. Claims are also considered unclean if a request is made to the health care professional for medical records. Claim investigations can delay the processing of the claim.

Important!

You must provide us with the required information in order for the claim to be eligible for consideration as a "clean claim." If changes are made to the required data elements, this information shall be provided to network providers at least thirty (30) days before the effective date of the changes.

NUBC and NUCC Resources Available

A description of the data elements necessary to ensure that facility claims are without "defect or impropriety" can be found in the current **Official UB-04 Data Specifications Manual**. This manual is available from the National Uniform Billing Committee (NUBC) and can be found on their website at nubc.org.

For professional services, please see the current **1500 Health Insurance Claim Form Reference Instruction Manual** from the National Uniform Claim Committee (NUCC) and available at nucc.org.

6.1 Timely Filing Requirements

What is Timely Filing?

Timely filing is a Highmark requirement whereby a claim must be filed within a certain time period after the last date of service relating to such claim or the payment/denial of the primary payer, or it will be denied by Highmark.

Timely Filing Policy

Any claims not submitted and received within the time frame as established within your contract will be denied for untimeliness. If timely filing is not established within your contract, claims must be received within 365 days of the last date of service in Pennsylvania and West Virginia, and within 180 days of the date of service in Delaware, unless the member's policy provides for a different period.

If Highmark is the secondary payer, claims must be submitted with an attached Explanation of Benefits (EOB) and received within the same timely filing time frames as when Highmark is primary; however, the time frame is **based on the primary payer's finalized or payment date,** as shown on the EOB attachment.

New York Timely Filing Policy

For providers in New York

All initial claims (original bill type) must be submitted to Highmark Blue Cross Blue Shield and Highmark Blue Shield within 365 days from the date of service/discharge. The calculation begins from the date of service, discharge date, or last date of treatment up to 365 days, including weekends. All corrected claim submissions (bill type ending in 7) must be received within 365 days from the last date of processing of the original claim submission, including weekends. The last finalization date of the original claim will be utilized as the processing date. Claims that are submitted after the above outlined timeframe will be denied. Do not delay the billing of a claim for any reason.

If a claim denies for timely filing and you have previously submitted the claim within 365 days, resubmit the claim and denial with your appeal.

Timely filing does not apply to:

- Early Intervention Providers – There is no time limit
- Workers Compensation
- VA Hospital and Providers – 72 months timely filing

PA CHIP Timely Filing

For providers in Pennsylvania

The Pennsylvania Children's Health Insurance Program (CHIP) requires providers to submit all claims for services provided to CHIP enrollees to Highmark **within 180 days** from the date of service or discharge.

Highmark as Secondary Payer

When Highmark is a secondary payer, a provider must submit a claim within the timely filing time frames indicated above and attach an EOB to the claim that documents the date the primary payer adjudicated the claim. Secondary claims not submitted within the timely filing period will be denied and both Highmark and the member held harmless. Electronically enabled providers should submit secondary claims electronically using the proper Claim Adjustment Segment (CAS) code segments.

When it is known or there is a reason to believe that other coverage exists, claims are not paid until the other carrier's liability has been investigated. Highmark may send a letter/questionnaire to the covered person.

- If the covered person responds to the letter/questionnaire indicating that he/she is covered by additional policies, the records are marked to indicate that the other carrier information is required to complete claims processing when the other carrier's policy is primary.
- If the covered person does not respond promptly to Highmark's request for information, Highmark will deny claim payment using a remark code indicating the covered person is responsible. The provider may seek reimbursement from the covered person.

Note: Federal Employee Program (FEP) claims are not denied but are pended until a response is received from the covered person. Highmark will not provide benefits for these FEP claims until a response is received.

6.1 Prompt Payment Requirements

Pennsylvania

For providers in Pennsylvania

The Prompt Payment Provision of Pennsylvania's Act 68 of 1998 stipulates that health insurers pay "clean claims" within 45 days of receipt. The 45-day requirement only begins once all of the information needed to process the claim is obtained. The legislation mandates that interest penalties are to be paid to providers for claim payments issued more than 45 days from the receipt of the claim.

The following types of claims are excluded from the interest penalty requirement:

- Rejected (zero-paid) claims
- Voided claims
- Adjusted claims
- Administrative Services Only (ASO Accounts)
- Federal Employee Program claims
- BlueCard ITS home claims
- Claims with Provider Submission errors
- Claims for which the interest payment is calculated to be less than $2

Interest penalty payments are calculated on the basis of 10% per annum interest and the number of penalty days. **Penalty days** are the number of days beyond the 45 day parameter, which were required for the processing of the claim.

The formula for calculating Act 68 interest penalty payments is as follows:

[(annual interest % / payment days in a year) x Amount paid on the claim] x Penalty Days

or

[(.10/365) x Amount paid on the claim] x Penalty Days

Interest payments will appear on the remittance line for each claim to which they apply, and will be totaled for each segment of the remittance (e.g., Regular Utilization). The field titled “Interest Calc” on the Claim Detail page displays any prompt payment penalty interest that may apply to a particular claim. The interest information is also reported in the 835 Electronic Remittance.

Highmark consistently processes claims well within the 45-day requirement. In fact, clean claims submitted electronically receive priority processing and are finalized within 7 to 14 days. With this in mind, we encourage you to submit all claims electronically to take advantage of the faster processing.

Delaware

For providers in Delaware

Delaware Insurance Regulation 1310, Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services, requires that health insurers pay “clean claims” within 30 days of receipt. A clean claim is defined as a paper or electronic claim submitted on the appropriate form which includes data for all relevant fields provided in the format called for by the form. The regulation affords an additional time period when more information is needed to adjudicate the claim. The 30-day requirement begins when Highmark Delaware receives a clean claim.

West Virginia

For providers in West Virginia

The Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the “Prompt Pay Act” (“the Act”), applies to health insurance contracts insured by Highmark West Virginia, with certain exceptions. For claims subject to the Act, Highmark West Virginia adheres to the standards for processing and payment of claims established by the Act.

Highmark West Virginia will generally either pay or deny a clean claim subject to the Act within 40 days of receipt if submitted manually, or 30 days if submitted electronically. For clean claims subject to the Act that are not paid within 40 days, Highmark West Virginia will pay interest, at the rate of 10% per year, on clean claims, accruing after the 40th day. We will provide an explanation of the interest assessed at the time the claim is paid.

For more detailed information, please see the next section of this unit, **West Virginia Prompt Pay Act**.

6.1 West Virginia Prompt Pay Act

For providers in West Virginia

Applicability

The Ethics and Fairness In Insurance Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the “Prompt Pay Act” (“the Act”), applies to health insurance contracts insured by Highmark

West Virginia, with certain exceptions. For claims subject to the Act, Highmark West Virginia adheres to the standards for processing and payment of claims established by the Act. These standards are summarized in this section of this unit or are addressed in other locations of this manual. The Act does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To providers outside of West Virginia;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, Medicare Supplemental, and the West Virginia Public Employees Insurance Agency (PEIA);
- To most self-funded plans where Highmark West Virginia acts as a third party administrator;
- To BlueCard® claims;
- To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions);
- When there is a good faith dispute about the legitimacy of the amount of the claim;
- When there is a reasonable basis, supported by specific information, that a claim was submitted fraudulently or with material misrepresentation; or
- Where Highmark West Virginia's failure to comply is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond our reasonable control.

Payment of Clean Claims

Highmark West Virginia will generally either pay or deny a clean claim subject to the Act within 40 days of receipt if submitted manually, or 30 days if submitted electronically, except in the following circumstances:

- Another payer or party is responsible for the claim;
- We are coordinating benefits with another payer;
- The provider has already been paid for the claim;
- The claim was submitted fraudulently; or
- There was a material misinterpretation in the claim.

A **clean claim** means a claim: (1) that has no material defect or impropriety, including all reasonably required information and substantiating documentation to determine eligibility or to adjudicate the claim; or (2) with respect to which Highmark West Virginia has not timely notified the person submitting the

claim of any such defect or impropriety in accordance with the information in “Requests for additional information.”

Record of Claim Receipt

Highmark West Virginia maintains a written or electronic record of the date of receipt of a claim. The person submitting the claim may inspect the record on request and may rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim.

If we fail to maintain such a record, the claim will be considered to be received three business days after it was submitted, based upon the written or electronic record of the date of submittal by the person submitting the claim.

Requests for Additional Information

For claims subject to the Act, if Highmark West Virginia reasonably believes that information or documentation is required to process a claim or determine if it is a clean claim, then we will:

- Request such information within 30 days after receipt of the claim;
- Use all reasonable efforts to ask for all desired information in one request;
- If necessary, make only one additional request for information;
- Make such additional request within 15 days after receiving the information from the first request; or
- Make the second request only if the information could not have been reasonably identified at the time of the original request or if there was a material failure to provide the information initially requested.

Upon receipt of the information requested, we will either pay or deny the claim within 30 days.

We cannot refuse to pay a claim for covered benefits if we fail to request needed information within 30 days of receipt of the claim, unless this failure was caused in material part by the person submitting the claim. Highmark West Virginia is not precluded from imposing a retroactive denial of payment of such a claim, unless this denial would be in conflict with the Act’s standards on retroactive denials.

Interest

For clean claims subject to the Act that are not paid within 40 days, Highmark West Virginia will pay interest, at the rate of 10% per year, on clean claims, accruing after the 40th day. We will provide an

explanation of the interest assessed at the time the claim is paid.

Limitation on Denial of Claims Where Authorization, Eligibility, and Coverage Verified

Under the terms of its health plan contracts, Highmark West Virginia will reimburse for a health care service only if:

- The service is a covered service under the member's plan;
- The member is eligible on the date of service;
- The service is medically necessary; and
- Another party or payer is not responsible for payment.

If Highmark West Virginia advises a provider or member in advance of the provision of a service that: (1) the service is covered under the member's plan; (2) the member is eligible; **AND** (3) via pre-certification or pre-authorization, the service is medically necessary, then we will pay a clean claim under the Act for the service unless:

- The claim documentation clearly fails to support the claim as originally pre- certified or pre-authorized;
- Another payer or party is responsible for the payment;
- The provider has already been paid for the service;
- The claim was submitted fraudulently or the pre-certification or pre- authorization was based in whole or material part on erroneous information provided by the provider, member, or other person not related to Highmark West Virginia;
- The patient was not eligible on the date of service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;
- There is a dispute regarding the amount of the charges submitted; or
- The service provided was not a covered service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, at the time of verification that the service was not covered.

Retroactive Denials

Under the Act, Highmark West Virginia may retroactively deny an entire previously paid claim insured by Highmark West Virginia for a period of one year from the date the claim was originally paid. The Act and its one-year time limit does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To contracted providers outside of West Virginia;
- To claims paid under an ERISA self-funded plan;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, and PEIA;
- When a good faith dispute about the legitimacy of the amount of the claim is involved (e.g., disputed audit findings during the resolution process);
- Where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g., fire, pandemic flu);
- Where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g., Unclaimed Property Act);
- To BlueCard claims; or
- To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions).

Provider Recovery Process

Under the Act, upon receipt of a retroactive denial, the provider has 40 days to either: (1) notify Highmark West Virginia of the provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Highmark West Virginia within 30 days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation.

Highmark West Virginia will notify the provider of its final decision within 30 days after receipt of the provider's notice of dispute. If the retroactive denial is upheld, the provider must pay the amount due within 30 days or the amount will be offset against future payments

6.1 Self-Funded Accounts

Policy

Highmark acts **only** as a third-party administrator for a self-funded benefit plan (i.e., the benefits are not insured by Highmark and our services are administrative only). We shall not be required to pay a provider's claim for services rendered to a member of the self-funded plan unless and until the self-funded plan pays or reimburses Highmark for the amount of the claim and the administrative cost to process and pay the claim. Highmark does not insure, underwrite, or guarantee the responsibility or liability of any self-funded plan to provide benefits or to make or administer payments.

If a self-funded plan fails to provide payment or reimbursement to Highmark to fund claims (whether such claims have been paid already by Highmark or not), then a provider shall not hold Highmark liable, but must look to the self-funded plan or the patient for payment. Highmark may demand the return of any payment to the provider, or may set off against amounts owed to the provider, for any claims for which a self-funded plan fails to make payment or reimbursement to Highmark.

Identifying Members

Member ID cards identify members of self-funded accounts. Providers may contact the telephone number on the back of the card to inquire about the current eligibility status of the member, or current funding status of the self-funded account.

Special Circumstances for Terminated Accounts

Upon termination of a self-funded group, Highmark will continue to process claims for a period of time as specified in the terminated self-funded account's contract. This is otherwise referred to as a "run-out period." Often the run-out period is less than 12 months, and claims received after this period will be denied.

6.1 New Patient vs. Established Patient

Certain evaluation and management (E&M) Current Procedural Terminology (CPT®) codes distinguish between new and established patients. New patient visits are reported with procedure codes 99201, 99202, 99203, 99204, or 99205. Once the provider establishes a new patient, subsequent visits should be billed with 99211, 99212, 99213, 99214, or 99215.

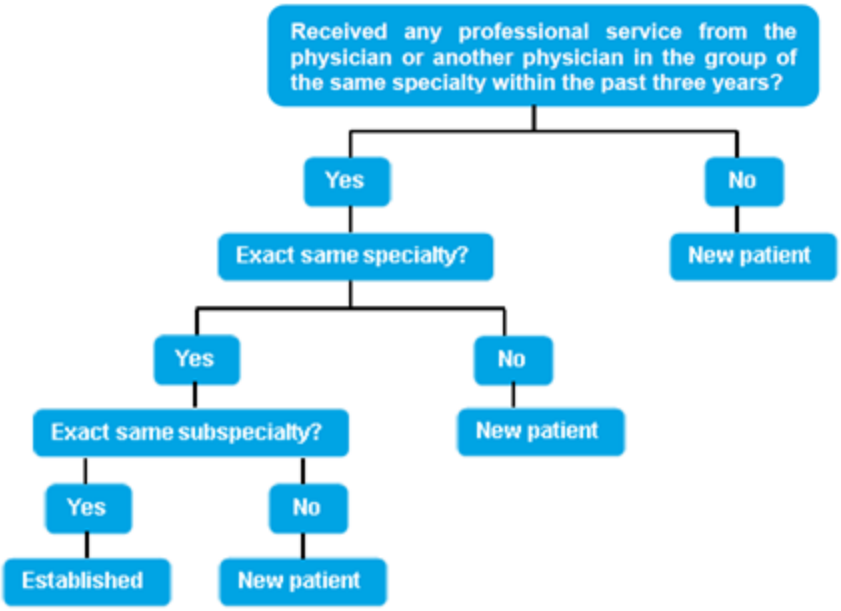
CPT Guidelines for New vs. Established Patients

The 2015 CPT guidelines define new and established patients according to the “three-year” rule.

- A new patient is “one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”
- An established patient is “one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

CPT Decision Tree for New vs. Established Patients

The “Decision Tree for New vs. Established Patients” from the CPT E/M Services Guidelines is reproduced here and can be used to help you determine if a patient is new or established.



6.1 Service Facility Location

Providers are required to report all locations to Highmark so they can be properly enumerated in our system. For professional providers, this includes all practice locations, while facilities must report all off-

campus locations. When submitting claims, the **actual location where services were delivered must always be reported** to avoid unnecessary processing delays, claim denials, or refund requests.

The **Service Facility Location** field on a claim is used to report the physical location where the services were performed. Highmark requires professional and facility providers to always complete the Service Facility Location when the location where services were rendered differs from the billing address being reported on the claim **or** from the main facility location (e.g., services delivered at a hospital's off-site outpatient surgery center).

It is also important to complete the Service Facility Location field to easily locate your patients' medical records when necessary. Highmark requests records for Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality improvement activities. Identifying the place where services are rendered eliminates unnecessary calls to provider offices to locate medical records.

Important!

A physical street address **must** be reported for the Service Facility Location — a P.O. Box or lock box will not be accepted.

Professional Claims (837P/1500)

The Service Facility Location is reported on professional claims as follows:

- Electronic 837P: **Loop 2310C**
- Paper 1500 claim form: **Item# 32 a, b, c**

For additional information for completing Item #32 on the 1500 claim form, please see the manual's **Chapter 6.5: 1500 Claim Form Guidelines.**

For more information on submitting professional claims via Availity, Click here.

Facility Claims (837I /UB-04)

Facilities report the Service Facility Location as follows:

- Electronic 837I: **Loop 2310E**
- Paper UB-04 claim form: **Form Locator 01**

For more information on submitting professional claims via Availity, Click here.

6.1 Diagnosis Code Reporting

International Classification of Diseases (IDC)

The International Classification of Diseases (ICD) is a medical code set maintained by the World Health Organization (WHO). It was developed so that medical terms reported by physicians, medical examiners, and coroners can be grouped together for statistical purposes.

ICD-10 Compliance

Effective October 1, 2015, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is the standard for reporting patient diagnoses, replacing ICD-9-CM. ICD-10 provides more specific data than ICD-9 and better reflects current medical practice. The added detail embedded within ICD-10 codes informs health care providers and health plans of patient incidence and history, which improves the effectiveness of case management and care coordination functions. **Highmark will accept only ICD-10-CM diagnosis codes on claims for dates of service October 1, 2015 and after.**

Please Note: ICD-10 diagnosis code reporting does not directly affect provider use of the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

Highest Level of Specificity Required

Highmark requires you to report the highest level of specificity when reporting diagnosis codes on medical-surgical claim forms.

Since Highmark's claims processing system applies medical payment guidelines based on diagnosis codes, you must report the most appropriate diagnosis code(s) on every claim. The diagnosis must be valid for the date of service reported.

Document and Code All Coexisting Conditions

The Centers for Medicare & Medicaid Services (CMS) instructs providers to code all conditions that coexist at the time of a visit and impact the member's treatment plan or management of their care.

Do not report conditions that previously existed but are no longer being treated.

Be as Accurate as Possible

Highmark will reject your claims for payment if you submit them without complete or accurate diagnosis codes.

6.1 Reporting National Drug Codes

Converting NDCS from 10-Digits to 11-Digits

Many National Drug Codes (NDCs) are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10- digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format.

The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted additional "0" is in a **bold font and underlined** in the following example. Note that hyphens indicated below are used solely to illustrate the various formatting examples for NDCs. **Do not use hyphens when entering the actual data in your paper claim form.**

Converting NDCS from 10-Digits to 11-Digits

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01 Zyprexa® 10mg Vial	**0**0002759701

5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62 Xolair® 150mg vial	50242**0**04062
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60575-4112-1 Synagis® 50mg vial	6057541120**1**

6.1 Additional Diagnostic Code Reporting (New York Only)

For providers in New York

Lesions

The CPT4 codes for lesion treatments include specific verbiage that needs to be considered in determining whether more than one unit of service or line of service can be billed for a code and if any other codes can be billed with it. Listed below are the CPT4 codes and the maximum number of units that should be reported on a claim for a date of service.

Code Verbiage	Maximum Units
11055 Paring or cutting of benign hyperkeratotic lesion (e.g. corn or callus); single lesion	01

11056 Two to four lesions	01
11057 More than four lesions	01
17000 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curretement), premalignant lesions (e.g., actinic keratoses); first lesion	01
17003 Second through 14th lesion, each (list separately in addition to code for first lesion)	13
17004 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curretement), premalignant lesions (e.g., actinic keratoses), 15 or more lesions	01
17110 Destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions	01

17111 15 or more lesions • No more than one of the following codes can be reported for an encounter: 11055, 11056, 11057 • 17003 can only be billed with 17000. Do not report 17004 in conjunction with codes 17000 or 17003 • Code 17111 cannot be reported with 17110	01

Mammography

Please be sure to use the appropriate CPT codes when billing mammography to differentiate diagnostic from screening.

Diagnostic codes should be used when the procedure is ordered because of a suspicion of breast disease (due to symptoms or clinical findings), patient history of breast cancer or biopsy proven breast disease.

Screening mammography

A screening code should be used when the procedure is done as a baseline or on a routine basis.

Multiple, Bilateral, and Multiple Bilateral Procedures

Surgical

In accordance with Current Procedural Terminology (CPT) guidelines, bilateral procedures should be billed on one line only, utilizing the modifier 50; enter one as 01 in the units field and bill your total bilateral charge.

Bilateral Billing Examples

- Bilateral breast reconstruction – report as code 19357 with modifier 50 on one claim line with 01 in the units field.
- Bilateral lower and upper blepharoplasties – report as:

- 15820 with modifier 50 on the first claim line with 01 units
- 15822 with modifier 50 on the second claim line with 01 units

Note: For bilateral services, do not bill modifier LT/RT or any other site- specific modifier other than 50.

Multiple Procedures

Separate billing is allowed for multiple procedures performed on the same day **that add significant time or complexity and are not incidental or an integral part of the primary procedure**. The primary procedure is reimbursed at the fee schedule amount; eligible secondary procedures are reimbursed at 50 percent.

Multiple procedures that involve the **same service** performed more than once (such as CPT code 26100, arthrotomy of each carpometacarpal joint of the left hand), **should be billed as five separate lines on the claim form** along with the modifier 59 or the HCPCS individual digit modifiers on lines two through five in order to clarify that the additional lines are definitely separate services.

Procedure code descriptions including more than one unit of service provided, (such as code 95117, professional services for allergy immunotherapy, two or more injections, or code 96406, intralesional injections, more than seven lesions), **are reported on one line with only one unit.**

Final reimbursement is also determined after applying usual edits such as (but not limited to) preauthorization, cosmetic coverage and bundling. In addition, the member's contract must be active at the time the service is rendered.

Physician Exceptions (Does not apply to hospital category reimbursement)

When the CPT code description includes: "each additional" (for example, code 63048, laminectomy, each additional cervical, thoracic, or lumbar segment), **report the code on one line with the number of additional segments indicated in the units field.**

When the CPT code states: "specify number of tests, doses" (such as code 95024, intradermal tests with allergenic extracts), **report the code on one line with the number of tests, doses, etc., indicated in the units field.**

Non-Ionic Low Osmolality Contrast Media

Contrast media will not be considered for separate payment and cannot be billed to the patient. Reimbursement for contrast media is included in the allowance for the radiology service. To maintain

accurate records of the use of non-ionic contrast media, use the appropriate CPT/HCPCS code.

Sleep Studies

Modifier 26 (for the physician component/CMS 1500 or 837P claim) and modifier TC (for the hospital or technical services/UB04 or 837I claim) must be used when a sleep study is performed at a hospital or affiliated clinic.

The policies and procedures referenced in this section represent our standard for claims submission, payment, and adjustment. Certain providers may be subject to different guidelines due to contractual limitation or expansions.

	Type of Claim	Revenue Codes	Bill Type	CPT Codes	*Roll-Up/Reimbursem
1	Ambulatory Surgery	0360-0361, 0490, 0750, & 0790	131	Yes Valid Category CPT Code Required	Yes/Category and con may allow for additic reimbursement of elig implantable prosthe devices (revenue coc 274 & 278), pacemak (revenue code 275 Eligible secondary procedures pay at 5 percent.
1a	Cancelled Ambulatory Surgery	0360-0361, 0490, 0750, & 0790	131	Yes Valid Category CPT Code Required	Bill Claim with Occurr Code 43. Reimbursen based on record revie use modifier 53.

2	Emergency Room/"Urgent Care" Service within Emergency Department	0450, 0459	13X	Yes 99281-99285	Yes/Case Rate
2a	ER Physician Fee	0981 (For hospital employed MD's only)	13X	Yes	No/Fee Schedule
3	Observation	0762	13X	No	Per diem/per case, pa addition to ER
4	Urgent Care Centers	456	89X 13X	Yes 99201-99205 99211-99215 99281-99285	YES/All-inclusive case (fee schedule)
5	Clinic	Must be billed on a HCFA1500/ANSI837 Professional Form.	N/A	Yes	NA / Follows physici reimbursement guidel TC split for Medica Primary will be accep on a UB92.

6	Chemotherapy*	0280-0289, 0331, 0332, 0335	13X	No	Identified high-cost dr labs and diagnostics according to your schedule of allowan
7	Radiation Therapy	0330, 0333, 0339	13X	Yes	NA/Services pay according to your schedule of allowanc addition to identified h cost drugs, labs an diagnostics.
9	Home Infusion Therapy	0640 - 0649	33X 34X	Yes	No / Schedule of allowance
8	Transfusion*	0390, 0391	13X	Yes - 391 36430-36460	NO / Blood Storage Processing (Rev Code is not payable. Identi high-cost Injectable dı diagnostic services a labs pay according to schedule of allowan
9	Cast Room*	0700, 0709	131	No	Labs, diagnostic serv and durable medic equipment pay accor to fee schedule.
10	Infusion Therapy*	0260-0269	131	No	Labs and diagnosti services pay per yo

					schedule of allowan Drugs are paid accor to guidelines indicate "High-Cost Drugs' (category #28).
11	Dialysis	0820, 0821, 0830, 0831, 0840, 0841, 0849, 0850, 0851, 0859	13X 72X	Yes, per contract	Ancillaries paid in add if not included in composite reimbursement.
12	Epogen	0634-0635	13X 72X	Yes	No/Per Unit. Appropr HCPCS code should billed indicating uni given in unit field or u value code 68
13	Pre-Admission Testing		13X	Yes	Refer to Guidelines f Diagnostics. Bill wi Occurrence Code 41. up to ambulatory surgery/IP stay.
14	False Labor	0720 - 0729	13X	No	Per contract, ER pe diem/case rate is pa 59025 present should schedule of allowan
15	Recovery Room	0710 - 0719	13X	No	Roll-up to ambulato surgery, ER or Observa Will not pay if billed al

16	Ambulance	0540 - 0549	131	N/A	Charges (Should not up if billed with 450 -
17	Cardiac Rehab	0943	131	Yes	Schedule of Allowan Follow applicable prot for guidelines and limitations
18	Diagnostic Testing	0300-0309, 0310-0319, 0340-0349, 0350-0359, 0400-0409, 0460-0469, 0470-0479, 0480, 0482, 0489, 0610-0619, 0621-0622, 0720, 0730-0739, 0740-0749, 0920-0929	131	Yes	Schedule of Allowar
21	Durable Medical Equipment (DME)	0290 - 0293, 0299, 0946, 0947	13X	Yes	Schedule of Allowar
19	Electric Shock Psych / Other	0900, 0901, 0902, 0919	13X	Yes	Schedule of Allowar
20	OP/Alcohol/Drug	0905, 0912, 0914, 0915, 0916, 0944, 0945	13X 89X	Yes	Schedule of Allowar

21	Therapies PT, OT, ST	0420-0429, 0430-0439, 0440-0449, 0530-0539, 0940-0941, 0949	13X	Yes	Schedule of Allowanc each per day
22	Fetal Non-Stress	0720	131	Yes (59025)	Schedule of Allowar
23	Hospice	065X	81X 82X	N/A	Flat rate per visit; i Medicare eligible ar member elects int Hospice Care, Medica responsible for all cla
24	Home Health Care	055X , 056X, 057X, 042X, 043X 044X	33X 34X	N/A	YES/Pays off reven code per visit except code 572 - HHA whi pays per hour.
25	Prosthetics and Implantables	0274, 0278, 0275	13X	HCPCS	Category and contra may allow addition payment for eligibl implantables. Paym equal to invoice cos subject to post-paym audit. 0276 Intraocu lenses are included i category 6 or 8 surg

26	Treatment Room*	0760, 0761	13X	Yes	Pays according to yo schedule of allowan
27	Inhalation Therapy	0410 - 0419	131	Yes	Pays according to yo schedule of allowar
28	High-Cost Drugs	0636	131	Yes (HCPCS)	Pays according to yo schedule of allowan
29	Supplies	0270, 0271, 0272, 0273, 0277 & 0279	131	No	These revenue codes not be paid if billed w unbundled service
30	Miscellaneous Pharmaceuticals	0250-0259	131	No	These revenue codes not be paid if billed w unbundled service
31	Sleep Studies/ Polysomnography	0740, 0920	131	95805-95811	Payable per fee schec
32	Lithotripsy	360, 490, 790	131	Yes Valid Category CPT Code Required	0290 - 0293, 0299, 09 0947YES / Seconda procedures pay at 5 percent.

*Service could pay up to $50 per day for room charge.

6.1 Reporting Workers' Compensation Related Services

Workers' compensation insurance covers medical expenses for work-related injuries or illnesses. Highmark is not liable to pay claims for members under these circumstances, unless the services are determined to be ineligible under workers' compensation benefits. Highmark employs several processes to ensure the services provided to our members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

In order for our members' medical services to be paid in a timely manner, network participating providers must assist in our efforts by properly reporting on claim submissions when services were for employment-related conditions or injuries.

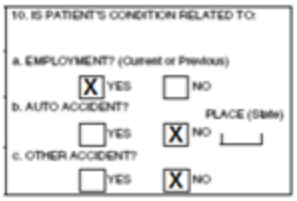
Guidelines are provided below for the additional fields required on claims when reporting services related to workers' compensation on both professional and facility claims.

Reporting on the 1500 Claim Form

Item Numbers 10 and 14 must be completed on the 1500 claim form when reporting professional services related to workers' compensation.

Item #10 – Is Patient's Condition Related To:

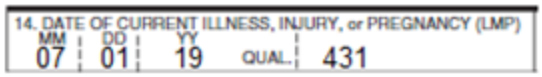
- Enter an "X" in **Yes** for **Employment (10a**) to indicate whether one or more of the services reported in Item#24 is for a condition or injury that occurred on the job.
- Place an "X" in NO for 10b and 10c.



Item #14 – Date Of Current Illness, Injury, Or Pregnancy (LMP):

- Enter the date of onset of the work-related illness or the date of injury in 6-digit format (MM|DD|YY).

- Enter qualifier **431** (Onset of Current Symptoms or Illness) to the right of the vertical dotted line.



Note: If known, additional information that would assist in the processing of these claims can be included to avoid any unnecessary delays in finalizing the claims (e.g., workers' compensation insurer information or claim denial notice from workers' compensation).

Reporting on the 837P

For professional electronic claims (837P), the following crosswalk outlines the required fields on the 837P that correspond to the required fields on the 1500 claim form:

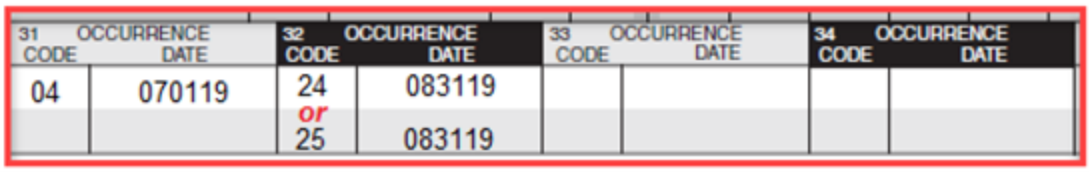
1500 Form Locator 837P

Item#	Locator Description	Loop ID	Segment/ Data Element	Code	Electronic Description
10a	Is Patient's Condition Related To: Employment?	2300	CLM11	EM (Employment)	Related Causes Code
14	Date Of Current Illness, Injury, Or Pregnancy (LMP)	2300	DTP01 DTP03	431 D8 (CCYYMMDD)	Onset of Illness Date or Accident Date

Reporting on the UB-04 Claim Form

For facilities submitting claims for services that are work-related and for which workers' compensation may apply, **Locator 31: Occurrence Code and Date** must be completed on the UB-04 (CMS 1450) claim form in addition to all other required fields.

You must enter **Occurrence Code 04** to indicate services are "Accident/Employment Related." And then enter the date of onset of the work-related illness or the date of the work-related accident in 6-digit format (MMDDYY):



31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE
04	070119	24	083119				
		or					
		25	083119				

In addition, either Occurrence Code 24 **or** 25 must be entered to report a denial of the claim by the workers' compensation insurer or the termination of workers' compensation coverage.

- **Occurrence Code 24 = Date Insurance Denied.** Code indicating the date the denial of coverage was received by the health care facility from any insurer.
- **Occurrence Code 25 = Date Benefits Terminated by Primary Payer.** Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.

Note: If known, additional information that would assist in the processing of these claims can be included to avoid any unnecessary delays in finalizing the claims (e.g., workers' compensation insurer information or claim denial notice from workers' compensation).

Reporting on the 837i

For institutional electronic claims (837I), the table below identifies the required fields that are equivalent to Locator 31 on the UB-04 for entering occurrence codes and corresponding dates for work-related services.

UB-04 Form Locator	837I

Locator	Locator Description	Loop	Segment	Code	Electronic Description
31	Occurrence Code/ Date	2300	HI01-1 HI01-3	BH (04 & either 24 or 25) D8 (CCYYMMDD)	Occurrence Code/ Date

For More Information

To learn more about the processes applied when Highmark members have coverage under another insurer(s), please see **Chapter 6.6: Coordination of Benefits**.

6.1 Documentation Requirements

Highmark requires that patient records document every service submitted for payment. This includes diagnostic tests, medical care, surgery, and any other services eligible for payment by Highmark.* You should not routinely submit this documentation with your claims except in circumstance when required (e.g., when using modifier 22). If documentation is needed, Highmark will request it. Please retain your office records for audit purposes.

Hospital and office records must verify that a service: 1) was actually performed; 2) was performed at the level reported; and 3) was medically necessary. The services billed by the provider must be documented by personal notes and orders in the patient's records.

**In Pennsylvania, regulations issued by the Pennsylvania Board of Medical Education and Licensure support this policy.*

Criteria for Documentation Submission

Highmark will use this criteria to determine if the provider has met the appropriate documentation requirements:

- Hospital medical visits: The admission and discharge records, doctor's orders, and progress notes should clearly reflect the type, level of care, and medical necessity of treatment billed by the doctor. The records not only should reflect the doctor's personal involvement in treating the patient, but also should reflect and be co-signed by the interns and residents who write the progress notes and order sheets;
- Surgical services: The operative report should indicate the name of the surgeon who performed the service. Minor surgical procedures not requiring an operative note must be documented in the progress notes. Also, the records should indicate the condition or diagnosis that documents the medical necessity for the surgery;
- Consultation: A consultation includes a history and an examination of the patient by a consultant whose services were requested by the attending physician. There should be a written report signed by the consultant. Additionally, the medical necessity for the consultation must be documented;
- Anesthesia: The anesthesia and/or operative report should indicate the name of the person who actually performed the anesthesia service. Anesthesia time units begin when the doctor begins to prepare the patient for induction and ends when the patient may be safely placed under postoperative supervision and the doctor is no longer in personal attendance. The records should reflect the actual time units reported;
- Medical reports: Office records should contain the patient's symptoms and/or complaints, diagnoses, tests performed, test results and treatment given or planned. In addition, the copies of hospital records should be clear and readable. In cases involving concurrent medical care, the consulting physician should submit these records with the request for review;
- Emergency medical/accident: Claims for emergency medical and emergency accident services always should include a date of onset and a date of service. Emergency medical services should be reported with the appropriate evaluation and management code, the ET (emergency services) modifier, and a diagnosis code that reflects an emergency medical service.

6.1 Claim Status Inquiries

Providers can check the status of a claim by using Availity® Claim Status or the 276/277 Health Care Claim Status Request and Response transactions. For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

Claim Status

Claim Status in Availity lets you view real-time, detailed claims information for any member, whether claims were submitted electronically or on paper. You can track the status of a claim from the start of the adjudication process until the time of payment.

To check the status of a claim in Availity:

1. In the Availity Essentials menu bar, select **Claims & Payments** | **Claim Status**.
2. Search for claims by member in the **Member Search** tab.

276/277 – Health Care Claim Status Request and Response Transaction

The HIPAA-mandated 276/277 electronic claim status request and response are a paired transaction set — the 276 transaction is used by the provider to request the status of a claim(s) and the 277 transaction is used by the payer to respond with information regarding the specified claim(s). The response returned by the payer indicates where the claim is in the adjudication process (e.g., pending or finalized). If finalized, detailed information is provided on whether the claim is paid or denied, and if denied or rejected, the reason is included.

Highmark will accept and return 276/277 transactions in Version 5010 format only. These transactions will only be accepted and returned via real-time; trading partners are not able to submit electronic inquiry transactions in a batch mode.

Information about the 276/277 transactions can be found in the *EDI Guide*, available on the Electronic Data Interchange (EDI) website. To access the website from the Provider Resource Center, select **Claims & Authorization** then **Reimbursement Resources.** Links to **Electronic Data Interchange (EDI) Services** are on that landing page; or you can click on the applicable link below to access the applicable site directly:

- Pennsylvania: highmark.com/edi

- Delaware: highmark.com/edi-bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

Providers in all regions can contact Highmark EDI Services by telephone at **800-992-0246**.

6.1 Claim Inquiry

A claim inquiry is the ordinary means providers use to communicate their questions regarding pending, paid, or denied claims.

When Claim Inquiry is Appropriate

An inquiry should be submitted if the provider has a question about the status of a claim. Complete research should be completed by the provider prior to submitting the inquiry. A claim inquiry is appropriate if any of the atypical situations listed below occurs:

- A claim has been pending for more than 45 days beyond the received date
- A claim has been paid, but the facility questions the payment amount
- A claim is denied and the facility questions the denial reason

Claim inquiries can be launched from Availity® by selecting **Message this Payer** from the claim detail in **Claim Status.**

276/277 Health Care Claim Status Request and Response Transactions

Claim inquiry can also be done using the 276/277 Health Care Claim Status Request and Response electronic transactions. Information about the 276/277 transactions can be found on the Electronic Data Interchange (EDI) website.

To access the EDI Services website from the Provider Resource Center, select **Claims & Authorization** then **Reimbursement Resources**. Links to **Electronic Data Interchange (EDI) Services** are on that landing page; or you can click on the applicable link below to access the applicable site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/edi-bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

Providers in all regions can contact Highmark EDI Services by telephone at **800-992-0246**.

6.1 Highmark's Internal Billing Dispute Process

Disputes Overview

Any provider who treats a Highmark member has the right to dispute claims payment decisions made by Highmark. **Any claim dispute between a provider and Highmark arising from a provider's request for payment is solely a contract dispute between the provider and Highmark, and does not involve any other party.** Accordingly, it is important to note that the dispute must not be made against the plan through which a member receives benefits. This limitation applies to plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) and/or the Patient Protection and Affordable Care Act of 2010 (PPACA).

Please note that neither plans nor plan sponsors are parties to any contracts with providers. The terms as to which providers are bound by are governed by its contract with Highmark. Such provider contracts are not binding upon any plan or plan sponsor.

Anti-Assignment Provisions

All Highmark insurance policies for members contain anti-assignment provisions. This means that a provider cannot be a "participant" or "beneficiary" or "receive benefits" (covered services) under the terms of a member's plan (whether insured or self-insured). Only members are entitled to receive benefits. **As a result, a provider cannot dispute a claim with benefit plans or plan sponsors in the event a member's benefits are denied in whole or in part.**

Submitting A Billing Dispute

Highmark offers several ways for providers to express dissatisfaction with their claims payment or lack thereof. Network participating providers may:

- Submit an inquiry using Message this Payer in Availity®
- Call Provider Services
- Send written correspondence to Customer Service

It is the provider's responsibility to submit all necessary information about the billing dispute and any additional documentation. If Highmark determines there is incomplete information, the provider will be contacted to provide the necessary information.

Billing Dispute Process

Once all documentation is received, a billing dispute is routed to the appropriate department for research and review. A service representative will review the applicable claim(s) and determine whether the claim(s) processed correctly.

Individual departments within Highmark have varying levels of review and will notify the provider at various stages of the review, as applicable. In certain instances, internal billing dispute processes are considered final. In cases where eligibility requirements are met, further billing dispute resolution processes may be available.

No matter the outcome, each provider who submits a billing dispute will receive notification advising them of the outcome and the reason for the decision. Actions will be taken to remedy the billing dispute, if the provider's contention was correct.

BlueCard®

Please contact Highmark directly for billing disputes rather than contacting the out-of-area member's Home Plan.

Unresolved Disputes

For providers in Pennsylvania

In Pennsylvania, a billing dispute with a health services doctor (as defined in 40 Pa. C.S.A. Section 6302) which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration.

6.1 Top Billing Errors – and How to Avoid Them

Common Claims Reporting Errors

Claims processing experts identified these top errors that cause claims to process incorrectly.

Some common reporting errors...	Correction
Incorrect provider number listed	Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner. If practices are unsure which National Provider Identifier (NPI) to use (assignment account/group or individual practitioner/group member), they should contact Highmark Provider Services using the Highmark provider portal.
Performing provider name and number	The performing provider name and provider identification number should be reported on the claim when it is different than the billing provider identification number.
Invalid place of service codes submitted and/or the facility name and number is not listed	Ensure the correct place of service code is being used. When the place of service is different than the billing provider's address (e.g., Hospital or Skilled Nursing Facility),

	ensure a service facility location and identification number are reported.
NOC (not otherwise classified) codes listed without descriptions	Descriptions of the service provided must be reported on the claim for NOC codes.
Applicable coordination of benefits/other insurance information and/or documentation is not accompanying the claim	Please make an effort to report electronically or attach coordination of benefits/other insurance information.
Member identification numbers are incomplete	List the complete member identification number including any alpha prefix.
Claims are range-dated but the number of services do not clearly correspond with the date range (e.g., indication that services were performed 01-01-23 through 01-10-23 but list only five services)	When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range-dating (indicating that services span from one date through another date). If they do not correspond on a one-to-one basis, you should itemize the services.
Submit Healthcare Common Procedure Coding System (HCPCS) codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2022 with a code that was not in place until 2023, or vice versa).	Report correct procedure codes that are valid for the date of service.

Invalid diagnosis code	Report diagnosis codes that are the highest degree of specificity and valid for the date of service.

6.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 2: Electronic Claim Submission

6.2 Benefits of Electronic Claim Submission

All it takes is a computer, the proper software, and an Internet connection for electronic claims submission. Instead of printing, bundling, and sending paper claims through the mail, simply enter and store claims data through your office computer.

Faster Claim Payment

Electronic claims are convenient, confidential, and operational around the clock. Highmark's claim processing system places a higher priority on claims filed electronically. Electronic claims will typically process in seven to 14 calendar days, whereas paper claims will process in 21 to 27 calendar days.

Regulatory Compliance

The payment progress targets defined above that are used in Pennsylvania are in compliance with timely claims payment regulations defined by Pennsylvania's Act 68, and reflect processing of clean claims that do not require manual intervention or investigation.

The payment progress targets defined above that are used in Delaware are in compliance with timely claims payment regulations defined by Delaware Insurance Regulation 1310, and reflect processing of clean claims that do not require investigation.

In West Virginia, the payment progress targets defined above are used and are in compliance with the timely claims payment regulations defined by the Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the "Prompt Pay Act", and reflect processing of clean claims that do not require investigation.

For more information on these regulations, please see the manual's **Chapter 6.1: General Claim Submission Guidelines.**

Cost Effective

Electronic claim submission increases staff productivity by speeding claim preparation and delivery. Many of the paper claim processes are eliminated such as form printing, bundling, postage, and mailing.

Many errors experienced in the keying and processing of paper claim forms are reduced or eliminated. Electronic claim submission means greater claim acceptance rates and reduced staff time in claim research and resubmissions.

Convenient and Confidential

Electronic submission provides the added benefit of both claim preparation and delivery at your convenience. Postal service hours of operation or delays do not limit your productivity. Electronic claims can be submitted 24 hours a day, seven days a week, 365 days a year. It is safe, immediate, and direct to Highmark. EDI security standards are in place to ensure your claim data remains confidential and secure.

Claim Submission

For providers in Delaware, Pennsylvania, and West Virginia

HIPAA-compliant 1500 (837P) and UB (837I) claim submission transactions are available to participating professional providers and facilities in Availity.

For More Information

For information on signing up for EDI and also Availity, please see the manual's **Chapter 1.3: Electronic Solutions – EDI & Availity.**

To learn more about electronic claims submission, visit the **Electronic Data Interchange (EDI) Services** website. You can access the site by selecting **Claims & Authorization** then **Reimbursement Resources** from the main menu on the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

6.2 Highmark EDI Services Support

The Highmark EDI Operations support staff is comprised of trained personnel dedicated to supporting electronic communications. They provide information and assistance with questions or problems you encounter with any aspect of your EDI transactions.

Support is free and staff is available Monday through Friday from 8 a.m. to 5 p.m. To save time when calling, be prepared to provide your Trading Partner number, NPI, and log-on identification to the support analyst.

EDI Phone Contact

Delaware, Pennsylvania, and West Virginia:

To contact a support analyst by phone, call **800-992-0246**.

New York: For support, call Administrative Services of Kansas at **800-472-6481**.

Accessible 24 Hours a Day, 7 Days a Week

Electronic transactions can be sent and retrieved seven days a week, 24 hours a day. Electronic transactions can be submitted once or multiple times per day or week. Claim transmittal and report retrieval schedules are controlled by each office.

Information on EDI Claim Submission can be found on the EDI website by visiting the **Electronic Data Interchange (EDI) Services** website via the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

The EDI website has the most up-to-date information about doing business electronically with Highmark. Highmark recommends that you bookmark this site and consider it your first source when you have a problem or question.

6.2 Required Electronic Claim Submission Formats

In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop and maintain uniform standards for Electronic Data Interchange (EDI). **ASC X12N** is the section of ASC X12 for the health insurance industry's administrative transactions.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Administrative Simplification provisions named ASC X12N as the mandated standard to be used for electronic transmission of health care transactions.

Required Claim Submission Format

The current HIPAA electronic transaction standards for health care eligibility, claim status, referrals, claims, and remittances are the **ASC X12N Version 5010** transactions. The required formats for electronic claim submission are:

- **Professional:** ASC X12N 837 Health Care Claim: Professional Transaction Version 005010 (“837P”)
- **Institutional:** ASC X12N837 Health Care Claim: Institutional Transaction Version 005010 (“837I”)

Types of Electronic Submission

For providers in Delaware, Pennsylvania, and West Virginia

The following types of electronic claim submission are available to participating facilities:

- Batch submission and Real-Time Estimation/Adjudication (limited to a single claim) via any electronic data interchange vendor
- Availity® Facility Claim

Professional providers have the following options:

- Submission via any electronic data interchange vendor or billing service
- Availity® Professional Claim

Note: The Availity claim submission transactions are compliant with the HIPAA 837P and 837I formats.

6.2 Submitting Claims(NY Only)

For providers in New York

Submitting Claims

To improve accuracy and timeliness of paper claim submissions, we utilize Optical Character Recognition/Intelligent Character Recognition (OCR/ICR). To maximize the efficiency of this technology, we are asking providers who submit paper claims to use the red CMS 1500 (2-12) or UB-04 standard claim forms.

NOTE: Edits for electronic claims and paper claims are exactly the same. Submitting a paper claim that originally rejected electronically without fixing the problem will only lead to a rejection of the paper claim as well.

All claims for Medicare-covered services and items that are the result of physician's order or referral shall include the ordering/referring physician's name, NPI, and taxonomy code in boxes 17, 17a, and 17b of the CMS 1500 claim form. The following services/situations require the submission of the referring/ordering provider information. This is not an all-inclusive list:

- Medicare-covered services and items that are the result of a physician's order or referral
- Parenteral and enteral nutrition
- Immunosuppressive drug claims
- Hepatitis B claims
- Diagnostic laboratory services
- Diagnostic radiology services
- Portable x-ray services
- Durable medical equipment

When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests)

Claim Submission Tips

- Use the red CMS 1500 or UB-04 claim forms.
- Check your printer to ensure that your ink is dark.
- Do not highlight data on the claim form.
- Check your printer to ensure that it is lined up with the fields on the claim form.
- If the information submitted is incorrect or missing, we may generate a letter asking you to resubmit the claim with the correct information.
- The use of any other type of CMS1500 or UB-04 claim forms other than the red forms will delay processing.
- Paper claims must have a physical address in box 33; if a PO Box is submitted, the claim will be returned for correction and resubmission.
- ZIP Codes must be submitted with 9 digits
- Include the referring/ordering physician NPI as required by CMS billing requirements.

Submitting Appeals

Submit all timely filing appeal requests in writing, stating the reason for the delay of submission beyond 365 days. The claims you are appealing must be on paper and attached to your appeal. Please keep copies of the information you send for ease in identifying claims that will be approved/denied.

Electronically Submitted Claims:

For electronic claims that have not been processed, please submit one of the following reports with your appeal request and claim(s):

- Deleted Claim Edit Report
- Clearinghouse Response files

If you would prefer to receive these reports instead of your vendor, please contact ASK at 800-472-6481.

If you are using the electronic response file to do automatic posting of errors or claims accepted, the following information needs to be included on the report you send to us:

- Error record
- Record sequence
- Error code
- Clearinghouse messages
- Error field
- Error description

Continue to balance your submission counts to those on the Clearinghouse Response file. If a discrepancy exists between the counts, notify our Help Desk immediately. The Clearinghouse Response file will be the only notification you will receive about a claim deleted in the transmission.

If you currently do not receive any of the above reports or experience discrepancies on claim counts, contact ASK at 800-472-6481.

Clearinghouse Rejections

If a claim rejects in the clearinghouse (i.e., invalid member identification number), submit your deleted claim edit report and claim with your appeal.

Coordination of Benefits

If an insurance carrier other than Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York is the primary carrier, then providers must submit the other carrier's payment voucher and claim within three months of the payment from the other carrier. COB claims can be submitted using the 8371 or 837P. Providers do not need to submit the other carrier explanation of benefits (EOB) if all of the information is submitted on the 837.

If providers are receiving an 835 (electronic remittance), they may or may not have a paper voucher or EOB to submit to Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York. The information received on the 835 should be incorporated into the secondary fields on the 837.

Incorrect Insurance Information

If the member provided incorrect insurance information, the denial notice from the other carrier must be submitted with the original claim within three months of the other carrier's denial.

No Coverage

If a participating provider, in dealing with a patient finds that he/she has no insurance, the member should be asked to sign and date a patient responsibility form or waiver.

A provider may seek payment from the patient for any services provided. If the member realizes that he or she has Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York coverage after a provider has billed the member and the claim is beyond the 365-day timely filing limit, the provider should submit the signed waiver/patient responsibility form and claim with your appeal. Do not re-bill the member.

If you do not have a signed waiver, submit copies of billing statements with your claim(s) and appeal that indicates that you have billed the member who has now advised you that he/she has Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York insurance.

Member Held Harmless

Participating providers are responsible to abide by the stipulations of the Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York provider agreements. In

cases where services were not billed to us within the timely filing limits, you cannot bill the member directly.

The member is to be held harmless. The reimbursement issue is between you as a participating provider and us as the insurer. You may file the claim late with a request to waive the limit with an explanation. Upon review of your appeal, approval or denial will be determined. However, at no time is the member to be held responsible.

Filing Requirements for Members and Non-Participating Providers

Claims submitted by members or non-participating providers (for traditional and approved services through our managed care contracts) must be submitted within the following time frames:

- Major Medical: 12 months
- Traditional: 12 months

If claims, requests for adjustments, appeals or claim reviews are submitted by the member or a non-participating provider after the above time frames, the claim will be denied. The non-participating provider can bill the member for these denied claims.

New York State Prompt Pay Interest

Prompt Pay Interest exceeding $1.99 per claim is generated on a daily basis for claims not processed within 30 days of Blue Cross Blue Shield's receipt of the claim. Checks and wire payments are issued more frequently than the weekly cycle to ensure that prompt pay requirements are met. Any interest paid appears under the "Interest Paid" column on your payment voucher.

Claims submitted for adjustment due to errors caused by Blue Cross Blue Shield processing receive prompt pay interest.

The following are excluded from prompt pay interest:

- Administrative Services Only (ASO) & Administrative Services for National Accounts (NSO) contracts
- Federal Employee Plan (FEP) contracts
- Services rendered by out-of-state providers
- Senior Blue and BlueSaver claims from non-participating providers

- National Accounts, when an out-of-state Plan, is the control Plan
- Blue Card claims for Members from Plans outside New York State, home and host If you are a capitated provider billing for fee-for-service procedures, prompt pay interest will be calculated for those claims, if necessary.

Coordination of Benefits Payments

Coordination of benefits applies to members who have more than one group health insurance contract. Blue Cross Blue Shield coordinates benefit payments with other carriers to ensure members receive all of the benefits to which they are entitled and to prevent duplicate payments. Other insurance information should be verified each time that a patient visits your office.

Prior Authorization and Referral Requirements

For managed care (including POS in-network claims), all prior authorization/referral policies and procedures apply, even though Blue Cross Blue Shield may be the secondary payer.

For Preferred Provider Organization (PPO) contracts, all prior authorization policies and procedures apply, even though Blue Cross Blue Shield may be the secondary payer.

If appropriate prior authorization of services has not been made, or if a valid referral has not been issued before processing a claim, we may deny payment even on a secondary basis if the services are determined not to be medically necessary.

Primacy

When a patient is covered by two or more health insurance plans, one plan is determined to be primary and its benefits are applied to the claim. The following rules apply when determining which carrier is primary:

1. If one policy does not have a COB provision, then it will be primary.
2. If the patient is covered under one policy as the employee and under another policy as a dependent, the policy which covers the patient as an employee will be primary.
3. The primary policy for children is the policy of the parent whose birthday (month and day) falls earlier in the year. If both parents have the same birthday, the policy that covered the parent longer is primary.

4. When there is more than one insurance policy and the parents are divorced or separated, the rules of primacy vary depending on the court decision.
5. If the patient is the policy holder and covered under one of the policies as an active employee, neither laid off nor retired, and also covered under another policy as a laid off or retired employee, the policy covering the patient as an active employee will be primary.
6. If none of the above applies, then the policy that has covered the patient for the longest time will be primary.

Submitting Claims for Secondary Reimbursement

Claims must be submitted electronically in the 837P or 8371 format, or on paper using a CMS 1500 or UB-04. All line items billed to the primary carrier should be submitted on the secondary claim.

Attach a copy of the primary carrier's Explanation of Benefits Statement and indicate balance due. The balance due is the amount to be considered by Blue Cross Blue Shield or the patient's responsibility.

Attach a copy of the primary carrier's Explanation of Benefits Statement. Claims submitted on paper without the Explanation of Benefits Statement, will be rejected.

PPO or POS Claims

When a claim for Traditional, PPO or POS out-of-network services is secondary, our payment will not exceed our allowance for the services. Also, the sum of the primary and secondary payments will not exceed the provider's charge.

Bill Your Usual Charge

Regardless of our allowance for a service, you should always bill your usual charge. This is beneficial in several ways:

1. It enables us to determine average charges for procedures.
2. By using one charge to bill all insurance companies, the chance of billing errors is reduced.
3. If more than one insurance company has liability for a claim, your standard charge eliminates confusion and helps to ensure proper payment.
4. **Professional Courtesy** – No reimbursement will be provided to a provider billing for professional services rendered to his/her immediate family, regardless of whether the family member has coverage under a Blue Cross Blue Shield contract. Immediate family is defined as the provider's

spouse, children, parents, and siblings. Blue Cross Blue Shield will not reimburse for services that would normally have been furnished without charge.

6.2 Real-Time Estimation and Adjudication

Highmark's Real-Time tools are available to all Availity-enabled contracted providers and to providers who submit electronic claims through a practice management system. These primary Real-Time capabilities include Real-Time Provider Estimation and Claims & Encounters.

These real-time capabilities give providers the ability to discuss member financial liability with patients when services are scheduled or provided. Providers could also collect applicable payment or make payment arrangements at the time of services, if they wish to do so.

Patient Cost Estimator

The Patient Cost Estimator tool gives providers the ability to submit requests for specific health care services before or at the time services are rendered and receive a current estimate of the member's financial liability within seconds before the services are rendered.

The estimate takes into account the cost of the service provided and the amount of the deductible, coinsurance, and/or copayment and other coverage provisions included in the member's benefit program. This information, in turn, can be utilized to set the member's cost expectations prior to receiving services and collect or make arrangements for payment at the time of service.

This tool should be used to give members an accurate estimate of their financial obligations prior to or at the time of service. To determine member liability after services are rendered, it is recommended that providers use Claims & Encounters (see below).

In Availity, this tool can be accessed in Eligibility and Benefits Inquiry.

Note: Patient Cost Estimator can be used for all Highmark products; however, estimate submission is not available for the Federal Employee Program (FEP).

Claims & Encounters (Claim Submission)

Claims & Encounters in Availity gives providers the added ability to submit claims for specific health care services and receive a fully adjudicated response within seconds. This allows providers to determine, at the time of service, the correct amount the member owes. This, in turn, enables the provider to collect payment or make payment arrangements for the member's share of the cost at the time of service.

Accelerated Provider Payment

Accelerated Provider Payment allows providers who meet certain criteria to receive accelerated payment on real-time submitted claims. Providers will receive more frequent payments from Highmark — within three business days for claims that have been submitted in real-time.

Note: Accelerated payment does not apply to amounts paid from the member's consumer spending account.

Accelerated Member EOB on Member Portal

Accelerated Explanation of Benefit (EOB) displays the member explanation of benefits (EOB) on the Highmark Member portal the next business day for all real-time submitted claims.

Refunding the Member

These Real-Time Capabilities allow providers to get fast, current, and accurate information to help in determining the patient's financial liability prior to or at the time of service. The provider tools will be especially useful as the member cost sharing increases and the use of spending accounts grow.

Please note, however, that if you collected payment from the member at the time of service for member liability, and then subsequently receive payment from Highmark and find an overpayment, be sure to issue the refund directly to the member **within 30 calendar days.**

Electronic Data Interchange (EDI) Services

Providers who are interested in integrating real-time capabilities within their practice management system should discuss this functionality with their software vendors. They should also review the Electronic Data Interchange (EDI) transaction and connectivity specifications in the Resources section on the EDI website.

To access the EDI website from the Provider Resource Center, select **Claims & Authorization** then **Reimbursement Resources** from the main menu, or click on the applicable link below to access the applicable site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

6.2 Claims Record Management

Highmark provides electronic acknowledgments to enhance your ability to track and monitor your claim transactions.

Acknowledgment Transactions

Electronic claims can be submitted via the 837 Professional (837P) and Institutional (837I) Health Care Claim Transactions. Upon receipt of the 837 transaction, there are several acknowledgment transactions available for tracking electronic claim submissions and payment depending on the capabilities of your software:

- 999 – Implementation Acknowledgment for Health Care Insurance
- 277CA – Claim Acknowledgement
- 835 – Electronic Remittance Advice ERA

Important!

Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York providers will receive electronic claims information from Administrative Services of Kansas (ASK - EDI).

999 – Implementation Acknowledgment for Health Care Insurance

When transmitting claims in HIPAA Version 5010, you will receive the 005010X231 999 Transaction verifying that Highmark received your claim(s) file and indicating whether the file was “accepted” or “rejected” for further claim editing.

277CA – Health Care Claim Acknowledgment

This transaction is available approximately 24 hours after an accepted/accepted with errors 999 Implementation Acknowledgment for Health Care Insurance report is accepted. After the EDI claim editing process is complete, you are able to verify through the 277CA Claim Acknowledgment transaction that your claims were accepted and forwarded for claims processing. The 277CA also identifies claims that did not pass or were rejected by the editing process due to data errors.

The 277CA should be reviewed after every accepted/accepted with errors claim file transmission because it provides a valuable and detailed analysis of your claim file. Claims that were accepted should not be resubmitted. Highmark will no longer attempt to correct or retrieve missing information — **this rejected claim data must be corrected and the claim resubmitted electronically.**

Trading partners submitting 837 claim transactions in Version 5010 must be able to accept the 005010X214 277 Health Care Claim Acknowledgment (277CA) Transaction.

835 – Health Care Claim Payment/Advice(Electronic Remittance Advice- ERA)

The 835 Health Care Claim Payment Advice, or Electronic Remittance Advice (ERA), is essentially an electronic version of a paper Explanation of Benefits (EOB) or remittance. When 835 ERA information is combined with an Accounts Receivable System (ARS), it provides an efficient method of reconciling your patients' accounts by providing financial information relating to your claim payments and denials. Your software vendor can advise you on your system's ERA and ARS capabilities.

Highmark's ERAs (835 transactions) are created on a weekly or daily basis to correspond with our weekly or daily payment cycles. Contact your software vendor to determine if your software is ERA capable. This transaction can help you reduce costs and improve office efficiency. Its benefits are:

- **Eliminates posting errors:** Little to no manual intervention, depending on the AR system, is necessary with electronic 835 posting. Errors associated with manual keying of payment data are eliminated.
- **Reduces posting time:** The 835 information allows you to electronically post payments to your AR system in a matter of minutes or hours instead of days. Actual posting time is dependent on the practice size and AR system. Electronic posting allows your staff more time to attend to patient needs instead of administrative tasks.
- **Accelerates payment process:** Electronic posting accelerates your ability to perform secondary billing of non-contractual financial liabilities. The Health Care Claim Payment/Advice (835)

payment transaction files become available for retrieval after the payment cycle is complete, and remains available for seven days. You can start your posting and subsequent secondary billing processes upon receipt of the electronic file.

For More Information

To learn more about claims record management transactions, please visit the Electronic Data Interchange (EDI) Services website via the Provider Resource Center (select **Claims & Authorization** then **Reimbursement Resources** from the main menu), or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv
- New York: https://www.ask-edi.com/

6.2 Attachments for Electronic Claims

Electronic Claim Attachments

It is not necessary or recommended that you submit claims requiring attachments via paper except in certain instances. These claims should be sent electronically utilizing the PWK, or paperwork attachment, specifications of the 837 electronic claim transaction. Two PWK option fields are built into the 837 transaction.

Supporting documentation can then be faxed or mailed to Highmark as indicated below for your service area:

Delaware	New York	Pennsylvania	West Virginia
Attention: Document Preparation/Image	**Attention:** Document Preparation	**Attention:** Document Preparation/Image	**Attention:** CDC Area

Fax to: 888-910-9601	**Fax to:** 877-286-5710	**Fax to:** 888-910-8797	**Fax to:** 844-235-7266
Mail to: Highmark Blue Cross Blue Shield Delaware PWK (Paperwork) Additional Documentation P.O. Box 8832 Wilmington, DE 19899	**Mail to:** Highmark Western and Northeastern NY PO Box 4208 Buffalo, NY 14240	**Mail to:** Highmark Blue Shield PWK (Paperwork) Additional Documentation P.O. Box 890176 Camp Hill, PA 17089-0176	**Mail to:** Highmark WV P.O. Box 7026 Wheeling, WV 26003

PWK Cover Sheet

When submitting the additional documentation, please use the applicable cover sheet for your service area:

- Pennsylvania: PWK (Paperwork) Supplemental Claim Information Cover Sheet
- Delaware: PWK (Paperwork)Supplemental Claim Information Cover Sheet
- West Virginia: Electronic Claim Attachment Cover Sheet
- Western New York: Claim Attachment Cover Sheet
- Northeastern New York: Claim Attachment Cover Sheet

These cover sheets are also available on the Provider Resource Center. Select **Resources & Education** then **Forms** from the main menu, and then select **Miscellaneous Forms.**

Visit EDI Website for PWK Specifications

To review the specifications and PWK process flow, please visit the Resource Center, and then select **Claims & Authorization** then **Reimbursement Resources** from the main menu to access the **Electronic Data Interchange (EDI) Services** website(s).

If you currently work with a trading partner (software vendor and/or clearinghouse), or have an information technology (IT) department within your facility, they will be able to assist you with the technical aspects of the specifications. Simply tell your trading partner that you want to begin submitting attachment claims electronically.

6.2 NAIC Codes

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

NAIC codes are unique identifiers assigned to individual insurance carriers. Accurate reporting of NAIC codes along with associated prefixes and suffixes to identify the appropriate payer and to control routing is critical for electronic claims submitted to Highmark EDI (Electronic Data Interchange).

Claims billed with the incorrect NAIC code will reject on your 277CA report as A3>116, “Claim submitted to the incorrect payer.” If this rejection is received, please file your claim electronically to the correct NAIC code. Please refer to the tables below for applicable NAIC codes for your service area.

Delaware

For providers in Delaware

Delaware NAIC Code Provider Type Products

NAIC Code	Provider Type	Products
00070	Facility provider types	• All Highmark Delaware products; BlueCard claims; and Medicare

		Advantage claims for any other Blue Plan.
00570	All other provider types	• All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.

New York

For providers in New York

Providers must submit claims through the Administrative Services of Kansas (ASK): www.ask-edi.com.

Highmark Western New York & Highmark Northeastern New York

NAIC Code	Provider Type	Products
55204	All Provider Types	All Commercial Products: BlueCard Products and Medicare Advantage Claims for any other Blue Plan.

**Providers will continue to submit claims to Empire for Empire/Anthem members who are seen in — Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties — that comprise the 13 counties of the Highmark Blue Shield of Northeastern New York service region.*

**Providers will continue to submit claims to Excellus for Excellus members who are seen in — Clinton, Essex, Fulton, and Montgomery counties — that comprise four of the 13 counties of the Highmark Blue Shield of Northeastern New York service region.*

Pennsylvania

For providers in Pennsylvania

Pennsylvania NAIC Code Provider Type Products

NAIC Code	Provider Type	Products
54771W	Western and Northeastern Regions – facility type providers (UB-04/837I)	• All Highmark commercial products; • Medicare Advantage Security Blue HMO-POS (prefixes **JOF, JOL**), Together Blue Medicare HMO (prefix **K9P**), and Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company (prefixes **ZPM, KHC**); and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771C	Central Region facility type providers (UB-04/837I)	• All Highmark commercial products; • Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company (prefixes **ZPM**, **KHC)**; and • All BlueCard products and Medicare Advantage claims

		for any other Blue Plan.
54771S	SEPA Region Facility Type Providers (UB-04/837I)	• All Highmark commercial products; • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771	All other provider types (1500/837P)	• All Highmark commercial products; • Medicare Advantage Security Blue HMO-POS (prefixes **JOF**, **JOL**), Together Blue Medicare HMO (prefix **K9P**), (Western Region only) and Medicare Advantage Community Blue Medicare HMO, all administered by Highmark Choice Company (prefixes **ZPM**, **KHC**); and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
15460	All provider types	• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes **HRT, HRF, FAS**) • Medicare Advantage Community Blue Medicare PPO) (prefixes **QLS, QMV, QJS, QKS**)

		and Community Blue Medicare Plus PPO (prefixes **FYO, FZO**); and • Medicare Advantage Complete Blue PPO (prefixes **C4K, CDE, FDE**) and Complete Blue Plus PPO (prefix **CDJ**).

West Virginia

For providers in West Virginia

West Virginia NAIC Code Provider Type Products

NAIC Code	Provider Type	Products
54828	All provider types	• All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
15459	All provider types	• Highmark Senior Solutions Company; Medicare Advantage; Freedom Blue PPO (West Virginia plan only with alpha prefix **HSR).**

6.2 Claim Status Inquiry

Highmark offers providers electronic means of checking the status of a claim through Availity® Claim Status Inquiry or the HIPAA 276/277 Health Care Claim Status Request and Response transactions. For more information, reference the *Highmark Provider Manual* **6.1 Claim Status Inquiries.**

6.2 Availity 1500 and UB Claim Submission

Availity® claim submission transactions let you submit HIPAA-compliant 837P Professional claims and 837I Institutional claims fast and easy in real-time. Availity's real-time, single claim-submission lets you know the status of a claim at the time of entry and claim errors are corrected online. When submitted on the date the services were rendered, these capabilities allow providers to accurately identify and collect member responsibility before the patient leaves the office.

Accessing Claim Submission Transactions

To access the claim submission transaction in Availity, go to Claims & Payments and then click on Claims & Encounters.

Availity® Customer Support

If you need assistance with an existing account and cannot log in to submit a ticket, or have started the registration process and are experiencing issues, you can call **800-AVAILITY (282-4548).** For more information about contacting Availity, click HERE.

6.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 3: Facility (UB-04/8371) Billing

6.3 Disclaimers

6.3 Facility Billing Overview

Highmark requires facility providers to bill electronically via 837 Institutional (837I) electronic transactions. HIPAA-compliant UB Claim Submission is also available in Availity®. In some cases, claim submission may be necessary on UB-04 paper claim forms.

Billing Professional Services

Highmark requires hospitals to bill all services performed by physicians and associated professionals via an 837P transaction (or, in rare circumstances, a 1500 claim form).

If Highmark audits find professional services are billed in error on 837I/UB-04 claims, payments will be retracted.

Billing Highlights

For providers in Pennsylvania

Billing Highlights are available in Pennsylvania to help facilities identify the information from the UB-04 locator fields that are required when billing specific facility type claims. In addition, helpful tips are offered to assist facilities with providing the needed information for each facility type claim submitted to Highmark.

The Billing Highlights are available on the Provider Resource Center when accessed via Availity — select **Claims & Authorization** from the main menu and look under **Reimbursement Resources.**

For More Information

Please see also **Chapter 4.3: Facility-Specific Guidelines** that contains information and guidelines specifically for facilities that may also include reporting guidelines (e.g., Observation Services).

6.3 Present on Admission/Adverse Events

Present on Admission (POA)

Highmark requires the submission of Present on Admission (POA) information on inpatient claims for all hospital providers. This applies to **all inpatient acute care hospitals (including critical access hospitals and children's inpatient facilities)** for all claims.

This requirement is designed to identify and prevent additional reimbursement to the provider for situations in which specified conditions occur during the course of an inpatient stay but, were not present at the time of admission. This mechanism serves to implement Highmark's policy on hospital-acquired conditions in the inpatient acute care hospital setting.

Potential Reduction in Payment for Hospital Acquired Conditions (HAC)

Medicare Grouper for all Diagnosis Related Groups (DRG)-reimbursed inpatient acute care hospitals, including critical access hospitals for commercial business, features logic that prevents the assignment of a higher Medicare Severity Diagnosis Related Groups (MS-DRG) to a claim reporting certain conditions not present on admission (when no other condition on the claim would otherwise trigger a higher MS-DRG).

Highmark will also apply a separate methodology and process to potentially **reduce payment to non-DRG reimbursed hospitals** for claims reporting any of the following conditions if not identified as present on admission (in the absence of other complications or major complications on the claims):

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection-mediastinitis after coronary artery bypass graft (CABG)
- Manifestations of poor glycemic control
- Deep vein thrombosis (DVT) and pulmonary embolism (PE) following certain orthopedic procedures
- Infections after bariatric surgery

- Surgical site infection following certain orthopedic procedures
- Surgical site infection following cardiac implantable electronic device (CIED) procedures
- Iatrogenic pneumothorax with venous catheterization

Non-Payment for "Wrong" Surgical Events for All Hospital Providers

Consistent with Centers for Medicare & Medicaid Services (CMS) policy, Highmark will not make payment for the following three “wrong” surgical events:

- The **wrong surgical or other invasive procedure** was performed
- Surgery or other invasive procedure was performed on the **wrong body part**
- Surgery or other invasive procedure was performed on the **wrong patient**

Reimbursement Policy RP-036

For additional information applicable to Highmark commercial products, please refer to Highmark Reimbursement Policy Bulletin RP-036: Preventable Serious Adverse Events**.**

Reimbursement policies are available on the Provider Resource Center. Select **Claims & Authorization** from the main menu. You'll find **Reimbursement Policy** under **Reimbursement Programs**.

6.3 National Correct Coding Initiative (NCCI) EDITS

The National Correct Coding Initiative (NCCI) edits were developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and reduce paid claim errors resulting from improper coding and inappropriate payments. Highmark began to systematically follow CMS guidelines and apply Medically Unlikely Edits (MUEs), a subset of these edits, effective January 1, 2012.

Highmark applies the NCCI edits on a systematic basis to outpatient facility claims rendered in an acute-care hospital for both commercial and Medicare Advantage business.

Systematic Application NCCI Edits

Although Highmark has always required contracted facilities to comply with industry coding standards such as those incorporated in the NCCI edits, it has not systematically applied this logic via claims edits under all reimbursement methods. Effective October 1, 2013, Highmark expanded the application of the NCCI edits to all acute care hospitals for outpatient Commercial and Medicare Advantage facility claims in order to produce more accurate payments and reduce the need for claim adjustments due to clerical or coding errors.

The systematic edits will be applied based on the date of service of the claim submitted.

Quarterly Updates

Highmark is unable to implement CMS-driven reimbursement changes (such as changes to the NCCI edits) on the CMS effective date. In some cases, the changes are transmitted to Highmark via its software vendor and cannot be implemented until the vendor has distributed the updated software. Even when a software vendor is not involved, all such changes must be evaluated in light of Highmark contracts and system constraints prior to implementation.

Highmark's implementation of CMS-driven changes to the quarterly version updates to the NCCI edits will therefore occur after CMS' implementation and after appropriate evaluation.

6.3 Claim Adjustments

To make changes to claims that have already been submitted to Highmark, facility providers are to use Adjustment Bill Types XX7, XX8, or XX5 for claims previously submitted by paper and electronically.

Corrected/Adjustment Bill Types

Please follow the specific guidelines provided in the table below for Adjustment Bill Types XX8, XX7, and XX5:

Adjustment Bill Type	When to Utilize	Highmark Action
XX5	This code is to be used for submitting additional new	Adjust the original claim to include the additional

Late Charges Only	charges or lines which were identified by the facility after the original claim was submitted (use XX7 for BlueCard®).	charges.
XX7 Replacement of prior claim	This code is to be used when a specific bill or line has been issued and needs to be restated in its entirety. When this code is used, Highmark will operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.	Adjust the original claim by overlaying data from XX7 claim onto original claim. The new payment amount or retraction will be processed on the original claim.
XX8 Void/Cancel Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill. Use of XX8 will cause the bill to be completely canceled from the Highmark system.	Void the original claim on the remittance.

Codes Used to Report Adjustment Claim on 835

Highmark uses the following codes to report adjustment claims on the 835:

- Claim Adjustment Group and Reason Code **CO129** (“Prior processing information appears incorrect”) will be used to deny the claim.
- Remark Code **N770** (“The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.”) will also be used on

these claims.

Original Claim Number Required

The original claim number is required when submitting adjustment bill types XX5, XX7, and XX8 on claims via Availity® **Claims & Encounters** or HIPAA 837I.

The original claim number should be reported in the **Adjustment Claim Link (ACL)** field.

Exceptions

Although the automated process handles the majority of electronically submitted adjustments, there are certain categories of adjustments that still require manual intervention. Among these are adjustments to previously adjusted claims.

Highmark will make every effort to avoid separation between the retraction and repayment components of these adjustments.

Remittance Advice

The Highmark Remittance Advice informs providers of the amount Highmark will pay for a specific claim. It will also detail both paid and denied claims.

Please refer to **Chapter 6.7: Payment/EOBs/Remittances** for specific and detailed information pertaining to the Remittance Advice.

6.3 Billing Outpatient Services When Unplanned Inpatient Admission is Determined Not Medically Necessary

For emergency (urgent, unplanned) admissions, the hospital is asked to obtain an authorization within 48 hours of the admission or as soon as the necessary clinical information is available.

- If the inpatient admission is authorized, the hospital should follow normal billing protocols and report the emergency room or observation services on the member's inpatient claim.
- If the inpatient admission is not authorized, the hospital should report the services provided as an outpatient claim after deciding not to appeal the inpatient denial or after the denial has not been

overturned on appeal.

Claim Submission for Outpatient Service

Highmark recommends that facilities wait to submit claims until all authorization determinations are made and, if inpatient admission is not authorized, until the facility decides whether to pursue an appeal. When it is determined that inpatient admission is not medically necessary, all outpatient services provided (e.g., emergency, observation) may be billed.

If an inpatient claim was submitted prior to a final determination, the provider can submit a claim for the outpatient services that were provided if the inpatient claim was denied. The provider must first submit an XX8 adjustment claim to void the original inpatient claim, and then a new claim can be submitted for the outpatient emergency or observation services.

If a facility submits an inpatient claim to Highmark without seeking preservice review and the required authorization, the claim will deny. The facility can request a retrospective review and submit the applicable medical records for the claim to be considered for payment. Appeal rights would apply in the event of a medical necessity denial.

Note: Condition code 44 should not be billed to Highmark on an outpatient claim when an inpatient admission has been denied (applies to traditional Medicare only).

Medical Record Documentation

If billing for outpatient services when it is determined that criteria are not met for inpatient admission, the medical record should clearly support the services actually provided and billed.

6.3 Guidelines for HIPPS Reporting

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types.

The Centers for Medicare & Medicaid Services (CMS) requires Health Insurance Prospective Payment System (HIPPS) codes on all Medicare Advantage claims for home health agency and skilled nursing facility providers, effective July 1, 2014.

Requirement

Highmark follows the CMS HIPPS reporting guidelines for **both commercial and Medicare Advantage** business. Home health and skilled nursing facility providers are required to submit the applicable HIPPS codes on claims for all commercial and Medicare Advantage Highmark members for dates of services on and after July 1, 2014.

Providers are required to report codes that are valid as of the date of service. Always consult the most current national UB Data Specifications Manual for the most updated list of codes.

This requirement does not change your current reimbursement method. Providers should continue to submit claims according to your contract.

Revenue Codes

Please report applicable revenue code that represent the prospective payment mechanism as follows:

Provider Type	Revenue Code	Gudelines
Home Health	**0023**	This revenue code (and the corresponding HIPPS codes) should be reported **in addition to** the revenue lines representing the home health service billed by the facility.
Skilled Nursing Facility	**0022**	This revenue code (and the corresponding HIPPS codes) should be reported **in addition to** the revenue lines representing the skilled nursing service billed by the facility. Bill

		the revenue line of 0022 with the appropriate Resource Utilization Group (RUG) code and the Assessment Reference Date (ARD).

HIPPS Codes

Ensure the appropriate HIPPS code is reported on all Commercial and Medicare Advantage claim submissions. Generate a new HIPPS code for each home health or skilled nursing episode according to CMS guidelines.

Special Considerations When Home & Community Care Transition Assigns the Rug Level

For providers in Pennsylvania and West Virginia

Home & Community Care Transition assigns the appropriate Resource Utilization Group (RUG) code level for Highmark's Medicare Advantage members receiving skilled rehabilitation therapy. In these scenarios, skilled nursing facilities will not complete the typical Medicare Prospective Payment System (PPS) Assessments.

Skilled nursing facilities should follow the guidelines outlined below when Home & Community Care Transition assigns the RUG Code level:

- **HIPPS code:** Home & Community Care Transition will only provide the RUG code level, which should be the first three digits of the HIPPS code.
- **Assessment Indicator (AI):** Skilled nursing facilities should report 60 as the AI for members receiving therapy.
- **Assessment Reference Date (ARD):** When using revenue code 0022, the ARD is reported in locator 31-34 with Occurrence Code 50.
- **Admission Date:** The admission date should be entered for Medicare Advantage members receiving skilled rehabilitation services when Home & Community Care Transition has assigned the RUG level.

For information on Highmark's partnership with Home & Community Care Transition for post-acute care management for Highmark Medicare Advantage members, please visit the Provider Resource Center. Select **Policies & Programs**. You'll find **Post-Acute Care Management for Medicare Advantage Members** under **Care Management Programs**.

Service Date

For revenue code 0023, the date of service should equal the date of the first billable service on the claim.

Units of Service

Units of service are required on each separate HIPPS revenue line.

- For each revenue code 0023: Units should always equal 1.
- For each revenue code 0022: The units for the multiple lines should equal the number of room and board days falling under that HIPPS code.

Billing Scenarios

The table below illustrates several billing scenarios that may occur when reporting Revenue code 0023:

If the provider reports...	Along with...	Then...
Home health Revenue code 0023	The corresponding HIPPS (HHRG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).

Skilled nursing Revenue code 0022	The corresponding HIPPS (RUG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).
Revenue code 0022 or 0023	A HIPPS code not valid as of the date of service, or in the incorrect format.	The claim will fail validation edits and be rejected back to the provider for correction.
Revenue code 0022 or 0023	A HIPPS code that does not correspond to the revenue submitted.	The claim will fail validation edits and be rejected back to the provider for correction.
Revenue code 0022 or 0023	A HCPCS/CPT code instead of a HIPPS code.	The claim will fail validation edits and be rejected back to the provider for correction.
No revenue code 0022 or 0023	A HIPPS code.	This is not an acceptable combination.

6.3 Outpatient Services Prior to an Inpatient Stay

Effective November 1, 2018, Highmark's policy on outpatient services prior to an inpatient admission applies a "three day rule" similar to that of the Centers for Medicare & Medicaid Services (CMS). Such

services include, but are not limited to, Emergency Department (ED), Observation (OBS), and Pre-Admission Testing (PAT).

Background

According to the CMS three-day rule, also known as the "72-hour rule," **diagnostic services** furnished by an admitting hospital three days prior to, and including the date of the beneficiary's admission, are considered inpatient services and are included in the inpatient payment.

For outpatient non-diagnostic services provided during that time frame, the hospital is permitted to separately bill the services if they are **unrelated** to the inpatient admission. However, if the non-diagnostic outpatient services are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

Highmark's Guidelines

Under Highmark's guidelines, outpatient services rendered within three days prior to an inpatient admission are considered inpatient services and are included in the inpatient payment when they are performed at the same facility for a **related** diagnosis.

Highmark will apply CMS' definition of the three-day window. Per CMS' guidelines, **the "three-day window" includes the day of the inpatient admission as well as the three days prior to the admission.** For example, if a member is admitted as an inpatient to a hospital on Wednesday, then outpatient services **related** to the inpatient admission and provided by the **same** hospital on Sunday, Monday, Tuesday, and Wednesday are billed on the inpatient claim and included in the inpatient payment.

These guidelines apply to Highmark's commercial and Medicare Advantage lines of business (except when the provider agreement states otherwise).

Unrelated Diagnosis

Please note that when outpatient services have been performed within the designated period prior to an inpatient admission **for an unrelated diagnosis**, those services are not to be included on the inpatient claim. These services should be billed independently.

Billing Guidelines

Please refer to the table below for guidelines on billing outpatient services on the inpatient claim **for commercial and Medicare Advantage** members:

Services	If...	Then...
Emergency Department (ED)	A member receives ED services **within a 3-day period** prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services are billed on the inpatient claim.
Observation	A member receives observation services **within a 3-day period** prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services are billed on the inpatient claim.
Pre-Admission Testing and Other Outpatient Services	A member receives pre-admission testing or other outpatient services **within a 3-day period** prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services are billed on the inpatient claim.

Claims Review

The admitting and/or principal diagnosis fields on the inpatient claim and the outpatient claims within the three-day period are reviewed in determining if the outpatient services rendered within that period are related to the inpatient admission.

Excluded Services (Commercial Members Only)

For members with commercial plans, there are certain outpatient services that are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are

not to be included on the inpatient claim and should be billed independently. Applicable services are as follows:

- **Chemotherapy and/or Outpatient Surgery:** These services should not be included on the inpatient claim if they are not performed on the same day of inpatient admission. If they are performed on the same day as the inpatient admission, they must be included on the inpatient claim.
- **Maternity Services:** Outpatient diagnostic and/or Emergency Department services for a maternity-related diagnosis provided prior to the inpatient admission should not be included on the inpatient claim.

Note: These policy exclusions are not applicable to Medicare Advantage members.

Professional Services (1500/837P)

Preoperative care furnished by a provider employed by the hospital within the three-day time period prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital.

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation even when surgery eventually was necessary. Highmark reserves the right to determine what medical care is acceptable to be reimbursed in these situations (except when the provider agreement states otherwise).

Reimbursement Policy RP-039

For additional information, please refer to Highmark's Reimbursement Policy RP-039 Outpatient Services Prior To An Inpatient Admission, effective November 1, 2018. This policy applies to Highmark's commercial lines of business in all of our service areas and also to Medicare Advantage products in Pennsylvania and West Virginia.

Highmark's reimbursement policies are available on the Provider Resource Center. Select **Claims & Authorization,** and then choose **Reimbursement Policy** which is under **Reimbursement Programs.**

6.3 Modifier Required for Off-Campus Outpatient Services

Requirement

Hospitals are required to report **modifier PO** (“Services, procedures, tests and/or surgeries furnished at off-campus provider-based outpatient department”) with every Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code for all outpatient items and services furnished in an off-campus, provider-based department of a hospital.

This mandatory billing requirement will help the Centers for Medicare & Medicaid Services (CMS) collect data on the frequency of, type of, and payment for services provided in off-campus provider-based hospital departments. Highmark has adopted this requirement for all lines of business, Commercial and Medicare Advantage, for similar reasons.

Main Campus and Off-Campus Defined

The main campus of a provider is defined as “the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.”

“Off-campus” references all other facilities or locations not meeting this requirement that are deemed to be provider based.

Where to Report on Claims

The PO modifier must be reported on your 837I electronic submissions (Loop 2400, SV2 Segment) and on any paper claim submissions (UB-04/CMS 1450 – Locator 44) for services performed at an off-campus provider-based outpatient department.

Reminder: Providers are required to provide the “Service Facility Location” information if it is different than the billing address (Loop 2310 E NM1, N3, and N4 on the 837I version 5010). For more information, see **Chapter 6.1: General Claim Submission Guidelines.**

6.3 Skilled Nursing Facility Consolidated Billing

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b), contains consolidated billing requirements for skilled nursing facilities (SNFs).

Consolidated billing requires the SNF itself to bill for the entire package of services that its residents receive, other than those individual types of services that appear on the list of exclusions specified in Section 1888(e)(2)(A)(ii) of the Social Security Act and regulations at 42 C.F.R. § 411.15(p)(2) or its successor.

Guidelines and Excluded Services

Highmark follows the Centers for Medicare & Medicaid Services (CMS) SNF consolidated billing guidelines for Medicare Advantage and commercial products.

There are a number of services excluded from SNF consolidated billing. These services are outside the Prospective Payment System (PPS) bundle, and are separately billable when furnished to a SNF resident by an outside supplier. The categories of services **excluded** from consolidated billing are:

- Physicians' services furnished to SNF residents
- Physician assistants (PAs) working under a physician's supervision
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician
- Certified nurse-midwives
- Qualified psychologists
- Certified registered nurse anesthetists
- Services described in Section 1861(s)(2)(F) of the Social Security Act
- Services described in Section 1861(s)(2)(O) of the Social Security Act
- Hospice care related to a resident's terminal condition
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission or from the SNF following a final discharge

Technical Component of Physician Services

Many physician services include both a professional and technical component. Although the professional component is excluded from consolidated billing, the **technical component is subject to consolidated billing**.

The technical component of physician services must be billed to and reimbursed by the SNF.

Physician "Incident to" Services

The consolidated billing exclusions do not apply to physician “incident to” services furnished by someone else as “incident to” the practitioner’s professional services. These “incident to” services furnished by others to SNF residents are subject to consolidated billing and must be billed by the SNF itself.

Therapy Services

Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that physical, occupational, and speech-language therapy services are subject to consolidated billing, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional.

Complex Services

Specific types of outpatient hospital services that are intensive, costly, or emergent that are not within the scope of care the SNF can provide are also excluded from consolidated billing. These services are billed by and payment is made to the provider who rendered the services. The medically necessary ambulance services that are furnished in conjunction with these services to transport the member to and from the hospital are also excluded from SNF consolidated billing.

These excluded categories include:

- Cardiac catheterization
- Emergency services
- Computerized axial tomography (CT) scans
- Radiation therapy services
- Magnetic resonance imaging (MRIs)
- Angiography
- Ambulatory surgery that involves the use of an operating room
- Certain lymphatic and venous procedures

Skilled Benefit Exhausted or Non-Skilled Level of Care

For providers in Delaware, Pennsylvania, and West Virginia

When a SNF provides care to a Medicare Advantage member who has either exhausted their skilled nursing benefit days or is receiving a non-skilled level of care, the SNF is no longer eligible for an inpatient per diem under Medicare Advantage.

However, the member may still use their Medicare Advantage coverage for certain Part B ancillary services. The SNF would be required to bill Highmark for all Part B ancillary services (including, but not limited to, lab, radiology, physical therapy, occupational therapy, speech therapy) provided to a Medicare Advantage member who is a resident of the SNF. This **does not apply** to durable medical equipment, prosthetics, orthotics, and respiratory equipment and to the complex services identified above.

This includes situations where the hospital's phlebotomist draws or collects specimens at the SNF for laboratory services that are performed at the hospital. The SNF will need to make arrangements for reimbursement to the hospitals for payment of these services.

The hospital is not permitted to bill for these ancillary services when administered to members who are residents in a SNF.

Reimbursement

Medicare Part B authorized services for Medicare Advantage members will be reimbursed via the Highmark SNF Outpatient Fee Schedule for Medicare Advantage Members.

For More Information

For more detailed information, please visit the SNF Consolidated Billing page on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for- Service-Payment/SNFPPS/ConsolidatedBilling.html

6.3 Skilled Nursing Facility Billing Outpatient Services

The Centers for Medicare & Medicaid Services (CMS) allows skilled nursing facilities (SNFs) to provide physical, occupational, and speech therapy services on an outpatient basis for beneficiaries residing in assisted living, residential, or personal care settings. These outpatient therapy services are available under the Part B benefit and the SNFs bill the services via the 837I/UB-04.

Highmark also allows SNFs to bill for outpatient therapy services for Highmark members with commercial and Medicare Advantage coverage. However, different guidelines apply for commercial and Medicare Advantage. These guidelines are outlined below.

Commercial Facility Agreements

Commercial agreements with SNFs are only inpatient agreements and do not contain provisions for outpatient services. However, SNFs contracted with Highmark for commercial products are able to bill for outpatient physical, occupational, and speech therapy services under the conditions outlined below:

- All therapists must be credentialed and contracted with Highmark.
- The SNF must establish a Highmark Assignment Account in order to bill on behalf of the credentialed/contracted therapists.
- All services must be billed via an electronic 837 Professional transaction or a 1500 claim form.

Before a SNF can bill for outpatient therapy services rendered to Highmark members with commercial coverage, the SNF must secure a Highmark Assignment Account. The Assignment Account allows SNFs to bill on behalf of the therapists.

Highmark provides an online form to request an Assignment Account. To access the form, select **Resources & Education** from the main menu on the Provider Resource Center, and then click on **Provider Information Management Forms** which is under **Forms**.

Payment will not be made for outpatient therapy services under the Commercial SNF Agreement when services are billed on an 837I or UB-04 claim.

Medicare Advantage Facility Agreements

For providers in Delaware, Pennsylvania, and West Virginia

Medicare Advantage agreements cover inpatient, Part A exhaust, and limited outpatient therapy services in a skilled setting. SNFs may also bill for authorized Part B outpatient physical, occupational, and speech therapy services for Highmark Medicare Advantage members residing in an assisted living, residential, or personal care setting.

SNFs must bill outpatient therapy services provided to Highmark Medicare Advantage members via an electronic 837 Institutional transaction or a UB-04 claim form.

6.3 Guidelines for Skilled Nursing Facilities Billing Portable X-ray Services for Medicare Advantage

For providers in Delaware, Pennsylvania, and West Virginia

This section provides instructions to skilled nursing facilities (SNFs) when billing for portable X-ray services rendered to Highmark Medicare Advantage members who have exhausted Part A benefits or are no longer receiving a Medicare skilled level of care.

Background

When billing for portable X-ray services when a Medicare Advantage member has exhausted Part A benefits or is no longer receiving skilled care, the site at which the service is rendered determines whether the SNF or the portable X-ray provider is responsible for the service.

- When the portable X-ray service is provided in a participating SNF, the SNF is responsible for billing the service to Highmark via an 837I electronic transaction or UB-04 claim form.
- When the portable X-ray service is rendered in a personal care home, assisted living facility, or independent living unit of a retirement community organization, the member is not considered a patient of the SNF. Therefore, the service must be billed by the portable X-ray provider via an 837P electronic transaction or 1500 claim form, even if the site is located on the campus of a participating SNF.

When the SNF is responsible for billing Highmark for the portable X-ray services, the SNF should follow the instructions provided below.

Three Components of the Service

When a portable X-ray provider renders services to a Highmark Medicare Advantage member in a participating SNF and the member has exhausted their Part A benefits or is no longer receiving a skilled level of care, the SNF can bill for three components of the service:

- The taking of the X-ray itself;
- Setup; and
- Transportation of the X-ray equipment and personnel to the site where the service will be provided.

In each case, the SNF is to report revenue code **032X** plus the procedure codes that most accurately and completely represent the services rendered. Units are required. In addition to the information below, all standard billing protocols apply.

X-Ray Itself

To bill for the X-ray itself, the facility must report revenue code **032X** plus the procedure code that most accurately and completely represents the radiological service(s) rendered. National coding guidelines must be followed, including the selection of the most comprehensive code applicable to the services rendered.

Given the choice of the most comprehensive code, units must equal the number of times the services described by the procedure code were performed.

Setup

The setup component of a radiological procedure performed by a portable X-ray provider should be billed using revenue code **032X** and procedure code **Q0092**.

For this component, units equal the number of eligible radiological procedures performed for the patient, except for re-takes of the same procedure.

Transportation for One Member

When only one Highmark Medicare Advantage member is seen by the portable X- ray provider during a given trip, the transportation component should be billed using revenue code **032X** and procedure code **R0070**.

When Multiple Members Seen

The SNF may bill for transportation only once for any given trip regardless of how many Highmark Medicare Advantage members receive portable X-ray services during the trip. Therefore, **procedure code R0070 may be reported on only one of the facility's claims for the Highmark Medicare Advantage members serviced during the trip**, as illustrated in the examples below.

Examples

In these scenarios, assume that all services were rendered in a participating SNF and to Highmark Medicare Advantage members who have exhausted their Part A benefits or are no longer receiving a Medicare skilled level of care.

Scenario 1: One Highmark Medicare Advantage Member is Seen During the Trip

Billing for Patient A

Component	Revenue Code	Procedure Code	Units
Transportation	032X	R0070	1
Setup	032X	Q0092	The number of eligible radiological services performed for this member
Radiology Service	032X	As appropriate for the service provided	The number of times the services describes by the procedure code were performed for this member during this trip

Scenario 2: Three Highmark Medicare Advantage Member are Seen During the Trip

Billing for Patient A

Component	Revenue Code	Procedure Code	Units
Transportation	032X	R0070	1
Setup	032X	Q0092	The number of eligible radiological services performed for this member
Radiology Service	032X	As appropriate for the service provided	The number of times the services describes by the procedure code were performed for this member during this trip

Billing for Patient B

Component	Revenue Code	Procedure Code	Units
Transportation	032X	None	None

Setup	032X	Q0092	The number of eligible radiological services performed for this member
Radiology Service	032X	As appropriate for the service provided	The number of times the services describes by the procedure code were performed for this member during this trip

Billing for Patient C

Component	Revenue Code	Procedure Code	Units
Transportation	032X	None	None
Setup	032X	Q0092	The number of eligible radiological services performed for this member
Radiology Service	032X	As appropriate for the service provided	The number of times the services describes by the procedure code were performed for

			this member during this trip

Return Trip

In the event that a portable X-ray provider would be required to make a return trip to a SNF within the same day, the SNF billing protocol would again mirror Scenario 1 or Scenario 2 depending on the number of Highmark Medicare Advantage members seen during the return trip.

6.3 Home Health Agency Billing Home Infusion Services for Medicare Advantage

For providers in Delaware, Pennsylvania, and West Virginia

Billing Guidelines

When a Medicare Advantage member is being treated under 60-day Episode of Care and concurrently receiving home infusion services, the proper billing methodology must be used by the home health agency.

If home infusion services are being provided, the existing 60-day Episode of Care must be closed and a new claim for a Partial Episodic Payment (PEP) with a discharge status of **"06"** must be submitted to Highmark.

Unrelated Service

If additional services are provided to the member that are unrelated to the home infusion services, a claim will need to be submitted for these services using the per visit reimbursement methodology.

Note: These additional services will need to be authorized by Highmark Clinical Services.

Infusion Services Completed

After the home infusion services have been completed, another 60-day Episode of Care can be submitted if the member requires additional home health services.

Note: An additional 60-day Episode of Care will need to be authorized by Highmark Clinical Services.

6.3 Reimbursement for Inpatient Hospice When Discharge Status Indicates Expired

Inpatient hospice facilities will receive reimbursement when the member's discharge status indicates expired. This policy applies to commercial products effective with discharge dates on or after August 1, 2014.

Requirement for Claim Submission

Highmark requires hospice providers to submit the eligible dates of service and the total number of units for inpatient hospice services, including the date of death. Hospice providers must use discharge status codes when submitting claims:

- 40 – Expired at home
- 41 – Expired in a medical facility
- 42 – Expired (place unknown)

Extending the Authorization to Include Date of Death

If the member has expired and the date of death is not covered by the existing authorization period, the facility must notify Highmark Clinical Services. This is to extend the authorization and enable the payment to be made for the member's expiration date.

6.3 Diagnostic vs. Routine Pap Smears

These guidelines clarify billing for both outpatient diagnostic pap smears and routine pap smears.

Billing for Routine Pap Smears

If billing for a **routine pap smear**, only report a **routine** diagnosis on the claim to ensure that the claim will process correctly.

Billing for Diagnostic Pap Smears

If billing for a **diagnostic pap smear** as a follow-up to a routine pap smear, and **no other services are being reported** on the claim, the diagnosis code reported should only be **diagnostic** and related to the symptom or chief complaint of the patient.

Note: If a routine diagnosis code is reported on a claim where the only service being billed is diagnostic, the claim will be viewed as routine and it may be rejected for benefit limitations.

Diagnostic Pap Smears With Routine Services

If billing for a diagnostic pap smear **and** a routine service:

- Report the diagnosis related to the symptom or chief complaint of the patient for the diagnostic pap smear, and
- Also report the routine diagnosis for the routine service provided.

6.3 Revised and Discontinued Bill Types for Home Health

On October 1, 2013, Highmark aligned with the National Uniform Billing Committee's (NUBC) decision to simplify code sets by revising and discontinuing certain bill types for Home Health providers.

Bill Types Revised or Discontinued

The following bill types have been revised and and/or discontinued:

Bill Type	Description of outpatient bill types prior to October 1, 2013	Description of outpatient bill types effective October 1, 2013
032x	Inpatient (plan of treatment under Part B only)	Home Health Services under a Plan of Treatment
033x	Home Health Services under a Plan of Treatment	Discontinued
034x	Other (for medical and surgical services not under a plan of treatment)	Home Health Services **not** under a Plan of Treatment

Important!

This requirement does not affect your reimbursement method. Providers should continue to submit claims according to your contract.

6.3 Guidelines for Submitting Paper Claims

Optical Character Recognition (OCR)

Although electronic claim submission is required, you may encounter a situation in which the submission of a paper claim is necessary. If this occurs, **you must always print or type all information on the claim form.** Clear, concise reporting on the form helps us to interpret the information correctly.

Highmark uses an Optical Character Recognition (OCR) scanner for direct entry of claims into its claims processing system. OCR technology is an automated alternative to manually entering claims data. The

OCR equipment scans the claim form, recognizes and “reads” the printed data, then stores the image for audit purposes. The scanner can read both computer-prepared and typewritten claim forms.

Tips for Submitting Paper Claims

To ensure that your facility’s claims are submitted in a format that allows for clear scanning, please observe the guidelines below so that the scanner can “read” and “interpret” the claim data correctly:

- Only use the approved red UB-04 paper claim form.
- Always send the **original** claim form to Highmark, since photocopies cannot be scanned. If your facility is using a multi-part form, please submit the top sheet, not one of the copies.
- Print the data on the form via computer, or type it within the boundaries of the fields provided on the form. **Do Not Hand-Write.**
- Use a print range of 10 or 12 characters per inch (CPI).
- Use black ink only. The scanner cannot read red ink.
- Do not use excessive amounts of correction fluid on the claims.
- Change the print ribbon or cartridge regularly to ensure print readability; light print cannot be read by the scanner.
- Do not use a rubber stamp to print data in any fields of the UB claim form.
- Do not highlight anything on the claim form or any necessary attachments; highlighted information becomes blackened out and is not legible.

This tip sheet is designed to highlight the fields of the UB-04 claim form that are required when submitting to Highmark.

Required Information

In order to avoid processing and payment delays, please complete the claim form in its entirety. If required information is not present on the claim, Highmark will return the claim to your facility for completion. Under certain circumstances, Highmark may contact the facility to obtain the missing data.

Exception: Major Medical Claims

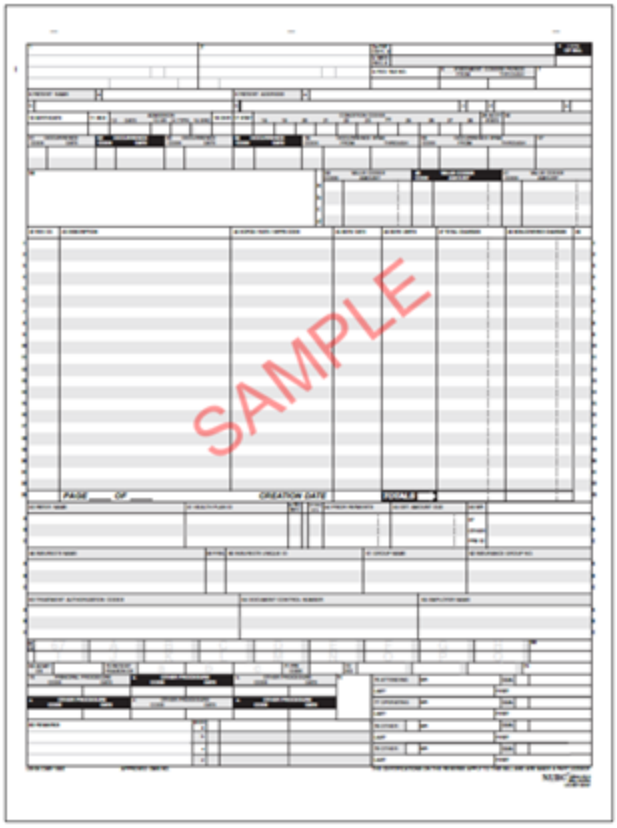
For providers in Pennsylvania

Pennsylvania Western Region facilities are required to submit Major Medical claims via a red UB-04 paper claim (available at https://www.nubc.org/), rather than electronically.

6.3 Sample UB-04 Claim Form

Sample UB-04

Click Here for a full-size version of the sample UB-04 claim form.



This tip sheet is designed to highlight the fields of the UB-04 claim form that are required when submitting to Highmark.

6.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 4: Professional (1500/837P) Reporting Tips

6.4 Introduction

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications have become integral to health care. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically. This unit provides general guidelines applicable to both paper and electronic 1500/837P professional claim submissions.

If you are not already billing electronically, please refer to **Chapter 1.3: Electronic Solutions - EDI & Availity** for information on how to take advantage of the electronic solutions available to you.

Required Formats

Use the following table to determine the required format for submitting claims:

If you submit...	Then use one of these formats...
Electronically	ASC X12N 837 Health Care Claim: Professional Transaction Version 005010
On paper	1500 Health Insurance Claim Form ("1500 Claim Form"), Version 02/12 **Note:** If you are using paper forms, please submit the original claim form. Photocopies or outdated versions of the 1500 form will not be accepted and will be returned to the provider.

Telemedicine Service

For complete information on telemedicine services, including billing guidelines specific to those services, please see **Chapter 2.5: Telemedicine Services.**

Guidelines Specific to 1500/Paper

Please see **Chapter 6.5: 1500 Claim Form Guidelines** for guidelines specific to the 1500 Health Insurance Claim Form and paper claim submissions.

Avoid Form 1099-MISC Errors

The information entered for the billing provider on the claim affects how your income is reported to the Internal Revenue Service (IRS). Highmark must notify the IRS of payments of $600 or more it makes to a provider or practice within a calendar year. If you received payments of $600 or more from Highmark in any calendar year, Highmark will send you a miscellaneous income statement (form 1099-Misc) at the end of January of the following year. **Please follow these guidelines so that Highmark reports your correct income to the IRS:**

- If the income is to be reported under the practice's name (group name) and tax identification number (TIN), please enter the group's NPI number as the billing provider on the claim. Highmark will then issue all checks payable to the group's name. The 1099-Misc form will also be issued under the group's name.
- If the income is to be reported under an individual's name and Social Security Number (in the case of a sole proprietor), please enter the individual's NPI number as the billing provider box the claim. Highmark will issue all checks payable to the individual provider's name. The 1099-Misc form will also be issued under the individual's name.

Note: Highmark discourages the use of Social Security numbers in lieu of business tax identification numbers whenever it requests a provider's tax identification number. A provider who chooses to submit his or her Social Security Number (SSN) as a tax identification number hereby acknowledges, understands, and agrees that Highmark will treat the SSN in the same manner in which it handles other providers' business tax identification numbers and shall not be liable to such provider for any intentional or unintentional disclosures of such SSN.

To guarantee that your 1099 is correct, make sure that your billing agent is using the correct provider number on all claims — paper or electronic. Highmark will not make changes to Form 1099 if the claims

(paper or electronic) were submitted with the performing provider incorrectly listed as the billing provider. If you have any questions about Form 1099-Misc issues, please call **866-425-8275**. You can also e-mail 1099inquiry@highmark.com.

Here is a detailed matrix that will show you how to submit your claims. The information in this matrix does not apply to individual health care professionals who report their services under their personal tax identification number, including sole proprietors.

Common Naming Convention	Highmark Terminology	CMS-1500 (08/05) Paper Claim Form Box Number	837 Professional Version 5010 Mapping
Billing Provider name	Assignment account (AA) or group name	33	Loop 2010AA Billing Provider Name NM103
Billing Provider address	AA or group address	33	Loop 2010AA Billing Provider Address N3 and N4
Billing Provider Tax Identification Number	AA or group tax identification number	25	Loop 2010AA Billing Provider Tax Identification REF02
Billing Provider National Provider Identifier (NPI)	AA or group NPI	33a (unshaded area)	Loop 2010AA Billing Provider Name NM109

Billing Provider specialty information	AA or group Taxonomy Code	33b (shaded area) Report PXC (Taxonomy qualifier) and Taxonomy Code*	Loop 2000A Billing Provider Specialty Information
Rendering Provider name	Performing provider name (individual person who performed the service)	Not applicable	Loop 2310B Rendering Provider Name NM103, NM104, NM105. Use when the provider performing the service is different than the Billing Provider (Loop 2010AA NM1)
Rendering Provider specialty information	Performing provider Taxonomy Code	24J, upper line (shaded area). In box 24I (ID Qual.), upper line (shaded area), report PXC.*	Loop 2310B Rendering Provider Specialty Information
Rendering Provider NPI	Performing provider NPI	24J, lower line (unshaded area)	Loop 2310B Rendering Provider NM109

**When the billing or rendering provider's NPI is associated with more than one Highmark-contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.*

6.4 Selecting a Level of Medical Decision Making For Coding An Evaluation and Management Service

The documentation for evaluation and management (E/M) services is based on three “key” components: history, physical exam, and medical decision making.

For purposes of medical record audits of evaluation and management (E/M) coding levels, Highmark expects that the medical records will reflect that the medical decision-making component is aligned with the complexity of the patient history and examination.

Medical Decision Making and Tools Used to Determine Complexity Level

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

1. the number of possible diagnoses and/or the number of management options that must be considered;
2. the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
3. the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The levels of E/M services recognize four levels of medical decision making: straight-forward, low complexity, moderate complexity, and high complexity.

In the medical review process, Highmark uses a scoring tool based on the instructions in the 1995 and 1997 Centers for Medicare & Medicaid Services (CMS) E/M documentation guidelines. Points are

assigned in accordance with the documented medical record to determine the complexity level of medical decision making.

Number of Diagnoses/Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on the number/types of problems addressed during the encounter, the complexity of establishing a diagnosis(es), and the management decisions that are made by the physician.

Table A: Number of Diagnoses AND Management Options	Points Assigned
Self-limiting or minor problems; stable, improved, or worsening	1 point
Established problem; stable, improved	1 point
Established problem; worsening	2 points
New problem; no additional workup planned	3 points
New problem; additional workup planned	4 points

An encounter is interaction between a covered Highmark member and a health care provider for which an evaluation and management service or other service(s) is rendered and results in a claim submission. Any testing, consultation, and/or referral that is being done beyond that encounter to assist the provider in medical decision making is **"additional workup planned."**

Additional workup planned is an element of review, which includes a number of diagnoses and management options. The additional workup planned element contributes to indicating the complexity of a patient's condition based on diagnostic tests. It is a key element for highly complex E/M services and

constitutes any testing, consultation, and/or referral that is being done **beyond the encounter** to assist the provider in medical decision making.

An example of additional workup planned is recommendation for additional follow-up care, with the discussion documented in the member's medical records. **A simple instruction to patients to contact their primary physician does not constitute additional workup planned.**

The examples below are based on a record review assessment and further illustrate the medical decision-making component scoring above.

Office E/M Documentation

1. Established problem – worsening: An established patient sees his/her gastroenterologist due to worsening of symptoms. Two points would be assigned for "Established problem - worsening" score.
2. New problem – additional workup planned: The patient presented to his/her new family practitioner with symptoms requiring additional tests and/or a referral to a specialist. In addition, the family practitioner contacts the specialist. Four points would be assigned for "New problem – additional workup planned" score.

Emergency Room/Emergency Department E/M Documentation

1. New problem – no additional workup planned: A patient presents with a low grade fever and pharyngitis. An examination is provided and the patient is sent home with a prescription and instructed to follow up with their primary care physician as needed. Three points would be assigned for "New problem – no additional workup planned" score.
2. New problem – additional workup planned: A patient presents with abdominal pain and hematuria. The ER/ED physician (or staff) schedules an outpatient MRI and/or communicates directly with the patient's primary physician or other specialist and schedules an appointment for follow-up after discharge from the ER/ED, with the discussion documented in the medical record. Four points for "New problem - additional workup planned" would be scored.

Credit is not given for additional workup planned if the clinical testing and/or consultation occurred during the ER/ED encounter or in the instance when the patient is simply instructed to contact their

primary physician.

Amount and/or Complexity of Data to be Reviewed

The amount and complexity of data to be reviewed is based on the types of diagnostic tests ordered/reviewed, obtaining history from others, and discussion with other health care providers.

Table B: Amount and/or Complexity of Data Reviewed	Points
Lab tests ordered and/or reviewed (regardless of number ordered)	1 point
X-rays ordered and/or reviewed (regardless of number ordered)	1 point
Procedures found in the Medicine section of CPT (90281-99199) ordered and/or reviewed	1 point
Discussion of test results with performing physician	1 point
Decision to obtain old record and/or obtain history from someone other than patient	1 point
Review and summary of old records and/or obtaining history from someone other than patient and/or discussion with other health care provider	2 points

Independent visualization of image, tracing, or specimen (not simply review of report)	2 points

Risk Level of Complication and/or Morbidity or Mortality

Tables A and B (above), in conjunction with Table C (below), describe specific point value information. In order for an E/M service to be assigned a particular medical decision making level, the service must score at or above that level in two out of the three categories.

Highmark uses the following risk table, which appears in both the 1995 and 1997 CMS published guidelines, as a tool for determining the appropriate risk level for a reported E/M visit.

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.

The highest level of risk in any one of the three categories — Presenting Problem(s), Diagnostic Procedure(s), or Management Options — determines the overall risk.

Table C: Assessment of Risk (Common Clinical Examples)

LEVEL OF RISK	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem (e.g., cold, insect bite, tinea, corporis)	• Laboratory tests requiring venipuncture • Chest X-ray • EKG/EEG • Urinalysis • Ultrasound (e.g., echo-cardiography)	• Rest • Gargles • Elastic bandages • Superficial dressings

		• KOH prep	
Low	• Two or more self-limited or minor problems • One stable chronic illness (e.g., well-controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness (e.g., cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (e.g., pulmonary function tests) • Non-cardiovascular imaging studies with contrast (e.g., barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem	• Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (e.g.,	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors • Prescription drug management

	with uncertain prognosis (e.g., lump in breast) • Acute illness with systematic symptoms (e.g., pyelonephritis, pneumonitis, colitis) • Acute complicated injury (e.g., head injury with brief loss of consciousness)	arteriogram, cardiac catheterization) • Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis)	• Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous, or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive

	embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (e.g., seizure, TIA, weakness, or sensory loss)	• Discography	monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Reimbursement Policy RP-057

Please see Highmark Reimbursement Policy Bulletin RP-057: Documentation Guidelines for Evaluation and Management Services for Highmark's documentation requirements for supporting the level of an E/M service reported and the eligibility for reimbursement based on fulfilling the required criteria.

For More Information

The E/M scoring tools used by Highmark in the medical record review process are available on the Provider Resource Center. To access, select **Claims & Authorization** from the main menu, and then **Guidelines & Tips** under **Reimbursement Resources**. There you'll find **Documentation Guidelines For Evaluation and Management Services.**

6.4 Billing First Priority Health Network PCP Services (PA Only)

For providers in Pennsylvania

Claims must be Submitted for PCP Capitated AND Billable Services

This information applies only to primary care physicians (PCPs) participating in the First Priority Health (FPH) managed care network in the 13-county Northeastern Region of Pennsylvania.

It is critical that **all** services rendered to members by FPH network PCPs be submitted for adjudication. This includes capitated (prepaid) services in addition to the PCP billable procedures, which are paid fee-for-service. The data captured on these claims allow us to monitor clinical activities, comply with accrediting bodies, and provide PCPs with fair capitation payments and accurate reports. Capitated services are not subject to coordination of benefits.

The PCP must submit claims with all the required information via an 837P electronic claim transaction or a paper claim using an original 1500 Health Insurance Claim Form, Version 02/12 (photocopies, discontinued, or outdated versions will not be accepted).

PCP Billable Services

For providers in Pennsylvania

Please refer to the PCP Billable Services list for procedures that are billable for fee-for-service reimbursement.

This list is also available on the Provider Resource Center. To access, select **Claims & Authorization** from the main menu, and then **Guidelines & Tips** under **Reimbursement Resources**. There you'll find the list.

For More Information

Please see the manual's **Chapter 6.7: Payment/EOBs/Remittances** for additional information on FPH network payment methodology.

6.4 Modifiers

A modifier is a two-character code — numeric, alphabetical, or alpha-numeric — that is placed after the usual procedure code. A modifier permits a provider to indicate whether a service or procedure has been altered by specific circumstances, but not changed its definition or code. Up to four modifiers can be reported for each service.

Essential Modifiers

Some modifiers that are essential to accurate claims processing and must be reported on the claim form, when applicable, are:

Modifier	Definition

LT	Identifies procedures performed on the left side of the body.
RT	Identifies procedures performed on the right side of the body.
50	Identifies bilateral procedures. Unless otherwise identified by a specific code, bilateral procedures should be identified by adding a 50 modifier to the appropriate procedure code.

Our claims processing system is programmed to look for RT or LT modifiers on codes for services that may be performed bilaterally. When reporting a procedure that can be performed on either side of the body, report the appropriate RT or LT modifier. If neither the 50, RT, nor LT modifiers are reported, one of the services will be rejected as a duplicate.

Modifier	Definition
76	Repeat procedure by same physician. Use this modifier to report all procedures or portions of procedures that are repeated on the same date.

The 76 modifier should be applied to the subsequent or repeat procedure only. Failure to use this modifier when appropriate will result in a rejection, as the service will be read as a duplicate.

Modifier	Definition
22	Unusual Procedural Services: One that is of greater complexity than that usually required

	for the listed procedure – identify that service by adding a 22 modifier to the standard procedure code.

The 22 modifier distinguishes the procedure performed as an unusual service, including extenuating medical circumstances. When you report a procedure code with a 22 modifier, Highmark recommends that you submit your claim electronically through an 837 transaction and use the Paperwork (PWK) Segment to report the type and transmission of the attachment.

PWK Cover Sheet and Submission

When using the PWK segment on electronic claim submissions, please use the applicable PWK cover sheet for your service area when submitting your supporting documentation:

- Pennsylvania: PWK (Paperwork) Supplemental Claim Information Cover Sheet
- Delaware: PWK (Paperwork) Supplemental Claim Information Cover Sheet
- West Virginia: Electronic Claims Attachment Cover Sheet

The cover sheet is also available on the Provider Resource Center. Select **Resources & Education** from the main menu, and then click on **Miscellaneous Forms** which is under **Forms.** For additional guidance on using the PWK segment, please see **Chapter 6.2: Electronic Claim Submission.**

Fax or mail supporting documentation to the applicable fax number or address as indicated below:

Pennsylvania	Delaware	West Virginia
Attention: Document Preparation/Image	**Attention:** Document Preparation/Image	**Attention: CDC Area**
Fax to: 888-910-8797	**Fax to:** 888-910-9601	**Fax to:** 844-235-7266

Mail to: Highmark Blue Shield PWK (Paperwork) Additional Documentation P.O. Box 890176 Camp Hill, PA 17089-0176	**Mail to:** Highmark Blue Cross Blue Shield Delaware PWK (Paperwork) Additional Documentation P.O. Box 8832 Wilmington, DE 19899	**Mail to:** Highmark West Virginia P.O. Box 7026 Wheeling, WV 26003-0766

Claim Review and Adjudication

One of our Professional Consultants will review your claim and supporting documentation. He or she will determine whether or not additional reimbursement is warranted based on the clinical circumstances documented in the medical records, and if so, how much additional reimbursement is appropriate. Claims with a procedure code with a 22 modifier will be adjudicated and will receive one of the following message codes:

- J6056 – Unusual procedural services were reported with no supporting documentation, therefore, no additional payment can be considered.
- J6057 – Unusual procedural services were reported and the supporting documentation was considered, but does not warrant an additional payment.
- J6058 – Unusual procedural services were reported and the supporting documentation was considered for the additional payment reflected under the allowance.

Highmark will conduct a one-time review of the supporting medical documentation that was submitted with the claim. If, after reviewing the claim, Highmark determines that additional payment is not warranted, it will not review the supporting documentation a second time. In this case, Highmark will deny your claim and you will receive message code J6057.

If you submit a claim for a procedure with a 22 modifier and do not send the supporting medical records within 21 days, Highmark will process the claim without considering the 22 modifier and will notify you by including message code J6056 on your Explanation of Benefits form. Highmark will consider the procedure you reported at the standard allowance.

If you send supporting documentation to Highmark after your claim was processed, you should perform

a claim inquiry through Availity®. Specific instructions as to where to submit supporting documentation will be included in the response to your claim inquiry. If you are not Availity-enabled, contact Provider Services for instructions on how to submit your supporting documentation.

Assistant at Surgery: Modifiers 80, 81, 82, & AS

An **assistant at surgery** is defined as a physician, nurse practitioner, clinical nurse specialist, or physician assistant who is licensed and actively assists the physician in charge of a case in performing a surgical procedure.

Doctors of medicine (MDs) and doctors of osteopathic medicine (DOs) must report physician **modifier 80, 81, or 82**, as applicable, on claims for assistant at surgery services.

80 -- Assistant surgeon
81 -- Minimum assistant surgeon
82 -- Assistant surgeon (when qualified resident surgeon not available)

The **AS modifier** must be reported on the claim when billing assistant at surgery services provided by physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS). This modifier is only valid for use by non-physician practitioners.

Highmark will reimburse eligible surgical procedures billed with modifiers 80, 81, 82, and AS if criteria are met. Payment may be made for surgical procedures with these modifiers only if the services of an assistant surgeon are applicable. Please see Highmark Reimbursement Policy Bulletin RP-001 Assistant at Surgery Services for reimbursement information.

In addition, please see the following medical policies for your service area for eligibility criteria for assistants at surgery:

- **Commercial:** Medical Policy S-16 Assistant Surgery Eligibility Criteria
- **Medicare Advantage**: see the Medicare Advantage Medical Policies are available on CMS' Medicare Coverage Database website .

Note: Please see also the information on the Delaware state mandate below.

Co-Surgery: Modifiers 62

Co-surgeons are defined as two or more surgeons, working together simultaneously as primary surgeons, to perform distinct parts of an operative procedure. Co-surgery is always performed during the same operative session.

When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report their distinct operative work by adding **modifier 62 - two surgeons** to the applicable procedure code(s) on the claim. Highmark will reimburse eligible surgical procedures billed with modifier 62 if criteria are met. Please see Highmark Reimbursement Policy Bulletin RP-002 Co-Surgery.

- Coverage guidelines for co-surgery can be found in Medical Policy S-112 Co-Surgery for commercial members. For Medicare Advantage members, please see the Medicare Advantage Medical Policies are available on CMS' Medicare Coverage Database website.

For additional information for Delaware, please see the Delaware state mandate information provided below.

Please Note: Co-surgery is not the same as "team surgery," which is defined as two or more doctors, usually with different skills and of different specialties, working together to carry out various procedures of a complicated surgery.

Delaware State Mandate

For providers in Delaware

Effective January 1, 2000, the Delaware Insurance Department adopted Regulation 1312 (formerly Regulation 83), which sets standards of payment for surgical assistants (including co-surgeons). The Delaware Regulation requires carriers to apply Medicare rules in determining whether surgical assistants and co-surgeons are eligible for reimbursement. Claims for assistant and co-surgery pay according to Centers for Medicare & Medicaid (CMS) guidelines (see CMS Online Manual, Pub. 100-04. Chapter 12). This regulation applies to Delaware health insurance policies that follow Delaware state mandates.

For More Information

Highmark reimbursement policies and medical policies are available on the Provider Resource Center. Reimbursement policies are found in **Claims & Authorization** then look under **Reimbursement Programs.** Medical policies are in **Policies & Programs.** Click on **Medical Policy.**

6.4 Reporting Bilateral Procedures

Bilateral Procedures (Examples on 02/12 1500 Claim Form)

When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report. There are several ways to report bilateral procedures. **Note:** Please see the next section of this unit for changes effective July 1, 2019.

“Right” and “left” modifiers

If you report bilateral services on two lines of service, report an RT modifier on one line and an LT modifier on the other. The number of services on each line should be “1.”

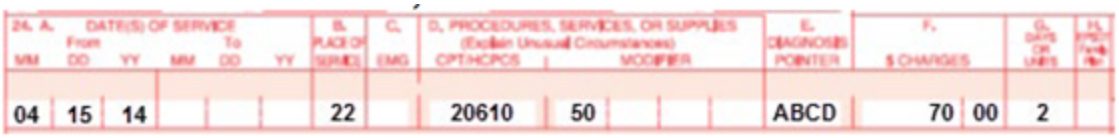
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
04	15	14				22		20610	RT	ABCD	35 00	1	
04	15	14				22		20610	LT	ABCD	35 00	1	

If you report bilateral services on one line of service, report RT and LT modifiers. The number of services should be “2.”

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
04	15	14				22		20610	RT	LT	ABCD	70 00	2	

“50” modifier

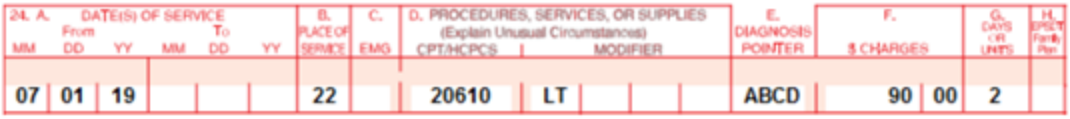
Bilateral procedures that are performed at the same operative session. If you report a “50” modifier to indicate bilateral procedures, report only one line of service. The number of services should always be “2.”



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
04	15	14				22		20610	50	ABCD	70 00	2	

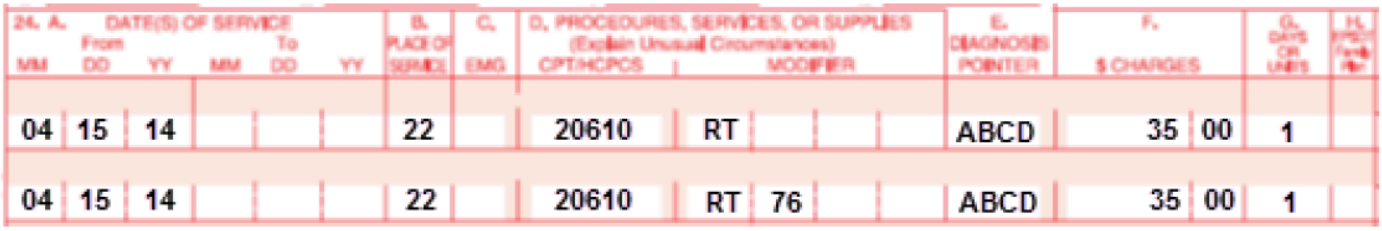
Multiple services on the same side of body

If you report multiple services performed on the same side of the body (e.g., right shoulder, right hip), you may follow either of these examples:



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
07	01	19				22		20610	LT	ABCD	90 00	2	

or



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
04	15	14				22		20610	RT	ABCD	35 00	1	
04	15	14				22		20610	RT 76	ABCD	35 00	1	

In this case, the 76 modifier must be reported on the second line that reports the same procedure code for correct payment to be made.

6.4 Bilateral Procedures: Reporting and Reimbursement

Effective for claims processed on and after July 1, 2019, Highmark will more closely follow the Centers for Medicare & Medicaid (CMS) reporting and reimbursement guidelines for bilateral procedures.

Bilateral procedures are procedures performed on both sides of the body during the same operative session or on the same day. Reimbursement for bilateral procedures is based on the modifier(s) reported as well as the Medicare Physician Fee Schedule (MPFS) bilateral indicator. Correct bilateral billing will ensure timely and accurate processing of these claims.

Modifiers for Bilateral Procedures

Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session.

Modifiers RT (Right) and LT (Left) are reported when bilateral procedures occur on the same day but not during the same operative session.

MPFS Bilateral Indicators

The MPFS bilateral indicators identify whether a procedure is allowed to be performed bilaterally and if payment adjustment rules apply.

Indicator	Description
0	Bilateral surgery payment adjustment does not apply. Do not use 50 modifier.
1	Bilateral surgery payment adjustment does apply (150%). Use 50 modifier if bilateral. Units = 1.
2	Bilateral surgery payment adjustment does not apply. Already priced as bilateral. Do not use 50

	modifier. Units = 1.
3	Bilateral surgery payment adjustment does not apply. Typically radiology or diagnostic tests.
9	Bilateral surgery concept does not apply.

The bilateral indicators for procedure codes can be found by using the searchable Physician Fee Schedule Look-Up Tool available at: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Reporting Modifiers and Units of Service

When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report.

Bilateral Modifier 50

Modifier 50 is used to report bilateral procedures that are performed at the same operative session. When reporting modifier 50 to indicate bilateral procedures, report the procedure on only one line. **The number of services should always be "1."**

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
07	01	19				22		20610	50	ABCD	90 00	1	

Right (RT) and Left (LT) Modifiers

This option is used when bilateral services are performed on both sides of the body on the same day but not during the same operative session. RT and LT modifiers are not used when modifier 50 is appropriate.

When reporting bilateral services using RT and LT modifiers, report modifier RT on one line and modifier LT on the other. **The number of services on each line should be "1."**

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
07	01	19				22		20610	RT	ABCD	45 00	1	
07	01	19				22		20610	LT	ABCD	45 00	1	

Multiple bilateral services on the same side of the body

Modifiers RT and LT are also used to report bilateral procedures codes when services are performed on only one side of the body. Procedures are reported with either the RT or LT modifier indicating the side of the body on which the procedures were performed.

If you report the same procedure performed in multiple locations on the same side of the body (e.g., right shoulder, right hip), you can report the services on either one or two claim lines. If reporting on one claim line, report the appropriate modifier for laterality (RT or LT) and the applicable number of units:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
07	01	19				22		20610	LT	ABCD	90 00	2	

If you report multiple services for the same side of the body on separate claim lines, you must append **modifier 76** for the second line that reports the same procedure code for correct payment to be made:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
07	01	19				22		20610	LT			ABCD	45 00	1	
07	01	19				22		20610	LT	76		ABCD	45 00	1	

Payment Rules

The bilateral indicators with their payment rules are listed below:

Bilateral Indicator	Payment Rules

0	**150% payment adjustment for bilateral procedures does not apply.** Codes with this identifier are typically unilateral and modifier 50 is not billable. If the procedure is reported with modifier 50 or with modifiers RT and LT, Highmark will base payment for the two sides on the lower of: 1. The total actual charge for both sides; or 2. 100% of the fee schedule amount for a single c
1	**150% payment adjustment for bilateral procedures applies.** If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a "2" in the units field), Highmark will base payment for these codes when reported as bilateral procedures on the lower of: 1. The actual charge for both sides; or 2. 150% of the fee schedule amount for a single code.
2	**150% payment adjustment for bilateral procedure does not apply.** Codes with this identifier are typically identified as bilateral in the code description and modifier 50 is not billable. Fees are already based on the procedures being performed as a bilateral procedure.

	If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a “2” in the units field), Highmark will base payment for both sides on the lower of: 1. The total actual charges by the physician for both sides; or 2. 100% of the fee schedule amount for a single code.
3	**The usual payment adjustment for bilateral procedures does not apply.** Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a “2” in the units field), Highmark will base payment on each side or organ or site of a paired organ on the lower of: 1. The actual charge for each side; or 2. 100% of the fee schedule amount for each side.
9	**Codes with this identifier do not apply to the bilateral concept.** Modifier 50 is not billable.

Coding Examples

Below are examples of both correct and incorrect coding of bilateral procedures performed on both sides of the body during the same operative session:

Correct Coding for Bilateral Procedures

Procedure code	Bilateral Indicator	Modifier reported	Units reported	HCPCS Code Descriptor and Rationale
23515	1	50	1	"Open treatment of clavicular fracture, includes internal fixation, when performed." **Rationale:** Code description does not identify procedure as bilateral; report modifier 50 with"1" unit of service.
64488	2		1	"Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)." **Rationale:** Code description

				identifies the procedure as bilateral; report procedure code without a modifier and with “1” unit of service.
52290	2		1	“Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral.” **Rationale:** Code description identifies procedure as unilateral or bilateral; report procedure code without a modifier and with “1” unit of service.
73070	3	50	1	“Radiological examination, elbow; two views.” **Rationale:** Code description does not identify procedure as bilateral; report modifier 50 and “1”

				unit of service for bilateral services.
23515	1	RT and LT	2	Do not use modifiers RT and LT on same claim line when modifier 50 applies.
64488	2	50	2	Code description identifies procedure as bilateral. Do not use modifier 50 or report 2 units of service.
52290	2	50	1	Code description identifies procedure as unilateral or bilateral. Do not use modifier 50 or report 2 units of service.
73070	3	RT and LT	2	Do not use modifiers RT and LT on same claim line when modifier 50 applies.

6.4 Timed Therapy Codes

Effective beginning April 1, 2016, Highmark follows Medicare's method of counting minutes for timed therapy codes for professional services for our commercial plans. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

Guidelines

Based on the work value of these codes, the expectation is that the provider's direct patient contact time for each unit will average 15 minutes in length. If only one service is provided in a day, providers should not bill for the services performed for less than eight minutes.

For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to eight minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then two units should be billed. The pattern remains the same for treatment times in excess of the chart below.

Timed intervals for one through eight units are as follows:

Minutes	Units
8 – 22	1
23 – 37	2

38 – 52	3
53 – 67	4
68 – 82	5
83 – 97	6
98 – 112	7
113 - 127	8

Example 1

7 Minutes of neuromuscular re-education (97112)

7 Minutes therapeutic exercise (97110)

7 Minutes manual therapy (97140)

21 Total Timed Minutes

Appropriate billing is for one unit. The qualified professional would select one appropriate CPT code (97112, 97110, or 97140) to bill since each code was performed for the same amount of time and only one unit is allowed based on the total timed minutes.

Example 2

18 Minutes therapeutic exercise (97110)

13 Minutes of manual therapy (97140)

10 Minutes of gait training (97116)

8 Minutes of ultrasound (97035)

49 Total Timed Minutes

Appropriate billing is for three units. Bill the procedures you spent the most time providing. You would have one unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (e.g., you may not bill four units for less than 53 minutes total time regardless of how many services were performed). You would still document the ultrasound in the notes.

For More Information

The Centers for Medicare & Medicaid Services (CMS) claims processing Publicationn100-04 can be referenced for additional details.

6.4 Frequency Type Codes and Adjustments

Claim frequency type codes are used when billing to indicate whether a claim is a new, original claim or an adjustment of a previously adjudicated (approved or denied) claim.

Valid Frequency Type Claims

There are three valid Frequency Type claims that can be initiated:

- **Frequency Type 1** is an original claim. All new claims are submitted with this value.
- **Frequency Type 7** is a replacement of a prior claim. Frequency Type 7 is used to correct data reported incorrectly on the original claim. The original claim number assigned by Highmark is required on this type of submission.
- **Frequency Type 8** is a void/cancellation of a prior claim. Frequency Type 8 is used to completely void a claim that was reported in error. The original claim number assigned by Highmark is required on this type of submission.

Electronic 837P Adjustment Requests

The HIPAA 837P allows you to submit a claim adjustment request electronically using a valid Frequency Type code. Highmark's automated process allows us to process most of these adjustment requests with both the retraction and the repayment on the same remittance.

In the HIPAA 837P Claim Transaction, the Frequency Type Code is reported in the 2300 Loop, CLM05-3 element. The original claim number is reported in Loop 2300, ORIGINAL REFERENCE NUMBER (ICD/DCN) REF segment.

Note: Adjusted claims can be submitted within Availity®.

1500 Paper Claim Adjustments

When submitting an adjustment request on a paper claim, enter a 7 for a corrected/replacement claim or an 8 to void a prior claim in Box 22 RESUBMISSION CODE, with the original Highmark claim number entered in the ORIGINAL REF. NO. field.

Frequency Type 7 — Replacement of a Prior Claim

Frequency Type 7 is used when a claim has been processed for payment but you identify an error on the original claim that needs to be corrected. The information you enter on the replacement claim represents a complete or partial replacement of the previously submitted claim.

Replacement claims can be submitted when a service was billed with an error such as the following:

- Incorrect procedure or diagnosis code
- Incorrect place of service
- Incorrect total charge
- Incorrect units

The replacement claim data is used to review, reprocess, and adjust the original Frequency Type 1

claim as appropriate. The result of the adjustment could be an additional payment, no change in payment, or taking back an overpayment.

The Frequency Type 7 replacement claim will be reflected as a denied claim on the explanation of benefits (EOB) and/or electronic remittance (835):

- Denials on the EOB will report proprietary code E0775 (“The adjustment request received from the provider has been processed. The original claim has been adjusted based on the information received.”).
- On the 835, Claim Adjustment Group and Reason Code CO129 (“Prior processing information appears incorrect”) will be used to deny the claim.
- Remark Code N770 (“The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.”) will also be used on these claims.

Providers should not “write off” these amounts as contractual obligation. If the original claim is adjudicated to reflect member liability (e.g., copay or coinsurance), the member is still responsible for these amounts.

Frequency Type 8 – Void/ Cancellation of a Prior Claim

The use of Frequency Type 8 reflects the entire elimination of a previously submitted claim. This code will cause the claim to be completely canceled from Highmark’s system. A voided claim can be submitted when changes such as the following are necessary:

- Change of provider number
- Change to member identification

The replacement claim data is used to void the original claim from Highmark’s system and normal offset processes are followed.

The Frequency Type 8 void/cancellation claim will be reflected as a denied claim on the EOB and/or electronic remittance (835):

- Denials on the EOB will report proprietary code E0775 (“The adjustment request received from the provider has been processed. The original claim has been adjusted based on the information received.”).
- On the 835, Claim Adjustment Group and Reason Code CO129 (“Prior processing information appears incorrect”) will be used to deny the claim.
- Remark Code N770 (“The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.”) will also be used on these claims.

Exceptions: Manual Processing of Re-adjustment Claims

Although the automated process handles the majority of electronically submitted adjustments, there are certain categories of adjustments that still require manual intervention. Among these are adjustments to previously adjusted claims.

The original claim number assigned by Highmark is required for all adjustment Frequency Type claims. This instruction still applies to claims that have already been adjusted and now require a second (or subsequent) adjustment process.

As a reminder, Highmark bases its payment for each adjustment on the updated original claim rather than the rejected Frequency 7 or Frequency 8 claims. To expedite this manual process, please report the original claim number — not the number of the previous adjustment bill — in the REF-ORIG-ICN-DCN field of the new Frequency Type 7 or Type 8 claim.

6.4 Anesthesia Reporting Tips

For the most efficient processing of anesthesia services, submit claims electronically. If you bill electronically, please refer to the *Highmark EDI Reference Guide*, available on the Highmark EDI Services website, for billing instructions. You can access the website from the Provider Resource Center by selecting **Claims & Authorization** from the main menu, then **Reimbursement Resources.**

Coverage for services may vary for individual members, based on the terms of the benefit contract. Please check Highmark members' benefits via Availity® or, if not Availity-enabled, call Provider Services. **The listing of a procedure code and/or terminology in this section does not necessarily indicate coverage.**

For more specific information about anesthesia services, please refer to Highmark Medical Policy. To access, select **Policies & Programs** from the main menu, and then click on **Medical Policy.**

Anesthesia Procedure Codes

Use the national CPT (Current Procedural Terminology) anesthesia five-digit procedure codes (00100-01999) to report the administration of anesthesia along with national anesthesia modifier codes.

If you report "not otherwise specified" (NOS) or "not otherwise classified" (NOC) anesthesia services, include an appropriate surgical HCPCS procedure code as the description of the actual service or surgery performed. If the only suitable surgical HCPCS procedure code is an NOC, you must include a complete description of the service performed.

Highmark will only accept a complete description of the services performed. **Highmark will not accept the terminology of a national procedure code as a description of the service performed.** You must describe the actual service or surgery performed; otherwise, Highmark may reject your claim.

Examples of NOS/NOC Reporting

Below are some examples of how to report "not otherwise specified" or "not otherwise classified" anesthesia services in conjunction **with the 7 qualifier** in the shaded lines of Item Number 24 on the **02/12** version of the 1500 Claim Form.

If the surgical procedure code **is not a NOS/NOC surgical service**, please report as follows:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
735341															
04	15	14	04	15	14	20		00830	AA	A	2750	00	243		NPI
															NPI
															NPI

When the surgical procedure code **is a NOS/NOC surgical service,** please report as follows:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
731899	Excision of tracheal tumor - cervical														
04	15	14	04	15	14	20		00320	QY	A	2750	00	243		NPI
731899	Excision of tracheal tumor - cervical														
04	15	14	04	15	14	20		00320	QX	A	2750	00	243		NPI
															NPI

Payment of Anesthesia Services

The following types of anesthesia qualify for payment as anesthesia services:

- Inhalation
- Regional:
  - Spinal (low spinal, saddle block)
  - Epidural (caudal)
  - Nerve block (retrobulbar, brachial plexus block, etc.)
  - Field block
- Intravenous
- Rectal
- Moderate (conscious) sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (01991, 01992 — when the block or injection is performed by a different provider) is eligible for payment.

Local anesthesia (A9270) which is direct infiltration of the incision, wound, or lesion is not a covered service.

Payment for anesthesia services is evaluated according to the **base unit** value, plus **time units,** plus eligible **modifying units** when appropriate, multiplied by a **monetary conversion factor.**

Anesthesia Base Units

Highmark applies anesthesia base units to procedure codes to determine reimbursement and uses Centers for Medicare & Medicaid Services (CMS) base units for reimbursement determination. Base unit values have been assigned to most anesthesia services (procedure codes 00100-01999) to reflect the difficulty of the anesthesia service including the usual pre-operative and postoperative care and evaluation.

The base value for anesthesia when multiple surgical procedures are performed is the base value for the procedure with the highest unit value. No payment is allowed for the base unit value of a second, third, etc., procedure.

Anesthesia Time Units

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under customary postoperative supervision. **You must document this time in the anesthesia record, but do not report start and stop times on a claim.**

Report the actual time spent administering anesthesia as minutes on the claim. Time must be indicated on all anesthesia claims. Highmark will convert total minutes to time units. A “time unit” is a measure of each 15-minute interval of the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by 15, rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units). On the 1500 Claim Form, report total anesthesia time as minutes in Item Number 24G, “DAYS or UNITS.”

Exception: Report units, not minutes, for moderate (conscious) sedation procedure codes 99143-99145 and 99148-99150. More information is available on moderate sedation later in this unit.

Medical Direction (Supervision) of Anesthesia Overview

Highmark defines the medical direction or supervision of anesthesia as direction, management, or instruction of anesthesia by one who is physically present or immediately available in the operating suite. A physician performing medical direction should not actually administer anesthesia.

Highmark limits reimbursement to the medical direction of no more than four anesthesia services being performed concurrently. When the physician is medically directing more than four procedures concurrently, he or she must submit documentation of the medical necessity for directing more than four procedures. Highmark will then review the claim on an individual consideration basis.

A physician medically directing four or fewer anesthesia procedures can concurrently:

- Address an emergency of short duration in the immediate area;
- Administer an epidural or caudal anesthetic to ease labor pain;
- Provide periodic, rather than continuous, monitoring of an obstetrical patient;
- Receive patients entering the operating suite for the next surgery;
- Check or discharge patients in the recovery room; or
- Handle scheduling matters.

Medical Direction (Supervision) of Anesthesia Modifiers

To identify who performed the anesthesia service, please report the appropriate anesthesia procedure code modifiers in conjunction with codes 00100-01999. Do not report the modifier's description on the claim form.

Modifier	Description
	Anesthesia services performed personally by anesthesiologist. (The AA modifier is one of several modifiers Highmark requires to identify who is performing an anesthesia service. Although this modifier's terminology states

AA	"performed personally by an anesthesiologist," any duly licensed and trained health care professional who is personally performing anesthesia services can report it. The AA modifier is not limited to physicians who specialize in anesthesiology.) **Note:** Do not report the AA modifier when the anesthesiologist is medically directing one or more anesthetists, regardless of the employment status of the anesthetists.
AD	Medical supervision by a physician: More than four concurrent procedures.
GC	This service has been performed in part by a resident under the direction of a teaching physician.
QK	Medical direction of two, three, or four concurrent anesthesia procedures.
QX	CRNA (Certified Registered Nurse Anesthetist) service with medical direction by a physician.
QY	Medical direction of one CRNA by an anesthesiologist.
QZ	CRNA service without medical direction by a physician.

47	Anesthesia by surgeon: Regional or general anesthesia provided by the operating surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) • Report modifier 47 in conjunction with the basic service, for example, the surgery code. • Do not use modifier 47 as a modifier for anesthesia codes 00100-01999. • Do not report modifier 47 for moderate sedation (see information about moderate sedation further in this unit.)

Medical Direction (Supervision) of Anesthesia Reporting/Payment

Medical Direction of a physician-in-training (e.g., intern or resident) – 100 percent total payment: Report modifier GC. Payment will be made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

Medical Direction of an employed CRNA – 100 percent total payment: When an anesthesiologist medically directs a CRNA, hired and paid by the anesthesiologist, **two lines on the claim form are required** when reporting the medical direction. Report modifiers QK and QX or QY and QX, as appropriate. Payment is made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

The employer (anesthesiologist) must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient, if needed.

Report the name and Highmark provider ID number including the alpha prefix and/or NPI (National Provider Identifier) of the physician who is medically directing the service in Item Number 24J of the 1500 Claim Form. Report the name of the physician who is medically directing the service in Item Number 31 of the claim form. **Do not include the CRNA's name on the claim form.**

Medical Direction of Non-Employed CRNA – 50 percent total payment: When an anesthesiologist medically directs a CRNA not employed by the anesthesiologist, e.g., hospital compensated, report modifier QK or QY, as appropriate. Payment of 50 percent of the fee allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist.

Medical Direction of Independently Practicing (non-employed) CRNA – 50 percent/50 percent total payment: When an anesthesiologist medically directs a CRNA who directly bills his/her services on a fee-for-service basis, i.e., independently practicing, the anesthesiologist should report modifiers QK or QY, as appropriate. The CRNA should report modifier QX. Payment of 50 percent of the fee that is allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist. The remaining 50 percent is paid to the CRNA who is directly billing his/her services on a fee-for-service basis.

Anesthesia Services Personally Performed by Physician – 100 percent total payment: Report modifier AA when:

1. The physician personally performs the entire service; and
2. The physician is present in the operating room for the entire case and is actively participating in the administration of anesthesia, even if an anesthetist assists in the care of the patient.

**For additional information, please see Highmark Reimbursement Policy* RP-033 Anesthesia Services*.*

Note : Effective November 1, 2018, this information applies to Highmark West Virginia.

Physical Status Units

Physical status units may be used to report the physical status of the patient undergoing surgery under anesthesia. Physical status should be reported under the appropriate modifier (P1-P6).

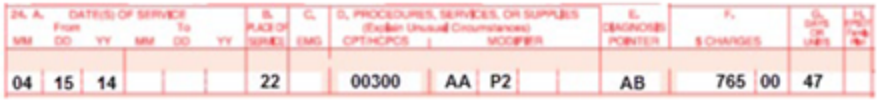
The list of modifiers to report physical status include:
Exception: You can report physical status with the applicable modifier. Report this modifier only in conjunction with the appropriate anesthesia procedure code (00100-01999).

The list of modifiers to report physical status include:

Modifier	Description	Modifying Units
P1	A normal, healthy patient	0
P2	A patient with a mild systemic disease	0
P3	A patient with a severe systemic disease	1
P4	A patient with a severe systemic disease that is a constant threat to life	2
P5	A moribund patient who's not expected to survive without the operation	3
P6	A declared brain-dead patient; organs removed for donor purposes	0

1500 Claim Form (02/12) Claim Example

1500 claim example for anesthesia services personally performed by physician:



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
04	15	14				22		00300	AA	P2		AB	765	00	47			

Administration of Anesthesia for Surgical/Nonsurgical Procedures, Same Provider

Anesthesia administered for covered services is eligible when rendered by a professional provider other than the operating surgeon, assistant surgeon, or attending professional provider. When anesthesia is reported by the operating surgeon, assistant surgeon, or attending professional provider, it is not covered. A participating, preferred, or network provider can bill the member for the denied anesthesia service.

A benefit exception is anesthesia administered by the operating surgeon, assistant surgeon, or attending professional provider for covered oral surgical procedures. This anesthesia is eligible for payment in addition to the oral surgery when performed in any place of service other than inpatient.

Use modifier 47 (anesthesia by surgeon) when general or regional anesthesia has been administered by the operating surgeon.

Modifier 59 is appropriate to use when a nerve block and surgery are reported by the same provider as treatment for two separate and distinct conditions, i.e., the nerve block is not performed as anesthesia for the surgery. In this instance, modifier 59 should be reported in conjunction with the nerve block procedure code.

Note: When an associate or member of the same practice group (who is other than the operating surgeon, his assistant, or attending provider) administers anesthesia, payment can be made for covered anesthesia services.

Moderate (Conscious) Sedation

Moderate sedation, also known as **conscious sedation**, induces an altered state of consciousness that minimizes pain and discomfort through the use of pain relievers and sedatives. Patients who receive moderate sedation usually are able to speak and respond throughout the procedure.

Effective January 1, 2017, the administration of moderate sedation for specified covered procedures that the sedation supports is eligible for separate payment. When moderate sedation has been administered by the operating surgeon who is also performing the procedure, report codes 99151-99153, G0500, as appropriate. Report codes 99155-99157, as appropriate, for moderate sedation for covered surgical services performed by other than the operating surgeon, assistant surgeon, or attending professional.

For moderate (conscious) sedation services on both electronic and paper claims, the provider must report units, not minutes, for codes 99151-99153, 99155-99157, and G0500. In addition, certification modifiers are not required when these codes are reported.

Other Modifiers

If anesthesia must be administered to a patient at two separate and distinct times during the same day, you must identify each anesthesia service performed within the separate session. Report modifier 78 or 79, as appropriate, on each service line of the claim form.

78 – Return to the operating room for a related procedure during the postoperative period

79 – Unrelated procedure or service by the same physician during the postoperative period

Consultation Services by an Anesthesiologist

Medicare Advantage Providers Only

Highmark will pay for a consultation (pre-operative work-up) performed by an anesthesiologist prior to surgery in accordance with the member's benefits.

A **consultation** is defined as a professional service furnished by a second physician at the written or verbal request of the attending physician. It includes a history, examination of the patient, evaluation of tests when applicable, and a written report filed with the patient's permanent record.

Anesthesia Related to Obstetrical Care

Anesthesia related to obstetrical care may include any of the following procedures:

- 01958 – anesthesia for external cephalic version procedure
- 01960 – anesthesia for vaginal delivery only

- 01961 – anesthesia for cesarean delivery only
- 01962 – anesthesia for urgent hysterectomy following delivery
- 01963 – anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
- 01965 – anesthesia for incomplete or missed abortion procedures
- 01966 – anesthesia for induced abortion procedures
- 01967 – neuraxial labor analgesia/anesthesia for planned vaginal delivery
- 01968 – anesthesia for cesarean delivery following labor analgesia
- 01969 – anesthesia for cesarean hysterectomy following labor analgesia
- 62273, 62281, 62282, 62311 – injection/nerve blocks (no catheter insertion)

When epidural anesthesia care is provided either 1) during labor only, or 2) during labor and vaginal delivery, code 01967 should be reported. The total time reported should reflect actual time in personal attendance (i.e., “face time”) with the patient. Payment for code 01967 will be based on the appropriate number of base units (BU) and total time units (TU) in attendance with the patient either during labor only or during labor with vaginal delivery.

When procedure code 01967 is reported in conjunction with either 01968 or 01969, the base units and time units for each code should be reimbursed. Time units reported should reflect actual time in personal attendance (“face time”) with the patient. The appropriate anesthesia modifier should be reported with each code to determine the level of reimbursement for each code, i.e., 100 percent or 50 percent, as in the following examples:

Example 1: The anesthesiologist personally performs the labor epidural and the cesarean section:

Line 1 01967AA BU + TU x conversion factor = 100%

Line 2 01968AA BU + TU x conversion factor = 100%

Example 2: The anesthesiologist personally performs the labor epidural and medically directs a CRNA (non-employee) during the cesarean section.

Line 1 01967AA BU + TU x conversion factor = 100%

Line 2 01968QK BU + TU x conversion factor x 50% = 50%

Note: Procedure codes 01960, 01961, and 01962 should not be reported in conjunction with 01967.

Daily management of epidural drug administration (01996) is also eligible for separate payment after the day on which an epidural catheter is inserted. Daily management reported on the same day as the catheter insertion is not covered. A participating, preferred, or network provider cannot bill the member for daily management on the same day as the catheter insertion.

Maximum Time Units for Continuous Epidurals

For providers in West Virginia

For Highmark West Virginia, payment for continuous epidurals will be reimbursed up to a maximum of 15 time units for 01967, 01960, and 01961 and for the combined time billed with 01967 and 01968.

A maximum of eight time units will apply to the West Virginia Small Business Plan.

6.4 Range Dating

Guidelines

Do not range date services, ***except*** in the following situations:

1. DME monthly rentals.
2. End stage renal disease (ESRD) related services – procedure codes 90918-90921.
3. In-hospital medical visits may be range dated if the services are identical and the visits were provided on consecutive dates of service within the same calendar month. **An exception to this is prolonged detention care: Do not range date these services even if rendered on consecutive days.**

Note: Do not report future dates of service on the claim form. Only report services that have actually

been rendered.

Reporting Dates for Radiation Therapy Code 77427

Five treatments, or “fractions,” of radiation therapy constitute a week of therapy whether or not the fractions occur on consecutive days. Since procedure code 77427 for radiation treatment management represents a week (or five fractions) of therapy management, the number of services reported for each multiple of five fractions should be one unit. The number of services reported for a week of five fractions would be one. **Do not range date these services. Submit code 77427 with a single date of service — not a date range. The date of the first fraction of therapy for the week being reported should be used as the date of service.**

Additional information for reporting 77427:

- Date of treatment weeks should not overlap.
- Hyperfractions of radiation therapy occur when two smaller doses are given in one day of treatment. One week of hyperfractions would include 10 hyperfractions or five days. The number of services billed for that week should be one.
- When providing radiation therapy services, the notation “course of treatment ended” should only be used when the final treatment has been administered.

6.4 Reporting Mid-Level Provider Services for Medicare Advantage (PA and WV Only)

For providers in Pennsylvania and West Virginia

Reporting Requirements

For most services performed by a mid-level provider, it is the billing provider’s responsibility to report the mid-level provider as the performing provider on Medicare Advantage claims. The only exception to this would be for “incident to” services for which the billing provider will report the physician as the

performing provider.

These requirements apply to nurse practitioners (NP), physician assistants (PA), clinical nurse specialists (CNS), and certified nurse-midwives (CNM).

Reimbursement for Services Performed by Mid-Level Providers

For providers in Pennsylvania and West Virginia

The reimbursement for all services not considered “incident to” is reduced when they are performed by a mid-level provider. Please see the following Highmark reimbursement policies for additional information:

- RP-001 Assistant at Surgery Services
- RP-010 Incident To Services
- RP-068 Mid-Level Practitioners and Advanced Practice Providers

Reimbursement policies are available on the Provider Resource Center under **Claims & Authorization.** Look under **Reimbursement Programs.**

Applicable Medicare Advantage Products

For providers in Pennsylvania and West Virginia

These reporting requirements and reimbursement cutbacks apply only to Highmark’s Medicare Advantage products, including:

- Freedom Blue PPO
- Community Blue Medicare PPO (PA Only)
- Community Blue Medicare Plus PPO (PA Central Region Only)
- Security Blue HMO–POS (PA Western Region only)
- Community Blue Medicare HMO (PA only)

For More Information

For more information on “incident to” billing, please see the Centers for Medicare & Medicaid Services (CMS) Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60, 60.1, 60.2, 60.3, and 60.4.

Reminder : CRNPS and PAS must be Enumerated & Listed on the Provider's File

For providers in Pennsylvania and West Virginia

Highmark, in compliance with Centers for Medicare & Medicaid Services (CMS) guidelines, requires all certified registered nurse practitioners (CRNPs) and physician assistants (PAs) to be enumerated and listed on the provider file under the Assignment Account for the group in which they practice. In order for CRNPs and PAs to be enumerated, Highmark must have their Medicare “Welcome” letters on file.

Once the practitioner is enumerated, the provider can update their Highmark provider file by using Provider Data Maintenance or Provider File Management in Availity®.

Split/Shared Visits

For providers in Pennsylvania and West Virginia

A split/shared Evaluation & Management (E&M) service is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where a physician and a qualified non-physician practitioner (NPP), such as a nurse practitioner (NP) or physician assistant (PA), each personally perform a substantive portion of an E&M visit face-to-face with the same patient on the same date of service. A substantive portion of an E&M visit involves all, or some portion of, the history, exam, or medical decision making (all key components of an E&M service). Highmark follows this policy for our Medicare Advantage products.

The physician and the NPP both must be in the same group practice or employed by the same employer. The split/shared E&M visit applies only to selected E&M visits and settings (hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E&M visit codes). The split/shared E&M policy does not apply to critical care services or procedures and cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) setting.

The rules for split/shared E&M services between physicians and NPPs, as summarized below, are described in the Medicare Claims Processing Manual, Chapter 12, Section 30.6.1:

1. **Office/Clinic Setting:** When the physician performs the E&M service, or when the E&M service is a split/shared encounter between the physician and NPP, provided to an "established" patient, and meets "incident to" requirements, the service must be reported using the physician's National Provider Identifier (NPI).

   If "incident to" requirements are not met for the split/shared E&M service, the service must be billed under the NPP's NPI, and payment will be made at the appropriate physician fee schedule payment.
2. **Hospital Inpatient/Outpatient/Emergency Department Setting:** When a hospital inpatient, hospital outpatient, or emergency department E&M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E&M encounter with the patient, the service may be billed under either the physician's or the NPP's NPI number.

   If there was no face-to-face encounter between the patient and the physician (e.g., if the physician participated in the service by only reviewing the patient's medical record), then the service may only be billed under the NPP's NPI.

   Payment will be made at the appropriate physician fee schedule rate based on the NPI entered on the claim.

Sufficient medical record documentation is the key to proper reimbursement for split/shared E&M services.

Note: “Incident to” a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. Please refer to the Medicare Benefit Policy Manual, Chapter 15, Section 60.1 for more information about incident to requirements.

6.4 Reporting Place of Service For Diagnostic Services Provided in a Hospital

When you submit claims to Highmark for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

Definitions

Outpatient – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds, or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician’s sole practice is located in a hospital or hospital-owned building; if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Provider Data Analysis to be recognized as an office practice.

Inpatient – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician’s office, and is then returned to the hospital, the physician must report services according to the patient’s status, in this case, inpatient. Therefore, you must report only “inpatient” as the place of service, rather than the place, such as “office” or “outpatient hospital”, where the service actually was performed. For example, if a mobile ultrasound, MRI, or CT unit locates on hospital grounds one day each

week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

Facility Identification Numbers

You must report a facility's National Provider Identification (NPI) number in addition to the facility name and address in Box 32 of the claim form. Claims submitted without the necessary information may result in payment delays.

For More Information

Please refer to **Chapter 4.5: Outpatient Radiology and Laboratory** for additional information on the requirements for privileging of providers who perform diagnostic imaging and for prior authorization of selected outpatient advanced diagnostic imaging services, such as MRIs, MRAs, CT scans, and PET scans.

6.4 Federal Employee Program (FEP) Claim Tips

Guidelines for Submitting FEP Claims

To ensure that your claims are accurately processed and paid without delay, please follow these guidelines in completing the claim form:

- When submitting claims for ambulance services, please include a completed trip report and detailed information concerning the medical necessity of the transport. The claim can be submitted electronically using the PWK segment.
- FEP Durable Medical Equipment (DME) claims: Claims submitted via paper or electronic method must be sent with a Certificate of Medical Necessity (CMN) the first time you submit a claim for the rental or purchase of a particular DME item. You can submit subsequent claims electronically for the same DME item while the CMN is in effect without submitting another copy of the CMN.

The claim can be submitted electronically using the PWK segment with the CMN faxed or mailed as indicated above.

- Do not range date services.
- Medications: When providing information about medication, be sure to include the name, the dosage, and the individual charge for each drug. Be sure that this information is legible.
- Use the appropriate address when submitting paper claims:

Pennsylvania	Delaware	West Virginia:	New York:
FEP Claims P.O. Box 890062 Camp Hill, PA 17089-0062	Federal Employee Program P.O. Box 8830 Wilmington, DE 19899	FEP Claims Highmark West Virginia P.O. Box 7026 Wheeling, WV 26003	Federal Employee Program P.O. Box 4208 Buffalo, NY 14240

- When reporting inpatient services, also report the service facility name and address.
- Submit FEP claims to the state where the services were rendered.
  Exceptions: Lab providers should file FEP claims in the state where the lab tests were performed, not where the specimen is drawn. DME providers should file FEP claims in the state where the provider is located, not where the DME supplies are delivered. The provider locations are determined by the mailing address.

6.4 Concurrent Major Medical Processing (PA Only)

For providers in Pennsylvania

Concurrent Major Medical processing is a feature included with our *Classic Blue* Traditional product. Classic Blue Traditional offers basic medical-surgical, hospital, and major medical coverage as one benefit package. For processing and payment purposes, the major medical benefits are incorporated into

the traditional benefits.

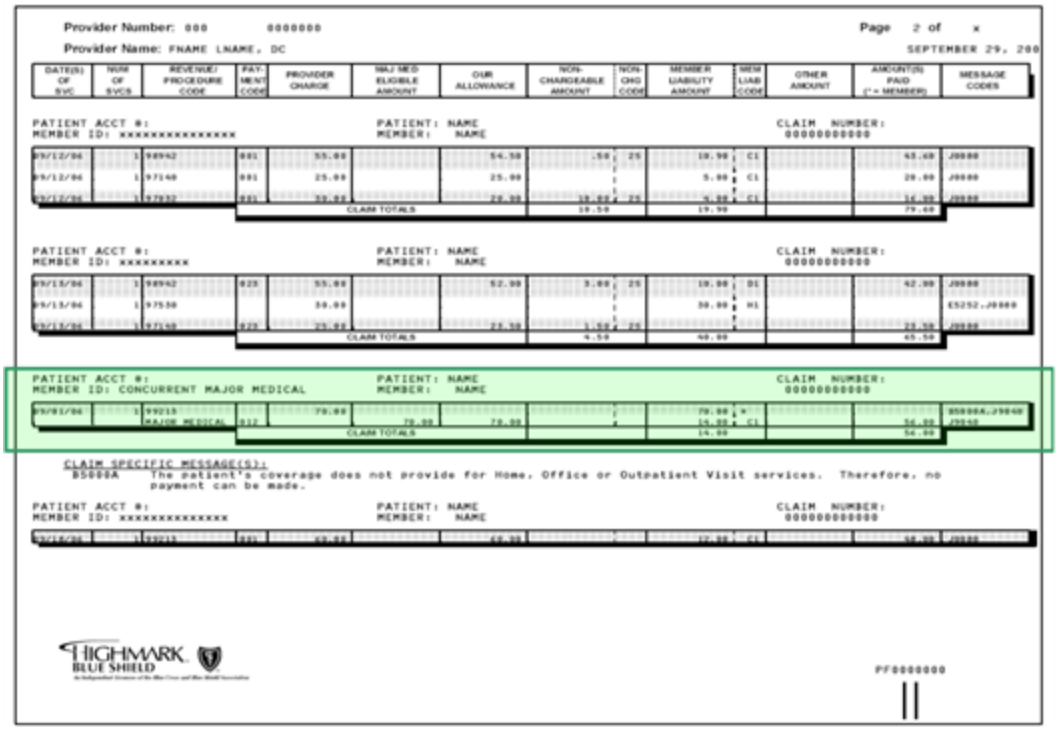
This process simplifies the billing process for providers who can report **all** professional services on one claim form and send it either electronically or on paper to Highmark. The services will process for basic coverage first, and then automatically process for major medical coverage. One Explanation of Benefits (EOB) shows you the details of both the basic and major medical processing.

You will receive the standard EOB for members who do not have concurrent major medical processing.

Sample EOB

For providers in Pennsylvania

The Major Medical service line is highlighted on this EOB example:



Provider Number: 000 0000000 Page 2 of x

Provider Name: FNAME LNAME, DC SEPTEMBER 29, 200

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	MAJ MED ELIGIBLE AMOUNT	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #: MEMBER ID: xxxxxxxxxxxxxxx						PATIENT: NAME MEMBER: NAME						CLAIM NUMBER: 000000000000	
09/12/96	1	98942	001	55.00		54.50	.50	25	10.90	C1		43.60	J0000
09/12/96	1	97140	001	25.00		25.00			5.00	C1		20.00	J0000
09/12/96	1	97032	001	20.00		20.00	10.00	25	4.00	C1		16.00	J0000
				CLAIM TOTALS			10.50		19.90			79.60	
PATIENT ACCT #: MEMBER ID: xxxxxxxxx						PATIENT: NAME MEMBER: NAME						CLAIM NUMBER: 000000000000	
09/13/96	1	98942	023	55.00		52.00	3.00	25	10.00	01		42.00	J0000
09/13/96	1	97530		30.00					30.00	H1			E5252,J0000
09/13/96	1	97140	023	25.00		23.50	1.50	25				23.50	J0000
				CLAIM TOTALS			4.50		40.00			65.50	
PATIENT ACCT #: MEMBER ID: CONCURRENT MAJOR MEDICAL						PATIENT: NAME MEMBER: NAME						CLAIM NUMBER: 000000000000	
09/01/96	1	99215 MAJOR MEDICAL	012	70.00	70.00	70.00		4	70.00 * 14.00 *	C1		56.00	B5000A,J9040 J9040
				CLAIM TOTALS					14.00			56.00	

CLAIM SPECIFIC MESSAGE(S):
B5000A The patient's coverage does not provide for Home, Office or Outpatient Visit services. Therefore, no payment can be made.

PATIENT ACCT #: MEMBER ID: xxxxxxxxxxxxxx						PATIENT: NAME MEMBER: NAME						CLAIM NUMBER: 000000000000	
09/16/96	1	99213	001	65.00		60.00			12.00	C1		48.00	J0000

HIGHMARK BLUE SHIELD

PF0000000

6.4 Medicare Part B Supplemental Claims (PA and WV Only)

For providers in Pennsylvania and West Virginia

For patients with Highmark Medicare Part B supplemental coverage, it is not necessary to submit a claim for payment after you submit one to Medicare Part B. The supplemental payment by Highmark should automatically follow the Medicare Part B payment.

The Centers for Medicare & Medicaid Services (CMS) consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need for providers to separately bill the secondary payer.

Medicare Claims Cross Over to Blue Plans

For providers in Pennsylvania and West Virginia

The claims you submit to the Medicare carrier will cross over to the Blue Plan only after the Medicare carrier has processed them. The Medicare carrier automatically advises the Blue Plan of Medicare's approved amount and payment for the billed services. Then the Blue Plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue Plan after you receive the Medicare carrier's payment. Whether you submit electronic or paper claims, it is not necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

Please allow 30 days for the secondary claim to process. If you have not received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status via Availity® before resubmitting.

To streamline the claim submission process and save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims.

If A Claim does not Cross Over

For providers in Pennsylvania and West Virginia

If you have not received payment from Highmark within 30 days and, after checking claim status in Availity, there is no indication of a claim, you can submit a claim to Highmark. Please be sure to submit the entire *Explanation of Medicare Benefits* statement.*

It is not necessary or recommended that you submit claims requiring attachments via paper. These supplemental claims can be submitted electronically using the Paperwork (PWK) segment.
The *Explanation of Medicare Benefits* statement can be faxed or mailed to the applicable fax number or address as indicated below.

When submitting the EOMB, please use the PWK cover sheet for your service area:

- Delaware: PWK (Paperwork) Supplemental Claim Information Cover Sheet
- Pennsylvania: PWK (Paperwork) Supplemental Claim Information Cover Sheet
- West Virginia: Electronic Claims Attachment Cover Sheet

The cover sheet is also available on the Provider Resource Center. Select **Resources & Education**, and then click on **Miscellaneous Forms** which is under **Forms**. For additional guidance on using the PWK segment, please see the section in this unit titled “Claim Attachments for Electronic Claims.”

**Do not highlight the Medicare payments in question. Either circle or place an asterisk (*) next to the information you want to bring to our attention. Provide the patient’s Highmark identification number and his/her complete name and address.*

Pennsylvania Delaware West Virginia

Attention: Document Preparation/Image	**Attention:** Document Preparation/Image	**Attention: CDC Area**
Fax to: 888-910-8797	**Fax to:** 888-910-9601	**Fax to:** 844-235-7266
Mail to: Highmark Blue Shield PWK (Paperwork) Additional Documentation P.O. Box 890176 Camp Hill, PA 17089-0176	**Mail to:** Highmark Blue Cross Blue Shield Delaware PWK (Paperwork) Additional Documentation P.O. Box 8832 Wilmington, DE 19899	**Mail to:** Highmark West Virginia P.O. Box 7026 Wheeling, WV 26003-0766

Paper Claim Submission

For providers in Pennsylvania and West Virginia

If you must submit a paper claim, mail the EOMB with a completed 1500 Claim Form (Version 02/12) to:

	Pennsylvania	Delaware	West Virginia
	Medigap: Highmark Blue Shield Medigap P.O. Box 898845 Camp Hill, PA 17089-8845	**All other products:** Highmark Blue Shield P.O. Box 890052 Camp Hill, PA 17089-0052	Highmark Blue Cross Blue Shield Delaware P.O. Box 8830 Wilmington, DE 19899-8830	Highmark Blue Cross Blue Shield West Virginia P.O. Box 7026 Wheeling, WV 26003

6.4 Personal Choice Claims (PA Only)

For providers in Pennsylvania

Independence Blue Cross (IBC), located in southeastern Pennsylvania, offers Personal Choice® PPO products for which Highmark has served as the electronic claims and remittance advice conduit to and from IBC. Highmark participating providers outside of IBC's five-county region had been directed to use IBC's NAIC code for electronic claim submissions.

All IBC Personal Choice PPO and Personal Choice 65 PPO claims will be processed by Highmark via BlueCard. Please see below for direction for submitting electronic claims.

Electronic Claims Submissions

For providers in Pennsylvania

Highmark participating professional providers outside of the five-county Philadelphia area (Philadelphia, Bucks, Chester, Montgomery, and Delaware counties) should direct Personal Choice claims to Highmark.

To be routed correctly, electronic submissions for Personal Choice PPO and Personal Choice 65 PPO claims in HIPAA-compliant ASC X12 837P format must include Highmark's NAIC code of **54771** in ISA-08 and GS-03.

Providers who participate in IBC's Personal Choice network should continue to submit claims directly to IBC.

Paper Claim Submissions

For providers in Pennsylvania

If submitting paper claims for Personal Choice and Personal Choice 65 members, please send claims to IBC at the following address:

Personal Choice Claims
P.O. Box 69352
Harrisburg, PA 17106-9352

Ancillary Claims

As with all BlueCard claims, ancillary providers should submit Personal Choice claims according to the BlueCard ancillary guidelines. Ancillary providers include independent clinical laboratory, suppliers of durable/home medical equipment and supplies, orthotic and prosthetic suppliers, and specialty pharmacy providers.

These guidelines are available in the manual's **Chapter 2.6: The BlueCard Program,** under the section titled Special Considerations for Claims Filing.

IBC Prefixes

For providers in Pennsylvania

For additional IBC payer information and an up-to-date listing of Personal Choice and Personal Choice 65 prefixes, please click on the following link: https://www.ibx.com/documents/35221/56665/payer-id-provider-number-reference-professional.pdf

Questions?

For providers in Pennsylvania

Any questions regarding electronic billing for Personal Choice and Personal Choice 65 should be directed to IBC's eBusiness Service Desk via:

- Telephone at **215-241-2305**, or
- email at claims.edi-admin@ibx.com

6.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the "manual" or "Highmark Provider Manual") are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 5: 1500 Claim Form Guidelines

6.5 The 1500 Health Insurance Claim Form

The 1500 Health Insurance Claim Form (“1500 Claim Form”) answers the needs of many health care payers. It is the basic claim form required by many payers for paper claims submitted by physicians and other professional providers. And now that electronic claim submission has become integral to health care, many of the software/hardware systems used by providers for submitting electronic claims depend on the existing 1500 Claim Form in its current image.

Prior to the development of the 1500 Claim Form, there was no standardized form for physicians and other health care providers to report health care services. In the 1980’s, the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations worked together through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort,

the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

The Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid-1990s. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. The official 1500 Health Insurance Claim Form data specifications are available through NUCC at nucc.org.

1500 Claim Form - 02/12 Version

Highmark accepts only the 02/12 version of the 1500 Claim Form. Photocopies, discontinued, or outdated versions of the 1500 Claim Form, including the 08/05 version, will not be accepted and will be returned to providers. Please remember that **only original red claim forms** will be accepted.

Photocopies of the 1500 Claim Form will not be accepted and will be returned to providers.

This tip sheet is designed to highlight the fields of the CMS-1500 (02/12) claim form that are required when submitting to Highmark.

Electronic Claims Submission

Highmark encourages providers who are submitting paper claims to consider electronic claims submission. Electronic transactions and online communications have become integral to health care. Today's technology can help you simplify business operations, cut costs, and increase efficiency in your office.

Electronic claims submission is a valuable method of streamlining claim submission and processing, and results in faster payment. Highmark supports a variety of HIPAA-compliant electronic claims and inquiry transactions. Please refer to **Chapter 1.3: Electronic Solutions – EDI & Availity** for information on how to take advantage of the electronic solutions available to you.

You may also want to consider Availity® for submitting claims to Highmark. Availity is provided to Highmark network participating providers at no cost. This Internet-based service seamlessly integrates all insurer-provider transactions into one system — HIPAA-compliant claims submission, claim status inquiry, claim investigation, eligibility, benefits, and much more! Availity even provides access to Highmark's tools for real-time claim estimation and adjudication. Additional information about Availity is also available in **Chapter 1.3: Electronic Solutions – EDI & Availity.**

6.5 OCR Scanning of Paper Claims

OCR Scanner Improves Paper Claims Processing Time

Highmark uses an OCR (Optical Character Recognition) scanner for direct entry of paper claims into its claims processing system, OSCAR (Optimum System for Claims Adjudication and Reporting). OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and "reads" the printed data, and then translates it into a format for direct entry into OSCAR. The scanner can "read" both computer-prepared and typewritten claim forms but **only if the data is within the borders of each box.**

Direct entry of claims by the OCR scanner is an advantage to you because it requires less human intervention in preparing and entering your claims. The scanner reads, numbers, and images your paper claims in one step. OCR scanning reduces claim entry time as well as entry errors. However, OCR claims do not receive the same priority processing as do electronically submitted claims.

For the most efficient processing, please use only original red 1500 Health Insurance Claim Forms. The OCR scanner is programmed to read this form. Highmark will not accept photocopies or discontinued versions of the 1500 Claim Form and will return claims received on these invalid forms. Providers will need to resubmit returned claims on valid, original forms for the claims to be entered into Highmark's claims processing system.

If you use computer billing software to complete the 1500 paper claim forms, please remember to use original, current versions of the form and not photocopies or older versions of the claim form.

How to Obtain Claim Forms

To obtain a supply of the current version of the 1500 Health Insurance Claim Form, please contact:

- Your current forms supplier; or
- TFP Data Systems: e-mail 1500form@tfpdata.com, or telephone **800-482-9367, ext. 58029;** or
- The Government Printing Office: http://bookstore.gpo.gov/catalog/government-forms-phone-directories, or telephone **866-512-1800.**

6.5 Guidelines For Submitting Paper Claims

In today's business world, there are no requirements to submit claims on paper. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically. However, if you are submitting paper claims, the guidelines provided below must be followed when completing the 1500 Health Insurance Claim Form. By following these guidelines, you can be assured that your claims will be scanned as quickly as possible, processed accurately, and paid without delay.

Note: Please be sure to reference **Chapter 6.1: General Claim Submission Guidelines** for general guidelines and reporting tips that apply to claims submissions in both paper and electronic formats.

Be Sure to Use the Correct Forms

Highmark will accept only the Version 02/12 1500 Health Insurance Claim Form. Always provide Highmark with the **original red** 1500 form. Do not send copies or forms printed in black ink on a laser printer – they cannot be scanned. **Photocopies, discontinued, or outdated versions of the 1500 Claim Form will not be accepted and will be returned to providers**. Resubmission on a valid form will be required.

Appropriate Printing of Forms

Always print or type all information on the claim form. Clear, concise reporting on the form helps us to interpret the information correctly.

- Use computer-printed forms or type the data within the boundaries of the boxes provided. **Do not hand-write**.
- Use black ink. **Do not use red ink**. The OCR image scanner cannot read red ink.
- Printing Specifications:
    - Use **10-pitch PICA** type.
    - Submit all claims on 20 pound paper.
    - **Do not use highlighters** to emphasize information on the claim form or attachments. Highlighted information becomes blackened out when imaged and is not legible.

If Multiple Forms are Necessary

In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment.

Do not carry balances forward. It also is important that you report all other essential information on each claim form.

Complete the claim form in its entirety. Our claims examiners review each claim individually. If you submit several claim forms for the same member but fill in only essential details on one form, Highmark will reject the claim forms.

We must have complete information before we can process the claim. If details are missing, Highmark will reject the claim.

Use the Appropriate Mailing Address

Mail the claim forms to the appropriate P.O. Box address. A complete listing of addresses can be found in **Chapter 1.2: Online Resources & Contact Information**.

6.5 Diagnosis Code Reporting

ICD-10 Compliance

For dates of service October 1, 2015 and after, Highmark will accept ICD-10-CM diagnosis codes only on claims.

Diagnosis Code Reporting Guidelines for the 1500 Claim Form (02/12)

The following diagnosis code reporting guidelines are for all lines of business:

1. Report diagnosis codes to the **highest level of specificity** available.
2. The **"ICD Indicator"** identifies the version of the ICD code set being reported. Enter the applicable ICD indicator: **0** (zero) for ICD-10-CM. **Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.**
3. Enter the codes to identify the patient's diagnosis and/or condition.
4. Claims **must** be submitted with ICD-10-CM diagnosis codes.
5. The lines allow for diagnosis codes at a maximum of seven characters.
6. You may report a maximum of 12 diagnosis codes.
7. Report only one diagnosis code on each line (labeled A-L) in Box 21 of the 02/12 1500 Claim Form.

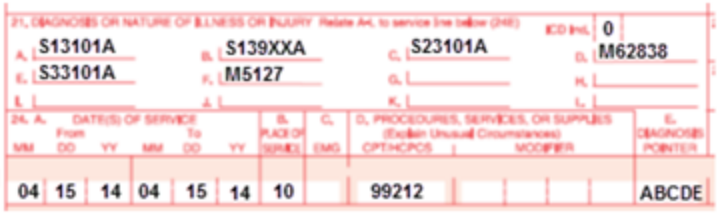
8. Enter the diagnosis codes **left-justified** on each line.
9. **Do not** include the decimal point within the diagnosis code.
10. **Do not** provide narrative description in this field.
11. Relate lines A - L to the lines of service in 24E by the **letter** of the line.
12. Substantiate all member diagnoses in the medical record.

For Medicare Advantage members:

In addition to above, include all diagnosis codes that impact the patient's evaluation, care, and treatment for the current problems.

1500 Claim Form (02/12) Reporting Example

This is an example of reporting **ICD-10-CM** diagnosis codes on the 02/12 version of the 1500 Claim Form.



6.5 Additional Tips for Submitting Paper Claims

The additional tips provided here will help to assure your claims submissions are completed accurately and to avoid any delays in processing. If you have a question about how to complete a claim form, contact Highmark's Provider Service.

Before You Begin...

Always verify the patient's information via Availity® or the HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction before completing the claim form. Availity's Eligibility and Benefits Inquiry function and the HIPAA 270/271 allow you to quickly confirm the member's coverage and the member information needed on the claim form.

General Tips for Completing the Claim Form

- Please do not staple over the Quick Response (QR) code symbol at the top of the Version 02/12 1500 Claim Form. Highmark's scanners read the symbol to identify that the 1500 Claim Form is the 02/12 version.
- Be certain to enter information within the correct fields on the form.
- Make sure that the member's identification number is correctly reported on the claim form (*including the alphabetical prefix*).
- Use an 8-digit format for reporting date of birth (MMDDYYYY).
- Submit a separate claim for each patient even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include coordination of benefits or Medicare information on the claim form when the patient qualifies.
- Always report your 10-digit NPI in Item Number 33a.
- Regularly change your printer's ink cartridge or typewriter ribbon to ensure print readability. Light print cannot be read by the scanner.
- Avoid using special characters such as dollar signs, hyphens, slashes, or periods.
- Avoid extra labeling in fields on claim form.
- Use X's for marking Yes or No blocks. Do not use other alphabetical indicators such as Y for Yes, N for No, F for Female, or M for Male.
- Do not use correction fluid on the claims.
- Leave the upper right-hand corner of the claim form blank for internal purposes. If you need to print information at the top of the form, use the open space in the center.
- If using a rubber stamp, do not stamp information in or over fields one through 33 or in the upper right hand corner of the claim form. Any stamps used should be in black ink only.
- Claims and other documents (inquiries, referrals, etc.) should never be taped or glued in any way. Staples should be avoided unless absolutely necessary.

When Completing Service Lines...

- Include the date each service was provided in 6-digit format (MM|DD|YY).
- Be certain the total charge equals the service line charges.
- Do not fill in blank fields or space with unnecessary data. For example, if hospitalization dates are not required, leave the field blank rather than entering 00/00/00 or XX/XX/XX.
- Include HCPCS codes to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.

- The claim form can only accommodate six lines of service. The top area of the six service lines is shaded and is the location for reporting supplemental information. Supplemental information can only be entered with a corresponding, completed service line. It is not intended to allow the billing of 12 lines of service.
- Report all information about a service on one line. If the service dates, diagnosis code, charge, etc., are reported on separate lines, the scanner “creates” an extra line. This may cause the claim to be returned to you for correction and re-submission.
- Use the procedure code that most closely describes the service. Written descriptions are only necessary if using NOC codes or when no procedure code is available. Unnecessary descriptions are problematic for OCR scanned claims.
- Not Otherwise Classified (NOC) Codes: When reporting NOC procedure codes, provide a written description of the item or service above the code in the shaded area of the service line on the claim form. When more than one NOC is submitted, provide an individual description and charge for each item.

Tips for Specific Reporting Needs

- Surgical procedures do not require operative notes unless:
  - An “individual consideration” (IC) or “unlisted procedure” code is reported.
  - The service performed is a new procedure.
  - The service performed is potentially cosmetic.
  - Multiple primary surgeons participated in a surgical procedure.
  - The terminology for the reported code indicates, “by report” (BR).
  - A pre-authorization letter advised you to submit specific reports.
  - The service involves unusual circumstances. Remember to also report modifier 22. If this modifier is not reported, the special circumstances will not be considered.
- When reporting circumcision for a baby boy, report the service on the baby’s claim, not the mother’s.
- When reporting services involving a multiple birth, report the services under the babies’ names, not as Baby A, Baby B, etc.

Avoid Including Unnecessary Attachments

- Do not submit a photocopy of the member’s identification card.
- Do not routinely send “Release of Information” forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Avoid the use of Post-it Notes on claims or inquiries. (Full sheets of paper are preferable.)

- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. We will request this information if it is necessary to process the claim.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment.
- The OCR scanner is designed to read computer-prepared or typewritten claim forms. Claims with superbill attachments cannot process through the OCR scanner. Type data from the superbill directly onto the claim form. Do not attach superbills for the same services you have reported on the claim form.

Mailing Tips

- Use flat envelopes for mailing claims.
- Do not fold claim forms. Folded or wrinkled claim forms cannot be effectively read by the scanner.

Examples of How to Submit Information Correctly

Insured's ID Number

Correct: YYZ123456789001
Incorrect: YYZ-123-456-789001; ID # YYZ123456789001

Charges

Correct: 20.00
Incorrect: $20.00

Date of Birth: 8-Digit Format

All Other Dates: 6-Digit Format

Correct: 12271949	**Correct:** 122713; 021414

Incorrect: 12/27/49; 12-27-1949	**Incorrect:** 12/27/13; 2-14-14

Insured's Policy Group Number

Correct: 123456; NAS123
Incorrect: GRP # 123456; GRP # NAS123

For More Information

For instructions on how to begin to submit claims electronically, please visit the EDI Trading Partner website via the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- New York: https://www.ask-edi.com/
- West Virginia: highmark.com/edi-wv

Or, you may call EDI Operations at **800-992-0246.**

6.5 1500 Claim Form Completion Instructions

The National Uniform Claim Committee (NUCC) released the 02/12 version of the 1500 Health Insurance Claim Form ("02/12 1500 Claim Form") in January 2014.

The instructions for completing the 1500 (02/12) paper claim form begin below. A "completed" 02/12 1500 Claim Form example is available at the end of this unit.

Important! Version 02/12 Required

Highmark will accept only the 02/12 version of the 1500 Claim Form. Also, please remember that **only original red claim forms** will be accepted (except in New York where both red and photocopies are acceptable). Photocopies, discontinued, or outdated versions of the 1500 Claim Form will not be accepted and will be returned.

Instructions for Completing the 1500 Claim Form Version (02/12)

Any data (e.g., diagnosis codes, charges, NPIs, etc.) used in the instructions and sample claim form is demonstrating how to enter data in the field and is not providing instruction on how to bill for certain services.

Note: Please refer to **Chapter 6.4: Professional (1500/837P) Reporting Tips** for additional information about specific claim reporting situations.

This tip sheet is designed to highlight the fields of the CMS-1500(02/12) claim form that are required when submitting to Highmark.

Item #	Field Title /Description	Instructions	
Top of Form	Carrier Block	Report name and address in the center of the open space. Do not report above Item #1a (this is where Highmark prints the claim number). **Please do not staple over the Quick Response (QR) code symbol.** Highmark's scanners read the symbol to identify that the 1500 Claim Form is the 02/12 version.	

1	Type of Health Insurance Coverage	For Highmark products, place an X in the "Other" box.	
1a	Insured’s ID Number	Enter insured's identification number exactly as shown on the insured's identification card. Be sure to include any alpha prefixes.	
2	Patient’s Name	Enter the patient's full last name, first name, and middle initial. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.	
3	Patient’s Birth Date, Sex	Enter the patient's 8-digit birth date (MM|DD|YYYY). Enter an X in the correct box	

		to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.	
4	Insured’s Name	Enter the insured's full last name, first name, and middle initial. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. **Do not use terms such as “Self” or “Same” if the patient is also the Insured.** If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.	
5	Patient’s Address	Enter the patient's mailing address. This field has 3 lines — the first line is for the street address; the second line, the city and state; and the third line, the ZIP Code.	

		“Patient’s Telephone” is not used in processing and is not required by Highmark. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP Code. Enter the 9-digit ZIP Code **without** the hyphen.	
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured. Only one box can be marked.	
7	Insured’s Address	Enter the insured's address. If Item #4 is completed, then this field should also be completed. This field has 3 lines — the first line is for the street address; the second line, the city and state; and the third line, the ZIP Code. “Insured’s Telephone” is not used in processing and is not required by Highmark. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g.,	

		123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP Code. Enter the 9-digit ZIP Code **without** the hyphen.	
8	Reserved for NUCC Use	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
9	Other Insured's Name	If Item #11d is marked, complete fields 9 and 9a-d; otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item #2. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. **Do not use periods within the name.** If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr)	

		and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.	
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.	
9b	Reserved for NUCC Use	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
9c	Reserved for NUCC Use	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name.	
10a,b,c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item #24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The 2-letter state code (e.g., PA, DE) must be shown if "YES"	

		is marked in Item #10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.	
10d	Claim Codes (Designated by NUCC)	Highmark requires the sub-set of Condition Codes approved by the NUCC in this field, when applicable. When reporting more than one code, enter three blank spaces and then the next code. The Condition Codes approved for use on the 1500 Claim Form are available at http://www.nucc.org under Code Sets.	
11	Insured's Policy, Group, or FECA Number	Enter the insured's policy or group number as it appears on the insured's health care identification card. **Do not use a hyphen or space as a separator within the policy or group number.** If Item #4 is completed, then this box should also be completed.	

11a	Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.	
11b	Other Claim ID (Designated By NUCC)	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the insured.	
11d	Is There Another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.	
12	Patient's or Authorized Person's Signature	**Highmark does not need this information to adjudicate the claim.** The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or	

		adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes, and (2) enter the date signed in 6-digit format (MM|DD|YY). If there is no signature on file, leave blank or enter "No Signature on File."	
13	Insured's or Authorized Person's Signature	**Highmark does not need this information to adjudicate the claim.** The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes, and (2) enter the date signed in 6-digit format	

		(MM|DD|YY). If there is no signature on file, leave blank or enter "No Signature on File."	
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Be sure to complete this field when services were performed as a result of accident or injury. Enter the applicable qualifier to identify which date is being reported: • 431 – Onset of Current Symptoms or Illness • 484 – Last Menstrual Period **Be sure to enter the date and qualifier in the correct fields.** The qualifier is entered to the right of the vertical, dotted line.	
		DE Only:	

		For physical, occupational, and speech therapy services: This box **must** be completed if the Highmark Delaware member has a per condition benefit.	
15	Other Date	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit format (MM|DD|YY). *(Previous pregnancies are not a similar illness.)* Leave blank if unknown. Enter the applicable qualifier to identify which date is being reported. • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date)	

		• 444 – First Visit or Consultation **Be sure to enter the date and qualifier in the correct fields.** The qualifier is entered between the left-hand set of vertical, dotted lines.	
		DE Only: **For physical, occupational, and speech therapy services:** Please provide date if applicable.	
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, a 6-digit (MM|DD|YY) date must be shown for the "from-to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.	
17	Name of Referring Provider or Other Source	Enter the name (first name, middle initial, last name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas.	

		A hyphen can be used for hyphenated names. If multiple providers are involved, **enter <u>one</u> provider only** using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported. • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider **Enter the qualifier to the left of the vertical, dotted line.**	
17a	Other ID#	**When the Referring Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate**	

		application of the provider's contractual business arrangements with Highmark. The **PXC** Provider Taxonomy qualifier is reported in the qualifier field to the immediate right of the box containing "17a," followed by the referring Provider's taxonomy code.	
17b	NPI#	Enter the NPI number of the referring provider, ordering provider, or other source in Item #17b.	
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MM|DD|YY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization (inpatient services only).	

19	Additional Claim Information (Designated By NUCC)	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
20	Outside Lab? $Charges	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
21	Diagnosis or Nature of Illness or Injury	The **"ICD Indicator"** identifies the version of the ICD code set being reported. Enter **0** (zero) for ICD-10-CM. **Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.** ********** In A – L, enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 diagnosis codes. Use the highest level of specificity. Enter the codes **left-justified** on each line. Do **not** include the decimal point within the diagnosis code. Relate lines A – L to	

		the lines of service in 24E by the letter of the line. **** Do not provide narrative description in this field. ** Highmark will accept only ICD-10-CM diagnosis codes.** ********** Please see instructions regarding Federal Employee Program (FEP) claims and anesthesia reporting in **Chapter 6.4: Professional (1500/837P) Reporting Tips.**	
22	Resubmission	When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. • 7 – Replacement of prior claim • 8 – Void/cancel of prior claim List the original reference number for resubmitted claims.	
23	Prior Authorization Number	For ambulance services, use this block to report the ZIP Code of the Point of Origin. (The 9-digit ZIP+4 Code is not required for the Point of	

		Origin but will be accepted if reported.) Ambulance providers who submit paper claims for non-emergent ambulance transports must attach a PMNC *(Physician's Medical Necessity Certification)* form to the claim.	
24		Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. **The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.** The following types of supplemental information and their qualifiers can be	

		entered **in the shaded lines of Boxes 24A through 24H:**	
		Qualifier	**Type of Information**
		7 Anesthesia information	Report the surgical HCPC procedure code when a 'Not Otherwise Specified' or 'Not Otherwise Classified' anesthesia service is reported. A complete description of the surgical service performed can be used in lieu of a surgical HCPC code or if the only applicable surgical procedure code is an NOC.
		ZZ Narrative description of unspecified code	Narrative description of unspecified code.

		N4 National Drug Codes (NDC)	National Drug Codes (NDC) for drugs: Report the qualifier, N4, prior to the 11-digit* NDC, e.g., N499999999999.
		To enter supplemental information **in the shaded area,** begin at Box 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code. *Many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10-digit to 11-digit format requires a strategically placed zero, dependent on the 10-digit format. For more information, refer to the section titled **Reporting National Drug Codes in Chapter 6.2:**	

		General Claim Submission Guidelines.	
24A	Date(s) of Service	Enter date(s) of service, from and to, in 6-digit format (MM|DD|YY). If one date of service only, enter that date under "From." Leave "To" blank. If grouping services, you may range date if the place of service, procedure code, charges, and individual provider for each line is identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in Item #24G. **An exception to this is prolonged detention care. Do not range date these services even when performed on consecutive days.**	
24B	Place of Service	Enter the appropriate 2-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at:	

		https://www.cms.gov/place-of-service-codes	
24C	EMG	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
24D	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of one procedure code and up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.	
24E	Diagnosis Pointer	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference	

		letter(s) should be A – L or multiple letters as applicable. **Enter letters left justified in the field.** Do not use commas between the letters; hyphens can be used for ranges of multiple letters. This field allows for the entry of 4 characters in the unshaded area. **Diagnosis codes must be entered in Item Number 21 only.** Do not enter them in 24E.	
24F	$ Charges	Enter the charge for each listed service. Enter the number right-justified in the left-hand area of the field. Do not use commas or dollar signs when reporting the dollar amount. Do not report negative dollar amounts. Enter 00 in the right-hand area of the field if the amount is a whole number.	
24G	Days or Units	Enter the number of days, units, or minutes. This field is most commonly used for multiple visits, units of	

		supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. When required by payers to provide the NDC units in addition to the HCPCS units, enter the applicable NDC units' qualifier and related units in the shaded line following the NDC qualifier and code. The following qualifiers are to be used when reporting an NDC quantity. Report the qualifier prior to the quantity, e.g., UN2.	
		F2 International Unit	**ML** Milliliter
		GR Gram	**UN** Unit
24H	EPSDT/Family Plan	**Highmark does not need this information to adjudicate the claim.** Leave blank.	
24I	ID Qualifier	The 'NPI' ID qualifier is pre-populated in the non-shaded area of Item #24I. (The Rendering Provider's NPI is reported in the non-shaded area of Item #24J.)	

		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark. When required to report the Rendering Provider's Taxonomy Code, enter the **PXC** Provider Taxonomy qualifier in the shaded area of Item #24I. **Note:** In most instances, the 3-character PXC qualifier can be printed within Item #24I. If the PXC qualifier runs into Item #24J, our Optical Character Recognition (OCR) scanner will still capture the qualifier and provider taxonomy correctly since 24I and 24J are read as one field.	

24J	Rendering Provider ID#	The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. Report the provider's information in Item Numbers 24I and 24J only when different from data recorded in Item Numbers 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in Item #33, you must report the rendering/performing provider information in Item #24I and Item #24J. Enter the Rendering Provider's NPI number in the non-shaded area of Item #24J. **Note:** In the case where a substitute provider (locum tenens) was used, the regular physician on whose behalf the services were furnished by a substitute is reported as the rendering provider. The HCPCS modifier **Q6** is entered after the procedure code(s) in Item 24D to indicate that the	

		services were provided by a substitute provider. **When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** In the shaded area of Item #24J, enter the Rendering Provider's Taxonomy Code when required.	

25	Federal Tax ID Number	Enter the federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. **This must be the tax ID which correlates to the billing provider reported in Item #33.**	
26	Patient's Account No.	Optional. Highmark does not require this number for processing; however, we can reference this number when contacting your office for additional information.	
27	Accept Assignment?	Enter an X in the correct box. Only one box can be marked. **Note:** This box is required for government claims only.	
28	Total Charge	Enter total charges for the services (i.e., total of all charges in column 24F). Enter amount right justified in the left-hand area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not	

		report negative dollar amounts. Enter 00 in the right-hand area if the amount is a whole number.	
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.	
30	Reserved For NUCC Use	Highmark does not need this information to adjudicate the claim. Leave blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	This field must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider's personal supervision. The name of the individual performing the service on the claim must be entered. The name may be	

		computer printed or typed. Simply reporting the name of the group is insufficient.	
32	Service Facility Location Information	Enter the name, address, city, state, and ZIP Code of the location where the services were rendered. The full nine digits of the ZIP+4 Code must be reported. Enter the 9-digit ZIP Code **without** the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 Code is not valid. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP+4 Code **Note:** A physical street address must be reported for the Service Facility Location — a P.O. Box or lock box will not be accepted. **Highmark requires the Service Facility Location when the service was**	

		performed at a secondary location and the provider's primary location was reported in Item #33. Highmark always requires the Service Facility Location when the Place of Service reported in Item #24B is one of the following: 21 – Inpatient Hospital 22 – Outpatient Hospital 23 – Emergency Room – Hospital 31 – Skilled Nursing Facility 32 – Nursing Facility 51 – Inpatient Psychiatric Facility 61 – Comprehensive Inpatient Rehabilitation Facility	
32a	Service Facility – NPI#	Enter the NPI number of the service facility location.	
32b	Service Facility – Other ID#	**When the National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This**	

		enables the accurate application of the provider's contractual business arrangements with Highmark. Enter the **PXC** Provider Taxonomy qualifier followed by the Provider's Taxonomy Code when required.	
33	Billing Provider Info & PH #	Item #33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the billing provider's name, address, ZIP Code, and telephone number. The full nine digits of the ZIP+4 Code must be reported. Enter the 9-digit ZIP Code **without** the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 code is not valid. The telephone number is to be entered in the area to the right of the box title. Enter the name and address information in the following format:	

		1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP+4 Code **Note:** A physical street address must be reported for the Billing Provider — a P.O. Box or lock box will not be accepted.	
33a	Billing Provider - NPI#	Enter the NPI number of the billing provider reported in Item #33.	
33b	Billing Provider - Other ID#	**When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** Enter the **PXC** qualifier followed by the Provider's Taxonomy Code when required.	

Additional Edit Checks for Paper Billers

Highmark does not attempt to correct or retrieve missing information for the situations listed below. Instead, these situations will result in a rejection of the claim, and you will be required to resubmit a new claim with the corrected data.

When a claim rejects, it is important for your billing staff and/or vendor to understand exactly what was wrong and what is needed to correct it.

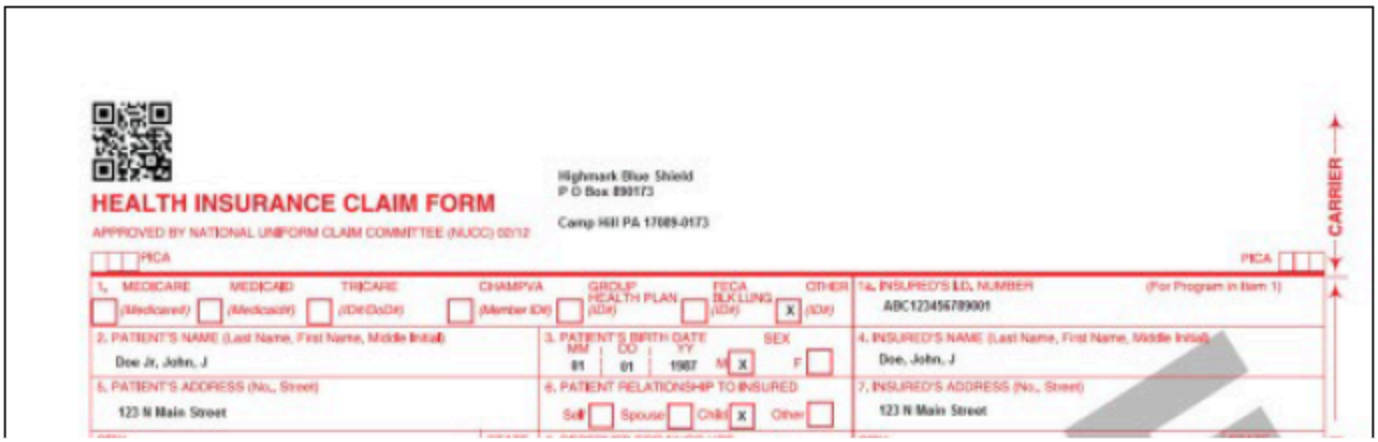
If you submit paper claims, you may encounter the following denial codes and descriptions on your explanation of benefits notices:

Rejection Code	Description
B5606	In order to process the claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically enabled providers should resubmit electronically.
P5039	In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically enabled providers should resubmit electronically.
P5040	The patient's coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.
P5010	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a

	corrected procedure code. Electronically enabled providers should resubmit electronically.
P5011	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5012	The patient's sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient's sex and/or a corrected procedure code or a complete description of service. Electronically enabled providers should resubmit electronically.

6.5 Sample 1500 (02/12) Health Insurance Claim Form

This tip sheet is designed to highlight the fields of the CMS-1500 (02/12) claim form that are required when submitting to Highmark.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Highmark Blue Shield
P O Box 890173
Camp Hill PA 17089-0173

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
						X	ABC123456789001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM / DD / YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe Jr, John, J	01 / 01 / 1987	M X F	Doe, John, J

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 N Main Street	Self Spouse Child X Other	123 N Main Street

6.5 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 6: Coordination of Benefits

6.6 Coordination of Benefits Overview

Coordination of benefits (COB) applies when a patient is covered by two or more health insurance policies. Highmark employs several processes to ensure the services provided to our members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

Coordination of Benefits Defined

Coordination of benefits (COB) is the process of determining which of a member's benefit plans should assume primary, secondary, and tertiary (first, second, and third) financial responsibility for health care services.

COB allows patients to receive up to 100% of the cost of covered services while ensuring that no one collects more than the actual cost of the covered health expenses. When a member is covered by more than one health plan, one plan is determined to be primary and its benefits are applied to the claim first; reimbursement of the remaining balance is considered through the secondary policy, subject to benefit provisions.

Payment sources include Highmark plans as well as other commercial health care plans, automobile/liability insurers, and government programs such as Workers' Compensation and Medicare.

Workers Compensation Insurance

Workers compensation insurance covers medical treatment for work-related injuries or illnesses.

- Federal and state laws require employers to provide this coverage to their employees.
- Employees are entitled to full coverage for all employment-related health care expenses through their workers compensation insurance.
- Highmark is not liable to pay claims under these circumstances, unless workers' compensation benefits have been exhausted.

Automobile Insurance

The following apply to coverage for medical treatment related to automobile accidents:.

- Highmark may pay for covered services after the automobile insurance benefits are exhausted.
- The Pennsylvania Motor Vehicle Financial Responsibility Law requires anyone who registers a motor vehicle in the state to provide for specific levels of medical insurance coverage. The law mandates a minimum of $5,000 in medical benefit coverage must be available for each accident victim. The victim's motor vehicle accident insurance is always the primary payer for the treatment of injuries sustained in an automobile accident.
- The law in Delaware mandates a minimum of $15,000 in Personal Injury Protection (PIP) coverage be available for each accident. PIP coverage is always primary in Delaware.
- Medical benefit coverage on motor vehicle insurance is not mandatory in West Virginia. However, if a member has medical benefits on their automobile policy, that coverage will be primary.

Note: Please be aware that automobile insurance laws can vary by state.

When Highmark is Secondary

Highmark coverage is considered secondary in the situations listed below:

If...	Then...
Injuries are received in an automobile accident	Automobile insurance is primary
Injuries are received in a work-related illness or injury	Workers' Compensation Program is primary
Injury or illness occurs when another party is judged to be responsible	Liability insurance is primary

Subrogation

Subrogation is the contractual and equitable right of Highmark to recover any payments paid for health care expenses which were the result of injuries caused by another person or entity.

- Subrogation helps by crediting the member's benefit plan with the recovered monies and controls the cost the customer and his/her employer pay for health care.
- Examples of other party liability include: product liability, property negligence, auto accident caused by another party, or accidental injury on someone else's property.

Network providers must assist in our subrogation efforts by indicating an accident, the accident date, and the diagnosis on the claim.

Authorization Requirements Still Apply

Please be aware that the authorization requirements for any Highmark benefit plan would still apply even if that benefit plan is secondary or tertiary for the services being reported.

Right of Recovery

If Highmark pays more for covered services than the applicable COB provision or that any other provision the member's contract requires, then we have the right to recover the excess from any person or entity to whom or for whom the payment was made. Recovery may be made through deductions and offsets from

any pending and subsequent claims. Highmark's right of recovery includes, among other things, periods where a member's premiums were delinquent or the individual was otherwise ineligible for coverage.

6.6 COB Questionnaire

For providers in Delaware, New York, and Pennsylvania

Reporting Other Insurance

Highmark primarily obtains other insurance information from employer groups for the employer's group members. However, Highmark also allows providers to collect this information at the time of service, and then report it to us to help reduce the number of claims suspended or rejected as a result of coordination of benefits (COB) situations.

Electronic COB Questionnaire

For providers in Delaware, New York, and Pennsylvania

In Delaware, New York, and Pennsylvania, Highmark offers a feature in Availity that allows you to quickly and easily report a member's other insurance by completing an electronic form.

Once you log into Availity, you can access the questionnaire directly from **Payer Spaces** under **Applications.** Click on **COB Questionnaire.**

Note: This questionnaire cannot be used for Medicare Advantage members, Law Enforcement Members (Plan Area 327), Federal Employees, Highmark West Virginia members (Plan Area 943), or members in Plan Area 362.

These members should be advised to contact Customer Service to report any changes in regard to other insurance.

6.6 Determining Order of Coverage

When coordination of benefits is applied, the order of the member's benefit plans must first be determined:

- If the coverage is **primary,** it bears the majority of the financial responsibility for claim costs.
- If the coverage is **secondary,** it may contribute toward any remaining amounts after the primary benefit plan has paid.
- If the coverage is **tertiary,** it may contribute toward any remaining amounts after both the primary and secondary benefit plans have paid what they are liable to pay.

Determining the order of benefit payment requires applying certain standard rules to the member's situation. Most health insurance carriers, including Highmark, use the following rules to decide who is primary.

Member's Own Benefit Plan

Typically, when a member has more than one benefit plan, the plan where the member is enrolled as the employee, or "subscriber," will be primary. A plan on which the individual is covered as a spouse or dependent is not primary, unless it is the only plan available.

Two Active Coverages

When a person is enrolled in two different plans, the plan that has provided coverage for the longer period of time will be primary.

Active Over Retiree/Laid-Off Coverage

If a member has coverage as an active employee of one company and is also covered as a retiree or laid-off worker of another company, the benefit plan from his or her active employment is considered primary **in most cases,** while the benefit plan of the other company is considered secondary.

In some cases, however, one of the group contracts may not include this provision. Under these circumstances, the coverage that has been in force the longest is considered primary.

Dependent Child

When both parents provide coverage for a dependent child, the plan of the parent whose date of birth (month and day) arrives earlier in the calendar year is the plan that pays first. The year of birth is not

relevant. For example, if the mother's birthday is March 10 and the father's birthday is March 20, the mother's plan would pay first. This is known as the" birthday rule."

The birthday rule applies only under the following conditions:

- The parents are married; or
- The parents are living together, they are not married to each other or anyone else, and they are not separated from each other; or
- There is a court order for joint custody with no assigned financial responsibility.

If the parents are separated or divorced, then:

- The plan of the parent with whom the child lives pays first.
- The plan of the stepparent with whom the child lives pays second.
- The plan of the parent without custody pays third.
- A court order can establish a different order*

**When such a decree exists, it is documented in the parent's membership file. This information is not available in Availity® Eligibility and Benefits. Providers must call the* Provider Service Center *to check for this information.*

6.6 COB Payment Methodologies

When Highmark is Primary

When Highmark is the primary coverage, the services are considered as though no other coverage is available. A health care professional who participates in our networks agrees to accept the program allowance as payment in full. The only amounts billable to the secondary insurance are for coinsurances, deductibles, amounts exceeding a maximum, and those charges denied as non-covered.

When Highmark is not Primary

When not the primary payer, Highmark uses several methodologies when processing claims. These COB payment methodologies include:

- National Association of Insurance Commissioners (NAIC) Model

- Regular COB
- Hard non-duplication
- Soft non-duplication I
- Soft non-duplication II
- Regular Medicare COB
- Customized COB

NAIC Model COB Regulation

Highmark has adopted the National Association of Insurance Commissioners (NAIC) Model COB Regulation. This regulation is the most common methodology used for calculating a secondary payment in COB situations. This model applies to all commercial group products. While the majority of commercial business has been moved to the NAIC model, certain national accounts and larger regional accounts have the option to not participate in this methodology.

The NAIC model COB regulation applies to institutional claims, professional claims, and ancillary claims. It applies to all health care professionals and providers regardless of their participating status with Highmark. The Blue Cross Blue Shield Association supports the NAIC model COB regulation. This is a common industry standard and is consistent with most insurers.

Note: Highmark's senior products, Medicare Advantage products, direct pay products, and the Federal Employee Program (FEP) do not use the NAIC Model.

Pennsylvania NAIC Model

For providers in Pennsylvania

With the Pennsylvania NAIC model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary "Other Insurance" carrier has paid more than or equal to the original Highmark payment, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark payment. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is paid at 100 percent reimbursement. The member always receives credit for the original Highmark deductible and coinsurance expenses.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Delaware and West Virginia NAIC Model

For providers in Delaware and West Virginia

With the Delaware and West Virginia NAIC model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary.

Highmark compares their primary benefit to the “Other Insurance” member liability. Highmark will pay the member liability up to, but not more than, what the Highmark primary payment would have been.

Highmark will follow Delaware and West Virginia State regulations, unless an ASO groups requests something different.

Regular COB Model Defined

With the Regular COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary.

Highmark compares their original allowance to the primary “Other Insurance” member liability. The lesser of the two amounts is considered for payment. Highmark will apply the member’s group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Hard Non-Duplication COB Model

With the Hard Non-Duplication COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary “Other Insurance” carrier has paid more than or equal to the original Highmark payment, or there is no primary Other Insurance member liability, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark payment. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is paid at 100% reimbursement. The member always receives credit for the original Highmark deductible and coinsurance expenses.

With this method, when Medicare is primary, Medicare Hard Non-Duplication coordination of benefits would be applied. Highmark first determines the amount it would have paid as primary using the Medicare allowance. From here, the calculations remain the same as in the Hard Non-Duplication definition.

Note: This pertains to Blue on Blue or Blue on Commercial Only.

Soft Non-Duplication I COB Model

With the Soft Non-Duplication I COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary “Other Insurance” carrier has paid more than the original Highmark allowance, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark allowance. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is considered for payment. Highmark will apply their group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Note: This pertains to Blue on Blue or Blue on Commercial ONLY.

Soft Non-Duplication II COB Model

With the Soft Non-duplication II model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary “Other Insurance” carrier has paid more than the original Highmark allowance, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark allowance. This amount is then compared to the original Highmark payment. The lesser of the two amounts is paid at 100% reimbursement, not to exceed the primary Other Insurance member liability. If the lesser of the two amounts is greater than the Other Insurance member liability, Highmark will pay the Other Insurance member liability at 100% reimbursement after any copayments are applied. The member always receives credit for the original Highmark deductible and coinsurance expenses. With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Note: This pertains to Blue on Blue or Blue on Commercial ONLY.

Regular Medicare COB Model

For Medicare participating providers or providers who are obligated to accept Medicare Assignment (MOM Legislation), when Medicare is primary, Highmark will coordinate benefits up to the Medicare allowance. Highmark will apply their group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

Customized COB Model

Self-funded (“ASO”) accounts may choose from any COB method option. Certain ASO Accounts may also be permitted to customize calculation methodologies. Custom COBs are methods considered to be outside of Highmark's regular COB method option.

COB Calculation Tip Sheet

In order to understand the different COB models outlined in this unit, click on this Tip Sheet document for examples of the following types of COB calculations:

- **COB Calculation Example #1:** An example COB calculation that illustrates an insurance payment that is **greater** than what Highmark would have paid if Highmark was primary.
- **COB Calculation Example #2:** An example COB calculation that illustrates an insurance payment that is **less** than what Highmark would have paid if Highmark was primary.

Blue on Blue

In many cases, duplicate coverage occurs when both the primary coverage and the secondary coverage are provided through Highmark. In most “Blue on Blue” cases, the paid-in-full regulations do apply for health care professionals who participate with Highmark networks.

6.6 COB Claim Submission

When submitting COB claims to Highmark when it is the secondary payer, please include all relative information from the primary insurer, including member liability (e.g., copayment, coinsurance, and deductible).

When Highmark processes a COB claim as the secondary payer, your Explanation of Benefits (EOB) may or may not show the amount the primary insurer paid. The EOB will also show the member's liability. A network provider cannot balance bill the member when Highmark made payment as secondary payer except for any copayment, coinsurance, deductible, or non-covered service under the secondary policy.

How can Providers Assist with the Process?

Health care providers can assist in the COB process by following these guidelines:

- When you file a COB claim, submit the claim to the primary carrier first.
- When Highmark is the secondary coverage, you must submit information about the primary insurer's claim payment and/or the denial of the claim to Highmark.
- When filing claims electronically, the nationally accepted electronic submission formats accommodate secondary claims submission.
- If you submit paper claim forms, you must also send us a copy of the other plan's Explanation of Benefits payment information.
- If both insurance companies make payments on a claim and the combined payments exceed your charge, notify Highmark Provider Service. Provider Service will investigate and advise if a refund is required.

6.6 Duplicate Payments

When a Duplicate Payment is Received

If you received a duplicate payment for a service, please follow these guidelines:

Pennsylvania:

Send refund checks for overpayments to:	Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17089-0150
To request a formal refund request for an offset…	Please call your regional Provider Service Center to initiate an offset.

Delaware:

Send refund checks for overpayments to:	Highmark Blue Cross Blue Shield Delaware Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991
To request a formal refund request for an offset…	Please contact Highmark Delaware's Provider Service Department.

West Virginia:

If you receive duplicate payment in a subrogation case, please send a written notice of duplicate payment to:	Highmark Blue Cross Blue Shield West Virginia Attention: Third Party Recoveries Department P.O. Box 1948 Parkersburg, WV 26102 **Fax** to: **304-424-0320**

Member Inquiries

If a member seeks advice on a duplicate payment, advise members to call the Highmark member service telephone number on the back of their identification cards for direction for their specific situation.

6.6 Medicare Beneficiaries (PA and WV Only)

For providers in Pennsylvania and West Virginia

When a member has Medicare and other insurance, there are certain rules that decide whether Medicare or the other insurance pays first.

Retiree Coverage

For providers in Pennsylvania and West Virginia

Medicare is typically primary for retirees and their spouses since their coverage is not on the basis of current active employment. An employer group retiree health plan with Highmark would be the secondary coverage for the retiree and spouse.

Medicare is Secondary Payer for the Working Aged

For providers in Pennsylvania and West Virginia

The Tax Equity and Fiscal Responsibility Act (TEFRA) requires that employers of 20 or more people offer their working-aged employees and their spouses aged 65 and over the same employee group health plan offered to other employees.

Under the TEFRA law and subsequent legislation, the employee group health plan is the primary payer and Medicare is the secondary payer of claims for working- aged employees in employer group health plans with 20 or more full-time and/or part-time employees. This applies when a single employer with 20

or more employees (as determined by the IRS) sponsors or contributes to the employee group health plan; or multiple employers sponsor or contribute to the employee group health plan and at least one of them has 20 or more employees.

Please contact Highmark Provider Service **to determine whether TEFRA applies.**

Active, Retiree/Laid-Off, & Medicare Coverage

For providers in Pennsylvania and West Virginia

If a member has coverage as an active employee of one company, coverage as a retiree or laid-off worker of another company, **and** Medicare coverage, either of the following scenarios could occur:

- If TEFRA applies, the active coverage is primary; Medicare is secondary; and the retiree coverage is tertiary.
- If TEFRA does not apply, Medicare is primary; the active coverage is secondary; and the retiree coverage is tertiary.

In the case of a husband and wife, it is possible that one may be actively employed while the other is retired, and one or both may also have Medicare coverage, in such a case, either of these scenarios could occur:

- If TEFRA applies, the active coverage is primary for both the husband and wife; Medicare is secondary; and the retiree/laid-off coverage is tertiary.
- If TEFRA does not apply, Medicare is primary for both the husband and the wife; the active coverage is secondary; and the retiree/laid-off coverage is tertiary.

If Medicare is not involved in this scenario, the husband and wife would each be primary under his or her own insurance.

Medicare and Persons with Disabilities

For providers in Pennsylvania and West Virginia

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) is a federal law that enabled the government to raise additional revenues to help reduce the deficit and balance the federal budget. One of the

provisions of OBRA-93 made Medicare the secondary payer for people who meet all of the following criteria:

1. Are under age 65;
2. Have Medicare coverage because of a disability other than permanent kidney failure; and
3. Are covered by a large group health plan (100 or more employees).

Those who can receive secondary Medicare coverage due to disability include:

- Disabled members who are covered by a large group health plan
- Disabled members who are the spouse of a person covered by a large group health plan
- Disabled child members with at least one parent covered by a large group health plan

End-Stage Renal Disease (ESRD)

For providers in Pennsylvania and West Virginia

Under certain circumstances, Medicare benefits are available to persons under the age of 65 who have end-stage renal disease (ESRD). For members who have coverage under an employee group health plan, Medicare and the group plan have specific, time-dependent roles in paying for care related to ESRD. The table below outlines this coverage process:

If...	Then...
It is within the first three months after the Medicare application has been made…	Only the employee group health plan coverage will be available.
The application for Medicare has been finalized, and the coordination period begins…	The employee group health plan is primary; Medicare is secondary.
The coordination period ends…	Medicare is primary; the employee group health plan is secondary.

Member is no longer ESRD for 12 consecutive months; ***or,*** the member is 36 months after a successful kidney transplant…	Medicare benefits end; only the employee group health plan will be available.

The waiting period is waived for ESRD members who undergo a kidney transplant within the first three months after applying for Medicare benefits. The same waiver is provided for members who participate in a course of self-dialysis training during the initial three-month period.

When a member's entitlement has ended and another course of dialysis and/or kidney transplant is needed, a new waiting period is not required. Medicare will be the secondary payer for persons with ESRD who fall into one of the following categories:

- Members who are also covered under an employee group health plan
- Members who are the spouse of a person covered by a group health plan
- Child members with at least one parent covered by an employee group health plan

Who is Primary?

For providers in Pennsylvania and West Virginia

The following table describes who is considered primary when a Medicare beneficiary also has group health coverage:

If…	Then…
The beneficiary has retiree insurance…	Medicare pays first.
The beneficiary is 65 or older, has group health plan coverage based on their own or their spouse's current employer, and the employer has **20 or more employees…**	The group health plan pays first.

The beneficiary is 65 or older, has group health plan coverage based on their own or their spouse's current employer, and the employer has **less than 20 employees…**	Medicare pays first.
The beneficiary is under 65 and disabled, has group health plan coverage based on their own or a family member's current employer, and the employer has **100 or more employees…**	The group health plan pays first.
The beneficiary is under 65 and disabled, has group health plan coverage based on their own or a family member's current employer, and the employer has **less than 100 employees…**	Medicare pays first.
The beneficiary has Medicare because of end-stage renal disease (ESRD)…	The group health plan will pay first for the first 30-month period after the beneficiary becomes eligible to enroll in Medicare. Medicare will then pay first after the initial 30-month period.

Note: In some cases, the employer may join with other employers or unions to forma multiple employer plan. If this happens only one of the employers or unions in the multiple employer plan is required to have the number of employees for a group health plan to pay first.

Group Coverage Doesn't Exist

For providers in Pennsylvania and West Virginia

If the employer group provides no coverage for particular services that are deemed to be medically appropriate (e.g., kidney transplant), then Medicare may pay for those services as the primary payer. This assumes that the medically appropriate service is covered under the Medicare program.

6.6 Medicare Crossover (PA and WV Only)

For providers in Pennsylvania and West Virginia

The Centers for Medicare & Medicaid Services (CMS) consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Crossover Process

For providers in Pennsylvania and West Virginia

Blue Plans implemented the Medicare crossover consolidation process system-wide. This process provides an increased level of one-step billing for your Medicare primary claims, streamlines your claim submissions, and reduces your administrative costs.

The claims you submit to the Medicare carrier cross over to the Blue Plan only after the Medicare carrier or intermediary has processed them. The Medicare carrier or intermediary automatically advises the Blue Plan of Medicare's approved amount and payment for the billed services. Then, the Blue Plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue Plan after you receive the Medicare carrier's or intermediary's payment.

Some providers submit paper claims and EOMB statements for secondary payment unnecessarily. Sending a paper claim and EOMB statement for secondary payment, or having your billing agency resubmit automatically, does not speed up the reimbursement of secondary payments. Instead, this costs you money and creates confusion for members. It also increases the volume of claims handled by the secondary payer and can slow down all claims processing and delay payments.

Whether you submit electronic or paper claims, it is no longer necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

If You Have Not Yet Received Secondary Payment From Highmark

For providers in Pennsylvania and West Virginia

Please allow at least 30 days for the secondary claim to process. If you have not received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status before resubmitting. To further streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims.

6.6 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 7: Payment/EOBs/Remittances

6.7 Overview

This unit addresses payment methodology for both professional and facility provider types, Explanation of Benefits (EOBs), the Facility Remittance Advice, guidance for overpayments and refunds, and special circumstances, such as payment for Federal Employee Program (FEP) members over 65 years of age.

Highmark Reimbursement Policies

Highmark's reimbursement policies contain general coding and reimbursement guidelines to help you avoid claim denials and receive timely payment. The policies are reviewed regularly and updated as necessary, with new policies added when a need is identified. When a policy is updated, past versions are stored within the Reimbursement Policy Bulletin and accessed by selecting the **Click Here for History Versions** link that will appear on the top right of the first page of the bulletin.

To access Highmark's reimbursement policies on the Provider Resource Center, select **Claims & Authorization** and then **Reimbursement Policies.**

Compliance with the Mental Health Parity and Addiction Equity Act

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Highmark utilizes the same processes, standards, factors, and strategies to develop provider reimbursement rates for providers that render medical services, behavioral health services, and substance abuse treatment services.

Medicare Advantage Sequestration Payment Reductions

For providers in Pennsylvania and West Virginia

As part of federal budget cuts mandated by the Sequestration Transparency Act, the Centers for Medicare & Medicaid Services (CMS) initiated a 2% cut in Medicare spending in the form of payment cuts to health care providers for Medicare claims.

Highmark applies sequestration payment reductions similar to those applied by original Medicare. The reductions are applied to all Highmark Medicare Advantage HMO and PPO claim payments after determining any applicable member deductible, member coinsurance, and any applicable Medicare secondary payment adjustments. There is no impact to member cost sharing.

Value-Based Reimbursement

Highmark's network management methodology also utilizes value-based reimbursement models, performance, and high-value networks and products. This strategy emphasizes efficiency and appropriateness, encourages provider/payer collaboration, and increases quality and cost improvement potential.

Highmark's value-based reimbursement strategy evaluates providers' ability to deliver the right care at the right time and in the most appropriate setting. Our value-based reimbursement programs place intense focus on care coordination and population health management principles. For more information, please see *Highmark's Provider Manual* **Chapter 5 Unit 7: Value-Based Reimbursement Programs.**

For More Information

Additional information, such as **Medical Policy** and **HCPCS Information,** is available under **Policies & Programs** on the Provider Resource Center to assist you in billing services for reimbursement from Highmark.

6.7 Payment Methodology for Professional Services

Highmark uses several mechanisms to reimburse professional providers for services rendered to its members. These mechanisms vary depending on the program in which the member is enrolled.

Fee Schedule Inquiries

Fee Schedule Inquiries in Availity® can be used to determine allowances for specific codes or to generate a list of frequently reported procedures for a given specialty. Go to **Claims & Authorization** and then **Fee Schedule Information.**

Requests for fee schedules for most frequently reported procedures can also be submitted in writing to the address below. Please include your provider name, address, and NPI (National Provider Identifier) on your request.

Highmark Blue Shield
Fee Based Pricing and Analysis
P.O. Box 890089
Camp Hill, PA 17089-0089

The fee information will provide the fee-for-service dollar amount allowable for each CPT code. Highmark will not require the participating physician to provide Highmark with billing rates as a precondition to providing fee information.

Plan Allowance

The Plan Allowance is based on the reimbursement terms contained in the Member's Plan Documents as well as their reimbursement amount contained in the fee schedule applicable to the product and provider. If the provider's charges are less than the plan allowance for a particular service, the fee paid to the provider for such service will not exceed the provider's charges. Plan Allowance amounts are updated periodically to respond to changing economic and market conditions.

Fee-for-Service Method

Fee-for-service claims are paid using the network fee schedule specific to the service area. For each service, the payment calculation selects the lower of the provider's billed amount or the Plan Allowance.

Fee-for-service payments may be subject to member program copayments, coinsurance, and deductibles. If the provider's charge is less than the Highmark Plan Allowance, including any incentive payments if applicable, the provider's charge will be paid.

Premier Blue Shield Fee Structure

For providers in Pennsylvania

Premier Blue Shield is Highmark's statewide selectively contracted network of preferred providers in Pennsylvania. It is not tied to a specific benefits program but supports a variety of Highmark programs.

Premier Blue Shield allowances are based on a fee schedule that emphasizes evaluation and management services. Adjustments to the Premier Blue Shield fee schedule are made, as needed, to assure providers are receiving fair reimbursement — and to assure that members have adequate access to primary care and specialty services.

Premier Blue Shield providers agree to accept Highmark's allowances as payment-in-full for covered services. Members are responsible for any applicable copayments, deductibles, or coinsurances.

The Premier Blue Shield Network Fee Schedule is available on the Provider Resource Center under **Claims & Authorization** then **Fee Schedule Information**.

First Priority Health PCP Payment Methodologies

For providers in Pennsylvania

The First Priority Health (FPH) managed care provider network supports the health maintenance organization (HMO) products in the 13-county Northeastern Region of Pennsylvania, including the Highmark Healthy Kids/Children's Health Insurance Program (CHIP).

There are several reimbursement methodologies available to primary care physicians (PCPs) participating in the FPH network, including capitation, billables, copayments, and fee-for-service reimbursement as more specifically set forth in your FPH participating provider agreement. For more details, please see *Highmark's Provider Manual* **Chapter 4 Unit 1: PCPs and Specialists.**

Medicare Advantage Claims are Paid Differently

For providers in Pennsylvania and West Virginia

Providers with a Medicare Advantage contract with Highmark are reimbursed for Medicare Advantage claims in accordance with their contracted rate, which is based on the Medicare fee schedule; however, it may not match the Medicare fee schedule exactly.

At a minimum, Medicare Advantage programs are required to provide coverage for the services covered by Traditional Medicare. They may also provide additional services and benefits. While a person is a member of Medicare Advantage, services are not paid by Traditional Medicare except for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.

6.7 Explanation of Benefits for Medical-Surgical Contracts

An Explanation of Benefits (EOB) statement is sent to network professional providers and to members via postal mail or electronically based on preference. Along with the claim payments, network providers receive an EOB listing all claims processed each week. This EOB lists each patient's claim separately.

Each individual member on the provider's EOB will also receive an EOB listing the services processed. (See example of a provider EOB later in this unit.)

Regardless of your practice location, all Highmark EOBs are available electronically on Availity® by choosing **Claims & Payments** and then click on **Remittance Viewer.**

Availity, Electronic EOBS, and EFT

After becoming Availity-enabled, providers must also enroll in electronic funds transfer and paperless Electronic Remittance Advices. For more information on electronic transaction requirements, see *Highmark's Provider Manual* **Chapter 1 Unit 3: Electronic Solutions – EDI & Availity.**

Non-Network Providers

Non-network providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-network provider for services performed.

6.7 Facility Payment Methodology

Highmark develops and maintains reimbursement methodologies for facility-type providers (UB-04/837I billers) that allow claims to pay at industry standards while taking into account the specific needs of the network participating facilities in our service areas. Reimbursement is in accordance with the payment and reimbursement terms contained in the provider's agreement.

Facility Inpatient

Highmark's general reimbursement methodology for commercial inpatient claims is designed to establish, on a prospective basis, fixed rates for inpatient services. Payment for medical/surgical inpatient services will be made on a per case basis, using the DRG (diagnosis related group) patient classification system.

Highmark develops their own DRG weights. However, the Centers for Medicare & Medicaid Services (CMS) reimbursement methods are reviewed regularly to determine what the impacts are to Highmark's reimbursement methods. These updates can occur annually or quarterly depending on the provider type.

Facility Outpatient: Highmark OPPS-Based Payment Method

Highmark has adopted the Medicare Outpatient Prospective Payment System (OPPS) that is based on the Ambulatory Payment Classification (APC) system and the use of the OPPS components in Highmark APC-based payment methods. OPPS was designed to pay acute care hospitals for most outpatient services.

The Highmark OPPS-based payment method is designed to use all the features, values, and workings of the Medicare OPPS, with the exception of select customized features. The payment method includes the APC grouper and pricer, relative weights, applicable edits, and quarterly updates.

Since its inception, CMS has made, and continues to make, changes and refinements to APCs and the entire OPPS. These changes are made every calendar quarter, with the most significant changes occurring at the start of each calendar year.

Highmark evaluates the appropriateness of CMS' new or revised components for potential modification. Highmark's implementation of each quarterly update is based on the time frame in which CMS releases the quarterly change notices and Highmark's receipt of such changes via the vendor software. The date of implementation will be posted in advance via the Highmark OPPS calendar on the Provider Resource Center when accessed via Availity®.

For More Information

For more details, you can find the **Highmark Outpatient Prospective Payment System (OPPS) Based Payment Method Provider Training Manual** and the **APC Pricing Component Update Calendar** on the Provider Resource Center. Look under **Claims & Authorization** and then **Reimbursement Resources**.

SNF RUG-Based Payment Methodology

Highmark currently uses a Resource Utilization Group (RUG) based payment methodology for all participating skilled nursing facility providers for both commercial and Medicare Advantage products. RUG-based reimbursement more closely approximates the relative resource intensity associated with treating individual skilled patients. Each RUG category translates into a per diem payment that is specific to each patient's condition.

The Highmark methodology is designed to use all the features, values, and workings of the Medicare per diem payment methodology with only a few exceptions.

6.7 Facility Remittance Advice

The Provider Remittance Advice is provided by Highmark's claim processing system and accounts for all claims adjudicated in the payment cycle, including those which have been denied. The Remittance Advice displays how the claim processes, including contractual adjustments, payments, and member liabilities.

Remittance Types and Availability

The facility Provider Remittance Advice is available in an online version via Availity® by going to **Claims & Payments** and then clicking on **Remittance Viewer.**

Providers can also choose to receive their claim payment information via an electronic remittance advice (Version 5010 – 835). Receipt of the 835 can be set up through contacting your electronic vendor or clearinghouse or directly by:

- **Delaware, Pennsylvania, and West Virginia:** receipt of the 835 is generated from PNC-ECHO Health Trust using the ECHO Payer ID 58379. To sign-up to receive ERAs visit ECHO Health's EFT/ERA enrollment page.
- **New York:** Receipt of the 835 is generated from the Administrative Services of Kansas (ASK).

For all Friday evening payment cycles, the 835 is available for viewing by Monday morning. The actual availability of the 835 files may also depend on your vendor.

Electronic Funds Transfer (EFT) payments associated with both the facility Remittance Advice and the Version 5010-835 are available on Wednesday.

EDI Support

For information on electronic remittance advice (Version 5010-835), please visit the Highmark EDI Services website. The EDI website is accessible on the Provider Resource Center by selecting **Claims & Authorization** then looking under **Reimbursement Resources,** or by clicking on the applicable link below for your service area:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde

- West Virginia: highmark.com/edi-wv
- New York: ask-edi.com/

An EDI support analyst may also be contacted by phone at **800-992-0246.**

6.7 ANSI Claim Adjustment Group and Reason Codes

American National Standard Institute (ANSI) codes are used to explain the adjudication of a claim and are the CMS-approved ANSI messages. **Group codes must be entered with all reason code(s)** to establish financial liability for the amount of the adjustment or to identify a post-initial-adjudication adjustment.

ANSI Group Codes (AGC)

The table below defines the ANSI Claim Adjustment Group Codes that appear in the field represented as AGC (column 2, line 4) on the Highmark Remittance Advice Detail Report:

Group Code	Description
Patient Responsibility (PR)	This code is used when the amount rejected is billable to the insured or the patient. Examples would include: amounts applied to deductibles, coinsurance, copayments, subscriber penalties, and patient assumed financial responsibility for a service considered not medically necessary. The amount adjusted is the responsibility of the patient.
Contractual Obligation (CO)	This code is used when the amount rejected is non-billable to the insured or the patient. The amount adjusted is not the patient's

	responsibility under any circumstance because of the obligation that exists between the provider and the payer, or because a regulatory requirement is in existence.
Payer Initiated Reductions (PI)	This code is used when the amount rejected is non-billable to the insured or the patient. In the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).
Other Adjustment (OA)	This is used when the amount rejected is non-billable to the insured or the patient. Additionally, this is used when there are miscellaneous adjustments being made to the rejected claim (for example, if the service is being processed on another claim that has not been paid). If no other category is appropriate, this one will be used.
Correction and Reversal (CR)	This code is used when the amount rejected is non-billable to the insured or the patient. For example, if the provider withdraws a claim, the claim will be rejected on reconciliation as a rejected claim. The claim is a reversal of a previously reported claim or claim payment.

ANSI Reason Codes (ARC)

ANSI Claim Adjustment Reason Codes (CARCs) appear on the remittance, designated as ARC (column 2, line 4), to communicate an adjustment. These codes explain why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code on the remittance.

Below is a list of commonly used Claim Adjustment Reason Codes:

1 Deductible Amount
2 Coinsurance Amount
3 Copayment Amount
18 Duplicate claim/service
29 The time limit for filing has expired.
35 Lifetime benefit maximums have been reached.
49 Non-covered services – Routine
78 Non-covered days/Room charge adjustment
96 Non-covered charge(s)
119 Benefit maximum has been reached for this time period.

For a complete current listing of Claim Adjustment Reason Codes, click here.

6.7 Overpayments and Refunds

Highmark offers streamlined, electronic processes that simplify how you notify Highmark of claim overpayment and how Highmark will notify you when we identify overpayments.

Provider Identifies Overpayment

If a provider identifies an overpayment:

- All Availity-enabled providers must use **Message this Payer** within **Claim Status** in Availity to notify Highmark of an overpayment. If you are not Availity-enabled and an overpayment was made, call

Highmark Provider Service to advise if you want the overpayment offset from a future payment.

- If Highmark agrees that an overpayment exists, it will adjust the payment so that the next Explanation of Benefits (EOB) statement and Electronic Remittance Advice (835) transaction (if used) will include details of the changes in the payment. It will also reduce the total payment for that EOB/835 by the amount of the overpayment. The EOB/835 detail, on a line-item basis, is clear and easy to post in your accounts receivable software. If you take advantage of the Electronic Remittance Advice (835) transaction, your office/facility can automatically post the refund.
- While less desirable, if you prefer to refund the amount of overpayment by sending a check. Send a check and a copy of the EOB with the overpaid claim circled to:

Pennsylvania | Delaware | West Virginia | New York

Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17089-0150	Highmark Blue Cross Blue Shield Delaware Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991	Highmark Attn: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark Blue Cross Blue Shield of Western New York **or** Highmark Blue Shield of Northeastern New York P.O. Box 4208 Buffalo New York 14240

Chip Provider Self Audit Protocol

For providers in Pennsylvania

Per the Highmark Healthy Kids/Pennsylvania Children's Health Insurance Program (CHIP) Provider Self Audit Protocol, providers are to mandatorily disclose overpayments or improper payments of CHIP funds within 60 days of identification and provide written description of the reason for the overpayment or improper payment.

Highmark Identifies an Overpayment

If Highmark identifies an overpayment:

- Highmark will notify your practice of all overpayments on a separate section of the EOB and Electronic Remittance Advice (835) transaction, if used. Highmark will not send notification of overpayment letters to you. The overpayment details in the new section of the EOB (future offset summary) and 835 reference an overpayment that will be withheld from a future check.
- The EOB/835 provides detail as to the reason for the refund request. It serves as notice that unless appealed or paid by check, the overpayment will be deducted from an EOB/835 approximately 60 days following the notification.
- If you agree with the refund request, you should take no action. Highmark will automatically deduct the overpayment from a future check. The deduction will be indicated on your EOB/835. If you do not want the overpayment withheld from a future check but prefer to write a check for the overpayment, send the check and a copy of the EOB with the overpaid claim circled to:

Pennsylvania	Delaware	West Virginia	New York
Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17089-0150	Highmark Blue Cross Blue Shield Delaware Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991	Highmark Attn: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark Blue Cross Blue Shield of Western New York **or** Highmark Blue Shield of Northeastern New York P.O. Box 4208 Buffalo New York 14240

6.7 Electronic Manual Payments

When a manual payment is requested for a provider and the provider is both EFT and Availity®-enabled, Highmark will send the provider an electronic payment instead of a paper check. **Electronic manual payments will have a unique check number that will begin with "77" (e.g., 7700000001).** An electronic remittance advice/EOB will not be issued for electronic manual payments.

How to Obtain Electronic Manual Payment Information

You can use Availity's Cash Management function to see payment details for an electronic manual payment. The **Cash Management** transaction provides a weekly payment accumulation and a summary of payments received for the current year. In addition, you may retrieve individual check details.

To access check details, select Payer Spaces and then select **Cash Management.** Click on the applicable check number from the list on the Provider Payment and History Inquiry page. You can view additional information about the payment in the **Comments** field on the check's **Detail Information** screen.

6.7 Payment for FEP Members Over 65

Federal Employee Program (FEP)

For certain Federal Employee Program (FEP) members aged 65 or older who do not have Medicare, the Federal Employee Health Benefit (FEHB) law limits payments for inpatient hospital care and physician care to what Medicare would pay. Outpatient hospital care and non-physician based care are not covered by this law.

The following chart provides information about the limits:

If the FEP Member is...	Then, for Inpatient Hospital Care...	And for Physician Care...

• age 65 or over; and • does not have Medicare Part A, Part B, or both; and • has the FEP Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and • is not employed in a position that gives FEHB coverage…	• the law requires payment based on an amount set by Medicare's rules for what Medicare would pay, not the actual charge. • the member is responsible for applicable cost-sharing amounts (i.e., coinsurance). • the member is not responsible for any charges greater than the Medicare-approved amount. • the law prohibits a hospital from collecting more than the Medicare-approved amount.	The law requires the payment and the member's applicable coinsurance or copayment be based on: • the Medicare-approved amount, or • the actual charge if it is lower than the Medicare-approved amount.

The following table explains member responsibility under each plan option:

If the Physician…	Then the FEP Member is Responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network…	Standard Option: Deductibles, coinsurance, and copayments.

	Basic Option:	Copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment for the claim and is in our PPO network…	Blue Focus:	Deductibles, coinsurance, and copayments.
Participates with Medicare or accepts Medicare assignment and is **not** in the Preferred network…	Standard Option:	Deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.
	Basic Option:	All charges.
Participates with Medicare and is not in the Preferred network…	Blue Focus:	All charges.
Does not participate with Medicare and is in our Preferred network…	Standard Option:	Deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	Copayments and coinsurance, and any balance up to 115% of the Medicare approved amount

	Blue Focus:	Deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
Does not participate with Medicare and is **not** in our Preferred network…	Standard Option:	Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	All charges.
	Blue Focus:	All charges.

6.7 Payment for the Highmark Healthy Kids Program (CHIP)

For providers in Pennsylvania

Promise™ ID Enrollment Required for Highmark Healthy Kids (CHIP) Payment

The Pennsylvania Department of Human Services (DHS) implemented the Affordable Care Act (ACA) Provider Enrollment and Screening provisions that require all providers who render, order, refer, or prescribe items or services to Highmark Healthy Kids (CHIP) enrollees to have a valid PROMISe ID. A valid PROMISe ID is required to receive payment for CHIP enrollee claims. Failure to have a valid PROMISe ID may result in denial of reimbursement.

For more information about PROMISe ID enrollment, please see *Highmark's Provider Manual* **Chapter 3 Unit 1: Network Participation Overview.**

Reimbursement

For providers in Pennsylvania

Participating providers accept Highmark's reimbursement for services as payment in full without balance billing the enrollees. There is no additional discount applied to provider reimbursement rates due to income level (providers receive the full Highmark CHIP reimbursement rate).

For the CHIP HMO plan, if covered services are not available from a network provider, preauthorization must be obtained to receive services from a provider outside the network.

Highmark Healthy Kids (CHIP) Provider Self Audit Protocol

For providers in Pennsylvania

Per the Pennsylvania Children's Health Insurance Program (CHIP) Provider Self Audit Protocol, providers are to mandatorily disclose overpayments or improper payments of Highmark Healthy Kids (CHIP) funds within 60 days of identification and provide written description of the reason for the overpayment or improper payment.

For more information on reporting overpayments to Highmark, please see the **Overpayments and Refunds** section of this unit.

FQHC/RHC Payment and Claim Submission

For providers in Pennsylvania

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires payment for services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be at least equivalent to Medicaid Prospective Payment System (PPS) rates for all CHIP encounters. The PPS rates are all-inclusive rates for encounter services provided, except for vaccine services.

All FQHCs and RHCs must bill for services using the **T1015** procedure code. The T1015 code is the required code to be able to pay the all-inclusive PPS rate and is defined as “clinic visit/encounter, all-inclusive.”

When the FQHCs are using the 1500 Claim Form, they must list T1015 in the first section of Item #24d. All pertinent services furnished during the encounter should be listed in the claim. FQHC PPS specific payment codes are listed on the Centers for Medicare & Medicaid Services (CMS) website.

General Guidelines for CHIP FQHC/RHC Claim Submissions:

1. Providers should include the T1015 HCPCS code indicating an encounter/service meeting the guidelines for CHIP has occurred.
2. Providers can either bill the T1015 HCPCS with a charge amount or a zero charge.
3. T1015 code must be billed on the same claim as the office visit and not separately.
4. Reimbursement at the PPS encounter rate may be split across lines on the claim. Base Pricing will prorate the claim allowance on eligible lines to apply the entire encounter/claim allowance to the claim.
5. All other procedures performed during the encounter on the claim (e.g. office visit, screening, behavioral assessment, etc.) must be billed with a charge amount and the procedure CPT code (as they would normally submit). Zero charge lines reported for CHIP enrollees will reject.
6. All vaccines should be billed with charge amounts and associated CPT code and do not need to be billed with the T1015 code.
7. Vaccine administrations should be billed with the charge amounts and associated CPT code and do not need to be billed with the T1015 code.
8. CHIP does not reimburse more than charge. Each claim is capped at charge before any enrollee liability and approved amounts are calculated.
9. CHIP enrollees may be liable for copays based on services.

Questions on FQHC PPS can be emailed to FQHC-PPS@cms.hhs.gov

For More Information

To learn more about Pennsylvania’s CHIP program, please see *Highmark’s Provider Manual* **Chapter 2 Unit 3: Other Government Programs.**

6.7 Non-Network Payment Guidelines

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

6.7 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the "manual" or "Highmark Provider Manual") are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 8: Payment Review

6.8 Financial Investigations and Provider Review (FIPR)

FIPR Overview

The mission of Highmark's Financial Investigations and Provider Review (FIPR) department is twofold:

1. Support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate.

2. Protect Highmark's assets by investigating and resolving suspected incidents of health care insurance fraud, waste, abuse, or material misrepresentation (FWAM).

In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider FWAM. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care FWAM. When necessary, FIPR carries out internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers, or members.

For more information on FIPR, please visit highmark.com. Click on **Fraud Prevention** in the blue area at the bottom of the page.

Highmark's Fraud Hotline

Highmark established a fraud hotline so that members and providers can notify FIPR of potential fraud. The fraud hotline is automated and allows anyone to leave a message.

If you suspect fraud, contact your local FIPR department within Highmark:

- Pennsylvania and Delaware: **800-438-2478**
- New York: **800-333-8451; 800-314-0025**
- West Virginia: **800-788-5661**

6.8 Defining the Issues: Fraud, Waste, Abuse, and Material Misrepresentation (FWAM)

Fraud

Fraud is defined by state and federal laws and typically occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the purpose of receiving payments that an individual or entity is not eligible to receive.

Example: Billing for services not rendered.

Waste

Waste is defined as the overutilization of professional medical services or the misuse of resources by a health care provider.

Example: A provider's belief is that all patients should receive an X-ray every time they have an appointment.

Abuse

Abuse is defined as incidents or practices of providers, physicians, or suppliers of services and equipment that are inconsistent with accepted sound medical, business, or fiscal practices.

Example: Billing separate services that should be bundled under one service code.

Material Misrepresentation

When a provider submits claims to Highmark for reimbursement, the provider is contractually obligated to ensure that the information in the claim accurately reflects the services performed as documented in the provider's records. Claims that do not accurately reflect the services performed are misrepresentations; when a misrepresentation results in an overpayment to the provider, it is a material misrepresentation.

Because the provider is contractually obligated to submit claims that accurately reflect the services performed, Highmark may retroactively adjust payments to reflect the services actually performed following a review of the provider's records or receipt of other information that indicates a claim materially misrepresents the services performed. Highmark may retroactively adjust payments in these circumstances and seek recoupment even where there is no evidence that the provider or entity intentionally submitted claims containing misrepresentations.

Example: Coding claims to reflect that a more complicated, higher level office visit was performed when a lower office visit code was more appropriate.

Note: These four definitions are not mutually exclusive and may overlap. For example, billing unbundled services that should be bundled under one service code may be both abuse and a misrepresentation or even fraud.

6.8 Payment Review Process

Payment review[1] is a key element of the screening process Highmark uses to assure that members receive health care services that are medically necessary and that the claims for these services are submitted properly. This process also ensures that claims are being paid in accordance with provider agreements, while at the same time addressing the integrity of the payment calculated by Highmark.

History of Payment Review

Highmark initiated payment review in 1962 in cooperation with the Pennsylvania Insurance Department. Since that time, it has increased in importance not only at Highmark but in the entire health care industry.

Payment reviews are now conducted in all Highmark service areas due to regulations established by Federal and State regulatory agencies, such as the Centers for Medicare & Medicaid Services (CMS), Federal Employee Program, and the respective State insurance departments. In addition, the national Blue Cross and Blue Shield Association (BCBSA) and the contracts we have with our group clients also require Highmark to monitor provider claims billing.

Ultimate Goals of Payment Review

The ultimate goals of payment review are to:

- Be a deterrent to fraud, waste, abuse, and material misrepresentation (“FWAM”) by performing advanced analytical and investigational payment reviews.
- Educate our provider community on appropriate reporting of services in accordance with industry standard and “Best Practice” guidelines.
- Ensure that payments are being made in accordance with contracted provider agreements.
- Ensure that payments are made consistent with medical policy and other Highmark guidelines.
- Identify, control, and eliminate aberrant and inappropriate claim coding.

In rare instances of suspected fraud, Highmark’s Financial Investigations and Provider Review (FIPR) tracks claim reporting to collect information that may become evidence for law enforcement officials or the courts. Professional physician consultants support and advise Highmark personnel in pre- and post-payment review activities.

[1]Unless otherwise specifically noted, when used in this Manual the term “payment review” is meant to also refer to the following processes, including but not limited to: provider audit/review, audit, claim(s)

audit/review, post-payment audit/review, retroactive post-payment audit/review, coding audit/review, E/M audit/review, pre- payment audit review, post-payment practice pattern review, and pre-payment practice pattern review.

Three Phases of Payment Review

1. **Initial claims review:** Highmark staff screens each claim received for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package. Frequently, Highmark pays for eligible services even though a more extensive review of a provider's practice pattern may take place at a later time.
2. **Pre-payment practice pattern review:** Staff looks closely at selected claims before the claims are paid in order to determine appropriateness of services billed and/or the medical necessity of the services reported.
3. **Post-payment practice pattern review:** Staff looks closely at selected claims after the claims have paid in order to determine appropriateness of claim coding, services billed, and medical necessity, if applicable. This involves long-term tracking and monitoring of many services rendered by providers.

Which Providers are Reviewed?

Highmark is required to monitor all providers in our participating, preferred, and managed care networks throughout Delaware, New York, Pennsylvania, and West Virginia. The claims being reviewed are for Highmark members and also for when Highmark is acting as the intermediary for contracted pricing for other Blue Cross and Blue Shield Plan members.

Who is Conducting Payment Reviews?

Highmark's FIPR team is comprised of experienced health care professionals with expertise in clinical, financial, revenue cycle, health information management, and coding specializations. These individuals include nurses, financial and IT analysts, investigators, medical coders, consultants, and auditors.

Due to the complexity of facility billing and payment methodologies, Highmark also uses external firms to assist in payment reviews of paid claims. These reviews are conducted to ensure that providers are complying with industry standards on appropriate billing and that payments are monitored for accuracy.

Professional consultants are also engaged to support and advise Highmark personnel in the identification of problematic billing and coding issues.

For purposes of this Chapter and unless otherwise noted, if a section refers to “FIPR,” it is also referring to external firms and professional consultants that may assist or support Highmark’s payment review processes.

When Problems are Identified

When a potential FWAM problem is identified, what actions are taken to correct the provider’s reporting?

1. FIPR performs an investigation of the potential FWAM.
2. FIPR notifies the provider of the findings.
3. FIPR educates the provider on proper coding and billing and expects the provider to adhere to such education on any future billing.
4. FIPR collects identified overpayments.
5. If potential fraud is detected, FIPR refers the issue to the appropriate law enforcement agency.

6.8 Techniques Used for Investigation

In the payment review process, Highmark employs various techniques to investigate potential issues of fraud, waste, abuse, and material misrepresentation (“FWAM”).

Routine Surveys of Paid Claims

Financial Investigations and Provider Review (FIPR) staff routinely surveys a percentage of all claims it receives. FIPR staff verifies the accuracy of claims by gathering information from hospital medical records departments, professional provider offices, or members.

Statistical Review of Cumulative Claims Payment Data

FIPR utilizes an internal system to investigate unusual utilization. Highmark developed this web-based application to gain faster access to claims data and also to enhance reporting capabilities. The system is able to generate both summary and detailed reports from seven years of available data.

The reporting capabilities of the system allow for comparison of a provider’s utilization to the utilization of other providers within the same geographic region and specialty. This type of comparison allows FIPR

to analyze utilization quickly and effectively, and it is these analyses that identify overutilization and potential fraudulent behavior.

Pre-Payment Review

FIPR employs predictive analytic software to search for and screen potentially aberrant claims. This software works by identifying patterns of suspicious behavior and provides a score based on that claim's degree of risk; the higher the score, the higher the fraud risk. Claims identified by this process are then reviewed for accuracy and appropriateness of payment and, if necessary, FIPR will open an investigation of the specific claim or the provider.

Highmark continually updates the FWAM detection tools based on improvements in technology and data analysis techniques.

Special Research Studies

FIPR frequently conducts special studies to identify new areas for review and to assess the adequacy of our present claims systems to ensure cost-effective quality health care for our members.

Ongoing Investigations

FIPR continues to closely monitor claims after the claims have been paid in order to determine the appropriateness of the services reported. This involves long-term trending and monitoring of many services.

Federal Deficit Reduction Act (DRA) of 2015 and Fraud, Waste, and Abuse

For providers in New York

Health care organizations subject to Section 6032 of the federal Deficit Reduction Act of 2005 (the "DRA") are required to educate their providers and contractors about the False Claims Act as well as the organization's policies and programs for detecting and preventing fraud, waste, and abuse. The following documents are intended to satisfy Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York's obligations under the DRA.

We know you share Blue Cross Blue Shield's goal of ensuring that all clinical and business activities are conducted in full compliance with applicable laws and government program requirements. Accordingly, we look forward to your cooperation in applying Blue Cross Blue Shield's fraud prevention and detection policies and programs in connection with the services you provide to our members.

If you have any questions regarding these documents, please do not hesitate to contact Blue Cross Blue Shield's fraud prevention program at 716-887-8451 or 800-333-8451.

Fraud Waste and Abuse Laws in Health Care:

- Fraud, Waste, or Abuse (Whistleblower) Policy
- Code of Conduct and Compliance Program
- Special Investigations Unit Deficit

6.8 When a Case is Identified

Process When a Potential Problem is Identified

When a potential problem is identified, a case investigation is initiated. Claims data is generated and reviewed.

Analysis of claims processed: A statistical analysis of the claims processed for a particular provider will be conducted. This analysis will compare all phases of a provider’s billing patterns to those of his or her peers.

Financial Investigations and Provider Review (FIPR) may select specific claims for a detailed review and also may select a statistical sample of claims. If a statistical sampling approach is used, FIPR would randomly select a population of claims and extrapolate the results over all the claims paid to a provider for a given period.

If irregularities are found during the investigation (for example, the provider is performing more of one particular service than his or her peers), FIPR will notify the provider of the potential irregularity and request a response.

On-site review: If warranted, an on-site review may be conducted. This usually includes obtaining copies of clinical records.

Patient interviews: Patients may also be interviewed to verify that services were performed as reported. If the patient's age or condition precludes an interview, the investigator(s) may interview the patient's relatives, as appropriate. These interviews may be necessary in all types of investigations conducted by FIPR. FIPR investigators are trained to avoid making improper comments about the provider or the quality or appropriateness of treatment the member received.

Discrepancies between information reported on the claim form and the member's recollection of the services performed are pursued carefully. FIPR investigators make every effort to assess the reliability of persons interviewed and the accuracy of their statements. Whenever possible, all interviews are recorded to memorialize the details of any statements made. The recording will protect the member as well as the investigator(s) from misinterpreted information, avoiding the change of specific details at a later time, and potentially provide evidence for use in all proceedings. (Warnings of audio recording are given to the interviewees to avoid potential wiretap violations.)

FIPR informs the provider of the final results of the case investigation if a change in behavior or a refund appears to be appropriate.

Review by FIPR Investigators

It is the responsibility of FIPR investigators to examine and summarize hospital and office records and reports of on-site reviews. They also review statistical information on payments made and compare claim coding to Highmark medical and payment policies.

Review by Professional Consultants

Although not required in every case, a professional consultant may be used to review documentation and provide a written opinion. The professional consultant program involves over 250 independent health care professionals who provide their perspective on issues of medical policy, clinical guidelines, and unusual claims.

A professional consultant is contracted as a Business Associate of Highmark. The consultants are typically actively practicing health care professionals, representing major professional specialties and disciplines. The consultants are required to:

- Provide written medical opinions regarding medical claims;
- Provide written medical opinions regarding medical policy;
- Provide written input for use in the development of reimbursement amounts for medical service; and
- Provide written medical opinions regarding provider practice patterns and utilization.

Referrals to consultants involve two separate and distinct types of reviews: pre-payment and post-payment. Pre-payment investigations are performed on the medical necessity or appropriateness of a service(s) or procedure code(s) prior to claims payment. Post-payment investigations involve utilizing professional consultants to review overall practice patterns and specific claims as necessary.

In these situations, the consultants are generally providing their opinion as to whether the documentation in the medical records supported the services billed and the level of care. If there is a lack of supportive documentation, the consultants advise what services, or level of care, should have been reported.

In order to assure the credibility of these reviews, every effort is made to use a consultant of the same specialty or subspecialty and similar practice. A consultant from a different geographic location is typically used in an attempt to ensure that the provider being reviewed receives a completely unbiased review. Additionally, the consultants are currently in active practice to assure they are aware of the latest developments in their specialties.

Provider Contact and Education

Following review, the provider may be contacted by a FIPR representative to discuss several items such as: the statistical data; the individual treatment patterns; the professional consultant's opinion; education on future reporting; and, if necessary, obtain a refund of overpaid monies.

6.8 Post-Payment Claim Review

This section summarizes how Financial Investigations and Provider Review (FIPR) staff conducts post-payment reviews of claim submissions and processing for potential fraud, waste, abuse, and material misrepresentation (FWAM).

Post-Payment Review

FIPR staff periodically performs post-payment reviews of providers who have been selected based on their utilization and billing patterns, relative to their peers. Providers and members may also be selected for review based on various other criteria including, but not limited to, potential allegations of wrongdoing, systemic billing errors, and Fraud Hotline tips.

A statistically random sample of records for the questioned services is reviewed. Typically, a certified professional coder and/or registered nurse perform the reviews. However, qualified external consultants may on occasion be contracted to perform such reviews on behalf of Highmark.

Similarly, FIPR staff may on occasion pend and review a provider or member's claim on a pre-payment basis.

Criteria Used in E/M Reviews

In the performance of E/M (evaluation and management) reviews (whether pre- or post-payment), the reviewer will use the following criteria to assess adequacy of documentation to support the level of service billed:

- Applicable E/M guidelines published by the American Medical Association (AMA) in the Current Procedural Terminology ("CPT") book and Documentation Guidelines for E/M Services published by the Centers for Medicare & Medicaid Services (CMS).
- Provider or business owner must state in writing (by letter or email) which E/M guidelines will be used to perform the review.
- The representations in each record must support the service billed and the level of care provided on each unique date. **Records that contain cloned documentation, conflicting information, or other such irregularities may be disallowed for reimbursement.** Reimbursement for any record containing such questioned documentation will be represented in overpayment calculations with zero reimbursement allowed.
- Each entry in the record must be made such that the documenter is obvious (name and credentials) and must include the date and specific time performed, including accurate start and stop time for the time-based procedures. Hard copy records must be signed on each page by the person providing the services (e.g., a physician assistant providing the services must sign their name and credentials in the medical records).
- Electronic medical records (EMR) must be recorded in order to specifically substantiate who performed each unique service, along with the date and specific time performed.

Treatment of Under Coding

FIPR reviewers document determinations of both over coding and under coding. In the event a FIPR reviewer determines that documentation supports a higher level code than billed, the reviewer gives credit for the underpayment.

Review of Results

At the conclusion of a payment review, the results are submitted in writing to the provider via certified mail, and facsimile if applicable. The provider is afforded the opportunity to rebut review findings by providing clarification and/or supporting documentation **within 30 calendar days.**

For providers in West Virginia responding to the receipt of a retroactive denial, please refer to the Prompt Pay Act “provider recovery process” located below.

Copies of review worksheets may be made available to the provider upon written request. Additionally, the provider may request a meeting with FIPR staff to:

- Ensure the provider understands the review process and results.
- Answer questions regarding correct billing and documentation.
- Afford the provider an opportunity to furnish additional supporting documentation and/or clarification.
- Discuss repayment arrangements, if applicable.

6.8 Retroactive Denials and Overpayments

If Highmark’s Financial Investigations and Provider Review (FIPR) identifies an overpayment, recovery of the overpayment is subject to each service region’s respective retroactive denial or overpayment collection laws as applicable.

The Prompt Pay Act

For providers in West Virginia

Under the Ethics and Fairness in Insurance Business Practices Act, W.Va. Code § 33-45-1 et seq. (the "Prompt Pay Act"), Highmark West Virginia may retroactively deny an entire previously paid claim insured by Highmark West Virginia for a period of one year from the date the claim was originally paid. See also **Chapter 6.1: General Claim Submission Guidelines** for additional information about the Prompt Pay Act.

The Prompt Pay Act does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To contracted providers outside of West Virginia;
- To claims paid under an Employee Retirement Income Security Act of 1974 (ERISA) self-funded plan;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, and Public Employees Insurance Agency (PEIA);
- To claims submitted fraudulently or which contain material misrepresentations;
- When a good faith dispute about the legitimacy of the amount of the claim is involved (e.g., disputed review findings during the resolution process);
- Where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g., fire, pandemic flu);
- Where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g., Unclaimed Property Act);
- To BlueCard claims;
- To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions); or
- A partial adjustment to an amount paid that is not a denial of an entire previously paid claim.

Provider Recovery Process

For providers in West Virginia

Under the Prompt Pay Act, upon receipt of a retroactive denial, the provider has 40 days to either: (1) notify Highmark West Virginia of the provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Highmark West Virginia within 30 days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation. Highmark West Virginia will review as an appeal and notify the provider of its final decision within 30 days after receipt of the provider's notice of dispute. Please see the section titled **Post-Payment Dispute Resolution Process – Appeals & External Review.**

If the retroactive denial is upheld, the provider must pay the amount due within 30 days or the amount will be offset against future payments unless the provider notifies Highmark West Virginia in writing that the provider is disputing the review findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for West Virginia providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement.

For overpayments and refunds not initiated by FIPR, see the section on "Overpayments and Refunds" in the manual's **Chapter 6.7: Payment/EOBs/Remittances.**

The Retroactive Denial of Reimbursement Act

For providers in Pennsylvania

The Retroactive Denial of Reimbursement Act, 40 Pa. C.S. § 3801 et seq. (the "Retroactive Denial Act"), prohibits the retroactive denial of a reimbursement to a health care provider (hereinafter "provider") as a result of an overpayment determination more than 24 months after the date the insurer initially paid the provider. The Retroactive Denial Act does not apply:

- To claims in which the information submitted therein constitutes fraud, waste, or abuse as those terms are defined in the Retroactive Denial Act;
- To duplicate claims;
- To claims in which denial was required by a Federal or State government plan;
- To claims where the services were subject to coordination of benefits with another insurer, the medical assistance program, or the Medicare program; or
- To services furnished by providers that are not licensed, certified, or approved by the Commonwealth of Pennsylvania to provide health care or professional medical services.

Note: If Highmark submits a written request for medical or billing records to the provider, the provider has up to 60 days to provide the requested records, and the period of time for which it takes the provider to

collect the requested records shall be added to the 24 month period.

Provider Recovery Process

For providers in Pennsylvania

Under the Retroactive Denial Act, if Highmark retroactively denies reimbursement to a provider, Highmark shall give the provider a written statement specifying the basis for the retroactive denial. If the provider disputes the retroactive denial, the provider shall notify Highmark in writing that the provider is disputing the findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for Pennsylvania providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement.

For overpayments and refunds not initiated by FIPR, see the section on “Overpayments and Refunds” in the manual’s **Chapter 6.7: Payment/EOBs/Remittances.**

Collection Overpayment Act

For providers in Delaware

Title 18, Chapter 27 of the Delaware Code, 18 Del. C. § 2730 (the “Collection Overpayment Act”), prohibits the initiation of collection of overpayments from a health care provider (hereinafter “provider”) by a health insurer or health plan more than 24 months after the original payment for the claim was made. The Collection Overpayment Act does not apply:

- When the health insurer or health plan overpayment recovery efforts are based on a reasonable belief that fraud, abuse, or other intentional misconduct was committed;
- When the recovery of the overpayment is required by, or initiated at the request of, a self-insured plan;
- When the recovery of the overpayment is required by a state or federal government plan; or
- To certain coverages excluded by the Collection Overpayment Act’s definition of health plan (e.g., accident-only, credit, Medicaid plans, long- term care or disability income insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance).

Provider Recovery Process

For providers in Delaware

Under the Collection Overpayment Act, if Highmark Delaware seeks to collect an overpayment, the provider shall be given written notice identifying the error and providing justification for the overpayment recovery. If the provider disputes the overpayment, the provider shall notify Highmark Delaware in writing that the provider is disputing the findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for Delaware providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement. During the dispute resolution process, the provider will be entitled to any relevant claims information pursuant to the Collection Overpayment Act.

For overpayments and refunds not initiated by FIPR, see the section on “Overpayments and Refunds” in the manual’s **Chapter 6.7: Payment/EOBs/Remittances.**

New York State Insurance Law

For providers in New York

New York State Insurance Law § 3224-b states a health plan shall not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are:

- Based on a reasonable belief of fraud or other intentional misconduct;
- Required by, or initiated at the request of, a self-insured plan;
- Required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees, or members.

Provider Recovery Process

For providers in New York

For overpayment to healthcare providers — other than recovery for duplicate payments — Highmark New York shall provide 30 days written notice to health care providers before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such health care providers.

Such notice shall state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment. Highmark New York shall provide a health care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for health care providers to follow to challenge an overpayment recovery. Such a challenge shall set forth the specific grounds on which the provider is challenging the overpayment recovery.

For overpayments and refunds not initiated by FIPR, see the section on "Overpayments and Refunds" in the manual's **Chapter 6.7: Payment/EOBs/Remittances.**

6.8 Post-Payment Dispute Resolution Process – Appeals and External Reviews

The post-payment review dispute resolution process is intended to address a multitude of disputes and provides a means whereby Highmark and the provider will resolve any disputes related to claims for services submitted to Highmark.

Any provider that treats a Highmark member has the right to dispute claims payment decisions made by Highmark. It is important to note that the dispute will be governed by the terms of the provider's contract with Highmark and not under the plan through which a member receives benefits. A provider's request for payment of services will be made directly to Highmark rather than the plan providing the member's benefits. This includes plans governed by either the Employee Retirement Income Security Act of 1974 (ERISA) or the Patient Protection and Affordable Care Act of 2010 (PPACA). Therefore, any claim dispute between a provider and Highmark arising from a provider's request for payment is solely a contract dispute between the provider and Highmark, and does not involve any other party.

In addition, benefit plans and plan sponsors are not parties to any contracts with providers. Providers are bound to the terms of their respective contracts with Highmark. Such provider contracts are not binding upon any benefit plan or plan sponsor.

What is a Post-Payment Review Dispute?

A post-payment review dispute is a dispute that arises as a result of one or more claims reviews conducted by Highmark and/or its designated agents. Post-payment review disputes include, but are not limited to, coding disputes.

A coding dispute shall mean a dispute that arises as a result of one or more claims coding reviews as conducted by Highmark and/or its designated agent and that: (a) result in a disagreement as to the appropriate code(s) assigned to a particular diagnosis and/or service rendered or supplied by Provider to a Member; and (b) has not been resolved by the parties through informal means.

Disputes regarding benefit coverage are not claim review disputes.

Anti-Assignment Provision

All Highmark insurance policies for members contain anti-assignment provisions. As a result, a provider cannot dispute a claim with benefit plans or plan sponsors in the event a member's benefits are denied in whole or in part unless the provider follows the appropriate steps to be the member's authorized representative for purposes of a member appeal. An assignment of benefits form is not enough, is not valid under member policies, and will not be recognized by Highmark. In addition, member appeals are separate and apart from the claim review dispute process outlined in this unit.

When a Provider Disagrees with the Review Findings

If providers disagree with the review findings, they have the opportunity to appeal the findings to Highmark and may also have external review options.

Please refer to the region-specific sections below for additional information for consideration as well as the section titled **Retroactive Denials and Overpayments.**

Appeal Rights in Pennsylvania

For providers in Pennsylvania

Professional health service doctors, as defined in 40 Pa. C.S.A. § 6302, in Pennsylvania may have the right to appeal their case to the Medical Review Committee (MRC). Determinations made by the MRC are binding on both the health service doctor and Highmark. For additional information, please refer to the **Highmark Medical Review Committee (PA Only)** section of this unit.

The appeal rights of facility providers in Pennsylvania vary based on the type of review that was conducted:

- Cases involving coding issues are referred to an independent review organization (IRO). For additional information, please refer to the **Independent Review Organization (IRO)** section in this unit.
- Cases involving non-coding issues are handled through Mediation or Arbitration in accordance with the terms of the provider's contract with Highmark.

Appeal Rights in Delaware

For providers in Delaware

The appeal rights of professional providers in Delaware vary based on the type of review that was conducted:

- The denial, in whole or part, of claims based on medical necessity may be appealed to the Highmark Delaware Utilization Management Program Appeal Process.
- The denial, in whole or part, of claims based on reasons other than medical necessity may be appealed to the Highmark Delaware Provider Services Department.

If professional providers in Delaware are not satisfied with Highmark Delaware's final appeal decision, they have a right to appeal their case to the Delaware Department of Insurance. Determinations made by the Delaware Department of Insurance are binding on both the provider and Highmark Delaware, except the losing party in such an arbitration shall have a right to trial de novo in the Delaware Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within 30 days of the date of the arbitration decision being rendered. For additional information, please refer to the **Delaware Department of Insurance (DE Only)** section of this unit.

The appeal rights of facility providers in Delaware vary based on the type of review that was conducted:

- The denial, in whole or part, of claims based on medical necessity may be appealed to the Highmark Delaware Utilization Management Program Appeal Process.
- The denial, in whole or part, of claims based on reasons other than medical necessity may be appealed to Highmark Delaware Provider Services Department.
- Cases involving coding issues may be appealed to an independent review organization (IRO). For addition information, please refer to the **Independent Review Organization (IRO)** section in this

unit.

If facility providers in Delaware are not satisfied with the final appeal decision, they have a right to appeal their case to the Delaware Department of Insurance. Determinations made by the Delaware Department of Insurance are binding on both the facility provider and Highmark Delaware except the losing party in such an arbitration shall have a right to trial de novo in the Delaware Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within 30 days of the date of the arbitration decision being rendered. For additional information, please refer to the **Delaware Department of Insurance (DE Only)** section of this unit.

Appeal Rights in West Virginia

For providers in West Virginia

Professional Providers:

Professional providers who do not agree with FIPR review findings must request an appeal within the time frame stated in the Notice of Review Results Letter. Following review of the appeal, the provider will receive a determination letter explaining the findings.

If professional providers in West Virginia are not satisfied with the appeal determination, they may have the right to request review by an **Independent Review Organization (IRO).** Determinations made by the IRO are binding on both the provider and Highmark West Virginia. For additional information, please refer to the Independent Review Organization (IRO) section of this unit. All available review options are subject to the terms of the Provider/Network Agreement.

Facility Providers:

Facility providers that do not agree with the review findings must request an appeal within the time frame stated in the Review Findings Letter. Following review of the appeal, the provider will receive a determination letter explaining the findings.

If facility providers in West Virginia are not satisfied with the appeal determination, additional review options vary based the type of review that was conducted:

- Cases involving coding issues are referred to an IRO. For additional information, please see the **Independent Review Organization (IRO)** section in this unit.

- Cases involving non-coding issues are handled through Mediation or Arbitration.

All available review options are subject to the terms of the Provider/Network Agreement.

Appeal Rights in New York

For providers in New York

Professional Providers:

If a professional provider in New York is not satisfied with the appeal determination, the practitioner may have the right to request review by an independent review organization (IRO). Determinations made by the IRO are binding on both the provider and Highmark New York. For additional information, please refer to the Independent Review Organization (IRO) section of this unit. All available review options are subject to the terms of the Provider/Network Agreement.

Once the parties have exhausted, all attempts to resolve the dispute, including non-binding mediation, the parties can submit the dispute to binding arbitration with the American Health Lawyers Association (AHLA) for a final determination.

The arbitration shall be held at a location in Buffalo or Albany, New York, to be mutually agreed upon by the parties and conducted pursuant to the Rules of Procedure for Arbitration of the AHLA, Alternative Dispute Resolution Service. Unless otherwise agreed upon by the parties in writing, the dispute shall be determined by a panel of three arbitrators who are members of the AHLA, are current members of the AHLA panel of Dispute Resolvers, and are attorneys who are familiar with issues relating to payment for hospital services by health care plans. Each party shall appoint one arbitrator and the third shall be mutually selected by the two arbitrators appointed by the parties.

Facility Providers:

Facility providers who do not agree with the review findings must request an appeal within the time frame stated in the Review Findings Letter. Following review of the appeal, the provider will receive a determination letter explaining the findings.

If a facility provider in New York is not satisfied with the appeal determination, the facility provider may request Mediation or Arbitration in accordance with the terms of the provider's contract with Highmark Blue Cross Blue Shield/Highmark Blue Shield.

6.8 Independent Review Organization (IRO)

Use of an Independent Review Organization

When a provider disputes a coding decision made by Highmark or its designated agent, the provider and Highmark shall make a good faith effort to resolve the dispute by first exhausting available appeal options and shall discuss the matter with the appropriate representative(s).

Subject to the applicable Provider/Network Agreement, following exhaustion of available appeal option(s), if the provider remains in disagreement with the findings, the provider may request review by an Independent Review Organization (IRO), which may be referred to as a certified review entity ("CRE"), to perform a review and conclusively resolve the dispute.

The provider must state its intention to either accept Highmark's or its designee's findings or request review by an IRO within the time period as set forth in written correspondence, i.e., the Appeal Determination Letter. The letter will also include a list of two IRO entities from which the provider must choose. All listed IROs shall be independent entities from Highmark (other than with respect to any contract with Highmark to provide IRO services).

If the provider fails to timely respond with its intention to appeal and its selection of an IRO from the list, then the parties agree that the provider shall be deemed to have accepted the decision made by Highmark or its designee, and Highmark will initiate repayment efforts up to and including performing automatic offset against future payments to recoup the stated overpayment.

The resolution process set forth herein is the sole means for resolving coding disputes.

Binding Decision

For providers in Pennsylvania and West Virginia

For providers in **Pennsylvania,** in instances where an agreement between the provider and Highmark states that the decision by the IRO shall be **final and binding on, and non-appealable by, Highmark and**

the provider/business owner, each party waives its right to commence litigation as to the coding review dispute in a court of law as well as appeal the determination by the IRO of a coding review dispute to a court of law.

For providers in **West Virginia,** the decision of the IRO shall be final and binding on Highmark and the provider/business owner.

IRO Fees and Costs

For providers in Delaware, New York, and Pennsylvania

For providers where a contractual agreement or a letter of agreement is in place regarding the use of an IRO, when the IRO's decision is **fully in favor of one party, the other party shall pay the entire fees and costs** associated with the IRO's review and decision. If the IRO's decision is partly in favor of each **party, the parties shall share equally the cost of the review.** If required by the IRO, Highmark and the provider shall make escrow deposits to cover the costs of the review by the IRO.

IRO Fees and Costs

For providers in West Virginia

For **West Virginia** providers, when the IRO's decision is **fully in favor of one party, the other party shall pay the entire fees and costs** associated with the IRO's review and decision. If the IRO's decision is partly in favor of each **party, the parties shall share equally the cost of the review.** If required by the IRO, Highmark and the provider shall make escrow deposits to cover the costs of the review by the IRO.

Limitation Time Period

All disputes not resolved by negotiation as described in this section of this unit must be submitted to an IRO within the time period provided by the applicable limitation of time for bringing such action or proceeding as contained in the network agreement, hospital agreement, or, where applicable, federal or state law.

6.8 Highmark Medical Review Committee (PA Only)

For providers in Pennsylvania

MRC Overview

In Pennsylvania, any claims review dispute involving claims submitted by a health service doctor that remains unresolved may be referred to the Medical Review Committee (MRC) for consideration as required by law or the health service doctor's contract with Highmark.

The MRC is charged with hearing matters, disputes, or controversies relating to the professional health services rendered by health service doctors, or any questions involving professional ethics.

What is the MRC?

For providers in Pennsylvania

The Medical Review Committee (MRC) is made up predominantly of health care professionals and is established pursuant to the Bylaws of Highmark Inc. The Medical Review Committee investigates and resolves claim disputes arising out of the relationship between the Corporation and professional health care providers in Pennsylvania who render health services to Highmark members; certain restrictions apply. The committee's decisions are based on current medical practices and Highmark Medical Policy.

In addition, appeals of credentialing decisions are directed to the Medical Review Committee. In the event of an appeal, the Highmark Medical Review Committee is available, upon written request, to any professional network practitioner who has been notified of termination or a denial decision. The Medical Review Committee's decision is final and not subject to further appeal.

Breakdown of Committee Members

For providers in Pennsylvania

The Medical Review Committee consists of at least eight members. A majority of the members of the Medical Review Committee are providers who are participating providers, preferred providers, or network

providers (“provider members”). The balance are consumers covered under health care contracts issued by the Corporation (“consumer members”).

Organization Members

For providers in Pennsylvania

At least two-thirds of the members of the Medical Review Committee shall have no relationship with Highmark (other than as providers who submit claims in the ordinary course of business or members covered by one of Highmark’s health care programs). No member shall be a member of the Board of Directors of Highmark.

Provider Members

For providers in Pennsylvania

The provider members of the Medical Review Committee are representative of the various health care professions and specialties whose services are covered by Highmark. At least three-fourths of the provider members of the Highmark Medical Review Committee must be medical doctors or doctors of osteopathy.

Conflict of Interest

For providers in Pennsylvania

No member of the Medical Review Committee who has any conflict of interest that would prevent him or her from rendering a fair and impartial decision or is in economic competition with a provider shall participate in the decision-making process with respect to such practitioner.

MRC Process

For providers in Pennsylvania

Determinations made by Highmark's Medical Review Committee (MRC) are based on current medical practice, Highmark Medical Policy, and Highmark credentialing policy. If you choose the MRC, its decision is considered your final level of internal appeal. You will be notified of the MRC decision in writing.

The committee is made up of a variety of degree specialties and lay members. The Review Committee Selection Committee is responsible for appointing MRC members. As per the Bylaws of Highmark Inc., the Medical Review Committee is charged with the following responsibilities:

- Consider unresolved matters, disputes, or controversies arising out of the relationship between the Corporation and any provider, including any questions involving professional ethics;
- Review any matter affecting the status of a health care professional as a network provider of the Corporation;
- Conduct hearings to resolve disputes involving the status of health care professionals as Participating Providers in accordance with Article IX of the Bylaws of the Corporation;
- Consider appeals by providers who are rejected or terminated as network providers in any network provider panel.
- The MRC is empowered to take a wide range of actions to resolve disputes. A provider has the right to be present throughout the proceedings and may be represented by legal counsel. MRC consideration is the provider's final level of internal appeal.

How to Submit a Matter to the MRC

After all other appeals with Highmark are exhausted, providers in Pennsylvania may submit a matter for review to the Medical Review Committee in writing to:

Secretary, Medical Review Committee (MRC)
Financial Investigations & Provider Review
Highmark Inc.
1800 Center Street
CH1BHM-041B
Camp Hill, PA 17011

Review Committee Guidelines

The **Highmark Blue Shield Review Committee Guidelines** are available in the Appendix of the Highmark Provider Manual (in Pennsylvania only).

You can access the Appendix from the **Additional Resources** box at the bottom of the manual home page.

6.8 Delaware Department of Insurance (DE Only)

For providers in Delaware

Appeals to Highmark Delaware

In Delaware, any provider review conducted by Financial Investigations and Provider Review (FIPR) staff that remains unresolved can be referred to the Delaware Department of Insurance (DOI) for consideration.

Arbitration

For providers in Delaware

If a provider is not satisfied with a Highmark Delaware final appeal decision regarding reimbursement, the provider may have a right to arbitration.

If the provider is a provider as defined by 18 Del. C. §333(a)(1), the provider has the right to seek review of Highmark Delaware's decision regarding the final disposition of a claim(s). The Delaware Department of Insurance provides claim arbitration services, which are in addition to, but do not replace, any other legal or equitable right the provider may have to review this decision or any right of review based on the provider's contract with Highmark Delaware.

The provider may contact the Delaware Department of Insurance for information about arbitration by calling the Arbitration Secretary at **302-674-7322.** The provider may also go to the Delaware Insurance Department to personally discuss the arbitration process between the hours of 8:30 a.m. and 4:00 p.m. at the following location:

The Rodney Building
841 Silver Lake Blvd.
Dover, DE 19904

All requests for arbitration must be filed **within 60 days** from the date the provider receives the adverse determination from Highmark Delaware; otherwise, the Highmark Delaware decision will be final.

6.8 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Chapter 7 - Appendix

This appendix covers Medicare Advantage (MA) member Evidence of Coverage Booklets (EOCs), MA compliance language, Article VIII Bylaws of Highmark, Review Committee Guidelines, Third Party Codes of Conduct, Professional Regulations, Legal Information, and Highmark's disclaimer.

Unit 1: Medicare Advantage Member Evidence of Coverage Booklets

The Medicare Advantage Member Evidence of Coverage Booklets explain how Medicare Advantage members get their health care and drug coverage.

READ MORE

Unit 2: Medicare Advantage Compliance Language

The regulations governing the Medicare Advantage program set forth required terms for both Medicare Advantage plans and contracted providers. In order to make contracted providers aware of such terms, the Centers for Medicare & Medicaid Services ("CMS") has created a contracting checklist for Medicare Advantage plans to follow in developing providers' contracts and related policies and procedures.

READ MORE

Unit 3: Article VIII of the Bylaws of Highmark, Inc.

These bylaws includes subjects such as general topics; the Medical Review Committee Selection Committee; the appointment, terms and removal of Medical Review Committee Members; officers of the

Medical Review Committee; the submission and proceedings; and the proceedings involving status of registered health service doctors.
READ MORE

Unit 4: Review Committee Guidelines

Highmark Inc. (“Highmark”), doing business as Highmark Blue Shield, operates under the provisions of Act 271 of 1972 (40 PA. C.S. Section 6301 et seq.). Section 6324 (c) of the Act requires that all matters, disputes or controversies relating to professional health service doctors or any questions involving professional ethics shall be considered and determined only by health service doctors selected in a manner prescribed in the Bylaws of the professional health service corporation involved.

READ MORE

Unit 5: Third Party Code of Conduct

The Third Party Code of Conduct includes expectations of providers and their staffs when conducting business with and/or on behalf of Highmark.

READ MORE

Unit 6: Professional Regulations

This unit includes links to Highmark professional regulations for participating providers.

READ MORE

Unit 7: Medicare Advantage Supplemental Requirements

This unit includes a supplemental document to Highmark's Medicare Acute Care Provider Agreement. For providers in Pennsylvania and West Virginia.

READ MORE

Unit 8: Legal Information

The information in this manual is issued by Highmark Inc. d/b/a Highmark Blue Shield on behalf of its affiliated Blue companies, which serve the regions set forth in this unit and which are independent licensees of the Blue Cross and Blue Shield Association.

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Unit 9: Disclaimer

This unit includes Highmark's disclaimers about this provider manual.

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Unit 1 : Medicare Advantage Member Evidence of Coverage Booklets

7.1 Medicare Advantage Member Evidence of Coverage Booklets

The Medicare Advantage Member Evidence of Coverage Booklets explain how Medicare Advantage members get their health care and drug coverage.

- Delaware, Pennsylvania, and West Virginia
    - Once you click on the link, enter your Zip Code to find the appropriate plan documents for your Highmark region.
- Western New York
- Northeastern New York

6.1 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a

Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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Unit 2: Medicare Advantage Compliance Language

7.2 Medicare Advantage Compliance Language

The regulations governing the Medicare Advantage program set forth required terms for both Medicare Advantage plans and contracted providers. In order to make contracted providers aware of such terms, the Centers for Medicare & Medicaid Services (“CMS”) has created a contracting checklist for Medicare Advantage plans to follow in developing providers’ contracts and related policies and procedures. That checklist is included in Chapter 11 of the CMS Medicare Managed Care Manual (Section 100.4), a copy of which is available on the CMS website.

In certain cases, regulatory language must be included in the actual contractual document governing the relationship between the Medicare Advantage plan and the provider. In other cases, CMS allows a Medicare Advantage plan to include required terms in its policies and procedures that are made available to contracted providers.

The provisions that follow are Medicare Advantage compliance terms included in the Highmark Senior Health Company (“HSHC”) and Highmark Choice Company (“HCC”) policies and procedures. Provider is required to comply with all such provisions, including, but not limited to, taking all necessary actions as may be specifically noted or such actions as may be required and requested by HSHC or HCC as applicable in order for HSHC or HCC, as applicable, to meet its obligations as a Medicare Advantage plan. All requirements set forth in this document shall apply to all Medicare Advantage plans, including HSHC and HCC.

1. Provider will safeguard the privacy of any information that identifies a particular member and will, and acknowledges that HSHC or HCC, as applicable, has procedures to maintain records in an accurate and timely manner. Pursuant to 42 C.F.R. § 422.118, or its successor, the following shall apply: (a) HSHC or HCC, as applicable, must establish and maintain procedures to, and Provider must, abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) HSHC or HCC, as applicable, and Provider

must safeguard the privacy of any information that identifies a particular member; (c) HSHC or HCC, as applicable, must establish and maintain procedures, and Provider must comply with the procedures that specify, (i) for what purposes the information will be used within the organization and (ii) to whom and for what purposes it will disclose the information outside the system; (d) HSHC or HCC, as applicable, must establish and maintain procedures to, and Provider must, ensure that medical information is released only in accordance with Federal or State law, or pursuant to court orders or subpoenas; (e) HSHC or HCC, as applicable, must establish and maintain procedures to, and Provider must, maintain records and information in an accurate and timely manner; and (f) HSHC or HCC, as applicable, must establish and maintain procedures to, and Provider must, ensure timely access by Medicare Advantage members to the records and information that pertain to them. (Required by 42 C.F.R. § 422.118 or its successor).

2. HSHC or HCC, as applicable, may offer benefits in a continuation area for those members who move permanently “out of area.” (Required by 42 C.F.R. § 422.54(b) or its successor).
3. Provider will not deny, limit or condition the furnishing of a service to a member, and HSHC or HCC, as applicable, will not deny, limit or condition the coverage or furnishing of benefits to an individual eligible to enroll in HSHC’s or HCC’s, as applicable, Medicare Advantage plan(s), on the basis of any factor that is related to health status, including, but not limited to, the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. (Required by 42 C.F.R. § 422.110(a) or its successor).
4. HSHC or HCC, as applicable, will make timely and reasonable payment to or on behalf of the member for emergency and urgently needed services obtained by a member from a non-contracted provider or supplier as provided in 42 C.F.R. § 422.100(b)(1)(ii) or its successor. (Required by 42 C.F.R. § 422.100(b)(1)(ii) or its successor).
5. HSHC or HCC, as applicable, will make timely and reasonable payment for renal dialysis provided by a non-contracted provider while a member is temporarily outside HSHC’s or HCC’s, as applicable, service area. (Required by 42 C.F.R. § 422.100(b)(1)(iv) or its successor).
6. HSHC or HCC, as applicable, provides Members with direct access (through self referral) to mammography screening and influenza vaccine. (Required by 42 C.F.R. § 422.100(g)(1) or its successor).
7. HSHC or HCC, as applicable, will not impose, and Provider will not collect any, costsharing on members for influenza and pneumococcal vaccines. (Required by 42 C.F.R. § 422.100(g)(2) or its successor).

8. HSHC or HCC, as applicable, does and will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to meet the needs of the member population served. (Required by 42 C.F.R. § 422.112(a)(1) or its successor).
9. HSHC or HCC, as applicable, gives members who are women direct access to a women's health specialist within its provider network for routine and preventive services provided as basic benefits. (Required by 42 C.F.R. § 422.112(a)(3) or its successor).
10. HSHC or HCC, as applicable, must ensure that (a) the hours of operation of its contracted providers are convenient to the members served and do not discriminate against Medicare enrollee; and (b) plan services are available 24 hours a day, 7 days a week, when medically necessary. (Required by 42 C.F.R. §422.112(a)(7) or its successor). As applicable, Provider will maintain business hours and/or ensure Provider's services are available in accordance with the preceding requirements.
11. HSHC or HCC, as applicable, must adhere to the CMS marketing provisions contained in 42 C.F.R. § 422.80(a), (b) and (c), or its/their successor(s).
12. HSHC or HCC, as applicable, must ensure that services are provided in a culturally competent manner to all members including those with limited English proficiency or Page 3 of 6 reading skills and diverse cultural and ethnic backgrounds. (Required by 42 C.F.R. § 422.112(a)(8) or its successor).
13. HSHC or HCC, as applicable, must ensure continuity of care and integration of services through arrangements to include procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures that members may take to promote their own health. (Required by 42 C.F.R. § 422.112(b)(5) or its successor). As applicable, Provider will comply with these procedures.
14. HSHC or HCC, as applicable, has written policies regarding the implementation of advance directive rights, including, but not limited to, a statement that providers shall document in a prominent place in the applicable Member's medial record if the Member has executed an advance directive. (Required by 42 C.F.R. §422.128(b)(1)(ii)(E) or its successor). Provider will comply, as applicable, with that policy.
15. HSHC's or HCC's, as applicable, contract with CMS must contain a provision that it will provide all benefits covered by Medicare, and Provider must render services, in a manner consistent with professionally recognized standards of health care. (Required by 42 C.F.R. § 422.504(a)(3)(iii) or its successor).

16. HSHC or HCC, as applicable, must provide, and Provider shall comply with all, policies and procedures and contractual requirements providing for continuation of member health care benefits (a) for all members, for the duration of the contract period for which CMS payments have been made; and (b) for members who are hospitalized on the date HSHC or HCC, as applicable, terminates, or in the event of insolvency, through discharge. Such requirements may be met in any manner as described in 42 C.F.R. § 422.504(g)(3) or its successor. (Required by 42 C.F.R. § 422.504(g)(2)(i) and (ii), and § 422.504(g)(3) or its/their successor(s)).
17. All provider payment and incentive arrangements must be specified in the contractual arrangement between HSHC or HCC, as applicable, and Provider. (Required by 42 C.F.R. § 422.208 or its successor).
18. The payments that Provider receives from HSHC or HCC, as applicable, for covered services rendered to members enrolled in a Medicare Advantage are, in whole or part, from federal funds and, and therefore, Provider and HSHC or HCC, as applicable, are subject to certain laws as applicable to individuals and entities receiving federal funds. (Required by 42 C.F.R. § 422.504(h) or its successor).
19. HSHC or HCC, as applicable, is required to disclose information to members in the manner and the form prescribed by CMS as required under 42 C.F.R. § 422.111. (Required by 42 C.F.R. § 422.504(a)(4) or its successor).
20. HSHC or HCC, as applicable, is required to disclose all information that is necessary for CMS to administer and evaluate HSHC's or HCC's, as applicable, Medicare Advantage program(s) and to simultaneously establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (42 C.F.R. Page 4 of 6 § 422.64(a) and § 422.504(f)(2) or its/their successor(s)). Such information includes, but is not limited to, plan quality and performance indicators for the benefits under HSHC's or HCC's, as applicable, Medicare Advantage program(s) including (a) disenrollment rates for members electing to receive benefits under such program for the previous two years, 42 C.F.R. § 422.504(f)(2)(iv)(A) or its successor; (b) information on member satisfaction, 42 C.F.R. § 422.504(f)(2)(iv)(B) or its successor; and (c) information on health outcomes, 42 C.F.R. §422.504(f)(2)(iv)(C) or its successor. As required and/or requested, Provider will cooperate with HSHC or HCC, as applicable, and CMS in providing any of the preceding information that is under its control and/or in its possession.
21. HSHC or HCC, as applicable, must make a good faith effort to provide notice of termination of a contracted Provider at least 30 calendar days before the termination of the effective date to all members who are patients seen on a regular basis by the applicable Provider whose contract is terminating (which in the case of a primary care provider, means all members who are patients of

such provider), irrespective of whether the termination was for cause or without cause. (Required by 42 C.F.R. § 422.111(e) or its successor).

22. HSHC or HCC, as applicable, must comply with reporting requirements in 42 C.F.R. § 422.516, or its successor, and 42 C.F.R. § 422.504(l)(2) & (l)(3), or its/their successor(s), for submitting and certifying data to CMS. Provider will certify the accuracy, completeness and truthfulness of all data that HSHC or HCC, as applicable, is obligated to submit to CMS. (Required by 42 C.F.R. § 422.504(a)(8), or its successor, and § 422.504(l)(2) & (l)(3) or its/their successor(s)). As required and/or requested, Provider will further cooperate with HSHC or HCC, as applicable, and CMS in providing any of the preceding information that is under its control and/or in its possession.
23. HSHC or HCC, as applicable, must establish a formal mechanism to consult with the physicians who have agreed to provide services under HSHC's or HCC's, as applicable, Medicare Advantage program(s), regarding HSHC's or HCC's, as applicable, medical policy, quality assurance programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines are – (i) based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracted physicians; and (iv) are reviewed and updated periodically; (b) decisions with respect to utilization management are communicated to providers and, as appropriate, to members; and (c) decisions with respect to utilization management, member education, coverage of services, and other areas to which guidelines apply are consistent with such guidelines. (Required by 42 C.F.R. § 422.202(b) or its successor). In addition, HSHC or HCC, as applicable, must operate a quality assurance and performance improvement program and have an agreement for external quality review as required by 42 C.F.R. Subpart D or its successor. (Required by 42 C.F.R. § 504(a)(5) or its successor). Provider shall cooperate with all such medical policy, medical management procedures and quality assurance and performance improvement programs.
24. HSHC or HCC, as applicable, must give a physician written notice of the following when and if HSHC or HCC, as applicable, suspends or terminates an agreement under which Page 5 of 6 the physician provides services to members. The written notice must include the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physicians and numbers and mix of physicians needed to maintain an adequate network; and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. (Required by 42 C.F.R. §422.202(d)(1) or its successor).
25. Any without cause termination by HSHC or HCC, as applicable, or Provider requires at least sixty (60) days prior written notice. (Required by 42 C.F.R. § 422.202(d)(4) or its successor).

26. HSHC or HCC, as applicable, and Provider must comply with Federal laws and regulations designed to ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law; the False Claims Act (31 U.S.C. § 3729 et. seq.); and the anti-kickback statute (42 U.S.C. § 1320a-7b(b)). (Required by 42 C.F.R. § 422.504(h)(1) or its successor).
27. HSHC or HCC, as applicable, and Provider may not employ or contract with an individual (which in the case of HSHC or HCC, as applicable, includes, as applicable, Provider) who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity (which in the case of HSHC or HCC, as applicable, includes, as applicable, Provider) that employs or contracts with such an individual, for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; and/or (d) administrative services. (Required by 42 C.F.R. § 422.752(a)(8) or its successor).
28. HSHC or HCC, as applicable, has established and will maintain (a) a grievance procedure as described in 42 C.F.R. § 422.564, or its successor, for addressing issues that do involved organization determinations; (b) a procedure for making timely organization determinations; and (c) appeal procedures that meet the requirements of this subpart for issues that involve organization determinations. HSHC or HCC, as applicable, must ensure that all members receive notification about the (a) grievance and appeal procedures that are available to them; and (b) complaint process available to the member under the QIO process as set forth under 1154(a)(14) of the Social Security Act. (Required by 42 C.F.R. § 422.562(a) or its successor). Provider will comply with Medicare requirements regarding Member grievances, appeals, and complaints and will cooperate with HSHC or HCC, as applicable, in meeting its obligations to include, but not be limited to, the gathering and forwarding of information in a timely manner as well as compliance and adherence to any decisions rendered.
29. Provider shall comply with federal laws and regulations designed to prevent, detect and correct Fraud, Waste, and Abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq., as amended by the Patient Protection and Affordable Care Act of 2010), any False Claims Act that applies to customer, and the Anti-Kickback statute (42 U.S.C. § 1320a-7b(b)), 42 C.F.R. §§422.503(b)(4)(vi), 422.504(h)(1), 423.505(h)(1).

For purposes of this Section, Abuse, Fraud, and Waste are defined as follows:

- “Abuse” shall mean actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment

for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

- “Fraud” shall mean knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
- “Waste” shall mean the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program.

7.2 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.

Unit 3: Article VIII of the Bylaws of Highmark Inc.

7.3 Article VIII of the Bylaws of Highmark Inc.

Excerpt Revised May 20, 2019

ARTICLE VIII

Medical Review Committee

General.

- All matters, disputes or controversies relating to the professional health services (as defined in 40 Pa.C.S.A. § 6302(a)) rendered by Health Service Doctors (as defined in 40 Pa.C.S.A. §6302(a)) located in the Commonwealth of Pennsylvania to subscribers who have coverage under contracts issued or administered by the Corporation or any company controlling, controlled by or under common control with the Corporation (individually, an “Affiliated Entity” and collectively, “Affiliated Entities”), and any questions involving the professional ethics of such Health Service Doctors, shall be considered and determined exclusively by the committee established pursuant to this Article VIII in accordance with the requirements of 40 Pa.C.S.A. § 6324(c) (the “Medical Review Committee”). The Medical Review Committee shall provide a fair and impartial forum for resolution of all matters, disputes or controversies relating to professional health services rendered by Health Service Doctors and all questions involving professional ethics.
- The Medical Review Committee also shall provide a fair and impartial forum to consider and determine any other matters, disputes or controversies, or questions involving professional ethics, that may be submitted to the Medical Review Committee as required by law or regulation, or as may be provided in any written agreement between the Corporation or any Affiliated Entity, as the case may be, and any Health Service Doctor.

- The Medical Review Committee shall operate independently of the Corporation, and the Board of Directors shall have no authority over the decisions of the Medical Review Committee. Except as otherwise provided in Section 8.8, all decisions of the Medical Review Committee shall be final and binding upon all parties to any matter, dispute or controversy, or question involving professional ethics, submitted to the Medical Review Committee and may be entered as a final judgment enforceable against the parties thereto.
- The Corporation shall, at its expense, provide reasonable resources to the Medical Review Committee to discharge its duties under these Bylaws.

Medical Review Committee Selection Committee.

- The members of the Medical Review Committee, who must satisfy the requirements set forth in Section 8.3, shall be appointed and may be removed as provided in this Article VIII by the Medical Review Committee Selection Committee (the "Selection Committee").
- The Selection Committee shall consist of at least five (5) persons, at least a majority of whom shall be Health Service Doctors, and the balance of whom shall be subscribers who are not Health Service Doctors and who have coverage under contracts issued or administered by the Corporation or any Affiliated Entity. All Health Service Doctors who are members of the Selection Committee shall be parties to one or more professional provider agreements with the Corporation or an Affiliated Entity.
- No member of the Selection Committee may be a director, officer or employee of the Corporation or of any Affiliated Entities or a member of a Regional Advisory Board or the NEPA Advisory Board, nor may any such person have served on the Medical Review Committee during any part of the two (2) year period immediately prior to his or her appointment to the Selection Committee.
- The members of the Selection Committee shall be appointed by the Chairperson of the Board, and each shall hold office for a term of two (2) years.

Appointment of Medical Review Committee Members; Term; Removal. The Medical Review Committee shall consist of a maximum of nine (9) members, which shall be comprised of seven (7) Health Service Doctors and two (2) subscribers who are not Health Service Doctors and who have coverage under contracts issued or administered by the Corporation. Any person may submit to the Selection Committee names of prospective Medical Review Committee members; provided, however, that the Selection Committee shall not be bound to appoint any person whose name is so submitted. The Selection Committee shall make appointments to the Medical Review Committee using the following criteria:

- At least seventy-five percent (75%) of the Health Service Doctors who are members of the Medical Review Committee shall be medical doctors or doctors of osteopathy. All Health Service Doctors who are members of the Medical Review Committee, or the employer of the Health Service Doctor member, shall be parties to one or more professional provider agreements with the Corporation.
- No member of the Medical Review Committee shall be a director, officer or employee of the Corporation or of any Affiliated Entities or a member of a Regional Advisory Board or the NEPA Advisory Board. At least two-thirds (2/3) of the members of the Medical Review Committee shall have no relationship with the Corporation or any Affiliated Entities, other than, when applicable, as subscribers who have coverage through the Corporation or an Affiliated Entity or as Health Service Doctors who submit claims, or whose employer submits claims, in the ordinary course of business.
- No member of the Medical Review Committee shall have any conflict of interest that would prevent him or her from rendering a fair and impartial decision in matters, disputes or controversies, or questions involving professional ethics, between the Corporation, or, if applicable, any Affiliated Entities , and a Health Service Doctor; provided, however, that a member may be recused from individual matters, disputes or controversies, or questions involving professional ethics, in the event of any conflict of interest with respect thereto.
- No Health Service Doctor who is a member of the Medical Review Committee shall have any history of (a) material adverse utilization or claims coding determinations by the Medical Review Committee, or (b) material repayments to the Corporation or any Affiliated Entity resulting from utilization or claims coding reviews.
- The Health Service Doctors who are members of the Medical Review Committee shall be broadly representative of the various specialties whose professional health services generally are covered under health plan benefit contracts issued or administered by the Corporation or an Affiliated Entity.
- Members of the Medical Review Committee must be willing to commit to regular attendance at Medical Review Committee meetings and to devoting adequate time to Medical Review Committee business to permit them to fully understand matters, disputes and controversies, and questions involving professional ethics, coming before the Medical Review Committee and to give full and fair consideration to all matters, disputes and controversies, and questions involving professional ethics, coming before the Medical Review Committee.

8.3.7 Each member of the Medical Review Committee shall hold office for a term of two (2) years. Prior to the end of any Medical Review Committee member's two (2) year term, such member may be removed only for cause as determined by the Selection Committee, including, but not limited to, failure to regularly

attend Medical Review Committee meetings or to devote adequate attention to Medical Review Committee matters, disputes and controversies, and questions involving professional ethics, or no longer meeting the eligibility criteria pursuant to this Section 8.3. Vacancies on the Medical Review Committee may be filled by appointment by the Selection Committee. The Medical Review Committee member appointed shall serve the remaining unexpired term of the Medical Review Committee member replaced.

8.3.8 Members of the Medical Review Committee and the Selection Committee shall be entitled to be reimbursed for their reasonable expenses incurred in connection with attendance at meetings of the Medical Review Committee or the Selection Committee, as the case may be, and such other compensation for their services as may be determined by the Corporate Member.

Officers of the Medical Review Committee. The Medical Review Committee shall have three officers: a chairperson, a vice chairperson and a secretary, selected as follows:

- The Selection Committee shall appoint a chairperson of the Medical Review Committee. The chairperson shall be a member of the Medical Review Committee and shall preside at all meetings of the Medical Review Committee.
- The Selection Committee shall appoint a vice chairperson of the Medical Review Committee. The vice chairperson shall be a member of the Medical Review Committee and shall preside at meetings of the Medical Review Committee in the chairperson's absence. The vice chairperson also shall perform such other duties as the chairperson may assign.
- The Corporation shall provide one of its employees to serve as secretary for the Medical Review Committee. The secretary's role shall be solely that of administrator, and not that of a member of the Medical Review Committee. The secretary shall keep the minutes of the Medical Review Committee meetings and perform the duties enumerated in this Article VIII and such other duties as the Medical Review Committee may assign.

Submission of Matters to the Medical Review Committee. All matters, disputes or controversies relating to professional health services rendered by Health Service Doctors and questions involving professional ethics shall be submitted in record form to the secretary of the Medical Review Committee. Either the Corporation or an Affiliated Entity, or a Health Service Doctor may submit an eligible matter, dispute or controversy, or question involving professional ethics, to be heard by the Medical Review Committee.

Medical Review Committee Proceedings.

Recommend a referral to any appropriate committee, board or division of any applicable state or local professional society;

Recommend a referral to an appropriate law enforcement officer or agency of any applicable federal, state or local government if the Medical Review Committee believes that a Health Service Doctor secured payment for services performed on the basis of material false information submitted with claim(s) for such services;

Recommend a referral to any applicable state professional licensure board of a Health Service Doctor;

Render a determination that the Corporation or an Affiliated Entity is or is not entitled, in whole or in part, to a refund of fees paid to a Health Service Doctor;

Render a determination that authorizes the Corporation or an Affiliated Entity to collect any refund by withholding future payments due to a Health Service Doctor;

Render a determination for the denial, removal or suspension from one or more networks of the Corporation or an Affiliated Entity as a result of (i) a finding by the Medical Review Committee that such denial, removal or suspension is appropriate or (ii) a review of a Health Service Doctor's recredentialing application;

Render a determination of the eligibility of the Health Service Doctor for reimbursement of certain services pursuant to the applicable privileging requirements of the Corporation or an Affiliated Entity; or

Recommend any such other determination or take any other action as may be necessary or appropriate.

Violation of any of the Health Service Doctor's professional provider agreements with the Corporation or an Affiliated Entity or any regulations of the Corporation or an Affiliated Entity applicable to participating providers; or

Violation of any statute with which the Corporation or an Affiliated Entity or the Health Service Doctor is required to comply.

Pursuant to this Article VIII, upon a Health Service Doctor exhausting all other administrative remedies pursuant to the Health Service Doctor's provider agreements, the Medical Review Committee shall serve as the final and binding hearing body for all matters, disputes or controversies relating to the professional health services rendered by the Health Service Doctor, and for any questions involving the professional ethics of the Health Service Doctor.

Following the submission of an eligible matter, dispute or controversy, or question involving professional ethics, to the Medical Review Committee, the Corporation or the applicable Affiliated Entity shall prepare a position statement setting forth the relevant facts and any claims against the Health Service Doctor and the rationale for the decision, which shall be sent to the Health Service Doctor prior to the Medical Review Committee hearing. The Health Service Doctor shall be permitted to file a response in record form, which shall be filed with the secretary of the Medical Review Committee. The procedural guidelines of the Medical Review Committee shall further set forth the procedures and timeline to be followed by the Corporation or an Affiliated Entity, as the case may be, and the Health Service Doctor prior to the Medical Review Committee hearing.

The secretary of the Medical Review Committee or the secretary's designee promptly shall fix a time, date and place for such hearing of the Medical Review Committee. The applicable Health Service Doctor shall be given at least thirty (30) days' notice in record form by the secretary of the Medical Review Committee of the date, time and place of such hearing and shall be furnished with a copy of the position statement of the Corporation or an Affiliated Entity, as the case may be, and all relevant documentation with respect thereto.

The Health Service Doctor shall be afforded a reasonable opportunity to be heard before the Medical Review Committee. Parties before the Medical Review Committee may be represented by counsel, may present arguments, evidence and witnesses, and shall have an opportunity to question the other side's witnesses at the hearing (which may be held by means of conference telephone or other electronic technology by means of which all persons participating in the hearing can hear and be heard by each other); provided, however, that formal rules of evidence or procedure are not required to be followed.

If a decision by the Medical Review Committee is reportable to the National Practitioner Data Bank, the Health Service Doctor may request that a court reporter be present for the proceeding, and the Corporation will arrange for the court reporter to record the proceedings.

In connection with any such hearing, the Medical Review Committee may consider any:

- Violation of the Health Service Doctor's agreement(s) with the Corporation or an Affiliated Entity to render health care services or supplies to subscribers;
- Violation of any statute, regulation, policy or procedure with which the Corporation or an Affiliated Entity or the Health Service Doctor is required to comply;
- Violation of any of the regulations or requirements referenced in the Health Service Doctor's agreement(s) with the Corporation or an Affiliated Entity or coding requirements with which the

Health Service Doctor must comply, including coding guidance issued by independent organizations overseeing such codes; or

- Refusal to adhere to the billing, payment or service benefit provisions of any agreement issued by the Corporation or an Affiliated Entity which utilizes the applicable professional provider network in which the Health Service Doctor has agreed to participate.

Promptly following the hearing, the Medical Review Committee shall take whatever action it deems appropriate, based on the evidence and testimony produced at the hearing. The decision of the Medical Review Committee shall be sent to the Health Service Doctor within thirty (30) days of the hearing.

- The Medical Review Committee shall maintain written procedural guidelines to assure that each Health Service Doctor receives fair and impartial consideration of any matter, dispute or controversy, or question involving professional ethics, presented to the Medical Review Committee.
- Only the Health Service Doctors who are members of the Medical Review Committee may vote on any matter, dispute or controversy, or question involving professional ethics, brought before the Medical Review Committee.
- At least one-half (1/2) of the voting members of the Medical Review Committee shall constitute a quorum for the transaction of business, and the acts of a majority of voting members of the Medical Review Committee present at a meeting at which a quorum is present shall constitute the acts of the Medical Review Committee.
- The Medical Review Committee shall annually set the dates and locations of its regular meetings.
- Special meetings of the Medical Review Committee may be called at any time by the chairperson of the Medical Review Committee. The secretary of the Medical Review Committee or the secretary's designee shall provide notice of any special meeting of the Medical Review Committee at least thirty (30) calendar days prior thereto and shall state the reason for the special meeting and the date, time and place of the meeting. For regularly scheduled and special meetings of the Medical Review Committee, members shall attend in person unless excused. If attendance in person is excused, members of the Medical Review Committee may participate by conference telephone or other electronic technology by means of which all persons participating in the meeting can hear and be heard by each other.
- In considering any matter, dispute or controversy relating to professional health services rendered by Health Service Doctors, or any question involving professional ethics brought before it, the Medical Review Committee shall make decisions in accordance with the law, relevant contracts,

the applicable policies and procedures of the Corporation or an Affiliated Entity, as the case may be, and, if applicable, guidance issued by independent organizations.

- The Medical Review Committee shall have authority to take any one or more of the following actions (subject to any binding contractual prohibitions or restrictions agreed to in writing by the Corporation, or an Affiliated Entity, as the case may be):
- If a particular matter, dispute or controversy relating to professional health services rendered by a Health Service Doctor or a particular question involving professional ethics includes any actual or alleged action or failure to act which would justify denying a Health Service Doctor registration with the Corporation or an Affiliated Entity pursuant to 40 Pa.C.S.A. § 6324(a), or the suspension or termination of such registration, the Corporation or the Affiliated Entity, as the case may be, may request that a hearing be held by the Medical Review Committee in accordance with Section 8.8 to consider such registration status. Such action or failure to act may include by way of example and not limitation:
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Proceedings Involving Status of Registered Health Service Doctor.

- The procedures set forth in this Section 8.8 shall apply in all cases in which the Corporation or an Affiliated Entity or the Health Service Doctor has requested that a hearing of the Medical Review Committee be held to determine the status of an individual as a registered Health Service Doctor pursuant to 40 Pa.C.S.A. §6324(a). In any such case, the Corporation or the applicable Affiliated Entity shall prepare an appropriate position statement setting forth the relevant facts and any claims against the Health Service Doctor pursuant to Section 8.7.2. The procedures set forth in Section 8.7 shall be applicable to this Section 8.8.
- All testimony shall be recorded and a complete record shall be kept of the hearing.
- Following the hearing, the Medical Review Committee shall take whatever action it deems appropriate, based on the evidence and testimony produced at the hearing. If such action involves either the denial of registration as a Health Service Doctor with the Corporation or any Affiliated Entity or the suspension or termination of such registration, the matter shall be referred promptly to the Secretary of the Commonwealth of Pennsylvania Department of Health for approval or for such other action as said Secretary of Health may deem to be appropriate. The Health Service Doctor shall be notified of the decision within thirty (30) days of the hearing.

7.3 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

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Unit 4: Review Committee Guidelines

7.4 Review Committee Guidelines

Highmark Inc. (“Highmark”), doing business as Highmark Blue Shield, operates under the provisions of Act 271 of 1972 (40 PA. C.S. Section 6301 et seq.). Section 6324 (c) of the Act requires that all matters, disputes or controversies relating to professional health service doctors or any questions involving professional ethics shall be considered and determined only by health service doctors selected in a manner prescribed in the Bylaws of the professional health service corporation involved.

The Bylaws of Highmark Inc. (Article VIII) stipulates that the Medical Review Committee be formed to consider and determine all matters, disputes or controversies relating to the professional health services (as defined in 40 Pa.C.S.A. § 6302(a)) rendered by Health Service Doctors to subscribers who have coverage under contracts issued by Highmark, and any questions involving the professional ethics of such providers. The Bylaws of Highmark Inc. further direct that the Medical Review Committee shall maintain written procedural guidelines, which are set forth below.

The matters referred to the Medical Review Committee generally concern disputes with respect to overutilization and/or misutilization of services, coding of services rendered, professional ethics, credentialing, claims overpayments, failure to document services and other controversies relating to professional health services.

The following procedural guidelines are applicable to the Medical Review Committee:

1. For matters involving potential overutilization and/or misutilization of services or inappropriate quality of care, a review is conducted of the provider's practice pattern prior to referral to the Medical Review Committee. During this process, a sample of patient records, statistics, diagnostic aids, and/or other informational sources is reviewed. The results of such review, as well as the methodology used, will be made available to the provider when any adverse findings result. Should the provider disagree with the results of the review due to the sample size, the provider may request an expanded review.

2. If it is determined that an overpayment has been made, the amount of the overpayment will be calculated for a period of time not to exceed that permitted by the four-year Statute of Limitations governing contract claims. The results of such overpayment calculations will be made available to the provider. The provider will be furnished with the methodology used to calculate the overpayment.
3. If it is discovered in the review process that an underpayment has occurred, the provider may seek reimbursement, through the appropriate appeal mechanisms, for all claims involved during the same time period as the review by Highmark. Such claims must be supported by clinical records.
4. If the matter is not referred for prosecution, and does not involve the proposed suspension or termination of a participating/preferred/network provider, a Highmark representative will send a letter to the provider summarizing all findings and advising the provider of available appeal rights. The provider is furnished with a written statement outlining the basis of any refund demand. The provider is also advised of the repayment options available to him or her, and is provided with a copy of these Review Committee Guidelines. The provider will be encouraged to submit any additional information which could have a bearing on the matter and/or create the basis for an adjustment to the refund amount demanded, if any. If Highmark and the provider are unable to reach an agreement concerning the amount of any overpayment or any other matter relating to the review, Highmark will send a certified mail letter to the provider, furnishing at least thirty (30) calendar days' advance notice of the date of the Medical Review Committee meeting at which the provider's case will be considered and determined. Highmark's letter shall also notify the provider of his or her rights to appear before the Medical Review Committee and be represented by legal counsel. The provider will again be encouraged to provide any information which may be pertinent to the resolution of the matter, dispute or controversy. Accompanying the letter is another copy of the basis of any refund demand, the applicable sections of the Bylaws of Highmark Inc. pertaining to the Medical Review Committee, the Review Committee Guidelines and, if applicable, the Preferred Provider Agreement and/or Regulations for Preferred Providers and/or credentialing policies.
5. At least fifteen (15) calendar days prior to the date of the Medical Review Committee meeting at which the provider's case will be considered and determined, the provider will be given either a hard or electronic copy of the documentation to be provided to the Medical Review Committee.
6. A provider may forward information to the Medical Review Committee and/or may appear before the Medical Review Committee. A provider who chooses to appear before the Medical Review Committee will be notified of the date and time of his or her appearance at least fifteen (15) calendar days prior to the meeting. Such notification will inform the provider of the proceeding and

the provider's right to appear before the Medical Review Committee to express the reasons why he or she disagrees with Highmark's determination and/or to provide any other information which will aid the Medical Review Committee in its determination of the matter, dispute or controversy.

7. Upon providing Highmark with at least ten (10) calendar days' advance written notice, a provider may request that the Medical Review Committee postpone consideration of the matter, dispute or controversy until the next scheduled Medical Review Committee meeting. If, due to an emergency or other unanticipated circumstance, the provider's request is delivered to Highmark fewer than ten (10) calendar days before the meeting, the Medical Review Committee Chairperson will decide whether there is good cause to grant a postponement. As a general rule, a provider shall be granted only one postponement to hear a particular matter, dispute or controversy. A second postponement may be granted by the Chairperson only if the second request results from unanticipated circumstances beyond the provider's control. Within thirty (30) calendar days after the Medical Review Committee meeting, the provider will be advised in writing of all determinations made by the Medical Review Committee as to the matter, dispute or controversy. Such notification will include, but not be limited to, the amount of any overpayment or underpayment at issue and any other information the Medical Review Committee deems appropriate.
8. If the provider fails to refund any overpayment amounts within thirty (30) calendar days after notification of the Medical Review Committee's determination, Highmark shall be authorized to withhold payments otherwise due the provider and to assess interest. Interest will also be assessed on installment payment arrangements. Interest shall accrue on any unpaid balance at a rate equal to the then-prevailing United States Prime Rate as published in the "Money Rates" section of the Wall Street Journal print edition on January 1 of each year. If the Wall Street Journal is not published on January 1, then the next available edition of the Wall Street Journal will be used. The Prime Rate as determined by the Wall Street Journal on January 1 (or the next available edition, if necessary) shall be fixed as the interest rate for the entire calendar year until the following year's Prime Rate is published by the Wall Street Journal.
9. If the Medical Review Committee determines that a hearing should be held to consider a question involving professional ethics or to determine whether a provider should be suspended or terminated as a participating provider, the proceedings will be conducted as set forth in Article VIII, Section 8.7, of the Bylaws of Highmark Inc., and in the manner described in these guidelines.

7.4 Disclaimers

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

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Unit 5: Third Party Code of Conduct

7.5 Third Party Code of Conduct

The Third Party Code of Conduct includes expectations of providers and their staffs when conducting business with and/or on behalf of Highmark.

Unit 6: Professional Regulations

7.6 Professional Regulations

Below are links to Highmark professional regulations for participating providers.

- Highmark Professional Provider Agreement Regulations
- Highmark Blue Shield Regulations for Participating Providers, PremierBlue Shield Providers and Government Sponsored Program Providers

Unit 7: Medicare Advantage Supplemental Requirements

For providers in Pennsylvania and West Virginia

7.7 Medicare Advantage Supplemental Requirements

A supplemental document to Highmark's Medicare Acute Care Provider Agreement. For providers in Pennsylvania and West Virginia.

- Medicare Advantage Supplemental Requirements

Unit 8: Legal Information

7.8 Legal Information

The information in this manual is issued by the following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association:

- Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company.
- Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.
- Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.
- West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.
- Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.
- Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

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Amwell is a trademark of American Well Corporation. Amwell is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. Amwell is solely responsible for its telemedicine services.

Availity is an independent company that contracts with Highmark to offer provider portal services.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Doctor on Demand is a trademark of Doctor on Demand, Inc. Doctor on Demand is an independent company that provides telemedicine services and does not provider Blue Cross and/or Blue Shield products or services. Doctor on Demand is solely responsible for its telemedicine services.

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GeoBlue is a trade name for Worldwide Insurance Services, LLC, an independent licensee of the Blue Cross Blue Shield Association.

Helion is an independent company that provides post-acute network management services for Highmark Inc. and some of its affiliated health plans.

7.8 Disclaimers

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Unit 9: Disclaimer

7.9 Disclaimer

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose. The Highmark Provider Manual is the property of Highmark Inc. and its affiliated health plans (individually and collectively referred to herein as “Highmark”). The information, content, and design/organization of the Highmark Provider Manual are maintained by Highmark. Links to external websites referenced in the manual are for the convenience of the user. Such links do not constitute an official endorsement or approval by Highmark or any of its subsidiaries or affiliates with respect to the links’ content.

Highmark complies with all state and federal laws, including laws related to Medicare and our Medicare Advantage products. In cases where administrative requirements (as defined or described in the applicable provider agreement, including but not limited to, Highmark policy, Highmark Medical Policy, and/or the Highmark Provider Manual) conflict with federal or state laws or regulations, or directives of the Centers for Medicare & Medicaid Services (CMS) or other regulators, such laws, regulations, and/or directives shall apply.

Information in the Highmark Provider Manual is subject to change by Highmark. Information in the Highmark Provider Manual is subject to regulatory review and may also be changed at any time in accordance with regulatory requirements. All such changes may be published in provider newsletters, special mailings, and/or forms of online communications such as the Provider Resource Center.

In addition to the Highmark Provider Manual, please check the Provider Resource Center’s **Lastet Updates** section often for policy and procedure updates. The Highmark Provider Manual is binding upon providers together with other administrative requirements (as defined or described in the applicable provider agreement).

What's New in the Highmark Provider Manual

Last Updated: Friday, November 15, 2024

Below is a timeline of changes made to the *Highmark Provider Manual*. They are organized by the date the changes were implemented, with the most recent changes at the top of the page.

Always refer to the entire *Highmark Provider Manual* for complete guidance on policies and procedures for all providers participating in Highmark's networks.

November 15, 2024

Chapter 3, Unit 2: Professional Provider Credentialing

- In **3.2 Reconsiderations and Appeals**:
  - The **Reconsideration of a Credentials Committee Decision** section was made applicable to Pennsylvania only.
  - The following changes for Delaware and West Virginia were made to the **Appeals of Credentials Committee Decisions** section:
    - All appeals of Credentials Committee decisions for Delaware and West Virginia professional providers will be presented to the Highmark Network Quality and Credentials Committee (NQCC).
    - Appeals will no longer be presented to the Appeals Review Committee. The reconsideration step was removed.

October 24, 2024

Chapter 2, Unit 6: The BlueCard Program

- In **2.6 What is the BlueCard Program?**, the following information was added to the **Highmark Networks Supporting BlueCard** section:
  - **Northeastern New York:** Northeastern New York Provider Networks support the BlueCard Program.
  - **Western New York:** Western New York Provider Networks support the BlueCard Program.
- In **2.6 NAIC Codes**, information for Pennsylvania NAIC code 15460 was updated.

Chapter 3, Unit 1: Network Participation Overview

- In **3.1 Introduction to Network Participation**, Medicare Advantage was added as a network for acupuncturists in Delaware, Pennsylvania, and West Virginia.

Chapter 4, Unit 1: PCPs and Specialists

- In **4.1 Treatment of Immediate Relatives**, the language was updated to further define the eligibility of services provided to immediate relatives.

Chapter 5, Unit 3: Medicare Advantage Procedures

- In **5.3 Preservice Organization Determinations**, acupuncture was removed from the **Exceptions to Preservice Organization Determination Requirements** section.

Chapter 6, Unit 2:

- In **6.2 NAIC Codes**, information for Pennsylvania NAIC code 15460 was updated.

October 1, 2024

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- In 5.5 - **Filing an Appeal on Behalf of a Member**, the section on **Decision Time Frame** was updated.

September 24, 2024

Chapter 3, Unit 2: Professional Provider Credentialing

- The following updates occurred in the sections listed below:
  - **3.2 Highmark Network Credentialing Policy** > ADMITTING AND CLINICAL PRIVILEGE REQUIREMENTS – Physician assistant specialist was added to the list of specialties that waive the hospital clinical privilege requirement.
  - **3.2 Highmark Network Credentialing Policy** > TIME FRAME – Time frames for credentialing application procedures were updated for the following regions: Massachusetts, New York, Ohio, and West Virginia.
  - **3.2 Practitioner Quality and Board Certification** > HIGHMARK RECOGNIZED BOARDS FOR CERTIFICATION – American Board of Orthodontics (ABO) was added to the list of Highmark recognized boards for certification.

Chapter 4, Unit 7: Medical Records Documentation Requirements

- In **4.7 Additional Requirements to Support E/M Services**, language in the CODING GUIDELINES FOR E/M SERVICES section was updated to reflect coding guidance effective Jan. 1, 2023, based on medical decision-making or time considerations.

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- In **5.5 Filing an Appeal on Behalf of the Member**, the timeline for responses to non-urgent appeals in Pennsylvania and West Virginia was clarified in the DECISION TIME FRAME section to: 10 business days for preservice appeals and 30 calendar days for post-service appeals.

Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips

- In **6.4 Anesthesia Reporting Tips**, language stating the ANESTHESIA RELATED TO OBSTETRICAL CARE section applied to *Medicare Advantage Providers Only* was removed. Also, the list of procedure codes was updated to include additional identified codes.

Chapter 7, Unit 7: Medicare Advantage Supplemental Requirements

- As part of the consolidation to one Provider Resource Center, the Medicare Advantage Supplemental Requirements document was moved to the *Highmark Provider Manual* - Chapter 7: Appendix. It is a supplemental document to Highmark's Medicare Acute Care Provider Agreement and is applicable to providers in Pennsylvania and West Virginia only.

August 20, 2024

Chapter 3, Unit 2: Professional Provider Credentialing

- Changes were made to clarify the eligibility of Licensed Social Workers and other specialties regarding credentialing vs. enumeration in the following sections:
  - **3.2 Highmark Network Credentialing Policy** > MID-LEVEL AND ADVANCED PRACTICE PROVIDER (APP) ENUMERATION
  - **3.2 Credentialing Requirements for Behavioral Health** > LICENSED CLINICAL SOCIAL WORKER REQUIREMENTS

Chapter 4, Unit 7: Medical Records Documentation Requirements

- 4.7 Durable Medical Equipment and 4.7 Prosthetics were combined into one section — **4.7 Durable Medical Equipment, Prosthetics, Orthotics, & Supplies** (DMEPOS) — and the following information was updated/added:
  - **Prescribers** should update their documentation for the length of time DMEPOS is indicated for use every six months.
  - **Dispensing Prescriptions:** Standing orders are not permitted and should be written specific to the member's condition, unless otherwise stated in relevant medical policy.
  - **Customization and Modifications:** Manufacturer order forms must be included when a prescribing provider or supplier orders a specific type of DME, orthotics, or prosthetics for a member to support the item/device and the modifications or customizations added to the base item/device.
  - An ADDITIONAL ORTHOTICS GUIDELINES section was added and states that in addition to the requirements outlined in the DMEPOS section, documentation of relevant physical exams is required.

Chapter 5, Unit 3: Medicare Advantage Procedures

- In **5.3 Notice of Medicare Non-Coverage (NOMNC)**, the language was updated to reflect that the Centers for Medicare and Medicaid Services is requiring insurers to collect additional documentation from facilities for Quality Improvement Organization (QIO) program audits, effective Jan. 1, 2024. Specific instructions for locating the following forms were also included in this update:
  - Notice of Medicare Non-Coverage (NOMNC)
  - Detailed Explanation of Non-Coverage (DENC)

Chapter 5, Unit 6: Quality Management

- In **5.6 Functional Areas and Their Responsibilities**, the following change was made to the NEW YORK QUALITY IMPROVEMENT PROGRAM AUTHORITY AND STRUCTURE section under "QI Committee Structure": The name of the Amerigroup Joint Oversight Committee was changed to Wellpoint Joint Oversight Committee to reflect the vendor's new corporate name.

Chapter 5, Unit 7: Value-Based Reimbursement Programs

- In **5.7 Payment Innovation (DE, PA, and WV Only)**:
  - The POST-ACUTE SOLUTIONS section was updated to reflect that HM Home & Community Services is now known as Helion. In addition, updates were made to the value-based reimbursement (VBR) program descriptions, along with the regions where they are offered, as Helion has scaled these offerings across Delaware, Pennsylvania, and West Virginia.
  - An EPISODIC PAYMENT MODEL section was added.

Chapter 6, Unit 8: Payment Review

- In **6.8 Financial Investigations and Provider Review (FIPR)**, a new fraud hotline number (800-352-9100) was added for Delaware and Pennsylvania. Some minor wordsmithing changes were also made to this section.

Accessibility Expectations Update

All Accessibility Expectations were updated to align across all markets. These changes were applied to the following chapters and units in the *Highmark Provider Manual*:

- **Chapter 1, Unit 4: Highmark Member Information** > 1.4 Member Access to Physicians and Facilities > ACCESSIBILITY EXPECTATIONS FOR PROVIDERS
- **Chapter 4, Unit 1: PCPs and Specialists** > 4.1 PCP and Medical Specialist Accessibility Expectations > ACCESSIBILITY EXPECTATIONS FOR PROVIDERS
- **Chapter 4, Unit 2: Behavioral Health Providers** > 4.2 Accessibility Expectations for Behavioral Health > ACCESSIBILITY EXPECTATIONS

The updated expectations are in bold text below.

1. **PCP and Medical Specialists Expectations**
   1. Urgent Care Appointments updated to "**Immediate Response**."
   2. PCP Non-urgent Care Appointments updated to read as "Non-urgent, **regular care** appointments must be scheduled within **48-72 hours (three days).**
   3. Regular and Routine Care Appointments updated to read as "**Routine Care Appointments**" must be scheduled within **three weeks** of the member request.

1. Additional bullet added: **Subsequent routine wellness appointments must be scheduled within seven days of member request.**

4. New expectation added: **Follow-up visit** requires **care within five days of discharge or as clinically indicated.**

2. **Behavioral Health Provider Expectations**
   1. Urgent Care Appointments updated to "**Immediate Response**."
   2. Non-urgent Care Appointments updated to read as "Non-urgent, **regular care** appointments must be scheduled within **48-72 hours (three days).**
   3. Regular and Routine Care, initial visit was updated to read as "**Routine or Initial visit**" must be scheduled within **seven days** of the member request.
      1. Additional bullet added: **Subsequent routine wellness appointments must be scheduled within seven days of member request.**
   4. New expectation added: **Follow-up visit** requires **care within five days of discharge or as clinically indicated.**

August 13, 2024

Chapter 2, Unit 6: The BlueCard Program

- In **2.6 Contiguous County Contracting** and **Overlapping County Contracting**, updates were made to reflect all of the Highmark regions in which another Blues Plan operates. Language was also added to provide clarity on claims submission.

August 8, 2024

Chapter 5, Unit 1: Care Management Overview

- In **5.1 Enhanced Community Care Management (ECCM)**, the program description was updated.
  - NOTE: This section was also updated to remove West Virginia as an applicable state. ECCM is only available in Delaware and Pennsylvania.

July 19, 2024

Chapter 1, Unit 2: Online Resources & Contact Information

- In **1.2 Mailing Addresses**, "Claims Filing Addresses" documents that were linked under the CLAIMS FILING ADDRESSES heading were removed. That information is now included in tables in that

section.

- NOTE: The newly added tables include Federal Employee Program (FEP) addresses. For that reason, the FEP addresses were removed from **1.2 Contact Information**, which now includes language referring providers to **1.2 Mailing Addresses**.

Chapter 2, Unit 2: Medicare Advantage Products & Programs

- In **2.2 Highmark Medicare Advantage Products**, the following changes were made:
  - Separated the NENY Medicare Advantage PPO network from the Freedom Blue PPO network, which is in Delaware, Pennsylvania, and West Virginia.
  - Replaced the Senior Blue HMO network with the NENY Freedom HMO network for Northeastern New York.
  - Added the Together Blue HMO network in Western Pennsylvania.
  - Corrected the name of Western New York's WNY Medicare Advantage HMO.
  - Corrected the coverage of WNY Forever Blue PPO to only cover Western New York's service area.

Chapter 3, Unit 2: Professional Provider Credentialing

- In **3.2 Highmark Network Credentialing Policy**, a link to Reimbursement Policy (RP)-068 was added to the ADVANCED PRACTICE PROVIDER (APP) ENUMERATION section.

Chapter 4, Unit 2: Behavioral Health Providers

- In **4.2 General Information**, the Behavioral Health contact information, including both fax and phone numbers, was updated for all Highmark service regions.

Chapter 5, Unit 4: Behavioral Health

- In **5.4 Retrospective Review**, the Retrospective Review mailing address for mental health and substance use disorder treatment was updated for Delaware, Pennsylvania, and West Virginia.

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- **In 5.5 Expedited Provider Appeal Process**, the phone number to initiate an expedited provider appeal was updated for Delaware, Pennsylvania, and West Virginia.
- In **5.5 Standard Provider Appeal Process**:
  - The phone number to initiate a standard provider appeal was updated for Delaware, Pennsylvania, and West Virginia.
  - The mailing address for Behavioral Health Services (all service areas) was updated for post-service appeals and Federal Employee Program (FEP) provider appeals.

Chapter 6, Unit 3: Facility (UB-04/8371) Billing

- In **6.3 Present on Admission/Adverse Events**, a link to RP-036 was added to the REIMBURSEMENT POLICY RP-036 section.

Relinquishment of Washington County, Ohio

Highmark Blue Cross Blue Shield in West Virginia relinquished the Washington County, Ohio, service area. The change — which was requested by Highmark — was approved by the Blue Cross Blue Shield Association (BCBSA) in November 2023.

For this reason, references to Washington County, Ohio, were removed from the following areas of the manual:

- **1.1 About Highmark**
- **1.2 Highmark Websites** (PUBLIC WEBSITES section)
- **2.1 Introduction** (HIGHMARK'S CORPORATE ENTITIES section)
- **3.1 Directing Care to Network Providers** (LOCATING NETWORK PROVIDERS section)

July 1, 2024

Chapter 6, Unit 3: Facility (UB-04/8371) Billing

- In **6.3 Outpatient Services Prior To An Inpatient Stay**, a link to Reimbursement Policy (RP)-039 was added to the REIMBURSEMENT POLICY RP-039 section.

Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips

- In **6.4 Modifiers**:
  - A link to RP-001 was added to the ASSISTANT AT SURGERY: MODIFIERS 80, 81, 82, & AS section.
  - A link to RP-002 was added to the CO-SURGERY: MODIFIER 62 section.
- In **6.4 Anesthesia Reporting Tips**, a link to RP-033 was added to the MEDICAL DIRECTION (SUPERVISION) OF ANESTHESIA REPORTING/PAYMENT* section.
- In **6.4 Reporting Mid-Level Provider Services for Medicare Advantage (PA and WV Only)**, links to RP-001, RP-010, and RP-068 were added to the REIMBURSEMENT FOR SERVICES PERFORMED BY MID-LEVEL PROVIDERS section.

June 28, 2024

Effective July 1, 2024, West Virginia Law (Senate Bill 267) mandates the electronic submission of prior authorization requests. For this reason, fax references related to prior authorization for West Virginia were removed from the *Highmark Provider Manual*.

June 20, 2024

Chapter 5, Unit 1: Care Management Overview

- In **5.1 High-Risk Maternity (NY Only)**, the following changes occurred:
    - A link to the New York State Department of Health prenatal assessment form *(which only applies to Highmark Blue Cross Blue Shield members in Western New York)* was provided.
    - The phone number for Interventions for High-Risk Patients was updated to 800-871-5531.
    - The hyperlink for the Health Commerce System was updated.
    - Under the LABORATORY REPORTING REQUIREMENTS section, language was updated to align with recent changes made to **5.1 Practice Guidelines and Standards of Care for HIV (NY Only)**.
        - The email for reporting required data elements was updated to BHAELab@health.ny.gov.
        - The hyperlink for the NYS DOH HIV/AIDS Provider Portal was provided.
    - Additional minor wordsmithing and formatting changes were made.

Chapter 5, Unit 6: Quality Management

- In **5.6 Functional Areas and Their Responsibilities**, the language was updated to reflect that the Senior Medical Director is solely responsible for administration and implementation of the Health Care Quality Improvement Program, as the position of Vice President Health Management has been eliminated.

June 14, 2024

Chapter 3, Unit 2: Professional Provider Credentialing

- In **3.2 Termination from the Networks**, a MEMBER NOTIFICATION section was added to indicate that a provider's patients (who are Highmark members) will automatically be notified via U.S. Mail when that provider is terminated from the Highmark provider network.

Chapter 3, Unit 3: Professional Provider Guidelines

- **3.3 How to Resign from Network Participation** was updated to indicate that providers must use the electronic Request to Terminate a Contracted Network form if they decide to resign from the Highmark provider network. Other methods, including fax, have been eliminated. In addition, when providers decide to resign from the Highmark provider network, their patients — who are Highmark members — will be automatically notified via U.S. Mail.

Chapter 5, Unit 1: Care Management Overview

- In **5.1 Practice Guidelines and Standards of Care for HIV (NY Only)**, there were numerous updates, including:
  - **Lower threshold for recommending HIV testing:** Providers should now adopt a lower threshold for recommending HIV testing, as many patients may not be comfortable disclosing risk factors.
  - **Updated resources:** The manual now includes updated links and contact information for HIV testing resources, including the AIDS Institute NYSDOH Counseling and Testing Resources and the NYSDOH AIDS Institute Resource Directory.
  - **New HIV reporting requirements:** Healthcare providers are now required to report any HIV diagnosis within one day and complete the Medical Provider HIV/AIDS and Partner/Contact Report Form within seven days.
  - **Improved laboratory reporting requirements:** Laboratories are now required to report HIV-related test results with more detailed patient information to improve data quality and linkage to care.
  - **Updated reporting timeframe for suspected seroconversion:** The timeframe for reporting suspected seroconversion has been updated from 14 days to seven days.

Chapter 5, Unit 2: Authorizations

- In **5.2 Authorization Guidelines**, the VENDOR DELEGATION AND OVERSIGHT section was updated, as file audits are now conducted on a monthly, rather than a quarterly, basis.
- In **5.2 Emergency Services**, the following addition was made to the EMERGENCY CARE DEFINED section:
  - "Any condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act, including with respect to a pregnant woman who is having contractions — that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child."

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- In **5.5 Grievances and Appeals (NY Only)**, a few minor changes were made, including correcting a typo on the section title, “APPEALING AN UPHELD DENIAL (LEVEL II).”

May 30, 2024

Chapter 6, Unit 1: General Claim Submission Guidelines

- **6.1 Self-Funded Accounts**, which had been specific to West Virginia, was updated to be applicable to all Highmark service regions.

May 15, 2024

Chapter 3, Unit 2: Professional Provider Credentialing

- In the ADMITTING AND CLINICAL PRIVILEGE REQUIREMENTS section of **3.2 Highmark Network Credentialing Policy**, “Hospice & Palliative medicine” was added to the list of specialties for which the hospital clinical privilege requirement is waived.
- In the ADDITIONAL BEHAVIORAL HEALTH SPECIALTIES CRITERIA section of **3.2 Credentialing Requirements for Behavioral Health**, “licensed” was added to the requirements for the specialty of *Marriage and Family Therapist*.

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- The information in the following sections was updated to include Delaware as an applicable region:
  - **5.5 Medicare Advantage: Provider Appealing on Own Behalf (DE, PA, and WV Only)**
  - **5.5 Medicare Advantage: Appeals on Behalf of a Member (DE, PA, and WV Only)**

Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips

- In **6.4 Anesthesia Reporting Tips**, the language was updated to align with *Reimbursement Policy 033 (RP-033): Anesthesia Services*. The Physical Status Units table was enhanced, while the section on Modifying Units was eliminated.

May 6, 2024

All references to naviHealth in the Provider Manual have
been changed to Home & Community Care Transitions to reflect the company's name change. Home &

Community Care Transitions is a third-party vendor used by Highmark for post-acute care services for Highmark's Medicare Advantage members in Pennsylvania and West Virginia.

April 26, 2024

Highmark finalized changes to the Provider Manual related to the provider portal transition from NaviNet and HEALTHeNET (NY) to Availity. NaviNet and HEALTHeNET (NY) access for providers ended on April 26, 2024.

April 19, 2024

Chapter 2, Unit 6: The BlueCard Program

- In **2.6 Itemized Bills Required for High-Dollar Host Claims**, the amount considered a high-dollar claim was changed from “$100,000 or greater” to “$50,000 or greater.”
- In **2.6 NAIC Codes**, changes were made to the PENNSYLVANIA NAIC CODE PROVIDER TYPE PRODUCTS table to align with information in **Chapter 6, Unit 2: Electronic Claim Submission > 6.2 NAIC Codes**. The table was updated to include the following information:
  - For **54771W,** the Northeastern region was added.
  - For both **54771W** and **54771**, prefixes were added to these products:
    - Medicare Advantage Security Blue HMO-POS (prefixes JOF, JOL)
    - Together Blue Medicare HMO (prefix K9P)
    - Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company (prefixes ZPM, KHC)
  - For **54771C**, prefixes (ZPM, KHC) were added to Medicare Advantage Community Blue Medicare HMO administered by Highmark Choice Company.
  - **54771S** for Southeastern region facility type providers (UB-04/837I) was added.
  - For **15460,** this product was added:
    - Medicare Advantage Complete Blue PPO (prefix C4K)
  - Minor wordsmithing changes were made to both the **2.6 NAIC Codes** and **6.2 NAIC Codes** sections of the *Highmark Provider Manual*.

Chapter 3, Unit 2: Professional Provider Credentialing

- In **3.2 Highmark Network Credentialing Policy**, the ADVANCED PRACTICE PROVIDER (APP) ENUMERATION section was updated to point providers to *Reimbursement Policy 068 (RP-068): Mid-*

Level Practitioners and Advanced Practice Providers for more information instead of *Reimbursement Policy 010 (RP-010)*.

Chapter 5, Unit 4: Behavioral Health

- In **5.4 Retrospective Review**, the address for New York's Utilization Management Appeals Unit was updated in the table in the MAILING ADDRESS section.

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- In **5.5 Standard Provider Appeal Process**, the address for New York's Utilization Management Appeals Unit was updated in the table in the MAILING ADDRESSES section.
- In **5.5 Filing an Appeal on Behalf of the Member**, the address for New York's Utilization Management Appeals Unit was updated in the table in the WRITTEN REQUESTS section.

Chapter 5, Unit 6: Quality Management

- In **5.6 Quality Management Program Overview**, the ORGANIZATIONAL STRUCTURE section was updated to reflect current functional areas of the Quality Management Program. In addition, the OVERALL OBJECTIVES OF THE QUALITY PROGRAM section was updated with appropriate language.
- In **5.6 Highmark Quality Program Committees**, the CARE MANAGEMENT AND QUALITY COMMITTEE (CMQC) section was updated to add clarification that the committee represents "western and northeastern" New York.
- In **5.6 Functional Areas and Their Responsibilities**, the CLINICAL SERVICES – QUALITY section was updated with current department names and responsibilities for each area.
- In **5.6 Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations**, "Representatives" replaced "Management Analysts" in the following sentence in the PRACTICE SITE RESOURCES section: *The Practice Site Resources materials are used by Highmark Clinical Quality Representatives to educate the practitioner office designees when performing office site and medical record documentation reviews.*

Chapter 6, Unit 2: Electronic Claim Submission

- In **6.2 NAIC Codes**, minor wordsmithing changes were made to align with information in **Chapter 2, Unit 6: The BlueCard Program > 2.6 NAIC Codes**.

February 21, 2024

Chapter 2, Unit 2: Medicare Advantage Products & Programs

- **In 2.2 House Call Program,** information regarding the House Call program was updated, including:
  - The program is available to members in Highmark's Affordable Care Act and Medicaid lines of business — not just Medicare Advantage.
  - The participating vendors were updated.

Chapter 2, Unit 6: The BlueCard Program

- **In 2.6 NAIC Codes,** New York state information was added, including NAIC Code 55204, as well as claim submission procedures for Empire/Anthem and Excellus members when treated by Highmark providers.

Chapter 6, Unit 1: General Claim Submission Guidelines

In 6.1 Timely Filing Requirements, the New York Timely Filing Policy section was updated. Language was clarified to emphasize that all initial claims (original bill type) must be submitted within 365 days, including weekends, from the date of service/discharge. In addition, all corrected claim submissions (bill type ending in 7) must be received within 365 days from the last date of processing of the original claim submission, including weekends.

Chapter 6, Unit 2: Electronic Claim Submission

In 6.2 Submitting Claims (NY Only), the Claim Adjustment Policy and Exclusions to This Policy sections were removed to align New York with Highmark's overall claim adjustment policy.

Chapter 6, Unit 8: Payment Review

- The following New York-related updates were made:
  - **In 6.8 Financial Investigations and Provider Review (FIPR),** a second New York fraud hotline number was added.
  - **In 6.8 Payment Review Process,** New York was added as part of the participating, preferred, and managed care networks Highmark is required to monitor.
  - **In 6.8 Retroactive Denials and Overpayments,** a New York Stte Insurance Law section and a Provider Recovery Process section for New York were added.
  - **In 6.8 Post-Payment Dispute Resolution Process – Appeals and External Reviews:**
    - The Appeal Rights in New York section was updated.
    - Information on New York member appeal rights was removed, as similar content is available in **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals.**

January 29, 2024

Chapter 2, Unit 5: Telemedicine Services

- Throughout this unit, all references to Doctor on Demand were removed, as the vendor's relationship with Highmark ended on December 31, 2023. Other telemedicine services provided by Amwell — along with the applicable member benefit — were added to this section, including:
  - Urgent Care within the Telemedicine Service Benefit
  - Behavioral Health within Outpatient Mental Health
  - Primary Care under PCP/Physician Office Visit
  - Dermatology under Specialist Office Visit
  - Women's Health
    - Medical Care under Telemedicine Service
    - Therapy under Outpatient Mental Health
    - Lactation under Preventive Adult Care

Chapter 3, Unit 1: Network Participation Overview

In 3.1 Introduction to Network Participation, the **Additional Providers Eligible in NY** section was updated to add the following:

Effective January 1, 2024, Licensed Mental Health Counselors (LMHC) are also eligible in Medicaid and Medicare Advantage networks.

Effective January 1, 2024, Psychoanalysts with a Psychoanalyst license are eligible in all commercial networks.

- **In 3.1 Promise Enrollment Required for Pennsylvania Chip, the Your Promise ID Is Automatically Added to Highmark's Provider File** section was revised to reflect that practitioners no longer need to update their Promise ID with Highmark, as Promise ID updates are submitted electronically to Highmark by the Pennsylvania Department of Human Services.

Chapter 3, Unit 2: Professional Provider Credentialing

- In **3.2 Highmark Network Credentialing Policy,** the following changes were made:
  - **Types of Professional Providers Credentialed section:**
    - Licensed Dietitian – Nutritionists are not eligible for NY Medicaid.
    - Licensed Psychoanalysts are recognized by Highmark as a credentialed allied health professional in New York only.

- Under **24/7 Availability Requirements,** the following specialties were added as exempt:
  - Certified Diabetic Educators
  - Massage therapists
  - Psychologists who perform neuropsychological testing or psychological evaluations only
  - Read-only practitioners
- **Availability for Urgent and Routine Care** section:
  - Requirement for a minimum of 20 office hours a week — when not joining an existing group network — only applies to networks in Pennsylvania.
  - PCP practices in Pennsylvania not meeting this requirement will be subject to an on-site review every three years and will be noted in the provider directory as having limited hours.
- The **Time Frame – Highmark West Virginia Participating Practitioners** section was removed, as it is no longer a requirement for West Virginia.
- A **Time Frame – Massachusetts** section was added.
- In **3.2 The Credentialing Process,** the following change was made:
  - Under **Steps in The Initial Credentialing Process,** Step 4 was updated to remove the following from the list of what the Credentialing Department will review applications for:
    - Ability to enroll new members.
    - Office hour availability of at least 20 hours/week (PCP)
- In **3.2 Credentialing Requirements for Behavioral Health,** the following changes were made:
  - A **Licensed Psychoanalyst** section was added. Effective January 1, 2024, psychoanalysts must be licensed as a psychoanalyst in New York.
  - Under **Additional Behavioral Health Specialties Criteria,** "Behavioral Analysts/Behavioral specialists licensed or certified per state regulation" was added.
- In **3.2 Practitioner Quality and Board Certification,** under Highmark Recognized Boards for Certification, National Board of Physicians and Surgeons (NBPAS) was added.

Decmber 15, 2023

The Quick Reference/Contact Guide was updated to include Provider Service and Clinical Service numbers for our Southeastern Pennsylvania (SEPA) region. The NAIC code for SEPA facility claims was also added to the following sections of the manual:

- **Chapter 2, Unit 6: The BlueCard Program - NAIC Codes**
- **Chapter 2, Unit 6: The Bluecard Program - BlueCard Quick Tips**
- **Chapter 6, Unit 2: Billing & Payment - Electronic Claim Submission - NAIC Codes**

The new NAIC code was communicated to providers via Special Bulletin on November 30, 2023.

December 8, 2023

Chapter 2, Unit 4: Benefit Plan Programs

- Mentions of the vendor Sharecare and its offering, The RealAge® Test, were removed from the **2.4 Health Promotion Programs** section due to the relationship with Highmark ending on December 31, 2023. As part of this change, the **2.4 Highmark Wellness Rewards** section was also removed.

Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals

- In response to Pennsylvania Acts 146 and 68, grievance processes and nomenclature have been updated throughout this unit.

December 4, 2023

Information related to WholeHealth Living, a Tivity Health company, was removed from the Highmark Provider Manual because utilization management of physical medicine services is now managed by Highmark.

For more information, read our Special Bulletin **and** Frequently Asked Questions.

December 1, 2023

Chapter 5, Unit 2: Authorizations

- Changes were made throughout the **5.2 West Virginia Gold Card Program** section due to West Virginia Senate Bill 267.
  - West Virginia Senate Bill 267 requires prior authorizations to be submitted via an electronic portal. For more information on the bill, visit https://www.wvlegislature.gov.

November 30, 2023

Chapter 7, Unit 6: Professional Regulations

The Highmark Blue Shield Regulations for Participating Providers, PremierBlue Shield Providers and Government Sponsored Program Providers were updated. The Highmark Professional Provider Agreement Regulations were added with an effective date of January 1, 2024.

November 17, 2023

Chapter 2, Unit 1: Product Overview

- In the **2.1 Value-Based Benefits (DE, PA, WV Only)** section, the following changes were made:
  - "Depression" was removed from under **Targeted Conditions.**
  - Under **Program Options Continue To Expand,** a paragraph that referenced outdated "packages" was deleted.

Chapter 3, Unit 4: Organizational Provider Participation (Facility/Ancillary)

The Organizational Provider Participation, Credentialing, and Contracting Requirements document, which is hyperlinked in **3.4 Participation and Credentialing > Requirements and 3.4 Applications > Facilities and Ancillary Providers,** was updated.

Note: This document is also available on the *Organizational Initial Credentialing Set Up* PRC page (DE, PA, WV) and the *Facility/Ancillary (Organizational) Initial Credentialing Set Up* PRC page (NY).

Chapter 5, Unit 2: Authorizations

In the **5.2 Federal Employee Program (FEP) Prior Authorization Requirements** section, the following changes were made:

- Under **Other Services Requiring Prior Authorization,** a document containing a table that lists FEP services requiring prior authorization or notification was mislabeled as a "Tip Sheet." All references mentioning a Tip Sheet were deleted.

October 27, 2023

Chapter 1, Unit 3: Electronic Solutions: EDI & Availity

- Language was clarified and updated in the following sections:
  - In **1.3 Introduction** under **EDI Services and Availity®**, outdated language regarding vendors and computer equipment was deleted.
  - In **1.3 Electronic Data Interchange (EDI),** the table under **Highmark EDI Services** was updated with electronic transaction ID 275, along with its name.
  - In 1.3 **About Trading Partners** under **Trading Partner Types,** language was added that emphasized the importance of keeping provider and trading partner contact information updated.

- In **1.3 Getting Started with Electronic Claim Submission** under **Selecting A Practice Management System Vendor,** outdated language regarding computer equipment was removed.

Chapter 1, Unit 4: Highmark Member Information

- In **1.4 Member Access to Physicians and Facilities:**
  - Under **Accessibility Expectations for Providers:**
    - The table for **PCP and Medical Specialist Expectations** was updated to reflect that on-call arrangements with another Highmark credentialed participating practitioner is acceptable for after-hours care.
    - The table for **Behavioral Health Specialist Expectations** includes updated language for after-hours care that allows for a referral to a crisis line/center if prior arrangement has been made to reach the provider. This change applies to all four states in Highmark's footprint.
- The table under **Acceptable After-Hours Methods** reflects the change that an answering service — in addition to paging providers — can also transfer after-hours calls to them or another clinical staff person.

Chapter 2, Unit 6: The BlueCard Program

In the **2.6 NAIC Codes** section, the **Pennsylvania NAIC Code Provider Type Products** table was updated to include the product prefix — Medicare Advantage Complete Blue PPO (Prefix C4K) — for code **15460.**

Chapter 4, Unit 1: PCPs and Specialists

- In the **4.1 PCP and Medical Specialist Accessibility Expectations** section:
  - Under **Accessibility Expectations for Providers,** the table for **PCP and Medical Specialist Expectations** was updated to reflect that on-call arrangements with another Highmark credentialed participating practitioner is acceptable for after-hours care. This applies to all Highmark regions, including those in New York.
    - Similar changes were made to the table under **Acceptable After-Hours Methods.**

Chapter 4, Unit 2: Behavioral Health Providers

- In the **4.2 Accessibility Expectations** for Behavioral Health section:
  - Under **Accessibility Expectations,** the table for **Behavioral Health Provider Expectations** includes updated language for after-hours care that allows for a referral to a crisis line/center if prior arrangement has been made to reach the provider. This change applies to all four states in Highmark's footprint.
    - Similar changes were made to the table under **Acceptable After-Hours Methods.**

October 23, 2023

Highmark has started to make changes to the Provider Manual as part of the transition from NaviNet to Availity. Changes will continue through the transition period.

October 12, 2023

Chapter 7 – Appendix

- **Chapter 7, Unit 6: Professional Regulations** – which includes a link to the following document: Highmark Blue Shield Regulations for Participating Providers, PremierBlue Shield Providers and Government Sponsored Program Providers – was added to the *Highmark Provider Manual.* This was done to increase visibility of the document, originally published to the Provider Resource Center in a January 8, 2020, communication.

October 6, 2023

Chapter 1, Unit 4: Highmark Member Information

- In **1.4 Confidentiality of Member Information,** a **Confidentiality of Provider and Member Information and Medical Records** section was added for New York.

Chapter 5, Unit 6: Quality Management

- In **5.6 Clinical Quality,** a **Medical Record Review** section was added for New York.

Chapter 6, Unit 2: Electronic Claim Submission

- The **6.2 Submitting Claims (NY Only)** section was updated under **Claim Adjustment Policy.** The policy for New York was clarified to reflect that providers have 365 days from the date of service, rather than end of the calendar year, to request an adjustment or submit a correction on a claim.

September 21, 2023

Chapter 1, Unit 4: Highmark Member Information

- In the **1.4 Confidentiality of Member Information** section, the following language regarding robocalls to our call centers was added: "Highmark Inc. and its affiliated companies do not release information to artificial intelligence agencies. We will be glad to provide the information needed to the

appropriate human stakeholders. Please have a human use our self-service tools available at highmark.com, through our provider portal, or call Customer Service for any information needed."

Chapter 6, Unit 1: General Claim Submission Guidelines

In the 6.1 Top Billing Errors – **And How to Avoid Them** section, minor changes were made to the table under **Common Claims Reporting Errors.** Those changes include spelling out acronyms and updating the years used in examples.

September 5, 2023

Chapter 6, Unit 2: Electronic Claim Submission

- In the **6.2 NAIC Codes** section under **New York,** clarifying language was added for claims submitted on behalf of Empire/Anthem members who are seen in the following counties: Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington. These counties comprise the 13 counties of the Highmark Blue Shield of Northeastern New York service region.

August 24, 2023

Chapter 2, Unit 6: The BlueCard Program

- In the 2.6 NAIC Codes section, the **Pennsylvania NAIC Code Provider Type Products** table was updated. Prefixes were added to the following products for facility and other providers in Central and Western Pennsylvania:
  - Medicare Advantage Security Blue HMO-POS (prefixes **JOF, JOL**)
  - Medicare Advantage Community Blue Medicare HMO (prefixes **ZPM, KHC**)
  - Together Blue Medicare HMO administered by Highmark Choice Company (prefix **K9P**)

Chapter 3, Unit 2: Professional Provider Credentialing

- In the **3.2 Highmark Network Credentialing Policy** section, language under **24/7 Availability Requirements** was updated to reflect that a referral to a crisis line/center is acceptable as long as the provider or his/her designee can be reached.
- In the **3.2 Credentialing Requirements For Facility-Based Providers** section under **Facility-Based Practitioner Credentialing Policy,** updates were made to the credentialing policy for facility-based practitioners and include the following changes:
  - **In-Network Credentialing:** The following types of facility providers must be currently credentialed by an in-network skilled nursing facility, ambulatory surgery center, inpatient

hospital, and/or inpatient freestanding facility setting:

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

- **Out-of-Network:** To provide medical services to members outside of a network-participating facility, practitioners will be required to complete the initial credentialing and contracting processes.

Chapter 3, Unit 4: Organizational Provider Participation (Facility/Ancillary)

In the **3.4 Urgent Care Centers/Medical Aid Units** section, language under **Billing Guidelines** was updated to reflect that Federal Employee Program members do **not** have coverage for code S9088.

Chapter 6, Unit 2: Electronic Claim Submission

- In the **6.2 NAIC Codes** section:
  - The **Pennsylvania** table was updated. Prefixes were added to the following products for facility and other providers in Central Region and Western and Northeastern Regions:
    - Medicare Advantage Security Blue HMO- POS (prefixes **JOF, JOL**)
    - Medicare Advantage Community Blue Medicare HMO (prefixes **ZPM, KHC**)
    - Together Blue Medicare HMO administered by Highmark Choice Company (prefix **K9P**)
- The **New York** table was updated. Plan codes were eliminated from the table. The remaining code is NAIC Code **55204.**Language was clarified for claims submitted on behalf of Excellus members who live in the following four counties that were specified in this update: Clinton, Essex, Fulton, and Montgomery.

July 26, 2023

Chapter 5, Unit 1: Care Management Overview

- In the **5.1 Introduction to Care Management section**, “Wellness” replaced “Health Promotion (except in New York)” in a bulleted list of core services.
- In the **5.1 High-Risk Maternity (NY Only)** section:
  - Under **Benefits for Physicians,Mothers and Their Babies,** a link to the Preventive Health Guidelines page of the Provider Resource Center was added. There, the High-Risk Maternity

clinical practice guidelines are included in the Prenatal/Perinatal Care Preventive Health Guidelines.
    - Under **Postpartum Visit Components,** links for supporting documentation were updated.
- In the **5.1 Practice Guidelines and Standards of Care for HIV (NY Only)** section
    - Under **Aids Institute Nysdoh Counseling and Testing Resources,** the phone number for HIV Counseling was updated.
    - Under **Pregent Women and Exposed Infans Lost-to-Care Require Immediate Action for Re-Engagement,** the phone number for the New York State Department of Health Perinatal HIV Prevention Program was updated.

Chapter 5, Unit 2: Authorizations

- In the **5.2 Authorization Request Process** section:
    - Under **Home-Health Authorization Requests,** the language was updated to reflect that authorization procedures for Delaware, Pennsylvania, and West Virginia are the same for each region. Previous language gave the appearance that there were different regional procedures.
    - Under **Telephone Requests**, the contact information was updated. Professional providers should use the phone numbers for the appropriate Medicare Advantage program.

Chapter 5, Unit 6: Quality Management

- In the **5.6 Functional Areas and Their Responsibilities** section, the committee list under **QI Committee Structure** (for providers in New York) was updated to include Highmark Inc./Highmark NY Utilization Management Master Service Agreement (MSA) Joint Oversight, and Network Quality and Credentials Committee.
- In the **5.6 Case Review Process for Quality Concerns** section, language under **Important!** (for providers in New York) was updated to: “Members are able to make clinical quality of care complaints to the health plan.”
- In the 5.6 **Clinical Quality** section under **Condition Management Program**,HIV/AIDS was added to the list of chronic conditions for which members are eligible to receive health coaching.

July 20, 2023

Chapter 4, Unit 1: PCPs and Specialists

- The **4.1 PCP And Medical Specialist Accessibility Expectations** section was updated under **Accessibility Expectations for Providers.**For Urgent Care Appointments, the Performance Standard was changed from “Office visit within 1 day (24 hours)” to “Immediate response” in the PCP and Medical Specialist Accessibility Expectations table.

June 23, 2023

Chapter 4, Unit 2: Behavioral Health Providers

- The **4.2 General Information** section was updated under **Contact Information**. The contact information for Highmark Behavioral Health (BH) Services was updated to include a fax number for Delaware (DE), Pennsylvania (PA), and West Virginia (WV). In addition, Highmark BH Services no longer offers Sunday hours of operations.

Chapter 5, Unit 4: Behavioral Health

- The **5.4 General Information** section was updated under **Contact Information.** The contact information for Highmark Behavioral Health (BH) Services was updated to include a fax number for Delaware (DE), Pennsylvania (PA), and West Virginia (WV). In addition, Highmark BH Services no longer offers Sunday hours of operations.
- The **5.4 Services Requiring Authorization** section was updated under Inpatient Service. The bullet point for inpatient rehabilitation was updated to include "mental health treatment."
- The **5.4 Authorization Requests** section was updated under **NaviNet® Authorization Request SubmissionRequired** (applicable to providers in DE, PA, and WV) to include the following language: "However, if NaviNet is unavailable or the facility is not NaviNet-enabled, authorization reviews can be initiated by calling Highmark Behavioral Health Services at 1-800-258-9808 or faxing 1-877-650-6112."

Chapter 6, Unit 2: Electronic ClaimSubmission

- The **6.2 Submitting Claims (NY Only)** section was updated under **Claim Adjustment Policy.** The policy for New York was corrected to reflect that providers have 365 days, rather than 180 days, to file a claim adjustment request. This policy was implemented on January 1, 2022.

June 7, 2023

The section on **Additional Diagnostic Code Reporting (New York Only)** of Chapter 6, Unit 1 (General Claim Submission Guidelines) was updated to include a qualifying statement within the subsection on Sleep Studies noting that for Chemotherapy, Transfusion, Cast Room, Infusion Therapy and Treatment Rooms - the service could pay up to $50 per day for a room charge.

This qualifying statement was in the Provider Manual on the HealthNow provider websites, but was inadvertently omitted when transitioned to the Highmark Provider Resource Center websites.

May 24, 2023

The section on **High-Risk Maternity - NY Only** of Chapter 5, Unit 1 (Care Management Overview) was updated to include additional guidance under Interventions for High-Risk Patients. The following language was added: "After a total of no more than two (2) missed prenatal or one post-partum visit by the member, providers can call for Case Management assistance to request active member outreach at **877-878-8785** Monday through Friday 8 a.m. to 5 p.m. EST."

May 23, 2023

The new web-based *Highmark Provider Manual* was published on May 23, 2023.

Disclaimers

All revisions to this Highmark Provider Manual (the “manual” or “Highmark Provider Manual”) are controlled electronically. All paper copies and screen prints are considered uncontrolled and should not be relied upon for any purpose.